

CHAPTER 632

INSURANCE CONTRACTS IN SPECIFIC LINES

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

NOTE: Chapter 375, laws of 1975, which created subchapters I to VIII of Chapter 632 of the statutes, contains notes explaining the revision.

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.

Where spouses owned and insured property jointly, arson by husband did not bar wife from recovering fire insurance proceeds. *Hedtcke v. Sentry Ins. Co.* 109 W (2d) 461, 326 NW (2d) 727 (1982).

Insured's past rental of property did not preclude recovery under (2). *Kohnen v. Wisconsin Mut. Ins. Co.* 111 W (2d) 584, 331 NW (2d) 598 (Ct. App. 1983)

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 mortgagee 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.

632.10 Definitions applicable to property insurance escrow. In ss. 632.10 to 632.104:

(1) "Building and safety standards" means the requirements of chs. 101 and 145 and of any rule promulgated by the department of industry, labor and human relations under ch. 101 or 145, and standards of a 1st class city relating to the health and safety of occupants of buildings.

(2) "Deliver" means delivery in person, or delivery by deposit with the U.S. postal service of certified or 1st class mail addressed to the recipient at the recipient's last-known address.

(3) "Final settlement" means the amount that an insurer owes under a property insurance policy to the named insured and other interests named in the policy for loss to any insured building or other structure affixed to land that is caused by fire or explosion, excluding any amount payable for loss to contents or other personal property, for loss of use or business interruption and any amount payable under liability coverage under the policy, and that is determined by any of the following means:

- (a) Acceptance of a proof of loss by the insurer.
- (b) Execution of a release by the named insured.
- (c) Acceptance of an arbitration award by the insurer and named insured.
- (d) Judgment of a court of competent jurisdiction.

History: 1989 a 347

632.101 Policy terms. (1) **AFFECTED POLICIES.** Except as provided in sub. (2), every property insurance policy issued or delivered in this state, including property insurance policies issued under the mandatory risk-sharing plan operating under s. 619.01, that insures real property located in a 1st class city against loss caused by fire or explosion shall provide for payment of any final settlement under the policy in the manner described in ss. 632.102 to 632.104.

(2) **EXCLUDED POLICIES.** Sections 632.10 to 632.104 do not apply to property insurance policies issued in any of the following circumstances:

(a) By the local government property insurance fund under ch. 605.

(b) On a one- or 2-family dwelling that is occupied by the named insured as a principal residence, if any of the following is satisfied:

1. The named insured gives proof of occupancy to the insurer by a valid Wisconsin operator's license.

2. If the named insured does not possess a valid Wisconsin operator's license, the named insured gives proof of occupancy to the 1st class city by documentation approved by the 1st class city. Upon acceptance of the proof, the 1st class city shall immediately notify the insurer that a policy issued on the property is exempt from ss. 632.10 to 632.104.

History: 1989 a 347; 1991 a 315

632.102 Payment of final settlement. (1) **WITHHOLDING.** An insurer shall withhold from payment a portion of the final settlement as determined under sub. (2), if all of the following apply:

(a) The amount of the final settlement exceeds 50% of the total of all limits under all insurance policies covering the building and any other structure affixed to land that sustained the loss.

(b) The total amount of all insurance covering the building and any other structure affixed to land that sustained the loss is at least \$5,000.

(2) **AMOUNT WITHHELD.** The insurer shall withhold from payment of the final settlement an amount that is equal to the greater of the following:

(a) Twenty-five percent of the final settlement.

(b) The lesser of \$5,000 or the limits under the policy for coverage of the building or other structure affixed to land that sustained the loss.

(3) **NOTICE OF WITHHOLDING.** (a) Within 10 days after withholding the amount determined under sub. (2), the insurer shall deliver written notice of the withholding to all of the following persons:

1. The building inspection official of the 1st class city in which the insured real property is located.

2. The named insured.

3. Any mortgagee or other lienholder who has an existing lien against the insured real property and who is named in the policy.

4. If the final settlement was determined by judgment, the court in which the judgment was entered, in addition to the persons described in subs. 1. to 3.

(b) The notice of withholding shall include all of the following information:

1. The identity and address of the insurer.

2. The name and address of the named insured and each mortgagee or other lienholder entitled to notice under par. (a) 3.

3. The address of the insured real property.

4. The date of loss, policy number and claim number.

5. The amount of money withheld.

6. A summary of ss. 632.10 to 632.104, including a statement explaining all of the following:

a. That for the 1st class city to qualify for reimbursement of expenses from the funds withheld under this section, the 1st class city must, after the loss occurs but within 90 days after delivery of the notice of withholding under this subsection, commence proceedings under s. 66.05, 254.595 or 823.04 or under a local ordinance relating to demolition or abatement of nuisances or obtain a release signed by the named insured consenting to demolition with respect to the building or other structure; that if the 1st class city commences the proceedings or obtains the release within that time period, a part or all of the withheld funds may be used to defray the 1st class city's expenses; and that the withheld funds will be released to the named insured and other interests named in the policy if the 1st class city does not commence the proceedings or obtain the release within that time period.

b. That the withheld funds may be released to the named insured and other interests named in the policy if an official of the 1st class city determines under s. 632.103 (3) that the building or other structure has been repaired or replaced or the site restored to a dust-free and erosion-free condition.

(4) **INSURER'S LIABILITY.** In no event may an insurer be liable under a policy subject to ss. 632.10 to 632.104 for any amount greater than the lesser of the final settlement or the limits of liability set out in the policy.

(5) **IMMUNITY FOR INSURER.** No cause of action may arise against and no liability may be imposed upon an insurer or an agent or employe of an insurer for paying, withholding or transferring all or any portion of a final settlement as provided in ss. 632.10 to 632.104.

History: 1989 a 347; 1993 a 27.

632.103 Procedure for payment of withheld funds.

(1) **RELEASE TO 1ST CLASS CITY.** (a) To qualify for reimbursement of expenses under sub. (2), the 1st class city must do any of the following:

1. Commence proceedings under s. 66.05, 254.595 or 823.04 or under a local ordinance relating to demolition or abatement of nuisances, with respect to the building or other structure for which the funds are withheld.

2. Obtain a release signed by the named insured consenting to demolition of the building or other structure with respect to which the funds are withheld.

(b) The 1st class city shall commence proceedings under par. (a) 1. or obtain the release under par. (a) 2. after the occurrence of the loss to the building or other structure by fire or explosion but

within 90 days after delivery of the notice of withholding under s. 632.102 (3).

(c) When proceedings described in par. (a) 1 are commenced, the 1st class city shall notify, in writing, the insurer, the named insured and any mortgagee or other lienholder identified in the notice of withholding under s. 632.102 (3) (b) 2. that the proceedings are commenced.

(d) The 1st class city shall release all interest in the amount withheld under s. 632.102 (2) and the insurer shall promptly pay that amount to the named insured and other interests named in the policy if any of the following occurs:

1. The 1st class city fails to commence proceedings described in par. (a) 1. or obtain a release described in par. (a) 2. within the period provided in par. (b).

2. The 1st class city fails to notify the insurer as provided in par. (c).

(2) **REIMBURSEMENT OF EXPENSES.** (a) If the 1st class city satisfies sub. (1) (a) and (b) and, if applicable, notifies the insurer as required in sub. (1) (c), the insurer shall promptly upon receiving the statement under par. (b) deliver to the 1st class city funds withheld from the named insured's final settlement under s. 632.102 (2), to the extent necessary to reimburse the 1st class city for any of the following expenses:

1. Costs incurred in the course of enforcing s. 66.05 or a local ordinance relating to demolition, with respect to the building or other structure for which the funds are withheld.

2. Costs incurred in acting in accordance with a release signed by the named insured consenting to demolition of the building or other structure with respect to which the funds are withheld.

3. Costs incurred in abating a public nuisance under s. 254.595 or 823.04 or under a local ordinance relating to abating a public nuisance, with respect to the building or other structure for which the funds are withheld.

4. Reasonable administrative expenses incurred in connection with activities described in subds. 1. to 3., including but not limited to expenses for inspection, clerical, supervisory and attorney services.

(b) The insurer may not release any withheld funds to the 1st class city under par. (a) unless the 1st class city delivers to the insurer and the named insured an itemized statement of the actual costs incurred under par. (a) 1. to 4.

(c) The insurer shall promptly deliver to the named insured and other interests named in the policy any portion of the withheld funds that are not released to the 1st class city under par. (a).

(3) **RELEASE TO NAMED INSURED.** Except as provided in sub. (2), the insurer shall promptly deliver to the named insured and other interests named in the policy the funds withheld from the named insured's final settlement under s. 632.102 (2) if the 1st class city delivers a notice to the insurer that the building inspection official of the 1st class city, or other person who is authorized by the 1st class city's governing body to represent the 1st class city, has inspected the insured real property and verifies any of the following:

(a) That the damaged or destroyed portions of the building or other structure with respect to which the funds are withheld have been repaired or replaced in compliance with applicable building and safety standards, except to the extent that the withheld funds are needed to complete repair or replacement.

(b) That the damaged or destroyed building or other structure with respect to which the funds are withheld and all remnants of the building or other structure have been removed from the land on which the building or other structure was situated and the site has been restored to a dust-free and erosion-free condition in compliance with applicable building and safety standards.

History: 1989 a. 347; 1991 a. 32; 1993 a. 27.

632.104 Funds released to mortgagee. (1) **FIRST MORTGAGE IN DEFAULT.** The insurer shall release to a mortgagee funds withheld under s. 632.102, in an amount and within the

period provided in sub. (2), if all of the following conditions are satisfied:

(a) The mortgagee holds a first mortgage on the real property with respect to which the funds are being withheld, and the mortgage is in default.

(b) The mortgage was executed before March 1, 1991.

(c) The mortgagee delivers to the insurer a written request for release of the funds within 15 days after delivery of the notice of withholding under s. 632.102 (3).

(2) **AMOUNT RELEASED; TIMING.** If sub. (1) is satisfied, the insurer shall release to the mortgagee all or any portion of the funds withheld with respect to the mortgaged property as is necessary to satisfy an outstanding first lien mortgage of the mortgagee. The insurer shall release the funds within 10 days after receiving the request under sub. (1) (c).

History: 1989 a. 347.

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.

632.18 Rustproofing warranties insurance. A policy of insurance to cover a warranty, as defined in s. 100.205 (1) (g), shall fully cover the financial integrity of the warranty.

History: 1985 a. 29.

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.

Excess-of-policy coverage clause in reinsurance agreement constituted a liability insurance contract insuring against tortious failure to settle claim. *Ott v. All-Star Ins. Corp.* 99 W (2d) 635, 299 NW (2d) 839 (1981).

See note to 893.80, citing *Gonzalez v. City of Franklin*, 137 W (2d) 109, 430 NW (2d) 747 (1987).

Insurers must plead and prove their policy limits prior to verdict to restrict the judgment to the policy limits. *Price v. Hart*, 166 W (2d) 182, 480 NW (2d) 249 (Ct. App. 1991).

That policy is one of indemnity rather than liability does not prevent direct action against insurer. *Decade's Monthly Fund v. Whyte & Hirschboeck*, 173 W (2d) 665, 495 NW (2d) 335 (1993).

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).

Insurer's failure to join in insured motorist's petition to remove to federal court necessitated remand to state court. *Padden v. Gallaher*, 513 F Supp. 770 (1981).

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 \$25,000 per person and \$50,000 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 employees 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 employees 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 employees 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 motorcycle as defined in s. 340.01 (32) or a moped as defined in s. 340.01 (29m) if the motorcycle 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 an intoxicant or a controlled substance under ch. 161 or a combination thereof, under the influence of any other drug to a degree which renders him or her incapable of safely driving, or under the combined influence of an intoxicant and any other drug to a degree which renders him or her incapable of safely driving, or any use of the motor vehicle in a reckless manner. In this subdivision, "drug" has the meaning specified in s. 450.01 (10).

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

History: 1975 c. 375, 421; 1979 c. 102, 104; 1979 c. 177 ss. 67, 68; 1979 c. 221; 1981 c. 284; 1983 a. 243, 459; 1985 a. 146 s. 8

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 purporting 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-and-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. *Knigh 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 employee exclusion clause is only valid where tort-feasor and injured party are employees 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).

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).

Sub. (4) (a) 2. b. does not mandate coverage for accident involving insured's vehicle and unidentified motor vehicle when there was no physical contact between the vehicles. *Hayne v. Progressive N. Ins. Co.* 115 W (2d) 68, 339 NW (2d) 588 (1983).

Third parties may recover against insurer even though insured's fraudulent application voided policy under 631.11. *Rauch v. American Fam. Ins. Co.* 115 W (2d) 257, 340 NW (2d) 478 (1983).

See note to 814.025, citing *Radlein v. Industrial Fire & Cas. Ins. Co.* 117 W (2d) 605, 345 NW (2d) 874 (1984).

"Drive other car" exclusion which prohibited stacking of uninsured motorist benefits against same insurer was voided by 631.43. *Welch v. State Farm Mut. Auto. Ins. Co.* 122 W (2d) 172, 361 NW (2d) 680 (1985).

Motor vehicle operated by insured driver was not "uninsured" under (4). *Hemery v. American Fam. Mut. Ins. Co.* 127 W (2d) 304, 379 NW (2d) 860 (Ct. App. 1985).

Reducing clause in uninsured motorist provision was voided by (4) (a). *Nicholson v. Home Ins. Cos.* 137 W (2d) 581, 405 NW (2d) 327 (1987).

Because uninsured motorist coverage is "personal and portable", claimant was covered by policy on vehicle not involved in the accident. *Parks v. Waffle*, 138 W (2d) 70, 405 NW (2d) 690 (Ct. App. 1987).

Loss of consortium isn't separate bodily injury under policy's "each person" limitation. *Landsinger v. American Family*, 142 W (2d) 138, 417 NW (2d) 899 (Ct. App. 1987).

Insurer could not avoid uninsured motorist coverage based on policy provision excluding resident relatives who own their own car. *Hulsey v. American Family Mut. Ins.* 142 W (2d) 639, 419 NW (2d) 288 (Ct. App. 1987).

Reducing clause and "regular use" exclusionary clause violated (4) (a). *Niemann v. Badger Mut. Ins. Co.* 143 W (2d) 73, 420 NW (2d) 378 (Ct. App. 1988).

Auto insurer who pays under uninsured motorist provision is not a tortfeasor or tortfeasor's insurer against whom injured insured's medical insurer may assert subrogation claim. *Employers Health Ins. v. General Cas.* 161 W (2d) 937, 469 NW (2d) 172 (1991).

Policy may expand but not reduce uninsured motorist coverage; policy not statute determines coverage beyond statutory requirements. *Fletcher v. Aetna Casualty & Surety Co.* 165 W (2d) 350, 477 NW (2d) 90 (Ct. App. 1991).

Policy cannot limit uninsured motorist coverage to occupants of vehicles. *St. Paul Mercury Ins. Co. v. Zastrow*, 166 W (2d) 423, 480 NW (2d) 8 (1992).

Where the insurer of a vehicle becomes insolvent, the vehicle is uninsured under sub. (4) (a) 2. even though an insurance guaranty association assumes the liability of the insolvent insurer. *Fritsche v. Ford Motor Credit Co.* 171 W (2d) 280, 491 NW (2d) 119 (Ct. App. 1992).

To take advantage of sub. (5) (c), a policy must include language which either says permissive users are restricted to the minimum statutory limits of liability or that users may not avail themselves of the policy unless there is no other valid collectible insurance. *Carrell v. Wolken*, 173 W (2d) 426, 496 NW (2d) 651 (Ct. App. 1992).

A reducing clause unavailable to a tortfeasor which seeks to reduce uninsured motorist benefits is invalid; reduction for worker's compensation is not allowed. *United Fire & Cas. Co. v. Kleppe*, 174 W (2d) 637, 498 NW (2d) 226 (1993).

Adult members of a named insured's household must be deemed to be capable of giving themselves permission to drive under sub. (5). When the named insured is a corporation and the insurer knows the vehicle is owned by a corporation employee, the owner shall be treated as the named insured under sub. (5). *Home Ins. Co. v. Phillips*, 175 W (2d) 104, 499 NW (2d) 193 (Ct. App. 1993).

Where premium has been paid for underinsured motorist coverage under which no benefits may ever be paid due to the application of policy definitions, the coverage is illusory and against public policy. *Hoglund v. Secura Insurance*, 176 W (2d) 265, NW (2d) (Ct. App. 1993).

Despite policy restrictions to the contrary, under sub. (3) separate coverage must be provided to both a named insured and an additional insured where both are actively negligent. *Iaquinta v. Allstate Ins. Co.* 180 W (2d) 661, 510 NW (2d) 715 (Ct. App. 1993).

When the insurer defines uninsurance as including underinsurance, all case law concerning an insurer's duties and limitations in an uninsurance situation apply. *Sobieski v. Farmers Ins. Exchange*, 181 W (2d) 324, 510 NW (2d) 796 (Ct. App. 1993).

No policy issued pursuant to the ch. 344 financial responsibility statutes may exclude coverage for persons related by blood or marriage to the operator as mandated by s. 632.32 (6) (b) 1. *Bindrim v. Colonial Ins. Co.* 181 W (2d) 799, 512 NW (2d) 209 (Ct. App. 1994).

Sub. (4) (a) does not require the named insured in commercial fleet policies, where the named insured is a corporation or government entity, to be interpreted as including all the entity's employees. *Meyer v. City of Amery*, 185 W (2d) 537, 518 NW (2d) 296 (Ct. App. 1994).

Uninsured motorist coverage: Wisconsin courts open up additional avenues of recovery. *Dunphy*. WBB Nov 1982.

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]

Prejudice is not a component of the defense of noncooperation. *Schaefer v. North-ern Assurance Co.* 182 W (2d) 148, 513 NW (2d) 16 (Ct. App. 1994).

632.35 Prohibited rejection, cancellation and non-renewal. 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.

632.36 Accident in the course of business or employment. (1) **RATE AND OTHER TERMS.** An insurer may increase or charge a higher rate for a motor vehicle liability insurance policy issued or renewed on or after April 16, 1982, on the basis of an accident which occurs while the insured is operating a motor vehicle in the course of the insured's business or employment, only if the policy covers the insured for liability arising in the course of the insured's business or employment. An insurer may issue or renew a motor vehicle liability insurance policy on or after November 1, 1989, on terms that are less favorable to the insured than would otherwise be offered, including but not limited to the rate, because of an accident which occurs while the insured is operating a motor vehicle in the course of the insured's business or employment, only if the policy covers the insured for liability arising in the course of the insured's business or employment.

(2) **CANCELLATION OR NONRENEWAL.** An insurer may cancel a motor vehicle liability insurance policy that is issued or renewed on or after November 1, 1989, or refuse to renew a motor vehicle liability insurance policy on or after November 1, 1989, on the basis of an accident which occurs while the insured is operating a motor vehicle in the course of the insured's business or employment, only if the policy covers the insured for liability arising in the course of the insured's business or employment.

History: 1981 c. 178; 1989 a. 31.

632.365 Use of emission inspection data in setting rates. An insurer may not use odometer reading data collected in the course of an inspection under s. 110.20 (6) or (7) as a factor in setting rates or premiums for a motor vehicle liability insurance policy or as a factor in altering rates or premiums during the term, or at renewal, of such a policy. However, an insurer may use such data as a basis for investigation into the number of miles that the motor vehicle is normally driven.

History: 1991 a. 279; 1993 a. 213.

632.37 Motor vehicle glass repair practices; restriction on specifying vendor. An insurer that issues a motor vehicle insurance policy covering the repair or replacement of motor vehicle glass may not require, as a condition of that coverage, that an insured, or a 3rd party, making a claim under the policy for the repair or replacement of motor vehicle glass obtain services or parts from a particular vendor, or in a particular location, specified by the insurer.

History: 1991 a. 269.

632.38 Nonoriginal manufacturer replacement parts. (1) **DEFINITIONS.** In this section:

(a) "Insured" means the person who owns the motor vehicle that is subject to repair or the person seeking the repair on behalf of the owner.

(b) "Insurer's representative" means a person, excluding the person repairing the motor vehicle, who has agreed in writing to represent an insurer with respect to a claim.

(c) "Motor vehicle" means any motor-driven vehicle required to be registered under ch. 341 or exempt from registration under s. 341.05 (2), including a demonstrator or executive vehicle not titled or titled by a manufacturer or a motor vehicle dealer. "Motor vehicle" does not mean a moped, semitrailer or trailer designed for use in combination with a truck or truck tractor.

(d) "Nonoriginal manufacturer replacement part" means a replacement part that is not made by or for the manufacturer of an insured's motor vehicle.

(e) "Replacement part" means a replacement for any of the nonmechanical sheet metal or plastic parts that generally constitute the exterior of a motor vehicle, including inner and outer panels.

(2) **NOTICE OF INTENDED USE.** An insurer or the insurer's representative may not require directly or indirectly the use of a non-original manufacturer replacement part in the repair of an insured's motor vehicle, unless the insurer or the insurer's representative provides to the insured the notice described in this subsection in the manner required in sub. (3) or (4). The notice shall be in writing and shall include all of the following information:

(a) A clear identification of each nonoriginal manufacturer replacement part that is intended for use in the repair of the insured's motor vehicle.

(b) The following statement in not smaller than 10-point type: "This estimate has been prepared based on the use of one or more replacement parts supplied by a source other than the manufacturer of your motor vehicle. Warranties applicable to these replacement parts are provided by the manufacturer or distributor of the replacement parts rather than by the manufacturer of your motor vehicle."

(3) **DELIVERY OF NOTICE.** (a) The notice described in sub. (2) shall appear on or be attached to the estimate of the cost of repairing the insured's motor vehicle if the estimate is based on the use of one or more nonoriginal manufacturer replacement parts and is prepared by the insurer or the insurer's representative. The insurer or the insurer's representative shall deliver the estimate and notice to the insured before the motor vehicle is repaired.

(b) If the insurer or the insurer's representative directs the insured to obtain one or more estimates of the cost of repairing the insured's motor vehicle and the estimate approved by the insurer or the insurer's representative clearly identifies one or more non-original manufacturer replacement parts to be used in the repair,

the insurer or the insurer's representative shall assure delivery of the notice described in sub. (2) to the insured before the motor vehicle is repaired.

(c) The insurer or the insurer's representative may not require the person repairing the motor vehicle to give the notice described in sub. (2).

(d) Notwithstanding par. (b), if an insured authorizes repairs to begin prior to the approval by the insurer or the insurer's representative of an estimate that clearly identifies one or more non-original manufacturer replacement parts to be used in the repair, the insurer or the insurer's representative shall send the written notice described in sub. (2) by mail to the insured's last-known address no later than 3 working days after the insurer or the insurer's representative receives the estimate.

(4) **NOTICE BY TELEPHONE** Notwithstanding sub. (3), notice of the intention to use nonoriginal manufacturer replacement parts in the repair of the insured's motor vehicle may be given by the insurer or the insurer's representative by telephone. If such notice is given, the insurer or insurer's representative shall send the written notice described in sub. (2) by mail to the insured's last-known address no later than 3 working days after the telephone contact.

History: 1991 a. 176

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

Sub. (2) does not prohibit naming funeral director as beneficiary of life insurance policy in conjunction with separate agreement between insured and funeral director that proceeds will be used for funeral and burial expenses. 71 Atty. Gen. 7

Purpose of (2) is to prevent monopolistic or unfair trade practices. 76 Atty. Gen. 291.

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 as the minimum requirements under this section and are substantially in compliance with sub. (7m):

(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 the due date, of an amount specified in this section or an actuarially equivalent paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or a greater amount or earlier payment of endowment benefits.

(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) For policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. For other policies, 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 and a table showing any cash surrender value or paid-up nonforfeiture benefit available under the policy on each policy anniversary during the shorter of the first 20 policy years or the term of the policy assuming 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) (a) Any cash surrender value under the policy on default of a premium payment due on any policy anniversary shall be not less than any excess of the then present value of any existing paid-up additions and future guaranteed benefits which would have been provided by the policy, if there had been no default,

over the sum of the present value of the adjusted premiums under subs. (4) to (6m) corresponding to premiums which would have fallen due on and after the anniversary and the amount of any indebtedness to the company on the policy.

(b) For a policy issued on or after the operative date of sub. (6m) providing by rider or supplemental provision supplemental life insurance or annuity benefits at the option of the insured on payment of an additional premium, any cash surrender value under the policy on default of a premium payment due on a policy anniversary shall be not less than the sum of the following:

1. The cash surrender value under par. (a) for the policy without the rider or supplemental provision.

2. The cash surrender value under par. (a) for a policy providing only the benefits of the rider or supplemental provision.

(c) For a family policy issued on or after the operative date of sub. (6m) providing term insurance on the life of the spouse of the primary insured expiring before the spouse attains the age of 71, any cash surrender value under the policy on default of a premium payment due on a policy anniversary shall be not less than the sum of the following:

1. The cash surrender value under par. (a) for the policy without the term insurance on the life of the spouse.

2. The cash surrender value under par. (a) for a policy providing only the benefits of the term insurance on the life of the spouse.

(d) 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 shall be not less than the then present value of any existing paid-up additions and future guaranteed benefits provided by the policy 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 calcu-

lated 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).

(6m) (a) In this subsection:

1. "Additional expense allowance" means the sum of the following:

a. One percent of any positive excess of the average amount of insurance at the beginning of each of the first 10 policy years after an unscheduled change in benefits or premiums, over the average amount of insurance before the change at the beginning of each of the first 10 policy years after the next most recent change or date of issue, if there was no previous change.

b. One-hundred twenty-five percent of any positive increase in the nonforfeiture net level premium.

2. "Date of issue" means the date as of which the rated age of the insured is determined.

3. "Nonforfeiture interest rate" means 125% of the applicable calendar year valuation interest rate under s. 623.06 rounded to the nearest 0.25%.

4. "Nonforfeiture net level premium" means the present value at the date of issue of the guaranteed benefits provided by a policy divided by the present value at the date of issue of an annuity of one per year payable on the date of issue and each policy anniversary on which a premium is due.

5. "Premiums" do not include amounts payable as extra premiums to cover impairments or special hazards or a uniform annual contract charge or policy fee specified in the policy in the method to be used in calculating cash surrender values and paid-up nonforfeiture benefits.

(b) Except as provided under par. (d), adjusted premiums shall be calculated on an annual basis and shall be such a uniform percentage of the future premiums specified in the policy for each policy year that the present value at the date of issue of the adjusted premiums is equal to the sum of the following:

1. The present value at the date of issue of the future guaranteed benefits provided by the policy.

2. One percent of any uniform amount of insurance or one percent of the average amount of insurance at the beginning of each of the first 10 policy years.

3. One-hundred twenty-five percent of the nonforfeiture net level premium. For purposes of this subdivision, the nonforfeiture net level premium shall not exceed 4% of any uniform amount of insurance or 4% of the average amount of insurance at the beginning of each of the first 10 policy years.

(c) For policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums or which provide an

option for changes in benefits or premiums other than a change to a new policy:

1. The adjusted premiums and present values shall at the date of issue be calculated on the assumption that future benefits and premiums do not change and at the time of the change the future adjusted premiums, nonforfeiture net level premiums and present value shall be recalculated on the assumption that future benefits and premiums do not undergo further change.

2. Except as provided under par. (d), the recalculated future adjusted premiums for the policy shall be such a uniform percentage of the future premiums specified in the policy for each policy year that the present value at the time of the change of the adjusted premiums is equal to the excess of the sum of the present value at the time of the change of the future guaranteed benefits provided by the policy and any additional expense allowance over any cash surrender value at the time of the change or present value at the time of the change of any paid-up nonforfeiture benefit.

3. The recalculated nonforfeiture net level premium is equal to the sum of the nonforfeiture net level premium applicable before the change multiplied by the present value of an annuity of one per year payable on each anniversary of the policy on or after the date of the change on which a premium would have fallen due had the change not occurred, and the present value at the time of the change of the increase in future guaranteed benefits provided by the policy, divided by the present value at the time of the change of an annuity of one per year payable on each anniversary of the policy on or after the date of change on which a premium falls due.

(d) For a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide the higher uniform amounts of insurance on the standard basis.

(e) All adjusted premiums and present values under this section shall be calculated on the following bases:

1. For ordinary insurance policies, the commissioners 1980 standard ordinary mortality table or, at the election of the company for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with 10-year select mortality factors.

2. For industrial insurance policies, the commissioners 1961 standard industrial mortality table.

3. For policies issued in a calendar year, a rate of interest not exceeding the nonforfeiture interest rate for policies issued in that calendar year, except that:

a. At the option of the company, calculations for all policies issued in a calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate for policies issued in the immediately preceding calendar year.

b. Under any paid-up nonforfeiture benefit or any paid-up dividend addition, any cash surrender value available shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid-up nonforfeiture benefit or paid-up dividend additions.

c. A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit or any paid-up addition on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

d. In calculating the present value of any paid-up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those in the commissioners 1980 extended term insurance table for policies of ordinary insurance and not more than those in the commissioners 1961 industrial extended term insurance table for policies of industrial insurance.

e. For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on appropriate modifications of those tables.

f. Any ordinary mortality tables adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the commissioner's 1980 standard ordinary mortality table with or without 10-year select mortality factors or for the commissioner's 1980 extended term insurance table.

g. Any industrial mortality tables adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the commissioner's 1961 standard industrial mortality table or the commissioner's 1961 industrial extended term insurance table.

(f) Any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values does not require refiling of any other provisions of that policy form.

(g) This subsection applies to all policies issued on or after the operative date under par. (h) and subs. (4) to (6) do not apply to policies issued on or after the operative date under par. (h).

(h) After May 1, 1982, any company may file with the commissioner a written notice of its election to comply with this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for the company. If a company makes no election, the operative date of this subsection for the company is January 1, 1989.

(6t) (a) In this subsection, "plan" means a plan of life insurance:

1. Providing for premiums based on recent estimates of future experience available on or near a premium due date; or
2. For which the minimum nonforfeiture values cannot be determined under this section.

(b) No plan may be issued in this state unless the commissioner determines that:

1. The benefits and pattern of premiums do not mislead prospective policyholders or insureds; and
2. The benefits are substantially as favorable to policyholders and insureds as the minimum benefits required under this section.

(c) The commissioner shall by rule adopt a method consistent with the principles of this section for determining the minimum cash surrender values and paid-up nonforfeiture benefits provided by a plan.

(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 under subs. (2) to (6m) 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 amounts used to provide the additions. Notwithstanding sub. (2), additional benefits payable in the event of death or dismemberment by accident or accidental means, in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, 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, 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 the 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 as other policy benefits additional to life insurance and endowment benefits, and premiums for all of these additional benefits, shall be disregarded in ascertaining cash sur-

render values and nonforfeiture benefits required by this section, and none of these additional benefits may be required to be included in any paid-up nonforfeiture benefits.

(7m) (a) This subsection applies to all policies issued on or after January 1, 1984. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than 0.2% of any uniform amount of insurance or 0.2% of the average amount of insurance at the beginning of each of the first 10 policy years, from the sum of the following:

1. The greater of zero and the basic cash value under par. (b) on the policy anniversary.
2. The present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

(b) The basic cash value is the present value of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the present value on the policy anniversary of the nonforfeiture factors under par. (c) corresponding to premiums which would have fallen due on and after the policy anniversary. The effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage under subs. (2) or (4) to (6) shall be the same as the effects under subs. (2) or (4) to (6) on the cash surrender values under those subsections.

(c) The nonforfeiture factor for each policy year is an amount equal to a percentage of the adjusted premium under subs. (4) to (6m) for the policy year. Except as provided under par. (d), the percentage:

1. Must be the same for each policy year between the 2nd policy anniversary and the later of the 5th policy anniversary and the first policy anniversary at which there is available a cash surrender value, before including any paid-up additions and before deducting any indebtedness, of at least 0.2% of any uniform amount of insurance or 0.2% of the average amount of insurance at the beginning of each of the first 10 policy years; and
2. Must apply to at least 5 consecutive policy years after the latest of the policy anniversaries under subd. 1.

(d) No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy under sub. (6m) were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(e) All adjusted premiums and present values under this subsection shall be calculated on the mortality and interest bases applicable to the policy under this section. The cash surrender values under this subsection include any endowment benefits provided by the policy.

(f) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available in the event of default in a premium payment shall be determined by methods consistent with the methods under subs. (1) to (3), (6m) and (7). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits the same or similar to those under sub. (7) shall conform to the principles of this subsection.

(8) (a) This section does not apply to any:

1. Reinsurance.
2. Group insurance.
3. Pure endowment contract.
4. Annuity or reversionary annuity contract.
5. Term policy of uniform amount which provides no guaranteed nonforfeiture or endowment benefits of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy.
6. Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated under subs. (4) to (6m) is less than

the adjusted premium calculated under subs. (4) to (6m) on a term policy of uniform amount providing no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy.

7. Policy providing no guaranteed nonforfeiture or endowment benefits, for which any cash surrender value or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated under subs. (2) to (6m), does not exceed 2.5% of the amount of insurance at the beginning of the same policy year.

8. Policy delivered outside this state through an agent or other representative of the company issuing the policy.

(b) For purposes of this subsection, the age at expiry for a joint term life insurance policy is the age at expiry of the oldest life.

(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; Stats. 1977 s. 632.43; 1979 c. 110 s. 60 (13); 1981 c. 307; 1983 a. 189, 538

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 or 632.435 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; 1989 a. 332.

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.

632.475 Life insurance policy loans. (1) DEFINITIONS

In this section:

(a) "Policy" includes a life insurance policy, a certificate issued by a fraternal benefit society and an annuity contract.

(b) "Policy loan" means a loan by an insurer, including a premium loan, secured by the cash surrender value of a policy issued by the insurer.

(c) "Policy year" means a year beginning on the anniversary date of a policy.

(2) **INTEREST RATES.** A policy providing for policy loans shall contain a provision for a maximum interest rate on the loans in accordance with one but not both of the following:

(a) A provision permitting an adjustable maximum rate established from time to time by the insurer.

(b) A provision permitting a specified rate not exceeding 12% per year.

(3) **ADJUSTABLE MAXIMUM RATE.** The rate of interest charged on a policy loan under sub. (2) (a) shall not exceed the higher of the following:

(a) The rate used to compute the cash surrender values under the policy during the applicable period plus 1% per year.

(b) Moody's corporate bond yield average (monthly average corporates), as published by Moody's investors service, inc., or its successor, for the month ending 2 months before the rate is applied. If such monthly average is no longer published, a comparable average shall be substituted by the commissioner by rule.

(4) **FREQUENCY OF CHANGES.** If the maximum rate of interest is determined under sub. (2) (a) the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(5) **INTERVALS AND LIMITS ON CHANGES.** The maximum rate of interest for a policy subject to sub. (2) (a) shall be determined at regular intervals at least once every 12 months, but not more frequently than once in any 3-month period. At the intervals specified in the policy:

(a) The rate being charged may be changed as permitted under sub. (3) but no such change shall be less than 0.5% per year; and

(b) The rate being charged must be reduced to or below the maximum rate as determined under sub. (3) whenever the maximum is lower than the rate being charged by 0.5% or more per year.

(6) **NOTICE.** The life insurer shall:

(a) Notify the policyholder of the initial rate of interest on the loan at the time a policy loan is made, if the loan is not a premium loan.

(b) Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in par. (c).

(c) Send to policyholders with loans 30 days' advance notice of any increase in the interest rate.

(7) **COVERAGE CONTINUATION.** No policy may terminate in a policy year as the sole result of a change in the loan interest rate during that policy year. The insurer shall maintain coverage until it would have terminated if there had been no change.

(8) **POLICY PROVISIONS.** The pertinent provisions of subs. (2) and (4) shall be set forth in substance in the policies to which they apply.

History: 1981 c. 51; 1983 a. 215.

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]

Under facts of case, decedent's oral instruction to his attorney to change beneficiary was sufficient "act" under (1) (b) even though new beneficiary was not designated with sufficient specificity. *Empire Gen. Life Ins. v. Silverman*, 135 W (2d) 143, 399 NW (2d) 910 (1987).

632.485 Requirement that beneficiary not have intentionally killed the insured. (1) Except as provided in sub. (1m), a beneficiary of a life insurance policy who intentionally and unlawfully kills the person on whose life the policy is issued may not receive any benefit under the policy. The policy is payable as if the killer had predeceased the decedent.

(1m) A policyholder may provide in a life insurance policy issued on the policyholder's life, by a specific provision which includes reference to sub. (1), that sub. (1) does not apply with respect to a beneficiary of the policy.

(2) Section 852.01 (2m) (b) to (c) applies to this section.

History: 1981 c. 228; 1987 a. 222.

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.

Estoppel under this section may apply against insurers who seek a medical examiner's opinion regarding fitness for insurance without establishing any formal rules regarding the examiner's authority. *Grosse v. Protective Life Ins. Co.* 182 W (2d) 97, 513 NW (2d) 592 (1994).

632.55 Limitations on group life insurance. 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.

History: 1975 c. 371, 373, 375, 422; 1981 c. 40.

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 OR FRANCHISE 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) *Fraternal 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 non-distributable 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.

632.64 Certification of disability. Insurers doing a life insurance business in this state shall afford equal weight to a certification of disability signed by a physician with respect to matters within the scope of the physician's professional license and to a certification of disability signed by a chiropractor with respect to matters within the scope of the chiropractor's professional license for the purpose of insurance policies they issue. This section does not require an insurer to treat a certificate of disability as conclusive evidence of disability.

History: 1981 c. 55.

632.66 Annuity contracts without life contingencies. The commissioner may by rule authorize insurers to issue annuity contracts which are without life contingencies. If the commissioner authorizes insurers to issue annuity contracts without life contingencies, the commissioner shall promulgate rules regulating those contracts.

History: 1987 a. 247.

632.67 Effect of power of attorney for health care.

Executing a power of attorney for health care under ch. 155 may not be used to impair in any manner the procurement of a life insurance policy or to modify the terms of an existing life insurance policy. A life insurance policy may not be impaired or invalidated in any manner by the exercise of a health care decision by a health care agent on behalf of a person whose life is insured under the policy and who has authorized the health care agent under ch. 155.

History: 1989 a. 200.

SUBCHAPTER VI

DISABILITY INSURANCE

632.70 Exemption for plan under ch. 635. The health insurance mandates, as defined in s. 601.423 (1), that are provided under this subchapter apply to the small employer health insurance plan under subch. II of ch. 635 only to the extent determined by the small employer insurance board under s. 635.23 (1) (b).

History: 1991 a. 250.

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.

632.715 Reports of action against health care provider. Every insurer that has taken any action against a person who holds a license granted by the medical examining board or an affiliated credentialing board attached to the medical examining board shall notify the board or affiliated credentialing board of the action taken against the person if the action relates to unprofessional conduct or negligence in treatment by the person who holds the license.

History: 1985 a. 340; 1993 a. 107.

632.72 Medical assistance; assignment. (1) The providing of medical benefits under s. 49.02 or 49.046 or of medical assistance under s. 49.45, 49.46, 49.465, 49.468 or 49.47 constitutes an assignment to the department of health and social services or the county 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.

(2) An insurer may not impose on the department of health and social services, as assignee of a person who is covered under the policy of health and disability insurance and who is eligible for medical benefits under s. 49.02 or 49.046 or for medical assistance under s. 49.45, 49.46, 49.465, 49.468 or 49.47, requirements that are different from those imposed on any other agent or assignee of a person who is covered under the policy of health and disability insurance.

History: 1977 c. 29; 1985 a. 29; 1987 a. 27 s. 3202; 1989 a. 31, 173; 1991 a. 178, 214; 1993 a. 481.

632.725 Standardization of health care billing and insurance claim forms. (1) **DEFINITION.** In this section, "health care provider" has the meaning given in s. 146.81 (1).

(2) **RULES FOR STANDARDIZATION OF FORMS.** The commissioner, in consultation with the department of health and social services, shall, by rule, do all of the following:

(a) Establish a standardized billing format for health care services and require that a health care provider that provides health care services in this state use, by July 1, 1993, the standardized format for all printed billing forms.

(b) Establish a standardized claim format for health care insurance benefits and require that an insurer that provides health care coverage to one or more residents of this state use, by July 1, 1993, the standardized format for all printed claim forms.

(c) Establish a standardized explanation of benefits format for health care insurance benefits and require that an insurer that provides health care coverage to one or more residents of this state use, by July 1, 1993, the standardized format for all printed forms that contain an explanation of benefits. The rule shall also require that benefits be explained in easily understood language.

(d) Establish a uniform statewide patient identification system in which each individual who receives health care services in this state is assigned an identification number. The standardized billing format established under par. (a) and the standardized claim format established under par. (b) shall provide for the designation of an individual's patient identification number.

(3) PROPOSALS FOR LEGISLATION. The commissioner shall develop proposals for legislation for the use of the patient identification system established under sub. (2) (d) and for the implementation of the proposed uses, including any proposals for safeguarding patient confidentiality.

History: 1991 a 250.

632.73 Right to return policy. (1) RIGHT OF RETURN. A policyholder may return an 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. This subsection does not apply to medicare supplement policies, medicare replacement policies or long-term care insurance policies subject to sub. (2m).

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

(2m) MEDICARE SUPPLEMENT POLICIES, MEDICARE REPLACEMENT POLICIES AND LONG-TERM CARE INSURANCE POLICIES. Medicare supplement policies, medicare replacement policies and long-term care insurance policies shall have a notice that complies with this subsection prominently printed on the first page of the policy or certificate, or attached thereto. The notice shall state that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery to the policyholder or certificate holder and to have the premium refunded to the person who paid the premium if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. The commissioner may by rule exempt from this subsection certain classes of medicare supplement policies, medicare replacement policies and long-term care insurance policies, if the commissioner finds the exemption is not adverse to the interests of policyholders and certificate holders.

(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; 1981 c. 82; 1985 a. 29; 1985 a. 332 s. 253; 1989 a. 31.

632.74 Reinstatement of individual or franchise disability insurance policies. (1) CONDITIONS OF REINSTATEMENT. If an insurer, after termination of an individual or franchise disability insurance policy for nonpayment of premium, within one year after the termination accepts without reservation a premium payment, 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 45 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 subject to any provisions which are endorsed on or attached to the contract in connection with the reinstatement and which are fully and prominently disclosed to the policyholder.

History: 1975 c. 375; 1985 a. 280; 1987 a. 247.

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. This subsection does not apply to a group policy, as defined in s. 632.897 (1) (c), or an individual policy, as defined in s. 632.897 (1) (cm), that is subject to s. 632.897 (10).

(4) OUT-OF-STATE SERVICE PROVIDERS. Except as provided in s. 628.36, no disability insurance policy may exclude or limit coverage of health care services provided outside this state, if the services are provided within 75 miles of the insured's residence in a facility licensed or approved by the state where the facility is located.

(5) PAYMENTS FOR HOSPITAL SERVICES. No insurer may reimburse a hospital for patient health care costs at a rate exceeding the rate established under ch. 54, 1985 stats., or s. 146.60, 1983 stats., for care provided prior to July 1, 1987.

History: 1975 c. 375; 1979 c. 221; 1981 c. 304; 1983 a. 27; 1985 a. 29 s. 3202(27); 1987 a. 27; 1989 a. 31, 359.

632.755 Public assistance. (1g) (a) A disability insurance policy may not exclude a person or a person's dependent from coverage because the person or the dependent is eligible for assistance under ch. 49.

(b) A disability insurance policy may not terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for assistance under ch. 49.

(c) A disability insurance policy may not provide different benefits of coverage to a person or the person's dependent because the person or the dependent is eligible for assistance under ch. 49 than it provides to persons and their dependents who are not eligible for assistance under ch. 49.

(2) Benefits provided by a disability insurance policy shall be primary to those benefits provided under ch. 49.

History: 1985 a. 29; 1989 a. 173; 1991 a. 178, 214.

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. (a) 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.

(b) Notwithstanding par. (a), no claim for loss incurred or disability commencing after 6 months from the date of issue of a medicare supplement policy, medicare replacement policy or long-term care insurance policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage. A medicare supplement policy, medicare replacement policy or long-term care insurance policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. Notwithstanding par. (a), if on the basis of information contained in an application for insurance a medicare supplement policy, medicare replacement policy or long-term care insurance policy excludes from coverage a condition by name or specific description, the exclusion must terminate no later than 6 months after the date of issue of the medicare supplement policy, medicare replacement policy or long-term care insurance policy. The commissioner may by rule exempt from this paragraph certain classes of medicare supplement policies, medicare replacement policies and long-term care insurance policies, if the commissioner finds the exemption is not adverse to the interests of policyholders and certificate holders.

History: 1975 c. 375, 421; 1981 c. 82; 1985 a. 29; 1989 a. 31

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, but the commissioner may not promulgate a rule that conflicts with s. 632.755 nor approve a policy form that does not comply with s. 632.755.

(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; 1985 a. 29

632.775 Effect of power of attorney for health care.

(1) **INSURER MAY NOT REQUIRE.** An insurer may not require an individual to execute a power of attorney for health care under ch. 155 as a condition of coverage under a disability insurance policy.

(2) **EFFECT ON DISABILITY POLICIES.** Executing a power of attorney for health care under ch. 155 may not be used to impair in any manner the procurement of a disability insurance policy or to modify the terms of an existing disability insurance policy. A disability insurance policy may not be impaired or invalidated in any manner by the exercise of a health care decision by a health care agent on behalf of a person who is insured under the policy and who has authorized the health care agent under ch. 155.

History: 1989 a. 200

632.78 Required grace period for disability insurance policies. 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 section.

History: 1975 c. 375; 1977 c. 371; 1979 c. 75; 1979 c. 110 s. 60 (11); 1979 c. 221; 1981 c. 39

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 affected 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; 1981 c. 83; 1991 a. 315

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; Stats. 1975 s. 204.324; 1975 c. 422 s. 106; Stats. 1975 s. 632.79; 1979 c. 32, 221.

632.793 Notice of loss of primary insurance coverage due to age. (1) **NOTICE TO INSURED AND EMPLOYER.** If an individual who is covered under a group disability insurance policy, as defined in s. 632.895 (1) (a), that is purchased by or on behalf of an employer to provide coverage for employes will lose primary coverage under the policy upon reaching age 65, the insurer issuing the policy shall provide written notice of the change in coverage status by regular mail to the individual and shall send a copy of the notice by regular mail to the employer. The insurer shall provide the notice not less than 30 nor more than 60 days before the individual becomes 65 years of age. The notice shall specify the date on which the insurance coverage will no longer be primary and shall inform the individual that he or she will be eligible for coverage under the federal medicare program at age 65.

(2) **APPLICABILITY.** Subsection (1) does not apply if the employer has at least 20 employes for each working day in at least 20 calendar weeks in the current year or the preceding year.

History: 1993 a. 108.

632.795 Open enrollment upon liquidation. (1) **DEFINITION.** In this section, "liquidated insurer" means an insurer ordered liquidated under ch. 645 or under similar laws of another jurisdiction.

(2) **COVERAGE FOR GROUP MEMBERS.** Except as provided in sub. (5) and unless otherwise provided by rule or order of the commissioner, an insurer described in sub. (3) shall permit insureds or enrolled participants of a liquidated insurer's group health care policy or plan to obtain coverage under a comprehensive group health care policy or plan offered by the insurer in the manner and under the terms required by sub. (4).

(3) **PARTICIPATING INSURERS.** Subsection (2) applies to an insurer that participated in the most recent enrollment period in which the group members were able to choose among coverage offered by the liquidated insurer and coverage offered by one or more other insurers, if all of the following are satisfied:

(a) Coverage under a comprehensive group health care policy or plan offered by the insurer was selected by one or more members of the group in the most recent enrollment period.

(b) The most recent enrollment period occurred on or after July 1, 1989.

(4) **TERMS AND OFFERING OF COVERAGE.** (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, preexisting condition limitations, waiting periods or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

(b) An insurer subject to sub. (2) shall offer coverage to the group members, and the policyholder shall provide group members with the opportunity to obtain coverage, in the manner and

within the time limits required by the commissioner by rule or order.

(5) **MEDICAL ASSISTANCE ENROLLEES.** This section does not apply to persons enrolled in a health care plan offered by a liquidated insurer if the persons are enrolled in that plan under a contract between the department of health and social services and the liquidated insurer under s. 49.45 (2) (b) 2.

History: 1989 a. 23.

632.797 Disclosure of group health claims experience. (1) (a) Except as provided in subs. (2) and (3), an insurer shall provide the policyholder of a group or blanket disability insurance policy, or an employer that provides health care coverage to its employes through a multiple-employer trust, with the policyholder's or the employer's aggregate group health claims experience for the current policy period, and for up to 2 policy periods immediately preceding the current policy period if the insurer provided coverage during those periods, upon request from the policyholder or employer.

(b) The insurer shall provide the information under par. (a) no later than 30 days after receiving a request for that information from the policyholder or employer.

(c) The insurer may not charge the policyholder or the employer for providing the information under par. (a) one time in a 12-month period.

(2) An insurer is not required to provide the information under sub. (1) unless the policyholder or employer requesting the information provides coverage under the policy for at least 50 individuals, exclusive of individuals who have coverage under the policy as a dependent of another individual.

(3) Notwithstanding sub. (1), an insurer is not required to provide health claims experience under sub. (1) for any period of time that is before 18 months before the date on which the information is requested.

(4) Subsection (1) does not require that an insurer provide the policyholder of a group or blanket disability insurance policy, or an employer that provides health care coverage to its employes through a multiple-employer trust, with the health claims experience of an individual employe or insured.

(5) An insurer is not required under sub. (1) to provide information that identifies an individual or that is confidential under s. 146.82.

(6) An insurer that provides aggregate health claims experience information in compliance with this section is immune from civil liability for its acts or omissions in providing such information.

History: 1993 a. 448.

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.

632.81 Minimum standards for certain disability policies. The commissioner may by rule establish minimum standards for benefits, claims payments, marketing practices, compensation arrangements and reporting practices for medicare supplement policies, medicare replacement policies and long-term care insurance policies. The commissioner may by rule exempt from the minimum standards certain types of coverage, if the commissioner finds the exemption is not adverse to the interests of policyholders and certificate holders.

History: 1981 c. 82; 1985 a. 29; 1989 a. 31, 332.

632.82 Renewability of long-term care insurance policies. Notwithstanding s. 631.36 (2) to (5), the commissioner shall, by rule, require long-term care insurance policies that are

issued on an individual basis to include a provision restricting the insurer's ability to terminate or alter the long-term care insurance policy except for nonpayment of premium. The rule may specify exceptions to the restriction, including exceptions that allow insurers to do any of the following:

(1) Change the rates charged on a long-term care insurance policy if the rate change is made on a class basis.

(2) Refuse to renew a long-term care insurance policy if conditions specified in the rule are satisfied. The conditions shall, at a minimum, require all of the following:

(a) That the nonrenewal be on other than an individual basis.

(b) That the insurer demonstrate to the commissioner that renewal will affect the insurer's solvency or loss experience as specified in the rule.

History: 1989 a 31

632.825 Midterm termination of long-term care insurance policy by insured. (1) PERMITTED CANCELLATION AND REFUND (a) No insurer that provides coverage under a long-term care insurance policy may prohibit the insured under the policy from canceling the policy before the expiration of the agreed term.

(b) If an insured under a long-term care insurance policy cancels the policy before the expiration of the agreed term, the insurer shall issue a prorated premium refund to the insured.

(c) If an insured under a long-term care insurance policy dies during the term of the policy, the insurer shall issue a prorated premium refund to the insured's estate.

(2) POLICY PROVISION Every long-term care insurance policy shall contain a provision that appraises the insured of the insured's right to cancel and the insurer's premium refund responsibilities under sub. (1).

History: 1993 a 207

632.84 Benefit appeals under certain policies.

(1) DEFINITIONS In this section:

(a) "Nursing home" has the meaning given in s. 50.01 (3).

(b) "Nursing home insurance policy" means an individual or group insurance policy which provides coverage primarily for confinement or care in a nursing home.

(2) REVIEW AND APPEAL (a) Except as provided in sub. (3), an insurer offering a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long-term care insurance policy shall establish an internal procedure by which the policyholder or the certificate holder or a representative of the policyholder or the certificate holder may appeal the denial of any benefits under the medicare supplement policy, medicare replacement policy, nursing home insurance policy or long-term care insurance policy. The procedure established under this paragraph shall include all of the following:

1. The opportunity for the policyholder or certificate holder or a representative of the policyholder or certificate holder to submit a written request, which may be in any form and which may include supporting material, for review by the insurer of the denial of any benefits under the policy.

2. Within 30 days after receiving the request under subd. 1., disposition of the review and notification to the person submitting the request of the results of the review.

(b) An insurer shall describe the procedure established under par. (a) in every policy, group certificate and outline of coverage issued in connection with a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long-term care insurance policy.

(c) If an insurer denies any benefits under a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long-term care insurance policy, the insurer shall, at the time the insurer gives notice of the denial of any benefits,

provide the policyholder and certificate holder with a written description of the appeal process established under par. (a).

(d) An insurer offering a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long-term care insurance policy shall annually report to the commissioner a summary of all appeals filed under this section and the disposition of those appeals.

(3) EXCEPTIONS This section does not apply to a health maintenance organization, limited service health organization or preferred provider plan, as defined in s. 609.01.

History: 1987 a 156, 403; 1989 a 31

632.86 Restrictions on pharmaceutical services.

(1) In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a), except that the term does not include coverage under a health maintenance organization, as defined in s. 609.01 (2), a limited service health organization, as defined in s. 609.01 (3), a preferred provider plan, as defined in s. 609.01 (4), or a sickness care plan operated by a cooperative association organized under ss. 185.981 to 185.985.

(b) "Pharmaceutical mail order plan" means a plan under which prescribed drugs or devices are dispensed through the mail.

(c) "Prescribed drug or device" has the meaning given in s. 450.01 (18).

(2) No group or blanket disability insurance policy that provides coverage of prescribed drugs or devices through a pharmaceutical mail order plan may do any of the following:

(a) Exclude coverage, expressly or by implication, of any prescribed drug or device provided by a pharmacist or pharmacy selected by a covered individual if the pharmacist or pharmacy provides or agrees to provide prescribed drugs or devices under the terms of the policy and at the same cost to the insurer issuing the policy as a pharmaceutical mail order plan.

(b) Contain coverage, deductible or copayment provisions for prescribed drugs or devices provided by a pharmacist or pharmacy selected by a covered individual that are different from the coverage, deductible or copayment provisions for prescribed drugs or devices provided by a pharmaceutical mail order plan.

History: 1991 a 70

632.87 Restrictions on health care services. (1) 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 the services were not rendered by a physician as defined in s. 990.01 (28), unless the contract clearly excludes services by such practitioners, but no contract or plan may exclude services in violation of sub. (2m), (3), (4) or (5).

(2) No insurer may, under a contract or plan covering vision care services or procedures, refuse to provide coverage for vision care services or procedures provided by an optometrist licensed under ch. 449 within the scope of the practice of optometry, as defined in s. 449.01 (1), if the contract or plan includes coverage for the same services or procedures when provided by another health care provider.

(2m) (a) No health maintenance organization or preferred provider plan that provides vision care services or procedures within the scope of the practice of optometry, as defined in s. 449.01 (1), may do any of the following:

1. Fail to provide to persons covered by the health maintenance organization or preferred provider plan, at the time of enrollment and annually thereafter, a listing of then participating vision care providers, including participating optometrists, setting forth the names of the vision care providers in alphabetical order by last name and their respective business addresses and telephone numbers, with the listing of participating vision care providers to be incorporated in any listing of all participating health care providers that includes the same information regarding all

providers, if such listing is provided at the time of enrollment and annually thereafter, or with the listing of participating vision care providers otherwise to be provided separately.

2. Fail to provide to persons covered by the health maintenance organization or preferred provider plan, at the time vision care services or procedures are needed, the opportunity to choose optometrists from the listing under subd. 1. from whom the persons may obtain covered vision care services and procedures within the scope of the practice of optometry, as defined in s. 449.01 (1).

3. Fail to include as participating providers in the health maintenance organization or preferred provider plan optometrists licensed under ch. 449 in sufficient numbers to meet the demand of persons covered by the health maintenance organization or preferred provider plan for optometric services.

4. When vision care services or procedures are deemed appropriate by the health maintenance organization or preferred provider plan, restrict or discourage a person covered by the health maintenance organization or preferred provider plan from obtaining covered vision care services or procedures, within the scope of the practice of optometry as defined in s. 449.01 (1), from participating optometrists solely on the basis that the providers are optometrists.

(3) (a) No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath, even if different nomenclature is used to describe the condition or complaint. Examination by or referral from a physician shall not be a condition precedent for receipt of chiropractic care under this paragraph. This paragraph does not:

1. Prohibit the application of deductibles or coinsurance provisions to chiropractic and physician charges on an equal basis.

2. Prohibit the application of cost containment or quality assurance measures to chiropractic services in a manner that is consistent with cost containment or quality assurance measures generally applicable to physician services and that is consistent with this section.

(b) No insurer, under a policy, plan or contract covering diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, may do any of the following:

1. Restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor.

2. Refuse to provide coverage to an individual because that individual has been treated by a chiropractor.

3. Establish underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers.

4. Exclude or restrict health care coverage of a health condition solely because the condition may be treated by a chiropractor.

(c) An exclusion or a restriction that violates par. (b) is void in its entirety.

(4) No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed dentist within the scope of the dentist's license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by another health care provider, as defined in s. 146.81 (1).

(5) No insurer or self-insured school district, city or village may, under a policy, plan or contract covering gynecological services or procedures, exclude or refuse to provide coverage for Papanicolaou tests, pelvic examinations or associated laboratory fees when the test or examination is performed by a licensed nurse

practitioner, as defined in s. 632.895 (8) (a) 3., within the scope of the nurse practitioner's professional license, if the policy, plan or contract includes coverage for Papanicolaou tests, pelvic examinations or associated laboratory fees when the test or examination is performed by a physician.

History: 1975 c. 223, 371, 422; 1981 c. 205; 1983 a. 27; 1985 a. 29; 1987 a. 27; 1991 a. 39, 269

Legislative Council Note, 1975: This [sub (1)] 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) "Collateral" means a member of an insured's immediate family, as defined in s. 632.895 (1).

(c) "Hospital" means any of the following:

1. A hospital licensed under s. 50.35.

2. An approved private treatment facility as defined in s. 51.45 (2) (b).

3. An approved public treatment facility as defined in s. 51.45 (2) (c).

(d) "Inpatient hospital services" means services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are provided in a hospital to a bed patient in the hospital.

(e) "Outpatient services" means nonresidential services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems provided to an insured and, if for the purpose of enhancing the treatment of the insured, a collateral by any of the following:

1. A program in an outpatient treatment facility, if both are approved by the department of health and social services and established and maintained according to rules promulgated under s. 51.42 (7) (b).

2. A licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office.

3. A licensed psychologist who is listed in the national register of health service providers in psychology or who is certified by the American board of professional psychology.

(em) "Policy year" means any period of time as defined by the group or blanket disability insurance policy that does not exceed 12 consecutive months.

(f) "Transitional treatment arrangements" means services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided to an insured in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services, and that are specified by the commissioner by rule under sub. (4).

(2) REQUIRED COVERAGE (a) *Conditions covered.* 1. A group or blanket disability insurance policy issued by an insurer shall provide coverage of nervous and mental disorders and alcoholism and other drug abuse problems if required by and as provided in pars. (b) to (e).

2. Except as provided in pars. (b) to (e), coverage of conditions under subd. 1. by a policy may not be subject to exclusions or limitations that are not generally applicable to other conditions covered under the policy.

(b) *Minimum coverage of inpatient hospital, outpatient and transitional treatment arrangements.* 1. Except as provided in subd. 2., if a group or blanket disability insurance policy issued by an insurer provides coverage of inpatient hospital treatment or outpatient treatment or both, the policy shall provide coverage in every policy year as provided in pars. (c) to (dm), as appropriate, except that the total coverage under the policy for a policy year need not exceed \$7,000 or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), the equivalent benefits measured in services rendered.

2. The amount under subd. 1. may be reduced if the policy is written in combination with major medical coverage to the extent that results in combined coverage complying with subd. 1.

(c) *Minimum coverage of inpatient hospital services.* 1. If a group or blanket disability insurance policy issued by an insurer provides coverage of any inpatient hospital treatment, the policy shall provide coverage for inpatient hospital services for the treatment of conditions under par. (a) 1. as provided in subd. 2.

2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than the lesser of the following:

a. The expenses of the first 30 days as an inpatient in a hospital.

b. The first \$7,000 minus a copayment of up to 10% for inpatient hospital services or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), the first \$6,300 or the equivalent benefits measured in services rendered.

(d) *Minimum coverage of outpatient services.* 1. If a group or blanket disability insurance policy issued by an insurer provides coverage of any outpatient treatment, the policy shall provide coverage for outpatient services for the treatment of conditions under par. (a) 1. as provided in subd. 2.

2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than the first \$2,000 minus a copayment of up to 10% for outpatient services or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), the first \$1,800 or the equivalent benefits measured in services rendered.

(dm) *Minimum coverage of transitional treatment arrangements.* 1. If a group or blanket disability insurance policy issued by an insurer provides coverage of any inpatient hospital treatment or any outpatient treatment, the policy shall provide coverage for transitional treatment arrangements for the treatment of conditions under par. (a) 1 as provided in subd. 2.

2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than the first \$3,000 minus a copayment of up to 10% for transitional treatment arrangements or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), the first \$2,700 or the equivalent benefits measured in services rendered.

(e) *Exclusion.* This subsection does not apply to a health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

(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 an inpatient health care facility, as defined in s. 50.135 (1), or community-based residential facility, as defined in s. 50.01 (1g), owned or operated by a state or county, 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 or community-based residential facility.

(3m) ISSUANCE OF POLICY. Every group or blanket disability insurance policy subject to sub. (2) shall include a definition of "policy year".

(4) SPECIFY TRANSITIONAL TREATMENT ARRANGEMENTS BY RULE. The commissioner shall specify by rule the services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, including but not limited to day hospitalization, that are covered under sub. (2) (dm).

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

History: 1975 c. 223, 224, 375; 1977 c. 203 s. 106; 1979 c. 175, 221; 1981 c. 20 s. 2202 (20) (q); 1981 c. 39 ss. 14, 15, 22; 1981 c. 314; 1983 a. 27; 1983 a. 189 s. 329 (5); 1985 a. 29, 176; 1987 a. 195, 403; 1991 a. 39, 250; 1993 a. 27, 270.

632.895 Mandatory coverage. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" means surgical, medical, hospital, major medical or other health service coverage but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time or accident benefits.

(b) "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 or occupational therapy or speech-language pathology or respiratory care.

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.

NOTE: Subd. 5. is renumbered subd. 5. (intro.) and amended eff. 7-1-95 by 1993 Wis. Act 443 to read:

5. (intro.) Nutrition counseling provided by or under the supervision of one of the following, where such services are medically necessary as part of the home care plan:

a. A registered dietician.

NOTE: Subd. par. a. is created eff. 7-1-95 by 1993 Wis. Act 443.

b. A dietician certified under subch. IV of ch. 448, if the nutrition counseling is provided on or after July 1, 1995, and no later than June 30, 1999.

NOTE: Subd. par. b. is created eff. 7-1-95 by 1993 Wis. Act 443.

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.

(c) "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) "Immediate family" means the spouse, children, parents, grandparents, brothers and sisters of the insured and their spouses.

(2) HOME CARE (a) Every disability insurance policy which provides coverage of expenses incurred for inpatient 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) 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 persons 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.

(c) 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.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

(3) SKILLED NURSING CARE. 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. A disability insurance policy, other than a medicare supplement policy or medicare replacement policy, may limit coverage under this subsection 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 to a licensed skilled nursing care facility shall be no less than the maximum daily rate established for skilled nursing care in that facility by the department of health and social services for purposes of reimbursement under the medical assistance program under ss. 49.45 to 49.47. 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. If the disability insurance policy is other than a

medicare supplement policy or medicare replacement policy, 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. Coverage under any disability insurance policy governed by this subsection may be subject to a deductible that applies to the hospital care coverage provided by the policy. 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 ch. 49.

(4) KIDNEY DISEASE TREATMENT (a) Every disability insurance policy which provides hospital treatment coverage on an expense incurred basis shall provide 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 par. (d).

(b) No insurer is required to duplicate coverage available under the federal medicare program, nor duplicate any other insurance coverage the insured may have. Other insurance coverage does not include public assistance under ch. 49.

(c) 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.

(d) 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 subsection, which shall not be inconsistent with or less stringent than applicable federal standards.

(5) COVERAGE OF NEWBORN INFANTS. (a) Every disability insurance policy shall provide coverage for a newly born child of the insured from the moment of birth.

(b) Coverage for newly born children required under this subsection 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.

(c) 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.

(d) 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.

(e) This subsection 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 subsection.

(5m) COVERAGE OF GRANDCHILDREN. Every disability insurance policy issued or renewed on or after May 7, 1986, that provides coverage for any child of the insured shall provide the same coverage for all children of that child until that child is 18 years of age.

(6) EQUIPMENT AND SUPPLIES FOR TREATMENT OF DIABETES. Every disability insurance policy which provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin, used in the treatment of diabetes and coverage of diabetic self-management education programs. Coverage

required under this subsection shall be subject to the same deductible and coinsurance provisions of the policy as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

(7) **MATERNITY COVERAGE** Every group disability insurance policy which provides maternity coverage shall provide maternity coverage for all persons covered under the policy. Coverage required under this subsection may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

(8) **COVERAGE OF MAMMOGRAMS** (a) In this subsection:

1. "Direction" means verbal or written instructions, standing orders or protocols.

2. "Low-dose mammography" means the X-ray examination of a breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

3. "Nurse practitioner" means an individual who is licensed as a registered nurse under ch. 441 or the laws of another state and who satisfies any of the following:

a. Is certified as a primary care nurse practitioner or clinical nurse specialist by the American nurses' association or by the national board of pediatric nurse practitioners and associates.

am. Holds a master's degree in nursing from an accredited school of nursing.

b. Before July 1, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least 4 months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program.

c. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of subd. 3. b., and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

(b) 1. Except as provided in subd. 2. and par. (f), every disability insurance policy that provides coverage for a woman age 45 to 49 shall provide coverage for that woman of 2 examinations by low-dose mammography performed when the woman is age 45 to 49, if all of the following are satisfied:

a. Each examination by low-dose mammography is performed at the direction of a licensed physician or a nurse practitioner, except as provided in par. (e).

b. The woman has not had an examination by low-dose mammography within 2 years before each examination is performed.

2. A disability insurance policy need not provide coverage under subd. 1. to the extent that the woman had obtained one or more examinations by low-dose mammography while between the ages of 45 and 49 and before obtaining coverage under the disability insurance policy.

(c) Except as provided in par. (f), every disability insurance policy that provides coverage for a woman age 50 or older shall provide coverage for that woman of an annual examination by low-dose mammography to screen for the presence of breast cancer, if the examination is performed at the direction of a licensed physician or a nurse practitioner or if par. (e) applies.

(d) Coverage is required under this subsection despite whether the woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c) and (e), coverage under this subsection may only be subject to exclusions and limitations, including deductibles, copayments and restrictions on excessive charges, that are

applied to other radiological examinations covered under the disability insurance policy.

(e) A disability insurance policy shall cover an examination by low-dose mammography that is not performed at the direction of a licensed physician or a nurse practitioner but that is otherwise required to be covered under par. (b) or (c), if all of the following are satisfied:

1. The woman does not have an assigned or regular physician or nurse practitioner when the examination is performed.

2. The woman designates a physician to receive the results of the examination.

3. Any examination by low-dose mammography previously obtained by the woman was at the direction of a licensed physician or a nurse practitioner.

(f) This subsection does not apply to any of the following:

1. A disability insurance policy that only provides coverage of certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

3. A medicare replacement policy, a medicare supplement policy or a long-term care insurance policy.

(9) **DRUGS FOR TREATMENT OF HIV INFECTION** (a) In this subsection, "HIV infection" means the pathological state produced by a human body in response to the presence of HIV, as defined in s. 631.90 (1).

(b) Except as provided in par. (d), every disability insurance policy that is issued or renewed on or after April 28, 1990, and that provides coverage of prescription medication shall provide coverage for each drug that satisfies all of the following:

1. Is prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection.

2. Is approved by the federal food and drug administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36 for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and that is in, or has completed, a phase 3 clinical investigation performed in accordance with 21 CFR 312.20 to 312.33.

3. If the drug is an investigational new drug described in subd. 2., is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 CFR 312.34 to 312.36.

(c) Coverage of a drug under par. (b) may be subject to any copayments and deductibles that the disability insurance policy applies generally to other prescription medication covered by the disability insurance policy.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

3. A medicare replacement policy or a medicare supplement policy.

(10) **LEAD POISONING SCREENING** (a) Except as provided in par. (b), every disability insurance policy and every health care benefits plan provided on a self-insured basis by a county board under s. 59.07 (2), by a city or village under s. 66.184 or by a school district under s. 120.13 (2) shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and social services under s. 254.158.

(b) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.
2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).
3. A long-term care insurance policy, as defined in s. 600.03 (28g).
4. A medicare replacement policy, as defined in s. 600.03 (28p).
5. A medicare supplement policy, as defined in s. 600.03 (28r).

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450.

Commissioner can reasonably construe (3) to require insurer to pay facility's charge for care up to the maximum department of health and social services rate. *Mutual Benefit v. Ins. Comr.* 151 W (2d) 411, 444 NW (2d) 450 (Ct. App. 1989).

Sub. (2) (g) does not prohibit insurer from contracting away right to review medical necessity; provision does not apply until insurer has shown that its own determination is relevant to insurance contract. *Schroeder v. Blue Cross & Blue Shield*, 153 W (2d) 165, 450 NW (2d) 470 (Ct. App. 1989).

632.896 Mandatory coverage of adopted children.

(1) DEFINITIONS. In this section:

- (a) "Department" means the department of health and social services.
- (b) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).
- (c) "Placed for adoption" means any of the following:
 1. The department, a county department under s. 48.57 (1) (e) or (hm) or a child welfare agency licensed under s. 48.60 places a child in the insured's home for adoption and enters into an agreement under s. 48.833 with the insured.
 2. A court under s. 48.837 (6) (b) orders a child placed in the insured's home for adoption.
 3. A sending agency, as defined in s. 48.988 (2) (d), places a child in the insured's home under s. 48.988 for adoption, and the insured takes physical custody of the child at any location within the United States.
 4. The person bringing the child into this state has complied with s. 48.98, and the insured takes physical custody of the child at any location within the United States.
 5. A court of a foreign jurisdiction appoints the insured as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the insured's home for the purpose of adoption by the insured under s. 48.839.

(2) **ADOPTED OR PLACED FOR ADOPTION.** Every disability insurance policy that is issued or renewed on or after March 1, 1991, and that provides coverage for dependent children of the insured, as defined in the disability insurance policy, shall cover adopted children of the insured and children placed for adoption with the insured, on the same terms and conditions, including exclusions, limitations, deductibles and copayments, as other dependent children, except as provided in subs. (3) to (6).

(3) **WHEN COVERAGE BEGINS AND ENDS.** (a) 1. Coverage of a child under this section shall begin on the date that a court makes a final order granting adoption of the child by the insured or on the date that the child is placed for adoption with the insured, whichever occurs first.

2. Subdivision 1. does not require coverage to begin before coverage is available under the disability insurance policy for other dependent children.

(b) Coverage of a child placed for adoption with the insured is required under this section despite whether a court ultimately makes a final order granting adoption of the child by the insured. If adoption of a child who is placed for adoption with the insured is not finalized, the insurer may terminate coverage of the child when the child's adoptive placement with the insured terminates.

(4) **PREEXISTING CONDITIONS.** Notwithstanding s. 632.76 (2) (a), a disability insurance policy that is subject to sub. (2) and that is in effect when a court makes a final order granting adoption or when the child is placed for adoption may not exclude or limit cov-

erage of a disease or physical condition of the child on the ground that the disease or physical condition existed before coverage is required to begin under sub. (3).

(6) **NOTICE TO INSURER.** The disability insurance policy may require the insured to notify the insurer that a child is adopted or placed for adoption and to pay the insurer any premium or fees required to provide coverage for the child, within 60 days after coverage is required to begin under sub. (3). If the insured fails to give notice or make payment within 60 days as required by the disability insurance policy in accordance with this subsection, the disability insurance policy shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage.

History: 1989 a. 336

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

(ac) "Custodial parent" means the parent of a child who has been awarded physical placement with the child for more than 50% of the time.

(am) "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. or 1m. 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;

1m. A long-term care insurance policy issued by an insurer to a policyholder on behalf of a group;

2. An uninsured plan or program whereby a health maintenance organization, limited service health organization, preferred provider plan, 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, and a long-term care insurance policy.

(d) "Insurer" means the insurer in the case of a group policy as defined in par. (c) 1., 1m. 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.

(em) "Physical placement" has the meaning given in s. 767.001 (5).

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

(1m) Except as provided in sub. (10), this section applies to any group policy which would otherwise be exempt under s. 600.01 (1) (b) 3. if at least 150 of the certificate holders or insureds are residents of this state.

(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 more 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 1m. 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 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 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. This paragraph does not apply if the policy being converted is a long-term care insurance policy.

(bm) The commissioner shall specify, by rule, the minimum standards that an individual conversion policy must satisfy if the policy being converted is a long-term care insurance policy. An insurer provides reasonably similar individual coverage to a person converting a long-term care insurance policy if the person is offered an individual conversion policy that complies with the rules promulgated under this paragraph.

(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 subs. 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., 1m. 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 18 months after the terminated insured

elects the group coverage except as provided in s. 103.10 (9) (d). The conditions, rights and procedures governing conversion under sub. (4) (a) apply to this conversion.

(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) (a) 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, or set a premium for any child which is different from that which is set for other dependent children, based solely on any of the following:

1. The fact that the child does not reside with the group member or insured or is dependent on another parent rather than the group member or insured.
2. The proportion of the child's support provided by the group member or insured.
3. The fact that the group member or insured does not claim the child as an exemption for federal income tax purposes under 26 USC 151 (c) (1) (B), or as an exemption for state income tax purposes under s. 71.07 (8) (b) or under the laws of another state, if a court order under s. 767.25 (4m) or 767.51 (3m) or the laws of another state assigns responsibility for the child's health care expenses to the group member or insured.
4. The fact that the child is a nonmarital child.
5. The fact that the child resides outside the insurer's geographical service area.

(am) If a court orders an individual to provide coverage for health care expenses for a child of the individual and the individual is eligible for family coverage under a group policy or individual policy, the insurer shall do all of the following:

1. Provide family coverage under the group policy or individual policy for the individual's child, if eligible for coverage, without regard to any enrollment period restrictions that may apply under the policy.

2. Provide family coverage under the group policy or individual policy for the individual's child, if eligible for coverage, upon application by the individual, the child's other parent, the department of health and social services or the county designee under s. 59.07 (97).

3. After the child is covered under the group policy or individual policy, and as long as the individual is eligible for family coverage under the policy, continue to provide coverage for the child unless the insurer receives satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another group policy or individual policy that provides comparable health care coverage.

(b) Paragraphs (a) and (am) do not prohibit an insurer from determining the eligibility of a group member's or insured's child for coverage under the group policy or individual policy, or the premium for that coverage, based on factors that are not prohibited by par. (a) 1. to 5. and that the insurer applies generally to determine the eligibility of children for coverage, and the premium for coverage, under the group policy or individual policy.

(bf) If an insurer provides coverage under a group policy or an individual policy for a child of a group member or an insured who is not the custodial parent of the child, the insurer shall do all of the following:

1. Provide to the custodial parent of the child information related to the child's enrollment.

2. Permit the custodial parent of the child, a health care provider that provides services to the child or the department of health and social services to submit claims for covered services without the approval of the parent who is the group member or insured.

3. Pay claims directly to the health care provider, the custodial parent of the child or the department of health and social services, as appropriate.

(c) This subsection applies to any group policy that would otherwise be exempt under s. 600.01 (1) (b) 3. if at least 25 of the certificate holders or insureds are residents of this state.

History: 1979 c. 285, 355; 1981 c. 41; 1983 a. 27, 274; 1985 a. 29; 1987 a. 287, 413; 1989 a. 31; 1993 a. 481.

Cross-reference: See s. 49.45 (20) concerning exemption from continuation of group coverage.

Employe retirement income security act preempts any state law that relates to employe benefit plans. *General Split Corp. v. Mitchell*, 523 F Supp 427 (1981).

Wisconsin health insurance continuation/conversion law *Michal*, WBB February 1982.

SUBCHAPTER VII

FRATERNAL INSURANCE

632.91 Definition. In this subchapter, "insured employe" means an employe of a fraternal or of a subsidiary or other affiliate of a fraternal who is provided insurance benefits by the fraternal under s. 614.10 (2) (c) but is not a member of the fraternal.

History: 1989 a. 336; 1991 a. 189.

632.93 The fraternal contract. (1) ISSUANCE OF CERTIFICATE. A fraternal shall issue to each benefit member and insured employe 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 or insured employe, and the policy or certificate shall so state.

(2) **CHANGES IN LAWS OF FRATERNALS.** Except as provided in s. 614.24 (1m), any changes in the laws of a fraternal made subsequent to the issuance of a policy or certificate bind the member, beneficiary and insured employe 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 or insured employe 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; 1987 a. 361; 1989 a. 336

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 mis-

representation, 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 or insured employe may designate as beneficiary any person permitted by the laws of the fraternal. Those laws shall authorize the designation of the member's or insured employe's estate as beneficiary.

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

History: 1975 c. 373, 421; 1989 a. 336.

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.

632.99 Certifications of disability. Every insurer doing a health or disability insurance business in this state shall afford equal weight to a certification of disability signed by a physician with respect to matters within the scope of the physician's professional license and to a certification of disability signed by a chiropractor with respect to matters within the scope of the chiropractor's professional license for the purpose of insurance policies they issue. This section does not require an insurer to treat any certification of disability as conclusive evidence of disability.

History: 1981 c. 55.