Ins 3

Filed January 29, 1974
2:05 pm S.L.O.

STATE OF WISCONSIN )
) ss.
OFFICE OF THE COMMISSIONER OF INSURANCE)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, S. C. DuRose, Commissioner of Insurance and custodian of the official records of said office, do hereby certify that the annexed order amending and creating a rule relating to application forms and solicitation, underwriting and claims practices in individual accident and sickness insurance was issued by this office on January 29, 1974.

I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 29th day of January, 1974.

S. C. DuRose
Commissioner of Insurance

STATE OF WISCONSIN
DEPARTMENT OF STATE
RECEIVED AND FILED

JAN 29 1974

ROBERT C. ZIMMERMAN
SECRETARY OF STATE

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

Amending and Creating Rules

Pursuant to authority vested in the Commissioner of Insurance by section 601.41 (3), Wis. Stats., the Commissioner of Insurance hereby amends and creates rules as follows:

Section Ins 3.13 (4) (a) is amended to read:

(a) Application forms shall meet the requirements of Wis. Ad. Code section Ins 3.28 (3).

Section Ins 3.28 of the Wisconsin Administrative Code is created to read:

Ins 3.28 Solicitation, Underwriting and Claims Practices in Individual Accident and Sickness Insurance. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and of contracts issued by a plan subject to section 200.26, Wis. Stats. Sections of Wis. Stats. interpreted or implemented by this rule include but are not limited to sections 201.045 (3), 601.01 (3) (b), 611.20, and 618.12 (1).

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of any insurance issued by any insurer or fraternal benefit society under section 204.31, Wis. Stats., other than franchise insurance, and to any contract, other than one issued on a group or group type basis as defined in Wis. Adm. Code section Ins 6.51 (3), issued by a plan subject to section 200.26, Wis. Stats. For the purposes of this rule, the terms insurer, policy, and insurance agent or representative relate to organizations, contracts, and persons within the scope of this rule.

(3) APPLICATION FORM. An application form which becomes part of the insurance contract shall provide to the effect that statements made by the applicant in the application form regarding the general medical history or general health of a proposed insured person which require an opinion or the exercise of judgment are representations or are to the best of the applicant's knowledge and/or belief. Such form need not so provide with respect to statements regarding specifically named diseases, physical conditions, or types of medical consultation or treatment. Such form shall not require the applicant to state that he has not withheld any information or concealed any facts in completing the application; however, the applicant may be required to state that his answers are true and complete to the best of his knowledge and/or belief.

(4) SOLICITATION. An insurance agent or representative shall review carefully with the applicant all questions contained in each application which he prepares and shall set down in each such form all material information disclosed to him by the applicant in response to the questions in such form.

(5) UNDERWRITING. (a) An insurer shall make provision for adequate underwriting personnel and procedures so as to process without undue delay each application for insurance received by it.

(b) An insurer shall give due consideration to all statements in each application for insurance submitted to it and shall duly evaluate the proposed insured person before issuing coverage for such person.

(c) An insurer which issues coverage for a person without having resolved patently conflicting or incomplete statements in the application for the coverage, or fails to consider information furnished

to it in connection with the processing of such application, or in connection with individual coverage on such person previously issued by it and currently in force, shall not use such statements or information to void the coverage or to deny a claim.

(d) An insurer shall, within 10 days after the issuance or amendment of a policy, contract or certificate, furnish to the policyholder, subscriber or certificate holder, where the application for the coverage or the amended coverage is part of the insurance contract, a notice, in the form of a sticker to be attached to the first page of the policy, a letter, or other form containing substantially the following:

IMPORTANT NOTICE

CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the application attached to this notice or to your policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the insurer within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

(e) An insurer shall file with the Commissioner a description of the procedure it will follow and the form or forms it will use to meet the requirements of paragraph (d).

(f) An insurer which, after coverage for a person has been issued, receives information regarding such person which would reasonably be considered a sufficient basis to void or reform such person's coverage shall effect such voiding or reformation within a reasonable time, or the insurer shall be held to have waived its rights to such action.

(6) CLAIMS ADMINISTRATION. (a) If the existence of a disease or physical condition is duly disclosed in the application for coverage in response to the questions therein, the insurer shall not use the pre-existence defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss.

(b) If an application contains no question concerning the proposed insured person's health history or medical treatment history and regardless of whether it contains a question concerning the proposed insured person's general health at the time of the application, the insurer may use the pre-existence defense, under coverage providing such a defense, only with respect to losses incurred within twelve months from the effective date of coverage, unless the disease or physical condition causing the loss is excluded from coverage by name or specific description effective on the date of loss.

(c) An insurer shall not void coverage or deny a claim on the ground that the application for such coverage did not disclose certain information considered material to the risk if the application did not clearly require the disclosure of such information.

(d) A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition, as distinguished from the cause of such disease or physical condition, had manifested itself prior to such date. Such manifestation may be established by evidence of 1. medical diagnosis or treatment of such disease or physical condition prior to the effective date, or 2. the existence of symptoms of such disease or physical condition prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care, or treatment.

(e) Coverage which contains wording which requires the cause of the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with paragraph (d) of this subsection.

(f) An insurer shall not exclude or limit benefits, using the pre-existence defense, a waiting period, a benefit maximum or other policy limitation, where the claimant's medical records indicate a reasonable basis for distinguishing between the condition or conditions which necessitated the hospital confinement or the medical or surgical treatment for which claim is made or which resulted in the disability for which claim is made and a concurrently existing condition or conditions which did not contribute to the need for the confinement or treatment or did not contribute to the disability.

(7) EFFECTIVE DATE. (a) Subsections (4), (5) (a), (b), (c), and (e) and (6) shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after March 1, 1974.

(b) Subsections (3) and (5) (d) and (e) shall apply to all solicitation, underwriting and claims activities relating to Wisconsin residents after May 1, 1974.

Dated January 29, 1974.

S. C. DuRose
Commissioner of Insurance