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STATE OF WISCONSIN
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VEL PHILLIPS
SECRETARY OF STATE

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

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Thomas Hefty, Deputy Commissioner of Insurance and custodian of the official records of said office, do hereby certify that the annexed order amending rules relating to solicitation, underwriting and claims practices in individual, group, blanket and group type accident and sickness insurance was issued by this office March 2, 1982.

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 by name in the City of Madison, State of Wisconsin, this 2nd day of March, 1982.

Thomas R. Hefty
Deputy Commissioner of Insurance

6147B

5-1-82

ORDER OF THE COMMISSIONER OF INSURANCE

AMENDING RULES

Relating to solicitation, underwriting and claims practices in individual, group, blanket and group type accident and sickness insurance.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

The purpose of this rule is to amend Ins 3.28 and Ins 3.31 to clarify requirements about which there is currently confusion and inconsistent interpretation in the insurance industry.

These sections interpret and implement ss. 601.01 (2), 601.04 (3), 611.20, 618.12 (1) and 632.76, Stats.

Ins 3.28 (5) (c) and Ins 3.31 (3) (a) 3. c. are repealed and recreated to clarify prohibited reasons for voiding coverage or denying claims.

Ins 3.28 (5) (d) is repealed and recreated to make the requirement that insurers provide a notice concerning questions affecting insurability more specific. The proposed language merely reduces the possibility of misinterpretation on the part of insurers.

Ins 3.28 (5) (f) and Ins 3.31 (3) (a) 3. f. are amended to refer to the statutory time limit on insurer's rights to use information acquired after issuance of coverage.

Ins 3.28 (5) (g) is created to make it clear that certain statements appearing in an application for individual insurance may be used as a defense to a claim or to reform coverage only if it is in compliance with Ins 3.28 (5) (d). Similar language exists in Ins 3.31 (3) (a) 3.g. for group, blanket and group type insurance. This change would make the two rules more consistent.

Ins 3.28 (6) (b) and Ins 3.31 (3) (a) 4. b. are amended to make them consistent with s. 632.76 (2), Stats. As those sections apply to disability income insurance, it is necessary to refer to the time at which a disability commences in reference to pre-existing condition exclusions. Currently the rules refer only to when losses occur which is inappropriate as applied to disability income insurance. The current language of those sections specifies when the pre-existence defense in claim denial may be used. Proposed language is added to make it clear when the pre-existence defense may not be used.

Ins 3.28 (6) (d) and Ins 3.31 (3) (b) 1. and (4) (b) 1. are repealed and recreated to clarify the language which allow insurers to deny or reduce a claim on the basis of a pre-existing condition limitation when an insured has noticeable symptoms which would prompt a reasonable person to seek diagnosis, but the insured has failed to do so before the effective date of coverage.

Ins 3.28 (6) (f), Ins 3.31 (3) (b) 3. and Ins 3.31 (4) (b) 3. are repealed and recreated to clarify the prohibition of certain uses of the insureds' health history with regard to claims. Other minor editorial and cross-reference changes are also included.

Pursuant to the authority vested in the Commissioner of Insurance by section 601.41 (3), Wis. Stats., the Commissioner of Insurance hereby amends rules interpreting sections 601.04 (3), 601.01 (2), 611.20, 618.12 (1), and 632.76, Stats., as follows:

SECTION 1. Ins 3.28 (1) is amended to read:

Ins 3.28 (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 ch. 613, Stats. Sections of Stats. interpreted or implemented by this rule include but are not limited to ss. 601.04 (3), 601.01 (3) (b) (2), 611.20, ~~and~~ 618.12 (1), and 632.76, Stats.

SECTION 2. Ins 3.28 (2) is amended to read:

Ins 3.28 (2) SCOPE. This rule applies to the solicitation, underwriting and administration of any insurance issued by any insurer or fraternal benefit society under s. Ins 6.75 (1) (c) or (2) (c) and ss. 600.03 ~~(34m)~~ (35) (d) and ~~632.94, Stats.~~, 632.93, Stats., except credit accident and sickness insurance under s. Ins 6.75 (1) (c) 1. or (2) (c) 1, and to any contract, other than one

issued on a group or group type basis as defined in Wis. Adm. Code s. Ins 6.51 (3), issued by a plan subject to ch. 613, Stats. For the purpose of this rule, references to insurer, policy, and insurance agent or representative, also apply to organizations or associations operating non-profit plans, contracts, and persons within the scope of the rule, respectively.

SECTION 3. Ins 3.28 (5) (c) is repealed and recreated to read:

Ins 3.28 (5) (c) An insurer which issues coverage for a person shall not use the statements, information or material set out in subds. 1, 2 and 3 to void the coverage on the basis of misrepresentation in the application, or deny a claim on the basis of a pre-existing condition defense, unless the insurer has:

1. Resolved patently conflicting or incomplete statements in the application for the coverage;
2. Duly considered information furnished to it:
   a. In connection with the processing of such application, or
   b. In connection with individual coverage on the person previously issued by it and currently in force, or
3. Duly considered the material which it would have obtained through reasonable inquiry following due consideration of the statements or information.

SECTION 4. Ins 3.28 (5) (d) is repealed and recreated to read:

Ins 3.28 (5) (d) An insurer shall at the issuance or amendment of a policy, contract or subscriber certificate, furnish notice concerning statements in the application to the policyholder, contracting party or certificate holder, where the application for the coverage or

amended coverage contains questions relating to the medical history or other matters concerning the insurability of the person or persons being insured and the application is part of the insurance contract.

1. The notice shall be printed prominently in contrasting color on the first page of the policy, contract, or subscriber certificate or in the form of a sticker, letter or other form attached to the first page of the policy, contract or certificate, or a letter or other form to be mailed within 10 days after the issuance or amendment of coverage.
2. The notice shall contain substantially the following as to text and caption or title:

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.

SECTION 5. Ins 3.28 (5) (f) is amended to read:

Ins 3.28 (5) (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~~, as provided in s. 631.11 (4), Stats., or the insurer shall be held to have waived its rights to such action.

SECTION 6. Ins 3.28 (5) (g) is created to read:

Ins 3.28 (5) (g). An insurer may use statements in an application form as a defense to a claim or to avoid or reform coverage only if it has complied with par. (5) (d).

SECTION 7. Ins 3.28 (6) (b) is amended to read:

Ins 3.28 (6) (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 or disability commencing within twelve months from the effective date of coverage, unless the disease or physical condition causing the loss or disability is excluded from coverage by name or specific description effective on the date of loss or the date the disability commenced. If, after 12 months from the effective date of coverage, there is a reoccurrence of the disease or condition causing the loss or disability, then the pre-existence defense may not be used. Under a disability

income policy a disease or condition shall be deemed to have not reoccurred if the insured performs all important duties of the insured's or a comparable occupation on the same basis as before the disability, for at least 6 months. Under a policy other than disability income a disease or condition shall be deemed to have not reoccurred if a period of 6 months elapses during which no expenses are incurred for the same or related disease or condition.

SECTION 8. Ins 3.28 (6) (d) is repealed and recreated to read:

Ins 3.28 (6) (d) A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss or disability 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 and for which such diagnosis, care or treatment was not sought prior to such date.

SECTION 9. Ins 3.28 (6) (f) is repealed and recreated to read:

Ins 3.28 (6) (f) An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing

between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non-eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

1. A pre-existence defense;
2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;
3. A benefit maximum; or
4. Other policy limitation.

SECTION 10. Ins 3.31 (1) is amended to read:

Ins 3.31 (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 coverage issued by a plan subject to ss. 185.981 or ch. 613, Stats. Sections of Stats. interpreted or implemented by this rule include but are not limited to ss. 601.04 (3), 601.01 ~~(3)-(b)~~ (2), 611.20, ~~and~~ 618.12 (1) and 632.76, Stats.

SECTION 11. Ins 3.31 (2), (3) (intro.), (3) (c) and (4) are amended to read:

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of insurance issued by an insurer under s. 600.03 ~~(34m)~~ (35) (b) or (c), Stats., except credit accident and sickness

insurance under section Ins 6.75 (1) (c) 1. or (2) (c) 1., and coverage issued on a group basis or group type basis as defined in Wis. Adm. Code section Ins 6.51 (3) by a plan subject to s. 185.981, or ch. 613, Stats. For the purposes of this rule, references to insurer, certificate, insurance agent or representative, enrollment form and enrollee also apply to organizations or associations operating non-profit plans, contracts, summaries of coverage, persons within the scope of the rule, individual applications and applicants, respectively.

(3) GROUP AND GROUP TYPE INSURANCE. An insurer issuing insurance under S. 600.03 ~~(34m)~~ (35) (b), Stats., or group or group type coverage under s. 185.981 or ch. 613, Stats., shall,

(c) Where the group or group type plan is issued to trustees of a fund, use the plan's provisions regarding individual eligibility for coverage and individual termination of coverage to deny liability for or to defend against a claim only if the certificate issued pursuant to the plan, under an appropriate caption or captions, includes the applicable requirements regarding an individual's eligibility for coverage and the conditions under which an individual's coverage terminates under the plan.

(4) BLANKET INSURANCE. An insurer issuing insurance under s. 600.03 ~~(34m)~~ (35) (c), Stats., shall

SECTION 12. Ins 3.31 (3) (a) 3. c. is repealed and recreated to read:

Ins 3.31 (3) (a) 3. c. An insurer which issues evidence of coverage for a person shall not use the statements, information or material set out in subds. 1, 2 and 3 to void the coverage on the basis of misrepresentation in the enrollment form, or deny a claim on the basis

of a pre-existing condition defense, unless the insurer has resolved patently conflicting or incomplete statements in the enrollment form for the coverage, duly considered information furnished to it in connection with the processing of such enrollment form, or duly considered the material which it would have obtained through reasonable inquiry following due consideration of such statements or information.

SECTION 13. Ins 3.31 (3) (a) 3.d. is amended to read:

Ins 3.31 (3) (a) 3.d. An insurer shall furnish to the certificate holder or subscriber a notice printed prominently in contrasting color on the first page of the certificate or amendment, or in the form of a sticker or other form to be attached to the first page of the certificate or amendment, or furnish to the group policyholder or other such entity within 10 days after the issuance or amendment of coverage for delivery to the certificate holder or subscriber, a notice in the form of a letter or other form, such notice to contain substantially the following:

IMPORTANT NOTICE

CONCERNING STATEMENTS IN THE ENROLLMENT

FORM FOR YOUR INSURANCE

Please read the copy of the enrollment form attached to this notice or to your certificate or which has been otherwise previously delivered to you by the insurer or group policyholder. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the insurer within 10 days if any information shown on the form is not

correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

SECTION 14. Ins 3.31 (3) (a) 3.f. is amended to read:

Ins 3.28 (3) (a) 3. f. An insurer which, after evidence of 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~~, as provided in s. 631.11 (4), Stats., or the insurer shall be held to have waived its rights to such action.

SECTION 15. Ins 3.31 (3) (a) 4. b. is amended to read:

Ins 3.31 (3) (a) 4. b. If an enrollment form 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 enrollment, the insurer may use the pre-existence defense, under coverage providing such a defense, only with respect to losses incurred or disability commencing within 12 months from the effective date of the person's coverage, unless the disease or physical condition causing the loss or disability is excluded from coverage by name or specific description effective on the date of loss or the date the disability commenced. If after 12 months from the effective date of coverage, there is a reoccurrence of the disease or condition causing the loss or disability, then the pre-existence defense may not be used. Under a

disability income policy a disease or condition shall be deemed to have not reoccurred if the insured performs all important duties of a comparable occupation on the same basis as before the disability, for at least 6 months. Under a policy other than disability income a disease or condition shall be deemed to have not reoccurred if a period of 6 months elapses during which no expenses are incurred for the same or a related disease or condition.

SECTION 16. Ins 3.31 (3) (b) 1. and (4) (b) 1. are repealed and recreated to read:

Ins 3.31 (3) (b) 1. A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss or disability 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:

a. Medical diagnosis or treatment of such disease or physical condition prior to the effective date, or

b. The existence of symptoms of such disease or physical condition prior to the effective date which would cause an ordinarly prudent person to seek diagnosis, care or treatment and for which such diagnosis, care or treatment was not sought prior to such date.

Ins 3.31 (4) (b) 1. A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss

or disability 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 had manifested itself prior to such date. Such manifestation may be established by evidence of:

a. Medical diagnosis or treatment of such disease or physical condition prior to the effective date, or

b. 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 and for which such diagnosis, care or treatment was not sought prior to such date.

SECTION 17. Ins 3.31 (3) (b) 3. and 3.31 (4) (b) 3. is repealed and recreated to read:

Ins 3.31 (3) (b) 3. An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non-eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

1. A pre-existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

Ins 3.31 (4) (b) 3. An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non-eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

1. A pre-existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

As provided by s. 227.026 (1) (intro.), Stats., this section shall take effect on the first day of the month following publication in the administrative register.

Dated at Madison, Wisconsin, this 2nd day of March, 1982.

Thomas R. Hefty
Deputy Commissioner of Insurance

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