

Chapter Ins 3

CASUALTY INSURANCE

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Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be

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deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.08 Municipal bond insurance. (1) **PURPOSE.** This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) **SCOPE.** This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

(3) **DEFINITIONS.** (a) "Annual statement" means the fire and casualty annual statement form specified in s. Ins. 7.01 (5) (a).

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities, including revenue obligations, the interest on which is exempt from Federal income taxes, including those which are issued by or on behalf of:

1. Any state, territory or possession of the United States of America;
 2. Any political subdivision of any such state, territory or possession;
- or
3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

(i) "Policyholders' surplus" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

(4) **MINIMUM CAPITAL OR PERMANENT SURPLUS.** The minimum capital or permanent surplus of a municipal bond insurer shall be \$2 million for Register, October, 1984, No. 346

an insurer first authorized to do business in Wisconsin on or before January 1, 1984, or the amount required by statute or administrative order after that date for other municipal bond insurers.

(5) **LIMITATIONS AND RESTRICTIONS.** (a) Policies of municipal bond insurance shall be issued only to provide coverage on bonds of the type defined in sub. (3) (d).

(b) A municipal bond insurer may not have total net liability in respect to any one issue of municipal bonds in excess of an amount representing 10% of its policyholders' surplus.

(c) A municipal bond insurer may not have outstanding cumulative net liability, under in-force policies of municipal bond insurance, in an amount which exceeds the sum of:

1. Its capital and surplus, plus
2. The contingency reserve under sub. (9) plus
3. Fifty percent of the unearned premiums on the stated class of business.

(d) A municipal bond insurer may not have more than 25% of the principal amount which it has insured represented by the principal amount of municipal bonds issued primarily to finance property for use in a trade or business carried on by any person other than a governmental unit, and secured by a pledge of payments to be made by the person or of revenues to be derived from the trade or business.

(6) **PREMIUM.** The total consideration charged for municipal bond insurance policies, including policy and other fees or similar charges, shall be considered premium and shall be subject to the reserve requirements of subs. (8) and (9).

(7) **FINANCIAL STATEMENTS AND REPORTING.** (a) The financial condition and operations of a municipal bond insurer shall be reported on the annual statement.

(b) The total contingency reserve required by sub. (9) shall be reported as a liability in the annual statement. This liability may be reported as unpaid losses or other appropriately labeled write-in item. Appropriate entries shall be made in the underwriting and investment exhibit - statement of income of the annual statement. The change in contingency reserve for the year shall be reported in the annual statement as a reduction of or a deduction from underwriting income. If the contingency reserve is recorded as a loss liability, the change in the reserve shall be excluded from loss development similar to fidelity and surety losses incurred but not reported.

(c) A municipal bond insurer shall compute and maintain adequate case basis loss reserves to be reported in the underwriting and investment exhibit, unpaid losses and loss adjustment expenses, of the annual statement. The method used to determine the loss reserve shall accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid, and for claims incurred but not reported, provided:

1. No deduction may be made for anticipated salvage in computing case basis loss reserves.

2. If the amount of insured principal and interest on a defaulted issue of municipal bonds which is due and payable over the period of the next three years exceeds 10% of a municipal bond insurer's capital, surplus and contingency reserve, its case basis reserve so established shall be supported by a report from a qualified independent source.

(8) **UNEARNED PREMIUM RESERVE.** A municipal bond insurer shall compute and maintain an unearned premium reserve on an annual or on a monthly pro rata basis on all unexpired coverage, except that in the case of premiums paid more than one year in advance, the premium shall be earned proportionally with the expiration of exposure except as provided under sub. (12).

(9) **CONTINGENCY RESERVE.** (a) A municipal bond insurer shall establish a contingency reserve which shall consist of allocations of sums representing 50% of the earned premium on policies of municipal bond insurance except as provided under sub. (12).

(b) The contingency reserve established by this subsection shall be maintained for 240 months. That portion of the contingency reserve established and maintained for more than 240 months shall be released and may no longer constitute part of the contingency reserve except as provided under sub. (12).

(c) Subject to the approval of the commissioner, withdrawals may be made from the contingency reserve in any year in which the actual paid losses on municipal bond insurance policies exceed 35% of the earned premiums on municipal bonds insurance policies except as provided under sub. (12).

(d) A municipal bond insurer may invest the contingency reserve in tax and loss bonds purchased pursuant to 26 U.S.C.s. 832(e). The contingency reserve shall otherwise be invested only in classes of securities or types of investments specified in s. 620.22 (1), Stats., except as provided under sub. (12).

(10) **CONFLICTS OF INTEREST PROHIBITED.** No municipal bond insurer may pay any commission or make any gift of money, property or other valuable thing to any employe, agent, or representative of any issuer of municipal bonds or to any employe, agent or representative of any underwriter of any issue of the bonds as an inducement to the purchase of, or at any time there is in force, a policy insuring bonds, and no employe, agent or representative of the insurer or underwriter shall receive any payment or gift. However, violation of the provisions of this subsection does not render void the municipal bond insurance policy.

(11) **TRANSITION.** Unearned premium reserves and contingency loss reserves shall be computed and maintained on risks insured after the effective date of this section as required by subs. (8) and (9).

(12) **LAWS OR REGULATIONS OF OTHER JURISDICTIONS.** Whenever the laws or regulations of another jurisdiction in which a municipal bond insurer is licensed, require a larger unearned premium reserve or a larger contingency reserve in the aggregate than that set forth in this section, the establishment and maintenance of the larger aggregated, unearned premium reserve and contingency reserve complies with this rule.

Ins 3.09 Mortgage guaranty insurance. (1) **PURPOSE.** This section implements and interprets s. Ins 6.75 (2) (i) and (j) and ss. 601.42, 611.19 (1), 611.24, 618.21, 620.02, 623.02, 623.03, 623.04, 627.05 and 628.34 (12), Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) **SCOPE.** This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by s. Ins 6.75 (2) (i) and (j).

(3) **DEFINITIONS.** (a) "Amount at risk" means the coverage percentage or the claim settlement option percentage multiplied by the face of amount of a mortgage or by the insured amount of a lease.

(b) "Annual statement" means the fire and casualty annual statement form specified in s. Ins 7.01 (5) (a).

(c) "Contingency reserve" means the reserve established for the protection of policyholders against the effect of losses resulting from adverse economic cycles.

(d) "Equity" means the complement of the Loan-to-Value.

(e) "Face amount" means the entire indebtedness under an insured mortgage before computing any reduction because of an insurer's option limiting its coverage.

(f) "Loan-to-value" means the ratio of the entire indebtedness to value of the collateral property expressed as a percentage.

(g) "Mortgage guaranty account" means the portion of the Contingency Reserve which complies with 26 U.S.C. s. 832 (e) as amended.

(h) "Mortgage guaranty insurance" means that kind of insurance authorized by s. Ins 6.75 (2) (i).

(i) "Mortgage guaranty insurer" means an insurer which:

1. Insures pursuant to Ins 6.75 (2) (i), or
2. Insures pursuant to s. Ins 6.75 (2) (j) against loss arising from failure of debtors to meet financial obligations to creditors under evidences of indebtedness secured by a junior lien or charge on real estate.

(j) "Mortgage guaranty insurers report of policyholders position" means the annual supplementary report required by s. Ins 7.01 (24) (t).

(k) "NAIC Ratio — Investment Yield" means net investment income earned after taxes from the annual statement divided by mean invested assets.

(l) "Person" means any individual, corporation, association, partnership or any other legal entity.

(m) "Policyholders position" includes the contingency reserve established under sub. (14) and surplus as regards policyholders. "Minimum policyholders position" is calculated as described in sub. (5).

(n) "Surplus as regards policyholders" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

(4) **DISCRIMINATION.** No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the geographic location of the property or the applicant's sex, marital status, race, color, creed or national origin.

(5) **MINIMUM POLICYHOLDERS POSITION.** (a) A mortgage guaranty insurer shall maintain at all times a minimum policyholders position in the amount required by this section. The policyholders position shall be net of reinsurance ceded but shall include reinsurance assumed.

(b) If a mortgage guaranty insurer does not have the minimum amount of policyholders position required by this section it shall cease transacting new business until such time that its policyholders position is in compliance with this section.

(c) If a policy of mortgage guaranty insurance insures individual loans with a percentage claim settlement option on such loans, a mortgage guaranty insurer shall maintain a policyholders position based on: each \$100 of the face amount of the mortgage; the percentage coverage; and the loan-to-value category. The minimum amount of policyholders position shall be calculated in the following manner:

1. If the loan-to-value is greater than 75%, the minimum policyholders position per \$100 of the face amount of the mortgage for the specific percent coverage shall be as shown in the schedule below:

Percent Coverage	Policyholders Position Per \$100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per \$100 of the Face Amount of the Mortgage
5	\$0.20	55	\$1.50
10	0.40	60	1.55
15	0.60	65	1.60
20	0.80	70	1.65
25	1.00	75	1.75
30	1.10	80	1.80
35	1.20	85	1.85
40	1.30	90	1.90
45	1.35	95	1.95
50	1.40	100	2.00

2. If the loan-to-value is at least 50% and not more than 75%, the minimum amount of the policyholders position shall be 50% of the minimum of the amount calculated under subd. 1.

3. If the loan-to-value is less than 50%, the minimum amount of policyholders position shall be 25% of the amount calculated under subd. 1.

(d) If a policy of mortgage guaranty insurance provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be:

1. If the equity is not more than 50% and is at least 20%, or equity plus prior insurance or a deductible is at least 25% and not more than

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55%, the minimum amount of policyholders position shall be calculated as follows:

Percent Coverage	Policyholders Position Per \$100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per \$100 of the Face Amount of the Mortgage
1	\$0.30	50	\$0.825
5	0.50	60	0.85
10	0.60	70	0.875
15	0.65	75	0.90
20	0.70	80	0.925
25	0.75	90	0.95
30	0.775	100	1.00
40	0.80		

2. If the equity is less than 20%, or the equity plus prior insurance or a deductible is less than 25%, the minimum amount of policyholders position shall be 200% of the amount required by subd. 1.

3. If the equity is more than 50%, or the equity plus prior insurance or a deductible is more than 55%, the minimum amount of policyholders position shall be 50% of the amount required by subd. 1.

(e) If a policy of mortgage guaranty insurance provides for layers of coverage, deductibles or excess reinsurance, the minimum amount of policyholders position shall be computed by subtraction of the minimum position for the lower percentage coverage limit from the minimum position for the upper or greater coverage limit.

(f) If a policy of mortgage guaranty insurance provides for coverage on loans secured by junior liens, the policyholders position shall be:

1. If the policy provides coverage on individual loans, the minimum amount of policyholders position shall be calculated as in par. (c) as follows: a. the loan-to-value percent is the entire loan indebtedness on the property divided by the value of the property; b. the percent coverage is the insured portion of the junior loan divided by the entire loan indebtedness on the collateral property; and c. the face amount of the insured mortgage is the entire loan indebtedness on the property.

2. If the policy provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be calculated according to par. (d) as follows:

a. The equity is the complement of the loan-to-value percent calculated as in subd. 1; b. The percent coverage is calculated as in subd. 1; and c. The face amount of the insured mortgage is the entire loan indebtedness on the property.

(g) If a policy of mortgage guaranty insurance provides for coverage on leases, the policyholders position shall be \$4 for each \$100 of the insured amount of the lease.

(h) If a policy of mortgage guaranty insurance insures loans with a percentage loss settlement option coverage between any of the entries in the schedules in this subsection, then the factor for policyholders position per \$100 of the face amount of the mortgage shall be prorated between the factors for the nearest Percent Coverage listed.

(6) **LIMITATION ON INVESTMENT.** A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) **LIMITATION ON ASSUMPTION OF RISKS.** (a) A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by a single risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to transact such reinsurance in this state. "Contiguous" for the purpose of this subsection means not separated by more than one-half mile.

(b) A mortgage guaranty insurer shall not insure loans with balloon payment provisions unless the policy provides:

1. That liability for the balloon payment is specifically excluded; or
2. That at the time the lender calls the loan, the lender will offer new or extended financing at the then market rates; or
3. The scheduled maturity date of the balloon payment.

(7m) **MINIMUM CAPITAL OR PERMANENT SURPLUS.** The minimum amount of capital or permanent surplus of a mortgage guaranty insurer shall be \$2 million for an insurer first authorized to do business in Wisconsin on or after January 1, 1982, or the amount required by statute or administrative order before that date for other insurers.

(8) **REINSURANCE.** A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts, except it shall not enter into reinsurance arrangements designed to circumvent the compensation control provisions of sub. (15) or the contingency, reserve requirement of sub. (14). The unearned premium reserve required by sub. (13) and the contingency reserve required by sub. (14) shall be established and maintained in appropriate proportions in relation to risk retained by the original insurer and by the assuming reinsurer so that the total reserves established shall not be less than the reserve required by subs. (13) and (14).

(9) **ADVERTISING.** No mortgage guaranty insurer or any agent or representative of a mortgage guaranty insurer shall prepare or distribute or assist in preparing or distributing any brochure, pamphlet, report or any form of advertising to the effect that the real estate investments of any financial institution are "insured investments", unless the brochure, pamphlet, report or advertising clearly states that the loans are insured by insurers possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, as the case may be.

(10) **POLICY FORMS.** All policy forms and endorsements shall be filed with and be subject to approval of the commissioner. With respect to

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owner-occupied, single-family dwellings, the mortgage guaranty insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

(11) **PREMIUM.** (a) The total consideration charged for mortgage guaranty insurance policies, including policy and other fees or similar charges, shall be considered premium and must be stated in the policy and shall be subject to the reserve requirements of subs. (13) and (14).

(b) The rate making formula for mortgage guaranty insurance shall contain a factor or loading sufficient to produce the amount required for the contingency reserve prescribed by sub. (14).

(12) **REPORTING.** (a) The financial condition and operations of a mortgage guaranty insurer shall be reported annually on the annual statement.

(b) The total contingency reserve required by sub. (14) shall be reported as a liability in the annual statement. This liability may be reported as unpaid losses, mortgage guaranty account or other appropriately labeled write-in item. Appropriate entries shall be made in the underwriting and investment exhibit — statement of income of the annual statement. The change in contingency reserve for the year shall be reported in the annual statement as a reduction of or a deduction from underwriting income. If the contingency reserve is recorded as a loss liability the change in the reserve shall be excluded from loss development similar to fidelity and surety losses incurred but not reported. The development of the contingency reserve and policyholders position shall be shown in an appropriate supplemental schedule to the annual statement.

(c) A mortgage guaranty insurer shall compute and maintain adequate case basis loss reserves to be reported in the underwriting and investment exhibit, unpaid losses and loss adjustment expenses, of the annual statement. The method used to determine the loss reserve shall accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid, and for claims incurred but not reported, including estimated losses on:

1. Insured loans which have resulted in the conveyance of property to the insurer which remains unsold;
2. Insured loans in the process of foreclosure;
3. Insured loans in default for four months or for any lesser period which is defined as a default in the policy provision; and
4. Insured leases in default for 4 months or for any lesser period which is defined as a default in the policy provisions.

(d) In computing the case basis reserves required by par. (c), the following factors shall be considered together with the prospective adjustments reflecting historic data relative to prior claim settlements:

1. Prior to the exercise of the claim settlement option, the potential liability for which there must be a reserve shall consider the amount at risk or the potential claim amount minus the value of the real estate.
2. If the claim settlement option exercised results in recording the claim amount as the cost of acquisition of the property, the potential

liability is the claim amount minus the value of the real estate unless the real estate is recorded at market value.

3. If the claim settlement option exercised results in the payment of amounts equal to the monthly loan payments or lease rents, the potential liability is the present value, utilizing the insurer's NAIC financial ratio-investment yield, of the claim amounts minus the present value of the real estate or current rental income.

(e) Any property acquired pursuant to the exercise of the claim settlement option shall be valued net of encumbrances; and an amount of such property may be held as is permitted for nonlife insurer investments pursuant to s. 620.22 (5), Stats.

(f) Expenses shall be recorded and reported in accordance with ss. Ins 6.30 and 6.31.

(g) Amounts released from the contingency reserve pursuant to sub. (14) shall be treated on a first-in-first-out basis.

(h) An insurer which writes mortgage guaranty insurance and any other class of insurance business shall establish a segregated account for mortgage guaranty insurance or an insurer which writes more than one class of mortgage guaranty insurance shall establish a segregated account for each class of mortgage guaranty insurance. The classes of mortgage guaranty insurance are those types of insurance defined in:

1. s. Ins 6.75 (2) (i) 1 a and c; or
2. s. Ins 6.75 (2) (i) 1 b and 2; or
3. s. Ins 6.75 (2) (i) 1 d and (j).

(i) Each segregated account established under par. (h) shall contain:

1. The loss reserves required by par. (c);
2. The unearned premium reserve required by sub. (13) or (18);
3. The contingency reserve required by sub. (14) or (18); and
4. Any surplus required by the commissioner.

(13) **UNEARNED PREMIUM RESERVE.** (a) A mortgage guaranty insurer shall compute and maintain an unearned premium reserve on an annual or on a monthly pro rata basis on all unexpired coverage, except that in the case of premiums paid in advance for any coverage issued with a term shown in the schedule below the annual unearned premium factor specified shall apply:

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UNEARNED PREMIUM FACTOR TO BE APPLIED TO PREMIUMS IN FORCE ON VALUATION DATE

Contract Year Current at Val- uation Date	2 Year Coverage Period	3 Year Coverage Period	4 Year Coverage Period	5 Year Coverage Period	6 Year Coverage Period	7 Year Coverage Period	8 Year Coverage Period
1	88.7%	93.9%	95.7%	96.5%	97.0%	97.3%	97.5%
2	38.7%	66.7%	76.4%	81.0%	83.7%	85.4%	86.5%
3		22.9%	45.2%	56.0%	62.2%	66.2%	68.8%
4			14.5%	31.3%	41.1%	47.4%	51.3%
5				9.8%	22.7%	31.0%	36.2%
6					7.1%	17.1%	23.3%
7						5.4%	12.5%
8							3.8%
9							
10							
11							
12							
13							
14							
15							

Contract Year Current at Val- uation Date	9 Year Coverage Period	10 Year Coverage Period	11 Year Coverage Period	12 Year Coverage Period	13 Year Coverage Period	14 Year Coverage Period	15 Year Coverage Period
1	97.7%	97.7%	97.8%	97.8%	97.8%	97.8%	97.8%
2	87.3%	87.6%	87.9%	88.1%	88.1%	88.2%	88.2%
3	70.4%	71.3%	71.9%	72.3%	72.5%	72.6%	72.6%
4	53.8%	55.3%	56.1%	56.7%	57.1%	57.2%	57.3%
5	39.4%	41.3%	42.5%	43.2%	43.7%	43.9%	44.0%
6	27.2%	29.5%	30.9%	31.8%	32.3%	32.7%	32.8%
7	16.9%	19.6%	21.2%	22.1%	22.8%	23.2%	23.3%
8	8.6%	11.6%	13.3%	14.4%	15.1%	15.5%	15.7%
9	2.5%	5.6%	7.5%	8.6%	9.3%	9.9%	10.1%
10		1.6%	3.4%	4.6%	5.4%	6.0%	6.2%
11			0.9%	2.1%	2.9%	3.5%	3.7%
12				0.6%	1.3%	1.9%	2.1%
13					0.4%	0.9%	1.1%
14						0.3%	0.5%
15							0.1%

These unearned premium factors are calculated on the assumption that on the average a contract is written in the middle of the calendar year and that these factors are applied annually to groups of contracts segregated by term and expiration year. These factors include one-half of the earned premium applicable to the contract year current at the valuation date.

(b) On an annual premium plan that portion of the first year premium, excluding policy and other fees or similar charges, which exceeds twice the subsequent renewal premium rate, shall be considered a deferred risk charge and amortized in accordance with factors specified for a 10 year term coverage in par. (a) or in accordance with factors specified for a lesser term coverage in par. (a) as approved by the commissioner.

(c) On premiums paid in advance for coverage periods in excess of 15 years, the unearned portion of the premium during the first 15 years of coverage shall be the premium collected minus an amount equal to the premium that would have been earned had the applicable premium for 15 years' coverage been received. The premium remaining after 15 years shall be released from the unearned premium reserve pro rata over the remaining term of coverage.

(14) CONTINGENCY RESERVE. (a) Subject to sub. (8), there shall be an annual contribution to the contingency reserve which in the aggregate shall be the greater of:

1. 50% of the net earned premium reported in the annual statement;
or

2. The sum of:

a. The policyholders position established under sub. (5) on residential buildings designed for occupancy by not more than four families divided by 7;

b. The policyholders position established under sub. (5) on residential buildings designed for occupancy by 5 or more families divided by 5;

c. The policyholders position established under sub. (5) on buildings occupied for industrial or commercial purposes divided by 3; and

d. The policyholders position established under sub. (5) for leases divided by 10.

(b) If the mortgage guaranty coverage is not expressly provided for in this section, the commissioner may establish a rate formula factor that will produce a contingency reserve adequate for the risk assumed.

(c) The contingency reserve established by this subsection shall be maintained for 120 months. That portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.

(d) Subject to the approval of the commissioner, withdrawals may be made from the contingency reserve for incurred loss payments in any year exceeding the greater of 35% of the net earned premium or 70% of the amount contributed to the contingency reserve in that year. Funds used in this manner shall be accounted for on a first-in, first-out basis as provided in sub. (12) (e). [1977]

(e) The computations required by pars. (a) and (d) shall be made prior to increment or decrement because of contributions to the contingency reserve.

(15) CHARGES, COMMISSIONS AND REBATES. (a) Every mortgage guaranty insurer shall adopt, print and make available a schedule of premium charges for mortgage guaranty insurance coverages. The schedule shall show the entire amount of premium charge for each type of mortgage guaranty insurance coverage issued by the insurer.

(b) A mortgage guaranty insurer shall not knowingly pay, either directly or indirectly to an owner, purchaser, mortgagee of the real property or any interest therein or to any person who is acting as agent, representative, attorney or employe of such owner, purchaser, or mortgagee any commission, remuneration, dividend or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.

(c) In connection with the placement of any insurance, a mortgage guaranty insurer shall not cause or permit any commission, fee, remuneration, or other compensation to be paid to, or received by: any insured lender; any subsidiary or affiliate of any insured; any officer, di-

rector or employe of any insured; any member of their immediate family; any corporation, partnership, trust, trade association in which any insured is a member, or other entity in which any insured or any such officer, director, or employe or any member of their immediate family has a financial interest; or any designee, trustee, nominee, or other agent or representative of any of the foregoing.

(d) A mortgage guaranty insurer shall not make any rebate of any portion of the premium charge shown by the schedule required by par.

(a) A mortgage guaranty insurer shall not quote any premium charge to any person which is different than that currently available to others for the same type of mortgage guaranty insurancy coverage sold by the mortgage guaranty insurer. The amount by which any premium charge is less than that called for by the current schedule of premium charge is a rebate.

(e) A mortgage guaranty insurer shall not use compensating balances, special deposit accounts or engage in any practice which unduly delays its receipt of monies due or which involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employe of such owner, purchaser or mortgagee as a means of circumventing any part of this rule. Except for commercial checking accounts and normal deposits in support of an active bank line of credit, any deposit account bearing interest at rates less than is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this paragraph.

(f) A mortgage guaranty insurer shall make provision for prompt refund of any unearned premium in the event of termination of the insurance prior to its scheduled termination date. If the borrower paid or was charged for the premium, the refund shall be made to the borrower, or to the insured for the borrower's benefit, otherwise refund may be paid to the insured.

(g) This subsection is not intended to prohibit payment of appropriate policy dividends to borrowers.

(16) TRANSITION. Policyholders position, unearned premium reserves and contingency loss reserves shall be computed and maintained on risks insured after the effective date of this section as required by subs. (5), (13) and (14). Unearned premium reserves and contingency loss reserves on risks insured before the effective date of this rule may be computed and maintained either as required by subs. (13) and (14) or as required by this section as previously in effect.

(17) CONFLICT OF INTEREST. (a) If a member of a holding company system as defined in Ins 12.01 (3) (e), a mortgage guaranty insurer licensed to transact insurance in this state shall not, as a condition of its certificate of authority, knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate.

(b) A mortgage guaranty insurer, the holding company system of which it is a part or any affiliate shall not as a condition of the mortgage

guaranty insurer's certificate of authority, pay any commissions, remuneration, rebates or engage in activities proscribed in sub. (15).

(18) **LAWS OR REGULATIONS OF OTHER JURISDICTIONS.** Whenever the laws or regulations of another jurisdiction in which a mortgage guaranty insurer subject to the requirements of this rule is licensed, require a larger unearned premium reserve or a larger contingency reserve in the aggregate than that set forth in this rule, the establishment and maintenance of the larger unearned premium reserve or contingency reserve shall be deemed to be compliance with this rule.

History: Cr. Register, March, 1957, No. 15, eff. 4-1-57; am. (2), (3), (4) and (5), Register, January, 1959, No. 37, eff. 2-1-59; am. (4) (c), Register, August, 1959, No. 44, eff. 9-1-59; cr. (4) (e), Register, January, 1961, No. 61, eff. 2-1-61; am. (2), Register, January, 1967, No. 133, eff. 2-1-67; am. (2), (3) (a) and (b), and (4) (a) and (b); r. and recr. (5), Register, December, 1970, No. 180, eff. 1-1-71. r. and recr. Register, March, 1975, No. 231, eff. 4-1-75; emerg. am. (1), (2) and (3) (a), eff. 6-22-76; am. (1), (2) and (3) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1), (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79; r. and recr. (1), (3), (5), (12) and (14), am. (2), (4), (8), (13) (a) and (16), renun. (7) to be (7) (a) and cr. (7) (b) and (7m), Register, October, 1982, No. 322, eff. 11-1-82.

Ins 3.11 Multiple peril insurance contracts. (1) PURPOSE AND SCOPE. (a) This rule implements and interprets s. Ins 6.70 and chs. 625 and 631, Stats., by enumerating the minimum requirements for the writing of multiple peril insurance contracts. Nothing herein contained is intended to prohibit insurers or groups of insurers from justifying rates or premiums in the manner provided for by the rating laws.

(b) This rule shall apply to multiple peril insurance contracts permitted by s. Ins 6.70, and which include a type or types of coverage or a kind or kinds of insurance subject to ch. 625, Stats.

(c) Types of coverage or kinds of insurance which are not subject to ch. 625, Stats., or to the filing requirement provisions thereof, may not be included in multiple peril insurance contracts otherwise subject to said sections unless such entire multiple peril insurance contract is filed as being subject to this rule and said sections and the filing requirements thereof.

(2) **DEFINITION.** Multiple peril insurance contracts are contracts combining 2 or more types of coverage or kinds of insurance included in any one or more than one paragraph of s. Ins 6.75. Such contracts may be on the divisible or single (indivisible) rate or premium basis.

(3) **RATE MAKING.** (a) When underwriting experience is not available to support a filing, the information set forth in s. 625.12, Stats., may be furnished as supporting information.

(b) Premiums or rates may be modified for demonstrated, measurable, or anticipated variation from normal of the loss or expense experience resulting from the combination or types of coverage or kinds of insurance or other factors of the multiple peril insurance contract. Multiple peril contracts may be filed or revised on the basis of sufficient underwriting experience developed by the contract or such experience may be used in support of such filing.

(c) In the event that more than one rating organization cooperates in a single (indivisible) rate or premium multiple peril insurance filing, one of such cooperating rating organizations shall be designated as the sponsoring organization for such filing by each of the other cooperating

rating organizations and evidence of such designation included with the filing.

(4) **STANDARD POLICY.** The requirements of s. Ins 6.76 shall apply to any multiple peril insurance contract which includes insurance against loss or damage by fire.

History: Cr. Register, July, 1958, No. 31, eff. 8-1-58; am. (3) (a), Register, November, 1960, No. 59, eff. 12-1-60; emerg. am. (1), (2), (3) (a) and (4), eff. 6-22-76; am. (1), (2), (3)

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rating organizations and evidence of such designation included with the filing.

(4) **STANDARD POLICY.** The requirements of s. Ins 6.76 shall apply to any multiple peril insurance contract which includes insurance against loss or damage by fire.

History: Cr. Register, July, 1958, No. 31, eff. 8-1-58; am. (3) (a), Register, November, 1960, No. 59, eff. 12-1-60; emerg. am. (1), (2), (3) (a) and (4), eff. 6-22-76; am. (1), (2), (3)

(a) and (4), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) (a) and (b), (2) and (4), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.12 Filing procedures for disability insurance forms. (1)
PURPOSE. This rule establishes a procedure under which disability insurance policy forms must be filed before issuance or delivery in this state. This rule interprets, including but not limited to, the following Wisconsin Statutes: 601.01 (3), 601.41 and 631.20.

(2) **SCOPE.** This rule shall apply to all disability insurance forms subject to s. 631.01 (1), Stats., except as exempted under s. 631.01 (2), (4) and (5), Stats.

(3) **FILING PROCEDURE.** All such forms, including applications which are made a part of the contract, certificates, riders, endorsements and amendments, must be filed as follows:

(a) One copy of all such forms (two copies should be submitted if the insurer desires one copy stamped as approved and returned) shall be submitted with, in the case of a policy form, a copy of the application applying thereto, if such application is to be made a part of the contract. If such application form is already on file and has been previously approved, the form number and date of approval may be submitted rather than the form.

(b) If the nature of the information to be inserted in any blank space of any such form cannot be determined from the wording of the form, such blank space shall be filled in with hypothetical data to the extent needed to indicate the purpose and use of the form. As an alternative, such purpose and use may be explained in the filing letter submitted with the form.

(c) The filing letter shall be in duplicate and shall contain the following information:

1. The identifying form number and title, if any, of the form,
2. A general description of the form,
3. In case of an application, certificate, rider, endorsement or an amendment form, the form numbers, identifying symbols or types of policies with which such forms will be used, and
4. The form number and date of office approval of any form superseded by the filing.

(d) A certificate of compliance in a form substantially similar to that set forth in Exhibit A of this rule shall be submitted.

EXHIBIT A

(Each policy form filing under Ins 3.12 shall be accompanied by the following "Certification of Compliance" in substantially this form.)

CERTIFICATION OF COMPLIANCE

I, _____, an officer of
 _____ (name)
 _____, hereby certify that I have authority
 _____ (company name)
 to bind and obligate the company by filing of this (these) form (s). I
 further certify that, to the best of my information, knowledge and belief,

(a) The accompanying form (s) as identified by the listing attached hereto does (do) comply with all applicable provisions of the Wisconsin Statutes and with all applicable rules of the Commissioner of Insurance; and

(b) (1) The form (s) does (do) not contain any inconsistent, ambiguous, or misleading clauses;

(2) The form (s) does (do) not contain specifications or conditions that unreasonably or deceptively limit the risk purported to be assumed in the general coverage of the policy form (s);

(3) The only variations from a form currently on file with the Commissioner of Insurance and the only unconventional policy provisions are clearly marked or otherwise indicated on the respective pages _____ of the attached form (s) or in addendum attached thereto; and

(4) The attached form (s) is (are) in final printed format and is (are) exactly as will be offered for issuance or delivery in the State of Wisconsin after approval by the Commissioner of Insurance, except for hypothetical data and other appropriate variable material.

(signature)

(title)

(date)

Individual responsible for this filing:

Name: _____ Title: _____

Address: _____

Phone Number: _____ Date _____

History: Cr. Register, January, 1980, No. 289, eff. 2-1-80.

Ins 3.13 Individual accident and sickness insurance. (1) **PURPOSE.** This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of individual accident and sickness policies permitted by section Ins 6.75 (1) (c) or (2) (c), and franchise type accident and sickness policies permitted by s. 600.03 (34m) (d), Stats. The requirements in subsections (2), (3), (4), (5), and (6) are to be followed in substance, and wording other than that described may be used provided it is not less favorable to the insured or beneficiary.

(2) **POLICY PROVISIONS.** (a) If a policy is not to insure against sickness losses resulting from conditions in existence prior to the effective date of coverage, or in existence prior to a specified period after such effective date, the policy by its terms shall indicate that it covers sickness contracted and commencing (or beginning, or originating, or first manifested or words of similar import) after such effective date or after such specified period. Wording shall not be used that requires the cause of the condition or sickness, as distinguished from the condition or sickness

itself, to originate after such effective date or such specified period. (Note: It is understood that "sickness" as used herein means the condition or disease from which the disability or loss results.) Subsection (2) (a) shall not apply to nor prohibit the exclusion from coverage of a disease or physical condition by name or specific description.

(b) Where any "specified period" referred to in subsection (2) (a) exceeds 30 days, it shall apply to the occurrence of loss and not to the contracting or commencement of sickness after such period.

(c) A policy, other than a non-cancellable policy or a non-cancellable and guaranteed renewable policy or a guaranteed renewable policy, shall set forth the conditions under which the policy may be renewed, either by: A *brief description* of the policy's renewal conditions, or a *separate statement* referring to the policy's renewal conditions, or a separate appropriately captioned *renewal provision* appearing on or commencing on the first page.

1. The *brief description*, if used to meet the foregoing requirement, shall be printed, in type more prominent than that used in the policy's text, at the top or bottom of the policy's first page and on its filing back, if any, and shall describe its renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated in _____" (refer to appropriate policy provision), or "Renewal May be Refused as Stated in _____" (refer to appropriate policy provision). A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter.

2. The *separate statement*, if used to meet the foregoing requirement, shall be printed, in type more prominent than that used in the policy's text, at the top or bottom of the policy's first page and on its filing back, if any, and shall describe its renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated in _____" (refer to appropriate policy provision), or "Renewal May be Refused as Stated in _____" (refer to appropriate policy provision). A it believes is equally clear or more definite as to subject matter.

3. The *renewal provision* appearing on or commencing on the policy's first page, if used to meet the foregoing requirement, shall be preceded by a caption which describes the policy's renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated Below", or "Renewal May be Refused as Stated Herein". A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter. The caption shall be in type more prominent than that used in the policy's text.

(d) If the policy is not renewable, it shall be so described in the brief description or in a separate statement at the top or bottom of the first page and on the filing back, if any, or it shall be so described in a separate appropriately captioned provision on the first page. The brief description, or the separate statement, or the caption shall be printed in type more prominent than that used in the policy's text.

(e) 1. The terms "non-cancellable" or "non-cancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy a. until at least age 50, or b. in the case of a policy issued after age 44, for at least 5 years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

2. A non-cancellable or non-cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms "non-cancellable" or "non-cancellable and guaranteed renewable":

a. the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable, if other than lifetime,

b. the age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable.) and

c. that benefit payments are subject to an aggregate limit, if applicable.

3. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums a. until at least age 50, or b. in the case of a policy issued after age 44, for at least 5 years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

4. A guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

a. the age to or term for which the form is guaranteed renewable, if other than lifetime,

b. the age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable.)

c. that benefit payments are subject to an aggregate limit, if applicable, and

d. that the applicable premium rates may be changed.

Note: "Prominent use" as referred to in subparagraphs 2. and 4. is considered to include, but is not necessarily limited to, use in titles, brief descriptions, captions, bold-face type, or type larger than that used in the text of the form.

5. The foregoing limitation on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable" and

the limitation on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

6. Nothing herein contained is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or non-cancellable for any period during which they may actually be such, provided the terms used to describe them in policy contracts and advertising are not such as may readily be confused with the above terms.

7. The provisions of ss. 632.76 (1), 632.74 and 632.77 (3), Stats., are applicable to non-cancellable or non-cancellable and guaranteed renewable or guaranteed renewable policy forms as herein defined.

(f) Policies issued on a family basis shall clearly set forth the conditions relating to termination of coverage of any family member.

(g) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(h) A limited policy is one that contains unusual exclusions, limitations, reductions, or conditions of such a restrictive nature that the payments of benefits under such policy are limited in frequency or in amounts. All limited policies shall be so identified by having the words "THIS IS A LIMITED POLICY—READ IT CAREFULLY" imprinted or stamped diagonally across the face of the policy and the filing back, if any, in contrasting color from the text of the policy and in outline type not smaller than 18-point. When appropriate, these words may be varied by the insurer in a manner to indicate the type of policy; as for example, "THIS POLICY IS LIMITED TO AUTOMOBILE ACCIDENTS—READ IT CAREFULLY". Without limiting the general definition above, policies of the following types shall be defined as "limited": 1. School Accident, 2. Aviation Accident, 3. Polio, 4. Specified Disease, 5. Automobile Accident.

(i) If the policy excepts coverage while the insured is in military or naval service, the policy must provide for a refund of pro rata unearned premium upon request of the insured for any period the insured is not covered. However, if coverage is excluded only for loss resulting from military or naval service or war, the refund provision will not be required. This section shall not apply to non-cancellable policies or non-cancellable and guaranteed renewable policies or guaranteed renewable policies.

(j) The provision or notice regarding the right to return the policy required by s. 632.73, Stats., shall:

1. Be printed on or attached to the first page of the policy,

2. Have a caption or title which refers at least to the right to examine or to return the policy such as: "Right to Return Policy Within 10 Days of Receipt", "Notice: Right to Return Policy", "Right of Policy Examination", "Right to Examine Policy", "Right to Examine Policy for 10 Days", "10 Day Right to Examine Policy", "10 Day Right to Return Policy", or "Notice of 10 Day Right to Return Policy", or other wording,

subject to approval by the commissioner, which is believed to be equally clear or more definite as to subject matter, and

3. Provide an unrestricted right to return the policy, within 10 days from the date it is received by the policyholder, to the insurer at its home or branch office, if any, or to the agent through whom it was purchased; except it shall provide an unrestricted right to return the policy within 30 days of the date it is received by the policyholder in the case of a Medicare supplement policy subject to s. Ins 3.39 (4), (5), and (6), issued pursuant to a direct response solicitation. Provision shall not be made to require the policyholder to set out in writing the reasons for returning the policy, to require the policyholder to first consult with an agent of the insurer regarding the policy, or to limit the reasons for return.

(k) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(3) RIDERS AND ENDORSEMENTS. (a) A rider is an instrument signed by one or more officers of the insurer issuing the same to be attached to and form a part of a policy. All riders shall comply with the requirements of s. 204.31 (2) (a) 4, 1973 Stats.

(b) If the rider reduces or eliminates coverage of the policy, signed acceptance of the rider by the insured is necessary. However, signed acceptance of the rider is not necessary when the rider is attached at the time of the original issuance of the policy if notice of the attachment of the rider is affixed on the face and filing back, if any, in contrasting color, in not less than 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Rider Attached"

"Notice! See Exclusion Rider Attached"

"Notice! See Exception Rider Attached"

"Notice! See Limitation Rider Attached"

"Notice! See Reduction Rider Attached"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(c) An endorsement differs from a rider only in that it is applied to a policy by means of printing or stamping on the body of the policy. All endorsements shall comply with the requirements of s. 204.31 (2) (a) 4, 1973 Stats.

(d) If the endorsement reduces or eliminates coverage of the policy, signed acceptance of the endorsement by the insured is necessary. However, signed acceptance of the endorsement is not necessary when the endorsement is affixed at the time of the original issuance of the policy if notice of the endorsement is affixed on the face and filing back, if any, in contrasting color, in not less than 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Endorsement Included Herein"

"Notice! See Exclusion Endorsement Included Herein"

"Notice! See Exception Endorsement Included Herein"

"Notice! See Limitation Endorsement Included Herein"

"Notice! See Reduction Endorsement Included Herein"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(4) APPLICATIONS. (a) Application forms shall meet the requirements of s. Ins 3.28 (3).

(b) It shall not be necessary for the applicant to sign a proxy provision as a condition for obtaining insurance. The applicant's signature to the application must be separate and apart from any signature to a proxy provision.

(c) The application form, or the copy of it, attached to a policy shall be plainly printed or reproduced in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point.

(6) RATE FILINGS. (a) The following must be accompanied by a rate schedule:

1. Policy forms.

2. Rider or endorsement forms which affect the premium rate.

(b) The rate schedule shall bear the insurer's name and shall contain or be accompanied by the following information:

1. The form number or identification symbol of each policy, rider or endorsement to which the rates apply.

2. A schedule of rates including policy fees or rate changes at renewal, if any, variations, if any, based upon age, sex, occupation, or other classification.

3. An indication of the anticipated loss ratio on an earned-incurred basis.

4. Any revision of a rate filing shall be accompanied by a statement of the experience on the form and the anticipated loss ratio on an earned-incurred basis under the revised rate filing.

5. Subdivisions 3 and 4 shall not apply to non-cancellable policies or riders or non-cancellable and guaranteed renewable policies or riders or guaranteed renewable policies or riders.

History: Cr. Register, March, 1958, No. 27; subsections (1), (5), (6) eff. 4-1-58; subsections (2), (3), (4) eff. 5-15-58; am. (2) (c) and cr. (4) (c), Register, March, 1959, No. 39, eff. 4-1-59; am. (2) (e), (6) (b) 3 and 4, Register, November, 1959, No. 47, eff. 12-1-59; am. and renum. (2) (c), (d), (e), (f), (g) and (h); am. (3) and (6) (b) 5, Register, June, 1960, No. 54, eff. 7-1-60; am. (2) (e) 4, Register, November, 1960, No. 59, eff. 12-1-60; r. (2) (j), Register, April, 1963, No. 88, eff. 5-1-63; cr. (2) (j), Register, March, 1964, No. 99, eff. 4-1-64; am. (2) (e) 2 and 4, Register, April, 1964, No. 100, eff. 5-1-64; am. (2) (j) 2.; am. NOTE in (2) (j) 3; Register, March, 1969, No. 159; eff. 4-1-69; cr. (2) (k), Register, June, 1971, No. 186, eff. 7-1-71; am. (4) (a), Register, February, 1974, No. 218, eff. 3-1-74; emerg. am. (1), (2) (e) 7, (2) (j), (3) (a) and (c), eff. 6-22-76; am. (1), (2) (e) 7, (2) (j), (3) (a) and (c), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2) (e) 7, Register, March,

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1979, No. 279, eff. 4-1-79; r. (5), Register, January, 1980, No. 289, eff. 2-1-80; am. (2) (j) 3., Register, June, 1982, No. 318, eff. 7-1-82.

Ins 3.14 Group accident and sickness insurance. (1) **PURPOSE.** This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of group accident and sickness policies permitted by s. 600.03 (34m) (b), Stats.

(3) **RATE FILINGS.** Schedules of premium rates shall be filed in accordance with the requirements of ch. 601 and s. 631.20, Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) **CERTIFICATES.** (a) Each certificate issued to an employe or member of an insured group in connection with a group insurance policy shall include a statement in summary form of the provisions of the group policy relative to:

1. The essential features of the insurance coverage,
2. To whom benefits are payable,
3. Notice or proof of loss,
4. The time for paying benefits, and
5. The time within which suit may be brought.

(5) **COVERAGE REQUIREMENTS.** (a) Policies issued in accordance with s. 600.03 (34m) (b), Stats., shall offer to insure all eligible members of the group or association except any as to whom evidence of insurability is not satisfactory to the insurer. Cancellation of coverage of individual members of the group or association who have not withdrawn participation nor received maximum benefits is not permitted, except that the insurer may terminate or refuse renewal of an individual member who attains a specified age, retires or who ceases to actively engage in the duties of his profession or occupation on a full-time basis or ceases to be an active member of the association or labor union or an employe of the employer, or otherwise ceases to be an eligible member.

(b) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(c) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(6) **ELIGIBLE GROUPS.** In accordance with s. 600.03 (34m) (b), Stats.:

(a) the members of the board of directors of a corporation are eligible to be covered under a group accident and sickness policy issued to such corporation,

(b) the individual members of member organizations of an association, as defined in s. 600.03 (34m) (b), Stats., are eligible to be covered under a group accident and sickness policy issued to such association insuring employes of such association and employes of member organizations of such association, and

(c) the individuals supplying raw materials to a single processing plant and the employes of such processing plant are eligible to be covered under a group accident and sickness policy issued to such processing plant.

History: Cr. Register, March, 1958, No. 27; subsections (1), (2), (3), eff. 4-1-58; subsections (4), (5), eff. 5-1-58; renum. (5) to be (5) (a); cr. (5) (b), Register, November, 1959, No. 47, eff. 12-1-59; am. (1) (3), (5) (a) and cr. (6), Register, October, 1961, No. 70, eff. 11-1-61; am. (6), Register, February, 1962, No. 74, eff. 3-1-62; cr. (5) (c), Register, June, 1971, No. 186, eff. 7-1-71; emerg. am. (1), (3), (5) (a), (6) (intro.) and (6) (b), eff. 6-22-76; am. (1), (3), (5) (a), (6) (intro.) and (6) (b), Register, September, 1976, No. 249, eff. 10-1-76; r. (2), Register, January, 1980, No. 289, eff. 2-1-80.

Ins 3.15 Blanket accident and sickness insurance. (1) **PURPOSE.** This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of blanket accident and sickness policies permitted by s. 600.03 (34m) (c), Stats.

(3) **RATE FILINGS.** Schedules of premium rates shall be filed in accordance with the requirements of ch. 601 and s. 631.20, Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) **ELIGIBLE RISKS.** (a) In accordance with the provisions of s. 600.03 (34m) (c), Stats., the following are eligible for blanket accident and health insurance: 1. Volunteer fire departments, 2. National guard units, 3. Newspaper delivery boys, 4. Dependents of students, 5. Volunteer civil defense organizations, 6. Volunteer auxiliary police organizations, 7. Law enforcement agencies, 8. Cooperatives organized under ch. 185, Stats., on a membership basis without capital stock, 9. Registered guests in a motel, hotel, or resort, 10. Members or members and advisors of fraternal organizations including women's auxiliaries of such organizations and fraternal youth organizations, 11. Associations of sports officials, 12. Purchasers of protective athletic equipment, 13. Migrant workers, 14. Participants in racing meets, 15. Patrons or guests of a recreational facility or resort.

(b) A company may submit any other risk or class of risks, subject to approval by the commissioner, which it believes is properly eligible for blanket accident and health insurance.

(5) **COVERAGE REQUIREMENTS.** (a) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the pro-

visions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(b) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

History: Cr. Register, March, 1958, no. 27, eff. 4-1-58; am. (4) (a), cr. (5), Register, November, 1959, No. 47, eff. 12-1-59; am. (1), (3) and (4) (a), Register, October, 1961, No. 70, eff. 11-1-61; am. (4) (a), Register, April, 1963, No. 88, eff. 5-1-63; am. (4) (a), Register, June, 1963, No. 90, eff. 7-1-63; am. (4) (a), Register, October, 1963, No. 94, eff. 11-1-63; am. (4) (a), Register, August, 1964, No. 104, eff. 9-1-64; am. (4) (a), Register, August, 1968, No. 152, eff. 9-1-68; am. (4) (a), Register, March, 1969, No. 159, eff. 4-1-69; am. (4) (a), Register, August, 1970, No. 176, eff. 9-1-70; am. (4) (a), renum. (5) to be (5) (a), and cr. (b), Register, June, 1971, No. 186, eff. 7-1-71; emerg. am. (1), (3) and (4) (a), eff. 6-22-76; am. (1), (3) and (4) (a), Register, September, 1976, No. 249, eff. 10-1-76; r. (2), Register, January, 1980, No. 289, eff. 2-1-80.

Ins 3.17 Reserves for accident and sickness policies. (1) PURPOSE. This rule establishes minimum standards for insurance company active life reserves and claim liability reserves as authorized by ch. 623, Stats., and for fraternal benefit society reserves as authorized by s. 623.15, Stats.

(2) **SCOPE.** This rule shall apply to the kinds of insurance authorized by section Ins 6.75 (1) (c) or (2) (c), and shall also apply to fraternal benefit contracts subject to s. 632.94, Stats.

(3) **ACTIVE LIFE RESERVES, INDIVIDUAL AND FRANCHISE POLICIES.** Active life reserves are required for all in force policies issued subject to section Ins 6.75 (1) (c) or (2) (c), ss. 600.03 (34m) (d), and 632.94, Stats.

(a) For purposes of this rule, individual policies will be classified as follows:

1. Policies which are non-cancellable or non-cancellable and guaranteed renewable for life or to a specified age.
2. Policies which are guaranteed renewable for life or to a specified age.
3. Policies, other than those in subparagraph 5 of this paragraph, in which the insurer has reserved the right to cancel or refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

4. Franchise policies, as defined in s. 600.03 (34m) (d), Stats., issued under or subject to an agreement that, except for stated reasons, the insurer will not cancel or refuse to renew the coverage of individual insureds prior to a specified age unless all coverage under the same franchise group is terminated and which are based on the level premium principle.

5. All other franchise policies as defined in s. 600.03 (34m) (d), Stats.

6. Commercial policies and other policies not falling within subparagraphs 1 to 5, inclusive, of this paragraph.

(b) During the period within which the renewability of the policy is guaranteed or the insurer's right to refuse renewal is limited, the minimum reserves for policies described in subpar. 1, 2, 3, and 4 of par. (a) of this subsection shall be an amount computed on the basis of 2-year pre-

liminary term tabular mean reserves employing the following assumptions:

1. Mortality (Policies issued January 1, 1955 to December 31, 1967): American Men Ultimate Mortality Table or Commissioners 1941 Standard Ordinary Mortality Table or Commissioners 1958 Standard Ordinary Mortality Table. (See Table I at the end of this rule.)

2. Mortality (Policies issued after December 31, 1967): Commissioners 1958 Standard Ordinary Mortality Table. (See Table I at the end of this rule.)

3. Maximun. Interest Rate: $3\frac{1}{2}\%$ compounded annually.

4. Morbidity or Other Contingency:

a. Disability due to accident and sickness (Policies issued January 1, 1955 to December 31, 1967): The Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance adopted by the National Association of Insurance Commissioners on June 11, 1941. Pamphlet reprints of this table are on file in the offices of the commissioner of insurance, secretary of state, and revisor of statutes. Pamphlet reprints of said Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance are obtainable from the Health Insurance Association of America, 332 South Michigan Avenue, Chicago, Illinois 60604.

b. Disability due to accident and sickness (Policies issued after December 31, 1967): The 1964 Commissioners Disability Table adopted by the National Association of Insurance Commissioners on December 3, 1964. Copies of this table are on file in the offices of the commissioner of insurance, secretary of state, and revisor of statutes. Reprints of the 1964 Commissioners Disability Table and monetary values based on the table are available from the Health Insurance Association of America, 332 South Michigan Avenue, Chicago, Illinois 60604.

c. Hospital Expense Benefits—1956 Inter-Company Hospital Table. (See Tables II and III at the end of this rule.)

d. Surgical Expense Benefits—1956 Inter-Company Surgical Table. (See Tables IV and V at the end of this rule.)

e. Accident only, major medical expense, and other benefits not specified above—each company to establish reserves that place a sound value on the liabilities under such benefit.

(c) Mean reserves shall be diminished or offset by appropriate credit for the valuation net deferred premiums. In no event, however, shall the aggregate reserves for all policies issued on or after January 1, 1955, and valued on the mean reserve basis diminished by any credit for deferred premiums, be less than the gross pro rata unearned premiums under such policies.

(d) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same individual or family policy, but if all benefits of such policy collectively develop a negative reserve, credit shall not be taken for such amount.

(e) The minimum active life reserves for policies described in subparagraphs 5 and 6 of subsection (3) (a) of this rule shall be the pro rata gross unearned premium reserve.

(f) An insurer may use any reasonable assumptions as to the interest rate, mortality rates, or the rates of morbidity or other contingency, and may introduce a rate of voluntary termination of policies provided the reserve on all policies to which such assumptions are applied is not less in the aggregate than the amount determined according to the standards specified in paragraphs (b), (c), (d), and (e) of this subsection. Also, subject to the same condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under policies described in this subsection, including but not limited to the following:

1. The use of mid-terminal reserves in addition to either gross or net pro rata unearned premium reserves;
2. Optional use of either the level premium, the one-year preliminary term, or the two-year preliminary term method;
3. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;
4. The use of approximations such as those involving age groupings, groupings of several years of issue, or average amounts of indemnity;
5. The computation of the reserve for one policy benefit as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued;
6. The use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

(g) For statement purposes the net reserve liability for active lives may be shown as:

1. The mean reserve with offsetting asset items for net unpaid and deferred premiums; or
2. The excess of the mean reserve over the amount of net unpaid and deferred premiums; or
3. It may, regardless of the underlying method of calculation, be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve."

(h) Each insurer issuing policies described by subparagraph 2 of paragraph (a) of this subsection shall maintain historical fund accounts for each group of similar policy forms on a basis reflecting reasonable estimates of premiums, losses, expenses, and reserves. Such estimates shall not be inconsistent with the corresponding items in the Accident and Health Exhibit, Schedule H, of the Annual Statement—Life and Accident and Health Companies, Insurance Department Form 22-41—or with the corresponding items of the Underwriting and Investment Exhibit of the Annual Statement—Fire and Casualty Insurance Companies, Insurance Department Form 22-11. (Wis. Adm. Code section Ins 7.01 (5) (a) and (c).)

(4) **ACTIVE LIFE RESERVES, GROUP AND BLANKET POLICIES.** Active life reserves are required for all in force policies issued subject to s. 600.03 (34m) (b) and (c), Stats.

(a) The minimum active life reserve for such policies shall be the pro rata gross unearned premium reserve.

(b) An additional active life reserve shall be established for converted policies which may be issued under a conversion option for terminated employees. The minimum reserve shall be the excess of the morbidity costs for such policies over morbidity costs assumed in the premiums to be payable by or on behalf of terminated employees.

(5) **CLAIM LIABILITY RESERVES, INDIVIDUAL AND FRANCHISE.** Claim liability reserves to represent the value of amounts not yet due on claims are required for all policies issued subject to section Ins 6.75 (1) (c) or (2) (c), s. 600.03 (34m) (d), or 632.94, Stats.

(a) The minimum reserve for claim liabilities shall be computed employing the following assumptions:

1. Maximum Interest Rate: 3½% compounded annually.

2. Morbidity of Other Contingency:

a. Disability due to accident and sickness: The 1964 Commissioners Disability Table (see subsection (3) (b) 4.b of this rule), except that for unreported claims and resisted claims and claims with a duration of disablement of less than 2 years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years, along lines of Schedule O, Life and Accident and Health Annual Statement, Insurance Department Form 22-41. (Wis. Adm. Code section Ins. 7.01 (5) (c).)

b. All other benefits: The reserve shall be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years.

(b) Insurers may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim liability reserves.

(c) For policies with an elimination period, the duration of disablement should be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

(d) A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within 6 months of the new disability should be considered a continuation of the previous disability.

(6) **CLAIM LIABILITY RESERVES, GROUP AND BLANKET POLICIES.** Claim liability reserves to represent the value of amounts not yet due on claims are required for all policies issued subject to s. 600.03 (34m) (b) or (c), Stats.

(a) The minimum reserve for claim liabilities shall be computed employing the following assumptions:

1. Maximum Interest Rate: 3½% compounded annually.

2. Morbidity or Other Contingency:

a. Disability due to accident and sickness: The 1964 Commissioners Disability Table (see subsection (3) (b) 4.b. of this rule), except that

for unreported claims and resisted claims and claims with a duration of disablement of less than 2 years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years, along lines of Schedule O, Life and Accident and Health Annual Statement, Insurance Department Form 22-41. (Wis. Adm. Code section Ins 7.01 (5) (c).)

b. All other benefits: The reserve shall be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years.

(b) Insurers may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim liability reserves.

(c) For policies with an elimination period, the duration of disablement should be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

(d) A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within 6 months of the new disability should be considered a continuation of the previous disability.

(7) REVALUATION OF EXISTING ACTIVE LIFE RESERVES AND CLAIM LIABILITY RESERVES. An insurer may elect to establish and maintain active life reserves or claim liability reserves for policies issued prior to January 1, 1968 in accordance with the standards prescribed herein for policies issued after December, 31, 1967. In making such election, an insurer may elect to revalue all previous issues or, at its option, may revalue only certain blocks of issues as determined by issue date or plan of coverage. Claim reserves may be revalued independent of active life reserves. Such election shall be made by filing written notice with the commissioner, stating the effective date of the election and identifying the active life reserves or claim liability reserves or issues of policies to be revalued.

Note: Reserve Fund. This rule is based on the concept of the reserve as a fund which, together with future net premiums, will meet the benefit payments arising from the group of policies valued as they accrue in the future. It should be observed that the application of a formula for the calculation of such reserves to an individual policy does not produce a meaningful result since few policyholders will experience average morbidity. For the policyholder in impaired health, the necessary reserve, if it could be determined, would be very much greater than the average result for policyholders as a whole, and for a policyholder in good health such reserve would be less than the average.

Level Premium Principle. Policies written on the "level premium principle" are those where the premium has been designed to be level—or the same—for either the life of the insured or to the termination age in the policy such as age 60 or 65.

Occupation. Experience tables available for the determination of reserves are generally based upon the average results of the insured policyholders and therefore represent a cross section of the insured population, including individuals with unusual freedom from occupational and other hazards, as well as those subject to a considerable extra hazard owing to occupation or avocation. Accordingly, it is not considered necessary to make special provision in the valuation of the liabilities for policies involving special occupational hazards. It may also be observed that where tabular reserve methods are employed the incidence of any additional cost owing to occupational hazard may be such that there will be no increase in the reserve otherwise required.

Two-Year Preliminary Term. The preliminary term method of valuation recognizes the fact that expenses in the first year are much higher than those in renewal years and normally leave none of the first year premium available for the reserve fund. This method has been

long accepted as appropriate and adequate for valuation purposes of life insurance. In contrast to life insurance, the claim cost at the early policy years under accident and health insurance may be substantial. Thus, for two policy years or even longer, the insurer may have a substantial unliquidated initial expense before setting up any additional reserve. For these reasons this rule provides for a preliminary term period of two years in the minimum reserve basis.

Assumptions as to Rate of Termination of Policies. The voluntary termination of policies may have a substantial effect on the level of premiums required for accident and health policies as well as on the amount of the reserve which should be maintained. In view, however, of the wide variation in termination rates among different insurers and the fluctuation of termination rates with changing business conditions, it is not recommended, at this time, that a rate of voluntary termination be employed in the calculation of minimum reserves. It is recommended, however, that an insurer be permitted to employ a lapse rate in the computation of reserves, provided that the net result is at least equal to the minimum reserves specified by the regulations.

Accidental Death Benefits. Any recognized table of accidental death rates, such as the 1959 Accidental Death Benefits Table, *Transactions of the Society of Actuaries*, Vol. XI, p. 754, may be used for establishing reserves for an accidental death benefit.

Medical Expense Benefits. With respect to benefits payable on a per diem or per visit basis, it is suggested that reserves be established according to appropriate percentages of the incidence of disability if benefits are payable during total disability only, or of the incidence of hospitalization if benefits are limited to in-hospital care. For in-hospital medical expense benefits payable on cases not involving surgery, available evidence indicates that 40% of the corresponding per diem hospital confinement cost may represent a reasonable estimate of the benefit cost for valuation purposes.

Major Medical Expense Benefits. As a basis for the valuation of major medical expense benefits pending the accumulation and analysis of inter-company experience data, reference may be made to the material presented by Mr. Morton D. Miller, *Transactions of the Society of Actuaries*, Vol. VII, p. 1, and by Mr. Charles N. Walker, *Transactions of the Society of Actuaries*, Vol. VII, p. 404.

New or Experimental Benefits. For some benefits there will be insufficient data for the development of experience tables suitable for general use in computing reserves. With respect to such benefits each insurer should, on the basis of its appraisal of the benefit costs, establish and maintain reserves which place a sound value on the liabilities thereunder.

Net Annual Claim Costs. For use in developing net annual claim costs in computing reserves, as well as to assist in valuing policies under these requirements, it is recommended that companies make use of the paper "Reserves for Individual Hospital and Surgical Expense Insurance" appearing in the *Transactions of the Society of Actuaries*, Vol. IX, p. 334.

COMMISSIONER OF INSURANCE

TABLE I
YEARLY DEATH RATE PER 1000 (1000qx)

AMERICAN MEN ULTIMATE MORTALITY TABLE (AM^o)

COMMISSIONERS 1941 STANDARD ORDINARY MORTALITY TABLE
(1941 CSO)

COMMISSIONERS 1958 STANDARD ORDINARY MORTALITY TABLE
(1958 CSO)

Age	1000qx			Age	1000qx		
	AM(5)	1941 CSO	1958 CSO		AM(5)	1941 CSO	1958 CSO
0	112.46*	22.58	7.08	52	13.62	14.30	9.96
1	26.39	5.77	1.76	53	14.78	15.43	10.89
2	11.87	4.14	1.52	54	16.08	16.65	11.90
3	7.09	3.38	1.46	55	17.47	17.98	13.00
4	4.91	2.99	1.40	56	19.02	19.43	14.21
5	3.94	2.76	1.35	57	20.69	21.00	15.54
6	3.38	2.61	1.30	58	22.51	22.71	17.00
7	3.05	2.47	1.26	59	24.49	24.57	18.59
8	2.93	2.31	1.23	60	26.68	26.59	20.34
9	2.96	2.12	1.21	61	29.03	28.78	22.24
10	3.07	1.97	1.21	62	31.58	31.18	24.31
11	3.17	1.91	1.23	63	34.37	33.76	26.57
12	3.26	1.92	1.26	64	37.38	36.58	29.04
13	3.32	1.98	1.32	65	40.66	39.64	31.75
14	3.39	2.07	1.39	66	44.18	42.96	34.74
15	3.46	2.15	1.46	67	48.03	46.56	38.04
16	3.53	2.19	1.54	68	52.16	50.46	41.68
17	3.63	2.25	1.62	69	56.64	54.70	45.61
18	3.71	2.30	1.69	70	61.47	59.30	49.79
19	3.81	2.37	1.74	71	66.70	64.27	54.15
20	3.92	2.43	1.79	72	72.33	69.66	58.65
21	4.02	2.51	1.83	73	78.39	75.50	63.26
22	4.12	2.59	1.86	74	84.92	81.81	68.12
23	4.18	2.68	1.89	75	91.94	88.64	73.37
24	4.25	2.77	1.91	76	99.51	96.02	79.18
25	4.31	2.88	1.93	77	107.65	103.99	85.70
26	4.35	2.99	1.96	78	116.31	112.59	93.06
27	4.39	3.11	1.99	79	125.69	121.86	101.19
28	4.41	3.25	2.03	80	135.74	131.85	109.98
29	4.43	3.40	2.08	81	146.42	142.60	119.35
30	4.46	3.56	2.13	82	157.87	154.16	129.17
31	4.48	3.73	2.19	83	170.05	166.57	139.38
32	4.51	3.92	2.25	84	183.15	179.88	150.01
33	4.59	4.12	2.32	85	197.07	194.13	161.14
34	4.68	4.35	2.40	86	211.80	209.37	172.82
35	4.78	4.59	2.51	87	227.29	225.63	185.13
36	4.94	4.86	2.64	88	244.08	243.00	198.25
37	5.12	5.15	2.80	89	261.70	261.44	212.46
38	5.32	5.46	3.01	90	280.35	280.99	228.14
39	5.56	5.81	3.25	91	299.46	301.73	245.77
40	5.84	6.18	3.53	92	321.08	323.64	265.93
41	6.16	6.59	3.84	93	341.88	346.66	289.30
42	6.54	7.03	4.17	94	363.64	371.00	316.66
43	6.94	7.51	4.53	95	387.76	396.21	351.24
44	7.42	8.04	4.92	96	411.11	447.19	400.56
45	7.94	8.61	5.35	97	443.40	548.26	488.42
46	8.52	9.23	5.83	98	457.63	724.67	668.15
47	9.18	9.91	6.36	99	500.00	1000.00	1000.00
48	9.89	10.64	6.95	100	562.50		
49	10.70	11.45	7.60	101	571.43		
50	11.58	12.32	8.32	102	666.67		
51	12.54	13.27	9.11	103	1000.00		

* Bowerman's Extension.

TABLE II
1956 INTER-COMPANY HOSPITAL TABLE
NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES

Attained Age	Room and Board Benefit* 90 Day Maximum		Maternity Expense Benefit
	Male	Female	Female For \$100 Max. Benefit
20-----	5.83	6.79	32.84
21-----	5.82	7.05	30.62
22-----	5.81	7.31	28.50
23-----	5.80	7.57	26.52
24-----	5.80	7.84	24.69
25-----	5.79	8.10	22.95
26-----	5.77	8.36	21.27
27-----	5.74	8.63	19.60
28-----	5.72	8.90	17.92
29-----	5.72	9.17	16.26
30-----	5.77	9.44	14.65
31-----	5.86	9.72	13.12
32-----	5.99	10.01	11.70
33-----	6.14	10.30	10.40
34-----	6.33	10.59	9.20
35-----	6.54	10.88	8.08
36-----	6.78	11.17	7.02
37-----	7.06	11.47	6.00
38-----	7.36	11.76	4.99
39-----	7.69	12.06	4.01
40-----	8.05	12.36	3.10
41-----	8.44	12.66	2.28
42-----	8.86	12.97	1.60
43-----	9.30	13.28	1.08
44-----	9.77	13.59	0.68
45-----	10.25	13.90	0.39
46-----	10.75	14.21	0.17
47-----	11.28	14.52	
48-----	11.83	14.83	
49-----	12.38	15.15	
50-----	12.93	15.48	
51-----	13.48	15.82	
52-----	14.03	16.16	
53-----	14.59	16.50	
54-----	15.15	16.86	
55-----	15.71	17.23	
56-----	16.28	17.60	
57-----	16.84	17.98	
58-----	17.42	18.37	
59-----	18.00	18.78	
60-----	18.60	19.23	
61-----	19.20	19.70	
62-----	19.81	20.19	
63-----	20.43	20.71	
64-----	21.08	21.27	
65-----	21.77	21.89	
66-----	22.40	22.47	
67-----	22.95	22.99	
68-----	23.60	23.62	
69-----	24.48	24.49	
70-----	25.75	25.75	
71-----	27.57	27.57	
72-----	29.83	29.83	
73-----	32.31	32.31	
74-----	34.78	34.78	
75-----	37.00	37.00	
76-----	38.98	38.98	
77-----	40.87	40.87	
78-----	42.67	42.67	
79-----	44.38	44.38	
80-----	46.00	46.00	

*Use 40% of the Net Annual Claim Cost per \$1 of Room and Board Benefit to obtain the Net Annual Claim Cost for each dollar of Daily Maximum Physician's In-Hospital Calls Benefit.

TABLE III
1956 INTER-COMPANY HOSPITAL TABLE
NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES
MISCELLANEOUS HOSPITAL EXPENSE BENEFIT

Attained Age	Males					Females					Attained Age
	For an Unallocated Maximum of					For an Unallocated Maximum of					
	\$25	\$50	\$100	\$150	\$250	\$25	\$50	\$100	\$150	\$250	
20	1.96	3.13	4.90	5.96	7.44	2.34	3.74	5.85	7.12	8.88	20
21	1.96	3.14	4.95	6.02	7.53	2.41	3.88	6.10	7.43	9.29	21
22	1.95	3.15	4.98	6.07	7.60	2.48	4.01	6.34	7.74	9.69	22
23	1.94	3.15	5.01	6.13	7.68	2.55	4.14	6.58	8.05	10.08	23
24	1.94	3.16	5.04	6.18	7.75	2.62	4.27	6.82	8.35	10.48	24
25	1.93	3.16	5.07	6.22	7.81	2.68	4.39	7.05	8.65	10.87	25
26	1.91	3.15	5.08	6.25	7.86	2.74	4.51	7.27	8.94	11.24	26
27	1.90	3.14	5.08	6.26	7.89	2.79	4.62	7.49	9.22	11.61	27
28	1.88	3.12	5.09	6.27	7.91	2.84	4.73	7.70	9.50	11.97	28
29	1.86	3.11	5.09	6.29	7.94	2.89	4.83	7.90	9.76	12.32	29
30	1.86	3.12	5.13	6.35	8.02	2.94	4.94	8.11	10.04	12.69	30
31	1.86	3.14	5.18	6.42	8.12	2.99	5.05	8.33	10.33	13.06	31
32	1.87	3.17	5.25	6.52	8.25	3.04	5.15	8.54	10.60	13.42	32
33	1.88	3.21	5.34	6.64	8.42	3.09	5.26	8.75	10.88	13.79	33
34	1.90	3.25	5.44	6.77	8.59	3.13	5.36	8.97	11.17	14.17	34
35	1.93	3.31	5.56	6.93	8.80	3.18	5.47	9.18	11.45	14.53	35
36	1.96	3.38	5.70	7.11	9.04	3.22	5.56	9.38	11.72	14.89	36
37	1.99	3.46	5.86	7.33	9.32	3.27	5.67	9.60	12.00	15.27	37
38	2.04	3.55	6.03	7.56	9.62	3.31	5.77	9.81	12.28	15.64	38
39	2.08	3.65	6.23	7.81	9.96	3.35	5.86	10.01	12.56	16.00	39
40	2.13	3.74	6.42	8.06	10.28	3.39	5.96	10.22	12.83	16.37	40
41	2.18	3.85	6.62	8.32	10.62	3.43	6.06	10.42	13.10	16.73	41
42	2.22	3.95	6.82	8.58	10.97	3.46	6.15	10.62	13.37	17.09	42
43	2.28	4.06	7.04	8.87	11.34	3.50	6.24	10.82	13.65	17.45	43
44	2.33	4.17	7.26	9.16	11.73	3.54	6.33	11.02	13.92	17.81	44
45	2.39	4.29	7.50	9.48	12.14	3.57	6.43	11.22	14.19	18.17	45
46	2.45	4.42	7.75	9.81	12.57	3.61	6.52	11.43	14.46	18.54	46
47	2.51	4.55	8.01	10.15	13.02	3.64	6.61	11.62	14.73	18.89	47
48	2.58	4.70	8.29	10.52	13.51	3.67	6.69	11.82	14.99	19.25	48
49	2.65	4.85	8.59	10.90	14.01	3.70	6.78	12.02	15.26	19.61	49

WISCONSIN ADMINISTRATIVE CODE

TABLE III—Continued

Attained Age	Males					Females					Attained age
	For an Unallocated Maximum of					For an Unallocated Maximum of					
	\$25	\$50	\$100	\$150	\$250	\$25	\$50	\$100	\$150	\$250	
50	2.72	5.00	8.89	11.30	14.53	3.74	6.87	12.22	15.54	19.97	50
51	2.80	5.17	9.22	11.73	15.09	3.77	6.96	12.42	15.80	20.33	51
52	2.88	5.34	9.55	12.17	15.67	3.80	7.05	12.62	16.08	20.70	52
53	2.96	5.51	9.90	12.63	16.27	3.83	7.13	12.82	16.35	21.06	53
54	3.05	5.70	10.28	13.12	16.91	3.86	7.22	13.01	16.61	21.41	54
55	3.14	5.90	10.67	13.64	17.59	3.89	7.30	13.21	16.88	21.78	55
56	3.24	6.11	11.09	14.19	18.32	3.91	7.39	13.40	17.15	22.14	56
57	3.35	6.35	11.55	14.80	19.11	3.94	7.47	13.61	17.43	22.51	57
58	3.46	6.58	12.02	15.41	19.92	3.97	7.55	13.79	17.69	22.86	58
59	3.57	6.82	12.49	16.04	20.74	4.00	7.64	13.99	17.96	23.22	59
60	3.67	7.04	12.93	16.61	21.49	4.02	7.72	14.19	18.23	23.59	60
61	3.76	7.24	13.34	17.16	22.21	4.05	7.81	14.39	18.51	23.96	61
62	3.84	7.43	13.74	17.69	22.91	4.08	7.89	14.59	18.77	24.32	62
63	3.92	7.62	14.13	18.20	23.59	4.10	7.98	14.79	19.05	24.69	63
64	3.99	7.79	14.49	18.69	24.24	4.13	8.06	14.98	19.32	25.06	64
65	4.06	7.95	14.83	19.14	24.84	4.15	8.14	15.18	19.59	25.42	65
66	4.12	8.10	15.15	19.57	25.40	4.18	8.22	15.38	19.86	25.79	66
67	4.16	8.23	15.43	19.95	25.91	4.21	8.31	15.59	20.15	26.18	67
68	4.21	8.34	15.70	20.31	26.39	4.23	8.39	15.79	20.43	26.55	68
69	4.24	8.45	15.95	20.65	26.85	4.25	8.47	15.98	20.70	26.91	69
70	4.28	8.55	16.18	20.96	27.27	4.28	8.55	16.18	20.96	27.27	70
71	4.30	8.61	16.39	21.26	27.67	4.30	8.61	16.39	21.26	27.67	71
72	4.32	8.64	16.57	21.51	28.01	4.32	8.64	16.57	21.51	28.01	72
73	4.34	8.68	16.75	21.76	28.34	4.34	8.68	16.75	21.76	28.34	73
74	4.35	8.70	16.90	21.97	28.63	4.35	8.70	16.90	21.97	28.63	74
75	4.36	8.72	17.06	22.19	28.94	4.36	8.72	17.06	22.19	28.94	75
76	4.37	8.74	17.21	22.41	29.23	4.37	8.74	17.21	22.41	29.23	76
77	4.38	8.76	17.35	22.61	29.51	4.38	8.76	17.35	22.61	29.51	77
78	4.39	8.77	17.49	22.81	29.79	4.39	8.77	17.49	22.81	29.79	78
79	4.39	8.78	17.55	22.99	30.03	4.39	8.78	17.55	22.99	30.03	79
80	4.39	8.78	17.56	23.16	30.27	4.39	8.78	17.56	23.16	30.27	80

TABLE IV
1956 INTER-COMPANY SURGICAL TABLE
NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES

Surgical Expense Benefit*			Surgical Expense Benefit*		
		Male	Female		
Attained Age	For \$200 "Standard" Schedule		Attained Age	For \$200 "Standard" Schedule	
20-----	3.60	4.40	43-----	3.92	8.25
21-----	3.56	4.68	44-----	4.03	8.24
22-----	3.52	4.95	45-----	4.14	8.20
23-----	3.48	5.21	46-----	4.26	8.12
24-----	3.46	5.46	47-----	4.40	8.01
25-----	3.44	5.70	48-----	4.54	7.88
26-----	3.43	5.93	49-----	4.69	7.74
27-----	3.42	6.16			
28-----	3.43	6.37	50-----	4.84	7.62
29-----	3.43	6.58	51-----	5.00	7.51
			52-----	5.16	7.40
30-----	3.44	6.76	53-----	5.32	7.30
31-----	3.45	6.92	54-----	5.49	7.20
32-----	3.46	7.06	55-----	5.64	7.12
33-----	3.48	7.18	56-----	5.79	7.05
34-----	3.50	7.31	57-----	5.94	7.00
35-----	3.52	7.44	58-----	6.08	6.95
36-----	3.54	7.59	59-----	6.21	6.90
37-----	3.56	7.75			
38-----	3.59	7.91	60-----	6.32	6.86
39-----	3.63	8.04	61-----	6.42	6.82
			62-----	6.50	6.77
40-----	3.68	8.14	63-----	6.56	6.73
41-----	3.75	8.20	64-----	6.62	6.70
42-----	3.83	8.24	65-----	6.66	6.66

*In order to obtain Net Annual Claim Costs for a particular Surgical Schedule, follow the procedure outlined in Table V

TABLE V

1956 INTER-COMPANY SURGICAL TABLE
EVALUATION SCHEDULE FOR SURGICAL BENEFITS
PER \$100 SCHEDULE

Procedure	Weight	Amount Payable per \$100 Maximum (Prorated if Maximum is other than \$100)	Product
Adult Male			
Benign tumors and cysts, superficial removal----	.564		
Appendectomy-----	.712		
Cholecystectomy-----	.095		
Herniotomy, single-----	.391		
Herniotomy, bilateral-----	.101		
Hemorrhoidectomy, Int. or Ext.-----	.229		
Hemorrhoidectomy, Int. and Ext.-----	.154		
Prostatectomy, perineal or suprapubic-----	.059		
Nasal septum, submucous resection-----	.130		
Tonsillectomy and/or Adenoidectomy-----	.711		
Adult Female			
Thyroidectomy, subtotal-----	.087		
Appendectomy-----	.429		
Cholecystectomy-----	.160		
Dilation and curettage-----	.330		
Uterine fixation-----	.096		
Panhysterectomy-----	.157		
Hysterectomy—abd.-----	.326		
Hysterectomy—vag.-----	.065		
Other uterine operations incl. oophorectomy etc.-----	.110		
Tonsillectomy and adenoidectomy-----	.304		

The weights are so determined that the sum of the products evaluates a schedule as a percentage of "standard", and are derived from the frequencies for the commoner operations. Apply the above factors (percentage of "standard") to the net annual claim costs for a \$200 "standard" schedule shown in Table IV to obtain the adjusted net annual claim costs for a particular schedule (\$200 basis). Where the particular schedule is for some amount other than \$200, the factors should be adjusted accordingly (i.e. \$250 schedule multiply by 1.25.)

History: Cr. Register, April, 1959, No. 40, eff. 5-1-59; am. (2) (a) and (b), Register, June, 1960, No. 54, eff. 7-1-60; am. (3) (a) and Table 1, Register, October, 1960, No. 58, eff. 11-1-60; r. and recr., Register, January, 1967, No. 133, eff. 2-1-67; emerg. am. to (1) to (6), eff. 6-22-76; am. (1), (2), (3) (intro.), (3) (a), 4 and 5, (3) (e), (4) (intro.), (4) (a), (5) and (6), Register, September, 1976, No. 249, eff. 10-1-76; am. (2), (3) and (5), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.18 Total consideration for accident and sickness insurance policies. The total consideration charged for accident and sickness insurance policies must include policy and other fees. Such total consideration charged must be stated in the policy, and shall be subject to the reserve requirements of ch. 623, Stats., and Wis. Adm. Code section Ins 3.17, and must be the basis for computing the amount to be refunded in the event of cancellation of the policy.

History: Cr. Register, May, 1959, No. 41, eff. 6-1-59; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor. (1) This rule implements and interprets ss. 204.321 (1) (d) and 206.60 (2), 1973 Stats., with regard to issuance of a group policy of accident and sickness insurance issued to a creditor to insure debtors of a creditor.

Register, March, 1979, No. 279

(2) A group accident and sickness insurance policy may be issued to a creditor to insure debtors of the creditor if the class or classes of insured debtors meet the requirements of pars. (a) and (c) of s. 206.60 (2), Stats., [1973] and such a policy shall be subject to the requirements of such paragraphs in addition to other requirements applicable to group accident and sickness insurance policies.

History: Cr. Register, November, 1959, No. 47, eff. 12-1-59; am. Register, September, 1963, No. 93, eff. 10-1-63; r. (3), Register, February, 1973, No. 206, eff. 3-1-73; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles. (1) **PURPOSE.** In accordance with s. 204.49 (4), Stats., this rule is to accomplish the purpose and enforce the provisions of ch. 625, Stats., in relation to automobile physical damage insurance for substandard risks.

(2) **SCOPE.** This rule applies to any automobile physical damage insurance policy procured or delivered by a finance company.

(3) **DEFINITIONS.** (a) *Substandard risk* means an applicant for insurance who presents a greater exposure to loss than that contemplated by commonly used rate classifications as evidenced by one or more of the following conditions:

1. Record of traffic accidents.
2. Record of traffic law violations.
3. Undesirable occupational circumstances.
4. Undesirable moral characteristics.

(b) *Substandard risk rate* means a rate or premium charge that reflects the greater than normal exposure to loss which is assumed by an insurer writing insurance for a substandard risk.

(4) **RATES FOR SUBSTANDARD RISKS.** (a) Any increased rate charged for substandard risks shall not be excessive, inadequate, or unfairly discriminatory.

(b) It shall be unfairly discriminatory to charge a rate or premium that does not reasonably measure the variation between risks and each risk's exposure to loss.

(c) Classification rates filed for substandard risks may not exceed 150% of the rate level generally in use for normal risks unless the filing also provides for the modification of classification rates in accordance with a schedule which establishes standards for measuring variation in hazards or expense provisions or both.

(5) **INSURANCE COVERAGE.** (a) The automobile physical damage insurance afforded shall be substantially that customarily in use for normal business.

(b) The applicant shall not be required to purchase more coverage than is customarily necessary to protect the interests of the mortgagee. The issuance of a policy shall not be made contingent on the acceptance by the applicant of unwanted or excessively broad coverages.

(c) Single interest coverage may be issued only when double interest coverage is not obtainable. The applicant must be given the opportunity

to procure his own insurance, and if he can procure same within 25 days there shall be no charge for the single interest coverage.

(6) **POLICY FORMS.** The purchaser must be furnished with a complete policy form clearly setting forth the nature and extent of all coverages and premiums charged therefor.

(7) **RATING STATEMENT.** No policy written on the basis of a sub-standard risk rate schedule shall be issued unless it contains a statement printed in bold-faced type, preferably in a contrasting color, reading substantially as follows: This policy has been rated in accordance with a special rating schedule filed with the commissioner of insurance providing for higher premium charges than those generally applicable for average risks. If the coverage or premium is not satisfactory, you may secure your own insurance.

History: Cr. Register, March, 1960, No. 51, eff. 4-1-60; emerg. am. (1), eff. 6-22-76; am. (1), Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.22 Bail bond insurance. **History:** Cr. Register, April, 1964, No. 100, eff. 6-1-64; r. (3) Register, December, 1967, No. 144, eff. 1-1-68; emerg. am. (1), (2) (b) and (c), (5) and (6), eff. 6-22-76; am. (1), (2) (b) and (c), (5) and (6), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2) (b), Register, March, 1979, No. 279, eff. 4-1-79; r. Register, March, 1980, No. 291, eff. 4-1-80.

Ins 3.23 Franchise accident and sickness insurance. (1) **FRANCHISE GROUP HEADQUARTERS.** A franchise group described in s. 600.03 (34m) (d), Stats., need not have its headquarters or other executive offices domiciled in Wisconsin.

(2) **ACCOUNTING.** All premiums paid in connection with franchise accident and sickness insurance on Wisconsin residents shall be reported for annual statement purposes as Wisconsin business and shall be subject to the applicable Wisconsin premium tax.

History: Cr. Register, May, 1964, No. 101, eff. 6-1-64; emerg. am. (1) eff. 6-22-76; am. (1), Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.25 Credit life insurance and credit accident and sickness insurance. (1) **PURPOSE.** The purpose of this rule is to assist in the maintenance of a fair and equitable credit insurance market and to protect the interest of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life insurance and credit accident and sickness insurance. This rule interprets and implements, including but not limited to the following Wisconsin Statutes: ss. 623.06, 601.01 (3) (b) and (c), 601.42, 625.11, 625.12, 625.34, 631.20, 632.44 (3) and 632.60.

(2) **SCOPE.** (a) This rule shall apply to the transaction of credit life insurance defined in section Ins 6.75 (1) (a) 1. and 632.44, Stats., and to the transaction of credit accident and sickness insurance as defined in section Ins 6.75 (1) (c) 1. or (2) (c) 1.

(b) This rule shall be the basis for review of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates pertaining thereto submitted for filing after the effective date of this rule.

(c) This rule shall not apply to an individual or group life insurance policy or an individual or group accident and sickness insurance policy which insures only debtors whose indebtedness to a creditor is for a term in excess of 5 years.

Register, March, 1980, No. 291

(3) **FORMS OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE.** Credit life insurance and credit accident and sickness insurance shall be issued only in the following forms:

(a) Individual policies of life insurance issued to debtors on the non-renewable, nonconvertible term plan;

(b) Individual policies of accident and sickness insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

(d) Group policies of accident and sickness insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

(4) (a) The amount of credit life insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable in installments to the creditor. The amount of insurance on the life of any debtor shall at no time exceed the amount of the unpaid indebtedness.

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(b) The total amount of periodic indemnity payable by credit accident and sickness insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic schedule of unpaid installments of indebtedness, and the amount of each periodic indemnity shall not exceed the original total amount of periodic indemnity divided by the number of periodic installments.

(5) **TERM OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE.** The term of any credit life insurance or credit accident and sickness insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of indebtedness except when extended without additional cost to the debtor or as an incident to a deferral, refinancing or consolidation agreement. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In any renewal or refinancing of the indebtedness the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, but this does not apply to an amount of indebtedness, exclusive of refinancing charges, in excess of the original indebtedness outstanding at the time of refinancing. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in subsection (8).

(6) **PROVISIONS OF POLICIES AND CERTIFICATES OF INSURANCE; DISCLOSURE TO DEBTORS.** (a) All credit life insurance and credit accident and sickness insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance and/or credit accident and sickness insurance shall, in addition to other requirements of law set forth:

1. The name and home office address of the insurer,
2. The name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor,
3. The premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and sickness insurance,
4. A description of the coverage including the amount and term thereof, and any exceptions, limitations and restrictions,

5. A provision that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate, and

6. A provision that the insurance on any debtor will be cancelled and refund made if his indebtedness is terminated through prepayment or otherwise.

(c) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.

(d) If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance shall:

1. Be delivered to the debtor at the time such indebtedness is incurred,
2. Be signed by the debtor,
3. Set forth the name and home office address of the insurer,
4. Set forth the name or names of the debtor,
5. Set forth the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and sickness insurance, and
6. Set forth the amount, term and a brief description of the coverage provided including all exclusions and exceptions.

(dm) The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificates of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in subsection (5).

(e) If the named insurer does not accept the risk, then and in such event the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer, if any, and the information required by subsection (6) (b), and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made.

(f) If a contract of insurance provides for a limitation of the amount of coverage related to insurance provided by other contracts in force on the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing by him in an instrument separate from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the limitation of amount of coverage. The brief description or separate statement, if used

to meet the foregoing requirement, shall be printed on the first page of the individual policy or group certificate in type more prominent than that used in the text of the policy or certificate and shall clearly indicate the limitation.

(g) If a contract of insurance provides for a limitation of coverage related to the age of the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing by him in an instrument separate from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the age limitation. The brief description or separate statement, if used to meet the foregoing requirement, shall be printed on the first page of the individual policy or group certificate in type more prominent than that used in the text of the policy or certificate and shall clearly indicate the limitation.

(h) Conspicuous notice of the debtor's right to return the policy, certificate of insurance or notice of proposed insurance within 10 days of incurring the indebtedness and to receive a refund of any premium paid if he is not satisfied with the insurance for any reason, as required by s. 424.203 (4), Stats., shall be furnished with or in the policy, certificate or notice of proposed insurance.

(i) Charges or premiums for credit life insurance or credit accident and sickness insurance may only be collected from debtors if the disclosure and authorization requirements of s. 422.202 (1) (b), Stats., are met. If 2 debtors are to be insured for credit life insurance each must receive the disclosure information and each must request credit life insurance coverage.

(7) FILING OF POLICY FORMS. (a) All policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner. In the case of credit transactions covered under a group policy issued in another state or jurisdiction, the insurer shall file for approval only the group certificate and notice of proposed insurance to be used in this state, and the premium rates to be used in connection with such certificate and notice.

(b) The commissioner shall within 30 days after the filing of any such policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement or rider, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any law or of any administrative rule.

(c) If the commissioner notifies the insurer that the form is disapproved, it may not issue or use such form. Such notice shall specify the reason for the disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until the expiration of 30 days after it has been so filed, unless the commissioner shall give his prior written approval thereto.

(d) The commissioner may, at any time after a hearing held not less than 20 days after written notice to the insurer, withdraw his approval of any such form on any ground set forth in paragraph (b) above. The written notice of such hearing shall state the reason for the proposed withdrawal.

(e) The insurer may not issue such forms or use them after the effective date of such withdrawal.

(8) **PREMIUMS AND REFUNDS.** (a) Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit accident and sickness insurance policy for which the premium rate differs from that determined by the schedules of such insurer as then on file.

(b) The amount charged to a debtor for any credit life or credit accident and sickness insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(c) If a creditor requires a debtor to make any payment for credit life insurance or credit accident and sickness insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(d) A creditor may not remit and an insurer may not collect on a monthly outstanding balance basis if the insurance charge or premium is included as part of the outstanding indebtedness. This means that where the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of indebtedness, and any direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with such insurance charge, the creditor must remit and the insurer shall collect on a single premium basis only.

(e) Dividends on participating individual policies of credit insurance shall be payable to the individual insureds. Payment of such dividends may be deferred until such time as the policy is terminated.

(f) Each individual policy, or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided, however, that the premium schedule may prescribe a minimum refund of \$1 and no refund of a lesser amount need be made. The sum of the refunds due on all credit life insurance or credit accident and sickness insurance policies being terminated in connection with the indebtedness and all other credits due to the customer under chs. 421 to 428, Stats., shall be used to determine if a refund is due.

(g) Schedules for computing refunds in event of cancellation of credit insurance prior to the scheduled maturity date of the indebtedness must meet the following minimum requirements:

1. The refund of premium, in the case of credit insurance for which premiums are payable other than by a single premium, and in the case of level term credit life insurance, shall be equal to the pro-rata unearned gross premium. In the case of credit insurance paid by a single premium

the refund shall be equal to the amount computed by the "sum of digits" formula commonly known as the "Rule of 78".

2. The refund of the amount charged the debtor for insurance, in the case of credit insurance for which said amount is charged other than in single sum, and in the case of level term credit life insurance, shall be equal to the pro-rata unearned gross amount charged or to be charged. In the case of credit insurance for which the whole amount is charged in a single sum the refund shall be equal to the amount computed by the "sum of digits" formula commonly known as the "Rule of 78".

3. Refunds shall be based upon the number of full months prepaid from the maturity date of the policy, counting a fractional month of 16 days or more as a full month.

4. Upon termination of indebtedness repayable in a single sum prior to the scheduled maturity date, the refund shall be computed from the date of termination to the maturity date. If less than 15 days of a loan month has been earned, no charge may be made for that loan month, but if 15 days or more, a full month may be charged.

(h) If an insured indebtedness is transferred to another creditor any group credit life insurance or group credit accident and sickness insurance issued on that indebtedness may be continued, but the creditor policyholder must advise the insurer of each transfer within 30 days of its effective date.

(9) CLAIMS AND AUDIT PROCEDURES. (a) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

(c) No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer. However, nothing herein shall be construed to relieve the insurer of the responsibility for proper settlement, adjustment and payment of all claims in accordance with the terms of the insurance contract and this ruling.

(d) The insurer must make a good faith examination of each credit insurance account in the first year of the account and annually thereafter. The examination shall be made to assure that the creditor is conducting the insurance program in compliance with the credit insurance policy provisions, the insurer's administrative instructions furnished the creditor to implement the insurance program, and with the applicable credit insurance law and regulation of Wisconsin. The examination must include verification of the accuracy of the computation of premium payments, insurance charges made to debtors, and claim payments reported to the insurer by the creditor. The insurer will maintain records

of examinations for 2 years, and such records will be subject to call and review by the commissioner.

(10) **CHOICE OF INSURER.** When credit life insurance or credit accident and sickness insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

(11) **CREDIT INSURANCE PREMIUM RATE FILINGS.** (a) Every credit insurer shall file with the commissioner every premium rate schedule applicable to credit insurance in this state, together with the premium, loss, and expense experience on which the insurer bases the proposed premium rate, at least 30 days before the proposed effective date.

(b) In the absence of credible mortality or morbidity experience, the benefits provided under a credit insurance form shall be deemed not to be unreasonable in relation to the premium rate charged if the premium rates filed do not exceed the prima facie premium rate standards set forth in subs. (12) and (13) and if the forms provide benefits which are no more restrictive than the coverage standards enumerated.

(c) Nothing herein shall preclude an insurer from requesting approval of the commissioner for premium rates higher or lower than the prima facie rate standards on the basis of the mortality or morbidity rate actually experienced or anticipated.

(d) If an insurer proposes to provide coverage which is different from coverage described in subs. (12) and (13), the insurer must demonstrate to the commissioner's satisfaction that the premium rate schedule applicable for the coverage will produce loss ratios at least as great as those contemplated in the premium rate standards set forth or can reasonably be expected to produce such loss ratios.

(e) Where no debtor is paying an identifiable charge for any part of the premium for credit insurance the rates shall be such reasonable rates as are approved by the commissioner.

(12) **PRIMA FACIE CREDIT LIFE INSURANCE PREMIUM RATE STANDARDS.**

(a) The basic permissible loss ratio for credit life insurance shall be not less than 50%.

(b) The rate standard for premiums payable on the basis of monthly outstanding balance is \$0.616 per \$1,000 of insurance. The rates applicable to other methods of payment shall be actuarially equivalent.

(c) The rate standard for premiums payable on single premium decreasing term credit life insurance shall be computed according to the following formula:

$$P_n = \frac{(n)}{12} 0.40$$

Where P_n = Single premium rate per \$100 of initial insured indebtedness repayable in n equal monthly instalments

n = Original repayment period, in months

(d) The rate standard for premiums payable on single premium level term credit life insurance shall be computed according to the following formula:

$$P_n = \frac{(n) 0.616}{10}$$

Where P_n = Single premium rate per \$100 of level insured indebtedness repayable in n months

n = Original term of level indebtedness in months

(e) The rate standards for credit life insurance providing coverage on 2 lives with respect to a single indebtedness shall be 150% of the rate standard provided in pars. (b), (c), and (d), above.

(f) As an alternative to pars. (b), (c), or (d) above, where age data applicable to the insured debtors is available, rate standards may be based on such data, under a plan approved by the commissioner.

(g) The rate standards set forth herein shall be applicable for a plan of death benefits with or without requirements for evidence of insurability which contains:

1. No exclusions other than suicide within one year of the incurral of the indebtedness, and

2. No age restrictions, or only age restrictions making ineligible for coverage:

- a. Debtors less than age 18 at the time the indebtedness is incurred, or
- b. Debtors age 65 or over at the time the indebtedness is incurred, or
- c. Debtors who will have attained age 66 or over on the maturity date of the indebtedness.

(h) The rate standards set forth in this subsection shall not be applicable for a plan of death benefits wherein the amount of credit life insurance on the life of any debtor at any time exceeds \$10,000, or for which the term of the indebtedness insured exceeds 5 years.

(13) **PRIMA FACIE MAXIMUM CREDIT ACCIDENT AND SICKNESS INSURANCE PREMIUM RATE STANDARDS.** (a) If premiums are payable in one sum (single premium) for coverage for the entire duration of indebtedness, the premium rate standards for \$100 of initial amount of insured indebtedness repayable in equal monthly instalments are shown below. Premium rate standards for other benefit plans and for indebtedness repayable in instalments other than as shown shall be actuarially consistent with the indicated rate standards, but no individual policy of credit accident and sickness insurance or group policy of credit accident and sickness insurance shall be delivered or issued for delivery if the benefits are payable after a waiting period of less than 14 days, regardless of whether the payment of benefits are retroactive to the first day of disability.

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Original Number of Equal Monthly Instalments	14 days Non-Retroactive Elimination Period		30 Days
	6	\$1.39	
12	1.95		1.18
18	2.27		1.50
24	2.52		1.69
30	2.74		1.82
36	2.93		1.93
42	3.10		2.03
48	3.26		2.12
54	3.41		2.21
60	3.55		2.29
Basic permissible loss ratio	59%		52%

Original Number of Equal Monthly Instalments	14 Days Retroactive Waiting Period		30 Days
	6	\$1.74	
12	2.23		1.68
18	2.56		1.89
24	2.81		2.04
30	3.02		2.17
36	3.21		2.29
42	3.39		2.39
48	3.55		2.48
54	3.70		2.57
60	3.84		2.65
Basic permissible loss ratio	60%		57%

(b) The rate standards applicable for premiums payable on the basis of monthly outstanding balances shall be computed under the formula described in subd. 1 below except as provided in subd. 2:

1. For credit accident and sickness insurance benefit plans issued on an individual or a group basis the premiums payable shall be computed as follows:

$$p_n = \frac{20 P_n}{n + 1}$$

Where n = *Original* repayment period, in months

p_n = The Monthly Outstanding Balance Premium Rate per \$1,000 for an indebtedness repayable in equal monthly instalments with an *original* repayment period of n months

P_n = The Single Premium Rate per \$100 initial insured indebtedness with an *original* repayment period of n months, from par. (a) above.

The outstanding balance premium rate for an indebtedness with a given original repayment period is applicable to the outstanding balance of this indebtedness at each month during the period, regardless of the remaining repayment period.

2. For credit accident and sickness insurance benefit plans issued on a group basis, a composite monthly outstanding balance premium rate schedule may be used in lieu of the rate procedure described in subdivision 1 above for each benefit plan, to apply to all outstanding balances each month under such plan, irrespective of the type or duration of loan

making up such outstanding balances. Such composite monthly outstanding balance premium rate schedule will be approved for use only if the actuarial consistency of such composite rate with the prima facie maximum credit accident and sickness insurance premium rate standards and basic permissible loss ratios in par. (a) above is established, and the reasons for this use in lieu of the rate standard in subdivision 1 above are documented.

3. The rate deviation procedure outlined in sub. (14) shall be applied separately to any business written under subdivision 2 above, and the insurer shall maintain all pertinent data on such business separately.

(c) The rate standards set forth herein shall be applicable for a plan of benefits which contains:

1. No provision excluding or denying a claim for disability resulting from pre-existing conditions except for those conditions which manifested themselves to the insured debtor by requiring medical diagnosis or treatment or would have caused a reasonably prudent person to have sought the medical diagnosis or treatment, within 6 months preceding the effective date of the debtor's coverage and which caused loss within the 6 months following the effective date of coverage; provided, however, that disability commencing thereafter resulting from such condition shall be covered.

2. No other provision which excludes or restricts liability in the event of disability caused in a certain specified manner except that it may contain provisions excluding or restricting coverage in the event of pregnancy, intentionally self-inflicted injuries, foreign travel or residence, flight in non-scheduled aircraft, war or military service.

3. No age restrictions, or only age restrictions making ineligible for coverage:

- a. Debtors less than age 18 at the time the indebtedness is incurred, or
- b. Debtors age 65 or over at the time the indebtedness is incurred, or
- c. Debtors who will have attained age 66 or over on the maturity date of the indebtedness.

4. Provision for a daily benefit equal in amount to the initial indebtedness divided by the number of days in the period during which the indebtedness is scheduled to be repaid in equal monthly instalments.

5. Provides for benefits to be payable in the event of disability resulting from bodily injury or sickness, which disability commences while the debtor is insured hereunder and prevents the insured debtor from engaging in any gainful occupation for which he is reasonably qualified by reason of education, training or experience, except that during the initial 12 months of disability the inability of the insured to engage in his own occupation shall be the only test.

Note: This is not intended to preclude calculation of the daily benefit based on a 30 day month.

(d) The rate standards set forth in this subsection shall not apply for a plan of benefits wherein the aggregate of the periodic schedule of unpaid installments of indebtedness payable by credit accident and sick-

ness insurance exceeds \$10,000 or for which the term of the indebtedness insured exceeds 5 years.

(14) DEVIATION PROCEDURE AND CASE RATE DETERMINATION. (a) For cases of less than \$50,000 earned premiums (prima facie basis) the case rates shall be the prima facie rates. For cases of \$50,000 or greater earned premiums (prima facie basis) the actual case ratio shall be calculated as (actual ratio of claims incurred to premiums earned) divided by the basic permissible loss ratio shown in sub. (12) or (13). If the actual case ratio is within the acceptance range shown in the following credibility table, the case rates will be the prima facie rates. If the actual case ratio is outside the acceptance range, the adjusted case ratio will be calculated by adjusting the actual case ratio toward 100% by addition or subtraction of the "adjustment constant", also shown in the credibility table.

CREDIBILITY TABLE
Earned Premium (Prima Facie Basis)

Size Group	Small Loans or Credit Unions	Banks or Sales Finance	Acceptance Range	Adjustment Constant
CREDIT LIFE				
I	50,000-125,000	50,000- 200,000	0.80-1.20	0.15
II	125,000-300,000	200,000- 500,000	0.85-1.15	0.10
III	300,000-650,000	500,000-1,000,000	0.85-1.15	0.05
IV	650,000 or over	1,000,000 or over	0.90-1.10	0.00
CREDIT ACCIDENT AND SICKNESS				
I	50,000- 75,000	50,000- 100,000	0.80-1.20	0.15
II	75,000-125,000	100,000- 175,000	0.85-1.15	0.10
III	125,000-250,000	175,000- 350,000	0.85-1.15	0.05
IV	250,000 or over	350,000 or over	0.90-1.10	0.00

(b) If the adjusted case ratio exceeds 1.00, the case rate is the product of deviation factor f, and the prima facie rate shown in sub. (12) or (13), where

$$f = [(Adjusted\ case\ ratio - 1) \times 1.25 \times Basic\ Permissible\ Loss\ Ratio] + 1$$

(c) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, but greater than the limits specified in the following table, the case rates are the product of the deviation factor g, and the prima facie rates in sub. (13), where

$$g = 1 - [1 - adjusted\ case\ ratio \times 1.25 \times Basic\ Permissible\ Loss\ Ratio]$$

<i>Plan of Benefit</i>	<i>Limit</i>
14 days Retroactive Elimination Period -----	.55
14 days Non-Retroactive Elimination Period -----	.59
30 days Retroactive Elimination Period -----	.67
30 days Non-Retroactive Elimination Period -----	.89

$$Limit = \frac{.5 (1 - 1.25 \times Basic\ Permissible\ Loss\ Ratio)}{Basic\ Permissible\ Loss\ Ratio (1 - .5 \times 1.25)}$$

(Rounded down)

(d) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, and less than or equal to the limit specified in the

above table, the case rates are the product of the deviation factor h , and the prima facie rate in sub. (13) where

$$h = (\text{Adjusted Case Ratio} \times \text{Basic Permissible Loss Ratio} \times 2)$$

(e) If the adjusted case ratio for credit life insurance is less than 1.00, the case rate is the product of the deviation factor h and the prima facie rate in subsection (12) where

$$h = (\text{Adjusted Case Ratio})$$

(f) If the case rate determined by the above procedures is within 5¢ of the existing single premium rate per \$100 per year, the existing rate will be the case rate.

(g) The case rate as determined shall continue for a period equal to the experience period on which it was based. Where the case rate applies to a group of accounts, the rate will continue to apply to every account which was grouped for determination of the rate and to only those accounts. The insurer shall annually determine and submit for filing under sub. (8) (a) the applicable case rate calculated as prescribed herein.

(h) As used in this rule the following words mean:

1. Account—The aggregate credit life or credit accident and sickness coverage for a single plan of benefits and class of business written through a single creditor by the insurer, whether coverage is written on a group or individual policy basis.

2. Class of business—Means any of the following:

- a. Credit unions
- b. Commercial and savings banks
- c. Other cash loans (small loans, industrial bank loans, etc.)
- d. Other sales finance (discount transactions, etc.)

3. Experience year—A 12-month period ending on the policy anniversary or renewal date or on a calendar year-end. Experience for a given account or permitted combinations of accounts shall be reported consistently from year to year.

4. Case—a. An account, if the earned premium for the account based upon the prima facie premium rates promulgated in sub. (12) or (13) during the most recent 3 experience years has been \$50,000 or more. If the rates applicable to the account are not at the prima facie level or at a uniform percentage of the prima facie rates, the amount of premium which would have been earned at the prima facie rates shall be approximated by a reasonable method filed with the experience report.

b. A combination of all the insurer's accounts of the same plan of benefits and class of business, excluding all accounts which meet the criterion for inclusion under a. immediately preceding.

5. Experience period—The last 3 experience years unless a lower number of full years produces an earned premium in size group IV as shown in the credibility table.

(j) In determining the case ratios in this subsection for application of the deviation formula, the following rules shall be applied:

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1. If the coverage for a single creditor which qualifies for separate consideration under case definition a. above has been in force with the insurer for less than the experience period, the claim experience of the creditor while covered by any prior insurer shall be included to the extent necessary in determining the appropriate case ratios.

2. The case ratios shall be based wholly or partially on the experience of the insurer on the case within the state, or a group of states or on the total United States experience, so long as the insurer reports and files consistently for that case thereafter. An account which qualifies for separate treatment as a case but which provides coverage on a multi-state basis, may be considered in its entirety if the insurer so chooses excluding experience used for deviation purposes in any state, states or group of states.

(15) ACCOUNTING AND UNDERWRITING EXPERIENCE. Each insurer shall maintain records of premiums, losses and expenses of Wisconsin business separately for credit life insurance and credit accident and sickness insurance on a calendar year basis or on a policy year basis. Such underwriting experience shall be maintained for each form of policy, creditor, and class of creditor. This information shall be subject to call annually by the commissioner.

(16) FINANCIAL STATEMENT MINIMUM RESERVES. (a) Each insurer shall show, as a liability in any financial statement or report required under s. 601.42, Stats., its policy or unearned premium reserve in an amount not less than as computed in pars. (b), (c) and (d). If a credit insurance policy provides any combination of life insurance benefits, disability benefits and accident and sickness insurance benefits, a reserve must be established separately for the life insurance benefits, for the disability benefits and for the accident and sickness insurance benefits.

(b) The reserve for individual credit life insurance policies shall be not less than 130% of the Commissioner's 1958 Standard Ordinary Mortality Table at 3½% annual interest.

(c) The reserve for group credit life insurance policies shall be not less than 130% of the Commissioner's 1960 Standard Group Mortality Table at 3½% annual interest.

(d) The reserve for credit accident and sickness insurance policies and for disability benefits in credit life insurance policies shall be not less than the greater of 130% of the Commissioner's 1964 Disability Table at 3½% annual interest or the pro rata unearned premium reserve.

(17) SUBMISSION OF POLICY FORMS AND RATE SCHEDULES IN USE. Each insurer subject to this rule shall file with the commissioner on or before October 1, 1972, a listing of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates pertaining thereto which have been heretofore approved and which the insurer intends to issue or use in Wisconsin after the effective date of this rule.

(18) PENALTY. Violations of this rule shall subject the insurer or agent to s. 601.64, Stats.

(19) SEPARABILITY. If any provision or clause of this ruling or the application thereof to any person or circumstance is, for any reason held

invalid, the remainder of this ruling and the application of such provision to other persons or circumstances shall not be affected thereby.

Note: It is the intent of this rule that it shall apply prospectively to the review for approval of policy and other forms of credit life and credit accident and sickness insurance and to the rates applicable to such forms that are submitted for filing after the effective date. Individual hearings will be held to consider whether credit life and credit accident and sickness insurance contract forms and rate levels presently in use provide benefits that are reasonable in relation to premium charges.

History: Cr. Register, August, 1972, No. 200, eff. 9-1-72; cr. (2) (c), (6) (h) and (8) (h); am. (4) (b), (5), (8) (f), (12), (13) (a), (14) (e), and r. (17) (a), Register, February, 1973, No. 206, eff. 3-1-73; am. (4), (5), (6) (a), (6) (h), (8) (f), (12) (g) 2, (13) (c) 3, (14) (c) and (d) and cr. (6) (i) and (13) (c) 5, Register, April, 1975, No. 232, eff. 5-1-75; am. (13) (b), Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (4) and (11) (d), cr. (12) (h) and (13) (d), Register, March, 1977, No. 255, eff. 4-1-77; am. (1), (2) and (14) (c), Register, March, 1979, No. 279, eff. 4-1-79; am. (12) (b) to (e), Register, September, 1981, No. 309, eff. 10-1-81.

Ins 3.26 Unfair trade practices in credit life and credit accident and sickness insurance. (1) **PURPOSE.** The purpose of this rule is to assist in the maintenance of a fair and equitable credit life insurance and credit accident and sickness insurance market. This rule interprets, including but not limited to, the following Wisconsin statutes: 601.04; 601.01 (3) (a), (b), (c), (g) and (h); 601.41 (1), (2) and (3) and ch. 628.

(2) **SCOPE.** This rule shall apply to the transaction of credit life insurance as defined in s. Ins 6.75 (1) (a) 1. and 632.44 (3), Stats., and the transaction of credit accident and sickness insurance as defined in s. Ins 6.75 (1) (c) 1. or (2) (c) 1.

(3) **UNFAIR TRADE PRACTICES DEFINED.** The following acts, whether done directly or indirectly, in consideration of or in connection with a policy issued or proposed to be issued are defined to be prohibited unfair trade practices in the transaction of insurance described in sub. (2) above:

(a) The offer or grant by an insurer of any special favor or advantage, or any valuable consideration or inducement not set out in the insurance contract. The payment of agents' commissions, reported annually in Schedule 24S, shall not be a violation of this paragraph but the acts cited in pars. (b), (c), (d), (e) and (f) may not in any way be construed as agents' commissions.

(b) The offer to deposit or the deposit with a bank or other financial institution, money or securities of the insurer or of any affiliate of the insurer with the design or intent that the deposit offset or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(c) The deposit with a bank or other financial institution of money or securities without interest or at a lesser rate of interest than is currently being paid other depositors on similar deposits with such bank or other financial institution. This shall not be construed to prohibit the maintenance by an insurer of such demand deposits as are reasonable necessary for use in the ordinary course of business of the insurer.

(d) The offer to sell or the sale of any capital stock or other security or certificate of indebtedness of the insurer or affiliated person.

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(e) The offer to pay or the payment of any part of the premium for any insurance on the life, health or property of any creditor or any employe or other person affiliated with the creditor.

(f) The extension to the creditor of credit for the remittance of premium beyond the grace period of a group policy or for more than 45 days from the effective date of an individual policy.

(4) PENALTY. Violations of this rule shall subject the insurer or agent to s. 601.64, Stats.

History: Cr. Register, October, 1972, No. 202, eff. 11-1-72; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance. (1) PURPOSE. The interest of prospective purchasers of accident and sickness insurance must be safeguarded by providing such persons with clear and unambiguous statements, explanations, advertisements and written proposals concerning the policies offered to them. This purpose can best be achieved by the establishment of and adherence to certain minimum standards of and guidelines for conduct in the advertising and sale of such insurance which prevent unfair competition among insurers and are conducive to the accurate presentation and description to the insurance buying public of policies of such insurance. This rule interprets and implements, including but not limited to, the following Wisconsin Statutes: ss. 628.34 and 601.01 (3).

(2) SCOPE. This rule shall apply to any solicitation, representation or advertisement in this state of any insurance specified in s. Ins 6.75 (1) (c) or (2) (c), made directly or indirectly by or on behalf of any insurer, fraternal benefit society, nonprofit service plan subject to ch. 613, Stats., voluntary nonprofit sickness care plan organized under s. 185.981, Stats., interscholastic benefit plan organized under s. 185.991, Stats., or agent as defined in ch. 628, Stats.

(3) INTERPRETATION OF REQUIREMENTS APPLICABLE TO ADVERTISEMENTS.

(a) The proper promotion, sale and expansion of accident and sickness insurance are in the public interest. This rule is to be construed in a manner which does not unduly restrict, inhibit or retard such promotion, sale and expansion.

(b) In applying this rule, it shall be recognized that advertising is essential in promoting a broader distribution of accident and sickness insurance. Advertising necessarily seeks to serve this purpose in various ways. Some advertisements are the direct or principal sales inducement and are designed to invite offers to contract. In other advertisements the function is to describe coverage broadly for the purpose of inviting inquiry for further information. Other advertisements are for the purpose of summarizing or explaining coverage after the sale has been made. Still other advertisements are solely for the purpose of promoting the interest of the reader in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement. These differences shall be considered in interpreting this rule.

(c) When applying this rule to a specific advertisement, the type of policy to which the advertisement refers and the detail, character, purpose, use and entire content of the advertisement shall be taken into consideration.

(d) This rule applies to individual, franchise, group and blanket accident and sickness insurance. Because these types of coverage differ in some respects, one interpretation will not always suffice; a specific interpretation for individual, franchise, group or blanket coverage may be indicated.

(e) The extent to which policy provisions need be disclosed in an advertisement will depend on the content, detail, character, purpose and use of the advertisement and the nature of the exceptions, reductions, limitations and other qualifications involved. The principal criterion is whether the advertisement has the capacity and tendency to mislead or deceive if such a provision is not disclosed.

(f) Whether an advertisement has the capacity and tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(4) **COVERAGE TYPES.** (a) An advertisement which is an invitation to inquire or an invitation to apply shall clearly and prominently designate and at least briefly describe the type or types of coverage provided by the policy advertised. The level and extent of benefits provided by or available under the coverage shall also be clearly indicated.

(b) The following are the standard types of coverage designations and the minimum adequate form of description that must be used. Any type of coverage authorized by Wisconsin Statutes which is not reasonably included within one or more of the standard coverage types listed shall be similarly and appropriately named and described so as to clearly disclose the benefits provided.

1. **Basic hospital expense benefits.** This coverage provides benefits for hospital room and board and miscellaneous hospital charges, based upon actual expenses incurred, up to stated maximum amounts.

2. **Basic medical expense benefits.** This coverage provides benefits for medical benefits based upon actual expenses incurred, up to stated maximum amounts.

3. **Basic surgical expense benefits.** This coverage provides benefits for surgical benefits based upon actual expenses incurred up to stated maximum amounts.

4. **Major medical or comprehensive expense benefits.** These coverages provide high maximum benefit amounts covering almost all types of medical care and contain deductible and co-insurance features.

5. **Disability income benefits.** This coverage provides periodic benefit payments to help replace income when the insured is unable to work as a result of illness or injury.

6. **Hospital confinement indemnity benefits.** This coverage provides benefits in a stated amount for confinement in a hospital, regardless of the hospital expenses actually incurred by the insured, due to such confinement.

7. **Accident only benefits.** This coverage provides benefits for losses for accidental bodily injury.

8. Specified disease or treatment benefits. This coverage provides benefits for treatment of a specific disease or diseases named in the policy or for specified treatment.

(5) GENERAL DEFINITIONS. (a) An *advertisement* relating to accident and sickness insurance for the purpose of this rule includes the following:

1. Printed and published material, audio visual material and descriptive literature of an insurer used in newspapers, magazines, other periodicals, radio and TV scripts, billboards and similar displays, excluding advertisements prepared for the sole purpose of obtaining employes, agents or agencies.

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters.

a. Including material used in the solicitation of renewals and reinstatements except for communications or notices which mention the cost of the insurance but do not describe benefits,

b. Excluding material in house organs of insurers, communications within an insurer's own organization not intended for dissemination to the public, individual communications of a personal nature, and correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket policy,

c. Including group and blanket booklets, summaries of coverage and other explanatory material issued to insured persons, and

d. Excluding general announcements from group or blanket policyholders to eligible individuals that a contract has been written.

3. Prepared sales talks, presentations of material for use by agents and representations made by agents in accordance therewith, excluding materials to be used solely by an insurer for the training and education of its employes or agents, and

4. Envelopes used in connection with the above.

(b) A *policy* for the purpose of this rule includes any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits whether on a cash indemnity, reimbursement or service basis,

1. Except such benefits contained in a policy providing another kind of insurance other than life, and

2. Except disability and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as

a. Provide additional benefits in case of death or dismemberment or loss of sight by accident or

b. Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or

annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(c) An *insurer* for the purpose of this rule includes any person, individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, nonprofit service plan subject to ch. 613, Stats., voluntary nonprofit sickness care plan organized under s. 185.981, Stats., interscholastic benefit plan organized under s. 185.991, Stats., and any other legal entity engaged in advertising a policy as herein defined.

(d) An *exception* for the purpose of this rule means any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of a risk not assumed under the policy.

(e) A *reduction* for the purpose of this rule means any provision in a policy which reduces the amount of the benefits. A risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

(f) A *limitation* for the purpose of this rule means any provision in a policy which restricts coverage under the policy other than an exception or a reduction.

(g) An *invitation to apply* means an advertisement which is the direct or principal sales inducement and is designed to invite an offer to contract. Such an advertisement, which usually describes benefits in considerable detail, attempts to persuade the reader or listener to make application for the policy advertised. Such an advertisement would indicate what coverage the purchaser would receive and what such coverage would cost.

(h) An *invitation to inquire* means an advertisement which is designed to attract the reader's or listener's interest in the policy so that he will inquire for further information or details. Such an advertisement describes the policy broadly and withholds some information regarding the policy without which the reader or listener would not reasonably decide to apply for the policy.

(i) An *institutional advertisement* means one which is prepared solely to promote the reader's or listener's interest in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement.

(j) A *testimonial* means any statement made by a policyholder, certificateholder or other person covered by the insurer which promotes the insurer and its policy by describing such person's benefits, favorable treatment or other experience under the policy.

(k) An *endorsement* for the purposes of subsection (13) of this rule means any statement promoting the insurer and its policy made by an individual, group of individuals, society, association or other organization which makes no reference to the endorser's experience under the policy.

(1) An *outline of coverage* means an appropriately and prominently captioned portion of a printed advertisement which is clearly set off from the rest of the advertisement by means such as placing it within a prominent border or box or printing it in contrasting color, or a separate

appropriately captioned or titled printed statement, which advertisement portion or printed statement contains only a summary of the benefits provided, a designation of the applicable type or types of coverage as defined in subsection (4) and, under appropriate captions, the information required by subsections (10) and (11).

(m) An individual policy issued on a *group basis* means an individual policy or contract issued where:

1. Coverage is provided to employes or members or classes thereof defined in terms of conditions pertaining to employment or membership in an association or other group which is eligible for franchise or group insurance as provided in s. 600.03 (34m) (a) and (b), Stats.,

2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the group,

3. Premiums or subscription charges are paid to the insurer by the employer, association or some designated person acting on behalf of the employer, association or covered persons, and

4. The insurance plan is sponsored by the employer or association.

(6) ADVERTISEMENTS AND REPRESENTATIONS IN GENERAL. (a) Advertisements and representations shall be truthful and not misleading in fact or in implication and shall accurately describe the policy to which they apply. Words or phrases the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used.

(b) Oral representations shall conform to the requirements of this rule.

(7) SUITABILITY OF POLICIES. No agent or insurer shall recommend to a prospective buyer the purchase of any individual policy without reasonable grounds to believe that the recommendation is not unsuitable to the applicant. The agent or insurer shall make such inquiry as may be necessary under the circumstances to determine that the purchase of such insurance is not unsuitable for the prospective buyer. This requirement shall not apply to an individual policy issued on a group basis.

(8) OUTLINE OF COVERAGE. (a) Every advertisement of a specific individual policy or policies which constitutes an invitation to apply shall include an outline of coverage as defined in subsection (5) (1).

(b) Every agent at the time of taking an application for an individual policy shall furnish the applicant an outline of coverage as defined in subsection (5) (1).

(c) The requirement for an outline of coverage shall not apply to an advertisement or the taking of an application for an individual policy issued on a group basis or an individual conversion policy issued under a group or franchise insurance plan.

(9) DECEPTIVE WORDS, PHRASES OR ILLUSTRATIONS. (a) An advertisement shall not exaggerate a benefit or minimize cost by overstatement, understatement or incompleteness. Information shall not be omitted or words, phrases, statements, references or illustrations shall not be used if such omission or use has the capacity and tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium

payable. An advertisement referring to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to mislead or deceive.

(b) The words and phrases "all", "full", "complete", "comprehensive", "unlimited", "up to", "as high as", "this policy will pay your hospital and surgical bills", "this policy will fill the gaps under Medicare and your present insurance" or "this policy will replace your income", or similar words and phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as fairly to describe such benefit.

(c) A policy covering only one disease or a list of specified diseases shall not be advertised so as to imply coverage beyond the terms of the policy. A particular disease shall not be referred to by more than one term so as to imply broader coverage than is the fact.

(d) The benefits of a policy which pays varying amounts for the same loss occurring under different conditions, or which pays benefits only when a loss occurs under certain conditions, shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.

(e) The maximum benefit available under a policy shall not be emphasized in a manner which exaggerates its relationship to any internal limits or other conditions of the policy.

(f) The aggregate amounts or the monthly or weekly benefits payable under coverages such as hospital or similar facility confinement indemnity or private duty nursing shall not be emphasized unless the actual amounts payable per day are disclosed with substantially equal prominence and in close conjunction with such statement. Any limit in the policy on the number of days of coverage provided shall be disclosed.

(g) Phrases such as "this policy pays \$1800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.

(h) An advertisement shall not state or imply that each member under a family policy is covered as to the maximum benefits advertised when such is not the fact.

(i) The importance of diseases rarely or never found in the class of persons to whom the policy is offered shall not be exaggerated in an advertisement.

(j) Examples of what benefits may be paid under a policy shall be shown only for losses from common illnesses or injuries rather than exceptional or rare illnesses or injuries.

(k) When a range of hospital room expense benefits is set forth in an advertisement, it shall be made clear that the insured will receive only the benefit indicated in the policy purchased. It shall not be implied that the insured may select his room expense benefit at the time of hospitalization.

(l) An advertisement shall not imply that the amount of benefits payable under a loss of time policy may be increased at time of disability according to the needs of the insured.

(m) The term "confining sickness" is an abbreviated expression and shall be explained if used in an advertisement.

(n) An advertisement shall not state that the insurer "pays hospital, surgical, medical bills", "pays dollars to offset the cost of medical care", "safeguards your standard of living", "pays full coverage", "pays complete coverage", "pays for financial needs", "provides for replacement of your lost paycheck", "guarantees your paycheck", "guarantees your income", "continues your income", "provides a guaranteed paycheck", "provides a guaranteed income" or "fills the gaps in Medicare" or use similar words or phrases unless the statement is literally true. Where appropriate, such or similar words or phrases may properly be used if preceded by the words "help", "aid", "assist" or similar words.

(o) An advertisement shall not state that the premiums will not be changed in the future unless such is the fact.

(p) An advertisement shall clearly indicate the provisions of any deductible under a policy.

(q) An advertisement shall not refer to a policy as a doctors policy or use words of similar import unless:

1. The advertisement includes a statement that the plan of benefits is not endorsed by or associated with any national, state or local medical society, or

2. The policy has been so endorsed by such a society and the advertisement meets the requirements of subsection (13) of this rule.

(r) If a policy contains any of the following or similar provisions, an advertisement referring to such policy shall not state that benefits are payable in addition to other insurance unless the statement contains an appropriate reference to the coverage excepted:

1. An other insurance exception, reduction, limitation or deductible
2. A coordination of benefits or non-duplication provision
3. An other insurance in this company provision
4. An insurance in other insurers provision
5. A relation of earnings to insurance provision
6. A workmen's compensation or employers' liability or occupational disease law exception, reduction, or limitation
7. A reduction based on social security benefits or other disability benefits, or
8. A Medicare exception, reduction, or limitation.

(s) An advertisement shall not state a policy's benefits are tax free unless an explanation of the rules applicable to the taxation of such types of accident and sickness benefits is clearly shown with equal prominence and in close conjunction with such statement. An advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall not state that such benefit is tax free.

(t) An advertisement shall not use the expressions "extra cash", "cash income", "income", "cash" or similar words or phrases in such a way as

to imply that the insured will receive benefits in excess of his expenses incurred while being sick, injured or hospitalized.

(u) The description in advertisements of government insurance programs, including Medicare, and of changes in such program shall be accurate and not give an incorrect impression as to the need for supplementary coverage. If gaps in such programs are referred to, they shall be described fairly so that the reader or listener can determine how the policy being advertised covers such gaps.

(v) An advertisement which refers to a policy as being a Medicare supplement shall:

1. Contain a prominent statement indicating which Medicare benefits the policy is intended to supplement (for example, hospital benefits) and which Medicare benefits the policy will not supplement (for example, medical-surgical benefits) and shall clearly disclose any gaps in Medicare coverage for which the policy does not provide benefits and

2. Clearly indicate the extent of the benefits if the policy bases benefits on expenses incurred beyond what Medicare covers and thus provides somewhat limited benefits for short term hospital confinements.

(w) An advertisement may refer to immediate coverage or guaranteed issuance of a policy only if suitable administrative procedures exist so that the policy is issued within a reasonable time after the application is received.

(x) If an advertisement indicates an initial premium which differs from the renewal premium on the same mode, the renewal premium shall be disclosed with equal prominence and in close conjunction with any statement of the initial premium. Any increase in premium or reduction in coverage because of age shall be clearly disclosed.

(y) An advertisement shall not state that the policy contains no waiting period unless pre-existing conditions are covered immediately or unless the status of pre-existing conditions is disclosed with equal prominence and in close conjunction with such statement.

(z) An advertisement shall not state that no age limit applies to a policy unless applications from applicants of any age are considered in good faith and such statement clearly indicates the date or age to which the policy may be renewed or that the company may refuse renewal.

(za) An advertisement shall not state that no medical, doctor's or physical examination is required or that no health, medical or doctor's statements or questions are required or that such examination, statements or questions are waived or otherwise state or imply that the applicant's physical condition or medical history will not affect the policy unless:

1. The statement indicates with equal prominence that it applies only to the issuance of the policy or to both the issuance of the policy and the payment of claims, and

2. Pre-existing conditions are covered immediately under the policy or the period of time following the effective date of the policy during which pre-existing conditions are not covered is disclosed with equal prominence and in close conjunction with such statement.

(zb) An advertisement of a limited policy as defined in Wisconsin Administrative Code section Ins 3.13 (2) (h) shall prominently indicate that the policy provided limited coverage with an appropriate statement such as "THIS IS A CANCER ONLY POLICY" or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY," and shall clearly disclose what injuries or sicknesses and what losses are covered.

(zc) An advertisement of a policy which provides benefits for injuries only or for sickness only shall prominently indicate that the policy covers injuries only or sickness only.

(zd) An advertisement shall not refer to a policy or coverage as being "special" unless it can be shown that there is a reasonable basis for the use of such a term.

(ze) An advertisement shall not set out exceptions, reductions or limitations from a policy worded in a positive manner to imply that they are beneficial features such as describing a waiting period as a benefit builder. Words and phrases used to disclose exceptions, reductions or limitations shall fairly and accurately describe their negative features. The words "only" or "minimum" or similar words or phrases shall not be used to refer to exceptions, reductions or limitations.

(zf) An advertisement shall not state or imply, or use similar words or phrases to the effect, that because no insurance agent will call and no commissions will be paid to agents the policy is a low cost plan.

(zg) Devices such as a safe drivers' award and other such awards shall not be used in connection with an advertisement.

(zh) An advertisement which describes or offers to provide information concerning the federal Medicare program or any related government program or changes in such programs shall:

1. Include no reference to such program on the envelope, the reply envelope or to the address side of the reply postal card, if any,
2. Include on any page containing a reference to such program an equally prominent statement to the effect that in providing supplemental coverage the insurer and agent involved in the solicitation is not in any manner connected with such program,
3. Contain a statement that it is an advertisement for insurance or is intended to obtain insurance prospects,
4. Prominently identify the insurer or insurers which issues the coverage, and
5. Prominently state that any material or information offered will be delivered in person by a representative of the insurer, if such is the case.

(10) EXCEPTIONS, REDUCTIONS AND LIMITATIONS. (a) When an advertisement refers to any dollar amount of benefits payable, period of time for which any benefit is payable, cost of policy, specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations (including waiting, elimination, probationary or similar periods and pre-existing condition exceptions) affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive subject to the following.

(b) An invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy or

2. Such an advertisement makes any reference to the policy's exceptions, reductions and limitations.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An institutional advertisement shall not be subject to the disclosure requirements of this subsection.

(f) If the policy advertised does not provide immediate coverage for pre-existing conditions, an application or enrollment form contained in or included with an advertisement to be completed by the applicant and returned to the insurer shall contain a question or statement immediately preceding the applicant's signature line which summarizes the pre-existing condition provisions of the policy. The following are a suggested question and statement; however, an insurer shall use wording which is appropriate to the actual pre-existing condition provisions of the policy advertised: "Do you understand that the policy applied for will not pay benefits during the first - - - - year (s) after the issue date for a disease or physical condition which you now have or have had in the past? Yes - - - -" or "I understand that the policy applied for will not pay benefits during the first - - - - year (s) after the issue date for a disease or physical condition which I now have or have had in the past."

(g) An advertisement which is subject to the disclosure requirements of this subsection shall in negative terms disclose the extent to which any loss is not covered if the cause of the loss is a condition which exists prior to the effective date of the policy. The expression "pre-existing conditions" shall not be used unless appropriately defined.

(h) If a medical examination is required for a policy, an advertisement of such policy shall disclose such requirement.

(i) The exceptions, reductions and limitations referred to in this subsection shall include:

1. Those which are set out in the policy under captions referring to exceptions, reductions, limitations or exclusions or are otherwise designated as such, and

2. Those which are not so captioned or designated contained in other portions of the policy such as a benefit provision, definition or uniform provision.

(j) The following are examples of exceptions, reductions and limitations which generally *do* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. War or act of war.

2. While in armed services.
3. Territorial restriction or coverage within United States and Canada.
4. Complete aviation exclusion.
5. Self-inflicted injury.
6. Injury inflicted by another person.
7. Time limitation on death, dismemberment or commencement of disability or medical treatment following an accident.
8. Pre-existing sickness or disease or other bodily infirmity.
9. Exclusion or reduction for loss due to specific diseases, classes of diseases or types of injuries.
10. Confinement restrictions in disability policies such as house confinement, bed confinement and confinement to the premises.
11. Waiting, elimination, probationary or similar periods.
12. Reduction in benefits because of age.
13. Any reduction in benefit during a period of disability.
14. Workmen's compensation or employers' liability law exclusion.
15. Occupational exclusion.
16. Violation of law.
17. Automatic benefit in lieu of another benefit.
18. Confinement in government hospital.
19. Pregnancy.
20. Miscarriage in sickness or accident and sickness policy.
21. Restrictions relating to organs not common to both sexes.
22. Restrictions on number of hospital hours before benefit accrues.
23. Insanity, mental diseases or disorders or nervous disorder.
24. Dental treatment, surgery or procedures.
25. Cosmetic surgery.
26. While intoxicated or under the influence of narcotics, or other language not substantially the same as the uniform individual policy provision regarding the use of intoxicants and narcotics.
27. Unemployed persons.
28. Retired persons.
29. While handling explosives or chemical compounds.
30. While or as a result of participating in speed contests.
31. While or as a result of riding a motorcycle or motorcycle attachment.

32. While or as a result of participating in professional athletics.
33. While or as a result of participating in certain specified sports.
34. While or as a result of serving as a volunteer fireman or in other hazardous occupations.
35. Riot or while participating in a riot.
36. Ptomaine poisoning.
37. Gas or poisonous vapor.
38. Sunstroke or heat prostration.
39. Freezing.
40. Poison ivy or fungus infection.
41. Requirement of permanent disability.
42. Reduction because of other insurance.
43. Limitations on the choice of providers or geographical area served.

(k) The following are examples of exceptions, reductions and limitations which generally *do not* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. Suicide or attempted suicide, while sane or insane.
2. Intentional self-inflicted injury.
3. Territorial restriction with no limitation of coverage while in United States and Canada.
4. Aviation exclusion under which passage on commercial airlines is covered.
5. Felony or illegal occupation.
6. All uniform individual policy provisions, both required and optional, other than those relating to other insurance.
7. Requirement for regular care by a physician.
8. Definition of total disability.
9. Definition of partial disability.
10. Definition of hospital.
11. Definition of specific total loss.
12. Definition of injury.
13. Definition of physician or surgeon.
14. Definition of nurse.
15. Definition of recurrent disability.
16. Definition of commercial air travel.
17. Provision that hernia will be considered a sickness.
18. Rest cure.
19. Diagnosis.

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20. Prosthetics.

21. Cosmetic surgery exclusion under which such surgery which results from injury is covered.

22. Dental treatment, surgery or procedures exclusion under which such treatment which results from injury to sound natural teeth is covered.

23. Bacterial infection exclusion under which pyogenic infection which results from injury is covered.

24. Eye examination for fitting of glasses.

25. Hearing aid.

26. Exclusion of sickness or disease in a policy providing only accident coverage.

27. Exclusion for miscarriage in policy providing only accident coverage.

(11) RENEWABILITY, CANCELLABILITY AND TERMINATION. An advertisement shall disclose, as required below, the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

(a) Any advertisement which refers to renewability, cancellability or termination of a policy shall be subject to the disclosure requirements of this subsection.

(b) An advertisement which refers to a policy benefit and which is an invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An advertisement which refers to a policy benefit and which is an invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Paragraph (a) or (f) applies or

2. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An advertisement which refers to a policy benefit and which is an institutional advertisement shall not be subject to the disclosure requirements of this subsection unless par. (a) or (f) applies.

(f) An advertisement which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy and which implies permanency shall be subject to the disclosure requirements of this subsection.

(g) The actual policy language concerning renewability, cancelability or termination need not be used in an advertisement subject to the disclosure requirements of this subsection. However, all pertinent information shall be disclosed.

(h) The qualifying conditions applicable to a non-cancellable policy and to a guaranteed renewable policy shall include age limits, aggregate benefit limits and modifications of benefits because of age, other than such modifications occurring at or about the time the policy terminates. A qualifying condition applicable to a guaranteed renewable policy shall be the insurer's reservation of the right to change premiums.

(i) The qualifying conditions shall be set forth with the language describing renewability.

(j) An advertisement of a group or blanket policy which would otherwise be subject to the disclosure requirements of this subsection need not disclose the policy's provisions relating to renewability, cancelability and termination. Such advertisement shall provide, however, as a minimum, that an insured person's coverage is contingent upon his continued membership in the group and the continuation of the plan.

(k) An advertisement of a non-cancellable policy or of a guaranteed renewable policy shall also be subject to subsection (25).

(1) An advertisement of a franchise, wholesale, collectively renewable, or non-renewable for stated reasons only policy, or any other policy under which the insurer has by policy provision limited its right to terminate to one or more reasons, shall accurately set forth the policy's renewal provisions if disclosure of such renewal provisions is required by paragraphs (a), (b), (c), (d) or (e) above. Such advertisement shall not state or imply renewal terms which are more favorable than those actually contained in the policy. Such advertisement shall not state or imply that the policy is guaranteed renewable or warranted renewable or that renewal is guaranteed or warranted or use other variations of such expressions.

(12) **IDENTITY OF INSURER.** (a) The identity of the insurer shall be made clear in all of its advertisements.

(b) An advertisement shall not use a trade name, an insurance group designation, the name of the parent company of the insurer, the name of a government agency or program, the name of a department or division of an insurer, the name of an agency, the name of any other organization, a service mark, a slogan, a symbol or any other device which has the capacity and tendency to mislead or deceive as to the identity of the insurer.

(c) An advertisement shall not use any combination of words, symbols or materials which, by its content, phraseology, shape, color, nature or other characteristics, is so similar to combinations of words, symbols or materials used by federal, state or local government agencies that it tends to confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with such a government agency.

(d) An advertisement shall not refer to an affiliate of the insurer without disclosing that the 2 organizations are separate legal entities.

(e) An advertisement shall not indicate an address for an insurer in such a way as to mislead or deceive as to its identity or licensing status. An advertisement which indicates an address for an insurer other than that of its home office shall clearly identify such address and clearly disclose the actual city and state of domicile of the insurer.

(13) TESTIMONIALS, ENDORSEMENTS OR COMMENDATIONS BY THIRD PARTIES. (a) An advertisement shall not contain a testimonial, endorsement or other commendatory statement concerning the insurer, its policies or activities by any person who receives any pay or remuneration, directly or indirectly, from the insurer in connection with such testimonial, endorsement or statement. Any advertisement containing a testimonial, endorsement or statement not prohibited by the foregoing, shall include a full and prominent disclosure therein of the relationship, direct or indirect, including but not limited to financial interest and remuneration, between the insurer and the person making such testimonial, endorsement or statement. The provisions of this paragraph do not apply to any person holding a Wisconsin insurance agent's license nor to any radio or television announcer or other person employed or compensated on a salaried or union wage scale basis.

(b) A testimonial or endorsement used in an advertisement shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced.

(c) An insurer shall not use a testimonial or endorsement:

1. Which is fictional,
2. Where the insurer has information indicating a substantial change of view on the part of the author,
3. Where it is reasonable to conclude that the views expressed do not correctly reflect the current opinion of the author,
4. For more than 2 years after the date on which it was originally given or 2 years after the date of a prior confirmation without obtaining a confirmation that the statement represents the author's current opinion,
5. Which does not accurately reflect the present practices of the insurer,
6. To advertise a policy other than the one for which such statement was given, unless the statement clearly has some reasonable application to the second policy,
7. In which a change or omission has been effected which alters or distorts its meaning or intent as originally written, or
8. If it contains a description of benefit payments which does not disclose the true nature of the insurance coverage under which the benefits were paid.

(d) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association or other organization, unless such is the fact. Any proprietary relationship between such society, association or other organization and the insurer shall be disclosed. If such society, association or other organization has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the advertisement shall clearly disclose such a fact.

(e) When a testimonial refers to benefits received under a policy, a summary of the pertinent claim information including claim number and date of loss shall be retained by the insurer with the advertisement in the advertising file required by subsection (28).

(f) An advertisement shall not state or imply that a government publication has commended or recommended the insurer or its policy.

(14) JURISDICTIONAL LICENSING; APPROVAL BY GOVERNMENTAL AGENCY.

(a) An advertisement which may be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(b) An advertisement shall not state or imply, or otherwise create the impression directly or indirectly, that the insurer, its financial condition or status, the payment of its claims, its policy forms or the merits or desirability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any agency of this state or the federal government.

(c) In any advertisement any reference to licensing shall contain an appropriate disclaimer that such reference is not to be construed as an endorsement or implied endorsement of the insurer or its products by any agency of this state or the commissioner of insurance.

(d) An advertisement shall not contain a reproduction of a portion of a state insurance department report of examination.

(15) INTRODUCTORY, INITIAL OR SPECIAL OFFERS AND LIMITED ENROLLMENT PERIODS.

(a) An advertisement shall not state or imply that a policy or combination of policies is an introductory, initial or special offer and that the applicant will receive advantages not available at a later date by accepting the offer, that only a limited number of policies will be sold, that a time is fixed for the discontinuance of the sale of the policy advertised because of special advantages available in the policy, or that an individual will receive special advantages by enrolling within an open enrollment period or by a deadline date, unless such is the fact.

(b) An advertisement shall not state or imply that enrollment under a policy is limited to a specific period unless the period of time permitted to enroll, which shall be not less than 10 days and not more than 40 days from the date of the advertisement, is disclosed.

(c) If the insurer making an introductory, initial or special offer has previously offered the same or similar policy on the same basis or intends to repeat the current offer for the same or similar policy, the advertisement shall so indicate.

(d) An insurer shall not establish for residents of this state a limited enrollment period within which an individual policy may be purchased less than 6 months after the close of an earlier limited enrollment period for the same or similar policy. Such restriction shall apply to all advertisements in newspapers, magazines and other periodicals circulated in this state, all mail advertisements sent to residents of this state and all radio and TV advertisements broadcast in this state. Such restriction shall not apply to the solicitation of enrollments under individual policies issued on a group basis.

(e) Where an insurer is an affiliate of a group of insurers under common management and control, the word "insurer" for the purposes of

this subsection means the insurance group. The requirements and restrictions applicable to an insurer shall apply to the insurance group.

(f) Similar policies for the purposes of this subsection include policies which provide similar benefits even though there may be differences in benefit amounts, elimination periods, renewal terms or ancillary benefits.

(16) **MAIL ORDER REFUSAL FORM.** An insurer shall not use a mail order advertisement which requires the recipient, in order to refuse a policy, to sign a refusal form and return it to the insurer.

(17) **GROUP, QUASI-GROUP OR SPECIAL CLASS IMPLICATIONS.** An advertisement shall not state or imply that prospective policyholders or members of a particular class of individuals become group or quasi-group members or are uniquely eligible for a special policy or coverage and as such will be subject to special rates or underwriting privileges or that a particular coverage or policy is exclusively for preferred risks, a particular segment of people, or a particular age group or groups, unless such is the fact.

(18) **INSPECTION OF POLICY** (a) An offer in an advertisement of free inspection of a policy or an offer of a premium refund shall not be a cure for misleading or deceptive statements contained in such advertisement.

(b) An advertisement which refers to the provision in the policy advertised regarding the right to return the policy shall disclose the time limitation applicable to such right.

(19) **IDENTIFICATION OF PLAN OR NUMBER OF POLICIES.** (a) When an advertisement refers to a choice regarding benefit amounts, it shall disclose that the benefit amounts provided will depend upon the plan selected and that the premium will vary with the amount of the benefits.

(b) When an advertisement refers to various benefits which may be contained in 2 or more policies, other than group policies, it shall disclose that such benefits are provided only through a combination of such policies.

(20) **USE OF STATISTICS.** (a) An advertisement which sets out the dollar amounts of claims paid, the number of persons insured or other statistical information shall identify the source of such statistical information and shall not be used unless it accurately reflects all of the relevant facts. Irrelevant statistical data shall not be used.

(b) An advertisement shall not imply that the statistical information given is derived from the insurer's experience under the policy advertised unless such is the fact. The advertisement shall specifically so state if such information applies to other policies or plans.

(c) If a loss ratio is to be shown in an advertisement, it shall be derived from either premiums received and benefits paid or premiums earned and losses incurred.

(d) If loss ratios are to be compared between insurers in an advertisement, comparison shall be limited to policies or plans of the same type issued to similar classes of risks.

(e) An advertisement which sets out the dollar amounts of claims paid shall also indicate the period during which such claims have been paid.

(21) **SERVICE FACILITIES.** An advertisement shall not:

(a) Contain untrue statements with respect to the time within which claims are paid.

(b) State or imply that claim settlements will be liberal or generous or use words of similar import.

(c) State or imply that claim settlements will be beyond the actual terms of the policy, or

(d) Contain a description of a claim which involves unique or highly unusual circumstances.

(22) **STATEMENTS ABOUT AN INSURER.** An advertisement shall not contain statements which are untrue in fact or are by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, experience or relative position in the insurance business.

(23) **DISPARAGING COMPARISONS AND STATEMENTS.** An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits and shall not falsely or unfairly disparage, discredit or criticize competitors, their policies, services or business methods or competing marketing methods.

(24) **METHOD OF DISCLOSURE OF REQUIRED INFORMATION.** (a) All information required to be disclosed by this rule shall be set out clearly, conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall be readily noticed and not minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

(b) An advertisement or representation of a specific individual policy or policies which constitutes an invitation to apply shall include an outline of coverage as required by subsection (8).

(c) Information required by this rule shall not be set out under inappropriate captions or headings or under inappropriate questions where a question and answer format is used.

(d) An advertisement of a hospital confinement indemnity policy shall disclose in close conjunction with any description of the benefits the existence in the policy of a provision which eliminates benefits for sickness and/or injury conditions for a stated number of days at the beginning of a hospital confinement.

(e) An advertisement of a non-cancellable policy or of a guaranteed renewable policy shall also be subject to subsection (25).

(25) **NON-CANCELLABLE AND GUARANTEED RENEWABLE POLICIES.** (a) No person, in the presentation, solicitation, effectuation, or sale of a policy, and no advertisement, relating to or used in connection with a policy, shall use the terms "non-cancellable" or "non-cancellable and guaranteed renewable" or "guaranteed renewable", except in connection with policies conforming to Wis. Adm. Code section Ins 3.13 (2) (e).

(b) An advertisement describing a non-cancellable and guaranteed renewable or guaranteed renewable policy form shall be subject to subsection (11).

(c) A printed advertisement describing a non-cancellable or non-cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms "non-cancellable" or "non-cancellable and guaranteed renewable":

1. The age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable), and

3. That benefit payments are subject to an aggregate limit, if applicable.

(d) A printed advertisement describing a guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

1. The age to or term for which the form is guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable)

3. That benefit payments are subject to an aggregate limit, if applicable, and

4. That the applicable premium rates may be changed.

(e) The foregoing limitations on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable"; and the foregoing limitations on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

(26) **FORM NUMBER.** An advertisement which is an invitation to apply or an invitation to inquire and which is mass-produced shall be identified by a form number. The form number shall be sufficient to distinguish it from any other advertising form or any policy, application or other form used by the insurer.

(27) **INSURER'S RESPONSIBILITY FOR ADVERTISEMENTS.** (a) The content, form and method of dissemination of all advertisements, regardless of by whom designed, created, written, printed or used, shall be the responsibility of the insurer whose policy is advertised.

(b) An insurer shall require its agents and any other person or agency acting on its behalf in preparing advertisements to submit proposed advertisements to it for approval prior to use.

(28) **INSURER'S ADVERTISING FILE.** Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its policies hereafter disseminated in this or any other state, whether or not licensed in such other state. With respect to group, blanket and franchise policies, all proposals prepared on the same printed form need not be included in the file; only typical examples of such proposals need be included. A notation shall be attached to each such advertisement in the file indicating the manner and extent of distribution and the form number of any policy, amendment, rider, or endorsement form advertised. A copy of the policy advertised, together with any amendment, rider or endorsement applicable thereto, shall be included in the file with each such advertisement. Such file shall be subject to regular and periodic inspection by the office of the commissioner of insurance. All such advertisements shall be maintained in such file for a period of 4 years or until the filing of the next regular examination report on the insurer, whichever is the longer period.

(29) **PENALTY.** Violations of this rule shall subject the violator to s. 601.64, Stats.

(30) **SEVERABILITY.** The provisions of this rule are severable. If any provision of this rule is invalid, or if the application of the rule to any person or circumstance is invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provision or application.

(31) **EFFECTIVE DATE.** This rule shall apply to all advertisements used in this state after June 1, 1973.

History: Cr. Register, April, 1973, No. 208, eff. 6-1-73; am. (zb), (11) (c) 1. and (11) (e), Register, August, 1973, No. 212, eff. 9-1-73; am. (5) (b) 1, Register, April, 1975, No. 232, eff. 5-1-75; emerg. am. (1), (2), (5) (c) and (m) 1, eff. 6-22-76; am. (1), (2), (5) (c) and (m) 1, Register, September, 1976, No. 249, eff. 10-1-76; cr. (9) (zh), Register, November, 1976, No. 251, eff. 12-1-76; am. (2), Register, March, 1979, No. 279, eff. 4-1-79; r. (29), Register, March, 1981, No. 303, eff. 4-1-81; cr. (10) (j) 43, Register, October, 1984, No. 346, eff. 11-1-84.

Ins 3.28 Solicitation, underwriting and claims practices in individual and franchise 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 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, 618.12 (1), and 632.76, Stats.

(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 (35) (d) and 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 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.

(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 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.

(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.

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

(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. (d).

(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 or disability commencing within 12 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 recurrence 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.

(c) An insurer shall not void coverage or deny a claim on the ground that the application for such coverage did not disclose certain informa-

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tion 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 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.

(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 par. (d) of this subsection.

(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.

(7) EFFECTIVE DATE. (a) Subsections (4), (5) (a), (b), (c), and (f) and (6) shall apply to all solicitation, underwriting, and claims activities, except under franchise insurance, relating to Wisconsin residents after March 1, 1974, except that sub. (6) (a) and (b) shall apply to policies issued after that date.

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

(c) This rule shall apply to all solicitation, underwriting and claims activities under franchise insurance relating to Wisconsin residents after December 1, 1974, except that sub. (6) (a) and (b) shall apply to

policies issued after that date and sub. (5) (d) and (e) shall apply to such activities after February 1, 1975.

Note: See sub. (7) for various effective dates for certain subsections.

History: Cr. Register, February, 1974, No. 218, eff. 3-1-74; am. (5) (d) (intro. par.), Register, July, 1974, No. 223, eff. 8-1-74; am. (2) and (7), Register, November, 1974, No. 227, eff. 12-1-74; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (1), (2), (5) (f) and (6) (b), cr. (5) (g), r. and recr. (5) (c) and (d) and (6) (d) and (f), Register, April, 1982, No. 316, eff. 5-1-82.

Ins 3.29 Replacement of accident and sickness insurance. (1)
PURPOSE. The purpose of this rule is to safeguard the interests of persons covered under accident and sickness insurance who consider the replacement of their insurance by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. This rule implements and interprets ss. 601.01 (3) (b) and 628.34, Stats.

(2) **SCOPE.** This rule shall apply to the solicitation of accident and sickness insurance covering residents of this state and issued by insurance corporations, fraternal benefit societies or nonprofit service plans in accordance with s. Ins 6.75 (1) (c) or (2) (c), s. 614.01 and ch. 613, Stats.

(3) **EXEMPT INSURANCE.** This rule shall not apply to the solicitation of the following accident and sickness insurance:

(a) Group, blanket or group type, except Medicare supplement insurance subject to s. Ins 3.39 (4), (5) and (6),

(b) Accident only,

(c) Single premium nonrenewable,

(d) Nonprofit dental care,

(e) Nonprofit prepaid optometric service,

(f) A limited policy conforming to Ins 3.13 (2) (h),

(g) Under which dental expenses only, prescription expenses only, vision care expenses only or blood service expenses only are covered,

(h) Conversion to another individual or family policy in the same insurer with continuous coverage,

(i) Conversion to an individual or family policy to replace group, blanket or group type coverage in the same insurer.

(4) **DEFINITIONS.** For the purposes of this rule:

(a) *Replacement* is any transaction wherein new accident and sickness insurance is to be purchased, and it is known to the agent or company at the time of application that as part of the transaction, existing accident and sickness insurance has been or is to be lapsed or the benefits thereof substantially reduced.

(b) *Continuous coverage* means that the benefits are not less than the benefits under the previous policy, and the policy also covers loss resulting from injury sustained or sickness contracted while coverage was in

force under the previous policy to the extent such loss is not covered under any extended benefit or similar provision of the previous policy.

(c) *Group type coverage* is as defined in Ins 6.51 (3).

(d) *Direct response insurance* is insurance issued to an applicant who has himself completed the application and forwarded it directly to the insurer in response to a solicitation coming into his possession by any means of mass communication.

(5) **REPLACEMENT QUESTION IN APPLICATION FORMS.** An application form for insurance subject to this rule shall contain a question to elicit information as to whether the insurance to be issued is to replace any insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(6) **NOTICE TO BE FURNISHED.** (a) An agent soliciting the sale of insurance shall, upon determining that the sale would involve replacement, furnish to the applicant, at the time of taking the application, the notice described in sub. (7) to be signed by the applicant.

(b) An insurer soliciting direct response insurance shall, upon determining that the sale would involve replacement, furnish to the applicant, before the policy is issued, the notice described in sub. (7) to be signed by the applicant.

(c) A copy of such notice shall be left with or retained by the applicant and a signed copy shall be retained by the insurer.

(7) (a) **NOTICE TO APPLICANT.** The notice required by sub. (6) shall provide, in substantially the following form:

**NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND
SICKNESS INSURANCE**

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by ----- Insurance Company. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy. (This language may be modified if pre-existing conditions are covered under the new policy.)

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective. (This language may be modified if pre-existing conditions are covered under the new policy.)

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on - - - - - (date)

Applicant

(b) The notice required by sub. (6) for a Medicare supplement policy subject to s. Ins 3.39 (4), (5), and (6), shall include an introductory statement in substantially the following form: Your new policy provides - - - - - days within which you may decide without cost whether you desire to keep the policy.

(8) VIOLATION. A violation of this rule shall be considered to be a misrepresentation for the purpose of inducing a person to purchase insurance. A person guilty of such violation shall be subject to s. 601.64, Stats.

(9) SEPARABILITY. If any provision of this rule shall be held invalid, the remainder of the rule shall not be affected by such invalidity.

(10) EFFECTIVE DATE. This rule shall become effective September 1, 1974.

History: Cr. Register, June, 1974, No. 222, eff. 9-1-74; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (3) (a) and (i), r. (3) (j), renum. (7) to be (7) (a) and am., cr. (7) (b), Register, June, 1982, No. 318, eff. 7-1-82.

Ins 3.30 Change of beneficiary and related provisions in accident and sickness insurance policies. (1) PURPOSE. The purpose of this rule is to establish guidelines for wording change of beneficiary provisions and related provisions in accident and sickness insurance policies.

(2) SCOPE. This rule shall apply to policy forms subject to s. Ins 6.75 (1) (c) or (2) (c), and s. 600.03 (34m) (b) (c) and (d), Stats.

(3) GUIDELINES. A change of beneficiary provisions and any related provision:

(a) Shall comply with s. 632.71, Stats., except as provided in ss. 631.81 and 632.77 (4), Stats., where applicable, and

(b) May include requirements or limitations which would be consistent with an orderly method of handling beneficiary designations and changes such as

1. A requirement that a beneficiary designation or change be recorded by the insurer,

2. A provision that a claim payment made before a change in beneficiary designation is recorded is not subject to such change,

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3. A requirement that a beneficiary designation or change be written as opposed to oral, or

4. A requirement that a beneficiary designation or change be given to a particular agent, representative or office.

History: Cr. Register, May, 1974, No. 221, eff. 6-1-74; emerg. am. (2) and (3) (a), eff. 6-22-76; am. (2) and (3) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.31 Eligibility for and solicitation, underwriting and claims practices in group, blanket and group type 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 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 (2), 611.20, 618.12 (1) and 632.76, Stats.

(2) **SCOPE.** This rule applies to the solicitation, underwriting and administration of insurance issued by an insurer under s. 600.03 (35) (b) or (c), Stats., except credit accident and sickness insurance under s. Ins 6.75 (1) (c) 1. or (2) (c) 1., and coverage issued on a group basis or group type basis as defined in s. 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 (35) (b), Stats., or group or group type coverage under s. 185.981 or ch. 613, Stats., shall,

(a) Where the enrollment form contains questions relating to the medical history of the person or persons to be covered, be subject to the following:

1. **Enrollment form.** An enrollment form shall provide to the effect that statements made by the enrollee in the enrollment form regarding the general medical history or general health of the proposed insured person which require an opinion or the exercise of judgment are representations or are to the best of the enrollee'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 forms shall not require the enrollee to state that he has not withheld any information or concealed any facts in completing the enrollment form; however, the enrollee may be required to state that his answers are true and complete.

2. **Solicitation.** An insurance agent or representative shall review carefully with the enrollee all questions contained in each enrollment form which he prepares and shall set down in each such form all material information disclosed to him by the enrollee in response to the questions in such form. This does not require that an insurance agent or representative prepare or assist in the preparation of each enrollment form.

3. Underwriting. a. An insurer shall make provision for adequate underwriting personnel and procedures so as to process without undue delay each enrollment form for insurance received by it.

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

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.

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.

(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 par. (a) 3. d.

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

g. An insurer may use statements in an enrollment form as a defense to the claim or to void or reform coverage only if it has complied with the requirements of par. (a) 3. d.

4. Claims administration. a. If the existence of a disease or physical condition was duly disclosed in the enrollment form for coverage in response to the questions therein 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 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 in-

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sured 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.

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

(b) Be subject to the following:

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 ordinarily prudent person to seek diagnosis, care, or treatment and for which such diagnosis, care or treatment was not sought prior to such date.

2. 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 par. (b) 1.

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.

(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 (35) (c) Stats., shall

(a) Include in an enrollment form used in connection with such insurance no question relating to the medical history or other matter concerning the insurability of the person or persons to be insured and

(b) Be subject to the following:

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.

2. 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 par. (b) 1. 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.

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(5) **EFFECTIVE DATE.** This rule shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after December 1, 1974, except that sub. (3) (a) 4. a. and b. shall apply to coverage issued after said date and sub. (3) (a) 3. d., e. and g. shall apply to such activities after February 1, 1975.

History: Cr. Register, November, 1974, No. 227, eff. 12-1-74; emerg. am. (1), (2), (3) (intro.) and (c) and (4), eff. 6-22-76; am. (1), (2), (3) (intro.) and (c) and (4), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (1), (2), (3) (intro.), (3) (a) 3. d., f. and 4. b., (3) (c) and (4), r. and recr. (3) (a) 3. c., (3) (b) 1. and 3., (4) (b) 1. and 3., Register, April, 1982, No. 316, eff. 5-1-82.

Ins 3.32 Title insurance; prohibited practices. (1) **PURPOSE.** This rule implements and interprets s. 601.01 (3) and ch. 628, Stats., for the purpose of prohibiting unfair practices in the transaction of the business of title insurance.

(2) **SCOPE.** This rule shall apply to all operations of title insurers which write the type of insurance authorized by s. Ins 6.75 (2) (h).

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(3) **DEFINITIONS.** (a) *Title insurer* as used in this rule means all insurance companies authorized to write title insurance as defined by section Ins 6.75 (2) (h), and includes all officers and employes of such insurance companies, all agents or representatives of such insurance companies, and all affiliated entities including the officers and employes of such affiliated entities.

(b) *Affiliated entity* as used in this rule means any person or business entity who, directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with, a title insurance company.

(c) *Such person* as used in this rule means any of the following, other than a title insurer or affiliated entity as defined herein, who order or influence, directly or indirectly, the ordering of title insurance and related services:

1. Any owner or prospective owner of real or personal property or any interest therein;
2. Any lender or prospective lender in a transaction involving an obligation secured or to be secured either in whole or in part by real or personal property or any interest therein; and
3. Any agent, representative, attorney or employe of any owner or prospective owner or of any lender or prospective lender.

(d) *Title insurance rates* as used in this rule means all charges made by a title insurer in connection with the issuance of a title insurance policy or a commitment to issue a title insurance policy and specifically includes search and examination charges and all other charges.

(e) *Supplementary rate information* as used in this rule has the meaning as defined in s. 625.02 (1), Stats.

(4) **PROHIBITED PRACTICES.** No title insurer shall engage in any of the following practices:

(a) Charging an amount for a title insurance policy or commitment for a title insurance policy other than the amount developed by application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner for use by the title insurer.

(b) Waiving, or offering to waive, all or any part of the applicable title insurance rate or premium developed by proper application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner.

(c) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when the property involved is ineligible for such reduced rate.

(d) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when such rate is not applicable in the particular transaction because the volume required to qualify for such reduced rate includes ineligible property.

(e) Paying, or offering to pay, the cancellation fee, the fee for a preliminary title report or other fee on behalf of any such person after inducing such person to cancel an order with another title insurer.

(f) Making or guaranteeing, or offering to make or guarantee, either directly or indirectly, any loan to any such person, regardless of the terms of the note or guarantee. This prohibition is not applicable to customary business collection procedures, claims settlement and salvage activities and other business activities totally unrelated to the solicitation of business for which a charge is made.

(g) Providing, or offering to provide, either directly or indirectly, a "compensating balance" or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by such lending institution to any such person, or for the express or implied purpose of influencing the placement or channeling of title insurance business by such lending institution. This shall not be construed to prohibit the maintenance by a title insurer of such demand deposits or escrow deposits as are reasonably necessary for use in the ordinary course of business of such title insurer.

(h) Paying, or offering to pay, the fees or charges of an outside professional (e.g., an attorney, engineer, appraiser, or surveyor) whose services are required by any such person to structure or complete a particular transaction.

(i) Paying, or offering to pay, all or any part of the salary of any employe of any such person.

(j) Paying, or offering to pay, any fee to any such person for any services unless such fee bears a reasonable relation to the services performed.

(k) Paying for, or offering to pay for, services by any such person which services are required to be performed by such person in his capacity as a real estate or mortgage broker or salesperson or agent.

(l) Furnishing or offering to furnish, or paying or offering to pay for, furniture, office supplies, telephones, equipment or automobiles to any such person, or paying for, or offering to pay for, any portion of the cost of renting, leasing, operating or maintaining any of the aforementioned items. Marketing and title insurance promotional items clearly of an advertising nature of token or nominal value, or supplies such as title insurance application blanks and related forms are not within the purview of this prohibition provided they are made available to all such persons on the same terms and conditions.

(m) Paying for, furnishing, or waiving, or offering to pay for, furnish, or waive, all or any part of the rent for space occupied by any such person.

(n) Renting, or offering to rent, space from any such person, regardless of the purpose, at a rent which is excessive when compared with rents for comparable space in the geographic area, or paying, or offering to pay, rent based in whole or in part on the volume of business generated by any such person except for a bona fide percentage lease based on the total volume of receipts of the title entity when the services of that title entity are offered from that location to the public generally.

(o) Paying for, or offering to pay for, gifts, vacations, business trips, convention expenses, travel expenses, membership fees, registration fees, lodging or meals on behalf of any such person, directly or indirectly, or supplying letters of credit, credit cards or any such benefits to any such person for any purpose whatsoever. This prohibition is directed at

prohibiting special favors to certain customers. It is not intended to preclude reasonable and customary business entertainment and trade association activities and expense incurred by the title insurer in the course of marketing its products and services. Moderate expenditures for food, meals, beverages and entertainment may be made, if correctly claimed and properly substantiated as a legitimate business expense.

(p) Paying for, or offering to pay for, money, prizes or other things of value for any such person in any kind of a contest or promotional endeavor. This prohibition applies whether or not the offer or payment of a benefit relates to the number of title orders placed or escrows opened with a title insurer or group of such insurers. It does not apply to offers or payments to trade associations, charitable or other functions where the thing of value is in the nature of a contribution or donation rather than a business solicitation.

(q) Paying for, or offering to pay for, any advertising concerning the title insurer which is to appear in a pamphlet, magazine, brochure, or any other advertising material promoted or distributed, with or without cost by any such person. Examples of this kind of advertising material are advertisements appearing in newsletters distributed by real estate brokers, tract brochures issued by land developers or builders, or jointly sponsored promotional magazines. This prohibition does not apply to brochures or other promotional items of the title insurer used in the marketing of its own products, to advertising in trade media or other media not promoted or solicited by such persons, nor to other forms of advertising provided the expected benefit to be derived from customers generally is fairly equivalent to the expense incurred.

(r) Paying for or furnishing, or offering to pay for or furnish any brochures, billboards, or advertisements of such persons, products or services appearing in newspapers, on the radio, or on television, or other advertising or promotional material published or distributed by, or on behalf of, any such person.

(5) PENALTY. Any violation of this rule shall subject the title insurer to the penalties and forfeitures provided by s. 601.64, Stats.

History: Cr. Register, December, 1975, No. 240, eff. 1-1-76; emerg. am. (1), (2) and (3) (a), eff. 6-22-76; am. (1) (2), (3) (a) and (4) (c), Register, September, 1976, No. 249, eff. 10-1-76; am. (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.38 Coverage of newborn infants. (1) PURPOSE. This section is intended to interpret and implement s. 632.91, Stats.

(2) INTERPRETATION AND IMPLEMENTATION. (a) Coverage of each newborn infant is required under a disability insurance policy if 1. the policy provides coverage for another family member, in addition to the insured person, such as the insured's spouse or a child, and 2. the policy specifically indicates that children of the insured person are eligible for coverage under the policy.

(b) Coverage is required under any type of disability insurance policy as described in par. (a), including not only policies providing hospital, surgical or medical expense benefits, but also all other types of policies described in par. (a), including accident only and short term policies.

(c) The benefits to be provided are those provided by the policy and payable, under the stated conditions except for waiting periods, for children covered or eligible for coverage under the policy.

(d) Benefits are required from the moment of birth for covered occurrences, losses, services or expenses which result from an injury or sickness condition, including congenital defects and birth abnormalities of the newborn infant to the extent that such covered occurrences, losses, services or expenses would not have been necessary for the routine post-natal care of the newborn child in the absence of such injury or sickness. In addition, under a policy providing coverage for hospital confinement and/or in-hospital doctor's charges, hospital confinement from birth continuing beyond what would otherwise be required for a healthy baby (e.g. 5 days) as certified by the attending physician to be medically necessary will be considered as resulting from a sickness condition.

(e) If a disability insurance policy provides coverage for routine examinations and immunizations, such coverage is required for covered children from the moment of birth.

(f) An insurer may underwrite a newborn, applying the underwriting standards normally used with the disability insurance policy form involved, and charge a substandard premium, if necessary, based upon such underwriting standards and the substandard rating plan applicable to such policy form. The insurer shall not refuse initial coverage for the newborn if the applicable premium, if any, is paid as required by s. 632.91 (3), Stats. Renewal coverage for a newborn shall not be refused except under a policy which permits individual termination of coverage and only as such policy's provisions permit.

(g) An insurer receiving an application, for a policy as described in par. (a) providing hospital and/or medical expense benefits, from a pregnant applicant or an applicant whose spouse is pregnant, may not issue such a policy to exclude or limit benefits for the expected child. Such a policy must be issued without such an exclusion or limitation, or the application must be declined or postponed.

(h) Coverage is not required for the child born, after termination of the mother's coverage, to a female insured under family coverage who is provided extended coverage for pregnancy expenses incurred in connection with the birth of such child.

(i) A disability insurance policy described in par. (a) shall contain the substance of s. 632.91 (1), (2), (3) and (4), Stats.

(j) Policies issued or renewed on or after November 8, 1975, and before May 5, 1976, shall be administered to comply with s. 204.325, Stats., contained in chapter 98, Laws of 1975. Policies issued or renewed on or after May 5, 1976, and before June 1, 1976, shall be administered to comply with s. 632.91, Stats., contained in chapter 224, Laws of 1975. Policies issued or renewed on or after June 1, 1976, shall be amended to comply with the requirements of s. 632.91, Stats.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; reprinted, Register, April, 1977, No. 256, to restore dropped text.

Ins 3.39 Standards for disability insurance sold to the medicare eligible. (1) **PURPOSE.** (a) This section establishes minimum requirements for disability insurance which may be sold to Medicare eligible persons as Medicare supplement coverage. A policy or certificate will be approved by the commissioner as a Medicare supplement if it provides the required coverage and if it contains the designation and caption appropriate to that level of coverage. A policy or certificate that is

designed, structured, or intended as a supplement to Medicare will be disapproved pursuant to s. 631.20, Stats., if that policy does not meet the minimum requirements of any of the 3 levels of coverage set out in sub. (5). Disclosure provisions are also established for other disability policies sold to Medicare eligible persons, because such policies have frequently been represented to, and purchased by, the Medicare eligible as supplements to Medicare.

(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing for clearly defined categories of Medicare supplement insurance and reasonable minimum levels of coverage for each category. The disclosure requirements and categories established are intended to provide to Medicare eligible persons guidelines that can be used to compare Medicare supplement insurance policies and certificates on the market and to aid them in the purchase of Medicare supplement insurance which is suitable for their needs. This section is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing a Medicare supplement policy or certificate, but also to assure the Medicare eligible persons of this state that no policy or certificate will be approved by the commissioner as a "Medicare supplement" unless it contains coverage which warrants the use of that label.

(c) Wisconsin statutes interpreted and implemented by this rule are ss. 185.983 (1m), 601.01 (2), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81.

(2) SCOPE. This section applies to individual and group disability policies sold to Medicare eligible persons as follows:

(a) Except as provided in pars. (d) and (e), subs. (4), (5), (6), and (9) apply to any group or individual Medicare supplement policy as defined in s. 600.03 (35) (e), Stats., including:

1. Any Medicare supplement policy issued by a voluntary nonprofit sickness care plan subject to ch. 185, Stats.;

2. Any certificate issued under a group Medicare supplement policy;

3. Any individual or group policy sold predominantly to the Medicare eligible which offers hospital, medical, surgical, or other disability coverage, except for a policy which offers solely nursing home, hospital confinement indemnity, or specified disease coverage; and

4. Any conversion contract offered to a Medicare eligible person, if the prior individual or group policy includes no provision inconsistent with the requirements of this section.

(b) Except as provided in pars. (d) and (e), subs. (7) and (9) apply to any individual disability policy sold to a person eligible for Medicare which is not a Medicare supplement as described in par. (a).

(c) Except as provided in par. (e), sub. (8) applies to:

1. Any conversion policy which is offered to a person eligible for Medicare as a replacement for prior individual or group hospital or medical coverage, other than a Medicare supplement policy described in par. (a); and

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2. Any individual or group hospital or medical policy which continues with changed benefits after the insured becomes eligible for Medicare.

(d) Except as provided in subs. (8) and (11), this section does not apply to:

1. A group policy issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or a combination of both, for employes or former employes or both, or for members or former members or both of the labor organizations;

2. A group policy issued to any professional, trade, or occupational association for its members, former members, retired members, or a combination of these if the association:

a. Is composed of individuals all of whom are or had been actively engaged in the same profession, trade, or occupation;

b. Has been maintained in good faith for purposes other than obtaining insurance; and

c. Has been in existence for at least two years prior to the date of its initial offering of the policy to its members, former members, or retired members;

3. Individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage which continues after an insured becomes eligible for Medicare; or

4. A conversion contract offered to a Medicare eligible person as a replacement for prior individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage, if the prior policy includes provisions which are inconsistent with the requirements of this section.

(e) This section does not apply to:

1. A policy providing solely accident, dental, vision, disability income, or credit disability income coverage; or

2. A single premium, non-renewable policy.

(3) DEFINITIONS. For the purpose of this section:

(a) "Medicare" means the hospital (Part A) and medical (Part B) insurance program established by title XVIII of the federal social security act of 1965, as amended; that is, 42 USC 1395 to 1395ss.

(b) "Medicare eligible persons" includes all persons who qualify for Medicare by reason of age.

(c) "Medicare eligible expenses" means health care expenses of the type covered by Medicare, to the extent recognized as medically necessary by Medicare, and, except as provided in sub. (5) (a) 3 f, to the extent recognized as reasonable by Medicare, which may or may not be fully reimbursed by Medicare. "Medicare Part A eligible expenses" means Medicare eligible expenses covered under Medicare Part A, and "Medicare Part B eligible expenses" means Medicare eligible expenses covered under Medicare Part B.

(d) "Medicare supplement coverage" means coverage which meets the definition in s. 600.03 (35) (e), Stats., as interpreted by sub. (2) (a), and which conforms to subs. (4), (5), and (6).

(e) "Hospital confinement indemnity coverage" means coverage as defined in s. Ins 3.27 (4) (b).

(f) "Specified disease coverage" means coverage which is limited to named or defined sickness conditions. The term does not include dental or vision care coverage.

(g) "Nursing home coverage" means coverage as described in s. Ins 3.46 (3).

(h) "Outline of coverage" means a printed statement which meets the requirements of s. Ins 3.27 (5) (1), and of sub. (4) (b).

(i) Terms such as "skilled nursing facility" and "benefit period" used in this section shall be as defined by Medicare.

(4) MEDICARE SUPPLEMENT POLICY OR CERTIFICATE REQUIREMENTS. No disability insurance policy or certificate comprehended by this section shall relate its coverage to Medicare or be structured, advertised, or marketed as a supplement to Medicare unless:

(a) The policy or certificate:

1. Provides at a minimum the coverage set out in sub. (5) and applicable statutes, and contains no exclusions or limitations other than those permitted by sub. (6);

2. Contains no pre-existing condition waiting period longer than 6 months, and does not define a pre-existing 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;

3. Contains no definitions of terms such as "skilled nursing facility", "hospital", "nurse", "physician", "Medicare eligible expenses", or "benefit period" which are worded less favorably to the insured person than the corresponding Medicare definition, and contains as a definition of the term, "Medicare", "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", "Title I, Part I of Public Law 39-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import;

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident;

5. Does not if the policy or certificate is "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable", provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the nonpayment of premium;

6. Provides that termination of the policy or certificate shall be without prejudice to a continuous loss which commenced while the policy or

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certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits;

7. Contains a renewal, continuation, or nonrenewal provision, on the first page of the policy or certificate, which satisfies the requirements of s. Ins 3.13 (2) (c), (d) and (e), and clearly states the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed;

8. Provides that benefits designed to cover cost sharing amounts under Medicare shall be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy provisions and ch. 625, Stats., and;

9. Prominently discloses any limitations on the choice of providers or geographical area of service.

10. Is approved by the commissioner.

(b) The policy in the case of an individual policy, or the certificate in the case of a group policy:

1. Contains in close conjunction on its first page the designation, printed in 18-point type of a style in general use, and the caption, printed in 12-point type of a style in general use, prescribed in sub. (5); and

2. Is plainly printed as to text in black or blue ink in type of a style in general use, the size of which is uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point.

(c) The outline of coverage for the policy or certificate:

1. Is provided to all applicants at the time application is made and, except in the case of direct response insurance, the insurer obtains written acknowledgement from the applicant that the outline was received;

2. Complies with s. Ins 3.27 (5) (1) and (9) (u), (v) and (zh) 2 and 4.

3. Is substituted so as to properly describe the policy or certificate when it is issued, if the outline provided at the time of application does not properly describe the coverage which was issued, and the substituted outline accompanies the policy or certificate when it is delivered and contains the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.";

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24-point type of a style in general use, and the caption, printed in a distinctly contrasting color in 18-point type of a style in general use, prescribed in sub. (5);

5. Is in the format prescribed in the appendix to this section;

6. Summarizes or refers to the coverage set out in applicable statutes; and

7. Is approved by the commissioner along with the policy or certificate form.

(d) Any rider or endorsement added to the policy or certificate:

1. Shall be set forth in the policy or certificate and, if a separate, additional premium is charged in connection with the rider or endorsement the premium charge shall be set forth in the policy or certificate; and

2. After the date of policy or certificate issue, shall be agreed to in writing signed by the insured, if the rider or endorsement increases benefits or coverage with an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

(e) The anticipated loss ratio for the policy form, that is, the expected percentage of the aggregate amount of premiums collected which will be returned to insureds in the form of aggregate benefits under the policy form:

1. Is computed on the basis of anticipated incurred claims and earned premiums as estimated for the entire period for which rates are computed to provide coverage, in accordance with accepted actuarial principles and practices;

2. Is at least 60% in the case of individual policies;

3. Is at least 60% in the case of group policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising;

4. Is at least 75% in the case of group policies other than those described in subd. 3; and

5. Is approved by the commissioner along with the policy form.

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY OR CERTIFICATE DESIGNATIONS, CAPTIONS, AND MINIMUM COVERAGES. For a policy or certificate to meet the requirements of sub. (4), it shall contain the authorized designation, caption and minimum coverage prescribed for one of the following categories of medicare supplement insurance. A health maintenance organization as defined in s. 628.36 (2m) (a), Stats., shall place the letters HMO in front of the required designation on any approved medicare supplement policy.

(a) A MEDICARE SUPPLEMENT 1 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 1

2. The following caption, except that the word "certificate" may be used in the last 2 sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all expenses listed below.

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a. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a maximum benefit of at least an additional 365 days per Medicare benefit period;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days;

e. All Medicare Part A eligible expenses for blood to the extent not covered by Medicare;

f. All usual and customary charges for Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to a minimum benefit of at least \$7,500 per calendar year;

g. At least 75% of usual and customary charges for prescription drugs based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to the \$7,500 calendar year maximum benefit for Medicare Part B eligible expenses; and

h. At least 50% of usual and customary charges for outpatient psychiatric treatment expenses, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, up to a lifetime maximum of at least \$1,000 which may be applied to the \$7,500 calendar year maximum benefit for Medicare Part B eligible expenses.

(b) A MEDICARE SUPPLEMENT 2 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 2

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days; and

e. All Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum benefit of at least \$5,000 per calendar year.

(c) A MEDICARE SUPPLEMENT 3 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 3

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, excluding inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, excluding inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, at least 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, excluding inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days; and

d. At least 20% of all Medicare Part B eligible expenses, except outpatient psychiatric care, regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of \$200 of such expenses and to a maximum benefit of at least \$5,000 per calendar year.

(6) PERMISSIBLE MEDICARE SUPPLEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in sub. (5) may:

1. Exclude expenses for which the insured is compensated by Medicare;
2. Exclude coverage for the initial deductibles for Medicare Parts A and B;
3. Include any exclusion or condition contained in Medicare, except that Medicare supplements 1 and 2 shall cover in-hospital treatment of mental illness the same as any other illness;
4. Contain an appropriate provision relating to the effect of other insurance on claims;
5. Contain a pre-existing condition waiting period provision as provided in sub. (4) (a) 2., which shall appear as a separate paragraph of the policy and shall be captioned or titled "Pre-existing Condition Limitations"; and
6. If issued by a voluntary nonprofit sickness care plan subject to ch. 185, Stats., or a health maintenance organization as defined by s. 628.36 (2m) (a), Stats., include territorial limitations which are generally applicable to all coverage issued by the plan.

(b) Where the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would cover. Medicare Part B eligible expenses incurred beyond what Medicare Part B would cover may not be excluded.

(c) The coverages set out in sub. (5) may not exclude, limit, or reduce coverage for specifically named or described pre-existing diseases or physical conditions, except as provided in par. (a) 5.

(d) A policy or certificate subject to sub. (5) which provides benefits for "usual", "reasonable", or "customary" charges, or charges described in similar terms, shall contain a definition of the terms and its outline of coverage shall explain the terms.

(7) INDIVIDUAL POLICIES PROVIDING NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY, SPECIFIED DISEASE AND OTHER COVERAGES. (a) *Caption requirements.* Captions required by this subsection shall be:

1. Printed and conspicuously placed on the first page of the Outline of Coverage,
2. Printed on a separate form attached to the first page of the policy, and
3. Printed in 18-point bold letters.

(b) *Nursing home coverage.* An individual policy form providing nursing home coverage subject to s. Ins 3.46 which is sold to a Medicare-eligible persons shall bear the following caption: This policy's nursing home benefits are not related to Medicare. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(c) *Hospital confinement indemnity coverage.* An individual policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person:

1. Shall not include benefits for nursing home confinement unless the nursing home coverage meets the standards set forth in s. Ins 3.46; and
2. Shall bear the following caption, if the policy provides no other types of coverage: This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

3. Shall bear the caption set forth in par. (e), if the policy provides other types of coverage in addition to the hospital confinement indemnity coverage.

(d) *Specified disease coverage.* An individual policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

1. The following designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, and

2. The following caption: This policy covers only one or more specified or rare illnesses. It is not a substitute for a broader policy which would generally cover any illness or injury. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(e) *Other coverage.* An individual disability policy sold to a Medicare eligible person, other than a form subject to sub. (5) or otherwise subject to the caption requirements in this subsection or exempted by sub. (2) (d) or (e), shall bear the following caption: This policy is not a Medicare supplement. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(f) *Use of terms.* Except as otherwise provided in this subsection, the terms "Medicare Supplement", "Medigap" and words of similar import shall not be used in a policy or in any advertisement or sales presentation for a policy, unless the policy conforms to sub. (4).

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) *Conversion requirements.* An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4), (5), and (6) shall be furnished by the insurer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

1. An outline of coverage as described in par. (d) and
2. A copy of the current edition of the pamphlet described in sub. (9).

(b) *Continuation requirements.* An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and whose coverage will continue with changed benefits (e.g., "carve-out" or reduced benefits) shall be furnished by the insurer, within 14 days of a request:

1. A comprehensive written explanation of the coverage to be provided after Medicare eligibility, and

2. A copy of the current edition of the pamphlet described in sub. (9).

(c) *Notice to group policyholder.* An insurer which provides group hospital or medical coverage shall furnish to each group policyholder:

1. Annual written notice of the availability of the materials described in pars. (a) and (b), where applicable, and

2. Within 14 days of a request, sufficient copies of the same or a similar notice to be distributed to the group members affected.

(d) *Outline of coverage.* The outline of coverage:

1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) (c) 2., 5. and 6. of this section and shall be submitted to the commissioner; and

2. For a conversion policy not subject to subd. 1., shall comply with sub. (7), where applicable, and s. Ins 3.27 (5) (1).

(9) "Health insurance advice for senior citizens" pamphlet. Every prospective Medicare eligible purchaser of any policy or certificate subject to this section which provides hospital or medical coverage, other than incidentally, or of any coverage added to an existing Medicare supplement policy or certificate must receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g). Except in the case of direct response insurance, written acknowledgement of receipt of this pamphlet shall be obtained by the insurer. This pamphlet prepared by the office of the commissioner of insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies from the commissioner at cost or may reproduce this pamphlet themselves. This pamphlet shall be periodically revised to reflect changes in Medicare and any other appropriate changes. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has received notice that the revised pamphlet is available at the commissioner's office.

(10) **APPROVAL NOT A RECOMMENDATION.** While the commissioner may authorize the use of a particular designation on a policy or certificate in accordance with this section, that authorization is not to be construed or advertised as a recommendation of any particular policy or certificate by the commissioner or the state of Wisconsin.

(11) **EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS.** Policies and certificates described in sub. (2) (d) of this section, even if they are Medicare supplement policies as defined in s. 600.03 (35) (e), Stats., shall not be subject to:

(a) The special right of return provision for Medicare supplement policies set forth in s. 632.73 (2m), Stats., and s. Ins 3.13 (2) (j) 3.; and

(b) The special pre-existing diseases provision for Medicare supplement policies set forth in s. 632.76 (2) (b), Stats.

(12) **SEVERABILITY.** If any provision of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the parts of this section are declared to be severable.

(13) **EFFECTIVE DATE.** This section was originally adopted in 1977 and was amended in 1978 and 1981. The requirements contained in or applications of the earlier versions which were not subsequently repealed continue to apply. The requirements or applications included in this revision apply to policies issued on or after July 1, 1982, except that the requirements or applications included in subs. (8) and (11) of this section apply to policies issued or renewed on or after July 1, 1982.

APPENDIX

(COMPANY NAME)

OUTLINE OF MEDICARE

SUPPLEMENT COVERAGE

(The designation and caption required by sub. (4) (c) 4.)

(1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Medicare Supplement Coverage** — Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and co-payment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(3) (a) (for intermediaries:)

Neither (insert company's name) nor its agents are connected with Medicare.

(b) (for direct responses:)

(insert company's name) is not connected with Medicare.

(c) (If the insurer has contracted with the federal government to provide medicare benefits, the disclosure required in pars. (a) and (b) may be modified to describe this relationship accurately.)

(4) (A brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order:)

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION . . . semiprivate room and board, general nursing and miscellaneous hospital services and supplies Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services	First 60 days	All but \$(260)		
	61st to 90th day	All but \$(65) a day		
	91st to 150th day	All but \$(130) a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE . . . In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital discharge.	First 20 days	100% of costs		
	Additional 80 days	All but \$(32.50) a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge [after \$(75) deductible]		

(5) (Statement that the policy does or does not cover the following:)

- (a) Private duty nursing,
- (b) Skilled nursing home care costs (beyond what is covered by Medicare),
- (c) Custodial nursing home care costs,
- (d) Intermediate nursing home care costs,

- (e) Home health care above number of visits covered by Medicare,
 - (f) Physician charges (above Medicare's reasonable charge),
 - (g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),
 - (h) Care received outside of U.S.A.,
 - (i) Dental care of dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.
 - (j) Coverage for care received outside the service area if this care is treated differently than other covered benefits.
- (6) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:)
- (a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)
 - (b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)
 - (c) (That there are limitations on the choice of providers or the geographical area served, if this is the case.)
 - (7) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.)
 - (8) If the coverage is provided by a health maintenance organization defined under s. 628.36 (2m) (a), Stats., the outline of coverage shall prominently disclose all restrictions associated with the use of emergency and urgent care services and information on how to file a claim for services received outside the service area.
 - (9) (The amount of premium for this policy.)

Drafting Note: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate. The outline is subject to s. Ins 3.27 (5) (1) and (9) (u), (v) and (zh) 2. and 4.

History: Cr. Register, July, 1977, No. 259, eff. 11-29-77; am. (13), Register, September, 1977, No. 261, eff. 1-1-78; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renun. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1-1-79; am. (4) (b) 1. a., (5) (a) 2. and (b) 2., (5) (c) 2. and (9), r. (5) (d) and (e), Register, April, 1981, No. 304, eff. 5-1-81; r. and recr. (7) (b), Register, May, 1981, No. 305, eff. 6-1-81; r. and recr. Register, June, 1982, No. 318, eff. 7-1-82; renun. (4) (a) 9. to be 10., cr. (4) (a) 9., am. (5) (intro.) and (6) (a) 6., Register, October, 1984, No. 346, eff. 11-1-84.

Ins 3.40 Authorized clauses for coordination of benefit provisions in group and blanket disability insurance policies [ss. 631.20, 631.21 (1) (b), 631.23, 631.43, 632.77 (3)]. (1) **PURPOSE.** This section establishes authorized coordination of benefit clauses for group and blanket disability insurance policies pursuant to s. 631.23, Stats., because it has been found that provision of language, content or form of these specific clauses is necessary to provide certainty of meaning of them, and regulation of contract forms will be more effective and litigation will be substantially reduced if there

is increased uniformity of these clauses. This section does not require the use of coordination of benefit or "other insurance" provisions but if such provisions are used, they must adhere substantially to this section. Liberalization of the prescribed language including rearrangement of the order of the clauses is permitted provided that the modified language is not less favorable to the insured person. Provisions for the reduction in benefits because of other insurance which are inconsistent with this section violate the criteria of s. 631.20, Stats., and may not be used.

(2) **SCOPE.** This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., providing 24-hour coverage for medical or dental care, treatment or expenses due to either injury or sickness which contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" clause or other provision, clause or exclusion by whatever name designated under which benefits would be reduced because of other insurance, other than an exclusion for expenses covered by workers compensation, employer's liability insurance or Medicare. A plan of coverage, such as major medical or excess medical, designed to be supplementary to a group or blanket policyholder's other coverage may provide that the plan shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

(3) **AUTHORIZED CLAUSES.** The clauses in subs. (4) to (10) shall be considered authorized clauses pursuant to s. 631.23, Stats., for use in policy forms subject to this section and collectively are a coordination of benefits provision and may be referred to as "this provision."

(4) **BENEFITS SUBJECT TO THIS PROVISION.** All of the benefits provided under this policy are subject to this provision.

(5) **BENEFITS SUBJECT TO THIS PROVISION [Alternate Clause].** Only the major medical expense benefits provided under this policy are subject to this provision. [When the policy provides both integrated major medical expense benefits and the basic benefits, but the "other insurance" provision applies to the major medical expense benefits only, this alternate wording is authorized.]

(6) **DEFINITIONS.** (a) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by group, blanket or franchise insurance coverage, service insurance plan contracts, group practice, individual practice and other prepayment coverage, or any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employe benefit organization plans, and any coverage under governmental programs, and any coverage required or provided by statute.

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(am) The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefit or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(b) "This Plan" means that portion of this policy which provides the benefits that are subject to this provision. Any benefits provided under this policy that are not subject to this provision constitute another Plan.

(c) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(d) "Claim Determination Period" means _____ [Insert here an appropriate period of time such as "Calendar year" or "Benefit Period as defined elsewhere in this policy."]

(7) **EFFECT ON BENEFITS.** (a) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expense incurred as to such person during such period, the sum of

1. The benefits that would be payable under this Plan in the absence of this provision, and

2. The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable Expenses.

(b) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph (c), shall not exceed the total of the Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(c) 1. If another Plan which is involved in paragraph (b) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

2. The other Plan's provision coordinating its benefits with those of this Plan includes Claim Determination Period and Facility of Payment provisions similar to those of this provision, and

3. The rules set forth in this subsection would require this Plan to determine its benefits before any other Plan then the benefits of the other Plan will be ignored for the purposes of determining the benefits under this Plan.

Ins 3

(d) For the purposes of paragraph (c), the rules establishing the order of benefit determination are:

1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers the person as a dependent;

2. The benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers the person as a dependent of a female person; except that in case of a person for whom claim is made as a dependent child,

a. When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody;

b. When parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody;

c. Notwithstanding subdivisions 2. a. and b., if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

3. When subdivisions 1. and 2. do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time.

(e) When this subsection operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and the reduced amount shall be charged against any applicable benefit limit of this Plan. [This clause may be omitted if the Plan provides only one benefit.]

(8) **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION.** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the insurer or service plan such information as may be necessary to implement this provision.

(9) **FACILITY OF PAYMENT.** Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of the payments, the insurer or service plan shall be fully discharged from liability under this Plan.

(10) **RIGHT OF RECOVERY.** Whenever payments have been made by the insurer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer or service plan shall have the right to recover such payments, to the extent of any excess, from among one or more of the following, as the insurer or service plan shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

(11) **LIMITATIONS ON AND VARIATIONS FROM DEFINITION OF PLAN.** The definition of a Plan in sub. (6) (a) enumerates the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim. The authorized definition clause may be varied in accordance with the substance of the following:

(a) The definition may not include individual or family policies, or individual or family subscriber contracts, except as authorized in paragraphs (b) through (f).

(b) The definition may include all group policies or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition, at the option of the insurer and its policyholder-client, whether or not individual policy forms are utilized and whether the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.

(c) The definition may include both group and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

(d) The definition may not include group or group-type hospital indemnity benefits written on a nonexpense incurred basis of \$30 per day or less unless they are characterized as reimbursement type benefits but are designed or administered so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceeds \$30 per day may be construed as being included under the definition of a "Plan."

(e) The definition may not include school accident type coverages, written on either an individual, group, blanket or franchise basis. In this context, school accident type coverages are defined to mean coverage covering grammar school and high school students for accidents only,

including athletic injuries, either on a 24-hour basis or "to and from school," for which the parent pays the entire premium.

(f) If Medicare or similar governmental benefits are included in the definition of a Plan, such benefits may be taken into consideration without expanding the definition of Allowable Expenses beyond the hospital, medical and surgical benefits as may be provided by the government program.

(12) DETERMINATION OF LENGTH OF TIME COVERED. (a) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, [e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan] would constitute the start of a new Plan for purposes of this section.

(b) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this section, that the claimant's length of time covered under that Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time coverage under that Plan has been in force.

(13) COORDINATION OF BENEFITS WITH OTHER PLAN WHOSE COVERAGE IS EXCESS TO ALL OTHER COVERAGE. It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other overinsurance provisions not consistent with the provisions of this section. Such plans may have been written by self-insured or nonregulated entities not presently subject to insurance regulation, or by insurers or service corporations under policies or contracts issued prior to the effective date of this section which have not yet been brought into conformance with this section. Carriers are urged to use the following claims administration procedures when one plan is "excess" to all other coverages and their policy or contract contains the coordination of benefits provisions of this section. A plan containing a coordination of benefits provision should pay first if it would be primary according to the order of benefit determination of subsection (7). In those cases where a group coordination of benefits plan would normally be considered secondary, the insurer should make every effort to coordinate in a secondary position with benefits available through any such "excess" plan. The insurer should try to secure the necessary information from the "excess" plan. But if such excess plan is unwilling to provide the carrier with the necessary information, the carrier should assume the primary position in order to avoid undue claim delays and hardship to the insured.

(14) **COORDINATION OF BENEFITS PAYABLE.** Insurers are urged to use the following claims administration procedures to expedite claim payments where coordination of benefits is involved:

(a) Improving exchange of benefit information;

(b) There should be continued and improved education of claim personnel, stressing accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP-1) Form by the inquiring insurer and the responding insurer. This education effort should also be encouraged through local claim associations;

(c) Claim personnel should be encouraged to make every effort, including use of the telephone, to speed up exchange of coordination of benefits information;

(d) Insurers should encourage building a local data file of other group plans in the area, with at least basic information on group health plans for major employers;

(e) Each insurer should establish a time limit after which full or partial payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other valid coverage should be conducted concurrently so as to create no further delay in the ultimate payment of benefits. Occasionally this will necessitate an insurer making payment as the primary insurer with a right of recovery in the event that subsequent investigation proves that payment as a secondary insurer should have been made.

(15) **SMALL CLAIMS WAIVER.** Insurers are urged to waive the investigation of possible other coverage for coordination of benefits purposes on claims less than \$50, but if additional liability is incurred to raise the small claim above \$50, the entire liability may be included in the coordination of benefits computation.

(16) **SUBROGATION.** The concept of coordination of benefits is clearly distinguishable from that of subrogation. Provisions for either may be included in a group disability insurance policy without compelling the inclusion or exclusion of the other.

(17) **EDUCATION OF INSURED.** Each insurer has an affirmative obligation to urge its respective group clients to take reasonable steps to assure that those insured by the group policy or subscriber contract have been exposed to reasonably concise explanations, with as little technical terminology as is commensurate with accuracy, as to the purpose and operation of coordination of benefits. Such educational effort may take the form of articles in the employer magazines or newspapers, speeches before the appropriate labor organization in the case of a unionized employer, brochures added to pay envelopes, notices on the company bulletin board, materials used by personnel department in counseling employees, and the like.

(18) **DISCLOSURE OF COORDINATION OF BENEFIT CLAUSES IN CERTIFICATES OF COVERAGE.** Each certificate of coverage under a group disability policy or contract which provides coordination of benefits pursuant to this section shall contain, at least in summary form, a description of the coordination of benefit clauses.

(19) **SEVERABILITY.** If any provision of this section or its application to any person or circumstances is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provisions or application, and to this end the parts of this section are declared to be severable.

(20) **EFFECTIVE DATE.** This section shall become effective on September 1, 1980. The authorized clauses, authorized modifications thereof and the substantive requirements of this section shall apply to all policy and contract forms subject to this section that are issued on or after this effective date. Policies or contracts which are otherwise subject to this section which are in force as of the effective date shall comply with this section by the later of the next anniversary or renewal date of the group policy or contract, or the expiration of the applicable collectively bargained contract pursuant to which they were written, if any.

History: Cr. Register, July, 1980, No. 295, eff. 9-1-80; am. (2), Register, January, 1981, No. 301, eff. 2-1-81.

Ins 3.41 Individual conversion policies. (1) **REASONABLY SIMILAR COVERAGE.** An insurer provides reasonably similar coverage under s. 632.897 (4), Stats., to a terminated insured as defined in s. 632.897 (1) (f), Stats., if a person is offered individual coverage substantially identical to the terminated coverage under the group policy or individual policy, or is offered his or her choice of the 3 plans described in s. Ins 3.42, Wis. Adm. Code, or is offered a high limit comprehensive plan of benefits approved for the purpose of conversion by the commissioner as meeting the standards described in s. Ins 3.43, Wis. Adm. Code. Individual conversion policies must include benefits required for individual disability insurance policies by subch. VI, ch. 632, Stats.

(2) **RENEWABILITY.** (a) Except as provided in par. (b), individual conversion policies shall be renewable at the option of the insured unless the insured fails to make timely payment of a required premium amount, there is over-insurance as provided by s. 632.897 (4) (d), Stats., or there was fraud or material misrepresentation in applying for any benefit under the policy.

(b) Conversion policies issued to a former spouse under s. 632.897 (9) (b), Stats., must include renewal provisions at least as favorable to the insured as did the previous coverage.

(3) **PREMIUM RATES.** (a) In determining the rates for the class of risks to be covered under individual conversion policies, the premium and loss experience of policies issued to meet the requirements of s. 632.897 (4), Stats., may be considered in determining the table of premium rates applicable to the age and class of risks of each person to be covered under the policy and to the type and amount of coverage provided.

(b) Except as provided in par. (c), conditions pertaining to health shall not be an acceptable basis for classification of risks.

(c) A conversion policy issued to a former spouse under s. 632.897 (9) (b), Stats., may be rated on the basis of a health condition if a similar rating had been previously applied to the prior individual coverage due to the same condition.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Register, April, 1981, No. 304

Ins 3.42 Plans of conversion coverage. Pursuant to s. 632.897 (4) (b), Stats., the following plans of conversion coverage are established.

(1) *Plan 1—Basic Coverage*—Plan 1 basic coverage consists of the following:

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the major metropolitan area of this state, for a maximum duration of 70 days per calendar year;

(b) Miscellaneous in-hospital expenses, including anesthesia services, up to a maximum amount of 20 times the hospital room and board daily expense benefits per calendar year; and

(c) In-hospital and out-of-hospital surgical expenses payable on a usual, customary and reasonable basis up to a maximum benefit of \$2,000 a calendar year.

(2) *Plan 2—Major Medical Expense Coverage*—Plan 2 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(a) A lifetime maximum benefit of \$75,000.

(b) Payment of benefits at the rate of 80% of covered hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches \$1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered at a usual, customary and reasonable level.

(c) A deductible for each benefit period of \$500 except that the deductible shall be \$1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a), (b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

Ins 3

(3) *Plan 3—Major Medical Expense Coverage*—Plan 3 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(Same as Plan 2 except that maximum benefit is \$100,000 and deductible is \$1,000 for an individual and \$2,000 for a family.)

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (2) (b) and (e), cr. (2) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

Ins 3.43 High limit comprehensive plan of benefits. (1) A policy form providing a high limit comprehensive plan of benefits may be approved as an individual conversion policy as provided by s. 632.897 (4) (b), Stats., if it provides comprehensive coverage of expenses of hospital, surgical and medical services of not less than the following:

(a) A lifetime maximum benefit of \$250,000.

(b) Payment of benefits at the rate of 80% of covered hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches \$1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered at a usual, customary and reasonable level.

(c) A deductible for each benefit period of at least \$250 and not more than \$500 except that the deductible shall be at least \$250 and not more than \$1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a), (b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

(2) The filing procedures of s. Ins 3.12, shall apply to policy forms filed as individual conversion policies.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (1) (b) and (e), cr. (1) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

Ins 3.44 Effective date of s. 632.897, Stats. (1) Section 632.897, Stats., applies to group policies issued or renewed on or after May 14, 1980, or if a policy is not renewed within 2 years after the effective date

of the act, s. 632.897, Stats., is effective at the end of 2 years from May 14, 1980.

(2) (a) A group policy as defined in s. 632.897 (1) (c) 1 or 3 shall be considered to have been renewed on any date specified in the policy as a renewal date or on any date on which the insurer or the insured changed the rate of premium for the group policy.

(b) A group policy as defined in s. 632.897 (1) (c) 2 shall be considered to have been renewed on any date on which an underlying collective bargaining agreement or other underlying contract is renewed, or on which a significant change is made in benefits.

(3) Section 632.897, Stats., applies to individual policies issued or renewed after May 14, 1980, except that it shall not apply to any individual policy in force on May 13, 1980, in which the insurer does not have the option of changing premiums.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.45 Conversion policies by insurers offering group policies only. Section 632.897 (4) (d) (first sentence), Stats., establishes that an insurer offering group policies only is not required to offer individual coverage. Since the insurer has no individual conversion policies which it may offer, it may not require a terminated insured who elected to continue coverage under s. 632.897 (2), Stats., to convert to individual coverage under s. 632.897 (6), Stats., after 12 months. The terminated person may continue group coverage except as provided in s. 632.897 (3) (a), Stats.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.46 Standards for nursing home insurance. (1) **FINDINGS.** Information on file in the office of the commissioner of insurance shows that significant misunderstanding exists with respect to nursing home insurance. In many cases, coverage under these policies is much less than the use of the label would warrant and includes few meaningful benefits beyond those already available to consumers as a result of s. 632.78 (4), Stats., and Ins 3.39, and the commissioner of insurance finds that such policies are inequitable, misleading, deceptive, obscure, and encouraging of misrepresentation as considered by s. 631.20 (2), Stats. Some of the sales presentations used to sell nursing home insurance are misleading, confusing, and incomplete, and the commissioner of insurance finds that such presentations are misleading and deceptive, and restrain competition unreasonably under s. 628.34 (12), Stats., and their continued use would constitute an unfair trade practice under s. 628.34 (11), Stats.

(2) **PURPOSE.** (a) This section establishes minimum requirements for insurance which may be sold as nursing home insurance. A policy will be disapproved pursuant to s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(b) This section seeks to reduce abuses and confusion associated with the sale of nursing home insurance by providing for minimum levels of coverage. It is designed not only to improve the ability of the consumer to make an informed choice as to whether to purchase a nursing home policy, but to assure that no policy will be approved by the commissioner

as a "nursing home policy" unless it contains coverage which warrants the use of that label.

(3) SCOPE. (a) Except as provided in par. (b), this section applies to any individual insurance policy or rider which provides coverage primarily for confinement or care in a nursing home. This section applies regardless of restrictions on the level of nursing home care provided by a policy, i.e., skilled, intermediate, limited, personal or residential care.

(b) This section shall not apply to a rider designed specifically to meet the requirement for coverage of skilled nursing care set forth in s. 632.78 (4), Stats.

(c) This section applies to any individual insurance policy issued on or after July 1, 1982 to a person eligible for Medicare by reason of age which provides coverage for confinement or care in a nursing home in addition to providing hospital confinement indemnity coverage as defined in s. Ins 3.27 (4) (b) 6.

(4) DEFINITIONS. For the purpose of this section:

(a) "Medicare" means the hospital and medical insurance program established by title XVIII of the federal social security act of 1965, as amended.

(b) "Medicare eligible persons" means all persons who qualify for Medicare.

(c) "Nursing home" means a nursing home as defined by s. 50.01 (3), Stats.

(5) NURSING HOME POLICY REQUIREMENTS. No insurance policy covered by this section shall be structured, advertised, or marketed as a nursing home policy unless:

(a) The policy provides at a minimum the coverage set out in sub. (6) of this section and applicable statutes.

(b) The policy is plainly printed as to text in black or blue ink in a type of a style in general use, the size of which is uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point.

(c) If the policy is sold to Medicare-eligible persons, it meets the requirements of s. Ins 3.39 (7) (b).

(6) MINIMUM COVERAGES. (a) Except as provided in pars. (b) through (g) of this section, a nursing home policy shall provide coverage for each person insured under the policy for any care received while a resident of any nursing home licensed by the state of Wisconsin pursuant to s. 50.02, Stats.

(b) Nursing home policies may limit benefits to a fixed daily benefit. The daily benefit may differ for different levels of care, but the lowest level of daily benefits shall not be less than \$10 a day.

(c) Nursing home policies may provide benefits subject to a deductible, but the deductible amount shall not exceed 60 days per lifetime.

(d) Nursing home policies may provide benefits subject to a lifetime maximum, but the lifetime maximum shall be at least 365 days of coverage.

(e) Nursing home policies may limit coverage to care certified as necessary by the attending physician and periodically recertified as necessary.

(f) Nursing home policies are not required to duplicate payments by Medicare for nursing home care.

(g) The following limitations and exclusions are prohibited in nursing home policies:

1. Coverage limited to only certain levels of care, such as skilled care.
2. Coverage limited to care received as a result of sickness or injury.
3. Coverage limited to care received after a hospital confinement.

(6m) SEVERABILITY. If any provision of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the parts of this section are declared to be severable.

(7) EFFECTIVE DATE. This rule shall take effect November 1, 1981.

History: Cr. Register, June, 1981, No. 305, eff. 11-1-81; cr. (3) (c), Register, June, 1982, No. 318, eff. 7-1-82.

Ins 3.47 Cancer insurance solicitation. (1) FINDINGS. Information on file in the office of the commissioner of insurance shows that significant misunderstanding exists with respect to cancer insurance. Consumers are not aware of the limitations of cancer insurance and do not know how cancer insurance policies fit in with other health insurance coverage. Many of the sales presentations used in the selling of cancer insurance are confusing, misleading and incomplete and consumers are not getting the information they need to make informed choices. The commissioner of insurance finds that such presentations and sales materials are misleading, deceptive and restrain competition unreasonably as considered by s. 628.34 (12), Stats., and that their continued use without additional information would constitute an unfair trade practice under s. 628.34 (11) and would result in misrepresentation as defined and prohibited in s. 628.34 (1), Stats.

(2) PURPOSE. The purpose of s. Ins 3.47 is to promulgate a rule interpreting s. 628.34 (12), relating to unfair trade practices. It requires insurers and intermediaries who sell cancer insurance to give all prospective buyers of cancer insurance a buyer's guide prepared by the National Association of Insurance Commissioners.

(3) SCOPE. This section applies to all individual, group and franchise insurance policies or riders which provide benefits for or are advertised as providing benefits primarily for the treatment of cancer. This rule does not apply to solicitations in which the booklet, "Health Insurance Advice for Senior Citizens," is given to applicants as required by s. Ins 3.39.

(4) **DEFINITION.** The "Information Sheet on Cancer Insurance" means the document which contains, and is limited to, the language set forth in Appendix I to this section.

(5) **DISCLOSURE REQUIREMENTS.** (a) The insurer and its intermediaries shall print and provide to all prospective purchasers of any policy subject to the rule a copy of the "Information Sheet on Cancer Insurance" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g).

(b) The "Information Sheet on Cancer Insurance" shall be printed in an easy to read type and not less than 12 pt. size.

(6) This rule shall become effective August 1, 1981.

History: Cr. Register, June, 1981, No. 306, eff. 8-1-81.

APPENDIX I

INFORMATION SHEET ON CANCER INSURANCE

Cancer Insurance is Not a Substitute for Comprehensive Coverage.

Should You Buy Cancer Insurance?

Caution: Limitations On Cancer Insurance.

Prepared by the National Association of Insurance Commissioners

CANCER INSURANCE . . .

Cancer insurance is one of the fastest growing and most controversial forms of health insurance. It provides benefits only if you get cancer. No policy will cover cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE . . .

Cancer treatment accounts for less than 6% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as \$100,000 to \$1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE? . . . MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease? If

you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low income people who are Medicaid recipients don't need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a Coordination of Benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May Not Be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs and nursing home care. For 1978, the average hospital cost for cancer treatment was \$4,228. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.

Don't be Misled by Emotions. While one in four Americans will get cancer over a lifetime, three in four will not. In any one year, only one American in 285 will get cancer. The odds are against a Policyholder receiving any benefits.

CAUTION: LIMITATIONS OF CANCER INSURANCE . . .

Cancer policies sold today vary widely in cost and coverage. Contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 16 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However, 99% of all cancer patients spend less than 60 days in the hospital. Large dollar amounts for extended benefits have very little value for most patients.

Many cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to \$1,500 for surgery costs or \$1,000 for radiation therapy, or it may have fixed payments such as \$50 or \$100 for each day in the hospital. Others limit total benefits to a fixed amount such as \$5,000 or \$10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

FOR ADDITIONAL HELP . . .

If you are considering a cancer policy, the company or agent should answer your questions. If you do not get the information you want, discuss the matter with your State Insurance Department.

• **Ins 3.48 Preferred provider plans.** (1) **SCOPE.** This section applies to all preferred provider plans as defined in s. 628.36 (2a) (a) 1., Stats.

(2) **EXCESSIVE DISTANCES.** (a) Except as provided in pars. (b) and (c), preferred provider plans shall offer coverage to a person only if preferred providers of primary care services and emergency services are available within 30 minutes' travel time of the person's place of residence.

(b) A preferred provider plan may offer coverage on a group basis to an employer for its employes or to an employe organization without taking into account the places of residence of the employes, if preferred providers of primary care services and emergency services are available either within the county or within 30 minutes' travel time of the employment location.

(c) A preferred provider plan may provide coverage to a person without taking into account the person's place of residence or employment if the person is informed in writing of the services covered and the location of all preferred providers and makes a written request for coverage.

(3) **CONTINUITY OF PATIENT CARE.** (a) Subject to pars. (b), (c), (d) and (e), a preferred provider plan which is offered on a group basis to an employer for its employes or to an employe organization shall extend enrollment periods for group members and their families who wish to be enrolled in the plan, but who are in a course of treatment with a provider not selected by the plan and wish to continue that course of treatment. Enrollment standards for those who request an extended enrollment period shall be no more restrictive than they are for those who enroll during the normal enrollment period.

(b) A preferred provider plan may require a group member to request an extended enrollment period during the normal enrollment period specified by the plan and to indicate the nature and the expected duration of the course of treatment.

(c) A preferred provider plan is not required to extend enrollment opportunities to a dependent of a group member unless the group member and any other dependents also receive an extension.

(d) A preferred provider plan may limit the extension of the enrollment period for a group member and dependents to 90 days after the effective date of the contract.

(e) A preferred provider plan shall receive no premiums and bear no responsibility for coverage of group members and their dependents until they are enrolled.

(f) When a person changes from one plan to another, the responsibilities of the prior and succeeding insurers outlined in s. Ins 6.51 (6), (7) and (8) shall apply.

(4) **SUBSTANTIALLY EQUIVALENT BENEFITS DEFINED.** (a) For purposes of s. 628.36 (2a) (d), Stats., plans will be considered to provide substantially equivalent benefits if they offer comparable coverage for the following services: hospital room and board, other inpatient hospital services, surgery, home and office physician services, inpatient physician care, x-ray and laboratory services.

(b) Notwithstanding par. (a), plans providing substantially equivalent benefits may differ as to premium, deductible, coinsurance, benefit maximum provisions and limitations on choice of providers.

(c) Plans providing substantially equivalent benefits may differ in their coverage of services other than those listed in par. (a).

(5) **ADEQUATE NOTICE.** (a) Preferred provider plans shall provide to policyholders information on the plan, including information on the services covered; a definition of emergency services if emergency services are covered differently than other services; the specific location of providers for each type of service; the cost of the plan; enrollment procedures; limitations on benefits, including limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization; and restrictions on choice of providers. This information shall be provided to employers at least 30 days before the first day of each enrollment period. The preferred provider plans shall ensure that employers make this information available to all prospective certificate holders in time for them to make an informed choice among available plans. If a preferred provider plan is offered on an individual basis, the information shall be given at the time of application.

(b) The information provided shall be legible, complete, understandable, presented in a meaningful sequence, contain a single section listing exclusions and limitations and define words and expressions which are not commonly understood or whose commonly understood meaning is not intended.

(c) The information provided shall meet the standards for an invitation to apply set forth in s. Ins 3.27.

(6) **NONPREFERRED PROVIDERS.** A preferred provider plan may require that, if a person enrolled in the plan receives health care services from providers not selected by the plan, the person shall pay, in addition to any applicable premium and deductible, an additional portion of the total payment to be made to the providers. The sum of these additional amounts may not be more than \$2,500 per year for individual coverage nor more than \$5,000 per year for family coverage.

(7) **SEVERABILITY.** If any provisions of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the parts of this section are declared to be severable.

History: Cr. Register, June, 1984, No. 342, eff. 7-1-84;

Ins 3.49 Wisconsin automobile insurance plan. (1) **PURPOSE.** This section interprets s. 619.01 (6), Stats., to continue a plan to make automobile insurance available to those who are unable to obtain it in the voluntary market by providing for the equitable distribution of applicants

among insurers and outlines access and grievance procedures for such a plan.

(2) DEFINITIONS. In this section

(a) "Committee" means the Governing Committee of the Wisconsin Automobile Insurance Plan which is the group of companies administering the Plan.

(b) "Plan" means the Wisconsin Automobile Insurance Plan, an unincorporated facility established by s. 204.51 [Stats., (1967)] and continued under s. 619.01 (6), Stats.

(3) FILING AND ACCESS. The Committee shall submit revisions to its rules, rates and forms for the Plan to the commissioner. Prior approval by the commissioner of the documents is required before they may become effective. The documents shall provide:

(a) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise and their assignment to insurers;

(b) Rates and rate modifications applicable to such risks which shall not be excessive, inadequate or unfairly discriminatory;

(c) The limits of liability which the insurer shall be required to assume;

(d) A method by which an applicant to the Plan denied insurance or an insured under the Plan whose insurance is terminated may request the Committee to review such denial or termination and by which an insurer subscribing to the Plan may request the Committee to review actions or decisions of the Plan which adversely affect such insurer. The method shall specify that such requests for review must be made in writing to the Plan and that the decision of the Committee in regard to such review may be appealed by the applicant, insured, or company to the commissioner of insurance as provided for in ch. Ins 5. A review or appeal does not operate as a stay of termination.

Note: These requirements reflect former s. 204.51 (2), Wis. Stats.

(e) The commissioner shall maintain files of the Plan's approved rules, rates, and forms and such documents must be made available for public inspection at the office of the commissioner of insurance.

History: Cr. Register, November, 1984, No. 347, eff. 12-1-84.