
1975 Senate Bill 642

Date published: **June 21, 1976**

CHAPTER 375, Laws of 1975

AN ACT to repeal 201.065, 201.075, 201.135, 201.17 to 201.20, 201.53 (1), 201.54, 203.01 to 203.08, 203.11, 203.13, 203.21, 203.22, 204.03, 204.04, 204.07, 204.075, 204.14 to 204.34, 204.36, 206.13 to 206.18, 206.25, 206.36, 206.385 (3), 206.39, 206.45, 206.49, 206.54, 206.60 to 206.64, 208.10, 208.11, 209.06, 209.07, 613.08 and 632.89 (2) (a) 2; to renumber 600.01 (1) and 601.20; to amend 201.04

(3c), (4a) and (18), 206.41 (5) (c), 208.162, 422.202 (1) (b) (intro.), 600.03 (28), 612.51 (1) (b) and (c) and 632.89 (4) and (6); to repeal and recreate 201.04 (3a), 206.385 (1), 612.51 (1) (a) and 613.02 (1) (b); and to create 600.01 (1) (a), 600.03 (34m), 601.20 (1) (title) and (3), 601.51, 601.53, chapter 631, subchapters I to VIII of chapter 632 and chapter 636 of the statutes, relating to insurance contracts and granting rule-making authority.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 201.04 (3a) of the statutes is repealed and recreated to read:

201.04 (3a) Group life insurance.

SECTION 2. 201.04 (3c), (4a) and (18) of the statutes are amended to read:

201.04 (3c) Credit Life Insurance.—On the lives of borrowers or purchasers of goods in connection with specific loans or credit transactions ~~as defined in s. 206.63 when all or a portion of the insurance is payable to the creditor in satisfaction of the debt.~~

(4a) Credit Accident and Sickness Insurance.—Against loss of time of debtors resulting from accident or sickness. ~~One debtor only may be covered in connection with any one indebtedness; the total indemnity shall not exceed the initial amount of such indebtedness or \$10,000, whichever is less; and coverage shall not extend beyond the term of indebtedness or 60 months, whichever is less when all or a portion of the insurance is payable to the creditor in satisfaction of the debt.~~

(18) Medical Payments and Other Supplemental Insurance.—Against expense, other than loss of time, in connection with the kinds of insurance specified in subs. (5), (6), (10), (13) and (17), and against loss, damage and expense, including loss of time, in connection with the kind of insurance specified in sub. (15), arising out of bodily injury to, or sickness, disease or death of, either or both the insured and others, by accident, with respect to which the insurer assumes an obligation to pay irrespective of the insured's legal liability therefor. ~~The requirements applicable to the insurance specified in sub. (4), including ss. 204.31 to 204.322, shall not apply when the insurance authorized by this subsection is assumed as a part of or as supplemental to the insurance specified in any other subsection of s. 201.04 as permitted in s. 201.05 (1), provided such loss, damage or expense arises out of a hazard directly related to such other insurance.~~

NOTE: Sub. (3c). Language was omitted in SECTIONS 1 and 2 that referred to ss. 206.60 and 206.63, containing limits on group life and group credit life insurance that are repealed by this act. The added language at the end of SECTION 2 is needed to keep the definition from sweeping in all life insurance taken out at the time of incurring a debt, whether or not the insurance is for the purpose of paying the debt. Much life insurance is taken out at the time of contracting a debt that is not properly called credit life insurance, because it is taken out independently by the borrower for prudential reasons.

Sub. (4a). The omitted portion of the subsection provides limits on such insurance. The limits are repealed as unnecessary. The last part of the section is needed in the same way that similar language is needed in 201.04 (3c). See SECTION 2.

Sub. (18). The repealed sentence of s. 201.04 (18) is not properly a part of the definition but is a provision relating to contract terms. It has been made into new s. 632.80.

SECTION 3. 201.065 and 201.075 of the statutes are repealed.

SECTION 4. 201.135 of the statutes is repealed.

SECTION 5. 201.17 to 201.20 of the statutes are repealed.

SECTION 6. 201.53 (1) of the statutes is repealed.

SECTION 7. 201.54 of the statutes is repealed.

SECTION 8. 203.01 to 203.08 of the statutes, as affected by supreme court order dated February 17, 1975, and effective January 1, 1976, are repealed.

SECTION 9. 203.11 and 203.13 of the statutes are repealed.

SECTION 10. 203.21 and 203.22 of the statutes are repealed.

SECTION 11. 204.03 and 204.04 of the statutes are repealed.

SECTION 12. 204.07 and 204.075 of the statutes are repealed.

SECTION 13. 204.14 to 204.34 of the statutes, as affected by the laws of 1975, are repealed.

SECTION 14. 204.36 of the statutes is repealed.

SECTION 15. 206.13 to 206.18 of the statutes are repealed.

SECTION 16. 206.25 of the statutes is repealed.

SECTION 17. 206.36 of the statutes is repealed.

NOTE: Section 201.065 is continued, in somewhat altered form, in ss. 632.47 and 632.71.

Section 201.075, slightly edited, has become s. 631.65.

Section 201.135 has become s. 631.51 (2), with some changes.

Section 201.17 has become s. 631.03, with some changes.

Section 201.19 in large part has become s. 631.83, with significant changes. One portion has become s. 631.13. See also s. 201.53 (1).

Section 201.20 has become s. 631.45.

Section 201.53 (1) has become assimilated in s. 631.13. See also s. 201.19.

Section 201.54 has become s. 631.51 (3), with some changes of substance.

Section 203.01 and the standard fire policy annexed to it are repealed, and are replaced by the liberalized approval procedure of ss. 631.20 to 631.27.

Section 203.02 (1) is incorporated within s. 631.13; the provision of s. 203.02 (2) dealing with corporate name is dealt with in s. 631.64, substantially amended.

The statement about nonassessability is not prohibited if not misleading and thus does not need to be in the statute. The same is true of the other statements authorized by sub. (2).

Section 203.04 is replaced by s. 631.85 so far as it is needed; the detail is not necessary.

Section 203.06 deals with the use of the standard fire insurance policy and thus is no longer needed, except for isolated provisions. Sub. (2) (a) 5 is replaced by s. 632.08. Sub. (2) (d) authorizes replacement cost coverage and is now in s. 632.05; sub. (5) authorizing companies jointly to offer contracts with several liability is now s. 631.41.

Section 203.07 is continued in substance in s. 632.09.

Section 203.08 has its counterpart in s. 631.15 (1).

Section 203.11 is replaced by s. 631.43, the scope of which is broadened to apply to all indemnity insurance instead of just fire insurance.

Section 203.13 (1) is incorporated in s. 631.09 (1) which is broadened to all lines of insurance and to include subsequently acquired information; sub. (2) is expanded to all property insurance and becomes s. 631.08 (2); sub. (3) becomes s. 631.09 (2), (4) and (6).

Section 203.21, the valued policy law, is repealed.

The first part of s. 203.22, on coinsurance, is repealed. See s. 631.45 for a more appropriate provision on coinsurance. The second part, on distribution of coverage, is also repealed.

Section 204.03 may be unnecessary, but that cannot be ascertained with assurance without an exhaustive search of the statute book; it is, therefore, continued in s. 632.17 (1), in substance.

Section 204.04 (1) and (2) have become s. 601.51. Sub. (3) has become s. 601.53.

Section 204.07 (except for the last sentence) has become s. 632.17 (2); the last sentence has become s. 632.14.

Section 204.075 is repealed; it is unsound.

Section 204.14 has become the last clause of s. 631.15 (1).

Section 204.23 is replaced by s. 632.25.

Section 204.29 (1) is too restrictive and inflexible for retention in the statute; it should be made the subject of rules. Sub. (3) is replaced by s. 631.81 (2) which is applicable to all insurance policies.

Section 204.295 has become s. 632.23, but is limited in application to liability coverages.

Section 204.30 as it now stands is the product of a score of statutes from over 4 decades; it lacks internal consistency and coherence. The scope of coverage of its subsections varies substantially. Although it has its main concern with automobile insurance, some of its provisions are considerably broader. Nevertheless it has basically been retained intact, modestly edited, except for subs. (1), (4) and (7). Except as indicated below, it will be found in s. 632.32.

Sub. (1) covers all liability insurance against personal injury as well as animal and motor vehicle liability insurance for property damage. It is slightly broadened to include all liability insurance, and is found in s. 632.22. Sub. (4) becomes s. 632.24, similarly broadened.

The principle of sub. (2) is enlarged and extended as a rule of law, not as a term of the contract, it is continued in essentially the present form in s. 632.32 (1).

Subs. (3) and (5) are continued in s. 632.32 (2) and (3). Sub. (6) is transferred to s. 632.34 (6), where it belongs by its terms. It is left unchanged.

Sub. (7) does not protect anyone nor change existing law in any way. Its probable intended effect is enacted in s. 632.34 (8), with considerable amendment.

Section 204.31 is Wisconsin's version of the model provisions for individual disability policies, promulgated by the National Association of

Insurance Commissioners. It should be continued essentially intact as a rule. Only those parts are continued in statutory form that seem important enough to justify it or where the commissioner's authority might be doubtful without statutory enactment. In this comment, only those parts are mentioned that are preserved in statutory form or are thought not to be sound.

Sub. (2) (a) 7 is continued in s. 631.13 generalized to all insurance.

Sub. (2) (a) 8 is continued as s. 632.73 except for certain exemptions that should be established by rule.

Sub. (2) (b) should not be continued. See comment to s. 631.01 (1).

*Sub. (3) (a) 1, first sentence, is continued in s. 631.13. The rest of the subdivision is unnecessary. Subd. 2.a and 2.am are continued in s. 632.76 (1); b is continued in s. 632.76 (2); subd. 3.a is continued in s. 632.78 (1); 3.b and c are adequately covered in s. 631.36 (4), except that the right to nonrenew pure accident policies at other times than anniversaries is further restricted by s. 631.36 (4) when compared with s. 204.31 (3) (a) 3 c (last sentence). Subd. 4 is covered by s. 632.74. Subd. 5 is covered by s. 631.81. The part of subd. 7 that should be statutory is continued in s. 631.81. Subd. 9 is covered by s. 632.77 (4). Subd. 12.a is covered by s. 632.71, incorporating s. 632.48. Sub. (3) (am) is continued in s. 632.78 (2).

Sub. (3) (b) 1 is replaced by s. 632.77 (1), subd. 2 by s. 632.77 (2), subds. 3 to 6 by s. 632.77 (3).

Sub. (3) (e) is replaced by s. 631.07.

Sub. (3) (i) is replaced by s. 631.15 (1) and (2).

Sub. (3m) is in part unnecessary and in part replaced by s. 632.87.

Sub. (4) (a) and (c) are replaced by s. 631.11 (1) and (2).

Sub. (5) is replaced by s. 631.81 (3); sub. (6) by s. 631.36 (2) (a) 4.

Section 204.315 becomes part of s. 632.88.

Section 204.32 is unnecessary. The only thing necessary is an appropriate definition of franchise insurance, for which see s. 600.03 (34m) (d).

Section 204.321 dealt with group disability insurance. Sub. (1) defined group insurance, but in restrictive terms that prohibited certain group policies rather than provided a proper definition. For a definition see s. 600.03 (34m) (b) in this bill.

Sub. (2) (a) 1 is covered in s. 631.11; subd. 3 is replaced by s. 631.61 (1); subd. 5 by s. 632.78 (1); and subd. 6 by s. 632.76 (1).

Par. (2) (b) is reflected in s. 631.81, s. 632.77 (4) and s. 632.71.

Part of sub. (2) (c) (last clause of first sentence) is covered by s. 632.86, part by s. 632.77 (4).

Section 204.322 dealt with blanket disability insurance. Sub. (1) is like its counterpart in s. 204.321 and has been treated in the same way. See s. 600.03 (34m) (c).

Sub. (2) (a) 1 is replaced in part by s. 631.13 and in part by s. 631.11 (1) and (2); subd. 4 is replaced by s. 632.78 (1).

Par. (b) is treated like its counterparts in s. 204.321. A part of par. (c) is replaced by s. 632.77, another by s. 632.86.

Section 204.33 is unnecessary, except for the last clause which is continued by s. 632.86. The rest is permitted because not prohibited.

Section 204.335 is continued in s. 632.88.

Section 204.34 is continued in s. 632.34, despite its ambiguities and the lack of clarity of its relationship to s. 632.32. Only editorial changes are made except for one substantive change.

Section 204.36 is replaced by s. 631.69.

Section 206.13 is replaced by s. 632.62.

Section 206.17 is comprehended within s. 631.20, et. seq.

Section 206.18 is obsolete, except for the first sentence of provision 2 which is continued as s. 632.44 (1).

Section 206.25 is replaced by s. 632.41 (1).

Section 206.36 is replaced by s. 632.62, which is broadened to all kinds of insurance and to cover voluntary dividends as well as promised dividends.

SECTION 18. 206.385 (1) of the statutes is repealed and recreated to read:

206.385 (1) No person may sell variable benefit contracts in this state except a licensed life insurance agent whose qualification to do so has been certified by the commissioner. The commissioner shall certify only those agents who pass a written examination prescribed by the commissioner.

NOTE: The repealed part of s. 206.385 (1) is replaced by s. 632.45 (1).

SECTION 19. 206.385 (3) and 206.39 of the statutes are repealed.

SECTION 20. 206.41 (5) (c) of the statutes is amended to read:

206.41 (5) (c) *Limited credit insurance license.* The commissioner may issue licenses permitting the sale of only credit life insurance as defined in ~~ss. s.~~ s. 201.04 (3c) ~~and 206.63~~, and credit accident and sickness insurance as defined in s. 201.04 (4a).

SECTION 21. 206.45 of the statutes is repealed.

SECTION 22. 206.49 of the statutes is repealed.

SECTION 23. 206.54 of the statutes is repealed.

SECTION 24. 206.60 to 206.64 of the statutes are repealed.

SECTION 25. 208.10 and 208.11 of the statutes are repealed.

NOTE: Section 206.385 (3) is repealed. The first sentence is unnecessary; the second is replaced by s. 631.20.

Section 206.39 is replaced by s. 632.42 (1).

Section 206.45 is continued in s. 631.11, which is applicable to all insurance. See comment on s. 631.11.

Most of s. 206.49 has become obsolete with the enactment of ch. 611, with which burial associations must comply. The part that should be retained becomes s. 632.41 (2).

Section 206.54, slightly modified, becomes s. 632.46 (3).

Section 206.60 is repealed and not replaced. This act repeals substantially all of the constraints that have existed on the use of mass marketing techniques in life and disability insurance. Group, franchise and blanket insurance are mass marketing devices that have won an important place in the insurance marketplace and have demonstrated great advantages over individual contracts, in certain contexts. Yet mass marketing has been needlessly subjected to excessive restriction. For example, s. 206.60 limits group life insurance to the following specified groups: employe-employer groups, creditor-debtor groups, labor union groups, trustees for employment

groups and credit unions, cooperatives or associations of public employes. Other groups which could advantageously utilize group protection were denied its use: professional associations, veterans groups, associations of retired persons, etc. Other states authorize the insurance of some kinds of groups not authorized in Wisconsin. Oregon authorizes group life insurance upon "the lives of persons who are associated in a common group for purposes other than obtaining insurance..." (Oregon Insurance Code, sec. 743.303). This act adopts the Oregon type of limitation. See s. 632.55 (1).

Section 206.60 also requires minimum participation and size for certain kinds of groups: Creditor-debtor groups, for example, have to receive new entrants at the rate of at least 100 per year and at least 75% have to participate if the insurance charges are to be paid by debtors. Smaller groups or those that might function with lower participation ratios are denied the possibility of group life protection. Group term life insurance coverage issued through employers or labor unions is also limited to a maximum between \$50,000 and \$75,000 depending on the annual compensation of the insured [see s. 206.60 (7), repealed by this act]. These amounts were increased from \$20,000/\$40,000 by the laws of 1969, ch. 346, s. 3. A limit of \$100,000 is retained in s. 632.55 (2) (created by this act).

There is another way to describe the matter. Removal of the limits will not make a great deal of difference. They are liberal enough to present no serious obstacles to the effective use of group insurance. But they are theoretically unsound and also impose no significant limitation. Hence removal makes good sense. Restrictions that do not significantly restrict merely encumber a law that is already too complex.

There are also limitations on the amount and terms of credit life, accident and sickness insurance that might be issued to an insured in ss. 201.04 (4a) and 206.63 (2) (a), which are also eliminated by this act.

Wisconsin has already opened the way completely for mass marketing of property and liability insurance in the new rating law (ch. 625), and this act takes similar steps in life and disability insurance. The statutory limitations on mass marketing methods are not necessary to protect policyholders or the public. Insurance men are able to make sound underwriting decisions on insurance policies without statutory directions on such matters as size of and extent of participation in groups, amount of coverage and other factors. Insurance companies should have maximum freedom to compete and innovate through mass marketing methods. Barriers to doing so are anticompetitive devices, not sound public policy. This act puts reliance on the ability of insurers properly to underwrite mass marketed coverages and on the ability of the marketplace to decide which approach is entitled to public favor, in each situation.

Though there is always the possibility of unfair discrimination through subsidy of groups by individual policyholders, the problem can be handled through the commissioner's power to deal with unfair discrimination directly.

Section 206.61 is repealed, but most of it is continued in a new form. A part of the introduction is preserved in s. 632.56 (4).

Sub. (1) is replaced by s. 632.56 (5).

Sub. (2) is replaced by s. 632.46 (2).

Sub. (3) is comprehended within s. 631.11.

Subs. (4), (5) and (6) are replaced by s. 632.56 (1), (2) and (3).

Sub. (7) is replaced by s. 631.61 (1).

Subs. (8), (9) and (10) are replaced by s. 632.57.

Sub. (11) is continued in s. 631.61 (1) and 632.92.

Section 206.63 is repealed. For the restrictions on mass marketing, see the above note on s. 206.60.

Sub. (1) (b) is continued in s. 632.44 (3) (a).

Sub. (2) (b) is in part continued in s. 632.44 (3) (a).

Sub. (2) (c) is continued in s. 632.60.

Sub. (3) (a) is replaced by s. 631.61 (1); par. (b) by s. 632.44 (3) (b); and sub. (4) by s. 632.44 (3) (c).

Sub. (5) is repealed as an unnecessary cross reference.

Section 206.64 (1) is replaced by s. 600.13 (34m) (d) and sub. (5) is replaced by s. 632.57. The remainder of the section is no longer necessary.

Section 208.10 is replaced by ss. 632.47 and 632.48.

Section 208.11 is replaced by s. 632.62.

SECTION 26. 208.162 of the statutes is amended to read:

208.162 Accident and health insurance and total and permanent disability insurance certificates. No domestic, foreign or alien society authorized to do business in this state shall issue or deliver in this state any certificate or other evidence of any contract of accident insurance or health insurance or of any total and permanent disability insurance contract unless and until the form thereof, together with the form of application and all riders or endorsements for use in connection therewith, has been filed with the commissioner of insurance, and approved by him as conforming to reasonable rules and regulations made by him and as not inconsistent with any other provisions of law applicable thereto. The commissioner of insurance shall, within a reasonable time after the filing of any such form, notify the society filing the same either of his approval or of his disapproval of such form. The commissioner of insurance may approve any such form which in his opinion contains provisions on any one or more of the several requirements made by him which are more favorable to the members than the ones so required. The commissioner of insurance shall have power to make, alter and supersede reasonable regulations prescribing the required, optional and prohibited provisions in such contracts, and such regulations shall conform, as far as practicable, to s. 204.31 (1) to (7). ~~Where the commissioner of insurance deems inapplicable, either in part or in their entirety, the provisions of the foregoing sections, he may prescribe the portions or summary thereof of the contract to be printed on the certificate issued to the member.~~ Any filing made hereunder shall be deemed approved unless disapproved within 30 days from the date of such filing.

SECTION 27. 209.06 and 209.07 of the statutes are repealed.

NOTE: Section 209.06 has been incorporated in s. 631.11.

Section 209.07 has become s. 632.50 and part of s. 632.71.

SECTION 28. 422.202 (1) (b) (intro.) of the statutes is amended to read:

422.202 (1) (b) (intro.) Charges or premiums for credit life insurance, as defined in ~~ss. s.~~ 201.04 (3c) and 206.63, or credit accident and sickness insurance, as defined in s. 201.04 (4a), if:

SECTION 29. 600.01 (1) of the statutes is renumbered 600.01 (1) (b).

SECTION 30. 600.01 (1) (a) of the statutes is created to read:

600.01 (1) (a) The insurance code restricts otherwise legitimate business activity and what the code does not prohibit is authorized unless contrary to other provisions of the law of this state.

NOTE: There is a widespread but entirely erroneous notion that the provisions of the insurance code constitute, in general, an enabling act. On the contrary, insurance is an area of free contractual activity except as restricted by the insurance code. It is well to have that point of departure clearly established by the statutes.

SECTION 31. 600.03 (28) of the statutes is amended to read:

600.03 (28) "Interest of the insured" when used in an insurance policy includes the interest of the named insured and of ~~his spouse whenever the property insured is owned~~ any other person with whom the named insured holds the insured property in joint tenancy.

SECTION 32. 600.03 (34m) of the statutes is created to read:

600.03 (34m) (a) "Policy" means any document other than a group certificate used to prescribe in writing the terms of an insurance contract, including endorsements and riders and service contracts issued by motor clubs.

(b) A "group insurance policy" is a policy covering a group of persons, and issued to a policyholder in behalf of the group for the benefit of group members who are selected under procedures defined in the policy or agreements collateral thereto, with or without members of their families or dependents.

(c) A "blanket insurance policy" is a group policy covering unscheduled classes of persons, with the persons insured to be determined by definition of the class with or without designation of the persons covered but without any individual underwriting.

(d) "Franchise insurance" is insurance provided in individual policies through a mass marketing arrangement involving a defined class of persons related in some other way than through the purchase of insurance.

NOTE: Present statutes [ss. 204.321 (1), 204.322 (1), 206.60] include "definitions" of group and blanket insurance which are less definitions than rules specifying the circumstances under which group and blanket insurance are lawful. These paragraphs seek to define these notions through their essential characteristics. Any rules restricting their use, if justified at all, belong in the chapters dealing with specific insurance contracts and with unfair trade practices. "Group" is used as a generic term that includes "blanket".

SECTION 33. 601.20 of the statutes is renumbered 601.20 (1).

SECTION 34. 601.20 (1) (title) and (3) of the statutes are created to read:

601.20 (1) (title) AUTHORIZATION TO FORM COUNCILS AND COMMITTEES.

(3) REQUIRED FORMS ADVISORY COUNCIL. The commissioner shall create a forms advisory council under sub. (1), with enough appointed members from different parts of the insurance industry to make possible the formation of subcommittees with special knowledge of different kinds of insurance. He may also appoint consumers with expertise in insurance to be members of the council.

NOTE: This council is created to aid the commissioner in the development of authorized clauses. See s. 631.23. Members should come from but should not represent different branches of the industry. The commissioner should also appoint knowledgeable consumers to the council. They can help protect the commissioner from allegations of subservience to the industry. There should be no difficulty in finding some competent consumer representatives to serve; it goes without saying that the industry can

supply the necessary talent. The structure and procedures of the council should be left in the control of the commissioner, not specifically provided by statute.

The council created by this subsection could have identical or overlapping membership with a council created under any other subsection.

SECTION 35. 601.51 of the statutes is created to read:

601.51 Provision of certified copies and notices. (1) **CERTIFIED COPIES.** On request of any insurer authorized to do a surety business and its payment of the fee under s. 601.31 (23), the commissioner shall mail a certified copy of its certificate of authority to any designated public officer in this state who requires such a certificate before accepting a bond. That public officer shall file it. Whenever a certified copy has been furnished to a public officer it is unnecessary, while the certificate remains effective, to attach a copy of it to any instrument of suretyship filed with him.

(2) **NOTICE OF REVOCATION OF CERTIFICATE.** Whenever the commissioner revokes the certificate of authority of any insurer authorized to do a surety business, he shall immediately give notice thereof to each officer to whom he has sent a certified copy under sub. (1).

NOTE: This continues the substance of s. 204.04 (1) and (2).

SECTION 36. 601.53 of the statutes is created to read:

601.53 Insolvency notices. (1) **INSURERS DOING A SURETY BUSINESS.** Whenever any authorized insurer doing a surety business has filed a petition for receivership, or is in the hands of a receiver under ch. 645 or otherwise or the commissioner has reason to believe the company is in financial difficulty or has unreasonably failed to carry out any of its contracts, he shall immediately notify every county judge and the clerks of all courts of record in the state. Upon the receipt of the notice it is the duty of county judges and clerks of courts of record to notify and require every fiduciary that has filed a bond on which the company is surety, forthwith to file a new bond with a new surety.

(2) **OTHER.** The commissioner as liquidator of an insurer shall send notices as provided in s. 645.47.

NOTE: Sub. (1) continues the substance of s. 204.04 (3). Sub. (2) is new and is a useful cross reference.

SECTION 37. 612.51 (1) (a) of the statutes is repealed and recreated to read:

612.51 (1) (a) That it is inequitable, unfairly discriminatory, misleading, deceptive, obscure or encourages misrepresentation, including cases where the form:

1. Is misleading because its benefits are too restricted to achieve the purposes for which the policy is sold;
2. Contains provisions whose natural consequence is to obscure or lessen competition;
3. Is unnecessarily verbose or complex in language; or
4. Is misleading, deceptive or obscure because of such physical aspects as format, typography, style, color, material or organization.

SECTION 38. 612.51 (1) (b) and (c) of the statutes are amended to read:

612.51 (1) (b) That it provides ~~coverage or~~ benefits or contains other provisions that would endanger the solidity of the insurer;

(c) That in the case of the policy, though not of riders and endorsements, it fails to provide the exact name of the insurer and the full address of its home office; or

NOTE: The changes in SECTIONS 37 and 38 are made so that s. 612.51 will follow as closely as possible the language of s. 631.20.

SECTION 39. 613.02 (1) (b) of the statutes, as created by chapter _____ (Senate Bill 17), laws of 1975, is amended to read:

613.02 (1) (b) Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to ss. ~~204.315, 204.335, 209.04, and 610.43, 632.86, 632.87, 632.89 and 632.90~~ and chs. 207, 600, 601, 617, 620, 623, 625, 631, 632 and 645 and to no other insurance laws.

SECTION 40. 613.08 of the statutes, as created by chapter _____ (Senate Bill 17), laws of 1975, is repealed.

NOTE: Section 613.08 is no longer needed when this chapter is enacted, inasmuch as ss. 631.20 to 631.27 will apply to service insurance contracts.

SECTION 41. Chapter 631 of the statutes is repealed and recreated to read:

CHAPTER 631

INSURANCE CONTRACTS GENERALLY

INTRODUCTORY NOTE: The contractual rights and duties of insurers and insureds, in our legal system, are determined primarily by the insurance contract as interpreted by an enormous body of case law. The terms of the contract in turn are largely the product of free choice by the insurer, with occasional participation of the policyholder where he is in a competitive position that enables him to negotiate for special terms. However, a few aspects of contract terms are controlled and supplemented by statutes, administrative determinations of the commissioner and a few limiting principles laid down in court decisions. Since the beginning of insurance regulation the number of statutory provisions regarding insurance contracts has constantly increased. In recent decades, the National Association of Insurance Commissioners (NAIC) has been very active in producing model bills relating to contract terms.

Some control over policy forms is necessary for the adequate protection of insureds, although some contracts, such as reinsurance and ocean marine insurance, are and should be essentially free from restriction. But the present pattern of control creates many problems, especially at the opposite end of the spectrum, where control is intensive. For example, the statutes and administrative rules which prescribe word for word the terms of the fire insurance policy (s. 203.01) have long been criticized as obstacles to progress in the fire insurance business. In particular, the standard policy impedes "development of simple and clear multiple line contracts." A.B.A., Current Annotations of the 1943 New York Standard Fire Insurance Policy, (1966) p. 7. See also Crichton, The Statutory Fire Insurance Policy, 1951 A.B.A. Proceedings of the Section of Insurance Law 131, 137-38. The original basic objective of the standard fire policy, uniformity, can be frustrated by the fact that its terms can be much varied by special endorsements, by conflicting court decisions in different states, and by statutory provisions in apparent conflict with the standard policy. See discussion in Introductory Note to Subchapter I of Chapter 632.

In other lines the statutes prescribe only part of the policy and generally allow free contractual development so long as a limited number of rules are complied with. But these statutes, too, have a tendency to be overly detailed, and to be slow to respond to new insurance developments.

Some statutes do not prescribe terms, but require the commissioner's approval for new policy forms, guiding him only by such general standards as "unjust," "unfair," "inequitable," "misleading," "deceptive," and "encouraging misrepresentation". An example is s. 200.26 (3) (c), for

nonprofit service plans where the commissioner has had the burden of determining in each instance whether contract terms, which are free from statutory prescription, meet the specified general standards.

Some divergence among lines of business is appropriate, but in general it seems best to steer a middle course that would at once subject most contracts to reasonable control, and would neither impose intensive and detailed statutory regimentation nor confer unlimited discretion on the commissioner. As much room should be left for the free play of competitive forces as is consistent with necessary protection of insureds. A way of balancing conflicting purposes is to replace much of the detail now elaborated in the statutes by a general statement of principles, supplemented by rules, which would give ample room both for evolution of the institution and for adjustment of contracts to meet the particular needs of special cases.

Some of the most important insurance statutes of the nineteenth century delegated the task of prescribing policy forms to the insurance commissioner. Constitutional challenge based on the notion that this was an unlawful delegation of legislative power led to abandonment of this approach. See O'Neil v. American Fire Insurance Company (1895), 160 Pa. 72, 30 Atl. 943; Dowling v. Lancashire Fire Insurance Company (1896), 92 Wis. 63, 65 N.W. 738. Under present constitutional doctrine similar objections would have only a remote chance of prevailing, if the delegation is defined by meaningful standards. See, e.g., State ex. rel. Wisconsin Inspection Bureau v. Whitman (1928), 196 Wis. 472, 505, 220 N.W. 929, 941.

While insurance department staffs may once have lacked the knowledge and experience to review and evaluate policy forms properly, the better departments now can do it adequately if appropriate resources are devoted to the task. Certainly that is true in Wisconsin.

The most important contribution to transparency of the market (i.e., a condition in which buyers can easily evaluate their options) would be a higher degree of standardization of those parts of policy forms that are not or should not be subjects of bargaining, focusing the buyer's attention instead on a limited number of crucial provisions appropriate for competition. Insurers should compete on clearly formulated variations in insurance benefits, premiums, and a few other major clauses — and very little on details of an ancillary nature such as the period for notice of loss or the appraisal procedure. Such ancillary clauses could be uniform without obstructing competition. However, development of such uniformity can only be encouraged, not mandated, by the provisions of this law. See, e.g., s. 631.23.

It also seems possible to devise a common format and organization of insurance policies in particular lines, i.e., for the order in which provisions are arranged in the policy and the manner in which they are displayed. This would facilitate understanding and comparison without obstructing innovation. Much of this occurs in the normal course of the business. The automobile policy is a good example.

Besides helping the policyholder, an approach to uniformity of form and content would add to the efficiency of regulation. When the number and diversity of policy forms submitted for approval is great, thorough examination is impossible. Greater uniformity would also improve the quality of statistics. The rigidity of statutory standard forms is undesirable, of course, as is suppression of all variation, which can contribute to meaningful competition if it is not excessive and is not mere gimmickry.

Of course, standardization cannot be relied on as the primary instrument for protecting the policyholder. Some contracts or provisions are not suitable for standardization. Moreover, there should be room for reasonable competition on other provisions than price. The legislature and the insurance department must continue to guard the ramparts — to make sure that policy terms are fair and reasonable in print and in application. Rules, guided by statutory standards explicit enough to make the legislature's ideas of public policy clear and to avoid the challenge of unconstitutional delegation, can help achieve these objectives, without forbidding innovative variation.

Most existing statutes place their emphasis on requiring in the policy certain substantive contract terms considered essential for the protection of the insured. To a considerable extent they are based on uniform laws developed by the National Association of Insurance Commissioners. The beneficial results of interstate cooperation should be preserved. But it is not necessary to do so in statutory form, which leads to rigidity and excessive complexity. It is sufficient to include adherence to recommendations of the NAIC as a standard for the commissioner in his rule-making activity; a model NAIC statute or rule should usually be a sufficient condition for promulgation of a rule. But many model NAIC statutes are too detailed and limiting. In this draft considerable effort has been expended toward liberalizing the approach the NAIC models have tended to rigidify.

Of course, rules implementing statutory standards cannot be the sole basis of policy control. Some basic problems of public policy the legislature will wish to resolve specifically by statute. An example is legislation concerning the renewal and cancellation of insurance policies, especially where tightness of the market has produced numerous complaints about allegedly arbitrary actions. See s. 631.36, which was created by ch. 144, laws of 1969, extending to most insurance policies a principle earlier applicable only to automobile insurance.

Another important question is the kind of insurance that should be subject to policy control. In reinsurance, the parties allegedly approach equal knowledge; if that is true, protection of the ceding insurer can be foregone. It is true, of course, that reinsurance terms may affect the interests of the ultimate insureds; for this reason some scrutiny is justified. Similarly, there are in all lines of insurance large policyholders who can employ expert advisers and are quite able to care for themselves. A general liberalization of policy forms control for them has been proposed as one method to solve the surplus lines problem. An effort to permit such distinctions is made in s. 631.01 (5).

Finally, the distinction between "form" and "contract" must be kept clearly in mind. Only forms are subject to approval and a degree of standardization, but even individual or "unformed" contracts are subject to the rules of law enunciated in these chapters.

Under s. 631.27 the commissioner may require a rule of law to be inserted in contracts, whether it is a formed or an individualized contract.

SUBCHAPTER I GENERAL RULES

631.01 Application of statutes. (1) **GENERAL.** This chapter and ch. 632 apply to all insurance policies delivered or issued for delivery in this state, on property ordinarily located in this state, on persons residing in this state when the policy is issued, or on business operations in this state, except:

(a) As provided in ss. 600.01 and 618.42;

(b) On business operations in this state if the contract is negotiated outside this state and if the operations in this state are incidental or subordinate to operations outside this state; and

(c) As otherwise provided in the statutes.

(2) REINSURANCE. Sections 631.05, 631.15 (1), 631.41, 631.45 and 631.81 apply to contracts used in reinsurance; the commissioner may specify by rule that reinsurance contracts are subject to other provisions of this chapter and ch. 632 if he finds that the interests of Wisconsin insureds, of ceding insurers domiciled in this state or of the public in this state so require.

(3) OCEAN MARINE INSURANCE. Sections 631.03 to 631.09, 631.15 (1) and (4), 631.20 (1), 631.27, 631.41 to 631.51, 631.64 to 631.81 and 631.85 apply to ocean marine insurance; the commissioner may specify by rule that ocean marine contracts are subject to other provisions of this chapter if he finds that the interests of Wisconsin insureds or creditors or of the public in this state so require.

(4) GROUP POLICIES AND ANNUITIES FOR ELEEMOSYNARY INSTITUTIONS. This chapter and ch. 632 do not apply to group policies or annuities provided on a basis as uniform nationally as state statutes permit to educational, scientific research, religious or charitable institutions organized without profit to any person, for the benefit of employes of such institutions. The commissioner may by order subject such contracts issued by a particular insurer to this chapter or ch. 632 or any portion of either if he finds, after a hearing, that the interests of Wisconsin insureds or creditors or the public of this state so require.

(5) OTHER EXCEPTIONS. The commissioner may by rule exempt any class of insurance contract or insurer from any or all of the provisions of this chapter and ch. 632 if the interests of Wisconsin insureds or creditors or of the public of this state do not require such regulation.

NOTE: Sub. (1) applies to contracts used in this state. The application to otherwise unregulated contracts issued by Wisconsin insurers outside this state, presently imposed by s. 204.31 (2) (b), does not serve any significant Wisconsin public policy purpose and is abandoned. Active regulation is limited to "forms". "Form" is defined in s. 600.03 (21). Most provisions of chs. 631 and 632 apply to all contracts, however, whether "formed" or not.

Sub. (2) exempts from the filing and approval requirements of this chapter a case in which the policyholder can generally protect himself adequately and where the benefits of administrative control of the contract terms would not be worth the cost. In reinsurance, the parties are both professionals. Only a few contract principles are applied to reinsurance.

Ocean marine insurance is also widely regarded as a similar case, both parties to the transaction being experienced or expertly advised, with the policyholder often being in a superior economic position to the insurer. This is an oversimplification, however, particularly with increasing participation in world trade by small businessmen. Many of them need the protection of regulation. But ocean marine is seldom sold except through brokers who, as a group, can be a powerful counterweight to the insurers. Also, there are special problems in controlling ocean marine insurance, arising from its international character. Thus wisdom seems to suggest for active regulation a filing requirement only, which is continued under sub. (3). More general insurance contract principles are made applicable to ocean marine contracts than to reinsurance, however. On the whole they do not involve regulatory intervention.

Sub. (4) continues present s. 631.01 with slight editorial changes.

Sub. (5) gives the commissioner power to exempt other classes of forms, too. One appropriate exemption would be large policies purchased by insureds advised by professional buyers. This should especially include large commercial enterprises doing business across state lines and primarily outside this state except where the type of insurance is such as to make Wisconsin control desirable. The exact limits of the exemption should be defined by rule, not statute, after getting advice from both buyers and insurers.

631.03 Insurance in mutuals. Any mutual under ch. 611 or 612 and any service corporation under ch. 613 may issue policies to any public or private corporation, board or association or to any unit of government, in any place in this state or elsewhere where it is authorized to do an insurance business. Any public or private corporation, board or association or unit of government in this state that is authorized to acquire insurance may make applications, enter into agreements for and hold policies in any mutual insurer or service corporation authorized under ch. 611, 612, 613 or 618.

NOTE: This continues s. 201.17, edited and enlarged. It is needed to make certain that private and public corporations and unincorporated associations are permitted to buy insurance from a mutual or service corporation. This latter is added to generalize the stated principle. The first sentence is probably not necessary but is continued to avoid the possible negative implication that might result from its elimination.

631.05 Oral contracts of insurance and binders. No provision of this code may be interpreted to forbid an oral contract of insurance or issuance of a written binder. The insurer shall issue a policy as soon as reasonably possible after issuance of any binder or negotiation of an oral contract.

NOTE: This section is intended to eliminate any such notion as that resulting in the decision in Schilbrek v. Inter-Ocean Gas. Co. (1923), 180 Wis. 120, 192 N.W. 456, that oral contracts or binders are impliedly forbidden because of particular sections of the code, especially those requiring certain contractual provisions. Of course this section does not require their use, either. However, the oral insurance contract is a useful — indeed, necessary — device in some kinds of insurance; so also is the written binder. Any doubt about validity should be eliminated, in any case in which the general law of insurance contracts would otherwise find them valid. The statute of frauds has application to insurance only for unusual situations, apart from contracts that are promises “to answer for the debt, default or miscarriage of another person”.

631.07 Insurable interest and consent. (1) **INSURABLE INTEREST.** No insurer may knowingly issue a policy to a person without an insurable interest in the subject of the insurance.

(2) **CONSENT IN LIFE AND DISABILITY INSURANCE.** Except under sub. (3), no insurer may knowingly issue an individual life or disability insurance policy to a person other than the one whose life or health is at risk unless the latter has given written consent to the issuance of the policy. Consent may be expressed by knowingly signing the application for the insurance with knowledge of the nature of the document, or in any other reasonable way.

(3) **CASES WHERE CONSENT IS UNNECESSARY OR MAY BE GIVEN BY ANOTHER.** (a) *Consent unnecessary.* A life or disability insurance policy may be taken out without consent in the following cases:

1. A person may obtain insurance on his dependent who does not have legal capacity;
2. A creditor may at the expense of the creditor obtain life or disability insurance on the debtor in an amount reasonably related to the amount of the debt;
3. A person may obtain a life or disability insurance policy on members of his family living with or dependent on him;
4. A person may obtain a disability insurance policy on others that would merely indemnify against expenses the policyholder would be legally or morally obligated to pay; and
5. The commissioner may promulgate rules permitting issuance of insurance for a limited term on the life or health of a person serving outside the continental United States in the public service of the United States, provided the policyholder is closely related by blood or by marriage to the person whose life or health is insured.

(b) *Consent given by another.* Consent may be given by another in the following cases:

1. A parent, a guardian of the person, or a person having legal custody as defined in s. 48.02 (10) may consent to the issuance of a policy on a dependent child.
2. A grandparent may consent to the issuance of life or disability insurance on a grandchild.
3. A court of general jurisdiction may give consent on ex parte application on the showing of any facts the court considers sufficient to justify such insurance.

(4) **EFFECT OF LACK OF INSURABLE INTEREST OR CONSENT.** No insurance policy is invalid merely because the policyholder lacks insurable interest or because consent has not been given, but a court with appropriate jurisdiction may order the proceeds to be paid to someone other than the person to whom the policy is designated to be payable, who is equitably entitled thereto, or may create a constructive trust in the proceeds or a part thereof, subject to terms and conditions of the policy other than those relating to insurable interest or consent.

NOTE: Insurable interest makes sense as an underwriting restriction but not as a prerequisite to the validity of an insurance policy. If viewed as a disincentive to deliberate loss-causing, it is largely ineffective; most known cases of homicide or of arson for insurance proceeds were committed by persons with a clear insurable interest. If viewed as a disincentive to gambling, it need only be pointed out that the house's cut is smaller in Las Vegas or at the local racetrack. The best way to discourage insurers from issuing insurance policies to persons without insurable interest is to make them pay if they do, not to permit them freely to issue such policies knowing that they have a good public policy defense that lets them off the hook whenever a loss occurs. The court should have power to order the proceeds paid as justice dictates.

Consent of the person at risk is the preferable device for protecting him in personal insurance. Some exceptions are necessary. It should be noted that lack of consent, too, does not invalidate the policy but makes it possible for a court to decide that the proceeds should go to someone other than as provided by the contract.

This section is primarily concerned with problems heretofore governed by case law; it incidentally also replaces s. 204.31 (3) (e).

631.08 Mistakes in contracts. (1) **GENERAL.** Except as otherwise provided in this code, general contract law applies to mistakes in insurance contracts.

(2) **PERSON TO WHOM PROCEEDS PAYABLE IN PROPERTY INSURANCE.** Mistake in designating the person to whom the insurance is payable in a policy of property insurance does not void the policy nor constitute a defense for the insurer unless the mistake was due to misrepresentation or concealment by the owner of the property or someone representing him in procuring the policy, or unless the company would not have issued or continued the policy if it had known the truth.

NOTE: Sub. (1) is new.

Sub. (2) continues s. 203.13 (2), broadening it from fire to all property insurance.

631.09 Knowledge and acts of agents. (1) **IMPUTATION OF KNOWLEDGE.** An insurer is deemed to know any fact material to the risk or which breaches a condition of the policy, if the agent who bound the insurer or issued the policy or transmitted the application to the insurer knew it at the time he acted, or if thereafter any of the insurer's agents with whom the policyholder is then dealing as agent of the insurer learns it in the course of his dealing with the policyholder, and knows that it pertains to a policy written by the insurer.

(2) **ACTS OF AGENT.** A failure by any policyholder or insured to perform an act required to perfect his rights under the policy, or failure to perform the act in the time and manner prescribed, does not affect the insurer's obligations under the policy if the failure was caused by an act, statement or representation or omission to perform a duty by an agent of the insurer who has apparent authority, whether or not he was within the actual scope of his authority.

(3) **EFFECT OF NOTICE TO AGENT.** Notice given by or on behalf of the policyholder or insured to any authorized agent of the insurer with particulars sufficient to identify the policy is notice to the insurer.

(4) **COLLUSION.** Subsections (1) and (2) do not apply if the agent and the policyholder or insured acted in collusion to deceive or defraud the insurer, or if the policyholder or insured knew the agent was acting beyond the scope of his authority.

(5) **GROUP POLICYHOLDER NOT AGENT.** No person is an agent of an insurer merely because he is a policyholder of a group insurance policy.

(6) **LIABILITY UNDER COMMON LAW.** This section does not diminish any liability of the insurer that would exist under common law.

NOTE: Sub. (1) extends present s. 203.13 (1) from some to all lines of insurance, and (2) and (4) make the same extension of s. 203.13 (3) and also extend it from conduct relating to loss to all kinds of conduct. This is an area in which courts deal liberally with insureds where justice seems to require it; thus, it is doubtful if these purported extensions change rights significantly. The effect does not depend on the agent's actual authority but on his acting in the normal course of his activity as an agent. Of course it must be as an agent who is dealing with the particular policyholder, and sub. (1) is expressly so limited; sub. (2) deals with cases where the agent is in fact dealing with the policyholder.

Sub. (3) is a generalized version of former s. 204.30 (2) which was applicable only to liability insurance and which was directed to receipt of notice only by "any authorized agent of the insurer within this state". There is precedent for broadening the required application of the notice requirement as here written. It is already voluntarily used for notice of loss in many widely used contracts such as the family automobile policy, the open stock burglary policy, the commercial blanket bond, and the comprehensive personal liability policy. All permit notice to the "company or any of its

authorized agents". The required provision, in its less stringent form, is also continued in s. 632.32 (1).

Sub. (5) is a precaution against finding a group policyholder to be an agent merely because he performs administrative acts in connection with the policy.

Sub. (6) continues the last sentence of s. 203.13 (3), generalized to all lines. It preserves common law protection of the insured.

631.11 Representations, warranties and conditions. (1) ENTIRE CONTRACT. (a) *Signed application for policy.* No statement, representation or warranty made by any person in the negotiation for an insurance contract affects the insurer's obligations under the policy unless it is stated in the policy, or in a written application signed by such person, a copy of which is made a part of the policy by attachment or endorsement.

(b) *Copy to be made available.* The policyholder and any person whose life or health is insured under the policy may request in writing a copy of the application if he did not receive the policy or a copy of it, or if the policy has been reinstated or renewed without attachment of a copy of the original application. If the insurer does not deliver or mail a copy as requested within 15 working days after receipt of the request by the insurer or its agent, or in the case of a group policy certificate holder does not inform him within the same period how he may inspect the policy and application during normal business hours at a place reasonably convenient to the certificate holder, nothing in the application affects the insurer's obligations under the policy to the person making the request. The person whose life or health is insured under a group policy has the same right to request a copy of any document subject to par. (c).

(c) *Signed application or enrollment form for group insurance certificate.* No statement, representation or warranty made by or on behalf of a particular certificate holder under a group policy affects the insurer's obligations under the certificate unless it is stated in the certificate, or in a written document signed by the certificate holder, a copy of which is supplied to the certificate holder or the beneficiary whose rights would be affected.

(2) EFFECT OF MISREPRESENTATION OR BREACH OF AFFIRMATIVE WARRANTY. No misrepresentation or breach of an affirmative warranty affects the insurer's obligations under the policy unless the insurer relies on it and it is either material or is made with intent to deceive, or unless the fact misrepresented or falsely warranted contributes to the loss.

(3) EFFECT OF FAILURE OF CONDITION OR BREACH OF PROMISSORY WARRANTY. No failure of a condition prior to the loss and no breach of a promissory warranty affects the insurer's obligations under the policy unless it exists at the time of the loss and either increases the risk at the time of the loss or contributes to the loss. This subsection does not apply to failure to tender payment of premium.

(4) EFFECT OF INSURER'S KNOWLEDGE. No misrepresentation made by or on behalf of the policyholder and no breach of an affirmative warranty or failure of a condition affects the insurer's obligations under the policy if at the time the policy is issued the insurer has either constructive knowledge of the facts under s. 631.09 (1) or actual knowledge. If the application is in the handwriting of the applicant, the insurer does not have constructive knowledge under s. 631.09 (1) merely because of the agent's knowledge. If after issuance of a policy the insurer acquires knowledge of sufficient facts to constitute a general defense to all claims under the policy, the defense is not available unless the insurer notifies the insured within 60 days after acquiring such knowledge of its intention to defend against a claim if one should arise,

or within 120 days if it is deemed necessary by the insurer to secure additional medical information.

(5) **FRATERNALS.** This section applies to fraternal, as defined in s. 208.01.

NOTE: This is a subject on which books might easily be written. The rigors of the harsh common law doctrines of representation, warranties and conditions have here been softened in conformity to the modern tendency of both case law and statute. The basic provision of the current law is s. 209.06; this proposed section is like s. 209.06, and unlike the corresponding statutes of many other states, in applying to all lines of insurance. But s. 209.06 is not a complete treatment of the subject, in many respects.

For example, it does not deal with failures of condition. This section explicitly brings failures of condition within the statutory provision. See sub. (3). Whether this actually changes anything is less certain. Insurance warranties, unlike sales warranties, are not obligations but have the effect of conditions. Some of the writing on the subject, including the writing of Patterson, treats the 2 terms as synonymous. But there is a line of cases, notably in Massachusetts, that distinguishes the 2 and allows insurers to evade a warranty statute by couching the provision in conditional language. In view of the existence of those cases, it is better to bring conditions explicitly into the statute. An alternative, taken by New York s. 150, is to define warranty broadly to include a condition. The present approach is better.

Sub. (1) makes misrepresentations and breach of warranty unavailable to the insurer unless contained in the policy or an attached and signed application. In this it follows ss. 204.31 (4) (a), 204.321 (2) (a) 1 and 206.61 (3) but appropriately generalizes the rule to all insurance. Section 206.45 is similar and is incorporated herein. For par. (b), see s. 204.31 (4) (a) and 206.45.

Sub. (2) carefully balances insurer's and insured's interests. Contribution to the loss is sufficient for avoidance. Insurer reliance plus either materiality or fraud is also sufficient. Nothing else will do. It would be possible to define materiality. But there is a great body of case law on it and unless the decision were made to codify insurance contract law as a whole it is better to leave its meaning to the courts. It is only occasionally that anything that contributes to the loss is not also material, so that these 2 alternative grounds overlap greatly. However, it is possible that a fact that would be considered immaterial by the jury, on the evidence that gets placed before it, would be decided by the jury to have contributed to the loss. Thus, addition of the contribution clause is a hedge against the "juridical" risk. It may also be argued that a fraudulent misrepresentation should be no defense if it is not material, i.e., would not have affected the underwriting decision of the insurer (or of a "reasonable" insurer, if that is the test of materiality). However, because fraud is seldom present unless a question is material this is also mainly a hedge against the juridical risk.

Some statutes are more generous to the insured. They reject reliance and materiality as sufficient criteria of effectiveness of a misrepresentation or false warranty. They insist on contribution to the loss as the necessary and sufficient condition. Such statutes are basically unfair to the insurer. They remove the pressure on the insured to tell the truth. He can lie with impunity, for the worst that will happen if he is caught is loss of the part of his coverage for which he either did not pay because his lie resulted in a lower premium, or for which he could not have obtained protection at any price

because the insurer would either have refused to issue the policy at all or would have insisted on attaching an excluding endorsement.

This draft seeks a better balance, protecting the insurer against fraud and violations of conditions that would preclude acceptance of the risk, and giving it access to the information it needs to underwrite, without giving it arbitrary power over the insured through application of the harsh common law doctrines.

Sub. (4) enforces the requirement of reliance by the insurer. Because many cases of constructive knowledge involve allegedly dishonest agents who are said to fill out applications inconsistently with what the applicant has told them, with a consequent conflict of testimony between agent and applicant, one useful way to deal with a fairly widespread problem is to induce the insurer to force its agents to have the policyholders themselves fill out the applications. Overcoming the constructive knowledge doctrine may provide the necessary incentive to the insurer to put the requisite pressure on its agents. If it cannot, it does not deserve the protection.

Sub. (5) continues s. 209.06 (3).

This section replaces not only s. 209.06, but also parts of ss. 204.31 (4) (a), 204.321 (2) (a) 1 and 206.61 (3).

631.13 Incorporation by reference. No insurance contract may contain any agreement or incorporate any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery except that:

(1) **RATES.** Any policy may by reference incorporate rate schedules and classifications of risks and short-rate tables filed with the commissioner; and

(2) **COMPLEX CONTRACTS.** By rule or order or by approval of a form the commissioner may authorize for complex contracts incorporation by reference of provisions for administrative arrangements, premium schedules and payment procedures.

NOTE: This continues a portion of s. 201.19 (1) as well as s. 201.53 (1) and numerous other provisions. The first exception is from s. 204.31 (2) (a) 7, but is generalized to all kinds of insurance. The 2 exceptions create no problems for consumers; the second would be particularly useful for complex group contracts.

631.15 Contract rights under noncomplying policies. (1) **ENFORCEMENT OF POLICY TERMS.** Except as otherwise specifically provided by statute, a policy is enforceable against the insurer according to its terms, even if it exceeds the authority of the insurer.

(2) **ENFORCEMENT OF POLICIES PROPERLY FILED AND NOT DISAPPROVED.** A policy issued in compliance with s. 631.20 (1) is, if it violates a specific statutory provision other than s. 631.20 (2), enforceable against the insurer as if it conformed to the violated statute.

(3) **ENFORCEMENT OF POLICIES ISSUED WITHOUT FILING OR APPROVAL.** A policy issued in violation of s. 631.20 (1) or (3) is, if it violates a rule, or a statute other than s. 631.20 (2), enforceable against the insurer as if it conformed to the statute or the rule.

(4) **REFORMATION OF CONTRACT.** Upon written request of the policyholder or an insured whose rights under the policy are continuing and not transitory, an insurer shall reform and reissue its written policy to comply with the requirements of the law existing at the date of issue of the policy.

NOTE: This section deals with the “private law” consequences of violation of s. 631.20. “Private law” is concerned with the rights of the parties among themselves; “public law” with the application of official sanctions. The “public law” effects are simply stated: the insurer is subject to the sanctions provided in chs. 601 and 645.

How far violation should be punished more directly by an alteration of private law rights, i.e., the rights of the parties among themselves, is a much more complex question. First, insured persons should always be able to enforce rights given them under the contract as issued, unless the contract violates a public policy so important that nullity of the contract is specified by statute as the consequence of violation. Sub. (1) provides this consequence, with the first qualifying clause leaving the door open for invalidation of a contract altogether if the public policy of another statute states that specifically. It follows but enlarges s. 203.08. The last clause continues and broadens the effect of s. 204.14. It may be unnecessary because of ss. 180.06 and 181.05, incorporated in ss. 611.07 (2) and 612.03, but is inserted for additional assurance.

Second, contracts issued with terms deviating in favor of the insurer from those prescribed by a specific statute should be, in effect, reformed to accord with the statute and then be enforced against the insurer. This is standard common law doctrine.

Contracts issued in violation of a rule should also be thus reformed and enforced against the insurer as reformed if, and only if, the insurer has either failed to file under s. 631.20 (1) or having filed, issued its contracts when they have been disapproved under s. 631.20 (1) or (3). If they have been filed but not disapproved, the insurer should not be punished with private law sanctions, i.e., the contract should not be directly affected. Thus, a rule is not given “private law” effect if the commissioner has had his chance to disapprove and has not done so, even if the rule is quite explicit. A statute, however, is given private law effect under those circumstances.

Similarly, if the form used is disapproved and the ground of disapproval is one of those grounds specified in s. 631.20 (2) other than violation of other statutes or a properly promulgated rule there should be no private law consequences, but only the public law sanctions of chs. 601 and 645. The insurer should be “punished” through public law devices and the contract must be given effect in accordance with its terms. It cannot appropriately be nullified, because that would punish the insured; it cannot be reformed because there is no precise language to which to reform it.

This section thus tries to determine and clearly state the private law effects of various violations more precisely than they have been previously, but in essence the result is in accord with common law doctrine and the public policy of the Wisconsin statutes, as found in ss. 203.08 and 204.31 (3) (i). It appropriately gives lesser effect to a rule than to a statute, by declining to give private law effect to a violation of a rule unless there is also violation of the filing or disapproval provisions of the statute.

Sub. (4) permits the policyholder actually to get a proper contract into his possession.

SUBCHAPTER II APPROVAL OF FORMS

PRELIMINARY NOTE: The version of this subchapter appearing here is as liberal vis-a-vis the industry as it is believed the laws can safely be. It is

believed, however, that it will provide adequate protection to consumers and will also be acceptable to the insurance industry, even if it is not the optimal set of approval provisions. It is a procedure that will be acceptable to the affected industry, although the industry (or parts of it) would prefer even more liberal treatment.

631.20 Filing and approval of forms. (1) **FILING.** No form subject to s. 631.01 (1), except as exempted under s. 631.01 (2) to (5), may be used unless it has been filed with and approved by the commissioner. It is deemed approved if it is not disapproved by him within 30 days after filing, or within a 30-day extension of that period ordered by him prior to the expiration of the first 30 days.

(2) **GROUNDS FOR DISAPPROVAL.** The commissioner may disapprove a form if he finds:

(a) That it is inequitable, unfairly discriminatory, misleading, deceptive, obscure or encourages misrepresentation, including cases where the form:

1. Is misleading because its benefits are too restricted to achieve the purposes for which the policy is sold;

2. Contains provisions whose natural consequence is to obscure or lessen competition;

3. Is unnecessarily verbose or complex in language; or

4. Is misleading, deceptive or obscure because of such physical aspects as format, typography, style, color, material or organization;

(b) That it provides benefits or contains other provisions that endanger the solidity of the insurer;

(c) That in the case of the policy, though not of riders and endorsements, it fails to provide the exact name of the insurer and the full address of its home office; or

(d) That it violates a statute or a rule promulgated by the commissioner, or is otherwise contrary to law.

(3) **SUBSEQUENT DISAPPROVAL.** Whenever the commissioner finds, after a hearing, that a form approved or deemed to be approved under sub. (1) would be disapproved under sub. (2) if newly filed, he may order that on or before a date not less than 30 nor more than 90 days after the order the use of the form shall be discontinued or appropriate changes shall be made.

(4) **CONTENTS OF ORDER OF DISAPPROVAL.** The commissioner's disapproval must be in writing and constitutes an order. It must state the reasons for his disapproval sufficiently explicitly that the insurer is provided reasonable guidance in reformulating its proposals.

(5) **EXPLICIT APPROVAL OF CERTAIN CLAUSES.** General approval of a form under this section, or failure to disapprove, does not constitute approval of clauses specified in s. 631.21.

NOTE: This section establishes a general requirement that all policy and application forms subject to s. 631.01 be filed with the commissioner, and provides that they may not be used unless he approves them or is deemed to have done so. Related provisions are presently scattered throughout the code: ss. 201.76, 204.31 (3) (g), 204.32 (4), 204.321 (3), 204.322 (5), 206.17, 206.59, 206.63 (5), 208.161, 208.162. Some of them required affirmative approval; some contemplated only filing and did not seem to authorize disapproval. The disparities result from different historical backgrounds of the provisions. The "deemer clause" approach of this section is better; it has been employed by the recent National Association of Insurance Commissioners' model bills on contract terms. It has the advantage that no

action by the commissioner is necessary in the vast majority of cases, where the forms pass the test without objection. Of course, a form may find its way into use without having been scrutinized at all, but a literal prior approval requirement is no better guarantee of careful scrutiny of all forms. The enormous number of forms to be processed and the shortage of competent and experienced personnel preclude such care. If careful scrutiny of policy terms is considered important, the solution is partly greater standardization and partly the deployment of more resources for the task.

Sub. (1) will have to be supplemented by rules of the sort already found in Wis. Adm. Code Ins. 6.05 concerning procedures and definitions. The terms "policy" (which includes riders and endorsements), and "form" (which contemplates a document prepared for repeated use but not one made especially for an individual risk), are defined in s. 600.03. The latter definition is a liberalization of the law. Contracts used only for one insured do not require filing. Even some formed contracts are specifically exempted from filing under s. 631.01 or may be exempted by rules promulgated thereunder.

Sub. (2) presents the grounds for disapproval. Par. (a) provides the basic standards which are then illustrated by subdivisions 1 to 4 in cases where further specification seems useful.

Subdivisions 1 and 2 assume as a starting point that competition should govern the scope of the benefits promised. It only defines outer limits where competition becomes too muddly to comprehend. The public must be given some protection against gimmicks and against policies which purport to satisfy a need but are so restricted, whether by definition of risks, by exclusions, by conditions or otherwise, as to make them ineffective to do so.

Subdivision 3 seeks understandability of contracts. The current trend toward "plain language" policies is desirable in principle but there should be wider recognition that an insurance contract is inherently complex and too much simplification can only produce more litigation.

Subdivision 4 deals with physical aspects of the form. To the extent possible all the terms of an insurance contract should be contained in a single unified document rather than in separate documents pasted or stapled together so as to preclude understanding. But the complexity of insurance needs is such that no absolute rule to that effect is practicable.

Par. (b) recognizes that unlimited coverage, especially if losses are largely within the control of the insured can be more dangerous than overly restrictive coverage, because it may endanger the solidity of the insurer.

Par. (c) protects against an insurer's failure to identify itself fully, perhaps because it is pressed to emphasize instead the identity of general agents or others.

Par. (d) includes legality as a standard.

Sub. (3) provides for subsequent disapproval of forms already in use, on the same standards as prior disapproval, but only after a hearing.

Sub. (4) makes indubitably clear what is already the case, that disapproval is an order, subject to s. 601.62 (3). It also requires that the order contain reasons, so that the insurer may know where to go next.

Sub. (5) makes it clear that approval under s. 631.20 does not constitute approval of certain clauses specified in s. 631.21, which must be explicitly approved or they will be null and void.

631.21 Explicit approval required. (1) **REQUIRED APPROVAL.** Despite the general approval of a form under s. 631.20, the following clauses are not approved even if contained in the form unless the commissioner gives explicit approval to them:

(a) *Expeditious notice.* Clauses requiring more expeditious notice than 1st class mail, as provided in s. 631.81 (2);

(b) *Limitations on payments.* Clauses limiting payments pursuant to s. 632.77 (3) unless the provision has been approved by the commissioner by rule; and

(c) *Reinstatement fees.* A schedule of reinstatement fees under s. 632.74, if made a part of the policy. Such a schedule need not be included in the contract but may be given approval as a separate document specifically made applicable to particular classes of policies.

(2) **EFFECT OF FAILURE TO OBTAIN EXPLICIT APPROVAL.** If an insurer fails to obtain explicit approval from the commissioner for the clauses under sub. (1), the clauses shall be null and void.

NOTE: This section is a convenient cross reference to help identify specific clauses the commissioner must approve explicitly because they are not approved by general approval of a form under s. 631.20.

631.23 Authorized clauses for insurance forms. (1) **PROMULGATION OF CLAUSES.** The commissioner may not promulgate mandatory uniform clauses that preclude an insurer from filing its own forms for approval under s. 631.20; he may only disapprove such forms on the basis of the criteria stated in that section. Subject thereto, the commissioner may promulgate authorized clauses by rule if he finds that:

(a) Price or coverage competition is ineffective because diversity in language or content makes comparison difficult;

(b) Provision of language, content or form of specific clauses is necessary to provide certainty of meaning of those clauses;

(c) Regulation of contract forms would be more effective or litigation would be substantially reduced if there were increased standardization of certain clauses; or

(d) Reasonable minimum standards of insurance protection are needed for policies to serve a useful purpose.

(2) **DEGREE OF SPECIFICITY.** Any rule creating an authorized clause may prescribe that to be treated as an authorized clause there must be verbatim or substantial adherence to prescribed language, that certain standards or criteria must be met, or that certain drafting principles must be followed. The rules may also permit liberalization of prescribed language. If the proposed rule prescribed verbatim adherence, the commissioner shall make a finding that substantial adherence to the prescribed language is not sufficient and that liberalization of prescribed language will frustrate the purposes of the prescription. If an insurer uses authorized clauses as part of filed forms the commissioner may only disapprove those clauses under s. 631.20 if he finds that improper combination of clauses makes them violate the criteria of s. 631.20.

(3) **CONSULTATION WITH FORMS ADVISORY COUNCIL.** No clause may be promulgated under this section without prior consultation with the forms advisory council created under s. 601.20 (3) or an appropriate subcommittee of such council.

NOTE: Uniform or standard clauses provide no panacea, and should not be used to make the market rigid. However, standardization of some clauses would help in contract regulation and the commissioner should have power to promulgate authorized standard clauses as necessary, for any clauses. Such standardization is, of course, the purpose of many of the NAIC model bills. It should be noted that under this section, promulgation of authorized clauses

requires certain findings by the commissioner after the hearing required by ch. 227.

631.27 Rules of law as provisions of contracts. By rule, the commissioner may require an insurer to insert in a policy any rule of law stated in this code that is applicable to the contents or interpretation of an insurance contract.

NOTE: Under the former statutes, many sections required that certain provisions be contained in certain policies. Under this draft, many such required provisions have been converted into rules of law. If the commissioner feels that any such rules should also be inserted into the policy as provisions of the contract, he should have the power to require it.

SUBCHAPTER III

SPECIFIC CLAUSES IN CONTRACTS

631.31 Clauses required to be on first page. (1) LIST OF CLAUSES. The following clauses of insurance policies shall appear on the first page of the policy:

- (a) *Corporate name.* The name of the insurer as required by s. 631.64;
- (b) *Several liability.* Information that 2 or more insurers undertake only several liability, as required by s. 631.41;
- (c) *Assessability.* That the policy is assessable, if it is, as required by s. 631.65;
- (d) *Variable benefits.* A statement that benefits are variable, as required by s. 632.45 (1); and
- (e) *Right to return policy.* The right to return a disability insurance policy under s. 632.73, except that this clause may be conspicuously attached to the first page rather than printed on it.

(2) MANNER OF DISPLAY. Clauses listed in sub. (1) shall be displayed conspicuously and separately from any other clauses.

631.36 Termination of insurance contracts by insurers. (1) SCOPE OF APPLICATION. (a) *General.* Except as otherwise provided by statute or by rule under par. (c), this section applies to all contracts of insurance based on forms which are subject to filing and approval under s. 631.20 (1).

(b) *Contracts more favorable to policyholder.* The contract may provide terms more favorable to policyholders than are required by this section.

(c) *Exemption by rule.* The commissioner may by rule totally or partially exempt from this section classes or parts of classes of insurance contracts if the policyholders do not need protection against arbitrary or unannounced termination.

(d) *Other rights.* The rights provided by this section are in addition to and do not prejudice any other rights the policyholder may have at common law or under other statutes.

(e) *Construction.* Nothing in this section prevents the rescission or reformation of any life or disability insurance contract not otherwise denied by the terms of the contract or by any other statute.

(2) MIDTERM CANCELLATION. (a) *Permissible grounds.* Except as provided by par. (c), no insurance policy may be canceled by the insurer prior to the expiration of the agreed term or one year from the effective date of the policy or renewal, whichever is less, except for failure to pay a premium when due or on grounds stated in the policy, which must be comprehended within one of the following classes:

1. Material misrepresentation;

2. Substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the contract;

3. Substantial breaches of contractual duties, conditions or warranties; or

4. Attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice under par. (b) accompanied by a tender of a pro rata return of premium.

(b) *Notice.* No cancellation under par. (a) is effective until at least 10 days after the 1st class mailing or delivery of a written notice to the policyholder.

(c) *New policies.* Pars. (a) and (b) do not apply to any insurance policy that has not been previously renewed if the policy has been in effect less than 60 days at the time the notice of cancellation is mailed or delivered. No cancellation under this paragraph is effective until at least 10 days after the 1st class mailing or delivery of a written notice to the policyholder. Subs. (6) and (7) do not apply to such a policy.

(3) ANNIVERSARY CANCELLATION. A policy may be issued for a term longer than one year or for an indefinite term with a clause providing for cancellation by the insurer by giving notice 30 days prior to any anniversary date, as provided in sub. (4) (a) for nonrenewals.

(4) NONRENEWAL. (a) *Notice required.* Subject to subs. (2) and (3), a policyholder has a right to have his policy renewed, on the terms then being applied by the insurer to similar risks, for an additional period of time equivalent to the expiring term if the agreed term is a year or less, or for one year if the agreed term is longer than one year, unless at least 30 days prior to the date of expiration provided in the policy a notice of intention not to renew the policy beyond the agreed expiration date is mailed or delivered to the policyholder, or with respect to failure timely to pay a renewal premium a notice is given, not more than 45 days nor less than 10 days prior to the due date of the premium, which states clearly the effect of nonpayment of premium by the due date.

(b) *Exceptions.* This subsection does not apply if the policyholder has insured elsewhere, has accepted replacement coverage or has requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable.

(5) RENEWAL WITH ALTERED TERMS. If the insurer offers or purports to renew the policy but on less favorable terms or at higher rates, the policyholder shall, for 30 days after he receives notice calling his attention to the changes in the policy, have the option of canceling the renewal policy on a pro rata basis. The calculation of return premiums or additional premium charge shall be on the basis of the new rates if the reason for cancellation is a general rate increase, and of the old rates if the rate change resulted from any other cause. No change except in favor of the policyholder is effective until 30 days after the policyholder is given notice of his right to cancel. This subsection does not apply if the higher rates result from an increase in the risk which results in a changed classification under the insurer's prevailing rate schedules.

(6) INFORMATION ABOUT GROUNDS. If a notice of cancellation or nonrenewal under sub. (2) (b) or (4) does not state with reasonable precision the facts on which the insurer's decision is based, the insurer must mail or deliver that information within 5 working days after receipt of a written request by the policyholder. No such notice is effective unless it contains adequate information about the policyholder's right to make the request.

(7) INFORMATION ABOUT PLANS. If a risk sharing plan under ch. 619 exists for the kind of coverage provided by the insurance being canceled or nonrenewed, no notice of cancellation or nonrenewal required under sub. (2) (b) or (4) is effective

unless it contains adequate instructions to the policyholder for applying for insurance through the plan.

(8) CANCELLATION FOR NONPAYMENT OF PREMIUM. Subs. (6) and (7) do not apply if the ground for cancellation or nonrenewal is nonpayment of the premium and if the notice so states.

(9) IMMUNITY. There is no liability on the part of and no cause of action of any nature arises against any insurer, its authorized representatives, its agents, its employes, or any firm, person or corporation furnishing to the insurer information relating to the reasons for cancellation or nonrenewal, for any statement made by them in complying or enabling the insurer to comply with this section, or for the provision of information pertaining thereto.

(10) CANCELLATION UPON REQUEST OF PREMIUM FINANCE COMPANY. Section 138.12 (11) applies to cancellation on request of a premium finance company.

(11) CANCELLATION UPON REQUEST OF CREDITOR. Section 424.303 applies to cancellation upon request of a creditor.

(12) WORKMEN'S COMPENSATION INSURANCE. Section 102.31 (1) (a) applies to the termination of workmen's compensation insurance.

NOTE: This section was created by ch. 144, laws of 1969, and at that time was explained by an extensive preliminary comment which was printed in the session laws and is not repeated here. In this draft, the section has been improved and elaborated.

Sub. (1) (a) has been altered in language but not in effect, to tie the section to the rest of this chapter. Other paragraphs in sub. (1) have been very slightly amended.

In sub. (2) (a), the grounds for cancellation have been restated. Except for subd. 4 they remain essentially the same; the latter is generalized from part of s. 204.31 (6). They may slightly enlarge the grounds for cancellation but still give full and fair protection to the insured against inappropriate cancellation. The part dealing with new policies has been put in par. (c), and the underwriting period reduced from 70 to 60 days, which is more common in comparable statutes.

Sub. (2) (b) has been made more restrictive in 2 respects. Ten days' notice seems enough for all cases. Moreover, no notice of cancellation for nonpayment of premium should be effective unless given after default. The subsection creates no problem in life insurance since life contracts do not ordinarily contain cancellation clauses. One that does should be subject to the rule.

Sub. (2) (c) deals with that part of present s. 631.36 (2) that deals with new policies.

Sub. (3) has been changed to make it clear that no cancellation rights are given directly by the statute but only by the contract itself.

Slight verbal changes are made in sub. (4) (a), and the last clause is added. A clause in par. (b) is omitted as unnecessary.

Sub. (5) is elaborated without change in its essential thrust.

Sub. (6) is very slightly modified.

Sub. (7) is reworded without change of substance.

Sub. (8) is new. The insurer should not have to supply any further information if cancellation is for nonpayment of premium.

Sub. (9) is the present sub. (8). It is unchanged in meaning but slightly edited.

Sub. (9) of s. 631.36 as enacted by ch. 144, laws of 1969, will be found as s. 632.35. It belongs in the chapter on special kinds of insurance since it is limited to automobile insurance.

The policyholder needs protection against cancellation by someone else with a power to request cancellation, such as a premium financing institution or creditor. Subs. (10) and (11) provide useful cross references.

Sub. (12) is new and provides a useful cross reference to make the insurance code as nearly self-contained as possible.

631.41 Policies jointly issued. Two or more insurers may together issue a policy in which their liability is either several or joint and several. If it is several, the heading of the policy shall conspicuously so state and the policy shall conspicuously state the proportion or amount of premium to be paid to each insurer and the type and the proportion or amount of liability each insurer agrees to assume.

NOTE: This continues and generalizes the essential part of s. 203.06 (5).

631.43 Other insurance provisions. (1) GENERAL. When 2 or more policies promise to indemnify an insured against the same loss, no "other insurance" provisions of the policy may reduce the aggregate protection of the insured below the lesser of the actual insured loss suffered by the insured or the total indemnification promised by the policies if there were no "other insurance" provisions. The policies may by their terms define the extent to which each is primary and each excess, but if the policies contain inconsistent terms on that point, the insurers shall be jointly and severally liable to the insured on any coverage where the terms are inconsistent, each to the full amount of coverage it provided. Settlement among the insurers shall not alter any rights of the insured.

(2) FRAUD AS A DEFENSE. Sub. (1) does not affect the right of an insurer to defend against a claim under the policy on the ground of fraudulent misrepresentation.

NOTE: This section is adapted from s. 203.11, but extended to all indemnity coverage, including the indemnity coverages in disability insurance. In one respect it is less liberal to the insured, by preserving fraud as a defense. There is no good reason to deprive an insurer of that defense, when applicable. Innocent misrepresentation, however, is not a defense. The most important objective of the law is to give the insured full protection with minimum difficulty and joint and several liability does that. The insurers may then settle accounts among themselves. They will usually be able to do so by agreement. If they cannot, a court can do so first by interpreting the terms of the policies and, where they are inconsistent, applying restitutionary principles. In the past "other insurance" clauses have often done injustice; that fact was the reason for the enactment of statutes like s. 203.11. Courts have dealt with these problems with reasonably good results even in the absence of such a provision, and there is no reason to doubt that they can do justice as between the insurers, once the insured has received full indemnity.

631.45 Limitations on loss to be borne by insurer. (1) GENERAL. An insurance policy indemnifying an insured against loss may by clear language limit the part of the loss to be borne by the insurer to a specified or determinable maximum amount, to loss in excess of a specified or determinable amount, to a specified percentage of the loss, which may vary with the amount of the loss, or by a combination of these methods. If the policy covers various risks, different limitations may be provided separately for each risk if the policy clearly so states.

(2) **PROPERTY COINSURANCE.** A policy indemnifying an insured against loss of or damage to property may limit the part of the loss to be borne by the insurer to a percentage of the total loss that corresponds to the ratio of the insured sum to a specified percentage of the value of the insured property.

NOTE: Deductibles, coinsurance and maximum limits are desirable techniques if they are not used in a misleading way. This section continues s. 201.20, but is much more explicit.

631.48 Nonwaiver clause. An insurer may insert in any insurance policy a provision that no change in the policy is valid unless approved by an executive officer of the insurer, or unless the approval is endorsed on the policy or attached to it, or both, and that no agent has authority to change the policy or waive any of its provisions. This does not preclude a person claiming a right under the policy from relying on waiver or estoppel in an appropriate case.

NOTE: This provision takes its point of departure from s. 204.31 (3) (a) 1, but with substantial changes. It makes a single rule applicable to all forms of insurance. It probably is declaratory of the common law, even where it has purportedly been modified by such provisions as s. 204.31 (3) (a) 1. The terms inserted in a policy cannot, in principle, do more than give a policyholder notice of the limited powers of agents; the insurer cannot by its contract deny itself the power to modify its contract at a later date or to give up any or all of its contractual rights. For that reason, any person with full authority to act for the insurer can nevertheless act inconsistently with the cautionary language and by his words or conduct waive a provision of the policy or estop the insurer, in accordance with case law doctrines. This is as it should be, for no contract language should compel a policyholder to ignore the words or conduct of an agent with plenary power.

631.51 Dividends on policies. (1) **LIFE INSURANCE AND ANNUITIES.** Section 632.62 applies to life insurance and annuities.

(2) **INSURANCE, OTHER THAN LIFE INSURANCE AND ANNUITIES.** Any insurer may distribute a portion of surplus attributable to policies other than life insurance or annuities, in amounts and with classifications the board of directors determines to be fair and reasonable. Such distribution may not be made contingent on the continuation of the policy or of premium payments except under s. 632.75 (2). A schedule explaining the basis for the distribution shall be filed with the commissioner prior to the distribution.

(3) **WHEN NOT SPECIFIED IN POLICY.** Any insurer may distribute surplus to any class of policyholders even if those policies do not so provide. A schedule explaining the basis for the distribution shall be filed with the commissioner at least 30 days prior to the distribution.

(4) **COMBINED DIVIDENDS.** It is permissible to provide an indivisible dividend to classes of policyholders having more than one type of policy, including a combination of life or annuities with other types of insurance.

NOTE: Sub. (1) provides a needed cross reference.

Sub. (2) continues s. 201.135 with some important changes. The problem of excessive accumulation of surplus is difficult to deal with directly. Two protective mechanisms already exist. The first is competition; generous and stable dividends are an important competitive argument. The second is existing rate regulation: initial rates may be declared excessive if too much surplus is accumulated or unfairly discriminatory if dividend classifications are inequitable. In principle, there is an argument for providing for direct review of board discretion. This bill rejects that possibility for 3 reasons: (1)

general powers of the commissioner enable him to persuade the insurer to change its practices if there is gross abuse of discretion — i.e., there is in any case informal review, to be sure without available sanctions; (2) the potential harassment of the insurer, especially by class actions, would be costly and should not be encouraged unduly; and (3) the interstate complications of such review make it impracticable. It would not be satisfactory to rely on the domiciliary commissioner to control dividend policy, for departments vary greatly in quality and philosophy, nor could each state intervene in dividend decisions solely for the policies in effect in that state. Each state can intervene separately, of course, on rates, and that is undoubtedly the ultimate regulatory weapon. Coupled with competition it is probably adequate.

Sub. (3) continues s. 201.54, but requires 30 days advance filing of the distribution schedule with the commissioner for noncontractual distributions so that he can exercise special surveillance on regulatory grounds.

Sub. (4) permits the grouping for dividend purposes of policyholders who have combinations of policies.

631.61 Group and blanket insurance. (1) CERTIFICATES. (a) *General.* Except under par. (d), an insurer issuing a group insurance policy other than blanket shall, as soon as practicable after the coverage is effective, provide a certificate for each member of the insured group, except that only one certificate need be provided for the members of a family unit. The certificate shall contain a summary of the essential features of the insurance coverage, including any rights of conversion to an individual policy. Upon receiving a written request therefor, the insurer shall also inform any insured how he may inspect a copy of the policy during normal business hours at a place reasonably convenient to the insured.

(b) *Blanket insurance.* The commissioner may by rule impose a similar requirement for any class of blanket insurance policies for which he finds that the group of persons covered is constant enough for such action to be practicable and not unreasonably expensive.

(c) *Method of providing certificates.* The certificate shall be provided in a manner reasonably calculated to bring it to the attention of the certificate holder. The insurer may deliver or mail it directly to the certificate holder or may deliver or mail the certificates in bulk to the policyholder to transmit to certificate holders, unless the insurer has reason to believe that the policyholder will not promptly transmit the certificates. An affidavit by the insurer that it has mailed the certificates in the usual course of business creates a rebuttable presumption that it has done so.

(d) *Substitutes.* The commissioner may by rule or order prescribe substitutes for delivery or mailing of certificates, including booklets describing the coverage, the posting of notices in the place of business, or publication in a house organ, if the substitutes are reasonably calculated to inform certificate holders of their rights.

(2) EFFECT OF FAILURE TO ISSUE CERTIFICATES. Unless a certificate or an authorized substitute has been made available to the certificate holder as required by this subsection, no act or omission by him after the coverage has become effective as to him, other than intentionally causing the loss insured against, affects the insurer's obligations under the insurance contract.

NOTE: Sub. (1) is adapted with substantial modifications from ss. 204.321 (2) (a) 3, 206.61 (7), (11) and 206.63 (3) (a). It permits direct delivery by the insurer as well as indirect delivery through the policyholder. It also provides for substitutes to give maximum flexibility. A certificate is not practicable for most cases of blanket insurance; it is only obligatory if the commissioner requires it by rule. For example, policies covering athletic

events in a school is a case where a certificate would seldom be practicable. The certificate or its substitute should provide reasonably full information, including any conditions on the basis of which the insurer may wish to raise a defense. While the many forms in which group insurance is legitimately written make this a difficult problem, providing the insured persons with adequate information on the coverage after it has begun is very important.

Sub. (2) seeks to put teeth into the requirement by giving violation a private law effect in some cases, by prohibiting the denial of benefits on account of breaches of conditions that are unknown to the insured because he does not have a document stating them.

631.64 Corporate name. Every insurance policy or annuity contract shall conspicuously display the name of the insurer on its first page.

NOTE: This continues the first sentence of s. 203.02 (2), substantially amended. It is narrowed by not requiring the name to contain the words "stock" or "mutual" except as that is indirectly required for new mutuals by s. 611.12 (2) (a); it is broadened from fire insurance to all insurance policies and annuity contracts.

631.65 Assessable policies. Every assessable policy, other than one issued by an insurer under ch. 612, shall conspicuously display on the first page, separately from any other provision and in type at least as large as any used in the body of the policy, the words "This policy is assessable".

NOTE: This section continues s. 201.075. It is not applicable to life insurance where assessment is forbidden by s. 632.41 (1), nor to town mutuals, where it is normal.

631.69 Insurance written in connection with finance plans. Any insurance contract written in connection with a finance plan or other credit transaction shall contain provisions to protect the insured from overreaching by the insurer or by the creditor in connection with the insurance, including a provision that a copy of the complete policy or a certificate containing all of the essential terms be furnished to the debtor and that there shall be an appropriate surrender value or refund of unearned premium to the debtor calculated on a basis approved by the commissioner if the debt is paid or if the insurance contract is rewritten because the original finance plan or credit transaction is altered or a new plan or transaction is entered into with the same or an affiliated lender. This section is satisfied by compliance with the terms of ch. 424, if they are applicable.

NOTE: This broadens s. 204.36, which applies to automobile purchases, to cover all cases of insurance protecting creditors. It includes voluntary as well as compulsory coverage. It permits variation in the refunding practices to reflect variations in termination cost in different classes of insurance.

631.81 Notice and proof of loss. (1) **TIMELINESS OF NOTICE.** Provided notice or proof of loss is furnished as soon as reasonably possible and within one year after the time it was required by the policy, failure to furnish such notice or proof within the time required by the policy does not invalidate or reduce a claim unless the insurer is prejudiced thereby and it was reasonably possible to meet the time limit.

(2) **METHOD OF GIVING NOTICE.** It is a sufficient service of notice or proof of loss if a 1st class postage prepaid envelope addressed to the insurer and containing the proper notice or proof is deposited in any U.S. post office within the time prescribed. The commissioner may expressly approve clauses requiring more expeditious methods of notice where that is reasonable.

(3) **MEANING OF INSURER'S ACTS.** The acknowledgment by the insurer of the receipt of notice, the furnishing of forms for filing proofs of loss, the acceptance of

such proofs, or the investigation of any claim are not alone sufficient to waive any of the rights of the insurer in defense of any claim arising under the insurance contract.

NOTE: Sub. (1) is generalized from ss. 204.30 (2) (second half) and 204.31 (3) (a) 7 (second sentence). It also covers the content of s. 204.31 (3) (a) 5. The first applies to most but not all liability insurance, the latter to individual disability. But the principle is sound and is closely approached by case law. The prejudice requirement is generalized from s. 204.34 (3). The principle should apply to all insurance contracts, even if some changes in the applicable periods may need to be made. Section 204.29 (1) now prescribes that "accident or casualty" insurers may not limit the time for notice of injury to less than 20 days. Rather than broadening or even continuing the scope of that provision, it should be repealed. It is unduly restrictive and inflexible. The proper time for giving notice of a loss or injury depends on the nature of the coverage and the nature of the benefit provided in the policy. In each class of insurance, the interests of the insured and insurer must be carefully evaluated and weighed against each other. For instance, the conditions for hospitalization benefits in case of plain sickness insurance are easy to check even after some time, and so are the conditions for medical benefits for services performed by physicians. The insurer's position in adjusting such claims may not be materially affected if it receives the hospital or doctors' bills months later. Some sickness insurers have their policyholders report reimbursable expenses only once a year in a comprehensive statement. The situation is different in accident insurance where the insurer has a clear interest in investigating the circumstances of the injury while the evidence is available. In many cases 20 days may be too long a delay to start a meaningful investigation. This is especially true in liability insurance, where it is of vital importance for the insurer to be able to investigate the third person's claim quickly. In contrast, the standard fire policy required "immediate written notice" of any loss, which seems unduly stringent in many cases.

A "reasonable" time limit for notice of loss cannot be fixed generally by statute but must be left for contract determination subject to approval under s. 631.20. This is also an appropriate case for authorized causes to be promulgated under s. 631.23. Sub. (1) guarantees that excusable delays do not hurt the policyholder.

Sub. (2) continues part of s. 204.29 (3) in a generalized form.

Sub. (3) comes from s. 204.31 (5). The provision is necessary to protect insurers against an overly policyholder-oriented attitude of some courts. It contains a sound general principle that should be extended to all kinds of insurance contracts. An insurer should not be estopped because it conducts its business in an orderly and systematic fashion. Of course, other facts may combine with the designated acts to give them a more substantial effect.

631.83 Limitation of actions. (1) STATUTORY PERIODS OF LIMITATION. (a) *Fire insurance.* An action on a fire insurance policy must be commenced within 12 months after the inception of the loss. This rule also applies to riders or endorsements attached to a fire insurance policy covering loss or damage to property or to the use of or income from property from any cause, and to separate windstorm or hail insurance policies.

(b) *Disability insurance.* An action on disability insurance coverage must be commenced within 3 years from the time written proof of loss is required to be furnished.

(c) *Claims based on absence of insured person.* Actions based on death in which absence is relied on as evidence of death are subject to s. 813.22.

(d) *Other.* Except as provided in this subsection or elsewhere in the insurance code, s. 893.19 (3) applies to actions on insurance policies.

(2) GENERAL LAW APPLICABLE TO LIMITATION OF ACTIONS. Except for the prescription of time periods under sub. (1) or elsewhere in the insurance code, the general law applicable to limitation of actions as modified by ch. 893 applies to actions on insurance policies.

(3) PROHIBITED CLAUSES OF POLICIES. No insurance policy may:

(a) *Shorten periods of limitation.* Limit the time for beginning an action on the policy to a time less than that authorized by the statutes;

(b) *Limit jurisdiction.* Prescribe in what court action may be brought thereon; or

(c) *Proscribe action.* Provide that no action may be brought.

(4) MINIMUM WAITING PERIOD FOR ACTION. No action may be brought against the insurer on an insurance policy to compel payment thereunder until at least 60 days after proof of loss has been furnished as required by the policy or such proof of loss has been waived, or the insurer has denied full payment, whichever is earlier. This subsection does not apply in any case in which the verified complaint alleges facts that would establish prejudice to the complainant by reason of such delay, other than the delay itself.

(5) TOLLING OF PERIOD OF LIMITATION. The period of limitation is tolled during the period in which the parties conducted an appraisal or arbitration procedure prescribed by the insurance policy or by law or agreed to by the parties.

NOTE: Sub. (1) (a) is adapted from part of s. 201.19 (1); par. (b) from ss. 204.31 (3) (a) 11, 204.32 (4), 204.321 (2) (b), and 204.322 (2) (b). Par. (c) is a necessary cross reference; par. (d) is the residual provision.

Sub. (2) makes limitation of actions on insurance policies subject to general law.

Sub. (3) continues the remainder of s. 201.19 (1).

Sub. (4) is generalized from s. 204.31 (3) (a) 11. It is desirable to lessen the burden on the judicial machinery caused by a practice, said to be prevalent, of instituting an action immediately to put additional pressure on an insurer. The insurer should be given an opportunity to pay before being sued. An insurer that always must be sued can and should be dealt with by the commissioner in other ways. The second sentence is necessary to make sure that the waiting period is not prejudicial to the claimant, beyond having to wait a short additional period to commence action.

Sub. (5) tolls the period of limitation in a case where otherwise the claimant might be prejudiced. It continues s. 201.19 (2).

631.85 Appraisal or arbitration. An insurance policy may contain provision for independent appraisal and compulsory arbitration, subject to the provisions of s. 631.20. If an approved policy provides for application to a court of record for the appointment of a disinterested appraiser, arbitrator or umpire, any court of record of this state except the supreme court may be requested to make an appointment. Upon appropriate request, the court shall make the appointment promptly.

NOTE: This replaces and generalizes the provision in the standard fire insurance policy under s. 203.01 and the detail of s. 203.04. The policy should provide its own detailed procedures, subject to approval under s.

631.20. All that is needed in the statutes is a provision authorizing the court to make the appointment on request.

SECTION 42. Subchapters I to VIII of chapter 632 of the statutes are created to read:

CHAPTER 632

INTRODUCTORY NOTE: This chapter contains provisions applying to specific types of insurance contracts. Only those provisions have been included that seem to reflect a public policy of sufficient importance to warrant statutory enactment. Other provisions, which are concerned with uniformity and completeness rather than with substance, have been left out; their objectives are now included either in general provisions or in standards prescribed for the commissioner to use in regulating policy forms.

Under the test applied here, few provisions seem worth statutory enactment — so few, indeed, that they can be put together in one short chapter.

SUBCHAPTER I

FIRE AND OTHER PROPERTY INSURANCE

INTRODUCTORY NOTE: The most conspicuous and well-known statutory provisions involving fire insurance contracts are those prescribing the standard fire policies. In Wisconsin, there were 2 slightly different forms, one for town mutuals [s. 202.085 (1)] and one for ordinary fire insurers [s. 203.01 (1)]. The first was repealed by ch. 22, laws of 1973, and replaced by s. 612.51 (2). The second is repealed here.

The standard fire policy was first enacted in Wisconsin in 1896 after a statute authorizing the insurance commissioner to prescribe such a policy had been declared unconstitutional by the Supreme Court. Dowling v. Lancashire Fire Ins. Co. (1896), 92 Wis. 63, 65 N.W. 738. About half the states have a statutory standard fire policy while a third of the states have a standard policy prescribed by the insurance commissioner. Modern constitutional doctrine would permit an authorizing statute and promulgation of a standard policy by rule. See State ex rel. Wisconsin Inspection Bureau v. Whitman (1928), 196 Wis. 472, 505, 220 N.W. 929, 941. But this law does not contemplate a required standard fire policy.

Uniformity was the main goal of the standard policy in the last century; uniformity within a state is important in the settlement of claims when there is multiple coverage. Superficial uniformity both within each state and among the states has been achieved to a remarkable degree, since most states have adopted the New York standard fire policy of 1943, with little variation. Uniformity among states is of greater importance now than formerly, in view of the multiple state operation of many insureds, and their desire for uniformity in their insurance protection.

However, a closer look reveals that the appearance of uniformity is deceptive. Further, the disadvantages of the standard fire policy in its present form outweigh any advantages it might have.

(1) While the New York standard fire policy can be used in the majority of states, it is not nationwide. The standard policies in a few states differ substantially from the New York form, while other states have minor deviations. See American Bar Association, Current Annotations of the 1943 New York Standard Fire Insurance Policy, (1966), pp. 7-10. Thus, national uniformity is not achieved through a national standard policy.

(2) More numerous, important and confusing than these overt differences are the indirect and concealed deviations resulting from endorsements, which make it difficult to know what the contract really says.

(3) Again, a serious problem has been created by statutory provisions which do not change the standard fire policy but are inconsistent with and presumably overrule it. For example, compare ss. 203.02 and 600.03 (28) with the place for the name of the insured on the standard policies in former ss. 202.085 (1) and 203.01 (1); s. 203.21 with the "actual cash value" language of the insuring clause; s. 209.06 (1) with lines 1-6 of the standard policy; s. 203.11 with line 25; 203.04 with lines 123-40; s. 201.19 (2) with lines 160-61; and s. 203.06 (2) (d) with "actual cash value" language of the insuring clause and with lines 141-47.

Conflicting or uncertain statutes of this sort make the "standard" fire policy much less uniform and reliable than it superficially appears to be. Under ss. 202.085 (1) and 203.01 (1) insurers were required by statute to use a policy form which in several respects was inconsistent with other statutes. If the standard policy were submitted for approval under s. 631.20, it should be disapproved as contrary to law and as misleading, deceptive, and encouraging misrepresentation.

(4) Another deficiency of the standard fire policy is that it is limited to insurance against loss by fire and lightning, when most property owners are no longer satisfied with basic coverage and require additional protection against windstorm, water damage, burglary and theft, damage to glass and liability. Instead of making separate insurance contracts for each of these coverages, insurers have chosen the more convenient and economical way of packaging coverages in one policy. From 1959 to 1971 commercial and homeowners' package policies moved from a position of insignificance to the second most important property-liability line, exceeded only by automobile insurance.

The legislature has recognized this trend by allowing fire insurers to add other perils to extend coverages under the standard policy by appropriate endorsements. Section 203.06 (1) even permitted such endorsements to contain "provisions and stipulations inconsistent with the standard policy, provided that the fire and lightning portions thereof shall be in accord substantially with such standard policy". But "the insuring provisions and contract conditions of the standard policy shall not be altered or amended in any manner".

Thus every policy that includes fire coverage, alone or in connection with other coverages, must recite the standard policy from beginning to end, even if it is inconsistent with the conditions and terms concerning the other perils. This requirement has hindered the development of comprehensible policy forms in which, in a logical and intelligible order and without contradiction, all clauses and conditions would be arranged in one document, with endorsements or riders being necessary only to take care of individual and extraordinary needs.

The authors of ABA Current Annotations of the 1943 New York Standard Fire Insurance Policy, 1966, agree that "while the standard fire policy has the obvious advantages of uniformity, it stands in the way of development of simple and clear multiple lines contracts". (p. 7)

Because the New York Standard Fire Policy now enjoys wide use, immediate and wholesale replacement of existing policies would place an

undue financial and organizational burden on the industry. There should be a transitional period for adjustment. The elimination of the required text of the standard policy clears the path for this development.

Specific provisions relating to fire insurance.

The former statutes contained a number of special provisions relating to fire insurance, most of which are repealed. Those include the valued policy law (s. 203.21), a badly conceived provision on coinsurance (s. 203.22, first part), and an unnecessary provision respecting distribution of coverage, which merely authorized what is permissible without the authorization (s. 203.22, second part).

632.05 Replacement cost of coverage. An insurer may agree in a property insurance policy to indemnify the insured for the amount it would cost to repair, rebuild or replace the damaged or destroyed insured property with new materials of like size, kind and quality.

NOTE: This provision continues the important part of s. 203.06 (2) (d), extended to all property insurance. Sound analysis would not invalidate such protection even in the absence of such a statute, but there is always a possibility that a court may be so influenced by the indemnity mystique surrounding fire insurance that in the absence of a statute it would consider replacement cost coverage contrary to public policy. This statute sets the question at rest and should be continued.

632.08 Mortgage clause. A provision for payment to a mortgagee or other owner of a security interest in property may be contained in or added by endorsement to any insurance policy protecting against loss or destruction of or damage to property. If the provision is contained in an endorsement and the insurance covers real property, any loss not exceeding \$500 shall be paid to the insured mortgagee.

NOTE: This replaces s. 203.06 (2) (a) 5. No change is intended except to increase the amount to be paid to the mortgagor from \$100 to \$500 to reflect increasing property values and the decreasing value of the dollar. Trivial losses should not be paid to a holder of a security who is not a named insured, even though his interest precedes that of the equity owner. The word "intended" is used advisedly in the second sentence of this note, for there is an ambiguity in the replaced section as to whether the rule of the second sentence applies when the security holder is a named insured in the original policy. Under this version it does not, and of course it should not. Named insureds should be paid in the order of priority of their interest in the property.

632.09 Choice of law. Every insurance against loss or destruction of or damage to property in this state or in the use of or income from property in this state is governed by the law of this state.

NOTE: This continues s. 203.07 in substance.

SUBCHAPTER II

SURETY INSURANCE

INTRODUCTORY NOTE: A number of provisions in the present law specifically relate to fidelity insurance and suretyship. Some are continued and one is repealed (s. 204.075, dealing with a surety's recourse against personal endorsers, which is not sound).

632.14 Bonds need not be under seal. No suretyship obligation need be under seal unless a seal is required by the applicable federal law or law of another jurisdiction.

NOTE: This replaces the last sentence of s. 204.07.

632.17 Validity of surety bonds. (1) FAILURE TO FILE CERTIFICATE. No instrument executed by an insurer authorized to do a surety business is ineffective because of failure to file the certificate of its authority to do business in this state or a certified copy thereof; but the officer with whom any instrument so executed has been filed or any person who might claim the benefit thereof may by written notice require the person filing the instrument to have a certified copy of the certificate of authority filed with the officer, and unless the copy is filed within 8 days after receipt of the notice the instrument does not satisfy the requirement that the instrument be supplied.

(2) SATISFACTION OF OBLIGATIONS TO PROVIDE SURETY. An undertaking in appropriate terms issued by an insurer authorized to do a surety business satisfies and is complete compliance with any authorization or requirement in the law of this state respecting surety bonds, undertakings or other similar obligations, and shall be accepted as such by any official authorized to receive or empowered to require such an undertaking, subject to sub. (1).

NOTE: Sub. (1) replaces s. 204.03; and sub. (2) replaces all of s. 204.07 except the last sentence, which is continued by s. 632.14. It is possible for an insurer doing a surety business to issue a bond of excessive size — one that violates the underwriting limit of s. 204.10, for example. Violation of that section should lead to action by the commissioner against the surety but should not invalidate its bond, on which others have relied.

SUBCHAPTER III

LIABILITY INSURANCE IN GENERAL

INTRODUCTORY NOTE: A number of general principles should be made applicable to liability insurance by statutes. For example, insolvency of the insured should not excuse the insurer from payment. Initially, liability policies existed for the indemnification of the policyholder; if he no longer needed indemnity because he was insolvent and thus judgment proof, the third party claimant was out of luck. But social policy has advanced far from its original position on liability insurance. The view is now dominant that the liability policy is intended to protect the third party claimant too, by providing him a solvent source of recovery. With this in mind, there should be an insolvency provision in all liability contracts.

Another example is direct action against an insurer. Wisconsin is in the forefront of the development of this public policy. Because it is still somewhat controversial and has only recently been dealt with by the legislature, s. 632.24 is intended only to preserve the existing state of the law. But a case can be made for much broader application.

632.22 Required provisions of liability insurance policies. Every liability insurance policy shall provide that the bankruptcy or insolvency of the insured shall not diminish any liability of the insurer to 3rd parties and that if execution against the insured is returned unsatisfied, an action may be maintained against the insurer to the extent that the liability is covered by the policy.

NOTE: This section covers s. 204.30 (1), slightly enlarged to cover all property damage liability insurance, and much edited.

632.23 Prohibited exclusions in aircraft insurance policies. No policy covering any liability arising out of the ownership, maintenance or use of an aircraft, may exclude or deny coverage because the aircraft is operated in violation of air regulation, whether derived from federal or state law or local ordinance.

NOTE: This continues s. 204.295, but only as applied to liability coverage. There is no justification for removing nonliability coverages from

the realm of free contract, but the interest of an insured third party claimant makes liability insurance a different case.

632.24 Direct action against insurer. Any bond or policy of insurance covering liability to others for negligence makes the insurer liable, up to the amounts stated in the bond or policy, to the persons entitled to recover against the insured for the death of any person or for injury to persons or property, irrespective of whether the liability is presently established or is contingent and to become fixed or certain by final judgment against the insured.

NOTE: This section is adapted from s. 204.30 (4) much edited but without change of meaning. Section 631.15 (2) makes it unnecessary to include the last sentence of s. 204.30 (4).

632.25 Limited effect of conditions in employer's liability policies. Any condition in an employer's liability policy requiring compliance by the insured with rules concerning the safety of persons shall be limited in its effect in such a way that in the event of breach by the insured the insurer shall nevertheless be responsible to the injured person under s. 632.24 as if the condition has not been breached, but shall be subrogated to the injured person's claim against the insured and be entitled to reimbursement by the latter.

NOTE: Section 204.23 required conditions concerning compliance with safety rules to state explicitly and clearly those requirements, rather than referring generally to "any law or ordinance". This may sometimes be difficult for the insurer. The conditions should be phrased as clearly as can be reasonably demanded, and the matter can be handled by the commissioner within the power provided by ch. 631.

The purpose of s. 204.23 was to avoid the consequence that any breach of condition that gave the insurer a valid defense would harm the injured employe. However, it seems unfair to let the employer escape reasonable sanctions for violation of safety rules. The best solution of this problem, which also arises in automobile liability insurance, is to give the insurer in such cases a defense against the employer (policyholder) but not against the employe (third party claimant). This section is designed to achieve this result. For automobile liability insurance, see s. 632.34.

SUBCHAPTER IV

ANIMAL, AUTOMOBILE AND MOTOR VEHICLE INSURANCE

INTRODUCTORY NOTE: This area of the law is in flux. After careful consideration of various possible approaches to the subject, it has seemed that the appropriate posture is to leave the present law essentially intact, including a number of ambiguities it contains. Suggested changes are controversial and, while it is not the object of the revision to avoid controversy, this controversy is a subject of great moment not only in Wisconsin but throughout the United States, and the revision of the Wisconsin insurance code does not seem the best vehicle for addressing the many difficult problems the area contains.

One principal reason for refraining from dealing fully with the area is that it scarcely belongs in the field of insurance law, even insurance contract law. The really difficult and controverted questions are of the general theory of torts, and the fact that insurance is involved at all is incidental. It is a way of funding tort liabilities fixed by tort law.

One difficulty is terminological. "Motor vehicle" has a very broad meaning but "motor vehicle liability policy" has a very narrow one, applying

only to policies required by the safety responsibility law. There is no convenient term for the voluntary policy (the usual one). It can cover any motor vehicle. Here it has been called "automobile" liability policy to distinguish it from the compulsory policy, but in fact it can be written on any motor vehicle.

632.32 Required provisions for animal and automobile liability insurance. (1)

NOTICE. Every policy of insurance against loss or damage for which the insured is liable, resulting from accident or injury to a person or loss or damage to property caused by animals or by any motor vehicle issued or delivered in this state may contain a provision that notice given by or on behalf of the insured to any authorized agent of the insurer within this state, with particulars sufficient to identify the insured, is notice to the insurer, and a provision that failure to give any notice required by the policy within the time specified does not invalidate any claim made by the insured if it is shown not to have been reasonably possible to give the notice within the prescribed time and that notice was given as soon as reasonably possible.

(2) COVERAGE. (a) *Definition of automobile handler.* In this subsection, "automobile handler" means an automobile sales agency, repair shop, service station, storage garage or public parking place.

(b) *Required provisions.* Every policy of the kind specified in sub. (1) issued or delivered in this state to the owner of a motor vehicle shall contain a provision substantially as follows: "The coverage provided by this policy applies, in the same manner and under the same provision as it is applicable to the named insured, to any person while riding in or operating any automobile described in this policy when the automobile is being used for purposes and in the manner described in the policy. Such coverage also extends to any person legally responsible for the operation of the automobile." However, the policy may limit coverage to instances in which the riding, use or operation is with the permission of the name insured, or if the insured is an individual with the permission of an adult member of the insured's household other than a chauffeur or domestic servant. In both cases such permission is permission without regard to s. 343.45 (2) or to whether the riding, use or operation is authorized by law. Any such policy issued to an automobile handler may provide that the coverage afforded to anyone other than the named insured, his agents or employes may be restricted to the limits under s. 344.01 (2) (d) and applies only when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent. Any such policy issued to anyone other than an automobile handler may provide that the coverage afforded thereunder to any automobile handler or its agents or employes is restricted to the limits under s. 344.01 (2) (d) and applies only when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent. If an automobile covered by this policy is sold or transferred the purchaser or transferee is not an additional insured without consent of the insurer, endorsed on the policy. No such policy issued to any automobile handler may exclude coverage upon any of its officers, agents or employes when the officers, agents or employes are operating automobiles owned by customers doing business with the automobile handler.

(3) UNINSURED MOTORIST COVERAGE. (a) *Required coverage.* Every policy of insurance delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state and insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out the ownership, maintenance or use of a motor vehicle shall provide therein or supplemental thereto in limits for bodily injury or death in the amount of at least \$15,000 per person and \$30,000 per accident under provisions approved by the commissioner, for the protection of persons injured who are legally entitled to recover

damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom. The uninsured motorist bodily injury coverage limits provided in such a policy may be made available to the insured up to the bodily injury coverage limits provided in the remaining portions of the policy.

(b) *Coverage in event of insolvency of insurer.* For purposes of this coverage, "uninsured motor vehicle" includes an insured motor vehicle if before or after the accident the liability insurer of the motor vehicle is declared insolvent by a court of competent jurisdiction. In that case, the insurer making payment under the uninsured motorists' coverage shall, to the extent of the payment, be subrogated to the rights of its insured.

NOTE: Subs. (1), (2) and (3) continue s. 204.30 (2), (3) and (5) respectively, with many editorial changes. In the case of sub. (2) some changes are made to permit though not to require somewhat broader coverage. In sub. (3) (a) the final sentence of s. 204.30 (5) (a) is omitted. It does not seem to add anything. The final sentence of s. 204.30 (5) (b) is also omitted. It seems unnecessary after the lapse of 9 years.

632.34 Provisions of motor vehicle liability policies. (1) **DEFINITION AND SCOPE.** "Motor vehicle liability policy" has the same meaning as in s. 344.33. This section applies only to motor vehicle liability policies and substitute means of security as described in sub. (2).

(2) **EXCLUSION OF CERTAIN USES PROHIBITED.** No policy of insurance, agreement of indemnity or bond covering liability or loss arising by reason of the ownership, maintenance or use of a motor vehicle issued in this state may exclude from the coverage afforded or benefits provided any of the following:

(a) Persons while driving or manipulating a motor vehicle, who shall be of an age authorized by law to do so;

(b) The operation, manipulation or use of the motor vehicle for unlawful purposes;

(c) The operation, manipulation or use of the motor vehicle while the driver is under the influence of intoxicating liquors or narcotics; while the motor vehicle is engaged in the transportation of liquor in violation of law, or while the motor vehicle is operated in a reckless manner.

(3) **EXCLUSION OF RELATIVES PROHIBITED.** No policy of insurance, agreement of indemnity or bond referred to in sub. (1) may exclude from the coverage afforded or benefits provided persons related by blood or marriage to the insured.

(4) **NOTICE PROVISION.** No policy of insurance, agreement of indemnity or bond as provided in sub. (1) may limit the time for the giving of notice of any accident or casualty covered thereby to less than 20 days. Failure to give notice does not bar liability under such policy of insurance, agreement of indemnity or bond if the insurer was not prejudiced by the failure, but the burden of proof is upon the person claiming there was no prejudice.

(5) **NAMED INSURED COVERED.** No policy of insurance, agreement of indemnity or bond referred to in sub. (1) may exclude from the coverage afforded or benefits provided liability on account of bodily injury, sickness or disease, including death resulting therefrom, sustained by any person who is a named insured.

(6) **PASSENGERS COVERED.** Every policy of insurance, agreement of indemnity or bond referred to in sub. (1) shall afford coverage in respect to liability on account of bodily injury, sickness or disease, including death resulting therefrom, sustained by any person who is a passenger in or on the insured vehicle.

(7) **MEDICAL PAYMENTS COVERAGE.** Every motor vehicle liability policy delivered or issued with respect to any motor vehicle registered or principally garaged in this state and insuring losses arising from liability for death or bodily injury of a person as a result of the ownership, maintenance or use of a motor vehicle shall provide therein or supplemental thereto, under provisions approved by the commissioner, medical payments or chiropractic payments or both in the amount of at least \$1,000 per person for protection of all persons operating or riding in the insured vehicle from losses resulting from bodily injury or death. The named insured may reject the coverage. If the named insured rejects the coverage, it need not be provided in a subsequent renewal policy issued to him by the same insurer unless the insured requests it in writing. Under the medical or chiropractic payments coverage, the insurer shall be subrogated to the rights of its insured to the extent of its payments.

(8) **DEFENSE OF NONCOOPERATION.** Every motor vehicle liability policy shall, if it contains a provision providing a defense to the insurer for lack of cooperation on the part of the insured, provide also that the defense is not effective against a 3rd person making a claim against the insurer unless there was collusion between the 3rd person and the insured, or unless the claimant was a passenger in or on the insured vehicle. If the defense is not effective against the claimant, the insurer is subrogated to the injured person's claim against the insured and is entitled to reimbursement by the latter.

NOTE: This section continues s. 204.34 with substantial editorial changes, and one substantive change in sub. (6). The relationship between ss. 632.32 and 632.34 is ambiguous, and is deliberately left so. "Motor vehicle liability policy" is defined by the provisions of ch. 344. See especially s. 344.01 (2) (b) and s. 344.33. This section provides for certain provisions it must, may or may not contain.

Sub. (1) is added as a convenient cross reference. It will help prevent confusion between ss. 632.32 and 632.34.

A portion of sub. (6) is deleted which presently permits exclusion of coverage for passengers by prominent display on the face of the policy. It gives no notice to anyone the policy was designed to protect and thus was absurd. It is reported that the exclusion is frequently used by insurers of motorcycles but seldom by insurers of automobiles. The principal liability of the motorcyclist, to the passenger, is thus not covered when the motorcyclist is exclusively at fault. If there is an automobile-motorcycle accident with some fault on both, the automobilist will be a joint tortfeasor jointly and severally liable to the passenger for the full damages. Contribution from the motorcyclist is unlikely because he is apt to be judgment proof and is impossible from his insurer because of the statutorily approved exemption from coverage. In such cases, the full burden of the injury to the motorcycle passenger is placed on the relatively innocent class and their insurers.

Sub. (7) is transferred from the area of proposed s. 632.32 [currently s. 204.30 (6)] to this section, where by its terms it belongs. It is continued with only editorial changes.

Sub. (8) does for motor vehicle liability policies what s. 204.30 (7) was probably intended (unsuccessfully) to do for all automobile liability policies. It is a clear change of existing law. It is quite consistent with the philosophy of s. 632.34, but not with that of s. 632.32. Section 632.34 is imbued with a purpose to provide maximum protection for injured third persons; s. 632.32 still retains many of the features of the original indemnity policy out of which the modern automobile liability policy evolved — under it the rights of third persons are essentially derivative from those of the insured. But see ss.

632.22 and 632.24 for an extension to third parties under all liability policies of some of the newer direct protection. Subrogation is provided for; the extended protection is only for the third party claimant, not the insured.

632.35 Prohibited cancellation and nonrenewal. No insurer may cancel or refuse to renew an automobile insurance policy solely because of the age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status or occupation of anyone who is an insured.

NOTE: This repeats s. 631.36 (9) as created by ch. 144, laws of 1969, which in turn continued former s. 204.341 (4). As contained here, the restriction applies to all automobile insurance, not just liability, but because it does not apply to all kinds of insurance it has its proper place in this chapter rather than in ch. 631 which applies generally to insurance contracts of all kinds.

SUBCHAPTER V LIFE INSURANCE AND ANNUITIES

632.41 Prohibited provisions in life insurance. (1) **ASSESSABLE POLICIES.** No insurer may issue assessable life insurance policies under which assessments or calls may be made upon policyholders or others.

(2) **BURIAL INSURANCE.** No contract in which the insurer agrees to pay for any of the incidents of burial may provide that the benefits are payable to an undertaker or any other person doing business related to burials.

(3) **DEATH PRESUMED FROM ABSENCE.** Section 813.22 (1) applies to all life insurance policies.

NOTE: Sub. (1) continues the substance of s. 206.25.

Sub. (2) continues the essential part of s. 206.49 in substance. It is not the provision of burial services that is objectionable, but the tie-in arrangement between an insurer and an undertaker.

Sub. (3) provides a needed cross reference.

632.42 Trustee and deposit agreements in life insurance. (1) **TRUSTEE AND OTHER AGREEMENTS.** An insurer may hold as a part of its general assets the proceeds of any policy subject to this subchapter under a trust or other agreement upon such terms and restrictions as to revocation by the policyholder and control by the beneficiary and with such exemptions from the claims of creditors of the beneficiary as the insurer and the policyholder agree to in writing. An insurer may also receive funds in such amounts and upon such conditions, including the right of the policyholder to withdraw unused portions thereof, as the insurer and the policyholder agree to in writing:

(a) *Advance premiums.* As premiums in advance upon policies or annuities subject to this subchapter; or

(b) *New policies.* To accumulate for the purchase of future policies or annuities subject to this subchapter.

(2) **ACCUMULATION OF FUNDS.** Any insurer may, in connection with life insurance or annuity contracts, accept funds remitted to it under an agreement for an accumulation of the funds for the purpose of providing annuities or other benefits, under such reasonable rules as are prescribed by the commissioner.

NOTE: Sub. (1) continues s. 206.39 (1), substantially edited. Sub. (2) continues s. 206.39 (2).

632.44 Required provisions in life insurance. (1) **SEPARATE BENEFITS.** Every life insurance policy shall specify separately each benefit promised in the policy.

(2) **GRACE PERIOD.** Every life insurance policy other than a group policy shall contain a provision entitling the policyholder to a grace period of not less than 31 days for the payment of any premium due except the first, during which the death benefit shall continue in force.

(3) **CREDIT LIFE.** (a) Individual credit life insurance policies shall be for nonrenewable, nonconvertible, term insurance. This restriction does not apply when evidence of insurability is required nor when the credit transaction is for more than 5 years.

(b) When the insured debtor has paid or has obligated himself to pay all or any part of the premium under an individual credit life insurance policy, the total charge to the debtor shall be shown in the policy issued to the insured debtor. However, the rate of charge to the debtor rather than the total charge may be shown where the indebtedness is variable from period to period and the premium is computed periodically on the outstanding balance. The policy shall contain provision for cancellation of insurance upon termination of indebtedness through prepayment and shall provide for a refund of any unearned charge to the debtor, computed on a formula filed with the commissioner.

(c) The insurer shall fully control and be responsible for the settlement or adjustment of all claims.

NOTE: Sub. (1) continues the first sentence of s. 206.18 (1), provision 2. That is the only part of s. 206.18 with continued significance.

Sub. (2) establishes a grace period for individual life policies; a slightly different one is applicable to group. See s. 632.56 (5).

Sub. (3) (a) continues s. 206.63 (1) (b) and a phrase from (1) (c); par. (b) and (c) continue s. 206.63 (3) (b) (considerably edited) and (4).

632.45 Contracts providing variable benefits. (1) **IDENTIFICATION.** Any contract issued under s. 611.25 or under any section of the code incorporating s. 611.25 by reference which provides for payment of benefits in variable amounts shall contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of the variable benefits. It shall contain appropriate nonforfeiture benefits in lieu of those under s. 206.181. Any such individual contract and any such certificate issued under a group contract shall state that the dollar amount may decrease or increase and shall conspicuously display on its first page a statement that the benefits thereunder are on a variable basis, with a statement where in the contract the details of the variable provisions may be found.

(2) **AMENDMENTS.** Any contract under sub. (1) shall state whether it may be amended as to investment policy, voting rights, and conduct of the business and affairs of any segregated account. Subject to any preemptive provision of federal law, any such amendment is subject to filing and approval under s. 631.20 and approval by a majority of the policyholders in the segregated account.

(3) **MARKETING PLAN.** Contracts under sub. (1), if they are not forms, may be issued only within the terms of a general marketing plan approved by the commissioner. The marketing plan shall be designed to protect the interests of the policyholders in regard to any voting rights and operation of the segregated account and amendment of the contract.

NOTE: Sub. (1) follows s. 206.385 (1) (first part) which requires that any variable benefit contract be prominently presented as such on the first page of the contract, and in the case of group insurance, on the first page of the certificate.

Sub. (2) is new. It makes clear that changes in investment policy and operating procedure of a segregated account are permissible. It is disadvantageous to both policyholders and insurer to be indefinitely locked into a particular investment policy or manner of operation. Amendments, if permitted by the contract, are subject to policyholder and commissioner approval. In all such cases, however, both the contracts and the commissioner's power to approve may be subject to preemptive federal law and that should be explicitly recognized in the law.

Sub. (3) is new. It is designed to trigger an approval process for tailor-made segregated accounts. The company and policyholder should have adequate leeway to negotiate individualized contracts relating to these accounts, but subject to approval on certain basic procedural aspects.

632.46 Incontestability and misstated age. (1) **INCONTESTABILITY OF INDIVIDUAL POLICIES.** Except under sub. (3) or (4) or for nonpayment of premiums, no individual life insurance policy may be contested after it has been in force from the date of issue for 2 years during the lifetime of the person whose life is at risk.

(2) **INCONTESTABILITY OF GROUP POLICIES.** Except under sub. (3) or (4) or for nonpayment of premiums, no group life insurance policy may be contested after it has been in force for 2 years from its date of issue and no coverage of any insured thereunder may be contested on the basis of a statement made by him relative to his insurability after the coverage has been in force on the insured for 2 years during the lifetime of the insured. No such statement may be used to contest coverage unless contained in a written instrument signed by the insured person.

(3) **MISSTATED AGE.** (a) Subject to par. (b), if the age of the person whose life is at risk is misstated in an application for a policy of life insurance and the error is not adjusted during his lifetime the amount payable under the policy is what the premium paid would have purchased if the age had been stated correctly.

(b) If the person whose life is at risk was, at the time the insurance was applied for, beyond the maximum age limit designated by the insurer, the insurer shall refund at least the amount of the premiums collected under the policy.

(4) **DISABILITY COVERAGES AND ADDITIONAL ACCIDENT BENEFITS.** Despite subs. (1) and (2), disability coverages and additional accident benefits may be contested at any time on the ground of fraudulent misrepresentation.

NOTE: Sub. (1) is new; it provides for incontestability of individual life insurance. By rule under s. 631.27, the commissioner can require it to be incorporated in the policy.

Sub. (2) continues s. 206.61 (2). In both subs. (1) and (2) the 2-year period is tolled by death.

Sub. (3) continues s. 206.54, in substance. There is an argument for addition of interest to the insurer's refund, under par. (b), in any case when the misstatement was an honest mistake. Much more often, one would suppose, the misstatement was a plain lie, and not having to pay interest is compensation (probably only partial, not complete) to the insurer to cover its expenses in connection with the abortive transaction. Separation of innocent misstatements from lies would cost more than it would be worth.

Sub. (4) preserves the right to contest under specified circumstances.

632.47 Assignment of life insurance rights. (1) **GENERAL.** Except as provided in sub. (3), the owner of any rights under a life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary and the rights secured under s. 632.57 or any other statute. An assignment valid under general

contract law vests the assigned rights in the assignee subject, so far as reasonably necessary for the protection of the insurer, to any provisions in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.

(2) **RELATIVE RIGHTS OF ASSIGNEE AND BENEFICIARY.** The rights of a beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee, unless the beneficiary was effectively designated as an irrevocable beneficiary prior to the assignment.

(3) **GROUP ANNUITIES.** Assignment may be expressly prohibited by a group contract providing annuities as retirement benefits.

NOTE: The section continues the basic thrust of s. 201.065, but with substantial modifications in language and some in content. No sound principle of insurance practice requires any limitations on the assignability of rights under a life insurance contract except such as are reasonably necessary to protect the insurer against the risk of double payment. Thus provisions in the policy that require some formal act by the owner to effectuate the assignment are permitted to have effect only to protect the insurer and then only if they are reasonable; they are ineffective to alter the general contract law of assignment as between assignor and assignee.

One exception exists. Group annuities designed to provide retirement benefits have a social purpose that makes it appropriate to restrict assignment as well as premature claiming of cash values. That is provided in sub. (3).

One other change made from s. 201.065 results from its peculiar phraseology. It appears to be written to preclude any future legislature from changing the enacted rule. That can surely not have been intended; if it was, it is ineffective and should not be expressed.

The breadth of this section is sufficient to make it clear that Wisconsin residents may avail themselves of the provisions of IRS Ruling 68-334 which states that irrevocable assignment of rights under a group life insurance policy may be made for the purpose of excluding the proceeds from the gross estate of the deceased for federal or state tax purposes. Such a specific provision may not be necessary in view of the case law of this state, but is inserted to eliminate any doubt.

632.48 Designation of beneficiary. (1) **POWERS OF POLICYHOLDERS.** Subject to s. 632.47 (2), no life insurance policy or annuity contract may restrict the right of a policyholder or certificate holder:

(a) *Irrevocable designation of beneficiary.* To make at any time an irrevocable designation of beneficiary effective at once or at some subsequent time; or

(b) *Change of beneficiary.* If the designation of beneficiary is not explicitly irrevocable, to change the beneficiary without the consent of the previously designated beneficiary. Subject to s. 853.17, as between the beneficiaries, any act that unequivocally indicates an intention to make the change is sufficient to effect it.

(2) **PROTECTION OF INSURER.** An insurer may prescribe formalities to be complied with for the change of beneficiaries, which may be only for its own protection. The insurer discharges its obligation under the insurance policy or certificate of insurance if it pays a properly designated beneficiary unless it has actual notice of either an assignment or a change in beneficiary designation made pursuant to sub. (1) (b). It has actual notice if the prescribed formalities are complied with.

NOTE: This provision states the preferable common law positions on a variety of problems, although it is not followed in all details in every jurisdiction. It is not intended to declare Wisconsin common law but to state

a new point of departure for case law. The insurer is protected from the risk of double payment if it pays the properly designated beneficiary before it has notice of a change under sub. (1) (b).

632.50 Estoppel from medical examination. If under the rules of any insurer issuing life insurance, its medical examiner has authority to issue a certificate of health, or to declare the proposed insured acceptable for insurance, and so reports to the insurer or its agent, the insurer is estopped to set up in defense of an action on the policy issued thereon that the proposed insured was not in the condition of health required by the policy at the time of issue or delivery, or that there was a preexisting condition not noted in the certificate or report, unless the certificate or report was procured through the fraudulent misrepresentation or nondisclosure by the applicant or proposed insured.

NOTE: This section is a substantially edited version of s. 209.07. Section 632.71 applies it to disability insurance, as s. 209.07 does. The preexisting condition clause is added, not with the intention of extending but rather of clarifying the meaning of the preceding clause. It is made less severe as against the insurer by binding the insurer only if the medical examiner is acting under the insurer's rules.

632.55 Limitations on group life insurance. (1) **NATURE OF GROUP.** No group life insurance policy may be issued on any group unless the group is formed in good faith for purposes other than to obtain insurance.

(2) **SIZE OF POLICIES.** No policy of group term life insurance may be issued on any group which, together with any other term life insurance policy on the same group, provides insurance on any one insured life in excess of \$100,000. This limitation of amount does not apply to any such group policy existing on July 15, 1949, or to any amount thereafter written under the policy or any amendments or substitution thereof.

NOTE: This section continues those limitations on the issuance of group life insurance that are widely felt to be necessary. It also preserves and incorporates the grandfather clause from s. 206.60 (7) (last sentence) [repealed by this act].

632.56 Required group life insurance provisions. Every group life insurance policy shall contain the following:

(1) **EVIDENCE OF INSURABILITY.** A provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

(2) **MISSTATEMENT OF AGE.** A provision specifying that an equitable adjustment of premiums or of benefits or of both will be made if the age of an insured person has been misstated and clearly stating the method of adjustment.

(3) **FACILITY OF PAYMENT.** A provision that any sum becoming due by reason of the death of an insured person is payable to the beneficiary designated by the insured person, subject to policy provisions if there is no designated beneficiary, and to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding \$1,000 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the insured person. This subsection does not apply to a policy issued to a creditor to insure his debtors.

(4) **NONFORFEITURE.** If it is not term insurance, equitable nonforfeiture provisions, but they need not be the same provisions as are in individual policies.

(5) **GRACE PERIOD.** A provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first. During the grace period the death benefit coverage shall continue in force, unless the policyholder gives the insurer advance written notice of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

NOTE: Subs. (1) to (3) continue s. 206.61 (4) to (6), with some changes. In particular, the amount in sub. (3) is increased from \$500 to \$1,000 to reflect inflation.

Sub. (4) is from s. 206.61 (intro.).

Sub. (5) continues s. 206.61 (1).

632.57 Conversion option in group and franchise life insurance. (1) **SCOPE OF APPLICATION.** This section applies to all group life insurance policies other than credit life insurance policies and applies to franchise life insurance policies providing term insurance renewable only while the insured is a member of the franchise unit.

(2) **CONVERSION RIGHT UPON LOSS OF ELIGIBILITY.** (a) If the insurance, or any portion of it, on a person insured under a policy covered by this section ceases because of termination of employment or of membership in the class or franchise unit eligible for coverage, the insurer shall, upon written application and payment of the first premium within 31 days after the termination, issue to the person, without evidence of insurability, an individual policy providing benefits reasonably similar in type and amount to those of the group or franchise insurance, but which need not include disability or other supplementary benefits.

(3) **TERMS OF CONVERSION.** (a) *Form of policy.* The individual policy shall, at the option of the applicant, be on any form then customarily issued by the insurer, except term insurance, at the age and for the amount applied for.

(b) *Amount of coverage.* The individual policy shall, at the option of the applicant, be in an amount as large as in the group or franchise life insurance which ceases, less any amount of insurance which has then matured as an endowment payable to the insured person, whether in one sum or in instalments or in the form of an annuity.

(c) *Premium rates.* The premium on the individual policy shall be at the customary rate then applied generally by the insurer to policies in the form and amount of the individual policy, to the class of risk to which the person then belongs without applying individual underwriting considerations, except as to occupation or avocation, and to his age on the effective date of the individual policy.

(4) **CONVERSION UPON TERMINATION OF GROUP INSURANCE.** If the group or franchise policy terminates or is amended so as to terminate the insurance of any class of insured persons, the insurer shall, on written application and payment of the first premium within 31 days after the termination, issue to any person whose insurance is thus terminated or amended, after having been in effect for at least 5 years, an individual policy on the same conditions as in subs. (2) and (3), less the amount of any other group or franchise insurance made available to him within 31 days thereafter as a consequence of the termination or amendment. The group policy may provide that the maximum amount of insurance available under this subsection is an amount not less than \$2,000 without a conversion charge and an additional amount not less than \$3,000 by paying the insurer's usual conversion charge on the additional amount.

(5) **EXTENSION OF CLAIMS UNDER GROUP OR FRANCHISE POLICY.** If a person insured under the group or franchise policy dies during the conversion period under sub. (2) to (4) and before an individual policy is effective, the amount of life

insurance which he would have been entitled to have issued to him as an individual policy shall be payable as a claim under the group or franchise policy, whether or not he has applied for the individual policy or paid the first premium.

NOTE: This continues the basic thrust of s. 206.61 (8) to (10), and 206.64 (5), with some changes. In sub. (4), e.g., the requirement that the person have been insured for 5 years is eliminated. There seems even less reason to require 5 years coverage when the insurance is terminated by the employer or insurer than when it is terminated by the employee leaving his employment, under sub. (2). A permitted limitation of \$2,000 is also increased to \$5,000 to reflect inflation since the bill was enacted. Above \$2,000 the insurer's usual conversion charge could be made chargeable by the terms of the conversion clause. Greater liberalization was proposed initially, but experience on conversion business has been bad by reason of anti-selection; viability of the insurance operation is too important to risk requiring undue liberality. These figures represent a compromise position that somewhat liberalizes the conversion privilege while keeping the anti-selection problem within reasonable bounds. The conversion charge is the amount charged against continuing groups when individual conversion takes place.

632.60 Limitation on credit life insurance. Nothing in this code authorizes licensees under s. 138.09 to require or accept insurance not permitted under s. 138.09 (7) (h).

NOTE: This continues s. 206.63 (2) (c).

632.62 Participating and nonparticipating policies. (1) AUTHORIZATION. (a) *Stock insurers.* A stock insurer may issue both participating and nonparticipating life insurance policies, subject to this section.

(b) *Fraternal and mutual insurers.* A fraternal or mutual insurer issuing life insurance policies may issue only participating policies, except for the following situations in which it may issue nonparticipating policies:

1. Paid-up, temporary, pure endowment insurance and annuity settlements provided in exchange for lapsed, surrendered or matured policies;
2. Annuities beginning within one year of the making of the contract; and
3. Such term insurance policies as the commissioner may exempt by rule.

(2) PARTICIPATION. Every participating policy shall by its terms give its holder full right to participate annually in the part of the surplus accumulations from the participating business of the insurer that are to be distributed.

(3) ACCOUNTING. Every insurer issuing both participating and nonparticipating policies shall separately account for the 2 classes of business and no part of the amounts accumulated or credited to the participating class may be voluntarily transferred to the nonparticipating class.

(4) DIVIDEND PAYMENTS. (a) *Deferred dividends.* No life insurance policy or certificate may be issued in which the accounting, apportionment and distribution of surplus is deferred for a period longer than one year.

(b) *Payment.* Every insurer doing a participating business shall annually ascertain the surplus over required reserves and other liabilities. After setting aside such contingency reserves as may be considered necessary and be lawful, such reasonable nondistributable surplus as is needed to permit orderly growth, making provision for the payment of reasonable dividends upon capital stock and such sums as are required by prior contracts to be held on account of deferred dividend policies, the remaining surplus shall be equitably apportioned and returned as a dividend to the

participating policyholders or certificate holders entitled to share therein. A dividend may be conditioned on the payment of the succeeding year's premium only on the first and second anniversaries of the policy.

NOTE: This section continues and combines ss. 206.13, 206.36 and 208.11, considerably reorganized. An exception is omitted that is stated in s. 206.13 (3) and would go in sub. (3), viz., "except such as the existing charter of the company may require". The words are believed to be inconsistent with the remainder of the section. If the funds have been accumulated from or belong to the participating policyholders, their rights could hardly be affected by the company's charter. This section does not prevent the payment of lawful dividends to shareholders.

The use of "reasonable" as a modifier of "dividends" in the second sentence of par. (b) recognizes the propriety of such limitations on profits to stockholders as are stated in Wis. Adm. Code Ins. 2.02.

SUBCHAPTER VI DISABILITY INSURANCE

632.71 Estoppel from medical examination, assignability and change of beneficiary. Sections 632.47 to 632.50 apply to disability insurance policies.

NOTE: This continues a portion of ss. 201.065, 204.31 (3) (a) 12. a and 209.07. Section 204.31 (3) (a) 12. b is repealed because it seems unsound to permit the insurer to change the rule permitting change of beneficiary.

632.73 Right to return policy. (1) **RIGHT OF RETURN.** A policyholder may return any individual or franchise disability policy within 10 days after receipt. If he does so, the contract is void, and all payments made under it shall be refunded.

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

(3) **EXEMPTIONS.** (a) *Specified.* This section does not apply to single premium nonrenewable policies issued for terms not greater than 6 months or covering accidents only or accidental bodily injuries only.

(b) *By rule.* The commissioner may by rule permit exemptions from subs. (1) and (2) for additional classes or parts of classes of insurance where the right to return the policy would be impracticable or is not necessary to protect the policyholder's interests.

NOTE: This is adapted and simplified from s. 204.31 (2) (a) 8 and 204.32 (4). Certain exceptions are specified by statute, and the commissioner should have power to create by rule additional exceptions as they are shown to be justified.

632.74 Reinstatement of individual or franchise disability insurance policies. (1) **CONDITIONS OF REINSTATEMENT.** If an insurer, after having canceled an individual or franchise disability insurance policy for nonpayment of premium, within one year after the cancellation accepts without reservation a premium payment covering more than the period of time for which premiums remained unpaid prior to the effective date of the cancellation, the policy is reinstated as of the date of the acceptance. There is no acceptance without reservation if the insurer delivers or mails a written statement of reservations within 30 days after receipt of the payment.

(2) **CONSEQUENCES OF REINSTATEMENT.** If a policy is reinstated under sub. (1) or if the insurer within one year after the termination issues to the policyholder a reinstatement policy, any losses resulting from accidents occurring or sickness beginning between the termination and the effective date of the reinstatement or the

new policy are not covered, and no premium is payable for that period, except to the extent that the premium is applied to a reserve for future losses. The insurer may also charge a reinstatement fee in accordance with a schedule that has been filed with and expressly approved by the commissioner as not excessive and not unreasonably discriminatory. In all other respects, the reinstated or renewed contract shall be treated as an uninterrupted contract.

NOTE: This is a substantially modified version of s. 204.31 (3) (a) 4.

a. Reinstatement is a measure that alleviates some of the hardship created by the nearly automatic termination of disability contracts upon failure to pay a premium. Its basic effect is that an insured does not lose the benefits of any incontestable rule (e.g., s. 632.76) if the insurer, after the policy has expired, chooses to accept a belated premium payment or a new application and thus renews the insurance relationship on nearly identical terms after only a short interruption.

Former law did not prescribe any time limits for reinstatement except that premiums could not be applied for any period more than 60 days prior to the reinstatement. This is inadequate in 2 respects. First, it permits the insurer to apply premiums to periods during which it has carried only minimal risk; in other words, the policyholder's payments could be retained by the insurer although there was little coverage. Sub. (2) is designed to prevent that by prohibiting the application of premium payments to any period during which there was no coverage, except as required for reserves plus a reasonable reinstatement fee. Second, former law permitted, theoretically at least, reinstatements many years after the termination of a policy. There should be a reasonable time limit after which reinstatements should no longer be possible. This section limits the reinstatement effects to actions within one year after cancellation.

632.75 Prohibited provisions for disability insurance. (1) DEATH PRESUMED FROM EXTENDED ABSENCE. Section 813.22 (1) applies to any disability insurance policy providing a death benefit.

(2) DIVIDENDS CONDITIONED ON CONTINUATION OF POLICY OR PAYMENT OF PREMIUMS. Except on the first or second anniversary, no dividend payable on a disability insurance policy may be made contingent on the continuation of the policy or on premium payments.

NOTE: Sub. (1) provides a needed cross reference.

Sub. (2) continues the last portion of s. 201.135.

632.76 Incontestability for disability insurance. (1) AVOIDANCE FOR MISREPRESENTATIONS. No statement made by an applicant in the application for individual disability insurance coverage and no statement made respecting his insurability by a person insured under a group policy, except fraudulent misrepresentation, is a basis for avoidance of the policy or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for 2 years. The policy may provide for incontestability even with respect to fraudulent misstatements.

(2) PREEXISTING DISEASES. No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss.

NOTE: Sub. (1) continues ss. 204.31 (3) (a) 2. a (first sentence) and 204.321 (2) (a) 6.

Sub. (2) continues s. 204.31 (3) (a) 2. b.

632.77 Permitted provisions for disability insurance policies. If any provisions are contained in a disability insurance policy dealing with the following subjects, they shall conform to the requirements specified:

(1) **CHANGE OF OCCUPATION.** Any provision respecting change of occupation may provide only for a lower maximum payment and for reduction of loss payments proportionate to the change in appropriate premium rates if the change is to a higher rated occupation, and must provide for retroactive reduction of premium rates at least to the last policy anniversary date if the change is to a lower rated occupation.

(2) **MISSTATEMENT OF AGE.** Any provision respecting misstatement of age may only provide for reduction of the loss payable to the amount that the premium paid would have purchased at the correct age.

(3) **LIMITATIONS ON PAYMENTS.** Any limitation on payments because of other insurance or because of the income of the insured must be in accordance with provisions approved by the commissioner by rule or explicitly approved in approving the policy form.

(4) **FACILITY OF PAYMENT.** Reasonable facility of payment clauses may be inserted. Payment in accordance with such clauses shall discharge the insurer's obligation to pay claims.

NOTE: Sub. (1) replaces s. 204.31 (3) (b) 1.

Sub. (2) replaces s. 204.31 (3) (b) 2.

Sub. (3) replaces s. 204.31 (3) (b) 3, 4, 5 and 6.

Sub. (4) replaces the unnecessary detail of s. 204.31 (3) (a) 9.

632.78 Required provisions for disability insurance policies. (1) **GRACE PERIOD.** Every disability insurance policy shall contain clauses providing for a grace period of at least 7 days for weekly premium policies, 10 days for monthly premium policies and 31 days for all other policies, for each premium after the first, during which the policy shall continue in force. In group and blanket policies the policy must provide for a grace period of at least 31 days unless the policyholder gives written notice of discontinuance prior to the date of discontinuance and in accordance with the policy terms. In group or blanket policies, the policy may provide for payment of a pro rata premium for the period the policy is in effect during the grace period under this subsection.

(2) **KIDNEY DISEASE TREATMENT.** Every disability insurance policy which provides hospital treatment coverage on an expense incurred basis shall contain a clause providing for coverage for hospital inpatient and outpatient kidney disease treatment, which may be limited to dialysis, transplantation and donor-related services, in an amount not less than \$30,000 annually, as defined by the department of health and social services under s. 632.89 (6). No insurer is required to duplicate coverage available under the federal medicare program, nor duplicate any other insurance coverage the insured may have. Coverage under this subsection may not be subject to exclusions or limitations, including deductibles and coinsurance factors, which are not generally applicable to other conditions covered under the policy.

NOTE: Sub. (1) continues ss. 204.31 (3) (a) 3, 204.321 (2) (a) 5 and 204.322 (2) (a) 4.

632.80 Restrictions on medical payments insurance. The provisions of this subchapter do not apply to medical payments insurance when it is a part of or supplemental to liability, steam boiler, elevator, automobile or other insurance covering loss of or damage to property, provided the loss, damage or expense arises out of a hazard directly related to such other insurance.

NOTE: This continues the second sentence of s. 201.04 (18), which is not a part of the definition but a provision respecting contract terms.

632.88 Policy extension for handicapped children. (1) TERMINATION OF COVERAGE. Every hospital or medical expense insurance policy or contract that provides that coverage of a dependent child of a person insured under the policy shall terminate upon attainment of a limiting age for dependent children specified in the policy shall also provide that the age limitation may not operate to terminate the coverage of a dependent child while the child is and continues to be both:

(a) Incapable of self-sustaining employment because of mental retardation or physical handicap; and

(b) Chiefly dependent upon the person insured under the policy for support and maintenance.

(2) PROOF OF INCAPACITY. The insurer may require that proof of the incapacity and dependency be furnished by the person insured under the policy within 31 days of the date the child attains the limiting age, and at any time thereafter except that the insurer may not require proof more frequently than annually after the 2-year period immediately following attainment of the limiting age by the child.

NOTE: This continues ss. 204.315 and 204.335.

SUBCHAPTER VII

FRATERNAL INSURANCE

NOTE: No sections enacted in this bill.

SUBCHAPTER VIII

MISCELLANEOUS

632.97 Application of proceeds of credit insurance policy. Payment to a creditor of any amounts insured under the terms of a credit insurance policy reduces the debt proportionately. This rule does not apply to an insurance policy on which the debtor pays no part of the premium, directly or indirectly.

NOTE: There is no justification for failure to reduce a debt to the extent that the creditor is compensated. The existence of this rule does not suggest that a serious problem exists, but there is no reason not to preclude one from developing. This continues part of s. 206.61 (11), but generalizes it. See also s. 631.69. A creditor has insurable interest in a debtor's life and health and under s. 631.07 does not need consent to protect himself by insurance. Such insurance need not extinguish the debt.

632.98 Workmen's compensation insurance contract provisions. Section 102.31 applies to workmen's compensation insurance.

NOTE: The insurance code should be self-contained so far as possible. Cross references such as this should be provided to insurance-related provisions elsewhere in the statutes. No changes are made in the provision.

SECTION 42g. 632.89 (2) (a) 2 of the statutes, as created by chapter _____, laws of 1975 (Senate Bill 17), is repealed.

SECTION 42r. 632.89 (4) and (6) of the statutes, as created by chapter _____, laws of 1975 (Senate Bill 17), are amended to read:

632.89 (4) AMOUNT OF PROTECTION FOR ORGANIZATIONS SUBJECT TO SUB. (3). Coverage under sub. (3) (b) and (c), combined with coverage under ~~sub. (2) (a) 2 s. 632.78 (2)~~, shall not be less than \$30,000 annually.

(6) RULES. The department of health and social services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under

this section and s. 632.78 (2), which shall not be inconsistent with or less stringent than applicable federal standards.

SECTION 43. Chapter 636 of the statutes is created to read:

CHAPTER 636

CLAIMS ADJUSTMENT

636.10 Timely payment of claims. (1) Unless otherwise provided by law, an insurer shall promptly pay every insurance claim. A claim shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of the loss. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer. Any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer. For the purpose of calculating the extent to which any claim is overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the U.S. mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of 12% per annum.

NOTE: This section continues s. 631.02, created by chapter 39, laws of 1975.

(2) Notwithstanding sub. (1), the payment of a claim shall not be overdue until 30 days after the insurer receives the proof of loss required under the policy or equivalent evidence of such loss. The payment of a claim shall not be overdue during any period in which the insurer is unable to pay such claim because there is no recipient who is legally able to give a valid release for such payment, or in which the insurer is unable to determine who is entitled to receive such payment, if the insurer has promptly notified the claimant of such inability and has offered in good faith to promptly pay said claim upon determination of who is entitled to receive such payment.

(3) This section applies only to the classes of claims enumerated in s. 646.11 (2).

SECTION 44. **Cross reference changes.** In the sections listed below in column A, the cross references shown in column B are changed to the cross references shown in column C:

A	B	C
Statute Sections	Old Cross References	New Cross References
19.11 (2)	204.07	632.17 (2)
59.13 (3)	204.07	632.17 (2)
60.48	204.07	632.17 (2)
61.26 (1)	204.07	632.17 (2)
62.09 (4) (b)	204.07	632.17 (2)
70.67 (1)	204.07	632.17 (2)
148.03 (2)	204.31 (3m)	632.87
206.59	206.17	631.20 to 631.27
208.03 (5)	206.39	632.42 (1)
218.01 (6) (e)	204.36	631.69
349.25 (2)	204.30 (4)	632.24
611.07 (6)	206.39	632.42 (1)
645.47 (1) (a)	204.04 (3)	601.53 (1)