Chapter Ins 6

GENERAL

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Ins 6.01 Foreign company to operate 2 years before admission. Experience has demonstrated that until a company has engaged in the business of insurance for at least 2 years there is not a sufficient basis upon which to form a judgment as to whether its methods and practices in the conduct of its business are such as to safeguard the interests of its policyholders and the people of this state. Therefore, no application of a foreign insurance company or mutual benefit society for a license to transact business in Wisconsin will be considered until it has continuously transacted the business of insurance for at least 2 years immediately prior to the making of such application for license.

Ins 6.02 Company to transact a kind of insurance 2 years before admission. (1) Experience has demonstrated that until a company has engaged in a kind of insurance or in another kind of insurance of the same class for at least 2 years, there is not a sufficient basis upon which to form a judgment as to whether its methods and practices in the conduct of its business in such kind of insurance or another kind in the same class of insurance, are such as to safeguard the interests of its policyholders and the people of this state. Therefore, no application of a foreign insurance company or mutual benefit society for a license to transact a kind of insurance business in Wisconsin will be considered until it has continuously transacted that kind of insurance, or another kind of insurance in the same class of insurance as that for which it makes such application; for at least 2 years immediately prior to making such application. For the purposes hereof, insurance is divided (A) into kinds of insurance accord-

ing to the provisions of section 201.04, Wis. Stats., each subsection setting forth a separate kind, and (B) into classes of insurance upon the basis of and including the said kinds as follows: (a) Fire insurance includes the kinds in section 201.04 (1), Wis. Stats., (as extended by section 203.28), (2) and (12).

(b) Life insurance includes the kinds in section 201.04 (3), Wis. Stats., but excluding all insurance on the health of persons other than that authorized in section 206.03, Wis. Stats.

(c) Casualty insurance includes the kinds in section 201.04 (4) through (11), and (13) through (18), Wis. Stats.

(2) Provided, however, that nothing herein shall preclude consideration of an application to transact the kind of insurance in section 201.04 (4), Wis. Stats., if the applicant company has transacted any of the kinds of insurance in sections 201.04 (3), (5), (13), (15), (16) and (18), Wis. Stats., continuously for 2 years immediately prior to the making of application for license to transact the kind of insurance in section 201.04 (4), Wis. Stats.

Ins 6.03 Nonresident casualty and fire insurance agents. (1) Separate licenses are required for the solicitation of casualty insurance business and of fire insurance business.

(2) A separate license is required for each company for which the nonresident agent solicits business in Wisconsin but the provisions of subsections 201.53 (5) and 209.04 (5), Wis. Stats., permit a licensed nonresident agent to interchange business and receive the whole or any part of the commission from a resident agent on business obtained under such nonresident license and exchanged with the resident agent.

(3) A license will be revoked if the nonresident agent brokers insurance, either in Wisconsin, his state of residence, or elsewhere, of the class (casualty or fire) of insurance covered by the license, unless the placing of such business constitutes an exchange between agents as authorized by subsection 209.04 (5), Wis. Stats. One who solicits brokerage business is not eligible to have a nonresident agent's license for the same class (casualty or fire) of business.

(4) The company which a nonresident wishes to represent as an agent must furnish a statement showing that the applicant is appointed to solicit insurance in Wisconsin as its agent and agree that it will be bound by his knowledge and acts to the same extent as it is in connection with authorized resident agents in Wisconsin.

(5) The applicant for a nonresident agent's license must agree that each policy written by him covering property or risks in Wisconsin will be countersigned by a duly licensed resident agent of the company issuing the policy.

(6) A statement by the supervisory head of the insurance department of the state of residence showing that the applicant is a licensed agent in his state of residence for the company which he desires to represent in Wisconsin must be furnished when application is made for a nonresident agent's license.

(7) The applicant will be required to make full disclosure regarding any connection which he may have as an employe or member

of any agency partnership, association or corporation, including the full names and residences of all members, officers, directors and stockholders.

(8) Licenses issued on or after November 1, 1949, shall expire on the next succeeding November 1st. The fee for each nonresident agent's license shall be $10.00.

Ins 6.04 Countersignature requirements. (1) Every policy of insurance issued or delivered in this state shall be countersigned by a licensed resident agent. Except in the case of the standard fire policy, an agent's signature on a copy of an application attached to and forming a part of a policy will be considered as satisfying this requirement.

(2) This rule shall not apply to: (a) Policies issued in accordance with sections 201.44 (6), 201.44 (8), 202.08, or 209.04 (10) (c), (d), (e) and (f), Wis. Stats.;

(b) Policies of life insurance;

(c) Service contracts issued by hospital service corporations authorized under section 182.032, Wis. Stats.;

(d) Contracts issued by state or county medical societies authorized under section 148.01, Wis. Stats.;

(e) Contracts issued under authority of chapter 185, Wis. Stats.

History: Cr. Register, April, 1958, No. 28, eff. 5-1-58; am. (2) (a), Register, April, 1963, No. 88, eff. 5-1-63.

(b) *Grades.* The passing grade on all examinations is 70. When an applicant passes an examination, a grade of "pass" is to be indicated on the application. When an applicant fails an examination, the numerical grade is to be indicated on the application. Results will be mailed to the applicant.

(c) *Frequency.* If the applicant fails the first examination, he must wait at least 5 days from the date of the first examination before taking a second examination of the same kind. For all lines except life, upon failure to pass the same kind of examination a second time, the applicant must wait at least 30 days from the date of the second examination before repeating the examination procedure. For life insurance, the applicant must wait at least 6 months from the date of the second examination, as required by section 206.41 (4) (b) 2, Wis. Stats.

(d) *Time and place of examinations.* 1. Examination for life insurance agents' licenses may be taken in the office of the commissioner of insurance any work day. Applicants must report between 7:45 and 10:30 a.m. or between 12:30 and 3:15 p.m.

2. Examinations for all kinds of insurance agents' licenses will be administered at 9:30 a.m. on the second Saturday of each month at the following examination centers: Eau Claire, Green Bay, Madison, Milwaukee, Oshkosh, Platteville, Racine, Rhinelander, Superior.

3. Examinations for all kinds of insurance agents' licenses will be administered at 9:30 a.m. on the fourth Saturday of each month at the following examination centers: La Crosse, Madison, Milwaukee, Rice Lake, Stevens Point.

4. The center in each city shall be indicated on the "Notice to Report for Examination" (Form 11–4B) (Wis. Adm. Code section Ins 7.01 (4) (m)) sent each applicant.

5. Applicants who do not live in Wisconsin will be examined through arrangement with the insurance regulatory authority of their state of residence.

History: Cr. Register, December, 1967, No. 144, eff. 1–1–68; r. and recr. (3) (d), Register, November, 1971, No. 191, eff. 12–1–71.

Ins 6.51 Group coverage discontinuance and replacement. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of group policyholders, insurance companies, nonprofit service plans, protected persons, claimants and the general public by setting forth principles and procedures applicable in providing coverage when a group or group type insurance contract is discontinued or replaced. This rule interprets and implements, including but not limited to the following Wisconsin statutes: Sections 200.26 (3) (c); 201.045; 204.32; 204.321; 206.60; 206.61; 206.64; and 601.01 (3) (b).

(2) SCOPE. This rule shall apply to all insurance policies issued or provided by an insurance company under authority of sections 201.04 (3) or 201.04 (4), Wis. Stats., on a group or group type basis covering persons as employees of employers or as members of unions or associations and to subscriber contracts issued or provided by an organization under authority of section 200.26, Wis. Stats., on a group or group type basis covering persons as employees of employers or as members of unions or associations.

(3) DEFINITION. The term "group type basis" means a benefit plan, other than "salary savings" or "salary budget" plans, utilizing indi-

vidual insurance policies or subscriber contracts, which meets the following conditions:

(a) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.

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

(c) There are arrangements for bulk payment of premiums or subscription charges to the insurer or non-profit service organization.

(d) There is sponsorship of the plan by the employer, union, or association.

(4) EFFECTIVE DATE OF DISCONTINUANCE FOR NON-PAYMENT OF PREMIUM OR SUBSCRIPTION CHARGES. (a) If a policy or contract subject to this rule provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

(b) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making premium payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.

(5) REQUIREMENTS FOR NOTICE OF DISCONTINUANCE. (a) Any notice of discontinuance so given by the carrier shall include a request to the group policyholder or other entity involved to notify employees covered under the policy or subscriber contract of the date as of which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims for losses incurred after such date. Such notice of discontinuance shall also advise, in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

(b) The carrier will prepare and furnish to the policyholder or other entity at the same time a supply of a notice form to be distributed to the employees or members concerned indicating such discontinuance and the effective date thereof, and urging the employees or members to refer to their certificates or contracts in order to determine what rights, if any, are available to them upon such discontinuance.

(6) EXTENSION OF BENEFITS. (a) Every group policy or other contract subject to this rule hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must provide

a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract during the continuance of total disability as required by the following paragraphs of this section.

(b) In the case of a group or group type life plan which contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the policy shall not operate to terminate such extension.

(c) In the case of a group or group type plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement.

(d) In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required. Such a provision will be considered reasonable if it provides an extension of at least 12 months under major medical and comprehensive medical type coverages, and under other types of hospital or medical expense coverages provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event which occurred while coverage was in force (e.g., an accident).

(e) Any applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability may be subject to the policy's or contract's regular benefit limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

(7) CONTINUANCE OF COVERAGE IN SITUATIONS INVOLVING REPLACEMENT OF ONE CARRIER BY ANOTHER. (a) This section shall indicate the carrier responsible for liability in those instances in which one carrier's contract replaces a plan of similar benefits of another.

(b) Liability of prior carrier. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity involved secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

(c) Liability of succeeding carrier:

1. Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively at work and non-confinement rules) shall be covered by that carrier's plan of benefits.

2. Each person not covered under the succeeding carrier's plan of benefits in accordance with subparagraph 1. above must nevertheless be covered by the succeeding carrier in accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.

a. The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.

b. Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:

i) The date the individual becomes eligible under the succeeding carrier's plan as described in subparagraph 1. above.

ii) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage (e.g., at termination of employment or ceasing to be an eligible dependent, as the case may be).

iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which subsection (6) requires an extension or accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by subsection (6) or, if the prior carrier's policy or contract is not subject to that section, would have been required of that carrier had its policy or contract been subject to subsection (6) at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

3. In the case of a pre-existing conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to pre-existing conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection during the period of time this limitation applies under the new plan shall be the lesser of

a. The benefits of the new plan determined without application of the pre-existing conditions limitation; and

b. The benefits of the prior plan.

4. The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.

5. In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this section, benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

(8) EFFECTIVE DATE. This rule shall apply to all insurance policies and subscriber contracts subject to the rule which are issued or renewed on or after January 1, 1973.

History: Cr. Register, October, 1972, No. 202, eff. 11–1–72.

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