Chapter Ins 3

CASUALTY INSURANCE

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

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

Ins 3.03 History: 1–2–56; r. Register, October, 1958, No. 34, eff. 11–1–58.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under section 204.28, Wis. Stats.

Ins 3.05 History: 1–2–56; r. Register, October, 1958, No. 34, eff. 11–1–58.

Ins 3.06 History: 1–2–56; r. Register, October, 1958, No. 34, eff. 11–1–58.

Ins 3.07 Rules in chapter 4, fire and allied lines insurance, applicable to casualty insurance. The following captioned rules under chapter 4, FIRE AND ALLIED LINES INSURANCE, are applicable to casualty insurance:

Ins 4.01 Mutual insurance companies operating on a post mortem assessment plan cannot limit assessments to a specified amount.

Ins 4.02 Nonassessable policies of mutual companies.

Ins 4.03 Policy, inspection and similar fees.

Ins 3.08 History: Cr. Register, October, 1956, No. 10, eff. 11–1–56; (19) is renum. to be (20); cr. (19), Register, June, 1960, No. 54, eff. 7–1–60; am. (19), Register, April, 1964, No. 100, eff. 5–164; r. Register, May, 1973, No. 209, eff. 6–1–73.

Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This rule is intended to implement and interpret applicable statutes for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) DEFINITION. Mortgage guaranty insurance is that kind of insurance authorized by section 201.04 (19), Wis. Stats., and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(3) ACCOUNTING AND REPORTING. (a) The financial position of an insurer shall be reported annually on the Fire and Casualty annual statement form specified by Wis. Adm. Code section Ins 7.01 (5) (a).

(b) Expenses shall be recorded and reported in accordance with Wis. Adm. Code sections Ins 6.30 and Ins 6.31.

(c) The unearned premium reserve shall be computed in accordance with section 201.18 (1), Wis. Stats., except that in the case of premiums paid in advance for ten-year policies the annual pro rata factors specified below or comparable monthly pro rata factors shall apply.

Year	Unearned Factor to be Applied to Premiums in Force	Year	Unearned Factor to be Applied to Premiums in Force
1	90.0%	6	19.0%
2	70.0%	7	12.0%
3	52.5%	8	7.0%
4	39.0%	9	3.5%
5	28.0%	10	1.0%

(d) From the premium remaining after establishment of the premium reserve specified in paragraph (c) of this subsection, a portion equal to the contingency factor prescribed in paragraph (c) of subsection (4) shall be maintained as a special contingency reservation of premium and reported in the financial statement as a liability.

(e) The case basis method shall be used to determine the loss reserve, which shall include a reserve for claims reported and unpaid and a reserve for claims incurred but not reported.

(4) CONTINGENCY RESERVE. (a) The reserve established in paragraph (d) of subsection (3) shall be maintained for 120 months for the purpose of protecting against the effect of adverse economic cycles and to permit mortgage guaranty insurance companies to comply with section 832 (e) of the federal internal revenue code. That portion of the special premium reserve established more than 120 months prior shall be released and shall no longer constitute part of the special reserve and may be used for usual corporate purposes.

(b) Subject to the approval of the commissioner, the reserve shall be available only for loss payments when the incurred losses in any one year exceed 35% of the corresponding earned premiums.

(c) The contingency factor in the rate formula shall be 50% of the premium remaining after establishment of the premium reserve specified in subsection (3) (c).

(d) In event of release of the special reserve for payment of losses, the contributions required by paragraph (d) of subsection (3) shall be treated on a first-in-first-out basis.

(e) Whenever the laws of any other state require a greater unearned premium reserve than that set forth in subsection (3) (c), the contingency reserve of mortgage guaranty insurers organized under the laws of that state may be an amount which when added to such unearned premium reserve will result in a reserve equal to the sum of the unearned premium reserve and the contingency reserve required of insurers organized under the laws of Wisconsin.

(5) POLICY FORMS. All policy forms and endorsements shall be filed with and be subject to the approval of the commissioner of insurance. With respect to owner-occupied single-family dwellings, the mortgage insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

History: Cr. Register, March, 1957, No. 15, eff. 4–1–57; am. (2), (3), (4) and (5), Register, January, 1959, No. 37, eff. 2–1–59; am. (4) (c), Register, August, 1959, No. 44, eff. 9–1–59; cr. (4) (e), Register, January, 1961, No. 61, eff. 2–1–61; am. (2), Register, January, 1967, No. 133, eff. 2–1–67; am. (2), (3) (a) and (b), and (4) (a) and (b); r. and recr. (5), Register, December, 1970, No. 180, eff. 1–1–71.

Ins 3.11 Multiple peril insurance contracts. (1) PURPOSE AND SCOPE. (a) This rule implements and interprets sections 201.05, 203.32, and 204.37 to 204.54 inclusive, Wis. Stats., by enumerating the minimum requirements for the writing of multiple peril insurance contracts. Nothing herein contained is intended to prohibit insurers or groups of insurers from justifying rates or premiums in the manner provided for by the rating laws.

(b) This rule shall apply to multiple peril insurance contracts permitted by section 201.05, Wis. Stats., and which include a type or

Next page is numbered 43

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

"Notice! See Elimination Endorsement Included Herein"
"Notice! See Exclusion Endorsement Included Herein"
"Notice! See Exception Endorsement Included Herein"
"Notice! See Limitation Endorsement Included Herein"
"Notice! See Reduction Endorsement Included Herein"

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

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

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

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

(5) FILING PROCEDURE. Policy forms, riders or endorsements submitted for review and approval must be filed as follows: (a) One copy of all such forms (two copies should be submitted if company desires one copy stamped as approved and returned) shall be submitted with a copy of the application applying thereto, if such application is to be made a part of the contract. If such application is already on file and has been previously approved, the form number and date of approval may be submitted rather than the application.

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

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

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

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

1. Policy forms.

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

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

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

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

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

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

5. Subsection (6), paragraphs (b) 3 and (b) 4, shall not apply to non-cancellable policies or riders or non-cancellable and guaranteed renewable policies or riders or guaranteed renewable policies or riders.

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

Ins 3.14 Group accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of group accident and sickness policies permitted by subsection 204.321 (1), Wis. Stats.

(2) FILING PROCEDURE. Policy forms, including certificates, riders or endorsements submitted for review and approval must be filed as follows: (a) One copy of all such forms (2 copies should be submitted if company desires one copy stamped as approved and returned) shall be submitted with a copy of the application applying thereto, if such application is to be made a part of the contract. If such application is already on file and has been previously approved, the form number and date of approval may be submitted rather than the application.

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

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

1. The identifying form number and title, if any, of the form.

2. A general description of the form.

tisements of the insurer's policies which were disseminated during the statement year complied or were made to comply in all respects with the provisions of the insurance laws of this state as implemented.

(30) PENALTY. Violations of this rule shall subject the violator to section 601.64, Wis. Stats.

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

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

History: Cr. Register, April, 1973, No. 208, eff. 6–1–73; am. (zb), (11) (c) 1. and (11) (e), Register, August, 1973, No. 212, eff. 9–1–73.

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

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

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

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

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

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

(c) An insurer which issues coverage for a person without having resolved patently conflicting or incomplete statements in the application for the coverage, or fails to consider information furnished to it in connection with the processing of such application, or in connection with individual coverage on such person previously issued by it and currently in force, shall not use such statements or information to void the coverage or to deny a claim.

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

IMPORTANT NOTICE
CONCERNING STATEMENTS IN THE APPLICATION
FOR YOUR INSURANCE

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

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

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

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

(b) If an application contains no question concerning the proposed insured person's health history or medical treatment history and regardless of whether it contains a question concerning the proposed insured person's general health at the time of the application, the insurer may use the pre-existence defense, under coverage providing such a defense, only with respect to losses incurred within

twelve months from the effective date of coverage, unless the disease or physical condition causing the loss is excluded from coverage by name or specific description effective on the date of loss.

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

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

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

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

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

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

History: Cr. Register, February, 1974, No. 218, eff. 3-1-74.

Next page is numbered 83