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

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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.

Ins 3.29 Repacement of accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to safeguard the interests of persons covered under accident and sickness insurance who consider the replacement of their insurance by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. This rule implements and interprets sections 201.53 (13), 207.04 (1) (a), and 601.01 (3) (b), Wis. Stats.

(2) SCOPE. This rule shall apply to the solicitation of accident and sickness insurance covering residents of this state and issued by insurance corporations, fraternal benefit societies or nonprofit service

plans in accordance with sections 201.04 (4), 208.01 or 200.26, Wis. Stats.

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

(a) Group, blanket or group type,

(b) Accident only,

(c) Single premium nonrenewable,

(d) Nonprofit dental care,

(e) Nonprofit prepaid optometric service,

(f) A limited policy conforming to Wisconsin Administrative Code section Ins 3.13 (2) (h),

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

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

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

(j) Change to a Medicare supplement policy which covers preexisting conditions, without any limitation, to replace a basic hospital expense, basic medical expense, basic surgical expense, or major-medical expense policy.

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

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

(b) *Continuous coverage* means that the benefits are not less than the benefits under the previous policy, and the policy also covers loss resulting from injury sustained or sickness contracted while coverage was in force under the previous policy to the extent such loss is not covered under any extended benefit or similar provision of the previous policy.

(c) *Group type coverage* is as defined in Wis. Adm. Code section Ins 6.51 (3).

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

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

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

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

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

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

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

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

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

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

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

The above "Notice to Applicant" was delivered to me on _____.
(Date)

_____
Applicant

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

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

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

History: Cr. Register, June, 1974, No. 222, eff. 9–1–74.

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

(2) SCOPE. This rule shall apply to policy forms subject to sections 204.31, 204.32, 204.321 or 204.322, Wis. Stats.

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

(a) Shall comply with section 204.31 (3) (a) (introductory paragraph) and 12, (c) and (d), Wis. Stats., except as provided in sections 204.321 (2) (b) or 204.322 (2) (b), Wis. Stats., where applicable, and

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

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

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

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

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

History: Cr. Register, May, 1974, No. 221, eff. 6–1–74.

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