# 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 3.04 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 3.07 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 3.09 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.

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 and franchise accident and sickness insurance.** (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and of contracts issued by a plan subject to 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 sections 204.31 or 204.32, Wis. Stats., except credit accident and sickness insurance under section 201.04 (4a), Wis. Stats., 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 purpose of this rule, references to insurer, policy, and insurance agent or representative, also apply to organizations or associations operating non-profit plans, contracts, and persons within the scope of the rule, respectively.

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

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

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

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

(c) An insurer which issues coverage for a person 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 or 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 contains questions relating to the medical history or other matters concerning the insurability of the person or persons being insured and 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 pre-existence 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 (f) and (6) shall apply to all solicitation, underwriting, and claims activities, except under franchise insurance, relating to Wisconsin residents after March 1, 1974, except that paragraphs (6) (a) and (b) shall apply to policies issued after that date.

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

(c) This rule shall apply to all solicitation, underwriting and claims activities under franchise insurance relating to Wisconsin residents after December 1, 1974, except that paragraphs (6) (a) and (b) shall apply to policies issued after that date and paragraphs (5) (d) and (e) shall apply to such activities after February 1, 1975.

**History:** Cr. Register, February, 1974, No. 218, eff. 3–1–74; am. (5) (d) (intro. par.), Register, July, 1974, No. 223, eff. 8–1–74; am. (2) and (7), Register, November, 1974, No. 227, eff. 12–1–74.

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

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

**Ins 3.31 Eligibility for and solicitation, underwriting and claims practices in group, blanket and group type accident and sickness insurance.** (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and coverage issued by a plan subject to sections 185.981 or 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).

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of insurance issued by an insurer under sections 204.321, or 204.322, Wis. Stats., except credit accident and sickness insurance under section 201.04 (4a), Wis. Stats., and coverage issued on a group basis or group type basis as defined in Wis. Adm. Code section Ins 6.51 (3) by a plan subject to sections 185.981, or 200.26, Wis. Stats. For the purposes of this rule, references to insurer, cer-

tificate, insurance agent or representative, enrollment form and enrollee also apply to organizations or associations operating non-profit plans, contracts, summaries of coverage, persons within the scope of the rule, individual applications and applicants, respectively.

(3) GROUP AND GROUP TYPE INSURANCE. An insurer issuing insurance under section 204.321, Wis. Stats., or group or group type coverage under section 185.981 or 200.26, Wis. Stats., shall,

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

1. Enrollment Form. An enrollment form shall provide to the effect that statements made by the enrollee in the enrollment form regarding the general medical history or general health of the proposed insured person which require an opinion or the exercise of judgment are representations or are to the best of the enrollee's knowledge and/or belief. Such form need not so provide with respect to statements regarding specifically named diseases, physical conditions, or types of medical consultation or treatment. Such forms shall not require the enrollee to state that he has not withheld any information or concealed any facts in completing the enrollment form; however, the enrollee may be required to state that his answers are true and complete.

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

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

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

c. An insurer which issues evidence of coverage for a person without having resolved patently conflicting or incomplete statements in the enrollment form for the coverage, or fails to consider information furnished to it, in connection with the processing of such enrollment form shall not use such statements or information to void the coverage or to deny a claim.

d. An insurer shall furnish to the certificate holder or subscriber a notice in the form of a sticker or other form to be attached to the first page of the certificate or amendment, or furnish to the group policyholder or other such entity within 10 days after the issuance or amendment of coverage for delivery to the certificate holder or subscriber a notice in the form of a letter or other form, such notice to contain substantially the following:

IMPORTANT NOTICE
CONCERNING STATEMENTS IN THE ENROLLMENT FORM
FOR YOUR INSURANCE

Please read the copy of the enrollment form attached to this

notice or to your certificate or which has been otherwise previously delivered to you by the insurer or group policyholder. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the insurer within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

e. An insurer shall file with the Commissioner a description of the procedure it will follow and the form or forms it will use to meet the requirements of subdivision 3. d. of this paragraph (a).

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

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

4. Claims Administration. a. If the existence of a disease or physical condition was duly disclosed in the enrollment form for coverage in response to the questions therein, 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 enrollment form contains no question concerning the proposed insured person's health history or medical treatment history and regardless of whether it contains a question concerning the proposed insured person's general health at the time of enrollment the insurer may use the pre-existence defense, under coverage providing such a defense, only with respect to losses incurred within twelve months from the effective date of the person's 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 enrollment form for such coverage did not disclose certain information considered material to the risk if the form did not clearly require the disclosure of such information.

(b) Be subject to the following:

1. A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss 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 medical diagnosis or treatment of such disease or physical condition prior to the effective date, or 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.

2. Coverage which contains wording which requires the cause of

the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with subparagraph 1 of this paragraph (b).

3. An insurer shall not exclude or limit benefits, using the pre-existence defense, a waiting period, a benefit maximum or other policy limitation, where the claimant's medical records indicate a reasonable basis for distinguishing between a 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 the 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.

(c) Where the group or group type plan is issued to trustees of a fund as described by section 204.321 (1) (c), Wis. Stats., use the plan's provisions regarding individual eligibility for coverage and individual termination of coverage to deny liability for or to defend against a claim only if the certificate issued pursuant to the plan, under an appropriate caption or captions, includes the applicable requirements regarding an individual's eligibility for coverage and the conditions under which an individual's coverage terminates under the plan.

(4) BLANKET INSURANCE. An insurer issuing insurance under section 204.322, Wis. Stats., shall

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

(b) Be subject to the following: 1. 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 medical diagnosis or treatment of such disease or physical condition prior to the effective date or 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.

2. Coverage which contains wording which requires the cause of the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with subparagraph 1. of this paragraph (b).

3. An insurer shall not exclude or limit benefits, using the pre-existence 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 con-

dition or conditions which did not contribute to the need for the confinement or treatment or did not contribute to the disability.

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

**History:** Cr. Register, November, 1974, No. 227, eff. 12–1–74.

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