(6) POLICY FORMS. The purchaser must be furnished with a complete policy form clearly setting forth the nature and extent of all coverages and premiums charged therefor.

(7) RATING STATEMENT. No policy written on the basis of a sub-standard risk rate schedule shall be issued unless it contains a statement printed in bold-faced type, preferably in a contrasting color, reading substantially as follows: This policy has been rated in accordance with a special rating schedule filed with the commissioner of insurance providing for higher premium charges than those generally applicable for average risks. If the coverage or premium is not satisfactory, you may secure your own insurance.

History: Cr. Register, March, 1960, No. 51, eff. 4-1-60.

Ins 3.21 "In the same industry", definition of. (1) The phrase "in the same industry", as used in section 204.321 (1) (c), Wis. Stats., may be construed so that establishments engaged in one of the following activities may be considered as being in the same industry: (a) retail trade, (b) wholesale trade, (c) service, (d) mining, (e) contract construction, (f) finance, insurance and real estate, (g) transportation, communication and other public utilities, and (h) manufacturing.

(2) The principal activity of an establishment shall control its classification.

(3) An insurer may submit other classifications of establishments, subject to the approval of the commissioner, which it believes may properly be considered as engaging in activities which are "in the same industry".

Note: The above rule is an outgrowth of the hearings held by the department on December 17, 1963, to consider the formulation of rules and guide lines which insurance companies could use to determine what groupings of employers might be permitted by the phrase "in the same industry" in sections 204.321 (1) (c) and 206.60 (4), Wis. Stats., to obtain group insurance coverage for their employees through the establishment of a trust. As a result of the hearing, the department has reviewed the background and history of the "in the same industry" provision which was adopted as a part of the "Group Life Insurance Definition" and "Group Life Insurance Standard Provisions", revised at New York on December 15, 1948, by the National Association of Insurance Commissioners and enacted as a part of the Wisconsin Statutes in 1949. The Department has concluded that the phrase "in the same industry" should be liberally construed. It provides a means whereby a small employer, not having a sufficient number of employees to qualify for a group plan of his own, may join with others and provide the benefits of group insurance to his employees and thereby compete in the labor market with the large employer. It has been emphasized to the department that the statutes involved are insurance statutes and that there is no underwriting reason which dictates greater detail or narrower classifications under the law. To require a more detailed breakdown only has the effect of adding to the administrative detail and expense of setting up such a plan, and such does not appear to be required nor in the public interest.

"The rule was amended May 1, 1975 so that it would apply to organizations engaged in manufacturing. This was accomplished by adding reference to manufacturing in subsection (1). This in effect removes the application of the advisory opinions of the Attorney General dated January 16, 1958 and December 30, 1958 on this subject."

For a general guide as to the types of organizations which fall within each of the groupings listed in subsection (1) of this rule, the department suggests that insurers refer to the division headings found in the "Standard Industrial Classification Manual" prepared by the United States Bureau of the Budget, Technical Committee on Industrial Classification, Office of Statistical Standards, 1957, and to other similar material such as the industrial classification starting on page XI of the "U.S. Census of Population 1960—Classified Index of Occupations and Industries," published by the United States Department of Commerce, Bureau of the Census, 1960; and Volume V, No. 1, "Wisconsin Commerce Reports," Bureau of Business Research and Service, Madison, Wisconsin, April 1, 1957.

History: Cr. Register, February, 1964, No. 98, eff. 3-1-64; am. (1), Register, April, 1975, No. 232, eff. 5-1-75.

Ins 3.22 Bail bond insurance. (1) PURPOSE. This rule is intended to implement and interpret applicable statutes including but not limited to sections 201.04 (7), 204.01 to 204.14, Wis. Stats., inclusive, and 209.04 Wis. Stats., for the purpose of establishing minimum requirements for the transaction of bail bond insurance.

(2) DEFINITIONS. (a) *Commissioner* means the commissioner of insurance.

(b) *Insurer* means any domestic, foreign, or alien insurance company which has qualified to transact fidelity business under subsection 201.04 (7), Wis. Stats.

(c) *Bail bondsman* means an individual who shall be appointed by an insurer by power of attorney as its licensed agent under section 209.04, Wis. Stats., to execute or countersign bail bonds in connection with judicial proceedings and who receives or is promised money or other things of value therefor.

(4) POWER OF ATTORNEY. Every insurer engaged in the writing of bail bonds shall submit to and have approved by the commissioner a sample power of attorney which shall be the only form of power of attorney the insurer shall issue in this state.

(5) BAIL BOND RATES. (a) Bail bond rates and premiums are subject to the provisions of sections 204.37 to 204.54, Wis. Stats. It is unlawful for any bail bondsman to execute a bail bond without charging the filed rate and premium therefor. No bail bondsman shall make any charge or collect or receive any fee, service fee, or consideration other than the premium based on rates and premiums as approved by the commissioner. Nothing in this rule shall prohibit collateral security or coindemnity agreements.

(b) The premium shall be a term charge for the term of the bond. No additional premium shall be charged in the event of a bind over except that if the amount of the bond has been increased a premium based on the approved rate for the amount of the increase may be charged.

(c) If the penal sum of the bond is reduced within 7 days after time of commitment by the original committing jurisdiction, the defendant shall be entitled to a refund of the premium in proportion to the amount of the reduction except that the minimum premium shall not be affected.

(d) The original premium charged and any additional or return premium required hereunder shall be shown or endorsed on the bond.

(6) ISSUANCE OF BAIL BONDS. No person shall execute or countersign bail bonds for a fee, or act in the capacity of a bail bondsman, or perform any of the functions, duties or powers prescribed for bail bondsmen, or collect any premium or fee under the provisions of this rule unless he is licensed as a bail bondsman under section 209.04, Wis. Stats.

History: Cr. Register, April, 1964, No. 100, eff. 6-1-64; r. (3) Register, December, 1967, No. 144, eff. 1-1-68.

Ins 3.23 Franchise accident and sickness insurance. (1) FRANCHISE GROUP HEADQUARTERS. A franchise group described in

section 204.32 (1), Wis. Stats., need not have its headquarters or other executive offices domiciled in Wisconsin.

(2) ACCOUNTING. All premiums paid in connection with franchise accident and sickness insurance on Wisconsin residents shall be reported for annual statement purposes as Wisconsin business and shall be subject to the applicable Wisconsin premium tax.

History: Cr. Register, May, 1964, No. 101, eff. 6-1-64.

Ins 3.25 Credit life insurance and credit accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to assist in the maintenance of a fair and equitable credit insurance market and to protect the interest of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life insurance and credit accident and sickness insurance. This rule interprets and implements, including but not limited to the following Wisconsin Statutes: sections 201.18, 204.31 (3) (g), 204.321 (4), 206.17, 206.20, 206.201, 206.60 (2), 206.63, 601.01 (3) (b) and (c), 601.42, 625.11, 625.12 and 625.34.

(2) SCOPE. (a) This rule shall apply to the transaction of credit life insurance defined in section 201.04 (3c) and 206.63, Wis. Stats., and to the transaction of credit accident and sickness insurance as defined in section 201.04 (4a), Wis. Stats.

(b) This rule shall be the basis for review of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates pertaining thereto submitted for filing after the effective date of this rule.

(c) This rule shall not apply to an individual or group life insurance policy or an individual or group accident and sickness insurance policy which insures only debtors whose indebtedness to a creditor is for a term in excess of 5 years.

(3) FORMS OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE. Credit life insurance and credit accident and sickness insurance shall be issued only in the following forms:

(a) Individual policies of life insurance issued to debtors on the nonrenewable, nonconvertible term plan;

(b) Individual policies of accident and sickness insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

(d) Group policies of accident and sickness insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

(4) (a) The amount of credit life insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable in installments to the creditor, or $10,000, whichever is less. Except for a consumer credit transaction primarily for an agricultural purpose (section 421.301 (4), Wis. Stats.), where the indebtedness is

repayable in one sum to the creditor, the insurance on the life of any debtor shall in no instance be in effect for a period in excess of 18 months except that such insurance may be continued for an additional period not exceeding 6 months in the case of default, extension or recasting of the loan. The amount of insurance on the life of any debtor shall at no time exceed the amount of unpaid indebtedness, or $10,000, whichever is less.

(b) The total amount of periodic indemnity payable by credit accident and sickness insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic schedule of unpaid instalments of indebtedness, or $10,000, whichever is less, and the amount of each periodic indemnity shall not exceed the original total amount of periodic indemnity divided by the number of periodic installments.

(5) TERM OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE. The term of any credit life insurance or credit accident and sickness insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of indebtedness except when extended without additional cost to the debtor or as an incident to a deferral, refinancing or consolidation agreement. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In any renewal or refinancing of the indebtedness the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, but this does not apply to an amount of indebtedness, exclusive of refinancing charges, in excess of the original indebtedness outstanding at the time of refinancing. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in subsection (8).

(6) PROVISIONS OF POLICIES AND CERTIFICATES OF INSURANCE; DISCLOSURE TO DEBTORS. (a) All credit life insurance and credit accident and sickness insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance and/or credit accident and sickness insurance shall, in addition to other requirements of law set forth:

1. The name and home office address of the insurer,

2. The name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor,

3. The premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and sickness insurance,

4. A description of the coverage including the amount and term thereof, and any exceptions, limitations and restrictions,

5. A provision that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate, and

6. A provision that the insurance on any debtor will be cancelled and refund made if his indebtedness is terminated through prepayment or otherwise.

(c) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.

(d) If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance shall;

1. Be delivered to the debtor at the time such indebtedness is incurred,

2. Be signed by the debtor,

3. Set forth the name and home office address of the insurer,

4. Set forth the name or names of the debtor,

5. Set forth the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and sickness insurance, and

6. Set forth the amount, term and a brief description of the coverage provided including all exclusions and exceptions.

(dm) The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificates of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in subsection (5).

(e) If the named insurer does not accept the risk, then and in such event the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer, if any, and the information required by subsection (6) (b),

and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made.

(f) If a contract of insurance provides for a limitation of the amount of coverage related to insurance provided by other contracts in force on the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing by him in an instrument separate from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the limitation of amount of coverage. The brief description or separate statement, if used to meet the foregoing requirement, shall be printed on the first page of the individual policy or group certificate in type more prominent than that used in the text of the policy or certificate and shall clearly indicate the limitation.

(g) If a contract of insurance provides for a limitation of coverage related to the age of the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing by him in an instrument separate from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the age limitation. The brief description or separate statement, if used to meet the foregoing requirement, shall be printed on the first page of the individual policy or group certificate in type more prominent than that used in the text of the policy or certificate and shall clearly indicate the limitation.

(h) Conspicuous notice of the debtor's right to return the policy, certificate of insurance or notice of proposed insurance within 10 days of incurring the indebtedness and to receive a refund of any premium paid if he is not satisfied with the insurance for any reason, as required by section 424.203 (4), Wis. Stats., shall be furnished with or in the policy, certificate or notice of proposed insurance.

(i) Charges or premiums for credit life insurance or credit accident and sickness insurance may only be collected from debtors if the disclosure and authorization requirements of section 422.202 (1) (b), Wis Stats., are met. If 2 debtors are to be insured for credit life insurance each must receive the disclosure information and each must request credit life insurance coverage.

(7) FILING OF POLICY FORMS. (a) All policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner. In the case of credit transactions covered under a group policy issued in another state or jurisdiction, the insurer shall file for approval only the group certificate and notice of proposed insurance to be used in this state, and the premium rates to be used in connection with such certificate and notice.

(b) The commissioner shall within 30 days after the filing of any such policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement or rider, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions which are unjust,

unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any law or of any administrative rule.

(c) If the commissioner notifies the insurer that the form is disapproved, it may not issue or use such form. Such notice shall specify the reason for the disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until the expiration of 30 days after it has been so filed, unless the commissioner shall give his prior written approval thereto.

(d) The commissioner may, at any time after a hearing held not less than 20 days after written notice to the insurer, withdraw his approval of any such form on any ground set forth in paragraph (b) above. The written notice of such hearing shall state the reason for the proposed withdrawal.

(e) The insurer may not issue such forms or use them after the effective date of such withdrawal.

(8) PREMIUMS AND REFUNDS. (a) Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit accident and sickness insurance policy for which the premium rate differs from that determined by the schedules of such insurer as then on file.

(b) The amount charged to a debtor for any credit life or credit accident and sickness insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(c) If a creditor requires a debtor to make any payment for credit life insurance or credit accident and sickness insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(d) A creditor may not remit and an insurer may not collect on a monthly outstanding balance basis if the insurance charge or premium is included as part of the outstanding indebtedness. This means that where the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of indebtedness, and any direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with such insurance charge, the creditor must remit and the insurer shall collect on a single premium basis only.

(e) Dividends on participating individual policies of credit insurance shall be payable to the individual insureds. Payment of such dividends may be deferred until such time as the policy is terminated.

(f) Each individual policy, or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided, however, that the premium

schedule may prescribe a minimum refund of $1 and no refund of a lesser amount need be made. The sum of the refunds due on all credit life insurance or credit accident and sickness insurance policies being terminated in connection with the indebtedness and all other credits due to the customer under chapters 421 to 428, Wis. Stats., shall be used to determine if a refund is due.

(g) Schedules for computing refunds in event of cancellation of credit insurance prior to the scheduled maturity date of the indebtedness must meet the following minimum requirements:

1. The refund of premium, in the case of credit insurance for which premiums are payable other than by a single premium, and in the case of level term credit life insurance, shall be equal to the pro-rata unearned gross premium. In the case of credit insurance paid by a single premium the refund shall be equal to the amount computed by the "sum of digits" formula commonly known as the "Rule of 78".

2. The refund of the amount charged the debtor for insurance, in the case of credit insurance for which said amount is charged other than in single sum, and in the case of level term credit life insurance, shall be equal to the pro-rata unearned gross amount charged or to be charged. In the case of credit insurance for which the whole amount is charged in a single sum the refund shall be equal to the amount computed by the "sum of digits" formula commonly known as the "Rule of 78".

3. Refunds shall be based upon the number of full months prepaid from the maturity date of the policy, counting a fractional month of 16 days or more as a full month.

4. Upon termination of indebtedness repayable in a single sum prior to the scheduled maturity date, the refund shall be computed from the date of termination to the maturity date. If less than 15 days of a loan month has been earned, no charge may be made for that loan month, but if 15 days or more, a full month may be charged.

(h) If an insured indebtedness is transferred to another creditor any group credit life insurance or group credit accident and sickness insurance issued on that indebtedness may be continued, but the creditor policyholder must advise the insurer of each transfer within 30 days of its effective date.

(9) CLAIMS AND AUDIT PROCEDURES. (a) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

(c) No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment

of claims due to the group policyholder subject to audit and review by the insurer. However, nothing herein shall be construed to relieve the insurer of the responsibility for proper settlement, adjustment and payment of all claims in accordance with the terms of the insurance contract and this ruling.

(d) The insurer must make a good faith examination of each credit insurance account in the first year of the account and annually thereafter. The examination shall be made to assure that the creditor is conducting the insurance program in compliance with the credit insurance policy provisions, the insurer's administrative instructions furnished the creditor to implement the insurance program, and with the applicable credit insurance law and regulation of Wisconsin. The examination must include verification of the accuracy of the computation of premium payments, insurance charges made to debtors, and claim payments reported to the insurer by the creditor. The insurer will maintain records of examinations for 2 years, and such records will be subject to call and review by the commissioner.

(10) CHOICE OF INSURER. When credit life insurance or credit accident and sickness insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

(11) CREDIT INSURANCE PREMIUM RATE FILINGS. (a) Every credit insurer shall file with the commissioner every premium rate schedule applicable to credit insurance in this state, together with the premium, loss, and expense experience on which the insurer bases the proposed premium rate, at least 30 days before the proposed effective date.

(b) In the absence of credible mortality or morbidity experience, the benefits provided under a credit insurance form shall be deemed not to be unreasonable in relation to the premium rate charged if the premium rates filed do not exceed the prima facie premium rate standards set forth in subsections (12) and (13) and if the forms provide benefits which are no more restrictive than the coverage standards enumerated.

(c) Nothing herein shall preclude an insurer from requesting approval of the commissioner for premium rates higher or lower than the prima facie rate standards on the basis of the mortality or morbidity rate actually experienced or anticipated.

(d) If an insurer proposes to provide coverage which is more restrictive than coverage described in subsections (12) and (13), the insurer must demonstrate to the commissioner's satisfaction that the premium rate schedule applicable for the coverage will produce loss ratios at least as great as those contemplated in the premium rate standards set forth or can reasonably be expected to produce such loss ratios.

(e) Where no debtor is paying an identifiable charge for any part of the premium for credit insurance the rates shall be such reasonable rates as are approved by the commissioner.

(12) PRIMA FACIE CREDIT LIFE INSURANCE PREMIUM RATE STANDARDS.

(a) The basic permissible loss ratio for credit life insurance shall be not less than 50%.

(b) The rate standard for premiums payable on the basis of monthly outstanding balance is $0.923 per $1,000 of insurance. The rates applicable to other methods of payment shall be actuarially equivalent.

(c) The rate standard for premiums payable on single premium decreasing term credit life insurance shall be computed according to the following formula:

$$P_n = \frac{[n]}{12} 0.60$$

Where P_n = Single premium rate per $100 of initial insured indebtedness repayable in n equal monthly instalments

n = Original repayment period, in months

(d) The rate standard for premiums payable on single premium level term credit life insurance shall be computed according to the following formula:

$$P_n = \frac{[n]}{10} 0.923$$

Where P_n = Single premium rate per $100 of level insured indebtedness repayable in n months

n = Original term of level indebtedness in months

(e) The rate standards for credit life insurance providing coverage on 2 lives with respect to a single indebtedness shall be 167% of the rate standard provided in paragraphs (b), (c), and (d), above.

(f) As an alternative to paragraphs (b), (c), or (d) above, where age data applicable to the insured debtors is available, rate standards may be based on such data, under a plan approved by the commissioner.

(g) The rate standards set forth herein shall be applicable for a plan of death benefits with or without requirements for evidence of insurability which contains:

1. No exclusions other than suicide within one year of the incurral of the indebtedness, and

2. No age restrictions, or only age restrictions making ineligible for coverage:

a. Debtors less than age 18 at the time the indebtedness is incurred, or

b. Debtors age 65 or over at the time the indebtedness is incurred, or

c. Debtors who will have attained age 66 or over on the maturity date of the indebtedness.

(13) PRIMA FACIE MAXIMUM CREDIT ACCIDENT AND SICKNESS INSURANCE PREMIUM RATE STANDARDS. (a) If premiums are payable in one sum (single premium) for coverage for the entire duration of indebtedness, the premium rate standards for $100 of initial amount of insured indebtedness repayable in equal monthly instalments are shown below. Premium rate standards for other benefit plans and for indebtedness repayable in instalments other than as shown shall be actuarially consistent with the indicated rate standards, but no individual policy of credit accident and sickness insurance or group policy of credit accident and sickness insurance shall be delivered or issued for delivery if the benefits are payable after a waiting period of less than 14 days, regardless of whether the payment of benefits are retroactive to the first day of disability.

Original Number of Equal Monthly Instalments	14 days	30 Days
	Non-Retroactive Elimination Period	
6	$1.39	$ .69
12	1.95	1.18
18	2.27	1.50
24	2.52	1.69
30	2.74	1.82
36	2.93	1.93
42	3.10	2.03
48	3.26	2.12
54	3.41	2.21
60	3.55	2.29
Basic permissable loss ratio	59%	52%

Original Number of Equal Monthly Instalments	14 Days	30 Days
	Retroactive Waiting Period	
6	$1.74	$1.19
12	2.23	1.68
18	2.56	1.89
24	2.81	2.04
30	3.02	2.17
36	3.21	2.29
42	3.39	2.39
48	3.55	2.48
54	3.70	2.57
60	3.84	2.65
Basic permissible loss ratio	60%	57%

(b) The rate standards applicable for premiums payable on the basis of monthly outstanding balances shall be computed as follows:

$$p_n = \frac{20\ P_n}{n+1}$$

Where n = *Original* repayment period, in months

p_n = The Monthly Outstanding Balance Premium Rate per $1,000 for an indebtedness repayable in equal monthly instalments with an *original* repayment period of n months

P_n = The Single Premium Rate per $100 initial insured indebtedness with an *original* repayment period of n months, from subsection (a) above.

(bm) The outstanding balance premium rate for an indebtedness with a given original repayment period is applicable to the outstanding balance of this indebtedness at each month during the period, regardless of the remaining repayment period.

(c) The rate standards set forth herein shall be applicable for a plan of benefits which contains:

1. No provision excluding or denying a claim for disability resulting from pre-existing conditions except for those conditions which manifested themselves to the insured debtor by requiring medical diagnosis or treatment or would have caused a reasonably prudent person to have sought the medical diagnosis or treatment, within 6 months preceding the effective date of the debtor's coverage and which caused loss within the 6 months following the effective date of coverage; provided, however, that disability commencing thereafter resulting from such condition shall be covered.

2. No other provision which excludes or restricts liability in the event of disability caused in a certain specified manner except that it may contain provisions excluding or restricting coverage in the event of pregnancy, intentionally self-inflicted injuries, foreign travel or residence, flight in non-scheduled aircraft, war or military service.

3. No age restrictions, or only age restrictions making ineligible for coverage:

a. Debtors less than age 18 at the time the indebtedness is incurred, or

b. Debtors age 65 or over at the time the indebtedness is incurred, or

c. Debtors who will have attained age 66 or over on the maturity date of the indebtedness.

4. Provision for a daily benefit equal in amount to the initial indebtedness divided by the number of days in the period during which the indebtedness is scheduled to be repaid in equal monthly instalments.

5. Provides for benefits to be payable in the event of disability resulting from bodily injury or sickness, which disability commences while the debtor is insured hereunder and prevents the insured debtor from engaging in any gainful occupation for which he is reasonably qualified by reason of education, training or experience, except that during the initial 12 months of disability the inability of the insured to engage in his own occupation shall be the only test.

Note: This is not intended to preclude calculation of the daily benefit based on a 30 day month.

(14) DEVIATION PROCEDURE AND CASE RATE DETERMINATION. (a) For cases of less than $50,000 earned premiums (prima facie basis) the case rates shall be the prima facie rates. For cases of $50,000 or greater earned premiums (prima facie basis) the actual case ratio shall be calculated as (actual ratio of claims incurred to premiums earned) divided by the basic permissible loss ratio shown in subsection (12) or (13). If the actual case ratio is within the acceptance range shown in the following credibility table, the case rates will be the prima facie rates. If the actual case ratio is outside the acceptance range, the adjusted case ratio will be calculated by adjusting the actual case ratio toward 100% by addition or subtraction of the "adjustment constant", also shown in the credibility table.

CREDIBILITY TABLE
Earned Premium (Prima Facie Basis)

Size Group	Small Loans or Credit Unions	Banks or Sales Finance	Acceptance Range	Adjustment Constant
CREDIT LIFE				
I	50,000-125,000	50,000- 200,000	0.80-1.20	0.15
II	125,000-300,000	200,000- 500,000	0.85-1.15	0.10
III	300,000-650,000	500,000-1,000,000	0.85-1.15	0.05
IV	650,000 or over	1,000,000 or over	0.90-1.10	0.00
CREDIT ACCIDENT AND SICKNESS				
I	50,000- 75,000	50,000- 100,000	0.80-1.20	0.15
II	75,000-125,000	100,000- 175,000	0.85-1.15	0.10
III	125,000-250,000	175,000- 350,000	0.85-1.15	0.05
IV	250,000 or over	350,000 or over	0.90-1.10	0.00

(b) If the adjusted case ratio exceeds 1.00, the case rate is the product of deviation factor f, and the prima facie rate shown in subsection (12) or (13), where

f= [(Adjusted case ratio—1) × 1.25 × Basic Permissible Loss Ratio] + 1

(c) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, but greater than the limits specified in the following table, the case rates are the product of the deviation factor g, and the prima facie rates in subsection (13), where

g= [1-adjusted case ratio × 1.25 × Basic Permissible Loss Ratio]

Plan of Benefit	*Limit*
14 days Retroactive Elimination Period	.55
14 days Non-Retroactive Elimination Period	.59
30 days Retroactive Elimination Period	.67
30 days Non-Retroactive Elimination Period	.89

$$\text{Limit} = \frac{.5\ (1\text{-}1.25 \times \text{Basic Permissible Loss Ratio})}{\text{Basic Permissible Loss Ratio}\ (1\text{-}.5 \times 1.25)}$$

(Rounded down)

(d) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, and less than or equal to the limit specified in the above table, the case rates are the product of the deviation factor h, and the prima facie rate in subsection (13) where

h=(Adjusted Case Ratio × Basic Permissible Loss Ratio × 2)

(e) If the adjusted case ratio for credit life insurance is less than 1.00, the case rate is the product of the deviation factor h and the prima facie rate in subsection (12) where

h= (Adjusted Case Ratio)

(f) If the case rate determined by the above procedures is within 5¢ of the existing single premium rate per $100 per year, the existing rate will be the case rate.

(g) The case rate as determined shall continue for a period equal to the experience period on which it was based. Where the case rate applies to a group of accounts, the rate will contiune to apply to every

account which was grouped for determination of the rate and to only those accounts. The insurer shall annually determine and submit for filing under subsection (8) (a) the applicable case rate calculated as prescribed herein.

(h) As used in this rule the following words mean:

1. Account—The aggregate credit life or credit accident and sickness coverage for a single plan of benefits and class of business written through a single creditor by the insurer, whether coverage is written on a group or individual policy basis.

2. Class of business—Means any of the following:

a. Credit unions

b. Commercial and savings banks

c. Other cash loans (small loans, industrial bank loans, etc.)

c. Other sales finance (discount transactions, etc.)

3. Experience year—A 12-month period ending on the policy anniversary or renewal date or on a calendar year-end. Experience for a given account or permitted combinations of accounts shall be reported consistently from year to year.

4. Case—a. An account, if the earned premium for the account based upon the prima facie premium rates promulgated in subsections (12) or (13) during the most recent 3 experience years has been $50,000 or more. If the rates applicable to the account are not at the prima facie level or at a uniform percentage of the prima facie rates, the amount of premium which would have been earned at the prima facie rates shall be approximated by a reasonable method filed with the experience report.

b. A combination of all the insurer's accounts of the same plan of benefits and class of business, excluding all accounts which meet the criterion for inclusion under a. immediately preceding.

5. Experience period—The last 3 experience years unless a lower number of full years produces an earned premium in size group IV as shown in the credibility table.

(j) In determining the case ratios in this subsection for application of the deviation formula, the following rules shall be applied:

1. If the coverage for a single creditor which qualifies for separate consideration under case definition a. above has been in force with the insurer for less than the experience period, the claim experience of the creditor while covered by any prior insurer shall be included to the extent necessary in determining the appropriate case ratios.

2. The case ratios shall be based wholly or partially on the experience of the insurer on the case whithin the state, or a group of states or on the total United States experience, so long as the insurer reports and files consistently for that case thereafter. An account which qualifies for separate treatment as a case but which provides coverage on a multi-state basis, may be considered in its entirety if the insurer so chooses excluding experience used for deviation purposes in any state, states or group of states.

(15) ACCOUNTING AND UNDERWRITING EXPERIENCE. Each insurer shall maintain records of premiums, losses and expenses of Wisconsin business separately for credit life insurance and credit accident and sickness insurance on a calendar year basis or on a policy year basis. Such underwriting experience shall be maintained for each form of policy, creditor, and class of creditor. This information shall be subject to call annually by the commissioner.

(16) FINANCIAL STATEMENT MINIMUM RESERVES. (a) Each insurer shall show, as a liability in any financial statement or report required under section 601.42, Wis. Stats., its policy or unearned premium reserve in an amount not less than as computed in paragraphs (b), (c) and (d). If a credit insurance policy provides any combination of life insurance benefits, disability benefits and accident and sickness insurance benefits, a reserve must be established separately for the life insurance benefits, for the disability benefits and for the accident and sickness insurance benefits.

(b) The reserve for individual credit life insurance policies shall be not less than 130% of the Commissioner's 1958 Standard Ordinary Mortality Table at 3½% annual interest.

(c) The reserve for group credit life insurance policies shall be not less than 130% of the Commissioner's 1960 Standard Group Mortality Table at 3½% annual interest.

(d) The reserve for credit accident and sickness insurance policies and for disability benefits in credit life insurance policies shall be not less than the greater of 130% of the Commissioner's 1964 Disability Table at 3½% annual interest or the pro rata unearned premium reserve.

(17) SUBMISSION OF POLICY FORMS AND RATE SCHEDULES IN USE. (b) Each insurer subject to this rule shall file with the commissioner on or before October 1, 1972, a listing of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates pertaining thereto which have been heretofore approved and which the insurer intends to issue or use in Wisconsin after the effective date of this rule.

(18) PENALTY. Violations of this rule shall subject the insurer or agent to section 601.64, Wis. Stats.

(19) SEPARABILITY. If any provision or clause of this ruling or the application thereof to any person or circumstance is, for any reason held invalid, the remainder of this ruling and the application of such provision to other persons or circumstances shall not be affected thereby.

Note: It is the intent of this rule that it shall apply prospectively to the review for approval of policy and other forms of credit life and credit accident and sickness insurance and to the rates applicable to such forms that are submitted for filing after the effective date. Individual hearings will be held to consider whether credit life and credit accident and sickness insurance contract forms and rate levels presently in use provide benefits that are reasonable in relation to premium charges.

History: Cr. Register, August, 1972, No. 200, eff. 9-1-72; cr. (2) (c), (6) (h) and (8) (h); am. (4) (b), (5), (8) (f), (12), (13) (a), (14) (e), and r. (17) (a), Register, February, 1973, No. 206, eff. 3-1-73; am. (4), (5), (6) (a) 6, (6) (h), (8) (f), (12) (g) 2, (13) (c) 3, (14) (c) and (d) and cr. (6) (i) and (13) (c) 5, Register, April, 1975, No. 232, eff. 5-1-75.

Ins 3.26 Unfair trade practices in credit life and credit accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to assist in the maintenance of a fair and equitable credit life insurance and credit accident and sickness insurance market. This rule interprets, including but not limited to, the following Wisconsin statutes: 201.045; 201.53 (2), (4), (7) and (8); 206.41 (10); 207.03; 207.04 (1) (d), (f), (g), (h), and (j); 209.04 (9); 601.01 (3) (a), (b), (c), (g) and (h); and 601.41 (1), (2) and (3).

(2) SCOPE. This rule shall apply to the transaction of credit life insurance as defined in section 201.04 (3c) and 206.63, Wis. Stats., and the transaction of credit accident and sickness insurance as defined in section 201.04 (4a), Wis. Stats.

(3) UNFAIR TRADE PRACTICES DEFINED. The following acts, whether done directly or indirectly, in consideration of or in connection with a policy issued or proposed to be issued are defined to be prohibited unfair trade practices in the transaction of insurance described in subsection (2) above:

(a) The offer or grant by an insurer of any special favor or advantage, or any valuable consideration or inducement not set out in the insurance contract. The payment of agents' commissions, reported annually in Schedule 24S, shall not be a violation of this paragraph but the acts cited in paragraphs (b), (c), (d), (e) and (f) may not in any way be construed as agents' commissions.

(b) The offer to deposit or the deposit with a bank or other financial institution, money or securities of the insurer or of any affiliate of the insurer with the design or intent that the deposit offset or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(c) The deposit with a bank or other financial institution of money or securities without interest or at a lesser rate of interest than is currently being paid other depositors on similar deposits with such bank or other financial institution. This shall not be construed to prohibit the maintenance by an insurer of such demand deposits as are reasonable necessary for use in the oridinary course of business of the insurer.

(d) The offer to sell or the sale of any capital stock or other security or certificate of indebtedness of the insurer or affiliated person.

(e) The offer to pay or the payment of any part of the premium for any insurance on the life, health or property of any creditor or any employe or other person affiliated with the creditor.

(f) The extension to the creditor of credit for the remittance of premium beyond the grace period of a group policy or for more than 45 days from the effective date of an individual policy.

(4) PENALTY. Violations of this rule shall subject the insurer or agent to section 601.64, Wis. Stats.

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

Register, April, 1975, No. 232

Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance. (1) PURPOSE. The interest of prospective purchasers of accident and sickness insurance must be safeguarded by providing such persons with clear and unambiguous statements, explanations, advertisements and written proposals concerning the policies offered to them. This purpose can best be achieved by the establishment of and adherence to certain minimum standards of and guidelines for conduct in the advertising and sale of such insurance which prevent unfair competition among insurers and are conducive to the accurate presentation and description to the insurance buying public of policies of such insurance. This rule interprets and implements, including but not limited to, the following Wisconsin Statutes: sections 207.04 (1) (a), (b) and (g) 2. and 601.01 (3).

(2) SCOPE. This rule shall apply to any solicitation, representation or advertisement in this state of any insurance specified in section 201.04 (4), Wis. Stats., made directly or indirectly by or on behalf of any insurer, fraternal benefit society, nonprofit service plan subject to section 200.26, Wis. Stats., voluntary nonprofit sickness care plan organized under section 185.981, Wis. Stats., interscholastic benefit plan organized under section 185.991, Wis. Stats., or agent as defined in section 209.047, Wis. Stats.

(3) INTERPRETATION OF REQUIREMENTS APPLICABLE TO ADVERTISEMENTS. (a) The proper promotion, sale and expansion of accident and sickness insurance are in the public interest. This rule is to be construed in a manner which does not unduly restrict, inhibit or retard such promotion, sale and expansion.

(b) In applying this rule, it shall be recognized that advertising is essential in promoting a broader distribution of accident and sickness insurance. Advertising necessarily seeks to serve this purpose in various ways. Some advertisements are the direct or principal sales inducement and are designed to invite offers to contract. In other advertisements the function is to describe coverage broadly for the purpose of inviting inquiry for further information.Other advertisements are for the purpose of summarizing or explanining coverage after the sale has been made. Still other advertisements are solely for the purpose of promoting the interest of the reader in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement. These differences shall be considered in interpreting this rule.

(c) When applying this rule to a specific advertisement, the type of policy to which the advertisement refers and the detail, character, purpose, use and entire content of the advertisement shall be taken into consideration.

(d) This rule applies to individual, franchise, group and blanket accident and sickness insurance. Because these types of coverage differ in some respects, one interpretation will not always suffice; a specific interpretation for individual, franchise, group or blanket coverage may be indicated.

(e) The extent to which policy provisions need be disclosed in an advertisement will depend on the content, detail, character, purpose and use of the advertisement and the nature of the exceptions,

reductions, limitations and other qualifications involved. The principal criterion is whether the advertisement has the capacity and tendency to mislead or deceive if such a provision is not disclosed.

(f) Whether an advertisement has the capacity and tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(4) COVERAGE TYPES. (a) An advertisement which is an invitation to inquire or an invitation to apply shall clearly and prominently designate and at least briefly describe the type or types of coverage provided by the policy advertised. The level and extent of benefits provided by or available under the coverage shall also be clearly indicated.

(b) The following are the standard types of coverage designations and the minimum adequate form of description that must be used. Any type of coverage authorized by Wisconsin Statutes which is not reasonably included within one or more of the standard coverage types listed shall be similarly and appropriately named and described so as to clearly disclose the benefits provided.

1. Basic hospital expense benefits. This coverage provides benefits for hospital room and board and miscellaneous hospital charges, based upon actual expenses incurred, up to stated maximum amounts.

2. Basic medical expense benefits. This coverage provides benefits for medical benefits based upon actual expenses incurred, up to stated maximum amounts.

3. Basic surgical expense benefits. This coverage provides benefits for surgical benefits based upon actual expenses incurred up to stated maximum amounts.

4. Major medical or comprehensive expense benefits. These coverages provide high maximum benefit amounts covering almost all types of medical care and contain deductible and co-insurance features.

5. Disability income benefits. This coverage provides periodic benefit payments to help replace income when the insured is unable to work as a result of illness or injury.

6. Hospital confinement indemnity benefits. This coverage provides benefits in a stated amount for confinement in a hospital, regardless of the hospital expenses actually incurred by the insured, due to such confinement.

7. Accident only benefits. This coverage provides benefits for losses for accidental bodily injury.

8. Specified disease or treatment benefits. This coverage provides benefits for treatment of a specific disease or diseases named in the policy or for specified treatment.

(5) GENERAL DEFINITIONS. (a) An *advertisement* relating to accident and sickness insurance for the purpose of this rule includes the following:

1. Printed and published material, audio visual material and descriptive literature of an insurer used in newspapers, magazines, other periodicals, radio and TV scripts, billboards and similar displays, excluding advertisements prepared for the sole purpose of obtaining employees, agents or agencies.

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters.

a. Including material used in the solicitation of renewals and reinstatements except for communications or notices which mention the cost of the insurance but do not describe benefits,

b. Excluding material in house organs of insurers, communications within an insurer's own organization not intended for dissemination to the public, individual communications of a personal nature, and correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket policy,

c. Including group and blanket booklets, summaries of coverage and other explanatory material issued to insured persons, and

d. Excluding general announcements from group or blanket policyholders to eligible individuals that a contract has been written.

3. Prepared sales talks, presentations of material for use by agents and representations made by agents in accordance therewith, excluding materials to be used solely by an insurer for the training and education of its employees or agents, and

4. Envelopes used in connection with the above.

(b) A *policy* for the purpose of this rule includes any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits whether on a cash indemnity, reimbursement or service basis,

1. Except such benefits contained in a policy providing another kind of insurance other than life, and

2. Except disability and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as

a. Provide additional benefits in case of death or dismenberment or loss of sight by accident or

b. Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(c) An *insurer* for the purpose of this rule includes any person, individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, nonprofit service plan subject to section 200.26, Wis. Stats., voluntary nonprofit sickness care plan organized under section 185.981, Wis. Stats., interscholastic

benefit plan organized under section 185.991, Wis. Stats., and any other legal entity engaged in advertising a policy as herein defined.

(d) An *exception* for the purpose of this rule means any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of a risk not assumed under the policy.

(e) A *reduction* for the purpose of this rule means any provision in a policy which reduces the amount of the benefits. A risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

(f) A *limitation* for the purpose of this rule means any provision in a policy which restricts coverage under the policy other than an exception or a reduction.

(g) An *invitation to apply* means an advertisement which is the direct or principal sales inducement and is designed to invite an offer to contract. Such an advertisement, which usually describes benefits in considerable detail, attempts to persuade the reader or listener to make application for the policy advertised. Such an advertisement would indicate what coverage the purchaser would receive and what such coverage would cost.

(h) An *invitation to inquire* means an advertisement which is designed to attract the reader's or listener's interest in the policy so that he will inquire for further information or details. Such an advertisement describes the policy broadly and withholds some information regarding the policy without which the reader or listener would not reasonably decide to apply for the policy.

(i) An *institutional advertisement* means one which is prepared solely to promote the reader's or listener's interest in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement.

(j) A *testimonial* means any statement made by a policyholder, certificateholder or other person covered by the insurer which promotes the insurer and its policy by describing such person's benefits, favorable treatment or other experience under the policy.

(k) An *endorsement* for the purposes of subsection (13) of this rule means any statement promoting the insurer and its policy made by an individual, group of individuals, society, association or other organization which makes no reference to the endorser's experience under the policy.

(l) An *outline of coverage* means an appropriately and prominently captioned portion of a printed advertisement which is clearly set off from the rest of the advertisement by means such as placing it within a prominent border or box or printing it in contracing color, or a separate appropriately captioned or titled printed statement, which advertisement portion or printed statement contains only a summary of the benefits provided, a designation of the applicable type or types of coverage as defined in subsection (4) and, under appropriate captions, the information required by subsections (10) and (11).

(m) An individual policy issued on a *group basis* means an individual policy or contract issued where:

1. Coverage is provided to employees or members or classes thereof defined in terms of conditions pertaining to employment or membership in an association or other group which is eligible for franchise or group insurance as provided in sections 204.32 and 204.321, Wis. Stats.,

2. 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 group.

3. Premiums or subscription charges are paid to the insurer by the employer, association or some designated person acting on behalf of the employer, association or covered persons, and

4. The insurance plan is sponsored by the employer or association.

(6) ADVERTISEMENTS AND REPRESENTATIONS IN GENERAL. (a) Advertisements and representations shall be truthful and not misleading in fact or in implication and shall accurately describe the policy to which they apply. Words or phrases the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used.

(b) Oral representations shall conform to the requirements of this rule.

(7) SUITABILITY OF POLICIES. No agent or insurer shall recommend to a prospective buyer the purchase of any individual policy without reasonable grounds to believe that the recommendation is not unsuitable to the applicant. The agent or insurer shall make such inquiry as may be necessary under the circumstances to determine that the purchase of such insurance is not unsuitable for the prospective buyer. This requirement shall not apply to an individual policy issued on a group basis.

(8) OUTLINE OF COVERAGE. (a) Every advertisement of a specific individual policy or policies which constitutes an invitation to apply shall include an outline of coverage as defined in subsection (5) (l).

(b) Every agent at the time of taking an application for an individual policy shall furnish the applicant an outline of coverage as defined in subsection (5) (l).

(c) The requirement for an outline of coverage shall not apply to an advertisement or the taking of an application for an individual policy issued on a group basis or an individual conversion policy issued under a group or franchise insurance plan.

(9) DECEPTIVE WORDS, PHRASES OR ILLUSTRATIONS. (a) An advertisement shall not exaggerate a benefit or minimize cost by overstatement, understatement or incompleteness. Information shall not be omitted or words, phrases, statements, references or illustrations shall not be used if such omission or use has the capacity and tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. An advertisement referring to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to mislead or deceive.

(b) The words and phrases "all", "full", "complete", "comprehensive", "unlimited", "up to", "as high as", "this policy will pay your hospital and surgical bills", "this policy will fill the gaps under Medicare and your present insurance" or "this policy will replace your income", or similar words and phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as fairly to describe such benefit.

(c) A policy covering only one disease or a list of specified diseases shall not be advertised so as to imply coverage beyond the terms of the policy. A particular disease shall not be referred to by more than one term so as to imply broader coverage than is the fact.

(d) The benefits of a policy which pays varying amounts for the same loss occurring under different conditions, or which pays benefits only when a loss occurs under certain conditions, shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.

(e) The maximum benefit available under a policy shall not be emphasized in a manner which exaggerates its relationship to any internal limits or other conditions of the policy.

(f) The aggregate amounts or the monthly or weekly benefits payable under coverages such as hospital or similar facility confinement indemnity or private duty nursing shall not be emphasized unless the actual amounts payable per day are disclosed with substantially equal prominence and in close conjunction with such statement. Any limit in the policy on the number of days of coverage provided shall be disclosed.

(g) Phrases such as "this policy pays $1800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.

(h) An advertisement shall not state or imply that each member under a family policy is covered as to the maximum benefits advertised when such is not the fact.

(i) The importance of diseases rarely or never found in the class of persons to whom the policy is offered shall not be exaggerated in an advertisement.

(j) Examples of what benefits may be paid under a policy shall be shown only for losses from common illnesses or injuries rather than exceptional or rare illnesses or injuries.

(k) When a range of hospital room expense benefits is set forth in an advertisement, it shall be made clear that the insured will receive only the benefit indicated in the policy purchased. It shall not be implied that the insured may select his room expense benefit at the time of hospitalization.

(l) An advertisement shall not imply that the amount of benefits payable under a loss of time policy may be increased at time of disability according to the needs of the insured.

(m) The term "confining sickness" is an abbreviated expression and shall be explained if used in an advertisement.

(n) An advertisement shall not state that the insurer "pays hospital, surgical, medical bills", "pays dollars to offset the cost of medical care", "safeguards your standard of living", "pays full coverage", "pays complete coverage", "pays for financial needs", "provides for replacement of your lost paycheck", "guarantees your paycheck", "guarantees your income", "continues your income", "provides a guaranteed paycheck", "provides a guaranteed income" or "fills the gaps in Medicare" or use similar words or phrases unless the statement is literally true. Where appropriate, such or similar words or phrases may properly be used if preceded by the words "help", "aid", "assist" or similar words.

(o) An advertisement shall not state that the premiums will not be changed in the future unless such is the fact.

(p) An advertisement shall clearly indicate the provisions of any deductible under a policy.

(q) An advertisement shall not refer to a policy as a doctors policy or use words of similar import unless:

1. The advertisement includes a statement that the plan of benefits is not endorsed by or associated with any national, state or local medical society, or

2. The policy has been so endorsed by such a society and the advertisement meets the requirements of subsection (13) of this rule.

(r) If a policy contains any of the following or similar provisions, an advertisement referring to such policy shall not state that benefits are payable in addition to other insurance unless the statement contains an appropriate reference to the coverage excepted:

1. An other insurance exception, reduction, limitation or deductible

2. A coordination of benefits or non-duplication provision

3. An other insurance in this company provision

4. An insurance in other insurers provision

5. A relation of earnings to insurance provision

6. A workmen's compensation or employers' liability or occupational disease law exception, reduction, or limitation

7. A reduction based on social security benefits or other disability benefits, or

8. A Medicare exception, reduction, or limitation.

(s) An advertisement shall not state a policy's benefits are tax free unless an explanation of the rules applicable to the taxation of such types of accident and sickness benefits is clearly shown with equal prominence and in close conjunction with such statement. An advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall not state that such benefit is tax free.

(t) An advertisement shall not use the expressions "extra cash", "cash income", "income", "cash" or similar words or phrases in such a

way as to imply that the insured will receive benefits in excess of his expenses incurred while being sick, injured or hospitalized.

(u) The description in advertisements of government insurance programs, including Medicare, and of changes in such program shall be accurate and not give an incorrect impression as to the need for supplementary coverage. If gaps in such programs are referred to, they shall be described fairly so that the reader or listener can determine how the policy being advertised covers such gaps.

(v) An advertisement which refers to a policy as being a Medicare supplement shall:

1. Contain a prominent statement indicating which Medicare benefits the policy is intended to supplement (for example, hospital benefits) and which Medicare benefits the policy will not supplement (for example, medical-surgical benefits) and shall clearly disclose any gaps in Medicare coverage for which the policy does not provide benefits and

2. Clearly indicate the extent of the benefits if the policy bases benefits on expenses incurred beyond what Medicare covers and thus provides somewhat limited benefits for short term hospital confinements.

(w) An advertisement may refer to immediate coverage or guaranteed issuance of a policy only if suitable administrative procedures exist so that the policy is issued within a reasonable time after the application is received.

(x) If an advertisement indicates an initial premium which differs from the renewal premium on the same mode, the renewal premium shall be disclosed with equal prominence and in close conjunction with any statement of the initial premium. Any increase in premium or reduction in coverage because of age shall be clearly disclosed.

(y) An advertisement shall not state that the policy contains no waiting period unless pre-existing conditions are covered immediately or unless the status of pre-existing conditions is disclosed with equal prominence and in close conjunction with such statement.

(z) An advertisement shall not state that no age limit applies to a policy unless applications from applicants of any age are considered in good faith and such statement clearly indicates the date or age to which the policy may be renewed or that the company may refuse renewal.

(za) An advertisement shall not state that no medical, doctor's or physical examination is required or that no health, medical or doctor's statements or questions are required or that such examination, statements or questions are waived or otherwise state or imply that the applicant's physical condition or medical history will not affect the policy unless:

1. The statement indicates with equal prominence that it applies only to the issuance of the policy or to both the issuance of the policy and the payment of claims, and

2. Pre-existing conditions are covered immediately under the policy or the peiod of time following the effective date of the policy during

which pre-existing conditions are not covered is disclosed with equal prominence and in close conjunction with such statement.

(zb) An advertisemt of a limited policy as defined in Wisconsin Administrative Code section Ins 3.13 (2) (h) shall prominently indicate that the policy provided limited coverage with an appropriate statement such as "THIS IS A CANCER ONLY POLICY" or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY," and shall clearly disclose what injuries or sicknesses and what losses are covered.

(zc) An advertisement of a policy which provides benefits for injuries only or for sickness only shall prominently indicate that the policy covers injuries only or sickness only.

(zd) An advertisement shall not refer to a policy or coverage as being "special" unless it can be shown that there is a reasonable basis for the use of such a term.

(ze) An advertisement shall not set out exceptions, reductions or limitations from a policy worded in a positive manner to imply that they are beneficial features such as describing a waiting period as a benefit builder. Words and phrases used to disclose exceptions, reductions or limitations shall fairly and accurately describe their negative features. The words "only" or "minimum" or similar words or phrases shall not be used to refer to exceptions, reductions or limitations.

(zf) An advertisement shall not state or imply, or use similar words or phrases to the effect, that because no insurance agent will call and no commissions will be paid to agents the policy is a low cost plan.

(zg) Devices such as a safe drivers' award and other such awards shall not be used in connection with an advertisement.

(10) EXCEPTIONS, REDUCTIONS AND LIMITATIONS. (a) When an advertisement refers to any dollar amount of benefits payable, period of time for which any benefit is payable, cost of policy, specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations (including waiting, elimination, probationary or similar periods and pre-existing condition exceptions) affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive subject to the following.

(b) An invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy or

2. Such an advertisement makes any reference to the policy's exceptions, reductions and limitations.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An institutional advertisement shall not be subject to the disclosure requirements of this subsection.

(f) If the policy advertised does not provide immediate coverage for pre-existing conditions, an application or enrollment form contained in or included with an advertisement to be completed by the applicant and returned to the insurer shall contain a question or statement immediately preceding the applicant's signature line which summarizes the pre-existing condition provisions of the policy. The following are a suggested question and statement; however, an insurer shall use wording which is appropriate to the actual pre-existing condition provisions of the policy advertised: "Do you understand that the policy applied for will not pay benefits during the first - - - - - year(s) after the issue date for a disease or physical condition which you now have or have had in the past? Yes - - - - - -" or "I understand that the policy applied for will not pay benefits during the first - - - - - year(s) after the issue date for a disease or physical condition which I now have or have had in the past."

(g) An advertisement which is subject to the disclosure requirements of this subsection shall in negative terms disclose the extent to which any loss is not covered if the cause of the loss is a condition which exists prior to the effective date of the policy. The expression "pre-existing conditions" shall not be used unless appropriately defined.

(h) If a medical examination is required for a policy, an advertisement of such policy shall disclose such requirement.

(i) The exceptions, reductions and limitations referred to in this subsection shall include:

1. Those which are set out in the policy under captions referring to exceptions, reductions, limitations or exclusions or are otherwise designated as such, and

2. Those which are not so captioned or designated contained in other portions of the policy such as a benefit provision, definition or uniform provision.

(j) The following are examples of exceptions, reductions and limitations which generally *do* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. War or act of war.

2. While in armed services.

3. Territorial restriction or coverage within United States and Canada.

4. Complete aviation exclusion.

5. Self-inflicted injury.

6. Injury inflicted by another person.

7. Time limitation on death, dismemberment or commencement of disability or medical treatment following an accident.

8. Pre-existing sickness or disease or other bodily infirmity.

9. Exclusion or reduction for loss due to specific diseases, classes of diseases or types of injuries.

10. Confinement restrictions in disability policies such as house confinement, bed confinement and confinement to the premises.

11. Waiting, elimination, probationary or similar periods.

12. Reduction in benefits because of age.

13. Any reduction in benefit during a period of disability.

14. Workmen's compensation or employers' liability law exclusion.

15. Occupational exclusion.

16. Violation of law.

17. Automatic benefit in lieu of another benefit.

18. Confinement in government hospital.

19. Pregnancy.

20. Miscarriage in sickness or accident and sickness policy.

21. Restrictions relating to organs not common to both sexes.

22.Restrictions on number of hospital hours before benefit accrues.

23. Insanity, mental diseases or disorders or nervous disorder.

24. Dental treatment, surgery or procedures.

25. Cosmetic surgery.

26. While intoxicated or under the influence of narcotics, or other language not substantially the same as the uniform individual policy provision regarding the use of intoxicants and narcotics.

27. Unemployed persons.

28. Retired persons.

29. While handling explosives or chemical compounds.

30. While or as a result of participating in speed contests.

31. While or as a result of riding a motorcycle or motorcycle attachment.

32. While or as a result of participating in professional athletics.

33. While or as a result of participating in certain specified sports.

34. While or as a result of serving as a volunteer fireman or in other hazardous occupations.

35. Riot or while participating in a riot.

36. Ptomaine poisoning.

37. Gas or poisonous vapor.

38. Sunstroke or heat prostration.

39. Freezing.

40. Poison ivy or fungus infection.

41. Requirement of permanent disability.

42. Reduction because of other insurance.

(k) The following are examples of exceptions, reductions and limitations which generally *do not* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. Suicide or attempted suicide, while sane or insane.

2. Intentional self-inflicted injury.

3. Territorial restriction with no limitation of coverage while in United States and Canada.

4. Aviation exclusion under which passage on commercial airlines is covered.

5. Felony or illegal occupation.

6. All uniform individual policy provisions, both required and optional, other than those relating to other insurance.

7. Requirement for regular care by a physician.

8. Definition of total disability.

9. Definition of partial disability.

10. Definition of hospital.

11. Definition of specific total loss.

12. Definition of injury.

13. Definition of physician or surgeon.

14. Definition of nurse.

15. Definition of recurrent disability.

16. Definition of commercial air travel.

17. Provision that hernia will be considered a sickness.

18. Rest Cure.

19. Diagnosis.

20. Prosthetics.

21. Cosmetic surgery exclusion under which such surgery which results from injury is covered.

22. Dental treatment, surgery or procedures exclusion under which such treatment which results from injury to sound natural teeth is covered.

23. Bacterial infection exclusion under which pyogenic infection which results from injury is covered.

24. Eye examination for fitting of glasses.

25. Hearing aid.

26. Exclusion of sickness or disease in a policy providing only accident coverage.

27. Exclusion for miscarriage in policy providing only accident coverage.

(11) RENEWABILITY, CANCELLABILITY AND TERMINATION. An advertisement shall disclose, as required below, the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

(a) Any advertisement which refers to renewability, cancellability or termination of a policy shall be subject to the disclosure requirements of this subsection.

(b) An advertisement which refers to a policy benefit and which is an invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An advertisement which refers to a policy benefit and which is an invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Paragraph (a) or (f) applies or

2. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An advertisement which refers to a policy benefit and which is an institutional advertisement shall not be subject to the disclosure requirements of this subsection unless paragraph (a) or (f) applies.

(f) An advertisement which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy and which implies permanency shall be subject to the disclosure requirements of this subsection.

(g) The actual policy language concerning renewability, cancelability or termination need not be used in an advertisement subject to the disclosure requirements of this subsection. However, all pertiment information shall be disclosed.

(h) The qualifying conditions applicable to a non-cancellable policy and to a guaranteed renewable policy shall include age limits, aggregate benefit limits and modifications of benefits because of age, other than such modifications occurring at or about the time the policy terminates. A qualifying condition applicable to a guaranteed renewable policy shall be the insurer's reservation of the right to change premiums.

(i) The qualifying conditions shall be set forth with the language describing renewability.

(j) An advertisement of a group or blanket policy which would otherwise be subject to the disclosure requirements of this subsection need not disclose the policy's provisions relating to renewability, cancellability and termination. Such advertisement shall provide, however, as a minimum, that an insured person's coverage is contingent upon his continued membership in the group and the continuation of the plan.

(k) An advertisement of a non-cancellable policy or of a guaranteed renewable policy shall also be subject to subsection (25).

(l) An advertisement of a franchise, wholesale, collectively renewable, or non-renewable for stated reasons only policy, or any other policy under which the insurer has by policy provision limited its right to terminate to one or more reasons, shall accurately set forth the policy's renewal provisions if disclosure of such renewal provisions is required by paragraphs (a), (b), (c), (d) or (e) above. Such advertisement shall not state or imply renewal terms which are more favorable than those actually contained in the policy. Such advertisement shall not state or imply that the policy is guaranteed renewable or warranted renewable or that renewal is guaranteed or warranted or use other variations of such expressions.

(12) IDENTITY OF INSURER. (a) The identity of the insurer shall be made clear in all of its advertisements.

(b) An advertisement shall not use a trade name, an insurance group designation, the name of the parent company of the insurer, the name of a government agency or program, the name of a department or division of an insurer, the name of an agency, the name of any other organization, a service mark, a slogan, a symbol or any other device which has the capacity and tendency to mislead or deceive as to the identity of the insurer.

(c) An advertisment shall not use any combination of words, symbols or materials which, by its content, phraseology, shape, color, nature or other characteristics, is so similar to combinations of words, symbols or materials used by federal, state or local government agencies that it tends to confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with such a government agency.

(d) An advertisement shall not refer to an affiliate of the insurer without disclosing that the 2 organizations are separate legal entities.

(e) An advertisement shall not indicate an address for an insurer ir such a way as to mislead or deceive as to its identity or licensing status. An advertisement which indicates an address for an insurer other than that of its home office shall clearly identify such address and clearly disclose the actual city and state of domicile of the insurer.

(13) TESTIMONIALS, ENDORSEMENTS OR COMMENDATIONS BY THIRD PARTIES. (a) An advertisment shall not contain a testimonial, endorsement or other commendatory statement concerning the insurer, its policies or activities by any person who receives any pay or remuneration, directly or inderectly, from the insurer in connection with such testimonial, endorsement or statement. Any advertisement containing a testimonial, endorsement or statement not prohibited by

the foregoing, shall include a full and prominent disclosure therein of the relationship, direct or indirect, including but not limited to financial interest and remuneration, between the insurer and the person making such testimonial, endorsement or statement. The provisions of this paragraph do not apply to any person holding a Wisconsin insurance agent's license nor to any radio or television announcer or other person employed or compensated on a salaried or union wage scale basis.

(b) A testimonial or endorsement used in an advertisement shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced.

(c) An insurer shall not use a testimonial or endorsement:

1. Which is fictional,

2. Where the insurer has information indicating a substantial change of view on the part of the author,

3. Where it is reasonable to conclude that the views expressed do not correctly reflect the current opinion of the author,

4. For more than 2 years after the date on which it was originally given or 2 years after the date of a prior confirmation without obtaining a confirmation that the statement represents the author's current opinion,

5. Which does not accurately reflect the present practices of the insurer,

6. To advertise a policy other than the one for which such statement was given, unless the statement clearly has some reasonable application to the second policy,

7. In which a change or omission has been effected which alters or distorts its meaning or intent as originally written, or

8. If it contains a description of benefit payments which does not disclose the true nature of the insurance coverage under which the benefits were paid.

(d) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association or other organization, unless such is the fact. Any proprietary relationship between such society, association or other organization and the insurer shall be disclosed. If such society, association or other organization has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the advertisement shall clearly disclose such a fact.

(e) When a testimonial refers to benefits received under a policy, a summary of the pertinent claim information including claim number and date of loss shall be retained by the insurer with the advertisement in the advertising file required by subsection (28).

(f) An advertisement shall not state or imply that a government publication has commended or recommended the insurer or its policy.

(14) JURISDICTIONAL LICENSING; APPROVAL BY GOVERNMENTAL AGENCY. (a) An advertisement which may be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(b) An advertisement shall not state or imply, or otherwise create the impression directly or indirectly, that the insurer, its financial condition or status, the payment of its claims, its policy forms or the merits or desirability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any agency of this state or the federal government.

(c) In any advertisment any reference to licensing shall contain an appropriate disclaimer that such reference is not to be construed as an endorsement or implied endorsement of the insurer or its products by any agency of this state or the commissioner of insurance.

(d) An advertisement shall not contain a reproduction of a portion of a state insurance department report of examination.

(15) INTRODUCTORY, INTIAL OR SPECIAL OFFERS AND LIMITED ENROLLMENT PERIODS. (a) An advertisement shall not state or imply that a policy or combination of policies is an introductory, initial or special offer and that the applicant will receive advantages not available at a later date by accepting the offer, that only a limited number of policies will be sold, that a time is fixed for the discontinuance of the sale of the policy advertised because of special advantages available in the policy, or that an individual will receive special advantages by enrolling within an open enrollment period or by a deadline date, unless such is the fact.

(b) An advertisement shall not state or imply that enrollment under a policy is limited to a specific period unless the period of time permitted to enroll, which shall be not less than 10 days and not more than 40 days from the date of the advertisement, is disclosed.

(c) If the insurer making an introductory, initial or special offer has previously offered the same or similar policy on the same basis or intends to repeat the current offer for the same or similar policy, the advertisement shall so indicate.

(d) An insurer shall not establish for residents of this state a limited enrollment period within which an individual policy may be purchased less than 6 months after the close of an earlier limited enrollment period for the same or similar policy. Such restriction shall apply to all advertisements in newspapers, magazines and other periodicals circulated in this state, all mail advertisements sent to residents of this state and all radio and TV advertisements broadcast in this state. Such restriction shall not apply to the solicitation of enrollments under individual policies issued on a group basis.

(e) Where an insurer is an affiliate of a group of insurers under common management and control, the word "insurer" for the purposes of this subsection means the insurance group. The requirements and restrictions applicable to an insurer shall apply to the insurance group.

(f) Similar policies for the purposes of this subsection include policies which provide similar benefits even though there may be

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(c) A printed advertisement describing a non-cancellable or non-cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms "non-cancellable" or "non-cancellable and guaranteed renewable":

1. The age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable), and

3. That benefit payments are subject to an aggregate limit, if applicable.

(d) A printed advertisement describing a guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

1. The age to or term for which the form is guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or form for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable).

3. That benefit payments are subject to an aggregate limit, if applicable, and

4. That the applicable premium rates may be changed.

(e) The foregoing limitations on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable"; and the foregoing limitations on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

(26) FORM NUMBER. An advertisement which is an invitation to apply or an invitation to inquire and which is mass-produced shall be identified by a form number. The form number shall be sufficient to distinguish it from any other advertising form or any policy, application or other form used by the insurer.

(27) INSURER'S RESPONSIBILITY FOR ADVERTISEMENTS. (a) The content, form and method of dissemination of all advertisements, regardless of by whom designed, created, written, printed or used, shall be the responsibility of the insurer whose policy is advertised.

(b) An insurer shall require its agents and any other person or agency acting on its behalf in preparing advertisements to submit proposed advertisements to it for approval prior to use.

(28) INSURER'S ADVERTISING FILE. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its policies hereafter disseminated in this or any other state, whether or not licensed in such other state. With respect to group, blanket and franchise policies, all proposals prepared on the same printed form need not be included in the file; only typical examples of such proposals need be included. A notation shall be attached to each such advertisement in the file indicating the manner and extent of distribution and the form number of any policy, amendment, rider, or endorsement form advertised. A copy of the policy advertised, together with any amendment, rider or endorsement applicable thereto, shall be included in the file with each such advertisement. Such file shall be subject to regular and periodic inspection by the office of the commissioner of insurance. All such advertisements shall be maintained in such file for a period of 4 years or until the filing of the next regular examination report on the insurer, whichever is the longer period.

(29) INSURER'S CERTIFICATE OF COMPLIANCE. Each insurer which is required to file an annual statement and which is subject to the provisions of this rule shall file with the office of the commissioner of insurance, together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information and belief, the advertising file required by subsection (28) was properly miantained and the advertisements 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; am. (5) (b) 1, Register, April, 1975, No. 232, eff. 5-1-75.

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 requried 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 ADMINISTRAITON. (a) If the existence of a disease or physical condition is duly disclosed in the applicaiton 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 pre-existing 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)

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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, certificate, insurance agent or representative, enrollment form and enrolle 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 cetificate 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 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 12 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 and 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 condition 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.