Chapter Ins 3

CASUALTY INSURANCE

Ins 3.01 Accumulation benefit riders attached to health and accident policies (p. 43)
Ins 3.02 Automobile fleets, vehicles not included in (p. 43)
Ins 3.04 Dividends not deducted from premiums in computing loss reserves (p. 43)
Ins 3.09 Mortgage guaranty insurance (p. 44)
Ins 3.11 Multiple peril insurance contracts (p. 50)
Ins 3.12 Filing procedures for disability insurance forms (p. 51)
Ins 3.13 Individual accident and sickness insurance (p. 52)
Ins 3.14 Group accident and sickness insurance (p. 58)
Ins 3.15 Blanket accident and sickness insurance (p. 59)
Ins 3.17 Reserves for accident and sickness policies (p. 60)
Ins 3.18 Total consideration for accident and sickness insurance policies (p. 72)
Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor (p. 72)
Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles (p. 73)
Ins 3.23 Franchise accident and sickness insurance (p. 74)
Ins 3.25 Credit life insurance and credit accident and sickness insurance (p. 74)
Ins 3.26 Unfair trade practices in credit life and credit accident and sickness insurance (p. 89)
Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance (p. 90)
Ins 3.28 Solicitation, underwriting and claims practices in individual and franchise accident and sickness insurance (p. 109)
Ins 3.29 Replacement of accident and sickness insurance (p. 112)
Ins 3.30 Change of beneficiary and related provisions in accident and sickness insurance policies (p. 114)
Ins 3.31 Eligibility for and solicitation, underwriting and claims practices in group, blanket and group type accident and sickness insurance (p. 115)
Ins 3.32 Title insurance; prohibited practices (p. 118)
Ins 3.36 Statistical reports - health professional liability insurance (p. 121)
Ins 3.38 Coverage of newborn infants (p. 124)
Ins 3.39 Standards for accident and sickness insurance sold to the Medicare eligible (p. 135)
Ins 3.40 Authorized clauses for coordination of benefit provisions in group and blanket disability insurance policies (p. 144)
Ins 3.41 Individual conversion policies (p. 146-4)
Ins 3.42 Plans of conversion coverage (p. 146-5)
Ins 3.43 High limit comprehensive plan of benefits (p. 146-5)
Ins 3.44 Effective date of s. 632.897, Stats. (p. 146-6)
Ins 3.45 Conversion policies by insurers offering group policies only (p. 146-6)
Ins 3.46 Standards for nursing home insurance (p. 146-6)

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

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

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may

not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This rule implements and interprets, including but not limited to, s. Ins 6.75 (2) (i) and ss. 611.02, 611.24, 618.01, 618.21, 620.02 and 623.04, Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) SCOPE. This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by s. Ins 6.75 (2) (i).

(3) DEFINITIONS. (a) Mortgage guaranty insurance is that kind of insurance authorized by s. Ins 6.75 (2) (i), and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(b) As used in this rule, "person" means any individual, corporation, association, partnership or any other legal entity.

(4) DISCRIMINATION. No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the applicant's sex, marital status, race, color, creed or national origin.

(5) LIMITATION OF TOTAL LIABILITY ASSUMED. A mortgage guaranty insurer shall not at any time have outstanding a total liability under its aggregate insurance policies, computed on the basis of its election to limit coverage and net of reinsurance assumed and of reinsurance ceded to an insurer authorized to transact such reinsurance in this state, exceeding 25 times the sum of its contingency reserve established under sub. (14) and its surplus as regards policyholders.

(6) LIMITATION ON INVESTMENT. A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) LIMITATION ON ASSUMPTION OF RISKS. A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by a single risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to transact such reinsurance in this state. "Contiguous" for the purpose of this subsection means not separated by more than one-half mile.

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts in any assuming insurer authorized to transact mortgage guaranty insurance in this state, except it shall not

5. Except for a Medicare Supplement 1 policy for which a specific requirement is set out in subsection (5) (a) 3. c., limit coverage of outpatient psychiatric treatment to 50% of the reasonable and necessary charges and to a lifetime benefit of $500.

6. Contain a pre-existing condition waiting period provision as provided in subsection (4) (a) 2.

(b) Where the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would cover. Medicare Part B expenses incurred beyond what Medicare Part B would cover may not be excluded.

(7) NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY AND SPECIFIED DISEASE COVERAGES. (a) Captions for the policies listed in this subsection shall be:

1. Printed and conspicuously placed on the first page of the Outline of Coverage,

2. Printed on a separate form attached to the first page of the policy, and

3. Printed in 18-point bold capital letters.

(b) Nursing Home Coverage. A policy form providing coverage for care in a nursing home shall meet the standards set forth in s. Ins 3.46, Wis. Adm. Code. Such a policy sold to Medicare-eligible persons shall bear the following caption: THE NURSING HOME BENEFIT OF THIS POLICY DOES NOT RELATE IN ANY WAY TO MEDICARE. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(c) Hospital Confinement Indemnity Coverage. A policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person shall bear the following Caption: THE HOSPITAL CONFINEMENT INDEMNITY BENEFIT OF THIS POLICY IS NOT DESIGNED TO FILL THE GAPS IN MEDICARE. IT WILL PAY YOU ONLY A STATED DOLLAR AMOUNT FOR A DESIGNATED NUMBER OF DAYS WHEN YOU ARE HOSPITAL CONFINED. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(d) Specified Disease Coverage. A policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

1. The following Designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, and

2. The following Caption: THIS POLICY IS DESIGNED TO COVER ONLY ONE OR MORE SPECIFIED OR RARE ILLNESSES. IT SHOULD NOT BE PURCHASED AS A SUBSTITUTE FOR HEALTH CARE EXPENSE COVERAGE WHICH WOULD GENERALLY COVER ANY ILLNESS OR INJURY. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET

"HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) An Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by an insurer upon request to each insured who will become eligible for Medicare and is offered a conversion policy under the terms of a group insurance policy.

(b) An insurer:

1. Which provides group insurance coverage shall furnish annually to each group policyholder written notice of the availability of the information described in pars. (a) or (d), where applicable, and upon request shall furnish sufficient copies of the same or similar notice to the group policyholder to be distributed to group members affected; and

2. Which provides individual or family insurance coverage shall furnish an Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time an insured who will become eligible for Medicare is furnished an application for conversion.

(c) Except as provided under par. (d), an insurer shall furnish an Outline of Coverage and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" within 14 calendar days after receipt of the request for such information.

(d) Upon request, a comprehensive written explanation of the insurance coverage to be provided after Medicare eligibility and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by the insurer within 14 calendar days after receipt of the request to each insured who will become eligible for Medicare whose coverage under an individual, family or group insurance policy will continue with changed benefits (e.g. "carve-out" or reduced benefits).

(e) The Outline of Coverage:

1. For a conversion policy which relates its benefits to or complements Medicare shall comply with subsection (4) (b) 1., 2., 3., and 6. of this rule and shall be submitted to the commissioner; and

2. For a conversion policy not subject to subd. 1. shall comply with subsection (7), where applicable, and section Ins 3.27 (5) (1).

(9) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy subject to this rule or coverage added to an existing Medicare Supplement policy must receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in Ins 3.27 (5) (g). This pamphlet prepared by the Office of the Commissioner of Insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies of this pamphlet from the commissioner at cost or may reproduce this pamphlet

themselves. This pamphlet shall be periodically revised to reflect changes in Medicare and any other appropriate changes. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has received notice that the revised pamphlet is available at the commissioner's office.

(10) APPROVAL NOT A RECOMMENDATION. While the commissioner may authorize the use of a particular Designation on a policy in accordance with this rule, that authorization is not to be construed or advertised as a recommendation of any particular policy by the commissioner or the state of Wisconsin.

(11) SEVERABILITY. If any provision of this rule or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the parts of the rule are declared to be severable.

(12) EFFECTIVE DATE. This rule shall take effect January 1, 1978.

History: Cr. Register, July, 1977, No. 259, eff. 8-1-77; am. (13), Register, September, 1977, No. 261, eff. 10-1-77; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renum. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1-1-79; am. (4) (b) 1.a., (5) (a) 2. and (b) 2., (5) (c) 2. and (9), r. (5) (d) and (e), Register, April, 1981, No. 304, eff. 5-1-81; r. and recr. (7) (b), Register, May, 1981, No. 305, eff. 6-1-81.

Ins 3.40 Authorized clauses for coordination of benefit provisions in group and blanket disability insurance policies [ss. 631.20, 631.21 (1) (b), 631.23, 631.43, 632.77 (3)]. (1) PURPOSE. This section establishes authorized coordination of benefit clauses for group and blanket disability insurance policies pursuant to s. 631.23, Stats., because it has been found that provision of language, content or form of these specific clauses is necessary to provide certainty of meaning of them, and regulation of contract forms will be more effective and litigation will be substantially reduced is there is increased uniformity of these clauses. This section does not require the use of coordination of benefit or "other insurance" provisions but if such provisions are used, they must adhere substantially to this section. Liberalization of the prescribed language including rearrangement of the order of the clauses is permitted provided that the modified language is not less favorable to the insured person. Provisions for the reduction in benefits because of other insurance which are inconsistent with this section violate the criteria of s. 631.20, Stats., and may not be used.

(2) SCOPE. This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., providing 24-hour coverage for medical or dental care, treatment or expenses due to either injury or sickness which contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" clause or other provision, clause or exclusion by whatever name designated under which benefits would be reduced because of other insurance, other than an exclusion for expenses covered by workers compensation, employer's liability insurance or Medicare. A plan of coverage, such as major medical or excess medical, designed to be supplementary to a group or blanket policyholder's other coverage may provide that the plan shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

(3) AUTHORIZED CLAUSES. The clauses in subs. (4) to (10) shall be considered authorized clauses pursuant to s. 631.23, Stats., for use in policy forms subject to this section and collectively are a coordination of benefits provision and may be referred to as "this provision."

(4) BENEFITS SUBJECT TO THIS PROVISION. All of the benefits provided under this policy are subject to this provision.

(5) BENEFITS SUBJECT TO THIS PROVISION [Alternate Clause]. Only the major medical expense benefits provided under this policy are subject to this provision. [When the policy provides both integrated major medical expense benefits and the basic benefits, but the "other insurance" provision applies to the major medical expense benefits only, this alternate wording is authorized.]

(6) DEFINITIONS. (a) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by group, blanket or franchise insurance coverage, service insurance plan contracts, group practice, individual practice and other prepayment coverage, or any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employe benefit organization plans, and any coverage under governmental programs, and any coverage required or provided by statute.

Ins 3.42 Plans of conversion coverage. Pursuant to s. 632.897 (4) (b), Stats., the following plans of conversion coverage are established.

(1) *Plan 1—Basic Coverage*—Plan 1 basic coverage consists of the following:

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the major metropolitan area of this state, for a maximum duration of 70 days per calendar year;

(b) Miscellaneous in-hospital expenses, including anesthesia services, up to a maximum amount of 20 times the hospital room and board daily expense benefits per calendar year; and

(c) In-hospital and out-of-hospital surgical expenses payable on a usual, customary and reasonable basis up to a maximum benefit of $2,000 a calendar year.

(2) *Plan 2—Major Medical Expense Coverage*—Plan 2 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(a) A lifetime maximum benefit of $75,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provided at a lesser rate, but not below 50%, and surgical expenses will be provided at a usual, customary and reasonable level.

(c) A deductible for each benefit period of $500 except that the deductible shall be $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

(3) *Plan 3—Major Medical Expense Coverage*—Plan 3 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(Same as Plan 2 except that maximum benefit is $100,000 and deductible is $1,000 for an individual and $2,000 for a family.)

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.43 High limit comprehensive plan of benefits. (1) A policy form providing a high limit comprehensive plan of benefits may be approved as an individual conversion policy as provided by s. 632.897 (4) (b), Stats., if it provides comprehensive coverage of expenses of hospital, surgical and medical services of not less than the following:

(a) A lifetime maximum benefit of $250,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provided at a lesser rate, but not below 50%, and surgical expenses will be provided at a usual, customary and reasonable level.

(c) A deductible for each benefit period of at least $250 and not more than $500 except that the deductible shall be at least $250 and not more than $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

(2) the filing procedures of s. Ins 3.12, Wis. Adm. Code, shall apply to policy forms filed as individual conversion policies.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.44 Effective date of s. 632.897, Stats. (1) Section 632.897, Stats., applies to group policies issued or renewed on or after May 14, 1980, or if a policy is not renewed within two years after the effective date of the act, s. 632.897, Stats., is effective at the end of 2 years from May 14, 1980.

(2) (a) A group policy as defined in s. 632.897 (1) (c) 1 or 3 shall be considered to have been renewed on any date specified in the policy as a renewal date or on any date on which the insurer or the insured changed the rate of premium for the group policy.

(b) A group policy as defined in s. 632.897 (1) (c) 2 shall be considered to have been renewed on any date on which an underlying collective bargaining agreement or other underlying contract is renewed, or on which a significant change is made in benefits.

(3) Section 632.897, Stats., applies to individual policies issued or renewed after May 14, 1980, except that it shall not apply to any individual policy in force on May 13, 1980, in which the insurer does not have the option of changing premiums.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.45 Conversion policies by insurers offering group policies only. Section 632.897 (4) (d) (first sentence), Stats., establishes that an insurer offering group policies only is not required to offer individual coverage. Since the insurer has no individual conversion policies which it may offer, it may not require a terminated insured who elected to continue coverage under s. 632.897 (2), Stats., to convert to individual coverage under s. 632.897 (6), Stats., after 12 months. The terminated person may continue group coverage except as provided in s. 632.897 (3) (a), Stats.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.46 Standards for nursing home insurance. (1) FINDINGS. Information on file in the office of the commissioner of insurance shows

that significant misunderstanding exists with respect to nursing home insurance. In many cases, coverage under these policies is much less than the use of the label would warrant and includes few meaningful benefits beyond those already available to consumers as a result of s. 632.78 (4), Stats., and Ins 3.39, Wis. Adm. Code, and the commissioner of insurance finds that such policies are inequitable, misleading, deceptive, obscure, and encouraging of misrepresentation as considered by s. 631.20 (2), Stats. Some of the sales presentations used to sell nursing home insurance are misleading, confusing, and incomplete, and the commissioner of insurance finds that such presentations are misleading and deceptive, and restrain competition unreasonably under s. 628.34 (12), Stats., and their continued use would constitute an unfair trade practice under s. 628.34 (11), Stats.

(2) PURPOSE. (a) This section establishes minimum requirements for insurance which may be sold as nursing home insurance. A policy will be disapproved pursuant to s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(b) This section seeks to reduce abuses and confusion associated with the sale of nursing home insurance by providing for minimum levels of coverage. It is designed not only to improve the ability of the consumer to make an informed choice as to whether to purchase a nursing home policy, but to assure that no policy will be approved by the commissioner as a "nursing home policy" unless it contains coverage which warrants the use of that label.

(3) SCOPE. (a) Except as provided in par. (b), this section applies to any individual insurance policy or rider which provides coverage primarily for confinement or care in a nursing home. This section applies regardless of restrictions on the level of nursing home care provided by a policy, i.e., skilled, intermediate, limited, personal or residential care.

(b) This section shall not apply to a rider designed specifically to meet the requirement for coverage of skilled nursing care set forth in s. 632.78 (4), Stats.

(4) DEFINITIONS. For the purpose of this section:

(a) "Medicare" means the hospital and medical insurance program established by title XVIII of the federal social security act of 1965, as amended.

(b) "Medicare eligible persons" means all persons who qualify for Medicare.

(c) "Nursing home" means a nursing home as defined by s. 50.01 (3), Stats.

(5) NURSING HOME POLICY REQUIREMENTS. No insurance policy covered by this section shall be structured, advertised, or marketed as a nursing home policy unless:

(a) The policy provides at a minimum the coverage set out in sub. (6) of this section and applicable statutes.

(b) The policy is plainly printed as to text in black or blue ink in a type of a style in general use, the size of which is uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point.

(c) If the policy is sold to Medicare-eligible persons, it meets the requirements of s. Ins 3.39 (7) (b), Wis. Adm. Code.

(6) MINIMUM COVERAGES. (a) Except as provided in pars. (b) through (g) of this section, a nursing home policy shall provide coverage for each person insured under the policy for any care received while a resident of any nursing home licensed by the state of Wisconsin pursuant to s. 50.02, Stats.

(b) Nursing home policies may limit benefits to a fixed daily benefit. The daily benefit may differ for different levels of care, but the lowest level of daily benefits shall not be less than $10 a day.

(c) Nursing home policies may provide benefits subject to a deductible, but the deductible amount shall not exceed 60 days per lifetime.

(d) Nursing home policies may provide benefits subject to a lifetime maximum, but the lifetime maximum shall be at least 365 days of coverage.

(e) Nursing home policies may limit coverage to care certified as necessary by the attending physician and periodically recertified as necessary.

(f) Nursing home policies are not required to duplicate payments by Medicare for nursing home care.

(g) The following limitations and exclusions are prohibited in nursing home policies:

1. Coverge limited to only certain levels of care, such as skilled care.

2. Coverage limited to care received as a result of sickness or injury.

3. Coverage limited to care received after a hospital confinement.

(6) SEVERABILITY. If any provision of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the parts of this section are declared to be severable.

(7) EFFECTIVE DATE. This rule shall take effect November 1, 1981.

History: Cr. Register, May, 1981, No. 305, eff. 11-1-81.