Chapter Ins 6
GENERAL

Ins 6.01 Foreign company to operate 2 years before admission. Experience has demonstrated that until a company has engaged in the business of insurance for at least 2 years there is not a sufficient basis upon which to form a judgment as to whether its methods and practices in the conduct of its business are such as to safeguard the interests of its policyholders and the people of this state. Therefore, no application of a foreign insurance company or mutual benefit society for a license to transact business in Wisconsin will be considered until it has continu-

ously transacted the business of insurance for at least 2 years immediately prior to the making of such application for license.

Ins 6.02 Company to transact a kind of insurance 2 years before admission. (1) Experience has demonstrated that until a company has engaged in a kind of insurance or in another kind of insurance of the same class for at least 2 years, there is not a sufficient basis upon which to form a judgment as to whether its methods and practices in the conduct of its business in such kind of insurance or another kind in the same class of insurance, are such as to safeguard the interests of its policyholders and the people of this state. Therefore, no application of a foreign insurance company or mutual benefit society for a license to transact a kind of insurance business in Wisconsin will be considered until it has continuously transacted that kind of insurance, or another kind of insurance in the same class of insurance as that for which it makes such application; for at least 2 years immediately prior to making such application. For the purposes hereof, insurance is divided into kinds of insurance according to the provisions of s. Ins 6.75 each subsection setting forth a separate kind, and into classes of insurance upon the basis of and including the said kinds as follows:

(a) Fire insurance includes the kinds in s. Ins 6.75 (2) (a).

(b) Life insurance includes the kinds in s. Ins 6.75 (1) (a) and (b) but excluding all insurance on the health of persons other than that authorized in s. 627.06, Stats., and s. Ins 6.70.

(c) Casualty insurance includes the kinds in s. Ins 6.75 (2) (c) through (n).

(2) Provided, however, that nothing herein shall preclude consideration of an application to transact the kind of insurance in Ins 6.75 (1) (e) or (2) (c) if the applicant company has transacted any of the kinds of insurance in Ins 6.75 (1) (a) and (b) or (2) (d), (e), (k) and (n) continuously for 2 years immediately prior to the making of application for license to transact the kind of insurance in Ins 6.75 (1) (e) or (2) (c).

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76; am. Register, March, 1979, No. 279, eff. 4-1-79.

Ins 6.05 Filing of property and casualty insurance forms. (1) PURPOSE. This rule is intended to implement and interpret s. 631.20, Stats., for the purpose of establishing filing procedures for certain property and casualty insurance policy forms.

(2) SCOPE. The requirements of this rule shall apply to insurance forms as defined in s. 600.03 (21), Stats., to be used to provide any of the lines or classes of insurance listed in Ins 6.75 (2) (a), (d), (e), (f), (g), (h), (i), (j), (l), (m) and (n).

(3) DEFINITIONS. In this rule, unless the context otherwise requires, the following words and terms shall have the following meanings:

(a) "Filing" shall mean:

1. Any matter submitted under this rule.

2. The act of filing such matter.

(b) "Basic policy forms" shall mean the basic insurance contracts used by any insurer including coverage parts or forms necessary to complete the contracts, amendatory endorsements needed to effect statu-

(c) Property insurance—as described in section Ins 6.75 (2) (a) and (2) (b);

(d) Casualty insurance—as described in section Ins 6.75 (2) (d) through (n);

(e) Credit life and credit accident and sickness insurance as described in sections Ins 6.75 (1) (a) 1. and Ins 6.75 (1) (c) 1. or (2) (c) 1.;

(g) Automobile insurance—as described in section Ins 6.75 (2) (e);

(h) Title insurance—as described in section Ins 6.75 (2) (h);

(i) Town mutual non-property insurance—as described in s. 612.31 (3), Stats.

History: Cr. Register, December, 1967, No. 144, eff. 1-1-68; r. and recr. (3) (d), Register, November, 1971, No. 191, eff. 12-1-71: am. (2) (e), Register, February, 1973, No. 206, eff. 3-1-73; am. (2) (h), Register, September, 1973, No. 213, eff. 10-1-73: cr. (2) (o), Register, May, 1975, No. 233, eff. 6-1-75; emerg. am. (1), (2), (3) (a) and (c), eff. 6-22-76; am. (1), (2), (3) (a) and (c), Register, September, 1976, No. 249, eff. 10-1-76; r. and recr., Register, August, 1977, No. 260, eff. 9-1-77; r. (2) (f), Register, October, 1981, No. 310, eff. 11-1-81.

Ins 6.51 Group coverage discontinuance and replacement. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of group policyholders, insurance companies, nonprofit service plans, protected persons, claimants and the general public by setting forth principals and procedures applicable in providing coverage when a group or group type insurance contract is discontinued or replaced. This rule interprets and implements, including but not limited to the following Wisconsin statutes: ss. 601.045, 600.03 (34m), 601.01 (3) (b) and ch. 613.

(2) SCOPE. This rule shall apply to all insurance policies issued or provided by an insurance company under authority of Ins 6.75 (1) (a) or (c) or (2) (c) on a group or group type basis covering persons as employes of employers or as members of unions or associations and to subscriber contracts issued or provided by an organization under authority of ch. 613, Stats., on a group or group type basis covering persons as employes of employers or as members of unions or associations.

(3) DEFINITION. The term "group type basis" means a benefit plan, other than "salary savings" or "salary budget" plans, utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

(a) Coverage is provided through insurance policies or subscriber contracts to classes of employes or members defined in terms of conditions pertaining to employment or membership.

(b) 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 particular organization or group.

(c) There are arrangements for bulk payment of premiums or subscription charges to the insurer or non-profit service organization.

(d) There is sponsorship of the plan by the employer, union, or association.

(4) EFFECTIVE DATE OF DISCONTINUANCE FOR NON-PAYMENT OF PREMIUM OR SUBSCRIPTION CHARGES. (a) If a policy or contract subject to this rule

provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

(b) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making premium payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.

(5) REQUIREMENTS FOR NOTICE OF DISCONTINUANCE. (a) Any notice of discontinuance so given by the carrier shall include a request to the group policyholder or other entity involved to notify employes covered under the policy or subscriber contract of the date as of which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims for losses incurred after such date. Such notice of discontinuance shall also advise, in any instance in which the plan involves employe contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

(b) The carrier will prepare and furnish to the policyholder or other entity at the same time a supply of a notice form to be distributed to the employes or members concerned indicating such discontinuance and the effective date thereof, and urging the employes or members to refer to their certificates or contracts in order to determine what rights, if any, are available to them upon such discontinuance.

(6) EXTENSION OF BENEFITS. (a) Every group policy or other contract subject to this rule hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract during the continuance of total disability as required by the following paragraphs of this section.

(b) In the case of a group or group type life plan which contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the policy shall not operate to terminate such extension.

(c) In the case of a group or group type plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement.

(d) In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required. Such a provision will be considered reasonable if it provides an extension of at least 12 months under major medical and comprehensive medical type coverages, and under other types of hospital or medical expense coverages provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event which occurred while coverage was in force (e.g., an accident).

(e) Any applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability must be subject to the policy's or contract's regular benefit limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

(7) CONTINUANCE OF COVERAGE IN SITUATIONS INVOLVING REPLACEMENT OF ONE CARRIER BY ANOTHER. (a) This section shall indicate the carrier responsible for liability in those instances in which one carrier's contract replaces a plan of similar benefits of another.

(b) Liability of prior carrier. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity involved secures replacement coverage from a new carrier, self-insures, or foregoes the provisions of coverage.

(c) Liability of succeeding carrier:

1. Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively at work and non-confinement rules) shall be covered by that carrier's plan of benefits.

2. Each person not covered under the succeeding carrier's plan of benefits in accordance with subparagraph 1. above must nevertheless be covered by the succeeding carrier in accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.

a. The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.

b. Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:

i) The date the individual becomes eligible under the succeeding carrier's plan as described in subparagraph 1. above.

ii) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions

applicable to individual termination of coverage (e.g., at termination of employment or ceasing to be an eligible dependent, as the case may be).

iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which subsection (6) requires an extension or accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by subsection (6) or, if the prior carrier's policy or contract is not subject to that section, would have been required of that carrier had its policy or contract been subject to subsection (6) at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

3. In the case of a pre-existing conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to pre-existing conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection during the period of time this limitation applies under the new plan shall be the lesser of

a. The benefits of the new plan determined without application of the pre-existing conditions limitation; and

b. The benefits of the prior plan.

4. The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.

5. In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this section, benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

(8) EFFECTIVE DATE. This rule shall apply to all insurance policies and subscriber contracts subject to the rule which are issued or renewed on or after January 1, 1973.

History: Cr. Register, October, 1972, No. 202, eff. 11-1-72; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (1), (2) and (7) (c), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 6.52 Biographical data relating to company officers and directors. (1) PURPOSE. This rule is intended to implement and interpret ss. 611.13 (2), 611.54 (1) (a), 611.57, 618.11 (4) and 618.21 (1) (b), Stats., for the purpose of setting standards for the reporting of biographical data relating to company officers, directors, promoters and incorporators, or other persons similarly situated.

results of a written examination; a review of the application form in accordance with section Ins 6.62 and all other pertinent records of the office of the commissioner of insurance.

(4) Applications shall be filed with the commissioner of insurance, Madison, Wisconsin, at least 22 days prior to the scheduled day of the written examination.

(5) The following fee schedule is established in accordance with s. 601.31 (17), Stats., for investigation and examination of an individual intermediary-broker:

Examination for one kind of authority	$25.00
Examination for two kinds of authority	30.00

(6) An individual applicant who obtains a passing grade on the written examination and submits a satisfactory application and meets all the requirements of Ins 6.62 (3) and the bonding and trust requirements of Ins 6.64 shall be issued an individual intermediary-broker license for that kind of authority for which he or she is qualified upon timely payment of a license issuing fee of $10.00 as authorized by section 601.31 (15), Stats.

(7) Written examination will be administered pursuant to section Ins 6.59 (6) and (8).

(8) An annual regulation charge will be required for each licensed individual intermediary-broker in accordance with s. 601.31 (15m), Stats.

History: Cr. Register, March, No. 279, eff. 4-1-79.

Ins 6.66 Proper exchange of business. (s. 628.61, Stats.). (1) Proper exchange of business means the forwarding of insurance business from one intermediary-agent who cannot, after due consideration, place the business with any of the insurers for which the agent is listed because of capacity problems, the refusal of the company to accept the risk or the onerous conditions it imposes on the insured, to an intermediary-broker or another intermediary-agent licensed for those lines of insurance whose insurers are able to accommodate the risk under conditions more favorable to the insured. The intermediary-agent forwarding the business is entitled to split the commission involved. Proper exchange of business is not the regular course of business and such forwarding of business is thereby distinguished from brokerage by its occasional and exceptional nature.

(2) No intermediary-agent may properly exchange business with another intermediary-agent or an intermediary-broker, unless:

(a) The soliciting intermediary-agent completes and signs an Exchange of Business Form; leaves one copy of the form with the insured prior to binding coverage, or if not feasible, notifies the insured of the contents of the form and subsequently gives the form to the insured; and retains one copy for his or her files;

(b) The intermediary-agent forwarding the business to a listed intermediary-agent or an intermediary-broker is licensed for the lines of business that are being exchanged;

(c) The intermediary-agent who receives the business and agrees to place it is licensed in the line or lines of insurance involved in the exchange; and

(d) Both the intermediary-agent forwarding the business and the intermediary-agent or intermediary-broker who places the business with the insurer sign the insurance application, or if no application is completed, the names of the intermediaries involved in the transaction appear on the policy issued.

(3) No intermediary-agent shall accept business solicited by another intermediary-agent which he or she knows, or has reason to know, is not exchanged in compliance with the provisions of this rule.

(4) The Exchange of Business Form shall contain statements:

(a) That such exchange is occasional within the meaning of this section;

(b) That the exchanged business originated in the normal course of business which, in the case of personal solicitations, means during solicitation for a particular insurer or group of insurers with whom the intermediary-agent is listed; and

(c) That after investigation it was found or demonstrated that the insurer (s) with whom the agent is listed is not capable of providing the desired coverage for any of the reasons set forth in sub (1).

(d) The following format shall be followed:

(2) In a mutual company organized for the insurance or guaranty of depositors or deposits in banks or trust companies, the maximum single risk may be fixed at a higher amount by the bylaws. Any such company may effect reinsurance in any authorized or unauthorized company that complies with s. 627.23, Stats. Insurance in any unauthorized company shall be reported annually and the same taxes paid upon the premiums as are paid by authorized companies.

History: Emerg. cr. eff. 6-22-76; cr. Register, September, 1976, No. 249, eff. 10-1-76; r. and recr. Register, August, 1981, No. 308, eff. 9-1-81.

Ins 6.73 Reinsurance. The provisions of ss. 201.27 and 201.31, 1973 Stats., are incorporated hereby by reference in their entirety.

History: Emerg. cr. eff. 6-22-76; cr. Register, September, 1976, No. 249, eff. 10-1-76.