(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 shall not use the statements, information or material set out in subds. 1, 2 and 3 to void the coverage on the basis of misrepresentation in the application, or deny a claim on the basis of a pre-existing condition defense, unless the insurer has:

1. Resolved patently conflicting or incomplete statements in the application for the coverage;

2. Duly considered information furnished to it:

a. In connection with the processing of such application, or

b. In connection with individual coverage on the person previously issued by it and currently in force, or

3. Duly considered the material which it would have obtained through reasonable inquiry following due consideration of the statements or information.

(d) An insurer shall at the issuance or amendment of a policy, contract or subscriber certificate, furnish notice concerning statements in the application to the policyholder, contracting party or certificate holder, where the application for the coverage or amended coverage contains questions relating to the medical history or other matters concerning the insurability of the person or persons being insured and the application is part of the insurance contract.

1. The notice shall be printed prominently in contrasting color on the first page of the policy, contract, or subscriber certificate or in the form of a sticker, letter or other form attached to the first page of the policy, contract or certificate, or a letter or other form to be mailed within 10 days after the issuance or amendment of coverage.

2. The notice shall contain substantially the following as to text and caption or title:

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 par. (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 as provided in s. 631.11 (4), Stats., or the insurer shall be held to have waived its rights to such action.

(g) An insurer may use statements in an application form as a defense to a claim or to avoid or reform coverage only if it has complied with par. (d).

(6) CLAIMS ADMINISTRATION. (a) If the existence of a disease or physical condition is duly disclosed in the application for coverage in response to the questions therein, the insurer shall not use the pre-existence defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss. This paragraph does not apply to a preexisting condition exclusion permitted under s. 635.17 (1), Stats.

(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 or disability commencing within 12 months from the effective date of coverage, unless the disease or physical condition causing the loss or disability is excluded from coverage by name or specific description effective on the date of loss or the date the disability commenced. If, after 12 months from the effective date of coverage, there is a reoccurrence of the disease or condition causing the loss or disability, then the pre-existence defense may not be used. Under a disability income policy a disease or condition shall be deemed to have not reoccurred if the insured performs all important duties of the insured's or a comparable occupation on the same basis as before the disability, for at least 6 months. Under a policy other than disability income a disease or condition shall be deemed to have not reoccurred if a period of 6 months elapses during which no expenses are incurred for the same or related disease or condition.

(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 or disability 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 and for which such diagnosis, care or treatment was not sought prior to such date.

(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 par. (d) of this subsection.

(f) An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non-eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

1. A pre-existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

(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 sub. (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 sub. (6) (a) and (b) shall apply to policies issued after that date and sub. (5) (d) and (e) shall apply to such activities after February 1, 1975.

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

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; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (1), (2), (5) (f) and (6) (b), cr. (5) (g), r. and recr. (5) (c) and (d) and (6) (d) and (f), Register, April, 1982, No. 316, eff. 5-1-82; correction in (1) and (2) made under s. 13.93 (2m) (b) 7, Stats., Register, April, 1992, No. 436; am. (6) (a), Register, November, 1993, No. 455, eff. 2-1-94.

Ins 3.29 Replacement of accident and sickness insurance. (1) PURPOSE. The purpose of this section 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 section implements and interprets ss. 601.01 (2) and 628.34, 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 s. Ins 6.75 (1) (c) or (2) (c), s. 614.01 and ch. 613, 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, except Medicare supplement insurance subject to s. Ins 3.39 (4), (5) and (7),

(b) Accident only,

(c) Single premium nonrenewable,

(d) Nonprofit dental care,

(e) Nonprofit prepaid optometric service,

(f) A limited policy conforming to s. 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.

(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 Ins 6.51 (3).

(d) *Direct response insurance* is insurance issued to an applicant who has completed the application and forwarded it directly to the insurer in response to a solicitation coming into his or her 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 sub. (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 sub. (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) (a) NOTICE TO APPLICANT. The notice required by sub. (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. (This language may be modified if pre-existing conditions are covered under the new 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. (This language may be modified if pre-existing conditions are covered under the new policy.)

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

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

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

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

The above "Notice to Applicant" was delivered to me on - - - - - - -. (date)

- - - - - - - - - -
Applicant

(b) The notice required by sub. (6) for a Medicare supplement policy subject to s. Ins 3.39 (4), (5), and (6), shall include an introductory statement in substantially the following form: Your new policy provides - - - - days within which you may decide without cost whether you desire to keep the policy.

(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 s. 601.64, Stats.

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

History: Cr. Register, June, 1974, No. 222, eff. 9-1-74; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (3) (a) and (i), r. (3) (j), renum. (7) to be (7) (a) and am., cr. (7) (b), Register, June, 1982, No. 318, eff. 7-1-82; r. (9) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; corrections in (1), (3) (a) and (4) (d) made under s. 13.93 (2m) (b) 5 and 7, Stats., Register, April, 1992, No. 436.

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 s. Ins 6.75 (1) (c) or (2) (c), and s. 600.03 (4), (22) and (23), Stats.

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

(a) Shall comply with s. 632.71, Stats., except as provided in ss. 631.81 and 632.77 (4), 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; emerg. am. (2) and (3) (a), eff. 6-22-76; am. (2) and (3) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79; correction in (2) made under s. 13.93 (2m) (b) 7, Stats., Register, April, 1992, No. 436.

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 ss. 185.981 or ch. 613, Stats. Sections of Stats. interpreted or implemented by this rule include but are not limited to ss. 601.04 (3), 601.01 (2), 611.20, 618.12 (1) and 632.76, Stats.

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of insurance issued by an insurer under s. 600.03 (4) or (23), Stats., except credit accident and sickness insurance under s. Ins 6.75 (1) (c) 1. or (2) (c) 1., and coverage issued on a group basis or group type basis as defined in s. Ins 6.51 (3) by a plan subject to s. 185.981, or ch. 613, Stats. For the purposes of this rule, references to insurer, certificate, insurance agent or representative, enrollment form and enrollee also apply to organizations or associations operating non-profit plans, contracts, summaries of coverage, persons within the scope of the rule, individual applications and applicants, respectively.

(3) GROUP AND GROUP TYPE INSURANCE. An insurer issuing insurance under s. 600.03 (23), Stats., or group or group type coverage under s. 185.981 or ch. 613, 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 or she has not withheld any information or concealed any facts in completing the enrollment form; however, the enrollee may be required to state that his or her 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 or she prepares and shall set down in each such form all material information disclosed to him or her 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 shall not use the statements, information or material set out in subds. 1, 2 and 3 to void the coverage on the basis of misrepresentation in the enrollment form, or deny a claim on the basis of a pre-existing condition defense, unless the insurer has resolved patently conflicting or incomplete statements in the enrollment form for the coverage, duly considered information furnished to it in connection with the processing of such enrollment form, or duly considered the material which it would have obtained through reasonable inquiry following due consideration of such statements or information.

d. An insurer shall furnish to the certificate holder or subscriber a notice printed prominently in contrasting color on the first page of the certificate or amendment, or 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 subpar. d.

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, as provided in s. 631.11 (4), Stats., 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 subpar. d.

4. Claims administration. a. If the existence of a disease or physical condition was duly disclosed in the enrollment form for coverage in response to the questions therein, the insurer shall not use the pre-existence defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss. This paragraph does not apply to a preexisting condition exclusion permitted under s. 635.17 (1), Stats.

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 or disability commencing within 12 months from the effective date of the person's coverage, unless the disease or physical condition causing the loss or disability is excluded from coverage by name or specific description effective on the date of loss or the date the disability commenced. If after 12 months from the effective

date of coverage, there is a reoccurrence of the disease or condition causing the loss or disability, then the pre-existence defense may not be used. Under a disability income policy a disease or condition shall be deemed to have not reoccurred if the insured performs all important duties of a comparable occupation on the same basis as before the disability, for at least 6 months. Under a policy other than disability income a disease or condition shall be deemed to have not reoccurred if a period of 6 months elapses during which no expenses are incurred for the same or a related disease or condition.

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 or disability 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:

a. Medical diagnosis or treatment of such disease or physical condition prior to the effective date, or

b. 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 and for which such diagnosis, care or treatment was not sought prior to such date.

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 subd. 1.

3. An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non-eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

1. A pre-existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

(c) Where the group or group type plan is issued to trustees of a fund, 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 s. 600.03 (35) (c) 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:

A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss or disability 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 had manifested itself prior to such date. Such manifestation may be established by evidence of:

a. Medical diagnosis or treatment of such disease or physical condition prior to the effective date, or

b. 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 and for which such diagnosis, care or treatment was not sought prior to such date.

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 par. (b) 1. b.

3. An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non-eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

1. A pre-existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

(5) EFFECTIVE DATE. This rule shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after December 1, 1974, except that sub. (3) (a) 4. a. and b. shall apply to coverage issued after said date and sub. (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; emerg. am. (1), (2), (3) (intro.) and (c) and (4), eff. 6-22-76; am. (1), (2), (3) (intro.) and (c) and (4), Register, September, 1976, No. 249, eff. 10-1-76; am. (1), (2), (3) (intro.) and (c) and (4), Register, November, 1993, No. 455, eff. 12-1-93.

ber, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (1), (2), (3) (intro.), (3) (a) 3. d., f. and 4. b., (3) (c) and (4), r. and recr. (3) (a) 3. c., (3) (b) 1. and 3., (4) (b) 1. and 3., Register, April, 1982, No. 316, eff. 5-1-82; correction in (2) and (3) (intro.) made under s. 13.93 (2m) (b) 7, Stats., Register, April, 1992, No. 436; am. (3) (a) 4. a., Register, November, 1993, No. 455, eff. 2-1-94.

Ins 3.32 Title insurance; prohibited practices. (1) PURPOSE. This rule implements and interprets s. 601.01 (3) and ch. 628, Stats., for the purpose of prohibiting unfair practices in the transaction of the business of title insurance.

(2) SCOPE. This section applies to all title insurers and title insurance agents.

(3) DEFINITIONS. In this section:

(a) "Affiliate" has the meaning provided under s. 600.03 (1), Stats.

(am) "Agent" has the meaning provided under s. 600.03 (lr), Stats.

(b) "Affiliate producer" means an affiliate of a producer of title insurance, but only for the 12-month period commencing after June 30, 1987, and after the end of any quarter calendar year in which the affiliate's gross revenue from operation in this state from title insurance directly or indirectly referred by affiliated producers of title insurance exceeds 40% of the affiliate's gross revenue from operations in this state for title insurance in the previous quarter calendar year. However, if the previous quarter calendar year commences prior to July 1, 1988, the percentage is 80%; and if it commences prior to July 1, 1989, the percentage is 60%. "Affiliate producer" does not include a person who is affiliated with producers of title insurance who are all attorneys if the affiliate examines the title for each title insurance policy it issues.

(bm) "Control" has the meaning provided under s. 600.03 (13), Stats.

(c) "Producer of title insurance" means any of the following, other than a title insurer, who order or influence, directly or indirectly, the ordering of title insurance and related services:

1. Any owner or prospective owner of real or personal property or any interest therein;

2. Any lender or prospective lender in a transaction involving an obligation secured or to be secured either in whole or in part by real or personal property or any interest therein; and

3. Any agent, representative, attorney or employe of any owner or prospective owner or of any lender or prospective lender.

4. An affiliate producer.

(cm) "Supplementary rate information" has the meaning provided under s. 625.02 (3), Stats.

(d) "Title insurance rates" means all charges made by a title insurer in connection with the issuance of a title insurance policy or a commitment to issue a title insurance policy and includes, but is not limited to, search and examination charges.

(e) "Title insurer" means all insurance companies authorized to write title insurance as defined by s. Ins 6.75 (2) (h) and their affiliates, and

includes all officers, employes and representatives of the insurance companies or their affiliates.

(4) PROHIBITED PRACTICES. No title insurer or agent of a title insurer may engage in any of the following practices:

(a) Charging an amount for a title insurance policy or commitment for a title insurance policy other than the amount developed by application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner for use by the title insurer.

(b) Waiving, or offering to waive, all or any part of the applicable title insurance rate or premium developed by proper application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner.

(c) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when the property involved is ineligible for such reduced rate.

(d) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when such rate is not applicable in the particular transaction because the volume required to qualify for such reduced rate includes ineligible property.

(e) Paying or offering to pay the cancellation fee, the fee for a preliminary title report or other fee on behalf of any producer of title insurance after inducing the person to cancel an order with another title insurer.

(f) Making or guaranteeing, or offering to make or guarantee, directly or indirectly, any loan to any producer of title insurance regardless of the terms of the note or guarantee. This prohibition is not applicable to customary business collection procedures, claims settlement and salvage activities and other business activities totally unrelated to the solicitation of business for which a charge is made.

(g) Providing or offering to provide, directly or indirectly, a "compensating balance" or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by the lending institution to any producer of title insurance, or for the express or implied purpose of influencing the placement or channeling of title insurance business by the lending institution. This paragraph does not prohibit the maintenance by a title insurer or agent of demand deposits or escrow deposits which are reasonably necessary for use in the ordinary course of the business of the title insurer or agent.

(h) Paying or offering to pay the fees or charges of an outside professional, including but not limited to, an attorney, engineer, appraiser, or surveyor, whose services are required by any producer of title insurance to structure or complete a particular transaction.

(i) Paying or offering to pay all or part of the salary of an employe of a producer of title insurance.

(j) Paying or offering to pay a fee to a producer of title insurance for services unless the fee bears a reasonable relation to the services performed. The determination of whether a fee bears a reasonable relation to the services performed means a recognition of time and effort spent, risk and expenses incurred, and an allowance for a reasonable level of

profit. After June 30, 1987, for purposes of this paragraph, a payment determined by applying a percentage amount or formula to the premium

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