Chapter Ins 3

CASUALTY INSURANCE

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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 3.03 History: 1–2–56; r. Register, October, 1958, No. 34, eff. 11–1–58.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under section 204.28, Wis. Stats.

Ins 3.05 History: 1–2–56; r. Register, October, 1958, No. 34, eff. 11–1–58.
Ins 3.06 History: 1–2–56; r. Register, October, 1958, No. 34, eff. 11–1–58.

Ins 3.07 Rules in chapter 4, fire and allied lines insurance, applicable to casualty insurance. The following captioned rules under chapter 4, FIRE AND ALLIED LINES INSURANCE, are applicable to casualty insurance:

Ins 4.01 Mutual insurance companies operating on a post mortem assessment plan cannot limit assessments to a specified amount.

Ins 4.02 Nonassessable policies of mutual companies.

Ins. 4.03 Policy, inspection and similar fees.

Ins 3.08 Advertisements of accident and sickness insurance. (1) PURPOSE (a) The purpose of these rules is to implement and interpret the statutory standards governing the advertisements of accident and sickness insurance. Section 204.31, Wis. Stats., provides that the commissioner of insurance may disapprove a form ". . . if it contains a

provision which is unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation of such policy . . ." Section 207.04 (1) (b), Wis. Stats., defines false information and advertising which is untrue, deceptive or misleading as an unfair method of competition and as an unfair and deceptive act or practice in the business of insurance.

(b) It is the intent of these rules to create a set of standards which are to be adhered to by the several insurers within the jurisdiction of this department which engage in the advertising of their accident and sickness insurance policies.

(c) When interpreting these rules as related to a specific advertisement, this department will consider the type of policy to which the advertisement refers; the content of the advertisement; and the detail, character, and purpose of such advertisement.

(d) Advertising material should have a reasonable relation to the policy it represents in regard to the content, purpose, and use of said policy. The test is whether or not the advertisement has the capacity or tendency to mislead or deceive.

(2) DEFINITIONS. (a) An advertisement for the purpose of these rules shall include: 1. Printed and published material and descriptive literature of an insurer used in newspapers, magazines, radio and TV scripts, billboards and similar displays; and

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

3. Prepared sales talks, presentations of material for use by agents, and representations made by agents in accordance therewith.

(b) Policy for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits or medical, surgical or hospital expense benefits, whether on a cash indemnity, reimbursement, or service basis, except when issued in connection with another kind of insurance other than life and except disability and double indemnity benefits included in life insurance and annuity contracts.

(c) Insurer for the purpose of these rules shall include any person, individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.

(d) These rules shall also apply to agents to the extent that they are responsible for the advertisement of any policy.

(3) ADVERTISEMENTS IN GENERAL. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used.

(4) ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED, OR PREMIUMS PAYABLE. (a) *Deceptive words, phrases or illustrations.* Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent

of any policy benefit payable, loss covered, or premium payable. An advertisement relating 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 deceive.

(b) *Examples of deceptive words and phrases prohibited by paragraph (a).* 1. The words and phrases "all", "full", "complete", "comprehensive", "unlimited", "up to", "as high as", "this policy will pay your hospital and surgical bills", 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.

2. 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. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

3. The benefits of a policy which pays varying amounts for the same loss occurring under different conditions or which pay 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.

4. Phrases such as "this policy pays $1,800 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.

(c) *Exceptions, reductions, and limitations.* When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive.

(d) *Definitions of terms used in paragraph (c).* 1. The term "exception" shall mean 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.

2. The term "reduction" shall mean any provision which reduces the amount of the benefit; 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.

3. The term "limitation" shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

(e) *Waiting, elimination, probationary, or similar periods.* When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement covered by subsection (4) (c) shall disclose the existence of such periods.

(f) *Pre-existing conditions.* 1. An advertisement covered by subsection (4) (c) shall disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy.

2. When a policy does not cover losses traceable to pre-existing conditions no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This limits the use of the phrase "no medical examination required" and phrases of similar import.

(5) NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELLABILITY AND TERMINATION. An advertisement which refers to renewability, cancellability or termination of a policy, or which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose 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.

(6) METHOD OF DISCLOSURE OF REQUIRED INFORMATION. All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

(7) TESTIMONIALS. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial makes as its own all of the statements contained therein, and the advertisement including such statements is subject to all of the provisions of these rules.

(8) USE OF STATISTICS. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact.

(9) INSPECTION OF POLICY. An offer in an advertisement of free inspection of a policy or offer of a premium refund is not a cure for misleading or deceptive statements contained in such advertisement.

(10) IDENTIFICATION OF PLAN OR NUMBER OF POLICIES. (a) When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

(b) When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

(11) DISPARAGING COMPARISONS AND STATEMENTS. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services, or business methods.

(12) JURISDICTIONAL LICENSING. (a) An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(b) Such advertisements by direct mail insurers shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of some language such as "This Company is licensed only in State A" or "This Company is not licensed in State B".

(13) IDENTITY OF INSURER. The identity of the insurer shall be made clear in all of its advertisements. An advertisement shall not use a trade name, service mark, slogan, symbol or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.

(14) GROUP OR QUASI-GROUP IMPLICATIONS. An advertisement of a particular policy shall not state or imply that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges, unless such is the fact.

(15) INTRODUCTORY, INITIAL, OR SPECIAL OFFERS. An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial, or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact.

(16) APPROVAL OR ENDORSEMENT BY THIRD PARTIES. (a) An advertisement shall not state or imply that an insurer or a policy has been approved or an insurer's financial condition has been examined and found to be satisfactory by a governmental agency, unless such is the fact.

(b) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organization, unless such is the fact.

(17) SERVICE FACILITIES. An advertisement shall not contain untrue statements with respect to the time within which claims are paid or statements which imply that claim settlements will be liberal or generous beyond the terms of the policy.

(18) STATEMENTS ABOUT AN INSURER. An advertisement shall not contain statements which are untrue in fact or by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age or relative position in the insurance business.

(19) SPECIAL ENFORCEMENT PROCEDURES FOR RULES GOVERNING THE ADVERTISEMENT OF ACCIDENT AND SICKNESS INSURANCE. (a) *Advertising file.* Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of individual policies and typical printed, published,

or prepared advertisements of blanket, franchise, and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this department. All such advertisements shall be maintained in said file for a period of not less than 3 years.

(b) *Certificate of compliance.* Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this regulation must file with this department 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 advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws of this state as implemented by this regulation.

History: Cr. Register, October, 1956, No. 10, eff. 11–1–56.

Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This rule is intended to implement and interpret applicable statutes for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) DEFINITION. Mortgage guaranty insurance is defined as insurance of mortgage lenders against loss by reason of nonpayment of mortgage indebtedness by the borrower, and is authorized by section 201.04 (9), Wis. Stats.

(3) ACCOUNTING. (a) The financial statement required by section 201.50, Wis. Stats., shall be furnished on the Fire and Casualty annual statement form.

(b) Expenses shall be recorded and reported in accordance with the "Uniform Classification of Expenses of Fire and Marine and Casualty and Surety Insurers."

(c) The unearned premium reserve shall be computed in accordance with section 201.18 (1), Wis. Stats., except that in the case of premiums paid in advance for ten-year policies the annual pro rata factors specified below or comparable monthly pro rata factors shall apply.

Year	Unearned Factor to be Applied to Premiums in Force	Year	Unearned Factor to be Applied to Premiums in Force
1	90.0%	6	19.0%
2	70.0%	7	12.0%
3	52.5%	8	7.0%
4	39.0%	9	3.5%
5	28.0%	10	1.0%

(d) From the premium remaining after establishment of the premium reserve specified in paragraph (c) of this subsection, a portion equal to the contingency factor prescribed in paragraph (c) of subsection (4) shall be maintained as a special contingency reservation of premium and reported in the financial statement as a liability.

(e) The case basis method shall be used to determine the loss reserve, which shall include a reserve for claims reported and unpaid and a reserve for claims incurred but not reported.

(4) CONTINGENCY RESERVE. (a) The reserve established in paragraph (d) of subsection (3) shall be maintained for 180 months for the purpose of protecting against the effect of adverse economic cycles. That portion of the special premium reserve established more than 180 months prior shall be released and shall no longer constitute part of the special reserve and may be used for usual corporate purposes.

(b) Subject to the approval of the commissioner, the reserve shall be available only for loss payments when the incurred losses in any one year exceed the rate formula expected losses by 10% of the corresponding earned premiums.

(c) The contingency factor in the rate formula shall be 50% of the premium remaining after establishment of the premium reserve specified in subsection (3) (c).

(d) In event of release of the special reserve for payment of losses, the contributions required by paragraph (d) of subsection (3) shall be treated on a first-in-first-out basis.

(5) RATE MAKING. (a) Mortgage guaranty insurance shall be subject to the provisions of sections 204.37 to 204.54 inclusive, Wis. Stats.

(b) The rate formula shall contemplate losses, expenses, contingency reserve, 2½% of premium for profit, and any other relevant factors.

(c) All policy forms and endorsements shall be filed with and be subject to the approval of the commissioner of insurance. With respect to owner-occupied single-family dwellings, the mortgage insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

History: Cr. Register, March, 1957, No. 15, eff. 4–1–57; am. (2), (3), (4) and (5), Register, January, 1959, eff. 2–1–59; am. (4) (c), Register, August, 1959, No. 44, eff. 9–1–59.

Ins 3.11 Multiple peril insurance contracts. (1) PURPOSE AND SCOPE. (a) This rule implements and interprets sections 201.05, 203.32, and 204.37 to 204.54 inclusive, Wis. Stats., by enumerating the minimum requirements for the writing of multiple peril insurance contracts. Nothing herein contained is intended to prohibit insurers or groups of insurers from justifying rates or premiums in the manner provided for by the rating laws.

(b) This rule shall apply to multiple peril insurance contracts permitted by section 201.05, Wis. Stats., and which include a type or types of coverage or a kind or kinds of insurance subject to section 203.32 or sections 204.37 to 204.54, inclusive, Wis. Stats.

(c) Types of coverage or kinds of insurance which are not subject to section 203.32 and sections 204.37 to 204.54 inclusive, Wis. Stats., or to the filing requirement provisions thereof, may not be included in multiple peril insurance contracts otherwise subject to said sections unless such entire multiple peril insurance contract is filed as being subject to this rule and said sections and the filing requirements thereof.

(2) DEFINITION. Multiple peril insurance contracts are contracts combining two or more types of coverage or kinds of insurance included in any one or more than one subsection of section 201.04, Wis.

Stats. Such contracts may be on the divisible or single (indivisible) rate or premium basis.

(3) RATE MAKING. (a) Premiums or rates must be predicated on the rating plans on file for such insurer(s) for each type of coverage or kind of insurance. Premiums or rates must contain, in addition to the charges for said kinds or types of insurance, an appropriate charge for such other perils or coverage as may be contemplated by the multiple peril insurance contract.

(b) Premiums or rates may be modified for demonstrated, measurable, or anticipated variation from normal of the loss or expense experience resulting from the combination or types of coverage or kinds of insurance or other factors of the multiple peril insurance contract. Multiple peril contracts may be filed or revised on the basis of sufficient underwriting experience developed by the contract or such experience may be used in support of such filing.

(c) In the event that more than one rating organization cooperates in a single (indivisible) rate or premium multiple peril insurance filing, one of such cooperating rating organizations shall be designated as the sponsoring organization for such filing by each of the other cooperating rating organizations and evidence of such designation included with the filing.

(4) STANDARD POLICY. The requirements of section 203.06, Wis. Stats., shall apply to any multiple peril insurance contract which includes insurance against loss or damage by fire.

History: Cr. Register, July, 1958, No. 31, eff. 8–1–58.

Ins 3.12 Membership fees and policy fees. (1) PURPOSE. This rule is intended to implement and interpret section 204.405, Wis. Stats., consistent with the purpose and scope of the applicable insurance statutes.

(2) DEFINITION. (a) Automobile coverage means the insurance against any loss, expense, and liability resulting from the ownership, maintenance, or use of any automobile or other vehicle except aircraft.

(b) Initial membership fee is the fee charged for any automobile coverage for membership in an insurance company at the time the policyholder first procures insurance from the insurance company.

(c) Policy fee is the fee charged for issuing an insurance policy.

(3) ACCOUNTING. Every initial membership fee, policy fee, or other similar charge for any automobile coverage shall be considered as additional premium for the first policy term subsequent to the collection or payment thereof: (a) For all annual statement purposes, including all summaries, tabulations, schedules, and exhibits;

(b) For recording and reporting in accordance with the uniform classification of expense for fire, marine, and casualty and surety insurance;

(c) For tax purposes;

(d) And shall be subject to all statutory requirements for reserves and financial statements;

(e) And reasonable allocation consistent with the company's method of operation for renewal business shall be made to each coverage for which there is a premium charge contained in the policy.

(4) INSURANCE RATES AND PREMIUM CHARGES. (a) Every initial membership fee, policy fee, or other similar charge for any automobile coverage shall be considered as additional premium for the first policy term subsequent to the collection or payment thereof and:

1. Shall be reasonable, equitable, and consistent with the company's method of operation;

2. Shall not discriminate unfairly between risks or classes;

3. Reasonable allocation shall be made to each coverage in accordance with the statistical plans applicable for the specific coverages contained in the policy;

4. In event of cancellation within the first policy term, shall be subject to return to at least the same extent as premium;

5. The conditions applicable to such fees shall be stated in the policy.

(b) Each and every consideration for the policy, including initial membership fee, policy fee, or other similar charge, and the premium, must be stated in the policy.

(c) With respect to the same kind or class of automobile coverage, an insurer may operate only on a plan which is limited to the use of the conventional premium method or to the use of an initial membership fee or policy fee or other similar charge.

(d) No policy fee or other similar charge shall be charged for renewal or extension of an insurance policy by endorsement or certificate.

History: Cr. Register, February, 1958, No. 26, eff. 3-1-58.

Ins 3.13 Individual accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of individual accident and sickness policies permitted by section 204.31, Wis. Stats., and franchise type accident and sickness policies permitted by section 204.32 (1), Wis. Stats. The requirements in subsections (2), (3), (4), (5), and (6) are to be followed in substance, and wording other than that described may be used provided it is not less favorable to the insured or beneficiary.

(2) POLICY PROVISIONS. (a) If a policy is not to insure against sickness losses resulting from conditions in existence prior to the effective date of coverage, or in existence prior to a specified period after such effective date, the policy by its terms shall indicate that it covers sickness contracted and commencing (or beginning, or originating, or first manifested or words of similar import) after such effective date or after such specified period. Wording shall not be used that requires the cause of the condition or sickness, as distinguished from the condition or sickness itself, to originate after such effective date or such specified period. (Note: It is understood that "sickness" as used herein means the condition or disease from which the disability or loss results.) Subsection (2) (a) shall not apply to nor prohibit the exclusion from coverage of a disease or physical condition by name or specific description.

(b) Where any "specified period" referred to in subsection (2) (a) exceeds 30 days, it shall apply to the occurrence of loss and not to the contracting or commencement of sickness after such period.

(c) 1. A policy, other than a guaranteed renewable policy, shall set forth the conditions under which the policy may be renewed, either by: A *brief description* of the policy's renewal conditions, or a *separate statement* referring to the policy's renewal conditions, or a separate appropriately captioned *renewal provision* appearing on or commencing on the first page.

a. The *brief description,* if used to meet the foregoing requirement, shall be printed, in type more prominent than that used in the policy's text, at the top or bottom of the policy's first page and on its filing back, if any, and shall describe its renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated in _____" (refer to appropriate policy provision), or "Renewal May be Refused as Stated in _____" (refer to appropriate policy provision). A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter.

b. The *separate statement,* if used to meet the foregoing requirement, shall be printed, in type more prominent than that used in the policy's text, at the top or bottom of the policy's first page and on its filing back, if any, and shall describe its renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated in _____" (refer to appropriate policy provision), or "Renewal May be Refused as Stated in _____" (refer to appropriate policy provision). A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter.

c. The *renewal provision* appearing on or commencing on the policy's first page, if used to meet the foregoing requirement, shall be preceded by a caption which describes the policy's renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated Below", or "Renewal May be Refused as Stated Herein". A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter. The caption shall be in type more prominent than that used in the policy's text.

2. If the policy is not renewable, it shall be so described in the brief description or in a separate statement at the top or bottom of the first page and on the filing back, if any, or it shall be so described in a separate appropriately captioned provision on the first page. The brief description, or the separate statement, or the caption shall be printed in type more prominent than that used in the policy's text.

3. If the policy contains a cancellation provision, it must be separately set out and captioned "Cancellation", and the existence of the cancellation provision must be referred to in the renewal provision by a specific cross reference in the renewal provision on the first page of the policy to the cancellation provision within.

(d) Policies issued on a family basis shall clearly set forth the conditions relating to termination of coverage of any family member.

(e) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(f) A limited policy is one that contains unusual exclusions, limitations, reductions, or conditions of such a restrictive nature that the payments of benefits under such policy are limited in frequency or in amounts. All limited policies shall be so identified by having the words "THIS IS A LIMITED POLICY—READ IT CAREFULLY" imprinted or stamped diagonally across the face of the policy and the filing back, if any, in contrasting color from the text of the policy and in outline type not smaller than eighteen point. When appropriate, these words may be varied by the insurer in a manner to indicate the type of policy; as for example, "THIS POLICY IS LIMITED TO AUTOMOBILE ACCIDENTS—READ IT CAREFULLY". Without limiting the general definition above, policies of the following types shall be defined as "limited": 1. School Accident, 2. Aviation Accident, 3. Polio, 4. Specified Disease, 5. Automobile Accident.

(g) If the policy excepts coverage while the insured is in military or naval service, the policy must provide for a refund of pro rata unearned premium upon request of the insured for any period the insured is not covered. However, if coverage is excluded only for loss resulting from military or naval service or war, the refund provision will not be required. This section shall not apply to guaranteed renewable policies.

(h) Policies which include sickness benefits and which do not cover pre-existing conditions, except single premium non-renewable policies, shall have printed thereon or attached thereto a notice stating in substance that the purchaser may return the policy within ten (10) days of delivery requesting cancellation and have any premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason; or, in lieu of the foregoing notice, a statement calling the applicant's attention to the status of pre-existing conditions under his coverage shall be set forth by the company by means of any one of the following methods:

1. Included in application.
2. Included in notice attached to the policy.
3. Printed or stamped on the policy.

The above enumerated methods are set forth without prejudice to the right of a company to submit another method, subject to approval by the commissioner, which it believes is equally clear or effective.

(3) RIDERS AND ENDORSEMENTS. (a) A rider is an instrument signed by one or more officers of the insurer issuing the same to be attached to and form a part of a policy. All riders shall comply with the requirements of section 204.31 (2) (a) 4, Wis. Stats. If the rider reduces or eliminates coverage of the policy, signed acceptance by the insured is necessary.

(b) An endorsement differs from a rider only in that it is applied to a policy by means of printing or stamping on the body of the policy. All endorsements shall comply with the requirements of sec-

tion 204.31 (2) (a) 4, Wis. Stats. If the endorsement reduces or eliminates coverage of the policy, signed acceptance by the insured is necessary; however, signed acceptance is not necessary when the endorsement is made at the time of the original issuance of the policy if notice of the endorsement is affixed on the face and filing back, if any, in contrasting color, in not less than twelve point type.

(4) APPLICATIONS. (a) Application forms shall indicate that answers to questions about the health of any proposed insured that call for an opinion, or require the exercise of judgment, are to the best of the applicant's knowledge and belief or words of similar import.

(b) It shall not be necessary for the applicant to sign a proxy provision as a condition for obtaining insurance. The applicant's signature to the application must be separate and apart from any signature to a proxy provision.

(c) The application form, or the copy of it, attached to a policy shall be plainly printed or reproduced in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point.

(5) FILING PROCEDURE. Policy forms, riders or endorsements submitted for review and approval must be filed as follows: (a) One copy of all such forms (two copies should be submitted if company desires one copy stamped as approved and returned) shall be submitted with a copy of the application applying thereto, if such application is to be made a part of the contract. If such application is already on file and has been previously approved, the form number and date of approval may be submitted rather than the application.

(b) If the nature of the information to be inserted in any blank space of any such form cannot be determined from the wording of the form, such blank space shall be filled in with hypothetical data to the extent needed to indicate the purpose and use of the form. As an alternative such purpose and use may be explained in the filing letter submitted with the form.

(c) The filing letter shall be in duplicate and shall contain the following information:

1. The identifying form number and title, if any, of the form.
2. A general description of the form.
3. In case of a rider or endorsement, the form numbers, identifying symbols or types of policies with which the rider or endorsement will be used.
4. The form number and date of department approval of any form superseded by the filing.

(6) RATE FILINGS. (a) The following must be accompanied by a rate schedule:

1. Policy forms.
2. Rider or endorsement forms which affect the premium rate.

(b) The rate schedule shall bear the insurer's name and shall contain or be accompanied by the following information:

1. The form number or identification symbol of each policy, rider or endorsement to which the rates apply.
2. A schedule of rates including policy fees or rate changes at renewal, if any, and variations, if any, based upon age, sex, occupation, or other classification.

3. An indication of the anticipated loss ratio on an earned-incurred basis.

4. Any revision of a rate filing shall be accompanied by a statement of the experience on the form and the anticipated loss ratio on an earned-incurred basis under the revised rate filing.

5. Subsection (6), paragraphs (b) 3 and (b) 4, shall not apply to guaranteed renewable policies or riders.

History: Cr. Register, March, 1958, No. 27; subsections (1), (5), (6) eff. 4–1–58; subsections (2), (3), (4) eff. 5–15–58; am. (2) (c) and cr. (4) (c), Register, March, 1959, No. 39, eff. 4–1–59; am. (2) (e), (6) (b) 3 and 4, Register, November, 1959, No. 47, eff. 12–1–59.

Ins 3.14 Group accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of group accident and sickness policies permitted by section 204.32 (2) (a), Wis. Stats.

(2) FILING PROCEDURE. Policy forms, including certificates, riders or endorsements submitted for review and approval must be filed as follows: (a) One copy of all such forms (2 copies should be submitted if company desires one copy stamped as approved and returned) shall be submitted with a copy of the application applying thereto, if such application is to be made a part of the contract. If such application is already on file and has been previously approved, the form number and date of approval may be submitted rather than the application.

(b) If the nature of the information to be inserted in any blank space of any such form cannot be determined from the wording of the form, such blank space shall be filled in with hypothetical data to the extent needed to indicate the purpose and use of the form. As an alternative such purpose and use may be explained in the filing letter submitted with the form.

(c) The filing letter shall be in duplicate and shall contain the following information:

1. The identifying form number and title, if any, of the form.
2. A general description of the form.
3. In case of a certificate, rider or endorsement, the form numbers, identifying symbols or types of policies with which the certificate, rider or endorsement will be used.
4. The form number and date of department approval of any form superseded by the filing.

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of section 204.32 (4), Wis. Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) CERTIFICATES. (a) Each certificate issued to an employee or member of an insured group in connection with a group insurance policy shall include a statement in summary form of the provisions of the group policy relative to:

1. The essential features of the insurance coverage,
2. To whom benefits are payable,
3. Notice or proof of loss,
4. The time for paying benefits, and
5. The time within which suit may be brought.

(5) COVERAGE REQUIREMENTS. (a) Policies issued in accordance with section 204.32 (2), Wis. Stats., shall offer to insure all eligible members of the group or association except any as to whom evidence of insurability is not satisfactory to the insurer. Cancellation of coverage of individual members of the group or association who have not withdrawn participation nor received maximum benefits is not permitted, except that the insurer may terminate or refuse renewal of an individual member who attains a specified age, retires or who ceases to actively engage in the duties of his profession or occupation on a full-time basis or ceases to be an active member of the association or labor union or an employe of the employer, or otherwise ceases to be an eligible member.

(b) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

History: Cr. Register, March, 1958, No. 27; subsections (1), (2), (3), eff. 4–1–58; subsections (4), (5), eff. 5–15–58; renum. (5) to be (5) (a); cr. (5) (b), Register, November, 1959, No. 47, eff. 12–1–59.

Ins 3.15 Blanket accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of blanket accident and sickness policies permitted by section 204.32 (3) (a), Wis. Stats.

(2) FILING PROCEDURE. Policy forms, including riders or endorsements submitted for review and approval must be filed as follows: (a) One copy of all such forms (2 copies should be submitted if company desires one copy stamped as approved and returned) shall be submitted with a copy of the application applying thereto, if such application is to be made a part of the contract. If such application is already on file and has been previously approved, the form number and date of approval may be submitted rather than the application.

(b) If the nature of the information to be inserted in any blank space of any such form cannot be determined from the wording of the form, such blank space shall be filled in with hypothetical data to the extent needed to indicate the purpose and use of the form. As an alternative such purpose and use may be explained in the filing letter submitted with the form.

(c) The filing letter shall be in duplicate and shall contain the following information:

1. The identifying form number and title, if any, of the form.
2. A general description of the form.
3. In case of a rider or endorsement, the form numbers, identifying symbols or types of policies with which the rider or endorsement will be used.
4. The form number and date of department approval of any form superseded by the filing.

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of section 204.32 (4), Wis. Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) ELIGIBLE RISKS. (a) In accordance with the provisions of section 204.32 (3) (a) 6, Wis. Stats., the following are eligible for blanket accident and health insurance: 1. Volunteer fire departments, 2. National Guard units, 3. Newspaper delivery boys, 4. Dependents of students, 5. Volunteer civil defense organizations, 6. Volunteer auxiliary police organizations, 7. Law enforcement agencies.

(b) A company may submit any other risk or class of risks, subject to approval by the commissioner, which it believes is properly eligible for blanket accident and health insurance.

(5) COVERAGE REQUIREMENTS. Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

History: Cr. Register, March, 1958, No. 27; eff. 4–1–58; am. (4) (a), cr. (5), Register, November, 1959, No. 47, eff. 12–1–59.

Ins 3.16 Credit accident and health insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing minimum requirements for the transaction of credit accident and health insurance.

(2) POLICY PROVISIONS. (a) Credit accident and health insurance policies may include credit life insurance benefits as defined in section 201.04 (3c), Wis. Stats. Credit accident and health insurance policies which include credit life insurance benefits shall contain all of the appropriate required provisions relating to such insurance.

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

1. The name and home office address of the insurer.
2. The name of the debtor.
3. The amount and term of the coverage.
4. The amount of premium or identifiable charge separately for credit accident and health insurance and for credit life insurance when the debtor has paid or obligated himself to pay all or any part of the premium or identifiable charge.
5. A description of the coverage, including any exceptions, limitations, or restrictions.
6. A provision that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness.
7. A provision that the insurance on any debtor will be cancelled if his indebtedness is terminated through prepayment, refinancing, or otherwise.
8. A provision that a refund will be granted, in the event of cancellation, calculated in accordance with a formula filed with the commissioner of insurance. This provision shall not be required if the debtor has not paid or obligated himself to pay all or any part of the premium or identifiable charge.

(c) If a contract of credit accident and health insurance provides for a limitation of coverage based upon an excessive amount of insurance on the debtor, such limitation shall be explained to him in connection with the placing of the insurance and shall be evidenced by an appropriate question in the application over the signature of the

debtor. Such question may be substantially of the following form which may be varied to meet the requirements of particular cases: Do you understand that the amount payable on this policy shall not be more than the excess of $_____ over the amount of other credit accident and health insurance which shall be payable? Answer _____.

(d) If a contract of credit accident and health insurance provides for a limitation of coverage based upon the age of the debtor, such limitation shall be explained to him in connection with the placing of the insurance and shall be evidenced by an appropriate question in the application over the signature of the debtor. Such question may be substantially of the following form which may be varied to meet the requirements of particular cases: Do you understand that the amount payable on this policy shall be the following percentages of the amount otherwise payable under this contract except for the restrictions based upon your present age? Answer _____.

Age	Percent Payable
Below 50	100%
51–54	75%
55–59	50%
60–64	25%
65 and over	None

(3) TERM OF CREDIT ACCIDENT AND HEALTH INSURANCE. The term of any credit accident and health 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. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor.

(4) AMOUNT OF CREDIT ACCIDENT AND HEALTH INSURANCE. The total amount of periodic indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not exceed the total of the periodic scheduled unpaid installments of indebtedness, and the amount of any individual periodic indemnity payment shall not exceed the scheduled installment due on the indebtedness, or shall not exceed the original indebtedness divided by the number of periodic installments. Periodic indemnity payments may not be payable for a period of disability more than 15 days after the scheduled maturity date of the indebtedness.

(5) REFUNDS IN EVENT OF CANCELLATION OF INSURANCE. Schedules for computing refunds in event of cancellation of credit accident and health insurance prior to the scheduled maturity date of the indebtedness must meet the following minimum requirements:

(a) Schedules used to compute the refund must provide for a return at least equal to that which would be provided by application of the so-called "Rule of 78" sometimes referred to as the "sum of the digits rule."

(b) 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.

(c) Credit must be given to the debtor for all refunds, regardless of amount, provided that no refund or credit need be made by an insurer if the amount thereof is less than one dollar.

(6) EVIDENCE OF INSURANCE. A policy or certificate of credit accident and health insurance must be delivered to the debtor within at least 30 days of the date upon which indebtedness is incurred. If a policy or 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, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the amounts of premium or identifiable charge separately in connection with credit accident and health insurance and credit life insurance, and a description of the coverage provided, shall be delivered to the debtor at the time the indebtedness is incurred. The copy of the application for or notice of proposed insurance shall 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 is prominently set forth therein. Said application for or notice of proposed insurance shall state that, upon acceptance by the insurer, the insurance shall become effective as of the date the indebtedness is incurred.

(7) APPROVAL OF FORMS AND RATES. (a) All forms of policies, riders, endorsements, certificates, applications, notices of proposed insurance, or other instruments which will be issued or delivered in Wisconsin as a part of a credit accident and health insurance contract shall be submitted to the commissioner of insurance for approval under the terms of this rule.

(b) No policy, rider, endorsement, certificate, application, notice of proposed insurance, or other form pertaining to a credit accident and health insurance contract shall be issued or delivered in Wisconsin on or after the effective date of this rule unless such forms are filed with the commissioner of insurance and approved by him. No credit accident and health insurance shall be effected on a debtor under an existing group policy, commencing with the policy anniversary date on or after the effective date of this regulation, unless a certificate of group insurance or a notice of proposed group insurance, as required herein, is delivered to the debtor on a form filed with the commissioner of insurance and approved by him.

(c) In considering a form of policy, rider, or endorsement for approval, the commissioner of insurance will also consider information submitted in the rate schedule which shall accompany such form. The rate schedule shall also be subject to approval by the commissioner of insurance and shall contain or be accompanied by the following information:

1. The form number or identification symbol of each policy, rider, or endorsement to which the rates apply.
2. A schedule of rates including variations, if any, based on age, sex, occupation, or other classification.
3. An indication of the anticipated benefits payable under the policy, including loss ratio.
4. If the rate filing is a revision of a prior filing, the new filing shall be accompanied by a statement of the experience on the form and the anticipated loss ratio under the revised rate filing.

(d) If an identifiable charge is made to the debtor under a policy of credit accident and health insurance, such identifiable charge shall not exceed the premium set forth in the rate schedule filed with the commissioner of insurance.

(e) On or before February 16, 1959, each insurer authorized to do business in Wisconsin shall furnish the commissioner of insurance a list of all policies, riders, endorsements, certificates, applications, notices of proposed insurance, or any other instruments which it intends to issue to insure residents of Wisconsin for credit accident and health insurance.

(8) ACCOUNTING. Insurers shall maintain records regarding premiums, losses, and other benefits and expenses separately for credit accident and health insurance and for credit life insurance provided by a policy form so that such experience may be filed with the commissioner of insurance at such times and in such manner as may be prescribed by him. The commissioner of insurance may require insurers to file with him such other information as he may deem necessary for the administration of credit accident and health insurance.

(9) NONWAIVER OF OTHER REQUIREMENTS. This rule does not confer any rights on lenders or other creditors which are not permitted by the laws which apply to them.

History: Cr. Register, December, 1958, No. 36, eff. 1–1–59; am. (5) (b), Register, March, 1959, No. 39, eff. 4–1–59; am. (2) (c), Register, May 1959, No. 41, eff. 6–1–59.

Ins 3.17 Reserves for accident and sickness policies. (1) In accordance with section 201.18 (4), Wis. Stats., the following requirements are adopted for the valuation of individual accident and sickness insurance policies.

(2) For purposes of this rule, individual accident and sickness insurance policies will be classified as follows:

(a) Policies which are guaranteed renewable for life or to a specified age, such as 60 or 65, at guaranteed premium rates.

(b) Policies which are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the insurer reserves the right to change the scale of premiums.

(c) Policies, other than those in paragraph (d) of this subsection, in which the insurer has reserved the right to cancel or refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

(d) Franchise policies, as defined in section 204.32 (1), Wis. Stats., issued under or subject to an agreement that, except for stated reasons, the insurer will not cancel or refuse to renew the coverage of individual insureds prior to a specified age unless all coverage under the same franchise group is terminated.

(e) Commercial policies and other policies not falling within paragraphs (a) to (d), inclusive, of this subsection.

(3) During the period within which the renewability of the policy is guaranteed or the insurer's right to refuse renewal is limited, the minimum reserves for policies described in paragraphs (a), (b), and (c) of subsection (2) of this rule, issued on or after January 1, 1955, shall be an amount computed on the basis of two-year preliminary term tabular mean reserves employing the following assumptions:

(a) Mortality: 1941 Commissioners Standard Ordinary Mortality Table or American Men Ultimate Mortality Table. (See Table I at the end of this rule.)

(b) Maximum Interest Rate: 3½% compounded annually.

(c) Morbidity or Other Contingency:

1. Disability due to accident and sickness—The Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance adopted by the National Association of Insurance Commissioners on June 11, 1941. Pamphlet reprints of this table are on file in the offices of the commissioner of insurance, secretary of state, and revisor of statutes. Pamphlet reprints of said Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance are obtainable from the Health Insurance Association of America, 168 North Michigan Avenue, Chicago 1, Illinois.

2. Hospital Expense Benefits—1956 Inter-company Hospital Table. (See Tables II and III at the end of this rule.)

3. Surgical Expense Benefits—1956 Inter-company Surgical Table. (See Tables IV and V at the end of this rule.)

4. Accident only, major medical expense, and other benefits not specified above—each company to establish reserves that place a sound value on the liabilities under such benefit.

(4) Mean reserves shall be diminished or offset by appropriate credit for the valuation net deferred premiums. In no event, however, shall the aggregate reserves for all policies issued on or after January 1, 1955, and valued on the mean reserve basis, diminished by any credit for deferred premiums, be less than the gross pro rata unearned premiums under such policies.

(5) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same individual or family policy, but if all benefits of such policy collectively develop a negative reserve, credit shall not be taken for such amount.

(6) The mean reserves for policies described in paragraphs (d) and (e) of subsection (2) of this rule shall be the pro rata gross unearned premium reserve as defined in section 201.18 (1), Wis. Stats.

(7) An insurer may use any reasonable assumptions as to the interest rate, mortality rates, or the rates of morbidity or other contingency, and may introduce a rate of voluntary termination of policies provided the reserve on all policies to which such assumptions are applied is not less in the aggregate than the amount determined according to the standards specified in subsections (3), (4), (5), and (6) of this rule. Also, subject to the same condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under policies described in subsection (2) of this rule, including but not limited to the following:

(a) The use of mid-terminal reserves in addition to either gross or net pro rata unearned premium reserves;

(b) Optional use of either the level premium, the one-year preliminary term, or the two-year preliminary term method;

(c) Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

(d) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity;

(e) The computation of the reserve for one policy benefit as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued;

(f) The use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

(8) For statement purposes the net reserve liability for active lives may be shown as:

(a) The mean reserve with offsetting asset items for net unpaid and deferred premiums; or

(b) The excess of the mean reserve over the amount of net unpaid and deferred premiums; or

(c) It may, regardless of the underlying method of calculation, be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve."

(9) Each insurer issuing policies described by paragraph (b) of subsection (2) of this rule shall maintain historical fund accounts for each group of similar policy forms on a basis reflecting reasonable estimates of premiums, losses, expenses, and reserves. Such estimates shall not be inconsistent with the corresponding items in the Accident and Health Exhibit, Schedule H, of the Annual Statement—Life and

Accident and Health Companies, Insurance Department Form 22–41 —or with the corresponding items of the Underwriting and Investment Exhibit of the Annual Statement—Fire and Casualty Insurance Companies, Insurance Department Form 22–11.

(Note: Comment and Explanation)

Reserve Fund. This rule is based on the concept of the reserve as a fund which, together with future net premiums, will meet the benefit payments arising from the group of policies valued as they accrue in the future. It should be observed that the application of a formula for the calculation of such reserves to an individual policy does not produce a meaningful result since few policyholders will experience average morbidity. For the policyholder in impaired health, the necessary reserve, if it could be determined, would be very much greater than the average result for policyholders as a whole, and for a policyholder in good health such reserve would be less than the average.

Occupation. Experience tables available for the determination of reserves are generally based upon the average results of the insured policyholders and therefore represent a cross section of the insured population, including individuals with unusual freedom from occupational and other accident hazards, as well as those subject to a considerable extra hazard owing to occupation or avocation. Accordingly, it is not considered necessary to make special provision in the valuation of the liabilities for policies involving special occupational hazards. It may also be observed that where tabular reserve methods are employed the incidence of any additional cost owing to occupational hazard may be such that there will be no increase in the reserve otherwise required.

Two-Year Preliminary Term. The preliminary term method of valuation recognizes the fact that expenses in the first year are much higher than those in renewal years and normally leave none of the first year premium available for the reserve fund. This method has been long accepted as appropriate and adequate for valuation purposes of life insurance. In contrast to life insurance, the claim cost at the early policy years under accident and health insurance may be substantial. Thus, for two policy years or even longer, the insurer may have a substantial unliquidated initial expense before setting up any additional reserve. For these reasons this rule provides for a preliminary term period of two years in the minimum reserve basis.

Assumptions as to Rate of Termination of Policies. The voluntary termination of policies may have a substantial effect on the level of premiums required for accident and health policies as well as on the amount of the reserve which should be maintained. In view, however, of the wide variation in termination rates among different insurers and the fluctuation of termination rates with changing business conditions, it is not recommended, at this time, that a rate of voluntary termination be employed in the calculation of minimum reserves. It is

recommended, however, that an insurer be permitted to employ a lapse rate in the computation of reserves, provided that the net result is at least equal to the minimum reserves specified by the regulations.

Loss of Time Benefits. Pending the development of a new table by the Society of Actuaries, the continued use of the Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance as a minimum basis is recommended. However, it is strongly recommended that in any case where, in the judgment of the company, this basis does not place a sound value on the liabilities under its accident and health policies an adequate reserve be established. Particular consideration should be given to the adequacy of reserves under policies which provide sickness benefits in excess of a two-year limit.

Benefits for Confining Disability. The continued use of the Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance as the minimum standard of valuation for loss of time policies providing house confinement sickness benefits in accordance with the National Association of Insurance Commissioners advisory ruling of June 11, 1941 is recommended. This ruling appears on page 162 of the Proceedings of the National Association of Insurance Commissioners, Seventy-second Session, 1941.

Accident-only Benefits. Any of the recognized tables of accidental death rates, such as the Inter-Company Double Indemnity Mortality Table, Transactions of the Actuarial Society of America, Vol. XXXV, p. 381, may be used as a basis for establishing reserves for the accidental death benefit. With respect to disability benefits payable only as a result of accidental injuries, it is suggested that companies may establish reserves based upon an appropriate modification of the Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance or such other table as may be used for valuing benefits payable for accident and sickness disability, such modification reflecting the proportion of disability arising from accidental injuries at each of the ages involved.

Medical Expense Benefits. With respect to benefits payable on a per diem or per visit basis, it is suggested that reserves be established according to appropriate percentages of the incidence of disability if benefits are payable during total disability only, or of the incidence of hospitalization if benefits are limited to in-hospital care. For in-hospital medical expense benefits payable on cases not involving surgery, available evidence indicates that 40% of the corresponding per diem hospital confinement cost may represent a reasonable estimate of the benefit cost for valuation purposes.

As a basis for the valuation of major medical expense benefits pending the accumulation and analysis of inter-company experience data, reference may be made to the material pre-

sented by Mr. Morton D. Miller, Transactions of the Society of Actuaries, Vol. VII, p. 1, and by Mr. Charles N. Walker, Transactions of the Society of Actuaries, Vol. VII, p. 404.

New or Experimental Benefits. For some benefits there will be insufficient data for the development of experience tables suitable for general use in computing reserves. With respect to such benefits each insurer should, on the basis of its appraisal of the benefit costs, establish and maintain reserves which place a sound value on the liabilities thereunder.

Net Annual Claim Costs. For use in developing net annual claim costs in computing reserves, as well as to assist in valuing policies under these requirements, it is recommended that companies make use of the paper "Reserves for Individual Hospital and Surgical Expense Insurance" appearing in the Transactions of the Society of Actuaries, Vol. IX, p. 334.)

TABLE I

YEARLY DEATH RATE PER 1000 ($1000q_x$)

AMERICAN MEN ULTIMATE MORTALITY TABLE (AM(6))

1941 COMMISSIONERS STANDARD ORDINARY MORTALITY TABLE (1941 CSO)

Age	$1000q_x$		Age	$1000q_x$	
	AM(5)	1941 CSO		AM(5)	1941 CSO
0	112.46*	22.58	52	13.62	14.30
1	26.39	5.77	53	14.78	15.43
2	11.87	4.14	54	16.08	16.65
3	7.09	3.38	55	17.47	17.98
4	4.91	2.99	56	19.02	19.43
5	3.94	2.76	57	20.69	21.00
6	3.38	2.61	58	22.51	22.71
7	3.05	2.47	59	24.49	24.57
8	2.93	2.31	60	26.68	26.59
9	2.96	2.12	61	29.03	28.78
10	3.07	1.97	62	31.58	31.18
11	3.17	1.91	63	34.37	33.76
12	3.26	1.92	64	37.38	36.58
13	3.32	1.98	65	40.66	39.64
14	3.39	2.07	66	44.18	42.96
15	3.46	2.15	67	48.03	46.56
16	3.53	2.19	68	52.16	50.46
17	3.63	2.25	69	56.64	54.70
18	3.71	2.30	70	61.47	59.30
19	3.81	2.37	71	66.70	64.27
20	3.92	2.43	72	72.33	69.66
21	4.02	2.51	73	78.39	75.50
22	4.12	2.59	74	84.92	81.81
23	4.18	2.68	75	91.94	88.64
24	4.25	2.77	76	99.51	96.02
25	4.31	2.88	77	107.65	103.99
26	4.35	2.99	78	116.31	112.59
27	4.39	3.11	79	125.69	121.86
28	4.41	3.25	80	135.74	131.85
29	4.43	3.40	81	146.42	142.60
30	4.46	3.56	82	157.87	154.16
31	4.48	3.73	83	170.05	166.57
32	4.51	3.92	84	183.15	179.88
33	4.59	4.12	85	197.07	194.13
34	4.68	4.35	86	211.80	209.37
35	4.78	4.59	87	227.29	225.63
36	4.94	4.86	88	244.08	243.00
37	5.12	5.15	89	261.70	261.44
38	5.32	5.46	90	280.35	280.99
39	5.56	5.81	91	299.46	301.73
40	5.84	6.18	92	321.08	323.64
41	6.16	6.59	93	341.88	346.66
42	6.54	7.03	94	363.64	371.00
43	6.94	7.51	95	387.76	396.21
44	7.42	8.04	96	411.11	447.19
45	7.94	8.61	97	448.40	548.26
46	8.52	9.23	98	457.63	724.67
47	9.18	9.91	99	500.00	1000.00
48	9.89	10.64	100	562.50	
49	10.70	11.45	101	571.43	
50	11.58	12.32	102	666.67	
51	12.54	13.27	103	1000.00	

*Bowerman's Extension.

TABLE II
1956 INTER-COMPANY HOSPITAL TABLE
NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES

Attained Age	Room and Board Benefit* 90 Day Maximum		Maternity Expense Benefit
	Male	Female	Female
	For $10 Daily Benefit		For $100 Max. Benefit
20	5.83	6.79	32.84
21	5.82	7.05	30.62
22	5.81	7.31	28.50
23	5.80	7.57	26.52
24	5.80	7.84	24.69
25	5.79	8.10	22.95
26	5.77	8.36	21.27
27	5.74	8.63	19.60
28	5.72	8.90	17.92
29	5.72	9.17	16.26
30	5.77	9.44	14.65
31	5.86	9.72	13.12
32	5.99	10.01	11.70
33	6.14	10.30	10.40
34	6.33	10.59	9.20
35	6.54	10.88	8.08
36	6.78	11.17	7.02
37	7.06	11.47	6.00
38	7.36	11.76	4.99
39	7.69	12.06	4.01
40	8.05	12.36	3.10
41	8.44	12.66	2.28
42	8.86	12.97	1.60
43	9.30	13.28	1.08
44	9.77	13.59	0.68
45	10.25	13.90	0.39
46	10.75	14.21	0.17
47	11.28	14.52	
48	11.83	14.83	
49	12.38	15.15	
50	12.93	15.48	
51	13.48	15.82	
52	14.03	16.16	
53	14.59	16.50	
54	15.15	16.86	
55	15.71	17.23	
56	16.28	17.60	
57	16.84	17.98	
58	17.42	18.37	
59	18.00	18.78	
60	18.60	19.23	
61	19.20	19.70	
62	19.81	20.19	
63	20.43	20.71	
64	21.08	21.27	
65	21.77	21.89	
66	22.40	22.47	
67	22.95	22.99	
68	23.60	23.62	
69	24.48	24.49	
70	25.75	25.75	
71	27.57	27.57	
72	29.83	29.83	
73	32.31	32.31	
74	34.78	34.78	
75	37.00	37.00	
76	38.98	38.98	
77	40.87	40.87	
78	42.67	42.67	
79	44.38	44.38	
80	46.00	46.00	

*Use 40% of the Net Annual Claim Cost per $1 of Room and Board Benefit to obtain the Net Annual Claim Cost for each dollar of Daily Maximum Physician's In-Hospital Calls Benefit.

TABLE III

1956 INTER-COMPANY HOSPITAL TABLE

NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES

MISCELLANEOUS HOSPITAL EXPENSE BENEFIT

Attained Age	Males					Females					Attained Age
	For an Unallocated Maximum of					For an Unallocated Maximum of					
	$25	$50	$100	$150	$250	$25	$50	$100	$150	$250	
20	1.96	3.13	4.90	5.96	7.44	2.34	3.74	5.85	7.12	8.88	20
21	1.96	3.14	4.95	6.02	7.53	2.41	3.88	6.10	7.43	9.29	21
22	1.95	3.15	4.98	6.07	7.60	2.48	4.01	6.34	7.74	9.69	22
23	1.94	3.15	5.01	6.13	7.68	2.55	4.14	6.58	8.05	10.08	23
24	1.94	3.16	5.04	6.18	7.75	2.62	4.27	6.82	8.35	10.48	24
25	1.93	3.16	5.07	6.22	7.81	2.68	4.39	7.05	8.65	10.87	25
26	1.91	3.15	5.08	6.25	7.86	2.74	4.51	7.27	8.94	11.24	26
27	1.90	3.14	5.08	6.26	7.89	2.79	4.62	7.49	9.22	11.61	27
28	1.88	3.12	5.09	6.27	7.91	2.84	4.73	7.70	9.50	11.97	28
29	1.86	3.11	5.09	6.29	7.94	2.89	4.83	7.90	9.76	12.32	29
30	1.86	3.12	5.13	6.35	8.02	2.94	4.94	8.11	10.04	12.69	30
31	1.86	3.14	5.18	6.42	8.12	2.99	5.05	8.33	10.33	13.06	31
32	1.87	3.17	5.25	6.52	8.25	3.04	5.15	8.54	10.60	13.42	32
33	1.88	3.21	5.34	6.64	8.42	3.09	5.26	8.75	10.88	13.79	33
34	1.90	3.25	5.44	6.77	8.59	3.13	5.36	8.97	11.17	14.17	34
35	1.93	3.31	5.56	6.93	8.80	3.18	5.47	9.18	11.45	14.53	35
36	1.96	3.38	5.70	7.11	9.04	3.22	5.56	9.38	11.72	14.89	36
37	1.99	3.46	5.86	7.33	9.32	3.27	5.67	9.60	12.00	15.27	37
38	2.04	3.55	6.03	7.56	9.62	3.31	5.77	9.81	12.28	15.64	38
39	2.08	3.65	6.23	7.81	9.96	3.35	5.86	10.01	12.56	16.00	39
40	2.13	3.74	6.42	8.06	10.28	3.39	5.96	10.22	12.83	16.37	40
41	2.18	3.85	6.62	8.32	10.62	3.43	6.06	10.42	13.10	16.73	41
42	2.22	3.95	6.82	8.58	10.97	3.46	6.15	10.62	13.37	17.09	42
43	2.28	4.06	7.04	8.87	11.34	3.50	6.24	10.82	13.65	17.45	43
44	2.33	4.17	7.26	9.16	11.73	3.54	6.33	11.02	13.92	17.81	44
45	2.39	4.29	7.50	9.48	12.14	3.57	6.43	11.22	14.19	18.17	45
46	2.45	4.42	7.75	9.81	12.57	3.61	6.52	11.43	14.46	18.54	46
47	2.51	4.55	8.01	10.15	13.02	3.64	6.61	11.62	14.73	18.89	47
48	2.58	4.70	8.29	10.52	13.51	3.67	6.69	11.82	14.99	19.25	48
49	2.65	4.85	8.59	10.90	14.01	3.70	6.78	12.02	15.26	19.61	49

TABLE III—Continued

Attained Age	Males					Females					Attained age
	For an Unallocated Maximum of					For an Unallocated Maximum of					
	$25	$50	$100	$150	$250	$25	$50	$100	$150	$250	
50	2.72	5.00	8.89	11.30	14.53	3.74	6.87	12.22	15.54	19.97	50
51	2.80	5.17	9.22	11.73	15.09	3.77	6.96	12.42	15.80	20.33	51
52	2.88	5.34	9.55	12.17	15.67	3.80	7.05	12.62	16.08	20.70	52
53	2.96	5.51	9.90	12.63	16.27	3.83	7.13	12.82	16.35	21.06	53
54	3.05	5.70	10.28	13.12	16.91	3.86	7.22	13.01	16.61	21.41	54
55	3.14	5.90	10.67	13.64	17.59	3.89	7.30	13.21	16.88	21.78	55
56	3.24	6.11	11.09	14.19	18.32	3.91	7.39	13.40	17.15	22.14	56
57	3.35	6.35	11.55	14.80	19.11	3.94	7.47	13.61	17.43	22.51	57
58	3.46	6.58	12.02	15.41	19.92	3.97	7.55	13.79	17.69	22.86	58
59	3.57	6.82	12.49	16.04	20.74	4.00	7.64	13.99	17.96	23.22	59
60	3.67	7.04	12.93	16.61	21.49	4.02	7.72	14.19	18.23	23.59	60
61	3.76	7.24	13.34	17.16	22.21	4.05	7.81	14.39	18.51	23.96	61
62	3.84	7.43	13.74	17.69	22.91	4.08	7.89	14.59	18.77	24.32	62
63	3.92	7.62	14.13	18.20	23.59	4.10	7.98	14.79	19.05	24.69	63
64	3.99	7.79	14.49	18.69	24.24	4.13	8.06	14.98	19.32	25.06	64
65	4.06	7.95	14.83	19.14	24.84	4.15	8.14	15.18	19.59	25.42	65
66	4.12	8.10	15.15	19.57	25.40	4.18	8.22	15.38	19.86	25.79	66
67	4.16	8.23	15.43	19.95	25.91	4.21	8.31	15.59	20.15	26.18	67
68	4.21	8.34	15.70	20.31	26.39	4.23	8.39	15.79	20.43	26.55	68
69	4.24	8.45	15.95	20.65	26.85	4.25	8.47	15.98	20.70	26.91	69
70	4.28	8.55	16.18	20.96	27.27	4.28	8.55	16.18	20.96	27.27	70
71	4.30	8.61	16.39	21.26	27.67	4.30	8.61	16.39	21.26	27.67	71
72	4.32	8.64	16.57	21.51	28.01	4.32	8.64	16.57	21.51	28.01	72
73	4.34	8.68	16.75	21.76	28.34	4.34	8.68	16.75	21.76	28.34	73
74	4.35	8.70	16.90	21.97	28.63	4.35	8.70	16.90	21.97	28.63	74
75	4.36	8.72	17.06	22.19	28.94	4.36	8.72	17.06	22.19	28.94	75
76	4.37	8.74	17.21	22.41	29.23	4.37	8.74	17.21	22.41	29.23	76
77	4.38	8.76	17.35	22.61	29.51	4.38	8.76	17.35	22.61	29.51	77
78	4.39	8.77	17.49	22.81	29.79	4.39	8.77	17.49	22.81	29.79	78
79	4.39	8.78	17.55	22.99	30.03	4.39	8.78	17.55	22.99	30.03	79
80	4.39	8.78	17.56	23.16	30.27	4.39	8.78	17.56	23.16	30.27	80

TABLE IV

1956 INTER-COMPANY SURGICAL TABLE

NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES

Attained Age	Surgical Expense Benefit*		Attained Age	Surgical Expense Benefit*	
	Male	Female		Male	Female
	For $200 "Standard" Schedule			For $200 "Standard" Schedule	
20	3.60	4.40	43	3.92	8.25
21	3.56	4.68	44	4.03	8.24
22	3.52	4.95	45	4.14	8.20
23	3.48	5.21	46	4.26	8.12
24	3.46	5.46	47	4.40	8.01
25	3.44	5.70	48	4.54	7.88
26	3.43	5.93	49	4.69	7.74
27	3.42	6.16			
28	3.43	6.37	50	4.84	7.62
29	3.43	6.58	51	5.00	7.51
			52	5.16	7.40
30	3.44	6.76	53	5.32	7.30
31	3.45	6.92	54	5.49	7.20
32	3.46	7.06	55	5.64	7.12
33	3.48	7.18	56	5.79	7.05
34	3.50	7.31	57	5.94	7.00
35	3.52	7.44	58	6.08	6.95
36	3.54	7.59	59	6.21	6.90
37	3.56	7.75			
38	3.59	7.91	60	6.32	6.86
39	3.63	8.04	61	6.42	6.82
			62	6.50	6.77
40	3.68	8.14	63	6.56	6.73
41	3.75	8.20	64	6.62	6.70
42	3.83	8.24	65	6.66	6.66

*In order to obtain Net Annual Claim Costs for a particular Surgical Schedule, follow the procedure outlined in Table V.

TABLE V

1956 INTER-COMPANY SURGICAL TABLE

EVALUATION SCHEDULE FOR SURGICAL BENEFITS PER $100 SCHEDULE

Procedure	Weight	Amount Payable per $100 Maximum (Prorated if Maximum is other than $100)	Product
	Adult Male		
Benign tumors and cysts, superficial removal	.564		
Appendectomy	.712		
Cholecystectomy	.095		
Herniotomy, single	.391		
Herniotomy, bilateral	.101		
Hemorrhoidectomy, Int. or Ext.	.229		
Hemorrhoidectomy, Int. and Ext.	.154		
Prostatectomy, perineal or suprapubic	.059		
Nasal septum, submucous resection	.130		
Tonsillectomy and/or Adenoidectomy	.711		
			Σ
	Adult Female		
Thyroidectomy, subtotal	.087		
Appendectomy	.429		
Cholecystectomy	.160		
Dilation and curettage	.330		
Uterine fixation	.096		
Panhysterectomy	.157		
Hysterectomy—abd.	.326		
Hysterectomy—vag.	.065		
Other uterine operations incl. oophorectomy etc.	.110		
Tonsillectomy and adenoidectomy	.304		
			Σ

The weights are so determined that the sum of the products evaluates a schedule as a percentage of "standard", and are derived from the frequencies for the commoner operations. Apply the above factors (percentage of "standard") to the net annual claim costs for a $200 "standard" schedule shown in Table IV to obtain the adjusted net annual claim costs for a particular schedule ($200 basis). Where the particular schedule is for some amount other than $200, the factors should be adjusted accordingly (i.e. $250 schedule multiply by 1.25.)

History: Cr. Register, April, 1959, No. 40, eff. 5–1–59.

Ins 3.18 Total consideration for accident and sickness insurance policies. The total consideration charged for accident and sickness insurance policies must include policy and other fees. Such total consideration charged must be stated in the policy, and shall be subject to the reserve requirements of section 201.18 (1), Wis. Stats., and Wis. Adm. Code section Ins 3.17, and must be the basis for computing the amount to be refunded in the event of cancellation of the policy.

History: Cr. Register, May, 1959, No. 41, eff. 6–1–59.

Ins 3.19 Group accident and health insurance insuring debtors of a creditor. (1) This rule implements and interprets sections 204.32 (2) (a) 4 and 206.60 (2), Wis. Stats., with regard to issuance of a group policy of accident and health insurance issued to a creditor to insure debtors of a creditor.

(2) A group accident and health insurance policy may be issued to a creditor to insure debtors of the creditor if the class or classes of insured debtors meet the requirements of subsections (a) and (c) of section 206.60 (2), Wis. Stats., and such a policy shall be subject to

the requirements of such subsections in addition to other requirements applicable to group accident and health insurance policies.

(3) A group accident and health policy which insures only debtors whose indebtedness to a creditor is for a term in excess of 48 months is not subject to the requirements of Wis. Adm. Code section Ins 3.16 or of sections 201.04 (4a) and 204.32 (5), Wis. Stats.

History: Cr. Register, November, 1959, No. 47, eff. 12–1–59.

Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles. (1) PURPOSE. In accordance with section 204.49 (4), Wis. Stats., this rule is to accomplish the purpose and enforce the provisions of sections 204.37 to 204.54, Wis. Stats., in relation to automobile physical damage insurance for substandard risks.

(2) SCOPE. This rule applies to any automobile physical damage insurance policy procured or delivered by a finance company.

(3) DEFINITIONS. (a) *Substandard risk* means an applicant for insurance who presents a greater exposure to loss than that contemplated by commonly used rate classifications as evidenced by one or more of the following conditions:

1. Record of traffic accidents.
2. Record of traffic law violations.
3. Undesirable occupational circumstances.
4. Undesirable moral characteristics.

(b) *Substandard risk rate* means a rate or premium charge that reflects the greater than normal exposure to loss which is assumed by an insurer writing insurance for a substandard risk.

(4) RATES FOR SUBSTANDARD RISKS. (a) Any increased rate charged for substandard risks shall not be excessive, inadequate, or unfairly discriminatory.

(b) It shall be unfairly discriminatory to charge a rate or premium that does not reasonably measure the variation between risks and each risk's exposure to loss.

(c) Classification rates filed for substandard risks may not exceed 150% of the rate level generally in use for normal risks unless the filing also provides for the modification of classification rates in accordance with a schedule which establishes standards for measuring variation in hazards or expense provisions or both.

(5) INSURANCE COVERAGE. (a) The automobile physical damage insurance afforded shall be substantially that customarily in use for normal business.

(b) The applicant shall not be required to purchase more coverage than is customarily necessary to protect the interests of the mortgagee. The issuance of a policy shall not be made contingent on the acceptance by the applicant of unwanted or excessively broad coverages.

(c) Single interest coverage may be issued only when double interest coverage is not obtainable. The applicant must be given the opportunity to procure his own insurance, and if he can procure same within 25 days there shall be no charge for the single interest coverage.

(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 substandard 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.

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