CHAPTER 610

INSURERS IN GENERAL

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Cross-reference: See definitions in ss. 600.03 and 628.02.

NOTE: Chapter 260, laws of 1971, which created this chapter, contains explanatory notes.

610.001 Purposes. The purposes of chs. 611 to 616 are:

(1) To provide an orderly procedure by which insurers may be created, governed and dissolved;

(2) To provide for procedures to merge, consolidate or convert various kinds of insurers;

(3) To provide for structure and management that will maximize democratic participation in the operation of insurers; and

(4) To prevent or control self-dealing by management in order to protect the interests of shareholders, policyholders, members, subscribers and the public.

History: 1971 c. 260; 1979 c. 102 s. 237; 1979 c. 261.

610.01 Definitions. In chs. 610 to 620 and 644, unless the context requires otherwise:

(1) "Director" includes "trustee".

(2) "Officer" does not include "director".

(3) "Promoter stock" means shares issued by a domestic stock corporation under ss. 611.18 (2) (a) 2. and 611.32 (1), and shares issued within 5 years after the initial issuance of the certificate of authority, to incorporators, directors, principal officers, members of the families of any of these persons, and to any corporations controlled by, or any trustee acting in behalf of, any of these persons.

(4) In any provision of ch. 180 or 181 made applicable by any section of chs. 600 to 646, "department" shall be read "commissioner of insurance".

History: 1971 c. 260; 1979 c. 102, 177; 1983 a. 189; 1995 a. 27; 1997 a. 227.

610.11 Qualified insurers. No person may do an insurance business as defined in s. 618.02 (2) on the person's own account in this state, either in person, or through agents or brokers, or through the mail or any other method of communication, except:

(1) An insurer authorized to do business in this state, within the limits of its certificate of authority; or

(2) An insurer doing business under s. 618.41.

History: 1971 c. 260; 1991 a. 316.

610.21 Other business. (1) PROHIBITION FOR DOMESTIC INSURERS. No domestic insurer may engage, directly or indirectly, in any business other than insurance and business reasonably incidental to its insurance business, except as specifically authorized by s. 611.26 (4), 611.26 (4) as incorporated by s. 614.24 (1), or s. 613.26 or any other provision of chs. 600 to 646; except that a domestic insurer not restricted under s. 620.03 may engage directly in any activity to the extent it is authorized to do so through a subsidiary.

(2) PROHIBITION FOR NONDOMESTIC INSURERS. No nondomestic insurer may engage in this state in any business forbidden to a domestic insurer, nor may the insurer engage in such business elsewhere if:

(a) The law of the insurer's domicile forbids an insurer to engage in such business; or

(b) The statutes of this state specifically prohibit a nondomestic insurer to engage in such business elsewhere; or

(c) The commissioner orders it to cease doing such business upon finding that doing such business is not consistent with the interests of its insureds, creditors or the public in this state; or that it gives the insurer a substantial competitive advantage in relation to domestic insurers.

(3) INCIDENTAL BUSINESS. "Incidental business" includes:

(a) The business of preparing and selling abstracts of title and related documents, if done by an insurer authorized to transact title insurance;

(b) Business that could be done through ancillary subsidiaries authorized under s. 611.26 (3), or, in the case of a nondomestic insurer, through corporations that would be so authorized if the insurer were domestic.

(4) ANNUITIES. For purposes of this section, "insurance" includes "annuities".

History: 1971 c. 260; 1975 c. 373; 1979 c. 102, 177; 1981 c. 307.

610.23 Power to hold property in other than own name. An insurer shall hold all investments and deposits of its funds in its own name except that:

(1) CUSTODIAL OR TRUST ARRANGEMENTS. Securities kept under a custodial agreement or trust arrangement with a bank or banking and trust company may be issued in the name of a nominee of the bank or banking and trust company; and

(2) BEARER SECURITIES. Any insurer may acquire and hold securities in bearer form.

History: 1975 c. 373.

Legislative Council Note, 1975: This section continues s. 201.24 (4), made applicable to all insurers. The power certainly exists under ss. 180.04 (17) and 181.04 (16) as incorporated in ss. 611.07 (1), 612.03 and 614.07 (1), but this section places it beyond doubt for all insurers and permits the repeal of s. 201.24 (4). [Bill 643-S]

610.24 Insurers as fundholders. All assets shall be held, invested and disbursed for the use and benefit of the insurer and no policyholder, member or beneficiary may have or acquire individual rights in such assets or become entitled to any apportionment or the surrender of any part of such assets, except as provided in the contract. An insurer may create, maintain, invest, disburse and apply any special funds necessary to carry out any purpose permitted by the laws of this state and the articles and bylaws of the insurer.

History: 1979 c. 102.

610.40 Continued effect of transitional provisions. Sections 610.41 to 610.53, 1981 stats., continue to apply to insurers affected by those sections before April 27, 1984.

History: 1983 a. 215.

610.50 Vital records. An insurer or an employee, agent or attorney of an insurer is not subject to s. 69.24 (1) (a) for copying a certified copy of a vital record for the insurer's own internal ad-

ministrative use in connection with the payment of insurance claims or benefits if the copy is marked "FOR ADMINISTRATIVE USE" and is retained in the files of the insurer or attorney.

History: 1987 a. 247.

610.60 Electronic delivery of notices and documents.

(1) DEFINITIONS. In this section:

(a) "Applicable law" means applicable statutory law and rules and regulations having the force of law.

(b) "Deliver by electronic means" includes any of the following:

1. Delivery to an electronic mail address at which a party has consented to receive notices or documents.

2. Posting on an electronic network or site that is accessible via the Internet by using a mobile application, computer, mobile device, tablet, or any other electronic device and sending separate notice of the posting to a party, directed to the electronic mail address at which the party has consented to receive notice of the posting.

(c) "Party" means a recipient of a notice or document required as part of an insurance transaction, including an applicant, an insured, or a policyholder.

(2) ELECTRONIC DELIVERY PERMITTED; EQUIVALENT TO OTHER METHODS. (a) Subject to par. (c), subs. (3) and (5) (b), and s. 137.12 (2r) (c), notice to a party, and any other document that is required under applicable law in an insurance transaction or that serves as evidence of insurance coverage, may be stored, presented, and delivered by electronic means, as long as the notice or other document meets the requirements of ch. 137.

(b) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under applicable law, including delivery by 1st class mail; 1st class mail, postage prepaid; certified mail; or registered mail.

(c) If a provision of, or rule promulgated under, chs. 600 to 655 that requires a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt and the verification or acknowledgment of receipt can be documented.

(3) CONDITIONS PRECEDENT FOR ELECTRONIC DELIVERY. (a) Unless sub. (5) (b) applies, an insurer may deliver notices and documents to a party by electronic means under this section if all of the following are satisfied:

1. The party affirmatively consented to that method of delivery and has not withdrawn the consent.

2. Before the party gave consent, the insurer provided the party with a statement of the hardware and software requirements for access to and retention of notices and documents delivered by electronic means.

3. The party consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party is able to access information in the electronic form that the insurer will use for delivery of notices and documents by electronic means.

4. Before the party gave consent, the insurer provided the party with a clear and conspicuous statement informing the party of all of the following:

a. The right or option of the party to have notices and documents provided or made available in paper or another nonelectronic form instead.

b. The right of the party to withdraw consent to have notices and documents delivered by electronic means and any fees, conditions, or consequences that are imposed if consent is withdrawn.

c. That the party's consent applies to any notices or documents that may be delivered by electronic means during the course of the relationship between the party and the insurer.

d. After consent for delivery by electronic means is given, the means, if any, by which a party may obtain a paper copy of a notice or document that has been delivered by electronic means and the fee, if any, for the paper copy.

e. The procedure a party must follow to withdraw consent to have notices and documents delivered by electronic means and to update information needed to contact the party electronically.

(b) If the conditions under par. (a) or sub. (5) (b) are satisfied, the insurer may elect to deliver all notices and documents by electronic means or only those notices and documents selected by the insurer.

(c) Even if the conditions under par. (a) or sub. (5) (b) are satisfied, the insurer may deliver any notice or document by 1st class mail; 1st class mail, postage prepaid; certified mail; or registered mail.

(4) MISCELLANEOUS RELATED PROVISIONS. (a) This section does not affect any requirement related to the content or timing of a notice or document required under applicable law.

(b) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party may not be denied solely because the contract or policy was delivered by electronic means if the insurer has obtained the electronic consent or confirmation of consent of the party in accordance with sub. (3) (a) 3. or has complied with sub. (5) (b).

(c) 1. A withdrawal of consent by a party becomes effective 30 days after the insurer receives the withdrawal.

2. A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent becomes effective.

(d) If an oral communication or a recording of an oral communication between a party and an insurer or an insurer's agent can be reliably stored and reproduced by the insurer, the oral communication or recording may qualify as a notice or document delivered by electronic means for purposes of this section. This paragraph does not apply to notices or documents that are required by applicable law to be in writing.

(e) If a provision of, or rule promulgated under, chs. 600 to 655 requires a signature or a notice or document to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice, or document.

(f) Except as provided in par. (d), this section does not and may not be construed to modify, limit, or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act, 15 USC 7001 et seq., as amended.

(g) If an insurer attempts to deliver a notice or document by electronic means to the most recent electronic mail address for the insured in the insurer's files and the insurer receives a notice that the delivery by electronic means has failed, the insurer shall deliver the notice or document by 1st class mail or by any other delivery method required for the notice or document by a provision of, or rule promulgated under, chs. 600 to 655.

(5) EFFECT ON EARLIER ELECTRONIC DELIVERY. (a) This section does not apply to a notice or document delivered by an insurer by electronic means before December 14, 2013, to a party who, before that date, consented to receive a notice or document by electronic means otherwise allowed by applicable law.

(b) If the consent of a party to receive certain notices or docu-

ments by electronic means is on file with an insurer before December 14, 2013, and, in accordance with this section, the insurer intends to deliver notices and documents to the party by electronic means, before delivering any additional notices or documents by electronic means, the insurer shall notify the party of all of the following:

1. The notices or documents that may be delivered by electronic means under this section that were not previously delivered by electronic means.

2. The party's right to withdraw consent to have any notices or documents delivered by electronic means.

(6) POSTING OF POLICIES AND ENDORSEMENTS ON INTERNET. Notwithstanding subs. (1) to (5), in lieu of delivery to a policyholder, insured, or applicant for insurance by any other method, an insurer may post on the insurer's Internet site any standard policy, and any endorsements to such a policy, that do not contain personally identifiable information. An insurer that elects to post such a policy and any endorsements to the policy on its Internet site shall comply with all of the following requirements:

(a) The policy and any endorsements must be accessible on the insurer's Internet site for as long as the policy is in effect.

(b) After the policy terminates, the insurer must retain copies of the policy and any endorsements to the policy as provided in any provision of, or rule promulgated under, chs. 600 to 655, but must make the policy and any endorsements to the policy available upon the request of an insured for at least 3 years.

(c) The policy and any endorsements must be posted in such a manner that the insured is able to print and save the policy and endorsements by using programs or applications that are widely available on the Internet and free to use.

(d) The insurer must provide all of the following information in, or simultaneously with, each declarations page that is provided when the policy is initially issued and when it is renewed:

1. A description of the exact policy and endorsement forms purchased by the insured.

2. The method by which the insured may obtain, upon request and without charge, a paper copy of the policy and any endorsements to the policy, which paper copy must be sent to the insured by mail if the insured so requests.

3. The address of the Internet site where the policy and any endorsements to the policy are posted.

(e) If the insurer makes any changes to the policy or an endorsement form, the insurer must provide notice to the insured of all of the following:

1. The change to the policy or endorsement form.

2. The insured's right to obtain and the method for obtaining, upon request and without charge, a paper copy of the policy or endorsement form, which paper copy must be sent to the insured by mail if the insured so requests.

3. The address of the Internet site where the policy or endorsement form is posted.

(7) OPTIONAL METHODS. Nothing in this section requires an insurer to deliver a notice or document by electronic means or to post policies and endorsements on an Internet site.

History: 2013 a. 73; 2019 a. 125.

610.61 Duty of life insurers to report abandoned property. An insurer doing a life insurance business shall report under subch. IV of ch. 177 any property presumed abandoned under subch. II of ch. 177.

History: 1979 c. 102; 1983 a. 408 s. 16; 2021 a. 87.

610.63 Permitted insurance plan electronic transmissions. (1) In this section:

(a) "Covered person" means an individual that receives health benefits through an employer-sponsored group health benefit plan, group health plan, or, if provided under a separate policy, certificate, or contract of insurance, limited scope-dental or vision benefits.

(b) "Employer" has the meaning given in s. 632.745 (6).

(c) "Group health benefit plan" has the meaning given in s. 632.745 (9).

(d) "Group health plan" has the meaning given in s. 632.745 (10).

(e) "Health maintenance organization insurer" has the meaning given in s. 600.03 (23c).

(f) "Insurer" has the meaning given in s. 600.03 (27).

(2) (a) Notwithstanding s. 610.60 (3) (a), an insurer or health maintenance organization insurer may agree to deliver all communications related to an insurance policy, plan, or contract to a covered person by electronic means when the covered person's employer consents to electronic delivery of documents on behalf of the covered person under the insurance policy, plan, or contract pursuant to par. (b).

(b) An employer may consent to the delivery of all communications related to an insurance policy, plan, or contract to covered persons by electronic means if the employer confirms all of the following for each covered person:

1. The covered person routinely uses electronic communications during the normal course of employment.

2. The covered person was given an opportunity to opt out of delivery by electronic means and will be given an opportunity to opt out of delivery by electronic means on an annual basis.

(c) An employer that consents to the delivery of all communications related to an insurance policy, plan, or contract by electronic means under par. (b) must confirm that all new covered persons will routinely use electronic communications during the normal course of employment and be given an opportunity to opt out of delivery by electronic means when added to the insurance policy, plan, or contract.

(d) Insurers and health maintenance organization insurers shall document compliance under this section.

History: 2023 a. 78.

610.65 Uniform claim processing form. Beginning no later than July 1, 2004, every insurer shall use the uniform claim processing form developed by the commissioner under s. 601.41 (9) (b) when processing a claim submitted by a health care provider, as defined in s. 146.81 (1) (a) to (p).

History: 2001 a. 109; 2009 a. 28.

610.70 Disclosure of personal medical information. (1) DEFINITIONS. In this section:

(a) "Health care provider" means any person licensed, registered, permitted or certified by the department of health services or the department of safety and professional services to provide health care services, items or supplies in this state.

(b) "Individual" means a natural person who is a resident of this state. For purposes of this paragraph, a person is a state resident if his or her last-known mailing address, according to the records of an insurer or insurance support organization, was in this state.

(c) 1. "Insurance support organization" means any person that regularly engages in assembling or collecting personal medical information about natural persons for the primary purpose of providing the personal medical information to insurers for insurance transactions, including the collection of personal medical information from insurers and other insurance support organizations for the purpose of detecting or preventing fraud, material

misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

2. Notwithstanding subd. 1., "insurance support organization" does not include insurance agents, government institutions, insurers or health care providers.

(d) "Insurance transaction" means any of the following involving insurance that is primarily for personal, family or household needs:

1. The determination of an individual's eligibility for an insurance coverage, benefit or payment.

2. The servicing of an insurance application, policy, contract or certificate.

(e) "Medical care institution" means a facility, as defined in s. 647.01 (4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, adult family home, assisted living facility, rural medical center, hospice or other place licensed, certified or approved by the department of health services under s. 49.70, 49.71, 49.72, 50.02, 50.03, 50.032, 50.033, 50.034, 50.35, 50.52, 50.90, 51.04, 51.08, or 51.09 or a facility under s. 45.50, 51.05, 51.06, or 252.10 or under ch. 233, or licensed or certified by a county department under s. 50.032 or 50.033.

(f) 1. "Personal medical information" means information concerning an individual that satisfies all of the following:

a. Relates to the individual's physical or mental health, medical history or medical treatment.

b. Is obtained from a health care provider, a medical care institution, the individual or the individual's spouse, parent or legal guardian.

2. "Personal medical information" does not include information that is obtained from the public records of a governmental authority and that is maintained by an insurer or its representatives for the purpose of insuring title to real property located in this state.

(2) DISCLOSURE AUTHORIZATION. (a) Any form that is used in connection with an insurance transaction and that authorizes the disclosure of personal medical information about an individual to an insurer shall comply with all of the following:

1. All instructions and other information contained in the form are presented in plain language.

2. The form is dated.

3. The form specifies the types of persons that are authorized to disclose information about the individual.

4. The form specifies the nature of the information that is authorized to be disclosed.

5. The form names the insurer, and identifies by generic reference representatives of the insurer, to whom the information is authorized to be disclosed.

6. The form specifies the purposes for which the information is being obtained.

7. Subject to par. (b), the form specifies the length of time for which the authorization remains valid.

8. The form advises that the individual, or an authorized representative of the individual, is entitled to receive a copy of the completed authorization form.

(b) 1. For an authorization under this subsection that will be used for the purpose of obtaining information in connection with an insurance policy application, an insurance policy reinstatement or a request for a change in policy benefits, the length of time specified in par. (a) 7. may not exceed 30 months from the date on which the authorization is signed.

2. For an authorization under this subsection that will be used for the purpose of obtaining information in connection with a claim for benefits under an insurance policy, the length of time specified in par. (a) 7. may not exceed the policy term or the pendency of a claim for benefits under the policy, whichever is longer.

(3) ACCESS TO RECORDED PERSONAL MEDICAL INFORMATION. (a) If, after proper identification, an individual or an authorized representative of an individual submits a written request to an insurer for access to recorded personal medical information that concerns the individual and that is in the insurer's possession, within 30 business days after receiving the request the insurer shall do all of the following:

1. Inform the individual or authorized representative of the nature and substance of the recorded personal medical information in writing, by telephone or by any other means of communication at the discretion of the insurer.

2. At the option of the individual or authorized representative, permit the individual or authorized representative to inspect and copy the recorded personal medical information, in person and during the insurer's normal business hours, or provide by mail to the individual or authorized representative a copy of the recorded personal medical information. If the recorded personal medical information is in coded form, the insurer shall provide to the individual or authorized representative an accurate written translation in plain language.

3. Disclose to the individual or authorized representative the identities, if recorded, of any persons to whom the insurer has disclosed the recorded personal medical information within 2 years prior to the request. If the identities are not recorded, the insurer shall disclose to the individual or authorized representative the names of any insurance agents, insurance support organizations or other entities to whom such information is normally disclosed.

4. Provide to the individual or authorized representative a summary of the procedures by which the individual or authorized representative may request the correction, amendment or deletion of any recorded personal medical information in the possession of the insurer.

(b) Notwithstanding par. (a), an insurer may, in the insurer's discretion, provide a copy of any recorded personal medical information requested by an individual or authorized representative under par. (a) to a health care provider who is designated by the individual or authorized representative and who is licensed, registered, permitted or certified to provide health care services with respect to the condition to which the information relates. If the insurer chooses to provide the information to the designated health care provider under this paragraph, the insurer shall notify the individual or authorized representative, at the time of disclosure, that the information has been provided to the health care provider.

(c) An insurer is required to comply with par. (a) or (b) only if the individual or authorized representative provides a reasonable description of the information that is the subject of the request and if the information is reasonably easy to locate and retrieve by the insurer.

(d) If an insurer receives personal medical information from a health care provider or a medical care institution with instructions restricting disclosure of the information under s. 51.30 (4) (d) 1. to the individual to whom the information relates, the insurer may not disclose the personal medical information to the individual under this subsection, but shall disclose to the individual the identity of the health care provider or a medical care institution that provided the information.

(e) Any copy of recorded personal medical information provided under par. (a) or (b) shall include the identity of the source of the information if the source is a health care provider or a medical care institution.

(f) An insurer may charge the individual a reasonable fee to cover the costs incurred in providing a copy of recorded personal medical information under par. (a) or (b).

(g) The requirements for an insurer under this subsection may be satisfied by another insurer, an insurance agent, an insurance support organization or any other entity authorized by the insurer to act on its behalf.

(h) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.

(4) CORRECTION, AMENDMENT OR DELETION OF RECORDED PERSONAL MEDICAL INFORMATION. (a) Within 30 business days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in the insurer's possession, an insurer shall do either of the following:

1. Comply with the request.

2. Notify the individual of all of the following:

a. That the insurer refuses to comply with the request.

b. The reasons for the refusal.

c. That the individual has a right to file a statement as provided in par. (c).

(b) An insurer that complies with a request under par. (a) shall notify the individual of that compliance in writing and furnish the correction, amendment or fact of deletion to all of the following:

1. Any person who may have received, within the preceding 2 years, the recorded personal medical information concerning the individual and who is specifically designated by the individual.

2. Any insurance support organization for which insurers are the primary source of personal medical information and to which the insurer, within the preceding 7 years, has systematically provided recorded personal medical information. This subdivision does not apply to an insurance support organization that does not maintain recorded personal medical information concerning the individual.

3. Any insurance support organization that furnished to the insurer the personal medical information that has been corrected, amended or deleted.

(c) If an insurer refuses to comply with a request under par. (a) 1., the individual making the request may file with the insurer, an insurance agent or an insurance support organization any of the following:

1. A concise statement setting forth the information that the individual believes to be correct, relevant or fair.

2. A concise statement setting forth the reasons why the individual disagrees with the insurer's refusal to correct, amend or delete the recorded personal medical information.

(d) If the individual files a statement under par. (c), the insurer shall do all of the following:

1. File any statement filed by the individual under par. (c) with the recorded personal medical information that is the subject of the request under par. (a) in such a manner that any person reviewing the recorded personal medical information will be aware of and have access to the statement.

2. In any subsequent disclosure by the insurer of the recorded personal medical information, clearly identify any matter in dispute and provide any statement filed by the individual under par. (c) that relates to the recorded personal medical information along with the information.

3. Furnish any statement filed by the individual under par. (c) to any person to whom the insurer would have been required to furnish a correction, amendment or fact of deletion under par. (b).

(e) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.

(5) DISCLOSURE OF PERSONAL MEDICAL INFORMATION BY INSURERS. Any disclosure by an insurer of personal medical information concerning an individual shall be consistent with the individual's signed disclosure authorization form, unless the disclosure satisfies any of the following:

(a) Is otherwise authorized by the individual, or by a person who is authorized to consent on behalf of an individual who lacks the capacity to consent.

(b) Is reasonably related to the protection of the insurer's interests in the assessment of causation, fault or liability or in the detection or prevention of criminal activity, fraud, material misrepresentation or material nondisclosure.

(c) Is made to an insurance regulatory authority or in response to an administrative or judicial order, including a search warrant or subpoena, that is valid on its face.

(d) Is otherwise permitted by law.

(e) Is made for purposes of pursuing a contribution or subrogation claim.

(f) Is made to a professional peer review organization, bill review organization, health care provider or medical consultant or reviewer for the purpose of reviewing the services, fees, treatment or conduct of a medical care institution or health care provider.

(g) Is made to a medical care institution or health care provider for any of the following purposes:

1. Verifying insurance coverage or benefits.

2. Conducting an operations or services audit to verify the individuals treated by the health care provider or at the medical care institution.

(h) Is made to a network plan that is offered by an insurer in order to make arrangements for coordinated health care in which personal medical information concerning an individual is available for providing treatment, making payment for health care under the plan and undertaking such plan operations as are necessary to fulfill the contract for provision of coordinated health care.

(i) Is made to a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurer's operations or services. Disclosure may be made under this paragraph only if the disclosure is reasonably necessary for the group policyholder to conduct the review or audit.

(j) Is made for purposes of enabling business decisions to be made regarding the purchase, transfer, merger, reinsurance or sale of all or part of an insurance business.

(k) Is made for purposes of actuarial or research studies or for accreditation or auditing. With respect to a disclosure made under this paragraph, any materials that allow for the identification of an individual must be returned to the insurer or destroyed as soon as reasonably practicable, and no individual may be identified in any actuarial, research, accreditation or auditing report.

(L) Is made to the insurer's legal representative for purposes of claims review or legal advice or defense.

(6) IMMUNITY. (a) A person is not liable to any person for any of the following:

1. Disclosing personal medical information in accordance with this section.

2. Furnishing personal medical information to an insurer or insurance support organization in accordance with this section.

(b) Paragraph (a) does not apply to the disclosure or furnishing of false information with malice or intent to injure any person.

(7) OBTAINING INFORMATION UNDER FALSE PRETENSES. (a) Any person who knowingly and willfully obtains information about an individual from an insurer or insurance support organization under false pretenses may be fined not more than $25,000 or imprisoned for not more than 9 months or both.

(b) Any person who knowingly and willfully obtains information about an individual from an insurer or insurance support organization under false pretenses shall be liable to the individual for actual damages to that individual, exemplary damages of not more than $25,000 and costs and reasonable actual attorney fees.

History: 1997 a. 231; 1999 a. 9, 79; 2005 a. 22; 2007 a. 20 s. 9121 (6) (a); 2011 a. 32.

Cross-reference: See also ch. Ins 25, Wis. adm. code.

610.80 Corporate governance annual disclosure. (1) DEFINITIONS. In this section:

(a) "Insurance holding company system" has the meaning given in s. 622.03 (2).

(b) "Insurer" has the meaning given in s. 622.03 (3).

(c) "Lead state" has the meaning given in s. 622.03 (4).

(2) DISCLOSURE REQUIREMENT. (a) An insurer or insurance holding company system of which an insurer is a member shall, annually no later than June 1, submit to the commissioner a corporate governance annual disclosure that contains the information described in sub. (3). If the insurer is a member of an insurance holding company system, the insurance holding company system shall submit the disclosure to the commissioner of the lead state in accordance with the laws of the lead state. Upon the commissioner's request, the insurer shall provide a copy of the disclosure when this state is not the lead state.

(b) The commissioner may request additional information from an insurer or insurance holding company system that the commissioner determines is necessary for the commissioner to understand an insurer's or insurer member of an insurance holding company system's corporate governance policies and the reporting or information system or controls implementing the policies.

(c) With respect to an insurer member of an insurance holding company system, if the commissioner wishes to review the disclosure under par. (a) or make a request for additional information about the disclosure under par. (a), the commissioner shall request the disclosure or additional information through the lead state before seeking the information from the insurer member of the insurance holding company system.

(d) The insurer or insurance holding company system has discretion over responses to inquiries regarding the disclosure under this section, provided that the disclosure is consistent with rules established by the commissioner regarding the disclosure and contains the material information necessary to permit the commissioner to gain an understanding of the insurer's or insurer member of an insurance holding company system's corporate governance structure, policies, and practices.

(e) Insurers providing information substantially similar to the information required by this section in other documents provided to the commissioner, including proxy statements or other state or federal filings provided to the commissioner, are not required to also provide that information in the corporate governance annual disclosure but are required to reference in the corporate governance annual disclosure the document in which the information is included.

(3) CONTENTS OF DISCLOSURE. The disclosure under sub. (2) (a) shall include all of the following:

(a) The signature of the chief executive officer or corporate secretary of the insurer or insurance holding company system attesting that, to the best of that individual's knowledge, the insurer has implemented the corporate governance practices described in the disclosure and that a copy of the disclosure was provided to the insurer's board of directors or an appropriate committee of the insurer's board of directors.

(b) An explanation of the level of corporate governance at which the disclosure provides its reporting, the criteria used to determine the level of reporting, and, if applicable, any change in the level of reporting from the previous disclosure. The insurer or insurance holding company system may provide information regarding corporate governance at the ultimate controlling parent, intermediate holding company, or individual legal entity level, depending upon how the insurer or insurance holding company system has structured its corporate governance. In determining at which level of reporting an insurer or insurance holding company system will make its disclosure, the insurer or insurance holding company system shall consider at which level the insurer or insurance holding company system does each of the following:

1. Determines risk appetite.

2. Collectively oversees earnings, capital, liquidity, operations, and reputation.

3. Coordinates and exercises supervision over earnings, capital, liquidity, operations, and reputation.

4. Places liability for failure to perform corporate governance duties.

(4) CONFIDENTIALITY. (a) All of the following apply to documents, materials, and other information in the possession or control of the commissioner that are obtained by, created by, or disclosed to the commissioner or any other person under this section:

1. The documents, materials, and other information are considered proprietary and contain trade secrets.

2. The documents, materials, and other information are confidential and privileged.

3. The documents, materials, and other information are not open to inspection or copying under s. 19.35 (1).

4. The documents, materials, and other information are not subject to subpoena or discovery and are not admissible as evidence in a civil action.

5. The commissioner may use the documents, materials, and other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

6. The commissioner may not make the documents, materials, or other information public without first obtaining written consent of the insurer.

(b) Neither the commissioner nor any person who received documents, materials, or other information related to the corporate governance annual disclosure required under this section may testify or be required to testify in any private civil action regarding documents, materials, or other information related to the corporate governance annual disclosure required under this section.

(c) Notwithstanding par. (a), the commissioner may share, upon request, documents, materials, or other information related to the corporate governance annual disclosure required under this section with other state, federal, and international financial regulatory agencies if the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information and has verified that it has the legal authority to maintain confidentiality. The commissioner may receive documents, materials, or other information related to similar corporate governance disclosures from other state, federal, and international financial regulatory agencies and shall maintain as confidential or privileged any documents, materials, or other information that is treated as confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials,

or other information. The sharing of documents under this paragraph does not constitute a delegation of regulatory authority and does not act as a waiver of privilege.

(d) Notwithstanding par. (a), the commissioner may share documents, materials, or other information related to the corporate governance annual disclosure required under this section with 3rd-party contractors and the National Association of Insurance Commissioners if the contractor or the National Association of Insurance Commissioners enters into an agreement with the commissioner that provides for all of the following:

1. Procedures and protocols for maintaining the confidentiality and security of documents, materials, and other information shared under this section.

2. Procedures for sharing by the National Association of Insurance Commissioners only with other state regulators in which the insurance group has domiciled insurers and who receive the information confidentially. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information related to the corporate governance annual disclosure required to be filed under this section and has verified in writing the legal authority to maintain confidentiality.

3. A provision specifying that the ownership of documents, materials, or other information shared under this section remains with the commissioner and the use of the information is at the direction of the commissioner.

4. A provision that prohibits the National Association of Insurance Commissioners or 3rd-party contractor from storing information shared under this paragraph in a permanent database after the underlying analysis is complete.

5. A provision requiring the National Association of Insurance Commissioners or 3rd-party contractor to provide prompt notice to the commissioner and to the insurer regarding any subpoena, request for disclosure, or request for production of information shared under this paragraph.

6. A requirement that the National Association of Insurance Commissioners or the 3rd-party contractor consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or the 3rd-party contractor may be required to disclose confidential information about the insurer shared under this paragraph.

(5) CONSULTANTS. The commissioner may retain, at the insurer's or insurer member of an insurance holding company system's expense, consultants that the commissioner determines are necessary to assist the commissioner in reviewing documents, materials, or other information submitted under this section.

(6) CONSTRUCTION. This section may not be read to prescribe or impose any standards or procedures with respect to corporate governance.

(7) RULE MAKING. The commissioner may promulgate any rules necessary to carry out the purposes of this section.

(8) INITIAL FILING DEADLINE. An insurer, or the insurance holding company system of which the insurer is a member, that is required to file a corporate governance annual disclosure under this section shall file its first corporate governance annual disclosure no later than the first June 1 that occurs after the date the final rules implementing this section are promulgated.

History: 2017 a. 313; 2019 a. 66.