CHAPTER 646

INSURANCE SECURITY FUND

SUBCHAPTER I
GENERAL ORGANIZATION
646.01 Scope and purposes.
646.03 Definitions.
646.11 Organization and administration of fund.
646.12 Administration of the fund.
646.13 Special duties and powers of the fund related to loss claims.
646.15 Proceedings involving insurers.
646.16 Payment of deposits made for benefit of creditors.
646.21 Custody and investment of assets.

SUBCHAPTER II
CLAIMS PROCEDURES
646.31 Eligible claims.
646.32 Appeal and review.
646.325 Recovery of amounts paid to 3rd parties.
646.33 Subrogation and cooperation.
646.35 Continuation of coverage.
646.41 Tax exemption.
646.51 Assessments.
646.60 Claims by security funds.
646.61 Disposal and transfer of assets.

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

NOTE: Chapter 109, laws of 1979, which repealed and recreated this chapter, contained notes explaining the revision.

SUBCHAPTER I

GENERAL ORGANIZATION

646.01 Scope and purposes. (1) SCOPE. (a) *General.* This chapter applies to:

1. All kinds and lines of direct insurance, except as provided in par. (b).

2. All insurers authorized to do business in this state except:

a. Fraternals that are not health maintenance organization insurers.

b. Assessable mutuals, including town mutuals.

c. Mutual municipal insurers under s. 611.11 (4).

e. Limited service health organization insurers.

f. Miscellaneous insurers and motor clubs under ch. 616.

g. State insurance funds under chs. 604 to 607.

h. Risk retention groups.

i. Service insurance corporations that offer only dental or vision care.

j. Nondomestic insurers that have not obtained a certificate of authority to do business in this state and that are doing business under s. 618.41 or 618.42.

k. Risk-sharing plans under ch. 619.

L. The patients compensation fund under s. 655.27.

(b) *Exceptions.* This chapter does not apply to any of the following:

1. Any portion of a life insurance policy or annuity contract that is not guaranteed by the insurer or under which the risk is borne by the policy or policyholder.

2. Title insurance.

3. Surety bonds, fidelity bonds and any other bonding obligations.

4. Bail bonds.

5. Mortgage guaranty, financial guaranty and other forms of insurance offering protection against investment risks.

6. Ocean marine insurance.

7. Credit insurance.

8. Product liability or completed operations liability insurance, and comprehensive general liability including either of these coverages, provided to a risk purchasing group or a member of a risk purchasing group.

9. Any self-funded, self-insured, or partially or wholly uninsured plan of an employer or other person to provide life insurance, annuity, or disability benefits to its employees or members to the extent that the plan is self-funded, self-insured, or uninsured.

10. Any liability for dividends or experience rating credits payable after the date of entry of the order of liquidation under an insurance or annuity contract, and any fees or allowances due any person, including the policyholder, in connection with service to or administration of the contract.

11. Any warranty or service contract.

11m. Any contractual liability policy that is issued to a warrantor, warranty plan, warranty plan administrator, or service contract provider and that provides coverage of any liability or performance arising out of or in connection with a warranty or service contract.

12. Municipal bond insurance.

13. Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk.

14. A policy issued by an insurer to, or a contract entered into by an insurer with, a care management organization, as defined in s. 46.2805 (1), or the department of health services or any other governmental entity under any state law to provide prepaid health care to medical assistance recipients.

15. An unallocated annuity contract.

16. A contractual agreement that obligates an insurer to provide a book value accounting guarantee for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, neither of which is an affiliate of the insurer.

17. Any liability under a policy or contract to the extent that it provides for interest or other changes in value that are to be determined by the use of an index or other external reference stated in the policy or contract and to the extent that the interest or other changes in value have not been credited to the policy or contract as of the date of the entry of the order of liquidation and are subject to forfeiture. If a policy's or contract's interest or other changes in value are credited less frequently than annually, for purposes of determining the values that have been credited and that are not subject to forfeiture, the interest or change in value determined by using the procedures specified in the policy or contract will be credited as if the contractual date of crediting interest or other changes in value was the date of entry of the order of liquidation and will not be subject to forfeiture.

18. The deductible, self-funded, or self-insured portion of a claim under a liability or worker's compensation insurance policy, regardless of the timing or method provided in the policy, endorsement, or any other agreement for payment of the deductible, self-funded, or self-insured amount by the insured. This subdivi-

sion does not apply to a worker's compensation insurance policy if the insured under the policy is a debtor under 11 USC 701, et seq., as of the deadline set by the liquidator for filing claims against the insolvent insurer.

19. A policy issued by an insurer to an enrollee under Title XVIII of the federal social security act, 42 USC 1395 to 1395ccc, or Title XIX of the federal social security act, 42 USC 1396 to 1396v, or a contract entered into by an insurer with the federal government or an agency of the federal government under Title XVIII or Title XIX of the federal social security act, to provide health care or prescription drug benefits to persons enrolled in Title XVIII or Title XIX programs.

20. A surplus lines insurance policy written by a domestic surplus lines insurer under s. 618.41 (1).

21. A policy issued by an insurer to the federal government or an agency of the federal government for the purpose of providing health insurance coverage to enrollees under the federal employee health benefit plan program under 5 USC 8901 et seq.

22. Funding agreements authorized under s. 632.66.

(2) PURPOSES. The purposes of this chapter are:

(a) To maintain public confidence in the promises of insurers by providing a mechanism for protecting insureds from excessive delay and loss in the event of liquidation of insurers and by assessing the cost of such protection among insurers; and

(b) To provide where appropriate for the continuation of protection under policies and supplementary contracts of life insurance, disability insurance and annuities.

History: 1971 c. 260; 1975 c. 373, 374, 422; 1979 c. 102, 109, 355; 1981 c. 20 s. 2202 (26) (c); 1983 a. 120; 1985 a. 216; 1987 a. 247, 325; 1989 a. 23; 1995 a. 27 s. 9130 (4); 1995 a. 236, 396; 1997 a. 35; 2003 a. 261; 2007 a. 20 s. 9121 (6) (a); 2007 a. 170; 2009 a. 342; 2011 a. 224; 2013 a. 20, 271; 2017 a. 16; 2021 a. 114.

The purpose of this chapter is to protect insureds against losses caused by insolvent insurers. Insureds of insolvent insurers are protected against subrogation claims to the extent of their policy limits. Fireman's Fund v. Pitco Frialator, 145 Wis. 2d 526, 427 N.W.2d 417 (Ct. App. 1988).

646.03 Definitions. In this chapter, unless the context indicates otherwise:

(1) "Board" means the board of directors of the insurance security fund created by s. 646.12.

(1m) "Direct insurance" does not include a policy or contract of reinsurance, except for the following:

(a) Reinsurance for which the reinsurer has issued assumption certificates under the reinsurance policy or contract.

(b) Reinsurance ceded by an assessable town mutual company.

(2) "Fund" means the insurance security fund created by s. 646.11.

(2m) "Health maintenance organization" has the meaning given under s. 609.01 (2).

(2p) "Insolvent insurer" means an insurer subject to this chapter that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(2r) "Limited service health organization" has the meaning given in s. 609.01 (3).

(3) "Liquidator" includes receiver or conservator.

(3m) "Long-term care insurance policy" has the meaning given in s. 600.03 (28g).

(4) With respect to a life or disability insurance policy or an annuity contract, "owner" or "policyholder" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. "Owner" or "policyholder" does not include a person with only a beneficial interest in a policy or contract.

(4m) "Retained asset account" means any mechanism in which the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, under a written supplementary contract not involving annuity benefits.

(5) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

History: 1979 c. 109, 110, 355; 1985 a. 29; 1995 a. 236; 2003 a. 261; 2009 a. 342; 2011 a. 224; 2025 a. 227.

646.11 Organization and administration of fund. (1) ORGANIZATION. There is created an organization to be known as the "insurance security fund." All insurers subject to this chapter are contributors to the fund as a result of their authority to transact business in this state. The fund shall consist of all of the following:

(a) All payments made by insurers under s. 646.51.

(b) The earnings resulting from investments under s. 646.21 (2).

(c) The amounts recovered under s. 645.72 (2) or a substantially similar law in the state of domicile of the insolvent insurer.

(d) Amounts reimbursed to the fund through its subrogation and assignment rights.

(e) Any other moneys received by the fund from time to time.

(2) ACCOUNTS. The fund shall be composed of 6 segregated accounts, one for life insurance and annuities, one for disability insurance other than policies issued or coverage provided by a health maintenance organization insurer, one for health maintenance organization insurers, one for long-term care insurance, one for all other kinds of insurance subject to this chapter, and an administrative account.

(3) EXPENSES OF FUND. Necessary expenses of administration of the fund incurred in connection with actual liquidations or with continuation of contracts under s. 646.35 shall be charged to the appropriate account of the fund. All other expenses shall be charged to the administrative account.

(4) LIABILITY. No contributor to the fund, person acting on the fund's behalf, insurer representative on the board, or alternate representative designated under s. 646.12 (1) (a) 3. is personally liable for any obligations of the fund. The rights of creditors are solely against the assets of the fund.

(5) IMMUNITY. No cause of action of any nature may arise against and no liability may be imposed upon the fund or its agents, employees, directors, including alternate representatives designated under s. 646.12 (1) (a) 3., or contributor insurers, or the commissioner or the commissioner's agents, employees, or representatives, for any act or omission by any of them in the performance of their powers and duties under this chapter.

History: 1979 c. 109, 221; 1983 a. 120; 1985 a. 216, 332; 1989 a. 23; 2003 a. 261; 2007 a. 170; 2023 a. 212; 2025 a. 227.

646.12 Administration of the fund. (1) COMPOSITION OF BOARD. (a) *Members.* 1. The fund shall be administered by a board of directors that shall consist of the attorney general, the state treasurer, and the commissioner, each of whom shall have full voting rights, and at least 9 but not more than 11 insurer representatives of domestic, foreign, and alien insurers subject to this chapter.

2. The commissioner shall appoint the insurer representative

members for 3-year terms, after considering recommendations of the other board members currently serving terms. In recommending candidates to fill the positions, the board shall consider whether all insurers subject to this chapter are fairly represented, including property and casualty insurers, life and health insurers, health maintenance organizations and service insurance corporations, and domestic and nondomestic insurers.

3. Each appointed insurer representative may designate an alternate representative to represent the insurer at any meeting of the board. Any person serving as an alternate representative shall, while serving, have all of the powers and responsibilities of the appointed insurer representative.

(b) *Chairperson.* The person to chair the board shall be elected by the members of the board annually at the first meeting after June 1.

(2) GENERAL POWERS AND DUTIES. The board shall:

(a) Adopt rules for the administration of this chapter, including delegation of any part of its powers and its own procedures.

(b) Create standing or special committees as needed. A minority of the members of any committee may be persons not members of the board.

(c) Delegate to the committees any of its powers and duties under this chapter, subject to review and reconsideration by the board.

(d) Employ or retain the personnel necessary to carry out the fund's duties and set compensation for the personnel. Personnel employed under this paragraph are not employees of the state and are not subject to s. 20.922 or ch. 230.

(e) Advise and make recommendations to the commissioner on any matter related to the possible insolvency of an insurer covered by this chapter, and respond to any reasonable questions presented by the commissioner. Information, recommendations and advice under this subsection are privileged and confidential and are not open to public inspection under s. 19.35 (1).

(f) 1. Keep records of all meetings of the fund and of its subcommittees that involve discussions of the activities of the fund in carrying out its powers and duties under this chapter.

2. Keep confidential the records under subd. 1. pertaining to specific liquidation proceedings involving an insurer until the termination of the liquidation proceedings or until sooner ordered to make the records public by a court of competent jurisdiction.

3. Keep confidential the records under subd. 1. pertaining to specific rehabilitation proceedings involving an insurer unless ordered to make the records public by a court of competent jurisdiction.

(g) Negotiate and contract with any liquidator to achieve the purposes of this chapter.

(h) Perform other acts necessary to achieve the purposes of this chapter.

(3) COMPENSATION. Members of the board and other committee members shall receive no compensation for services but may receive reimbursement for all reasonable and necessary expenses incurred in the performance of their respective duties as directors or as committee members.

(4) OTHER POWERS. The fund may join an organization consisting of one or more entities of other states performing comparable functions, in order to assist the fund in carrying out its powers and duties under this chapter and otherwise further the purposes of this chapter.

History: 1979 c. 109, 355; 1985 a. 216; 1987 a. 325; 1989 a. 332; 1995 a. 236; 2003 a. 261; 2007 a. 170.

Cross-reference: See also ch. Ins 11, Wis. adm. code.

646.13 Special duties and powers of the fund related to loss claims.

(1) DUTIES. The fund shall:

(a) Establish procedures and acceptable forms of proof for eligible claims, which shall correspond as closely as practicable with the corresponding rules under ch. 645.

(b) Stand in the position of the insurer in the investigation, compromise, settlement, denial, and payment of claims under s. 646.31 and the defense of 3rd-party claims against insureds, subject to the limitations of s. 645.43. The fund shall consult and cooperate with the liquidator in carrying out these duties.

(2) POWERS. The fund may:

(a) Review settlements, releases and judgments to which the insurer or its insureds were parties to determine the extent to which they may be properly contested.

(b) Exercise with respect to loss claims the powers that the liquidator has with respect to other claims under ch. 645 or a substantially similar law in the state of domicile of the insolvent insurer.

(c) With respect to any action against an insurer which is in liquidation, exercise the powers of the liquidator under s. 645.49 (1) or a substantially similar law in the state of domicile of the insolvent insurer.

(d) Have standing to appear in any liquidation proceedings in this state involving an insurer in liquidation, and have authority to appear or intervene before a court or agency of any other state having jurisdiction over an insolvent insurer, in accordance with the laws of that state, with respect to which the fund is or may become obligated or that has jurisdiction over any person or property against which the fund may have subrogation or other rights. Standing shall extend to all matters germane to the powers and duties of the fund, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the insolvent insurer and the determination of the policies or contracts and contractual obligations.

(e) Pursue salvage and subrogation with respect to paid covered claim obligations and retain any amounts recovered.

(f) Appoint and direct legal counsel for the defense of covered claims under insurance policies.

(g) Sue and be sued, make contracts, including a contract with an insured for administration and payment of claims for which the insured is responsible, and borrow money necessary to carry out its duties, including money with which to pay claims under s. 646.31 or to continue coverage under s. 646.35. The fund may offer as security for such loans its claims against the liquidator or its power to levy assessments under this chapter.

(h) Negotiate and contract with other guaranty associations to provide and receive administrative, claims, and other services that are usual to guaranty associations.

(3) NO DUTY OR LIABILITY. The fund has no duty or liability with respect to any claim filed as follows:

(a) With the liquidator under s. 645.61 after the original date for filing specified by the liquidator under s. 645.47 (2), unless the liquidator determines that the claim is considered to have been timely filed under s. 645.61 (2) and the claim participates fully in every distribution to the same extent as other timely filed claims in the same class.

(b) With a liquidator or court under the laws of any other state after the original date for filing specified by the liquidator or court, unless the liquidator or court determines that the claim is considered to have been timely filed under a law substantially similar to s. 645.61 (2) and the claim participates fully in every distribution to the same extent as other timely filed claims in the same class.

(c) Except for claims under life insurance policies, annuities, or noncancelable or guaranteed renewable disability insurance policies, and except for claims determined to be excused late fil-

ings as provided in pars. (a) and (b), if the original date for filing is extended by the liquidator or court, with a liquidator or court after the earlier of the following:

1. Eighteen months after the order of liquidation is entered.

2. The extended date for filing specified by the liquidator or court.

(d) Except for claims under life insurance policies, annuities, or noncancelable or guaranteed renewable disability insurance policies, and except for claims determined to be excused late filings as provided in pars. (a) and (b), if no date for filing is set by the liquidator or court, with a liquidator or court after 18 months after the order of liquidation is entered.

(4) WHEN DUTY TO DEFEND TERMINATES. Any obligation of the fund to defend an insured ceases upon the fund's payment, by settlement or on a judgment, of an amount equal to the lesser of the fund's covered claim obligation limit or the applicable policy limit, subject to any express policy terms regarding tender of limits.

History: 1979 c. 109; 1985 a. 216; 1987 a. 325; 1999 a. 30; 2003 a. 261; 2005 a. 253; 2007 a. 170; 2009 a. 342; 2021 a. 114; 2023 a. 212.

646.15 Proceedings involving insurers. (1) INJUNCTIONS AND ORDERS. (a) If an insurer is in liquidation, the fund may apply to the circuit court for Dane County for, and the court may grant, restraining orders, temporary and permanent injunctions, and other orders considered necessary and proper to prevent any of the following:

1. Interference with the fund or with its administrative proceedings.

2. The institution or further prosecution of any action or proceeding involving the insurer or in which the fund is obligated to defend a party.

3. The obtaining of a preference, judgment, garnishment or lien against the insurer or its assets.

4. Any other threatened or contemplated action that might prejudice the rights of policyholders or the administration of the liquidation or fund proceedings.

(b) Upon granting an application under par. (a), the court may retain jurisdiction of any further proceeding or relief, as the court considers necessary and proper, involving the insurer.

(2) EXCLUSIVE PROCEEDINGS. A court of this state does not have jurisdiction to entertain, hear or determine a proceeding or to grant relief if the proceeding or relief involves or is related to a nondomestic insurer which is in liquidation unless the court is so authorized under this chapter or ch. 645.

History: 1987 a. 325; 1999 a. 30; 2003 a. 261.

646.16 Payment of deposits made for benefit of creditors. (1) The commissioner shall promptly pay to the fund any deposit held in this state that was paid, as required by law or the commissioner, by the insolvent insurer for the benefit of creditors, including policyholders, and not turned over to the domiciliary liquidator upon the entry of a final order of liquidation of an insurer domiciled in this state or in a reciprocal state, as defined in s. 645.03 (1) (i). Of the amount paid to the fund under this subsection, the fund may retain the percentage determined by dividing the aggregate amount of policyholders' claims that are related to the insolvency and for which the fund has provided benefits under this chapter by the aggregate amount of all policyholders' claims in this state that are related to the insolvency. The fund shall remit the balance to the domiciliary liquidator.

(2) Any amount retained by the fund under sub. (1) shall be treated as a distribution of estate assets under s. 645.72 or a similar provision of the state of domicile of the insolvent insurer. Deposits subject to this section shall not be treated as deposits as security, escrow, or other security under s. 645.03 (1) (j).

History: 2003 a. 261.

646.21 Custody and investment of assets. (1) CUSTODY. Except as provided in sub. (2), the board controls the assets of the fund. The board shall select regulated financial institutions in this state which receive deposits in which to establish and maintain accounts for assets needed on a current basis. If practicable, the accounts shall earn interest.

(2) INVESTMENT OF ASSETS. The board may request that assets of the fund not needed currently be invested by the investment board under s. 25.17. If so requested, the investment board shall invest those assets in investments with maturities and liquidity appropriate to the probable needs of the fund for money to perform its duties. All income attributable to the investments shall be credited to the fund, and both income and principal shall be transferred to the fund on request of the board. Assets held by the fund shall be invested in a similar manner.

History: 1979 c. 109; 1983 a. 120; 2003 a. 261.

SUBCHAPTER II

CLAIMS PROCEDURES

646.31 Eligible claims. (1) CONDITIONS OF ELIGIBILITY. A claim is not eligible for payment from the fund unless it is an unpaid claim for a loss insured under the policy or annuity, or an unpaid claim under a supplementary contract providing for a retained asset account, and all of the following conditions are met:

(a) *Issued by authorized insurer.* The claim arises out of an insurance policy or annuity issued by an insurer which was authorized to do business in this state either at the time the policy or annuity was issued or when the insured event occurred, and against which an order of liquidation, which is not stayed, has been entered by a court of competent jurisdiction in the insurer's domiciliary state.

(b) *Assessability of insurer.* 1. The claim arises out of business not exempt from assessment under s. 646.01 (1).

2. The claim does not arise out of business against which assessments are prohibited under any federal or state law.

(c) *Contact with state.* The claim is a member of one of the classes of claims under sub. (2).

(cm) *Termination of coverage.* Except for claims under life insurance policies, annuities or noncancelable or guaranteed renewable disability insurance policies, the claim arises within 30 days after the order of liquidation is entered or before any of the following occur:

1. The policy expires, if the expiration date is less than 30 days after the order of liquidation is entered.

2. The insured replaces or cancels the policy, if either action is taken within 30 days after the order of liquidation is entered.

(d) *Exceptions.* The claim is not any of the following:

1. Based solely on a judgment.

2. Made for interest on any claim.

3. Made under s. 645.63 (2).

4. Subordinated under s. 645.90.

5. An indemnification recovered as a voidable preference under s. 645.54 (1) (c).

6. Made by an affiliate of an insurer in liquidation.

7. A retrospective premium rate adjustment.

8. Made for health care costs, as defined in s. 609.01 (1j), for which an enrollee, as defined in s. 609.01 (1d), or policyholder of

a health maintenance organization insurer is not liable under ss. 609.91 to 609.935.

9. Made for health care costs, as defined in s. 609.01 (1j), for which an enrollee, as defined in s. 609.01 (1d), or policyholder of a health maintenance organization is not liable for any reason.

10. Based on an obligation that does not arise under the express written terms of the policy or contract, including any of the following:

a. A claim based on marketing materials.

b. A claim based on misrepresentations regarding policy benefits.

c. An extra-contractual claim, including a claim for punitive or exemplary damages.

d. A claim for statutorily imposed multiple damages.

e. A claim for penalties or consequential or incidental damages.

f. A claim for bad faith damages.

11. In the case of a life or disability insurance policy or an annuity contract, based on side letters, riders, or other documents that do not meet or comply with applicable policy form filing or approval requirements.

(2) CLASSES OF CLAIMS TO BE PAID. No claim may be paid under this chapter unless the claim is in one of the following classes:

(a) *Residents.* 1. The claim of a policyholder, including a ceding assessable domestic insurer that is organized under ch. 612 and a domestic insurer that is a bona fide policyholder of the insurer in liquidation, who is a resident of this state under sub. (13).

2. Except for a claim of a beneficiary, assignee, or payee under a life or disability insurance policy or annuity contract, the claim of an insured, including a certificate holder, under a policy or annuity contract who is a resident of this state under sub. (13).

(b) *Certain nonresidents.* The claim is made under a life or disability insurance policy or annuity contract subject to this section and issued by a domestic insurer and the claimant is a resident of another state that provides coverage similar to the coverage provided under this chapter but does not provide coverage for the claimant because the insurer was not licensed in that state at the time specified as a requirement for coverage under that state's guaranty association law.

(c) *Owners of property interests.* The first-party claim of a person having an insurable interest in or related to property with a permanent location in this state at the time of the insured event.

(d) *Third-party claimants.* A claim under a liability or workers' compensation insurance policy, if either the insured or the 3rd-party claimant was a resident of this state at the time of the insured event.

(e) *Assignees.* The claim of a direct or indirect resident assignee, other than an insurer, of a person who except for the assignment could have claimed under par. (a), (b), (c) or (d).

(f) *Beneficiaries, assignees, and payees; life or disability policy or annuity contract.* Except for a claim of a nonresident certificate holder under a group policy or contract, a claim made under a life or disability insurance policy or annuity contract by a resident or nonresident beneficiary, assignee or payee of a person who fulfills all of the following criteria:

1. The person is a policyholder of, or a certificate holder under, the life or disability insurance policy or annuity contract.

2. The person is a resident of this state or could have made a claim under par. (b).

(g) *Payees; structured settlement annuity.* 1. Notwithstanding par. (f), the claim of a payee, or of a beneficiary of a deceased payee, under a structured settlement annuity if the payee, or deceased payee's beneficiary, is a resident of this state, regardless of where the policyholder of the structured settlement annuity resides.

2. Notwithstanding pars. (b) and (f), the claim of a payee, or of a beneficiary of a deceased payee, under a structured settlement annuity if the payee, or deceased payee's beneficiary, is not a resident of this state, if neither the payee, or deceased payee's beneficiary, nor the policyholder of the structured settlement annuity is eligible for coverage by an organization that is comparable to the fund in the state of which the payee, or deceased payee's beneficiary, or the policyholder is a resident, and if either of the following applies:

a. The policyholder is a resident of this state.

b. The policyholder is not a resident of this state, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the policyholder resides has an organization that is comparable to the fund.

(4) MAXIMUM CLAIM. (ag) For purposes of this subsection, "disability insurance" means comprehensive health insurance policies and major medical health insurance policies. "Disability insurance" does not include hospital indemnity; loss of time; accidental benefits; limited or specified benefit or other ancillary coverages; disability income insurance coverage; long-term care insurance coverage; insurance coverage that is supplemental to another insurance policy or program, including Medicare supplement insurance; or similar types of policies.

(ap) Except in regard to worker's compensation insurance and except as provided in par. (b), the obligation of the fund on a single risk, loss, or life, regardless of the number of policies or contracts, may not exceed $300,000, except that the aggregate liability of the fund for a single risk, loss, or life with respect to benefits for property insurance, liability insurance, and disability insurance, regardless of the number of those policies, may not exceed $500,000.

(b) The fund is not obligated to pay a claimant an amount in excess of the loss obligation of the insurer in liquidation under the policy or coverage from which the claim arises.

(6) COLLECTION FROM COLLATERAL SOURCES. (a) The portion of an otherwise eligible loss claim for which indemnification is provided by other benefits or advantages, which may not be included in the classes of claims specified in s. 645.68 (intro.), may not be claimed from the fund under this chapter or from the insured or policyholder. The claimant must exhaust such collateral sources before pursuing payment from the fund. This paragraph does not apply to the claim of an insured or payee under a structured settlement annuity.

(b) The fund may waive the application of par. (a) to claims under contracts subject to s. 646.35 (3), to the extent that the fund determines that application of par. (a) would be impracticable.

(c) Any person having an eligible claim which also constitutes a claim or legal right of recovery under any governmental insurance or guaranty program shall first exhaust all rights under that program, and any amount payable on an eligible claim under this chapter shall be reduced by the amount of recovery under that program.

(7) SETOFFS AND COUNTERCLAIMS. Section 645.56 applies to the settlement of loss claims. The fund shall give the liquidator a reasonable opportunity to inform the fund of possible setoffs and counterclaims before paying loss claims.

(8) NOTICE TO CLAIMANTS. The fund shall provide notice under s. 645.47 (2) to those potential loss claimants to whom the fund is liable under the section, if the liquidator has not done so.

(9) COLLECTION FROM OTHER FUNDS. A claim recoverable from more than one security fund shall be paid in the following order:

(a) By any security fund with an obligation to pay all loss claims of the insurer.

(b) If it is a first party claim for damage to property with a permanent location, by the fund of the location of the property.

(c) If it is a workers' compensation claim, by the fund of the residence of the claimant.

(cm) If it is a liability claim, by the fund of the residence of the policyholder.

(d) In any other case, by the fund of the residence of the insured.

(e) Any other funds liable to pay.

(9m) RECOVERY REDUCTION. Any recovery under this chapter shall be reduced by the amount of recovery from any other security fund.

(10) TEMPORARY MORATORIUMS. Before being obligated to make payments under this chapter to holders of life insurance or annuity contracts the fund may impose, with court approval, any of the following:

(a) Temporary moratoriums or liens on payments of cash values and policy loans, or on any other right to withdraw funds held in conjunction with those policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. If the court imposes a temporary moratorium or a moratorium charge on the payment of cash values or policy loans out of the assets of the insolvent insurer, or on any other right to withdraw, out of those assets, funds held in conjunction with those policies or contracts, the fund may defer the payment of cash values and policy loans and other rights to withdraw funds for the period of the moratorium or moratorium charge imposed by the court, except for any claims covered by the fund to be paid in accordance with a hardship procedure established by the liquidator and approved by the court.

(b) Permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the board finds that the amounts that may be assessed under this chapter are insufficient to ensure full and prompt performance of the fund's duties under this chapter, or that economic or financial conditions, as they affect insurers, are such that imposing such permanent policy or contract liens is in the public interest.

(11) SUBROGATION CLAIMS. (a) In this subsection:

1. "Health care costs" has the meaning given in s. 609.01 (1j).

2. "Insurance entity" means a reinsurer, an insurer, an insurance pool, or an underwriting association.

(b) An insurance entity may not assert a claim against the fund for any amount due from the insurer to the insurance entity as subrogation, contribution, or indemnification recoveries or otherwise, except as provided in sub. (2) (a). An insurance entity that has paid a claim and thereby has become subrogated or otherwise entitled to the amount of that claim may assert that claim against the liquidator of the insurer in liquidation but not against the insured of the insurer in liquidation.

(c) Notwithstanding par. (b), an insurance entity may assert a claim against the fund for health care costs if all of the following conditions are met:

1. The insurance entity paid the claim for health care costs under a disability insurance policy issued by the insurance entity.

2. The insurance entity is not obligated to pay the health care costs under the express terms of the disability insurance policy because the claim arose out of, or in the course of, the claimant's employment.

3. The claim is covered by a worker's compensation insurance policy and would otherwise be an eligible claim under this section.

(12) NET WORTH OF INSURED. Except for claims under s. 646.35, payment of a first-party claim under this chapter to an insured whose net worth, as defined in s. 646.325 (1), exceeds $25,000,000 is limited to the amount by which the aggregate of the insured's claims that satisfy subs. (1) to (7), (9) and (9m) plus the amount, if any, recovered from the insured under s. 646.325 exceeds 10 percent of the insured's net worth.

(13) RESIDENCY. For purposes of determining residency in this section:

(a) The residency of a claimant, insured, or policyholder that is not a natural person is the state in which the claimant's, insured's, or policyholder's principal place of business is located.

(b) In the case of a life or disability insurance policy or an annuity contract, residency means residency at the time of the liquidation order. In the case of any other kind of insurance covered by this chapter, residency means residency at the time of the insured event.

(c) A person's residency may be in only one state.

(d) If a person who is a citizen of the United States is a resident of a foreign country, or of a possession, territory, or protectorate of the United States, that does not have an organization similar to the fund, the person's residency is the domicile of the insurer that issued the policy or contract.

History: 1979 c. 109; 1983 a. 120 ss. 6 to 11, 19; 1985 a. 216; 1987 a. 325; 1989 a. 23, 31; 1995 a. 396; 1997 a. 237; 1999 a. 30; 2003 a. 261; 2005 a. 253; 2007 a. 170; 2009 a. 342; 2011 a. 224.

An offset under sub. (6) (a) must include amounts available to the claimant and not just amounts settled for. An offset of the policy limits of an applicable policy rather than the amount settled for was correct. Belongia v. Wisconsin Insurance Security Fund, 195 Wis. 2d 835, 537 N.W.2d 51 (Ct. App. 1995), 93-2622.

When a claim against the insured of an insolvent insurer was not filed until after the effective date of sub. (12), each of the insured's claims were subject to the sub. (12) net worth limitation. A. O. Smith Corp. v. Wisconsin Insurance Security Fund, 217 Wis. 2d 252, 580 N.W.2d 348 (Ct. App. 1998), 97-1517.

Town mutuals may recover as policyholders of their reinsurers under sub. (2) (a). Accordingly, the Fund has the authority to assess reinsurance companies of town mutuals, an authority it must exercise to ensure the Fund's solvency. American Eagle Insurance Company v. Wisconsin Insurance Security Fund, 2005 WI App 177, 286 Wis. 2d 689, 704 N.W.2d 44, 04-0274.

When an insurer becomes subrogated by paying medical expenses arising from injuries that are compensable under the worker's compensation statutes and the employer's worker's compensation insurance carrier is in liquidation, sub. (11) precludes LIRC from ordering the employer to reimburse the subrogated insurer for those expenses. Wisconsin Insurance Security Fund v. Labor and Industry Review Commission, 2005 WI App 242, 288 Wis. 2d 206, 707 N.W.2d 293, 04-2157.

646.32 Appeal and review. **(1)** APPEAL. A claimant whose claim is reduced or declared ineligible shall promptly be given notice of the determination and of the right to object under this section. The claimant may appeal to the board within 30 days after the mailing of the notice. The board may appoint a committee of the board or a hearing examiner to decide any such appeal. The claimant may not pursue the claim in court except as provided in sub. (2).

(2) REVIEW. Decisions of the board or its appointed committee or hearing examiner under sub. (1) are subject to judicial review in the circuit court for Dane County. A petition for judicial review shall be filed within 60 days of the decision.

History: 1979 c. 109; 2003 a. 261; 2009 a. 342.

646.325 Recovery of amounts paid to 3rd parties. **(1)** DEFINITION. In this section, "net worth" means the amount of an insured's total assets less the insured's total liabilities at the end of the insured's fiscal year immediately preceding the date the liquidation order was entered, as shown on the insured's audited financial statement or other substantiated financial information acceptable to the fund in its sole discretion. "Net worth" includes the consolidated net worth of all of the corporate affiliates, subsidiaries, operating divisions, holding companies, parent entities, and, if the insured is privately owned, natural persons who have an ownership interest, shown as insureds or additional insureds on the policy issued by the insurer. If the insured is a natural per-

son, "net worth" means the insured's total assets less the insured's total liabilities on December 31 immediately preceding the date the liquidation order was entered.

(2) RECOVERY FROM CERTAIN INSUREDS AND AFFILIATES. Except as provided in sub. (3), the fund may recover from a person the costs and expenses incurred in administering or defending a claim against the person by a 3rd party and the amount of any claim paid on behalf of the person to a 3rd party, if all of the following conditions are satisfied:

(a) The person on whose behalf the claim was administered, defended, or paid is any of the following:

1. An insured whose net worth exceeds $25,000,000.
2. An affiliate of the insurer in liquidation.
3. A person excluded under s. 646.01 (1) (b) 18.

(b) Adjudication of the claim resulted in no liability obligation on the person to pay the claim of the 3rd party or payment of the claim satisfied all or part of the person's liability obligations to 3rd parties.

(3) LIMITATION. The total amount recovered from an insured described in sub. (2) (a) 1. plus the amount of the insured's claims that satisfy s. 646.31 (1) to (7), (9) and (9m) but are not eligible for payment under s. 646.31 (12) may not exceed 10 percent of the insured's net worth.

(4) COSTS AND FEES. In addition to recovery under sub. (2), the fund may recover reasonable attorney fees, disbursements, and all other actual costs expended in pursuing recovery under sub. (2), plus interest calculated at the legal rate under s. 138.04, which shall begin to accrue on all amounts not paid within 30 days after the date of the fund's written notification to the insured of the amount due.

History: 1987 a. 325; 2003 a. 261; 2009 a. 342; 2021 a. 114.

646.33 Subrogation and cooperation. (1) SUBROGATION. (a) Upon payment to any loss claimant the fund is subrogated to the claimant's full right of recovery against the insurer and, to the same extent the insurer would have been subrogated, against any liquidator and any 3rd person. A person receiving benefits under this chapter thereby assigns to the fund the person's rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the extent of the benefits received, regardless of whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or the provision of substitute or alternative coverages.

(b) The subrogation rights of the fund under this subsection have the same priority against the assets of the insolvent insurer as the claimant's rights with respect to the insurer.

(c) In addition to the rights specified in pars. (a) and (b), the fund has all of the common law rights of subrogation and any other equitable or legal remedy that would have been available to the insolvent insurer or the claimant with respect to the covered policy or contract including, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of the benefits received under this chapter, against a person originally or by succession responsible for the losses that arise from the personal injury and that relate to the annuity or its payment.

(d) If any provision of this subsection is invalid or ineffective for any reason with respect to any person or claim, the amount payable by the fund with respect to the related covered obligations shall be reduced by any amount realized by any other person with respect to the person or claim that is attributable to the covered policy or contract.

(2) COOPERATION. The claimant shall cooperate with the fund in pursuing the fund's rights under sub. (1), including executing any necessary documents. If cooperation is withheld unreasonably, the fund may recover from the claimant any amount it has paid the claimant. The fund may require a claimant to execute a written assignment to it of the claimant's rights and causes of action relating to the covered policy or contract as a condition precedent to the receipt of any right or benefits under this chapter.

(2m) RECOVERY. (a) On recovery under this section, the fund may retain both the amount it has paid to the claimant and the amount it has expended to obtain the recovery and shall pay any balance to the claimant.

(b) If a claimant to whom the fund has provided benefits under this chapter recovers amounts with respect to which the fund has rights under this section, the claimant shall pay to the fund the portion of the recovery that is attributable to the covered policy or contract.

(3) CLAIMS AGAINST LIQUIDATOR. (a) The fund shall report periodically and whenever a reasonable request is made to any liquidator against whom subrogation rights exist under sub. (1) the claims paid and rejected together with estimates of unsettled claims made or anticipated against the fund.

(b) As a creditor of the insolvent insurer, the fund shall be entitled to receive disbursements of assets out of marshaled assets, consistent with s. 645.72 and any substantially similar laws of other states, as a credit against obligations under this chapter. If, within 120 days after a final determination of an insurer's insolvency by the receivership court, the liquidator has not applied to the court for approval of a proposal for disbursement of assets out of marshaled assets to insurance guaranty associations having obligations because of the insolvency, the fund may apply to the receivership court, in accordance with the law of the insolvent insurer's domicile, for approval of its own proposal for disbursement of the assets.

History: 1979 c. 109; 2003 a. 261; 2007 a. 170 ss. 35, 37.

646.35 Continuation of coverage. (1) SCOPE. This section applies to the following contracts when subject to this chapter:

(a) Annuities.

(b) Life insurance and supplementary contracts providing for retained asset accounts.

(c) Disability insurance.

(3) INSURER IN LIQUIDATION. (am) If an insurer that is subject to this chapter is in liquidation, the fund shall, subject to s. 646.31 (2), do either of the following:

1. Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies of the insolvent insurer within the scope of this section.

2. Assure performance of the contractual obligations of the insurer on such policies.

(bm) Whether the fund's duties under par. (am) are discharged by the fund under par. (am) 1. or 2. is at the fund's discretion. The fund shall provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the duties under par. (am) 1. or 2.

(4) CLAIMS AGAINST LIQUIDATOR. The fund has a claim against the liquidator for reasonable payments made to discharge its duties under this section. If the fund and the liquidator disagree regarding the reasonableness of such payments, either may apply to the court to determine the question. Such payments shall have the same priority as the class of claims under s. 645.68 (3).

(5) RATE INCREASES. The fund may increase any rates or premiums on policies during continuation of coverage under sub. (3) (am) 2. to the extent the policies permit the insurer to increase the rates or premiums. If the fund determines that the rates or premiums on policies that do not permit an increase or the rates or pre-

miums as increased to the extent permitted by the policies are inadequate under s. 625.11 (3), the fund may offer the policyholders the option of terminating the coverage or continuing the coverage at adequate rates or premiums as determined by the fund.

(6) LIMITATIONS. In performing its duties under this section:

(a) In the case of an annuity contract, the fund may limit its performance to payment of the then current value of the loss claim under s. 645.68 (3) as of the date of the order of liquidation, with interest to the date of payment, in lieu of the requirements of sub. (3).

(b) In the case of a disability insurance policy that is neither guaranteed renewable nor noncancelable, the fund is not obligated to continue the policy in force beyond 30 days after the date the order of liquidation is entered, or 30 days after the date established in the liquidation order of another state, but may continue the coverage under any disability insurance policy for up to 180 days after the date of the liquidation order.

(bm) For coverages continued pursuant to par. (b), the fund may substitute a comprehensive health insurance policy for a health maintenance organization policy that is subject to sub. (3), and increase rates or premiums for the substituted coverage as provided in sub. (5).

(c) In the case of a life insurance or annuity contract, the fund is not obligated to perform the responsibilities set forth in sub. (3) with respect to either of the following:

1. Any benefit payment liability, arising on or after the date of entry of the order of liquidation, to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract and employed in calculating returns or changes in value exceeds the rate of interest, which may not be less than zero, determined by subtracting 3 percentage points from the monthly corporate bond yield average, as most recently published by Moody's investors service or its successor.

2. Any benefit payment liability, arising before the date of entry of the order of liquidation, to the extent that the payment exceeds the rate of interest, which may not be less than zero, determined by subtracting 2 percentage points from the monthly corporate bond yield average, as published by Moody's investors service or its successor, when averaged over the 4-year period ending on the date of entry of the order of liquidation or averaged over such lesser period if the contract was issued less than 4 years before that date.

(7) EXCLUSION FOR COVERAGE UNDER ANOTHER FUND. (a) Notwithstanding s. 646.31 (9), the fund shall not provide coverage under this section to any person who, directly or indirectly, has coverage under any other state's security fund statutes.

(b) In determining whether par. (a) applies in a situation in which a person could potentially be covered by security funds of more than one state, par. (a) shall be construed in conjunction with other states' laws in such a manner as to result in coverage for the person by only one security fund.

(8) REINSURANCE. (a) In this subsection, "coverage date" means the date on which the fund becomes responsible for the obligations of an insolvent insurer.

(b) At any time within one year after the coverage date, the fund may elect to succeed to the insolvent insurer's rights and obligations that accrue on or after the coverage date and that relate to contracts covered, in whole or in part, by the fund under one or more indemnity reinsurance agreements entered into by the insolvent insurer as a ceding insurer and selected by the fund. The election shall be effected by a notice to the liquidator and to any affected reinsurer. The fund may not exercise an election under this paragraph with respect to a reinsurance agreement that the liquidator has expressly disaffirmed.

(c) With respect to each indemnity reinsurance agreement for which the fund makes an election under par. (b):

1. The fund shall be responsible for all unpaid premiums under the agreement, for periods both before and after the coverage date, and for the performance of all other obligations to be performed under the agreement after the coverage date, that relate in each case to contracts covered, in whole or in part, by the fund. The fund may charge contracts covered in part by the fund, through reasonable allocation methods, for the costs of reinsurance in excess of the obligations of the fund.

2. The fund is entitled to any amounts payable by the reinsurer under the agreement with respect to losses or events that occur in periods after the coverage date and that relate to contracts or contractual obligations covered, in whole or in part, by the fund. Upon receipt of any such amounts, the fund must pay to the beneficiary under the policy or contract on account of which the amounts were paid, the amount by which the benefits paid by the fund on account of the policy or contract less the retention of the insolvent insurer applicable to the loss or event is exceeded by the amount received by the fund.

3. Within 30 days after the election, the fund and the indemnity reinsurer must calculate the net balance due to or from the fund under the agreement as of the date of the election, giving full credit to all items paid by the insolvent insurer, the insurer's liquidator, and the indemnity reinsurer between the coverage date and the date of the election. The fund or the indemnity reinsurer shall pay the net balance due to the other within 5 days after the calculation is completed. The liquidator shall remit to the fund as promptly as practicable any amounts received by the liquidator that are due the fund under subd. 2.

4. If, within 60 days of the election, the fund pays all premiums due for periods both before and after the coverage date that relate to contracts covered, in whole or in part, by the fund, the reinsurer may not terminate the agreement insofar as it relates to contracts covered, in whole or in part, by the fund and may not set off against amounts due the fund any unpaid premium due for periods before the coverage date.

(d) If the fund transfers its obligations to another insurer and the fund and other insurer agree, unless the fund has previously expressly determined in writing that it will not exercise an election under par. (b), the other insurer succeeds to the rights and obligations of the fund under pars. (b) and (c), regardless of whether the fund has exercised an election under par. (b). If the other insurer succeeds to the fund's rights and obligations under pars. (b) and (c):

1. The indemnity reinsurance agreements automatically terminate for new reinsurance, unless the indemnity reinsurer and the other insurer agree to the contrary.

2. On and after the date on which an indemnity reinsurance agreement is transferred to the other insurer, the fund is no longer obligated to pay beneficiaries the amounts specified in par. (c) 2. with respect to that agreement.

(e) This subsection supersedes s. 645.58 (1), any applicable rules of the commissioner, and the provisions of any affected reinsurance agreement that provide for or require payment of reinsurance proceeds to the liquidator of the insolvent insurer on account of losses or events that occur after the coverage date. The liquidator remains entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur before the coverage date, subject to any applicable setoff provisions.

(f) Nothing in this subsection, except as expressly provided in this subsection:

1. Alters or modifies the terms or conditions of the indemnity reinsurance agreements of the insolvent insurer.

2. Abrogates or limits any rights of any reinsurer to rescind a reinsurance agreement.

3. Gives a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

(9) COVERAGE OBLIGATIONS. Notwithstanding sub. (3), in performing its obligations to provide coverage under this section, the fund is not required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of an insolvent insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

(10) BOARD DETERMINATIONS. The board shall have discretion to determine the means by which the fund may economically and efficiently provide benefits under this section. If the board has arranged or offered to provide benefits to a person under a plan or arrangement that fulfills the fund's obligations under this section, the person is not entitled to any benefits from the fund in addition to or other than those provided under the plan or arrangement.

History: 1979 c. 109; 1983 a. 120; 1985 a. 216; 1989 a. 23; 1995 a. 236; 2003 a. 261; 2005 a. 253; 2007 a. 168, 170; 2011 a. 224.

646.41 Tax exemption. The fund is exempt from payment of all fees and taxes levied by this state or any of its subdivisions or instrumentalities, except for fees and taxes levied by virtue of employment under s. 646.12 (2) (d).

History: 1979 c. 109.

646.51 Assessments. (1c) DEFINITIONS. In this section:

(a) "Authorize" means, with respect to assessments, to approve, by the adoption of a resolution by the board, that an assessment from insurers in a specified amount be called immediately or in the future. An assessment is authorized when the resolution is adopted by the board.

(b) "Call" means, with respect to assessments, to require payment, by the mailing of a notice to insurers by the fund, of an authorized assessment within the time set forth in the notice. An assessment is called when notice is mailed to insurers by the fund.

(c) "Premiums" means gross premiums and other considerations received for direct insurance and annuities, including considerations for a plan established under ss. 185.981 to 185.985, less return premiums and other considerations, dividends, and experience credits paid or credited to policyholders on such business. The term "premiums" does not include premiums or other considerations received for policies or contracts, or for portions of policies or contracts, for which coverage is not provided under this chapter, except that the amount of assessable premiums or other considerations shall not be reduced on account of limitations with respect to a single risk, loss, or life under s. 646.31 (4) or on account of interest limitations under s. 646.35 (6) (c).

(1m) DUTY TO ASSESS. To meet the board's obligations under this chapter, after a liquidation order has been issued, the board shall estimate separately for each of the accounts of s. 646.11 (2) and separately for life insurance policies and for annuity contracts in the life insurance and annuities account, the amounts necessary to make the payments provided by this chapter. The board shall authorize assessments separately for each account and separately for life insurance policies and for annuity contracts in the life insurance and annuities account.

(3) CALCULATION. (am) *General.* Except as provided in pars. (ar), (b), (bm), and (c), the board shall calculate the assessments as a percentage of premiums written in this state by each insurer in the classes protected by the accounts under s. 646.11 (2) for the year immediately preceding the year in which the board authorizes the assessment.

(ar) *Disability.* Except as provided in par. (c), with respect to the disability insurance account under s. 646.11 (2) and the health maintenance organization insurers account under s. 646.11 (2), the board shall calculate the assessments as a percentage of premiums written in this state by each insurer in the classes protected by the accounts for the year immediately preceding the year in which the board authorizes the assessment. If the assessment data for the year immediately preceding the year in which the board authorizes the assessment is not available when the assessment is called, the board may use the assessment data for the most recent year for which data is available.

(b) *Life and annuities.* Except as provided in par. (c), with respect to the life insurance and annuities account under s. 646.11 (2), the board shall calculate the assessments separately for life insurance policies and for annuity contracts as a percentage of premiums received in this state by each insurer in the classes protected by the account for the year immediately preceding the year in which the board authorizes the assessment. If the assessment data for the year immediately preceding the year in which the board authorizes the assessment is not available when the assessment is called, the board may use the assessment data for the most recent year for which data is available.

(bm) *Long-term care.* 1. Except as provided in par. (c), with respect to the long-term care insurance account under s. 646.11 (2), the board shall calculate the assessments against life, annuity, and disability premiums written in this state, including disability premiums written by health maintenance organization insurers, as set forth in subds. 2. and 3.

2. a. The board shall calculate the percentage of life insurance, annuity contract, and disability insurance premiums written by each life insurer and by each disability insurer, including health maintenance organization insurers, to which this chapter applies. The calculation shall be based on each insurer's total life insurance, annuity contract, and disability insurance premiums written in this state for the year preceding the year in which the assessment is authorized by the board, provided that the board's calculations under subd. 2. b., c., and d. excludes long-term care and disability income insurance premiums.

b. If the percentage of life insurance and annuity contract premiums written in this state by an insurer exceeds 50 percent of the insurer's total life insurance, annuity contract, and disability insurance premiums written in this state for the year preceding the year in which the assessment is authorized by the board, the insurer shall be classified as a life insurer.

c. If the percentage of disability insurance premiums, including premiums on products issued by health maintenance organization insurers, written in this state by an insurer exceeds 50 percent of the insurer's total life insurance, annuity contract, and disability insurance premiums written in this state for the year preceding the year in which the assessment is authorized by the board, the insurer shall be classified as a disability insurer.

d. If the percentage of life insurance and annuity contract premiums and the percentage of disability insurance premiums written in this state by an insurer each equal 50 percent of the insurer's total life insurance, annuity contract, and disability insurance premiums written in this state for the year preceding the year in which the assessment is authorized by the board, the insurer will be assigned the classification with the lower assessment base as determined under subd. 3.

e. If an insurer issues only disability income products or only long-term care insurance products in this state for the year preceding the year in which the assessment is authorized by the board, the insurer shall be classified as a disability insurer.

3. a. The board shall allocate 50 percent of the total assess-

ment authorized by the board for the long-term care insurance account pursuant to sub. (1m) to life insurers under subd. 2. and the board shall allocate 50 percent of the total assessment authorized by the board for the long-term care insurance account pursuant to sub. (1m) to disability insurers under subd. 2.

b. The board shall calculate the allocations for each insurer under subd. 3. a. as a percentage of the total premiums written in this state by insurers in the classes described under subd. 2. for the year preceding the year in which the assessment is authorized by the board. If the assessment data for the year immediately preceding the year in which the board authorizes the assessment is not available when the assessment is called, the board may use the assessment data for the most recent year for which data is available.

4. Upon an insurer's payment of an assessment imposed under this paragraph, the fund shall require the insurer to elect to claim one of the following:

a. Income and franchise tax credits under s. 71.07 (12), 71.28 (12), or 71.47 (12).

b. Insurer license fee credits under s. 76.634.

NOTE: The cross-reference to s. 76.634 was changed from s. 76.633 by the legislative reference bureau under s. 13.92 (1) (bm) 2. to reflect the renumbering under s. 13.92 (1) (bm) 2. of s. 76.633, as created by 2025 Wis. Act 227.

5. If an insurer elects to claim income and franchise tax credits described in subd. 4. a., no later than 60 days after an assessment imposed under this paragraph is collected from the insurer, the fund shall issue to the insurer a certification of the amount of the assessment that the insurer may claim as eligible for the credit under s. 71.07 (12), 71.28 (12), or 71.47 (12).

6. The fund shall certify the amount of the assessment imposed on an insurer under this paragraph that the insurer may claim as eligible for the credit under s. 71.07 (12), 71.28 (12), 71.47 (12), or 76.634. No later than 60 days after the collection of an assessment imposed on insurers under this paragraph, the fund shall provide to the office and the department of revenue a certification of all of the following:

NOTE: The cross-reference to s. 76.634 was changed from s. 76.633 by the legislative reference bureau under s. 13.92 (1) (bm) 2. to reflect the renumbering under s. 13.92 (1) (bm) 2. of s. 76.633, as created by 2025 Wis. Act 227.

a. The amount of the assessment that each insurer may claim as eligible for the credit under s. 71.07 (12), 71.28 (12), 71.47 (12), or 76.634.

NOTE: The cross-reference to s. 76.634 was changed from s. 76.633 by the legislative reference bureau under s. 13.92 (1) (bm) 2. to reflect the renumbering under s. 13.92 (1) (bm) 2. of s. 76.633, as created by 2025 Wis. Act 227.

b. The election made by each insurer under subd. 4.

(c) *Administrative assessments.* The board may authorize assessments on a prorated or nonprorated basis to meet administrative costs and other expenses whether or not related to the liquidation or rehabilitation of a particular insurer. Nonprorated assessments may not exceed $500 per insurer in any year.

(4) LIMITS. (a) Subject to pars. (b) and (d), the total of all assessments for an amount authorized by the board under this section with respect to an insurer may not, in one calendar year, exceed 2 percent of the insurer's assessable premiums under sub. (3) (am), (ar), (b), or (bm) on the types of policies and contracts that are covered by the account.

(b) If the maximum assessment under par. (a), together with the other assets of the fund in an account, does not provide in one year in the account an amount that is sufficient for the fund to meet its obligations, the board shall assess additional amounts in each succeeding year until the amounts available enable the fund to meet its obligations.

(c) Assessments to meet the obligations of the fund with respect to an insurer in liquidation may not be authorized or called unless the board makes a finding that it is necessary for implementing the purposes of this chapter. Recognizing that exact determinations may not always be possible, the board shall endeavor to classify and calculate assessments with a reasonable degree of accuracy. No authorized assessment may be called if the assets held in the appropriate account of the fund are sufficient to cover all estimated payments for liquidations in progress.

(d) If 2 or more assessments are authorized in one calendar year with respect to insurers placed in liquidation in different calendar years, the average annual premiums for purposes of the limitation in par. (a) shall be equal and limited to the higher of the 3-year annual premium average for the applicable account.

(5) COLLECTION. After the rate of assessment has been fixed, the fund shall send to each insurer a statement of the amount it is to pay. The fund shall designate whether the assessments shall be made payable in one sum or in installments.

(6) APPEAL AND REVIEW. Within 30 days after the fund sends the statement under sub. (5), an insurer, after paying the assessment under protest, may appeal the assessment to the board or a committee thereof. The decision of the board or committee on the appeal is subject to judicial review in the circuit court for Dane County. A petition for judicial review shall be filed within 60 days of the board's or committee's decision.

(7) RECOUPMENT OR TAX CREDIT. (a) An insurer's premium rates are not excessive because they contain an amount reasonably calculated to recoup assessments called under this chapter.

(b) Except as provided in par. (bm), if the premium rates on a class of business are fixed, so that it is not possible for an insurer to recoup its assessments by increasing premium rates on the class of business, the insurer may offset 20 percent of the amount of the Wisconsin portion of the assessment against the tax imposed under s. 71.43, 76.63, 76.65, 76.66, or 76.67 in each of the 5 calendar years following the year in which the assessment was paid.

(bm) 1. An insurer that pays an assessment under sub. (3) (bm) may claim a tax credit under s. 71.07 (12), 71.28 (12), 71.47 (12), or 76.634.

NOTE: The cross-reference to s. 76.634 was changed from s. 76.633 by the legislative reference bureau under s. 13.92 (1) (bm) 2. to reflect the renumbering under s. 13.92 (1) (bm) 2. of s. 76.633, as created by 2025 Wis. Act 227.

2. An insurer that claims a tax credit under s. 71.07 (12), 71.28 (12), or 71.47 (12) for a taxable year may not claim a credit under s. 76.634 for the same taxable year.

NOTE: The cross-reference to s. 76.634 was changed from s. 76.633 by the legislative reference bureau under s. 13.92 (1) (bm) 2. to reflect the renumbering under s. 13.92 (1) (bm) 2. of s. 76.633, as created by 2025 Wis. Act 227.

(c) If an insurer ceases doing business in this state, all assessments not yet offset may be offset against its tax liabilities to this state for the year it ceases doing business. If the offset exceeds the tax liabilities, no refund will be made and there will be no carry-forward of the deficit to later years.

(d) Any amount available for credit against future tax liabilities under this subsection may be regarded as an asset of the insurer under rules promulgated by the commissioner.

(8) ABATEMENT AND DEFERRAL. The board may abate or defer the assessment of an insurer in whole or part if payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. The amount by which an assessment is abated or deferred may be assessed under this section against other insurers. When the conditions that prompted the board to defer assessment of an insurer no longer exist, the insurer shall pay all assessments that were deferred in accordance with a repayment plan approved by the board.

(9) OBLIGATION TO CONTRIBUTE CEASES. (a) Except as provided in par. (b), if an insurer's license or certificate of authority to do business in this state terminates, expires, or is surrendered, the insurer's obligation to pay assessments under this section ceases beginning on the day after the insurer's license or certificate of authority terminates, expires, or is surrendered.

(b) An insurer whose license or certificate of authority to do business in this state terminates, expires, or is surrendered remains liable after the termination, expiration, or surrender to pay all of the following:

1. Assessments authorized or called before the insurer's license or certificate of authority terminated, expired, or was surrendered.

2. Assessments authorized or called after the insurer's license or certificate of authority terminated, expired, or was surrendered that relate to a liquidation order entered before the insurer's license or certificate of authority terminated, expired, or was surrendered.

(10) ASSESSMENT OF CONVERTING INSURERS. When an insurer converts to a different type of entity or license and the effect of the conversion is to subject the insurer to the liabilities of a different account or accounts of the fund, the converting insurer's obligation to pay assessments is as follows:

(a) *Assessments authorized prior to or during the year of conversion.* For assessments authorized by the board prior to or during the year in which the insurer's conversion to a different type of entity or license is effective, the insurer is liable for assessments to cover the obligations of the account or accounts to which it was subject prior to conversion.

(b) *Assessments authorized after the year of conversion.* For assessments authorized by the board after the year in which the insurer's conversion to a different type of entity or license is effective, the insurer is liable for assessments to cover the obligations of the account or accounts to which it is subject after conversion.

History: 1979 c. 109; 1983 a. 120; 1985 a. 216; 1989 a. 23, 31; 1995 a. 396; 1999 a. 30; 2003 a. 261; 2007 a. 170; 2009 a. 342; 2015 a. 90; 2021 a. 114; 2023 a. 212; 2025 a. 227; s. 13.92 (1) (bm) 2.; s. 35.17 correction in (7) (bm) 1.

646.60 Claims by security funds. (1) RECOGNITION. (a) *Settlements by the fund.* The liquidator is bound by determinations and settlements of covered loss claims, and by payments of claims, made by the fund under this chapter.

(b) *Settlements by comparable funds.* The liquidator is bound by determinations and settlements of covered loss claims, and by payments of claims, made by funds or organizations of other states that are comparable to the fund under this chapter if all of the following apply:

1. The laws of the other states give equivalent recognition to the determinations and settlements of loss claims, and to payments of claims, made by the fund.

2. If the same claim is reported as paid by 2 or more funds, payment shall be to the fund with a prior obligation under s. 646.31 (9).

(2) PRIORITIES. The subrogation claims of funds under sub. (1) for settlements of claims, including expenses in settling them, have the priority the claims would have under s. 645.68.

History: 1979 c. 109; 1999 a. 30; 2003 a. 261.

646.61 Disposal and transfer of assets. (1) After termination of all liquidations under any account of s. 646.11 (2), remaining assets in that account shall be redistributed among those who paid assessments under rules promulgated to ensure treatment that is as equitable to the contributing insurers as is practicable. Partial distributions may be made to insurers who were assessed after all claims against the fund arising from such liquidations have been paid.

(2) To meet the needs of the fund the fund may temporarily transfer assets from one account to another.

History: 1979 c. 109; 1983 a. 120; 2003 a. 261.