Chapter Ins 3

CASUALTY INSURANCE

Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

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

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

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

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

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

Ins 4.02 Nonassessable policies of mutual companies.

Ins 4.03 Policy, inspection and similar fees.

Ins 3.08 Advertisements of accident and sickness insurance. (1) PURPOSE (a) The purpose of these rules is to implement and interpret the statutory standards governing the advertisements of accident and sickness insurance. Section 204.31, Wis. Stats., provides that the commissioner of insurance may disapprove a form ". . . if it contains a provision which is unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation of such policy . . ." Section 207.04 (1) (b), Wis. Stats., defines false information and advertising which is untrue, deceptive or misleading as an unfair method of competition and as an unfair and deceptive act or practice in the business of insurance.

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

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

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

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

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

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

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

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

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

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

(4) ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED, OR PREMIUMS PAYABLE. (a) *Deceptive words, phrases or illustrations.*

Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered, or premium payable. An advertisement relating to any policy benefit payable, loss covered, or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.

(b) *Examples of deceptive words and phrases prohibited by paragraph (a).* 1. The words and phrases "all", "full", "complete", "comprehensive", "unlimited", "up to", "as high as", "this policy will pay your hospital and surgical bills", or "this policy will replace your income", or similar words and phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as fairly to describe such benefit.

2. A policy covering only one disease or a list of specified diseases shall not be advertised so as to imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

3. The benefits of a policy which pays varying amounts for the same loss occurring under different conditions or which pay benefits only when a loss occurs under certain conditions shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.

4. Phrases such as "this policy pays $1,800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.

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

(d) *Definitions of terms used in paragraph (c).* 1. The term "exception" shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

2. The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

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

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

(f) *Pre-existing conditions.* 1. An advertisement covered by subsection (4) (c) shall disclose the extent to which any loss is not

covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy.

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

(5) NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELLABILITY AND TERMINATION. An advertisement which refers to renewability, cancellability or termination of a policy, or which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(19) NON-CANCELLABLE AND GUARANTEED RENEWABLE POLICIES. (a) No person, in the presentation, solicitation, effectuation, or sale of a policy, and no advertisement, relating to or used in connection with a policy, shall use the terms "non-cancellable" or "non-cancellable and guaranteed renewable" or "guaranteed renewable", except in connection with polices conforming to Wis. Adm. Code subsection Ins 3.13 (2) (e).

(b) An advertisement describing a non-cancellable or non-cancellable and guaranteed renewable or guaranteed renewable policy form shall be subject to subsection (5).

(c) A printed advertisement describing a non-cancellable or non-cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms "non-cancellable" or "non-cancellable and guaranteed renewable":

1. the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable, if other than lifetime,

2. the age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable.) and

3. that benefit payments are subject to an aggregate limit, if applicable.

(d) A printed advertisement describing a guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

1. the age to or term for which the form is guaranteed renewable, if other than lifetime,

2. the age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable.)

3. that benefit payments are subject to an aggregate limit, if applicable, and

4. that the applicable premium rates may be changed.

(e) The foregoing limitations on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable"; and the foregoing limitations on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

Note: The intent of paragraphs (b), (c), and (d) is, first to emphasize that any advertisement of a non-cancellable or non-cancellable and guaranteed renewable or guaranteed renewable policy form is subject to subsection (5) and, second, to specify how subsection (5) should be complied with in connection with the prominent use of the terms "non-cancellable", "non-cancellable and guaranteed renewable", or "guaranteed renewable" in a printed advertisement of such form.

Subsection (5) is interpreted, with respect to any advertisement of a non-cancellable, or non-cancellable and guaranteed renewable, or guaranteed renewable policy form which refers to renewability, non-cancellability, or non-termination of the form, as requiring the disclosure of all provisions relating to renewal and termination and modification of benefits, losses covered, or premiums because of age or for other reasons, such disclosure to be effected in a manner which shall not minimize or render obscure the qualifying conditions. This interpretation is consistent with the interpretive guide prepared in 1956 by the subcommittee on interpretation of the National Association of Insurance Commissioners' rules governing advertisement of accident and sickness insurance.

"Prominent use" as referred to in paragraphs (c) and (d) is considered to include, but is not necessarily limited to, use in titles, captions, bold-face type or type larger than that used in the text of the advertisement.

The provisions in the original form of the subsection permitting as an alternative the setting out of the required information under appropriate captions of such prominence that such information shall not be minimized or rendered obscure were deleted. The deleted provisions were not consistent with the amended requirements or with subsection (5). Paragraphs (c) and (d) apply only to the prominent use of the terms "non-cancellable", "non-cancellable and guaranteed renewable", and "guaranteed renewable" in

printed advertisements, not to all descriptions of the non-cancellable or guaranteed renewable feature of a policy. Printed advertisements in which the subject terms are prominently used could not reasonably be considered to properly disclose the qualifying conditions if all or a part of such conditions are less prominent than the terms themselves.

(20) SPECIAL ENFORCEMENT PROCEDURES FOR RULES GOVERNING THE ADVERTISEMENT OF ACCIDENT AND SICKNESS INSURANCE. (a) *Advertising file.* Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of individual policies and typical printed, published, or prepared advertisements of blanket, franchise, and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this department. All such advertisements shall be maintained in said file for a period of not less than 3 years.

(b) *Certificate of compliance.* Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this regulation must file with this department together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information, and belief the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws of this state as implemented by this regulation.

History: Cr. Register, October, 1956, No. 10, eff. 11-1-56; (19) is renum. to be (20); cr. (19), Register, June, 1960, No. 54, eff. 7-1-60; am. (19), Register, April, 1964, No. 100, eff. 5-1-64.

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

(2) DEFINITION. Mortgage guaranty insurance is that kind of insurance authorized by section 201.04 (19), Wis. Stats., and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(3) ACCOUNTING AND REPORTING. (a) The financial position of an insurer shall be reported annually on the Fire and Casualty annual statement form specified by Wis. Adm. Code section Ins 7.01 (5) (a).

(b) Expenses shall be recorded and reported in accordance with Wis. Adm. Code sections Ins 6.30 and Ins 6.31.

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

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

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

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

(4) CONTINGENCY RESERVE. (a) The reserve established in paragraph (d) of subsection (3) shall be maintained for 120 months for the purpose of protecting against the effect of adverse economic cycles and to permit mortgage guaranty insurance companies to comply with section 832 (e) of the federal internal revenue code. That portion of the special premium reserve established more than 120 months prior shall be released and shall no longer constitute part of the special reserve and may be used for usual corporate purposes.

(b) Subject to the approval of the commissioner, the reserve shall be available only for loss payments when the incurred losses in any one year exceed 35% of the corresponding earned premiums.

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

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

(e) Whenever the laws of any other state require a greater unearned premium reserve than that set forth in subsection (3) (c), the contingency reserve of mortgage guaranty insurers organized under the laws of that state may be an amount which when added to such unearned premium reserve will result in a reserve equal to the sum of the unearned premium reserve and the contingency reserve required of insurers organized under the laws of Wisconsin.

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

History: Cr. Register, March, 1957, No. 15, eff. 4-1-57; am. (2), (3), (4) and (5), Register, January, 1959, No. 37, eff. 2-1-59; am. (4) (c), Register, August, 1959, No. 44, eff. 9-1-59; cr. (4) (e), Register, January, 1961, No. 61, eff. 2-1-61; am. (2), Register, January, 1967, No. 133, eff. 2-1-67; am. (2), (3) (a) and (b), and (4) (a) and (b); r. and recr. (5), Register, December, 1970, No. 180, eff. 1-1-71.

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

(b) This rule shall apply to multiple peril insurance contracts permitted by section 201.05, Wis. Stats., and which include a type or

types of coverage or a kind or kinds of insurance subject to section 203.32 or sections 204.37 to 204.54, inclusive, Wis. Stats.

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

(2) DEFINITION. Multiple peril insurance contracts are contracts combining two or more types of coverage or kinds of insurance included in any one or more than one subsection of section 201.04, Wis. Stats. Such contracts may be on the divisible or single (indivisible) rate or premium basis.

(3) RATE MAKING. (a) When underwriting experience is not available to support a filing, the information set forth in sections 203.32 (4) (b) and 204.40 (1), Wis. Stats., may be furnished as supporting information.

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

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

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

History: Cr. Register, July, 1958, No. 31, eff. 8-1-58; am. (3) (a), Register, November, 1960, No. 59, eff. 12-1-60.

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

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

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

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

(3) ACCOUNTING. Every initial membership fee, policy fee, or other similar charge for any automobile coverage shall be considered as

additional premium for the first policy term subsequent to the collection or payment thereof: (a) For all annual statement purposes, including all summaries, tabulations, schedules, and exhibits;

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

(c) For tax purposes;

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

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

(4) INSURANCE RATES AND PREMIUM CHARGES. (a) Every initial membership fee, policy fee, or other similar charge for any automobile coverage shall be considered as additional premium for the first policy term subsequent to the collection or payment thereof and: 1. Shall be reasonable, equitable, and consistent with the company's method of operation;

2. Shall not discriminate unfairly between risks or classes;

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

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

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

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

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

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

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

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

(2) POLICY PROVISIONS. (a) If a policy is not to insure against sickness losses resulting from conditions in existence prior to the effective date of coverage, or in existence prior to a specified period after such effective date, the policy by its terms shall indicate that it covers sickness contracted and commencing (or beginning, or origi-

nating, or first manifested or words of similar import) after such effective date or after such specified period. Wording shall not be used that requires the cause of the condition or sickness, as distinguished from the condition or sickness itself, to originate after such effective date or such specified period. (Note: It is understood that "sickness" as used herein means the condition or disease from which the disability or loss results.) Subsection (2) (a) shall not apply to nor prohibit the exclusion from coverage of a disease or physical condition by name or specific description.

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

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

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

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

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

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

(e) 1. The terms "non-cancellable" or "non-cancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy a. until at least age 50, or b. in the case of a policy issued after age 44, for at least 5 years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

2. A non-cancellable or non-cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms "non-cancellable" or "non-cancellable and guaranteed renewable":

a. the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable, if other than lifetime,

b. the age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable.) and

c. that benefit payments are subject to an aggregate limit, if applicable.

3. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums a. until at least age 50, or b. in the case of a policy issued after age 44, for at least 5 years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

4. A guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

a. the age to or term for which the form is guaranteed renewable, if other than lifetime,

b. the age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for whch the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable.)

c. that benefit payments are subject to an aggregate limit, if applicable, and

d. that the applicable premium rates may be changed.

Note: "Prominent use" as referred to in subparagraphs 2. and 4. is considered to include, but is not necessarily limited to, use in titles, brief descriptions, captions, bold-face type, or type larger than that used in the text of the form.

5. The foregoing limitation on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable" and the limitation on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

6. Nothing herein contained is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or non-cancellable for any period during which they may actually be such, provided the terms used to describe them in policy contracts and advertising are not such as may readily be confused with the above terms.

7. The provisions of subsections 204.31 (3) (a) 2. am. and 4. b. and (3) (b) 6. b. are applicable to non-cancellable or non-cancellable and guaranteed renewable or guaranteed renewable policy forms as herein defined.

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

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

(h) A limited policy is one that contains unusual exclusions, limitations, reductions, or conditions of such a restrictive nature that the payments of benefits under such policy are limited in frequency or in amounts. All limited policies shall be so identified by having the words "THIS IS A LIMITED POLICY—READ IT CAREFULLY" imprinted or stamped diagonally across the face of the policy and the filing back, if any, in contrasting color from the text of the policy and in outline type not smaller than 18-point. When appropriate, these words may be varied by the insurer in a manner to indicate the type of policy; as for example, "THIS POLICY IS LIMITED TO AUTOMOBILE ACCIDENTS—READ IT CAREFULLY". Without limiting the general definition above, policies of the following types shall be defined as "limited": 1. School Accident, 2. Aviation Accident, 3. Polio, 4. Specified Disease, 5. Automobile Accident.

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

(j) The provision or notice regarding the right to return the policy required by section 204.31 (2) (a) 8, Wis. Stats., shall:

1. be printed on or attached to the first page of the policy,

2. have a caption or title which refers at least to the right to examine or to return the policy such as: "Right to Return Policy Within 10 Days of Receipt", "Notice: Right to Return Policy", "Right of Policy Examination", "Right to Examine Policy", "Right to Examine Policy for 10 Days", "10 Day Right to Examine Policy", "10 Day Right to Return Policy", or "Notice of 10 Day Right to Return Policy", or other wording, subject to approval by the commis-

sioner, which is believed to be equally clear or more definite as to subject matter, and

3. provide an unrestricted right to return the policy, within 10 days from the date it is received by the policyholder, to the insurer at its home or branch office, if any, or to the agent through whom it was purchased. Provision shall not be made to require the policyholder to set out in writing the reasons for returning the policy, to require the policyholder to first consult with an agent of the insurer regarding the policy, or to limit the reasons for return.

Note: Paragraph (j) was adopted to assist in the application of section 204.31 (2) (a) 8, Wis. Stats., to the review of accident and sickness policy and other contract forms. The statute requires that the provision or notice regarding the right to return the policy must be appropriately captioned or titled. Since the important rights given the insured are to examine the policy and to return the policy, the rule requires that the caption or title must refer to at least one of these rights—examine or return. Without such reference, the caption or title is not considered appropriate.

The statute permits the insured to return his policy for refund to the home office or branch office of the insurer or to the agent through whom it was purchased. In order to assure that refund is made promptly, some insurers prefer to instruct the insured to return his policy to a particular office or agent for refund. Notices or provisions with such requirements will be approved on the basis that the insurer must recognize an insured's right to receive a full refund if he returns his policy to any other office or agent mentioned in the statute.

Also, the statute permits the insured to return his policy for refund within 10 days from the date he receives it. Some insurers' notices or provisions regarding such right, however, refer to delivery to the insured instead of receipt by the insured or do not specifically provide for the running of the 10 days from the date the insured receives the policy. Notices or provisions containing such wording will be approved on the basis that the insurer will not refuse a refund if the insured returns his policy within 10 days from the date he receives it.

(k) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

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

(b) If the rider reduces or eliminates coverage of the policy, signed acceptance of the rider by the insured is necessary. However, signed acceptance of the rider is not necessary when the rider is attached at the time of the original issuance of the policy if notice of the attachment of the rider is affixed on the face and filing back, if any, in contrasting color, in not less than 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Rider Attached"
"Notice! See Exclusion Rider Attached"
"Notice! See Exception Rider Attached"
"Notice! See Limitation Rider Attached"
"Notice! See Reduction Rider Attached"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(c) An endorsement differs from a rider only in that it is applied to a policy by means of printing or stamping on the body of the policy. All endorsements shall comply with the requirements of subsection 204.31 (2) (a) 4, Wis. Stats.

(d) If the endorsement reduces or eliminates coverage of the policy, signed acceptance of the endorsement by the insured is necessary. However, signed acceptance of the endorsement is not necessary when the endorsement is affixed at the time of the original issuance of the policy if notice of the endorsement is affixed on the face and filing back, if any, in contrasting color, in not less than 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Endorsement Included Herein"
"Notice! See Exclusion Endorsement Included Herein"
"Notice! See Exception Endorsement Included Herein"
"Notice! See Limitation Endorsement Included Herein"
"Notice! See Reduction Endorsement Included Herein"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

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

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

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

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

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

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

1. The identifying form number and title, if any, of the form.

2. A general description of the form.

3. In case of a rider or endorsement, the form numbers, identifying symbols or types of policies with which the rider or endorsement will be used.

4. The form number and date of department approval of any form superseded by the filing.

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

1. Policy forms.

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

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

1. The form number or identification symbol of each policy, rider or endorsement to which the rates apply.

2. A schedule of rates including policy fees or rate changes at renewal, if any, and variations, if any, based upon age, sex, occupation, or other classification.

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

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

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

History: Cr. Register, March, 1958, No. 27; subsections (1), (5), (6) eff. 4–1–58; subsections (2), (3), (4) eff. 5–15–58; am. (2) (c) and cr. (4) (c), Register, March, 1959, No. 39, eff. 4–1–59; am. (2) (e), (6) (b) 3 and 4, Register, November, 1959, No. 47, eff. 12–1–59; am. and renum. (2) (c), (d), (e), (f), (g) and (h); am. (3) and (6) (b) 5, Register, June, 1960, No. 54, eff. 7–1–60; am. (2) (e) 4, Register, November, 1960, No. 59, eff. 12–1–60; r. (2) (j), Register, April, 1963, No. 88, eff. 5–1–63; cr. (2) (j), Register, March, 1964, No. 99, eff. 4–1–64; am. (2) (e) 2 and 4, Register, April, 1964, No. 100, eff. 5–1–64; am. (2) (j) 2.; am. NOTE in (2) (j) 3; Register, March, 1969, No. 159, eff. 4–1–69; cr. (2) (k), Register, June, 1971, No. 186, eff. 7–1–71.

Ins 3.14 Group accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of group accident and sickness policies permitted by subsection 204.321 (1), Wis. Stats.

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

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

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

1. The identifying form number and title, if any, of the form.

2. A general description of the form.

3. In case of a certificate, rider or endorsement, the form numbers, identifying symbols or types of policies with which the certificate, rider or endorsement will be used.

4. The form number and date of department approval of any form superseded by the filing.

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of subsection 204.321 (3) (e), Wis. Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

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

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

(5) COVERAGE REQUIREMENTS. (a) Policies issued in accordance with section 204.321, Wis. Stats., shall offer to insure all eligible members of the group or association except any as to whom evidence of insurability is not satisfactory to the insurer. Cancellation of coverage of individual members of the group or association who have not withdrawn participation nor received maximum benefits is not permitted, except that the insurer may terminate or refuse renewal of an individual member who attains a specified age, retires or who ceases to actively engage in the duties of his profession or occupation on a full-time basis or ceases to be an active member of the association or labor union or an employe of the employer, or otherwise ceases to be an eligible member.

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

(c) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(6) ELIGIBLE GROUPS. In accordance with subsection 204.321 (1) (f), Wis. Stats.:

(a) the members of the board of directors of a corporation are eligible to be covered under a group accident and sickness policy issued to such corporation,

(b) the individual members of member organizations of an association, as defined in subsection 204.321 (1) (b), Wis. Stats., are eligible to be covered under a group accident and sickness policy issued to such association insuring employes of such association and employes of member organizations of such association, and

(c) the individuals supplying raw materials to a single processing plant and the employes of such processing plant are eligible to be

covered under a group accident and sickness policy issued to such processing plant.

History: Cr. Register, March, 1958, No. 27; subsections (1), (2), (3), eff. 4–1–58; subsections (4), (5), eff. 5–15–58; renum. (5) to be (5) (a); cr. (5) (b), Register, November, 1959, No. 47, eff. 12–1–59; am. (1) (3), (5) (a) and cr. (6), Register, October, 1961, No. 70, eff. 11–1–61; am. (6), Register, February, 1962, No. 74, eff. 3–1–62; cr. (5) (c), Register, June, 1971, No. 186, eff. 7–1–71.

Ins 3.15 **Blanket accident and sickness insurance.** (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of blanket accident and sickness policies permitted by subsection 204.322 (1), Wis. Stats.

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

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

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

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

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of subsection 204.322 (5) (e), Wis. Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) ELIGIBLE RISKS. (a) In accordance with the provisions of section 204.322 (1) (f), Wis. Stats., the following are eligible for blanket accident and health insurance: 1. Volunteer fire departments, 2. National guard units, 3. Newspaper delivery boys, 4. Dependents of students, 5. Volunteer civil defense organizations, 6. Volunteer auxiliary police organizations, 7. Law enforcement agencies, 8. Cooperatives organized under chapter 185, Wis. Stats., on a membership basis without capital stock, 9. Registered guests in a motel, hotel, or resort, 10. Members or members and advisors of fraternal organizations including women's auxiliaries of such organizations and fraternal youth organizations, 11. Associations of sports officials, 12. Purchasers of protective athletic equipment, 13. Migrant workers, 14.

Participants in racing meets, 15. Patrons or guests of a recreational facility or resort.

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

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

(b) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

History: Cr. Register, March, 1958, No. 27, eff. 4-1-58; am. (4) (a), cr. (5), Register, November, 1959, No. 47, eff. 12-1-59; am. (1), (3) and (4) (a), Register, October, 1961, No. 70, eff. 11-1-61; am. (4) (a), Register, April, 1963, No. 88, eff. 5-1-63; am. (4) (a), Register, June, 1963, No. 90, eff. 7-1-63; am. (4) (a), Register, October, 1963, No. 94, eff. 11-1-63; am. (4) (a), Register, August, 1964, No. 104, eff. 9-1-64; am. (4) (a), Register, August, 1968, No. 152, eff. 9-1-68; am. (4) (a), Register, March, 1969, No. 159, eff. 4-1-69; am. (4) (a), Register, August, 1970, No. 176, eff. 9-1-70; am. (4) (a), renum. (5) to be (5) (a), and cr. (b), Register, June, 1971, No. 186, eff. 7-1-71.

Ins. 3.16 History: Cr. Register, December, 1958, No. 36, eff. 1-1-59; am. (5) (b), Register, March, 1959, No. 39, eff. 4-1-59; am. (2) (c), Register, May, 1959, No. 41, eff. 6-1-59; am. (2) (b) 3 and 8; (2) (c) and (d); (5) (c); (6) and (7) (b), Register, October, 1961, No. 70, eff. 11-1-61; am. (3) and (4), Register, August, 1962, No. 80, eff. 9-1-62; r. Register, August, 1972, No. 200, eff. 9-1-72.

Ins 3.17 Reserves for accident and sickness policies. (1) PURPOSE. This rule establishes minimum standards for insurance company active life reserves and claim liability reserves as authorized by section 201.18 (4), Wis. Stats., and for fraternal benefit society reserves as authorized by section 208.28 (3), Wis. Stats.

(2) SCOPE. This rule shall apply to the kinds of insurance authorized by section 201.04 (4), Wis. Stats., and shall also apply to fraternal benefit contracts subject to section 208.162, Wis. Stats.

(3) ACTIVE LIFE RESERVES, INDIVIDUAL AND FRANCHISE POLICIES. Active life reserves are required for all in force policies issued subject to section 204.31, section 204.32, or section 208.162, Wis. Stats.

(a) For purposes of this rule, individual policies will be classified as follows:

1. Policies which are non-cancellable or non-cancellable and guaranteed renewable for life or to a specified age.

2. Policies which are guaranteed renewable for life or to a specified age.

3. Policies, other than those in subparagraph 5 of this paragraph, in which the insurer has reserved the right to cancel or refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

4. Franchise policies, as defined in section 204.32 (1), Wis. Stats., issued under or subject to an agreement that, except for stated reasons, the insurer will not cancel or refuse to renew the coverage of

individual insureds prior to a specified age unless all coverage under the same franchise group is terminated and which are based on the level premium principle.

5. All other franchise policies as defined in section 204.32 (1), Wis. Stats.

6. Commercial policies and other policies not falling within subparagraphs 1 to 5, inclusive, of this paragraph.

(b) During the period within which the renewability of the policy is guaranteed or the insurer's right to refuse renewal is limited, the minimum reserves for policies described in subparagraphs 1, 2, 3, and 4 of paragraph (a) of this subsection shall be an amount computed on the basis of two-year preliminary term tabular mean reserves employing the following assumptions:

1. Mortality (Policies issued January 1, 1955 to December 31, 1967): American Men Ultimate Mortality Table or Commissioners 1941 Standard Ordinary Mortality Table or Commissioners 1958 Standard Ordinary Mortality Table. (See Table I at the end of this rule.)

2. Mortality (Policies issued after December 31, 1967): Commissioners 1958 Standard Ordinary Mortality Table. (See Table I at the end of this rule.)

3. Maximum Interest Rate: 3½% compounded annually.

4. Morbidity or Other Contingency:

a. Disability due to accident and sickness (Policies issued January 1, 1955 to December 31, 1967): The Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance adopted by the National Association of Insurance Commissioners on June 11, 1941. Pamphlet reprints of this table are on file in the offices of the commissioner of insurance, secretary of state, and revisor of statutes. Pamphlet reprints of said Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance are obtainable from the Health Insurance Association of America, 332 South Michigan Avenue, Chicago, Illinois 60604.

b. Disability due to accident and sickness (Policies issued after December 31, 1967): The 1964 Commissioners Disability Table adopted by the National Association of Insurance Commissioners on December 3, 1964. Copies of this table are on file in the offices of the commissioner of insurance, secretary of state, and revisor of statutes. Reprints of the 1964 Commissioners Disability Table and monetary values based on the table are available from the Health Insurance Association of America, 332 South Michigan Avenue, Chicago, Illinois 60604.

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

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

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

(c) Mean reserves shall be diminished or offset by appropriate credit for the valuation net deferred premiums. In no event, however, shall the aggregate reserves for all policies issued on or after January

1, 1955, and valued on the mean reserve basis diminished by any credit for deferred premiums, be less than the gross pro rata unearned premiums under such policies.

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

(e) The minimum active life reserves for policies described in subparagraphs 5 and 6 of subsection (3) (a) of this rule shall be the pro rata gross unearned premium reserve as defined in section 201.18 (1), Wis. Stats.

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

1. The use of mid-terminal reserves in addition to either gross or net pro rata unearned premium reserves;

2. Optional use of either the level premium, the one-year preliminary term, or the two-year preliminary term method;

3. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

4. The use of approximations such as those involving age groupings, groupings of several years of issue, or average amounts of indemnity;

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

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

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

1. The mean reserve with offsetting asset items for net unpaid and deferred premiums; or

2. The excess of the mean reserve over the amount of net unpaid and deferred premiums; or

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

(h) Each insurer issuing policies described by subparagraph 2 of paragraph (a) of this subsection shall maintain historical fund accounts for each group of similar policy forms on a basis reflecting reasonable estimates of premiums, losses, expenses, and reserves. Such estimates shall not be inconsistent with the corresponding items in the Accident and Health Exhibit, Schedule H, of the Annual Statement—Life and Accident and Health Companies, Insurance Department Form 22-41—or with the corresponding items of the Under-

writing and Investment Exhibit of the Annual Statement—Fire and Casualty Insurance Companies, Insurance Department Form 22–11. (Wis. Adm. Code section Ins 7.01 (5) (a) and (c).)

(4) ACTIVE LIFE RESERVES, GROUP AND BLANKET POLICIES. Active life reserves are required for all in force policies issued subject to section 204.321 or section 204.322, Wis. Stats.

(a) The minimum active life reserve for such policies shall be the pro rata gross unearned premium reserve as defined in section 201.18 (1), Wis. Stats.

(b) An additional active life reserve shall be established for converted policies which may be issued under a conversion option for terminated employees. The minimum reserve shall be the excess of the morbidity costs for such policies over morbidity costs assumed in the premiums to be payable by or on behalf of terminated employees.

(5) CLAIM LIABILITY RESERVES, INDIVIDUAL AND FRANCHISE. Claim liability reserves to represent the value of amounts not yet due on claims are required for all policies issued subject to section 204.31, section 204.32, or section 208.162, Wis. Stats.

(a) The minimum reserve for claim liabilities shall be computed employing the following assumptions:

1. Maximum Interest Rate: 3½% compounded annually.

2. Morbidity or Other Contingency:

a. Disability due to accident and sickness: The 1964 Commissioners Disability Table (see subsection (3) (b) 4.b. of this rule), except that for unreported claims and resisted claims and claims with a duration of disablement of less than 2 years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years, along lines of Schedule O, Life and Accident and Health Annual Statement, Insurance Department Form 22–41. (Wis. Adm. Code section Ins 7.01 (5) (c).)

b. All other benefits: The reserve shall be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years.

(b) Insurers may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim liability reserves.

(c) For policies with an elimination period, the duration of disablement should be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

(d) A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within 6 months of the new disability should be considered a continuation of the previous disability.

(6) CLAIM LIABILITY RESERVES, GROUP AND BLANKET POLICIES. Claim liability reserves to represent the value of amounts not yet due on claims are required for all policies issued subject to section 204.321 or section 204.322, Wis. Stats.

(a) The minimum reserve for claim liabilities shall be computed employing the following assumptions:

1. Maximum Interest Rate: 3½% compounded annually.

2. Morbidity or Other Contingency:

a. Disability due to accident and sickness: The 1964 Commissioners Disability Table (see subsection (3) (b) 4.b. of this rule), except that for unreported claims and resisted claims and claims with a duration of disablement of less than 2 years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years, along lines of Schedule O, Life and Accident and Health Annual Statement, Insurance Department Form 22–41. (Wis. Adm. Code section Ins 7.01 (5) (c).)

b. All other benefits: The reserve shall be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years.

(b) Insurers may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim liability reserves.

(c) For policies with an elimination period, the duration of disablement should be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

(d) A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within 6 months of the new disability should be considered a continuation of the previous disability.

(7) REVALUATION OF EXISTING ACTIVE LIFE RESERVES AND CLAIM LIABILITY RESERVES. An insurer may elect to establish and maintain active life reserves or claim liability reserves for policies issued prior to January 1, 1968 in accordance with the standards prescribed herein for policies issued after December 31, 1967. In making such election, an insurer may elect to revalue all previous issues or, at its option, may revalue only certain blocks of issues as determined by issue date or plan of coverage. Claim reserves may be revalued independent of active life reserves. Such election shall be made by filing written notice with the commissioner, stating the effective date of the election and identifying the active life reserves or claim liability reserves or issues of policies to be revalued.

(Note: Comment and Explanation)

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

Level Premium Principle. Policies written on the "level premium principle" are those where the premium has been designed to be level—or the same—for either the life of the insured or to the termination age in the policy such as age 60 or 65.

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

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

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

Accidental Death Benefits. Any recognized table of accidental death rates, such as the 1959 Accidental Death Benefits Table, *Transactions of the Society of Actuaries*, Vol. XI, p. 754, may be used for establishing reserves for an accidental death benefit.

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

Major Medical Expense Benefits. As a basis for the valuation of major medical expense benefits pending the accumulation and analysis of inter-company experience data, reference may be made to the material presented by Mr. Morton D. Miller, *Transactions*

of the Society of Actuaries, Vol. VII, p. 1, and by Mr. Charles N. Walker, *Transactions of the Society of Actuaries*, Vol. VII, p. 404.

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

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

TABLE I

YEARLY DEATH RATE PER 1000 ($1000q_x$)

AMERICAN MEN ULTIMATE MORTALITY TABLE (AM(5))

COMMISSIONERS 1941 STANDARD ORDINARY MORTALITY TABLE (1941 CSO)

COMMISSIONERS 1958 STANDARD ORDINARY MORTALITY TABLE (1958 CSO)

Age	$1000q_x$			Age	$1000q_x$		
	AM(5)	1941 CSO	1958 CSO		AM(5)	1941 CSO	1958 CSO
0	112.46*	22.58	7.08	52	13.62	14.30	9.96
1	26.39	5.77	1.76	53	14.78	15.43	10.89
2	11.87	4.14	1.52	54	16.08	16.65	11.90
3	7.09	3.38	1.46	55	17.47	17.98	13.00
4	4.91	2.99	1.40	56	19.02	19.43	14.21
5	3.94	2.76	1.35	57	20.69	21.00	15.54
6	3.38	2.61	1.30	58	22.51	22.71	17.00
7	3.05	2.47	1.26	59	24.49	24.57	18.59
8	2.93	2.31	1.23	60	26.68	26.59	20.34
9	2.96	2.12	1.21	61	29.03	28.78	22.24
10	3.07	1.97	1.21	62	31.58	31.18	24.31
11	3.17	1.91	1.23	63	34.37	33.76	26.57
12	3.26	1.92	1.26	64	37.38	36.58	29.04
13	3.32	1.98	1.32	65	40.66	39.64	31.75
14	3.39	2.07	1.39	66	44.18	42.96	34.74
15	3.46	2.15	1.46	67	48.03	46.56	38.04
16	3.53	2.19	1.54	68	52.16	50.46	41.68
17	3.63	2.25	1.62	69	56.64	54.70	45.61
18	3.71	2.30	1.69	70	61.47	59.30	49.79
19	3.81	2.37	1.74	71	66.70	64.27	54.15
20	3.92	2.43	1.79	72	72.33	69.66	58.65
21	4.02	2.51	1.83	73	78.39	75.50	63.26
22	4.12	2.59	1.86	74	84.92	81.81	68.12
23	4.18	2.68	1.89	75	91.94	88.64	73.37
24	4.25	2.77	1.91	76	99.51	96.02	79.18
25	4.31	2.88	1.93	77	107.65	103.99	85.70
26	4.35	2.99	1.96	78	116.31	112.59	93.06
27	4.39	3.11	1.99	79	125.69	121.86	101.19
28	4.41	3.25	2.03	80	135.74	131.85	109.98
29	4.43	3.40	2.08	81	146.42	142.60	119.35
30	4.46	3.56	2.13	82	157.87	154.16	129.17
31	4.48	3.73	2.19	83	170.05	166.57	139.38
32	4.51	3.92	2.25	84	183.15	179.88	150.01
33	4.59	4.12	2.32	85	197.07	194.13	161.14
34	4.68	4.35	2.40	86	211.80	209.37	172.82
35	4.78	4.59	2.51	87	227.29	225.63	185.13
36	4.94	4.86	2.64	88	244.08	243.00	198.25
37	5.12	5.15	2.80	89	261.70	261.44	212.46
38	5.32	5.46	3.01	90	280.35	280.99	228.14
39	5.56	5.81	3.25	91	299.46	301.73	245.77
40	5.84	6.18	3.53	92	321.08	323.64	265.93
41	6.16	6.59	3.84	93	341.88	346.66	289.30
42	6.54	7.03	4.17	94	363.64	371.00	316.66
43	6.94	7.51	4.53	95	387.76	396.21	351.24
44	7.42	8.04	4.92	96	411.11	447.19	400.56
45	7.94	8.61	5.35	97	443.40	548.26	488.42
46	8.52	9.23	5.83	98	457.63	724.67	668.15
47	9.18	9.91	6.36	99	500.00	1000.00	1000.00
48	9.89	10.64	6.95	100	562.50		
49	10.70	11.45	7.60	101	571.43		
50	11.58	12.32	8.32	102	666.67		
51	12.54	13.27	9.11	103	1000.00		

*Bowerman's Extension.

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

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

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

TABLE III

1956 INTER-COMPANY HOSPITAL TABLE

NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES

MISCELLANEOUS HOSPITAL EXPENSE BENEFIT

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

TABLE III—Continued

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

TABLE IV

1956 INTER-COMPANY SURGICAL TABLE

NET ANNUAL CLAIM COSTS FOR USE IN COMPUTING RESERVES

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

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

TABLE V

1956 INTER-COMPANY SURGICAL TABLE

EVALUATION SCHEDULE FOR SURGICAL BENEFITS PER $100 SCHEDULE

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

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

History: Cr. Register, April, 1959, No. 40, eff. 5–1–59; am. (2) (a) and (b), Register, June, 1960, No. 54, eff. 7–1–60; am. (3) (a) and Table 1, Register, October, 1960, No. 58, eff. 11–1–60; r. and recr., Register, January, 1967, No. 133, eff. 2–1–67.

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

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

Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor. (1) This rule implements and interprets sections 204.321 (1) (d) and 206.60 (2), Wis. Stats., with regard to issuance of a group policy of accident and sickness insurance issued to a creditor to insure debtors of a creditor.

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

(3) A group accident and sickness policy which insures only debtors whose indebtedness to a creditor is for a term in excess of 48 months is not subject to the requirements of Wis. Adm. Code section Ins 3.16 or of sections 201.04 (4a) and 204.321 (4).

History: Cr. Register, November, 1959, No. 47, eff. 12–1–59; am. Register, September, 1963, No. 93, eff. 10–1–63.

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

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

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

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

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

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

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

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

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

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

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

(6) POLICY FORMS. The purchaser must be furnished with a complete policy form clearly setting forth the nature and extent of all coverages and premiums charged therefor.

(7) RATING STATEMENT. No policy written on the basis of a substandard risk rate schedule shall be issued unless it contains a statement printed in bold-faced type, preferably in a contrasting color, reading substantially as follows: This policy has been rated in accordance with a special rating schedule filed with the commissioner of insurance providing for higher premium charges than those generally applicable for average risks. If the coverage or premium is not satisfactory, you may secure your own insurance.

History: Cr. Register, March, 1960, No. 51, eff. 4–1–60.

Ins 3.21 "In the same industry", definition of. (1) The phrase "in the same industry", as used in section 204.321 (1) (c), Wis. Stats., may be construed so that establishments engaged in one of the following activities may be considered as being in the same industry: (a) retail trade, (b) wholesale trade, (c) service, (d) mining, (e) contract construction, (f) finance, insurance and real estate, and (g) transportation, communication and other public utilities.

(2) The principal activity of an establishment shall control its classification.

(3) An insurer may submit other classifications of establishments, subject to the approval of the commissioner, which it believes may properly be considered as engaging in activities which are "in the same industry".

Note: The above rule is an outgrowth of the hearings held by the department on December 17, 1963, to consider the formulation of rules and guide lines which insurance companies could use to determine what groupings of employers might be permitted by the phrase "in the same industry" in sections 204.321 (1) (c) and 206.60 (4), Wis. Stats., to obtain group insurance coverage for their employees through the establishment of a trust. As a result of the hearing, the department has reviewed the background and history of the "in the same industry" provision which was adopted as a part of the "Group Life Insurance Definition" and "Group Life Insurance Standard Provisions", revised at New York on December 15, 1948, by the National Association of Insurance Commissioners and enacted as a part of the Wisconsin Statutes in 1949. The Department has concluded that the phrase "in the same industry" should be liberally construed. It provides a means whereby a small employer, not having a sufficient number of employees to qualify for a group plan of his own, may join with others and provide the benefits of group insurance to his employees and thereby compete in the labor market with the large employer. It has been emphasized to the department that the statutes involved are insurance statutes and that there is no underwriting reason which dictates greater detail or narrower classifications under the law. To require a more detailed breakdown only has the effect of adding to the administrative detail and expense of setting up such a plan, and such does not appear to be required nor in the public interest.

The rule applies only to organizations engaged in activities other than manufacturing. Companies underwriting multiple employer trusts for employees engaged in manufacturing shall be guided by the opinions of the attorney general of the state of Wisconsin, dated January 16, 1958, and December 30, 1958 (47 OAG 16 and 47 OAG 326).

For a general guide as to the types of organizations which fall within each of the groupings listed in subsection (1) of this rule, the department suggests that insurers refer to the division headings found in the "Standard Industrial Classification Manual" prepared by the United States Bureau of the Budget, Technical Committee on Industrial Classification, Office of Statistical Standards, 1957, and to other similar material such as the industrial classification starting on page XI of the "U.S. Census of Population 1960—Classified Index of Occupations and Industries," published by the United States Department of Commerce, Bureau of the Census, 1960; and Volume V, No. 1, "Wisconsin Commerce Reports," Bureau of Business Research and Service, Madison, Wisconsin, April 1, 1957.

History: Cr. Register, February, 1964, No. 98, eff. 3–1–64.

Ins 3.22 Bail bond insurance. (1) PURPOSE. This rule is intended to implement and interpret applicable statutes including but not limited to sections 201.04 (7), 204.01 to 204.14, Wis. Stats., inclusive, and 209.04, Wis. Stats., for the purpose of establishing minimum requirements for the transaction of bail bond insurance.

(2) DEFINITIONS. (a) *Commissioner* means the commissioner of insurance.

(b) *Insurer* means any domestic, foreign, or alien insurance company which has qualified to transact fidelity business under subsection 201.04 (7), Wis. Stats.

(c) *Bail bondsman* means an individual who shall be appointed by an insurer by power of attorney as its licensed agent under section 209.04, Wis. Stats., to execute or countersign bail bonds in connection with judicial proceedings and who receives or is promised money or other things of value therefor.

(4) POWER OF ATTORNEY. Every insurer engaged in the writing of bail bonds shall submit to and have approved by the commissioner a sample power of attorney which shall be the only form of power of attorney the insurer shall issue in this state.

(5) BAIL BOND RATES. (a) Bail bond rates and premiums are subject to the provisions of sections 204.37 to 204.54, Wis. Stats. It is unlawful for any bail bondsman to execute a bail bond without charging the filed rate and premium therefor. No bail bondsman shall make any charge or collect or receive any fee, service fee, or considration other than the premium based on rates and premiums as approved by the commissioner. Nothing in this rule shall prohibit collateral security or coindemnity agreements.

(b) The premium shall be a term charge for the term of the bond. No additional premium shall be charged in the event of a bind over except that if the amount of the bond has been increased a premium based on the approved rate for the amount of the increase may be charged.

(c) If the penal sum of the bond is reduced within 7 days after time of commitment by the original committing jurisdiction, the defendant shall be entitled to a refund of the premium in proportion to the amount of the reduction except that the minimum premium shall not be affected.

(d) The original premium charged and any additional or return premium required hereunder shall be shown or endorsed on the bond.

(6) ISSUANCE OF BAIL BONDS. No person shall execute or countersign bail bonds for a fee, or act in the capacity of a bail bondsman, or perform any of the functions, duties or powers prescribed for bail bondsmen, or collect any premium or fee under the provisions of this rule unless he is licensed as a bail bondsman under section 209.04, Wis. Stats.

History: Cr. Register, April, 1964, No. 100, eff. 6-1-64; r. (3), Register, December, 1967, No. 144, eff. 1-1-68.

Ins 3.23 Franchise accident and sickness insurance. (1) FRANCHISE GROUP HEADQUARTERS. A franchise group described in section 204.32 (1), Wis. Stats., need not have its headquarters or other executive offices domiciled in Wisconsin.

(2) ACCOUNTING. All premiums paid in connection with franchise accident and sickness insurance on Wisconsin residents shall be reported for annual statement purposes as Wisconsin business and shall be subject to the applicable Wisconsin premium tax.

History: Cr Register, May, 1964, No. 101, eff. 6-1-64.

Ins 3.25 Credit life insurance and credit accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to assist in the maintenance of a fair and equitable credit insurance market and to protect the interest of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life insurance and credit accident and sickness insurance. This rule interprets and implements, including but not limited to the following Wisconsin statutes: sections 201.18, 204.31 (3) (g), 204.321 (4), 206.17, 206.20, 206.201, 206.60 (2), 206.63, 601.01 (3) (b) and (c), 601.42, 625.11, 625.12 and 625.34.

(2) SCOPE. (a) This rule shall apply to the transaction of credit life insurance defined in section 201.04 (3c) and 206.63, Wis. Stats., and to the transaction of credit accident and sickness insurance as defined in section 201.04 (4a), Wis. Stats.

(b) This rule shall be the basis for review of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates pertaining thereto submitted for filing after the effective date of this rule.

(3) FORMS OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE. Credit life insurance and credit accident and sickness insurance shall be issued only in the following forms:

(a) Individual policies of life insurance issued to debtors on the nonrenewable, nonconvertible term plan;

(b) Individual policies of accident and sickness insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

(d) Group policies of accident and sickness insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

(4) AMOUNT OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE. (a) The amount of credit life insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable in instalments to the creditor, or $10,000, whichever is less. Where the indebtedness is repayable in one sum to the creditor, the insurance on the life of any debtor shall in no instance be in effect for a period in excess of 18 months except that such insurance may be continued for an additional period not exceeding 6 months in the case of default, extension or recasting of the loan. The amount of the insurance on the life of any debtor shall at no time exceed the amount of the unpaid indebtedness, or $10,000, whichever is less.

(b) The total amount of periodic indemnity payable by credit accident and sickness insurance in the event of disability, as defined in

the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic instalments.

(5) TERM OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE. The term of any credit life insurance or credit accident and sickness insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In any renewal or refinancing of the indebtedness the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, but this does not apply to an amount of indebtedness, exclusive of refinancing charges, in excess of the original indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in subsection (8).

(6) PROVISIONS OF POLICIES AND CERTIFICATES OF INSURANCE; DISCLOSURE TO DEBTORS. (a) All credit life insurance and credit accident and sickness insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance, and/or credit accident and sickness insurance shall, in addition to other requirements of law set forth;

1. The name and home office address of the insurer,

2. The name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor,

3. The premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and sickness insurance,

4. A description of the coverage including the amount and term thereof, and any exceptions, limitations and restrictions,

5. A provision that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the

amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate, and

6. A provision that the insurance on any debtor will be cancelled and refund made if his indebtedness is terminated through prepayment or otherwise.

(c) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.

(d) If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance shall;

1. be delivered to the debtor at the time such indebtedness is incurred,

2. be signed by the debtor,

3. set forth the name and home office address of the insurer,

4. set forth the name or names of the debtor,

5. set forth the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and sickness insurance, and

6. set forth the amount, term and a brief description of the coverage provided.

The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificates of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in subsection (5).

(e) If the named insurer does not accept the risk, then and in such event the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer, if any, and the information required by subsection (6) (b), and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made.

(f) If a contract of insurance provides for a limitation of the amount of coverage related to insurance provided by other contracts in force on the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing by him in an instrument separate from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the limitation of amount of coverage. The brief description or separate statement, if used to meet the foregoing requirement, shall be printed on the first page of the individual policy or group

certificate in type more prominent than that used in the text of the policy or certificate and shall clearly indicate the limitation.

(g) If a contract of insurance provides for a limitation of coverage related to the age of the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing by him in an instrument separate from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the age limitation. The brief description or separate statement, if used to meet the foregoing requirement, shall be printed on the first page of the individual policy or group certificate in type more prominent than that used in the text of the policy or certificate and shall clearly indicate the limitation.

(7) FILING OF POLICY FORMS. (a) All policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner. In the case of credit transactions covered under a group policy issued in another state or jurisdiction, the insurer shall file for approval only the group certificate and notice of proposed insurance to be used in this state, and the premium rates to be used in connection with such certificate and notice.

(b) The commissioner shall within 30 days after the filing of any such policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement or rider, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any law or of any administrative rule.

(c) If the commissioner notifies the insurer that the form is disapproved, it may not issue or use such form. Such notice shall specify the reason for the disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until the expiration of 30 days after it has been so filed, unless the commissioner shall give his prior written approval thereto.

(d) The commissioner may, at any time after a hearing held not less than 20 days after written notice to the insurer, withdraw his approval of any such form on any ground set forth in subsection (b) above. The written notice of such hearing shall state the reason for the proposed withdrawal.

(e) The insurer may not issue such forms or use them after the effective date of such withdrawal.

(8) PREMIUMS AND REFUNDS. (a) Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit accident and sickness insurance policy for which the premium rate differs from that determined by the schedules of such insurer as then on file.

(b) The amount charged to a debtor for any credit life or credit

accident and sickness insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(c) If a creditor requires a debtor to make any payment for credit life insurance or credit accident and sickness insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(d) A creditor may not remit and an insurer may not collect on a monthly outstanding balance basis if the insurance charge or premium is included as part of the outstanding indebtedness. This means that where the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of indebtedness, and any direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with such insurance charge, the creditor must remit and the insurer shall collect on a single premium basis only.

(e) Dividends on participating individual policies of credit insurance shall be payable to the individual insureds. Payment of such dividends may be deferred until such time as the policy is terminated.

(f) Each individual policy, or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided, however, that the premium schedule may prescribe a minimum refund of $1 and no refund of a lesser amount need be made. The formula to be used in computing such refund shall be filed with and approved by the commissioner.

(g) Schedules for computing refunds in event of cancellation of credit insurance prior to the scheduled maturity date of the indebtedness must meet the following minimum requirements:

1. The refund of premium, in the case of credit insurance for which premiums are payable other than by a single premium, and in the case of level term credit life insurance, shall be equal to the pro-rata unearned gross premium. In the case of credit insurance paid by a single premium the refund shall be equal to the amount computed by the "sum of digits" formula commonly known as the "Rule of 78".

2. The refund of the amount charged the debtor for insurance, in the case of credit insurance for which said amount is charged other than in single sum, and in the case of level term credit life insurance, shall be equal to the pro-rata unearned gross amount charged or to be charged. In the case of credit insurance for which the whole amount is charged in a single sum the refund shall be equal to the amount computed by the "sum of digits" formula commonly known as the "Rule of 78".

3. Refunds shall be based upon the number of full months prepaid from the maturity date of the policy, counting a fractional month of 16 days or more as a full month.

4. Upon termination of indebtedness repayable in a single sum prior to the scheduled maturity date, the refund shall be computed from the date of termination to the maturity date. If less than 15

days of a loan month has been earned, no charge may be made for that loan month, but if 15 days or more, a full month may be charged.

(9) CLAIMS AND AUDIT PROCEDURES. (a) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

(c) No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer. However, nothing herein shall be construed to relieve the insurer of the responsibility for proper settlement, adjustment and payment of all claims in accordance with the terms of the insurance contract and this ruling.

(d) The insurer must make a good faith examination of each credit insurance account in the first year of the account and annually thereafter. The examination shall be made to assure that the creditor is conducting the insurance program in compliance with the credit insurance policy provisions, the insurer's administrative instructions furnished the creditor to implement the insurance program, and with the applicable credit insurance law and regulation of Wisconsin. The examination must include verification of the accuracy of the computation of premium payments, insurance charges made to debtors, and claim payments reported to the insurer by the creditor. The insurer will maintain records of examinations for 2 years, and such records will be subject to call and review by the commissioner.

(10) CHOICE OF INSURER. When credit life insurance or credit accident and sickness insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

(11) CREDIT INSURANCE PREMIUM RATE FILINGS. (a) Every credit insurer shall file with the commissioner every premium rate schedule applicable to credit insurance in this state, together with the premium, loss, and expense experience on which the insurer bases the proposed premium rate, at least 30 days before the proposed effective date.

(b) In the absence of credible mortality or morbidity experience, the benefits provided under a credit insurance form shall be deemed not to be unreasonable in relation to the premium rate charged if the premium rates filed do not exceed the prima facie premium rate standards set forth in sections (12) and (13) and if the forms provide benefits which are no more restrictive than the coverage standards enumerated.

(c) Nothing herein shall preclude an insurer from requesting approval of the commissioner for premium rates higher or lower than the prima facie rate standards on the basis of the mortality or morbidity rate actually experienced or anticipated.

(d) If an insurer proposes to provide coverage which is more restrictive than coverage described in subsections (12) and (13), the insurer must demonstrate to the commissioner's satisfaction that the premium rate schedule applicable for the coverage will produce loss ratios at least as great as those contemplated in the premium rate standards set forth or can reasonably be expected to produce such loss ratios.

(e) Where no debtor is paying an identifiable charge for any part of the premium for credit insurance the rates shall be such reasonable rates as are approved by the commissioner.

(12) PRIMA FACIE CREDIT LIFE INSURANCE PREMIUM RATE STANDARDS. (a) The basic permissible loss ratio for credit life insurance shall be not less than 60% except as provided in paragraph (e).

(b) The rate standard for premiums payable on the basis of monthly outstanding balances is $0.77 per $1,000 of insurance. Rates applicable to other methods of payment shall be actuarially equivalent.

(c) The rate standard for premiums payable on the single premium basis is $.50 per $100 of initial insured amount of indebtedness repayable in 12 equal monthly instalments. The single premium rate standards for repayment periods other than 12 months shall be computed according to the following formula:

$$P_n = \frac{[n+1]\ 0.77}{20}$$

Where P_n = Single premium rate per $100 of initial insured indebtedness repayable in n equal monthly instalments

n = Original repayment period, in months

(d) The rate standard for premiums payable on single premium level term credit life insurance is $0.93 per $100 of indebtedness for a 12 month term. The single premium rate standards for repayment periods other than 12 months shall be computed according to the following formula:

$$P_n = \frac{[n]\ 0.77}{10}$$

Where P_n = Single premium rate per $100 of level insured indebtedness repayable in n months

n = Original term of level indebtedness in months

(e) The rate standard for credit life insurance wherein the individual original indebtedness is $500 or less may be 120% of the rate otherwise applicable, but no creditor or insurer shall segment loans or use other means to avoid the rate standards set forth herein.

(f) The rate standards for credit life insurance providing coverage on two lives with respect to a single indebtedness shall be 150% of the rate standards provided in subsections (b), (c), (d), and (e) above.

(g) As an alternative to subsections (b), (c), or (d) above, where age data applicable to the insured debtors is available, rate standards may be based on such data, under a plan approved by the commissioner.

(h) The rate standards set forth herein shall be applicable for a plan of death benefits with or without requirements for evidence of insurability which contains:

1. No exclusions other than suicide within one year of the incurral of the indebtedness, and

2. No age restrictions, or only age restrictions making ineligible for coverage:

a. Debtors 65 or over at the time the indebtedness is incurred or

b. Debtors who will have attained age 66 or over on the maturity date of the indebtedness.

(13) PRIMA FACIE MAXIMUM CREDIT ACCIDENT AND SICKNESS INSURANCE PREMIUM RATE STANDARDS. (a) If premiums are payable in one sum (single premium) for coverage for the entire duration of indebtedness, the premium rate standards per $100 of initial amount of insured indebtedness repayable in equal monthly instalments are as shown below. Premium rate standards for other benefit plans and for indebtedness repayable in instalments other than as shown shall be actuarially consistent with the indicated rate standards.

Original Number of Equal Monthly Instalments	14 Days	30 Days
Non-Retroactive Elimination Period		
6	$1.39	$ .69
12	1.95	1.18
18	2.27	1.50
24	2.52	1.69
30	2.74	1.82
36	2.93	1.93
42	3.10	2.03
48	3.26	2.12
Basic permissible loss ratio	59%	52%
Retroactive Waiting Period		
6	$1.74	$1.19
12	2.23	1.68
18	2.56	1.89
24	2.81	2.04
30	3.02	2.17
36	3.21	2.29
42	3.39	2.39
48	3.55	2.48
Basic permissible loss ratio	61%	57%

(b) The rate standards applicable for premiums payable on the basis of monthly outstanding balances shall be computed as follows:

$$p_n = \frac{20\ P_n}{n+1}$$

Where n = *Original* repayment period, in months

p_n = The Monthly Outstanding Balance Premium Rate per $1,000 for an indebtedness repayable in equal monthly instalments with an *original* repayment period of n months

P_n = The Single Premium Rate per $100 initial insured indebtedness with an *original* repayment period of n months, from subsection (a) above.

The outstanding balance premium rate for an indebtedness with a given original repayment period is applicable to the outstanding balance of this indebtedness at each month during the period, regardless of the remaining repayment period.

(c) The rate standards set forth herein shall be applicable for a plan of benefits which contains:

1. No provision excluding or denying a claim for disability resulting from pre-existing conditions except for those conditions which manifested themselves to the insured debtor by requiring medical diagnosis or treatment or would have caused a reasonably prudent person to have sought the medical diagnosis or treatment, within six months preceding the effective date of the debtor's coverage and which caused loss within the six months following the effective date of coverage; provided, however, that disability commencing thereafter resulting from such condition shall be covered.

2. No other provision which excludes or restricts liability in the event of disability caused in a certain specified manner except that it may contain provisions excluding or restricting coverage in the event of pregnancy, intentionally self-inflicted injuries, foreign travel or residence, flight in non-scheduled aircraft, war or military service.

3. No age restrictions, or only age restrictions making ineligible for coverage:

a. debtors 65 or over at the time the indebtedness is incurred or

b. debtors who will have attained age 66 or over on the maturity date of the indebtedness.

4. Provision for a daily benefit equal in amount to the initial indebtedness divided by the number of days in the period during which the indebtedness is scheduled to be repaid in equal monthly instalments.

Note: This is not intended to preclude calculation of the daily benefit based on a 30 day month.

(14) DEVIATION PROCEDURE AND CASE RATE DETERMINATION. (a) For cases of less than $50,000 earned premiums (prima facie basis) the case rates shall be the prima facie rates. For cases of $50,000 or greater earned premiums (prima facie basis) the actual case ratio shall be calculated as (actual ratio of claims incurred to premiums earned) divided by the basic permissible loss ratio shown in subsection (12) or (13). If the actual case ratio is within the acceptance range shown in the following credibility table, the case rates will be the prima facie rates. If the actual case ratio is outside the acceptance range, the adjusted case ratio will be calculated by adjusting the actual case ratio toward 100% by addition or subtraction of the "adjustment constant", also shown in the credibility table.

CREDIBILITY TABLE
Earned Premium (Prima Facie Basis)

Size Group	Small Loans or Credit Unions	Banks or Sales Finance	Acceptance Range	Adjustment Constant
CREDIT LIFE				
I	50,000–125,000	50,000– 200,000	0.80–1.20	0.15
II	125,000–300,000	200,000– 500,000	0.85–1.15	0.10
III	300,000–650,000	500,000–1,000,000	0.85–1.15	0.05
IV	650,000 or over	1,000,000 or over	0.90–1.10	0.00
CREDIT ACCIDENT AND SICKNESS				
I	50,000– 75,000	50,000– 100,000	0.80–1.20	0.15
II	75,000–125,000	100,000– 175,000	0.85–1.15	0.10
III	125,000–250,000	175,000– 350,000	0.85–1.15	0.05
IV	250,000 or over	350,000 or over	0.90–1.10	0.00

(b) If the adjusted case ratio exceeds 1.00, the case rate is the product of deviation factor f, and the prima facie rate shown in subsection (12) or (13), where

$f = [(\text{Adjusted case ratio} - 1) \times 1.25 \times \text{Basic Permissible Loss Ratio}] + 1$

(c) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, but greater than the limit specified in the following table, the case rates are the product of the deviation factor g, and the prima facie rates in subsection (13), where

$g = 1 - [(1 - \text{adjusted case ratio}) \times 1.25 \times \text{Basic Permissible Loss Ratio}]$

Plan of Benefit	*Limit*
14 days Retroactive Elimination Period	.51
14 days Non-Retroactive Elimination Period	.59
30 days Retroactive Elimination Period	.67
30 days Non-Retroactive Elimination Period	.89

$$\text{Limit} = \frac{.5\ (1 - \text{Loading Factor} \times \text{Basic Loss Ratio})}{\text{Basic Permissible Loss Ratio}\ (1 - .5 \times \text{Loading Factor})}$$

(Rounded Down)

(d) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, and less than or equal to the limit specified in the above table, the case rates are the product of deviation factor h, and the prima facie rate in subsection (13), where

$h = (\text{Adjusted Case Ratio} \times \text{Basic Loss Ratio} \times 2)$

(e) If the adjusted case ratio for credit life insurance is less than 1.00, the case ratio is the product of the deviation factor h, and the prima facie rate in subsection (12) where

$h = (\text{Adjusted Case Ratio})$

(f) If the case rate determined by the above procedures is within 5¢ of the existing single premium rate per $100 per year, the existing rate will be the case rate.

(g) The case rate as determined shall continue for a period equal to the experience period on which it was based. Where the case rate applies to a group of accounts, the rate will continue to apply to every account which was grouped for determination of the rate and to only those accounts. The insurer shall annually determine and submit for filing under subsection 8 (a) the applicable case rate calculated as prescribed herein.

(h) As used in this rule the following words mean:

1. Account—The aggregate credit life or credit accident and sickness coverage for a single plan of benefits and class of business written through a single creditor by the insurer, whether coverage is written on a group or individual policy basis.

2. Class of business—Means any of the following:

a. Credit unions

b. Commercial and savings banks

c. Other cash loans (small loans, industrial bank loans, etc.)

d. Other sales finance (discount transactions, etc.)

3. Experience year—A 12-month period ending on the policy anniversary or renewal date or on a calendar year-end. Experience for a

given account or permitted combinations of accounts shall be reported consistently from year to year.

4. Case—a. An account, if the earned premium for the account based upon the prima facie premium rates promulgated in subsections (12) or (13) during the most recent 3 experience years has been $50,000 or more. If the rates applicable to the account are not at the prima facie level or at a uniform percentage of the prima facie rates, the amount of premium which would have been earned at the prima facie rates shall be approximated by a reasonable method filed with the experience report.

b. A combination of all the insurer's accounts of the same plan of benefits and class of business, excluding all accounts which meet the criterion for inclusion under

a. immediately preceding.

5. Experience period—The last 3 experience years unless a lower number of full years produces an earned premium in size group IV as shown in the credibility table.

(j) In determining the case ratios in this subsection for application of the deviation formula, the following rules shall be applied:

1. If the coverage for a single creditor which qualifies for separate consideration under case definition a. above has been in force with the insurer for less than the experience period, the claim experience of the creditor while covered by any prior insurer shall be included to the extent necessary in determining the appropriate case ratios.

2. The case ratios shall be based wholly or partially on the experience of the insurer on the case within the state, or a group of states or on the total United States experience, so long as the insurer reports and files consistently for that case thereafter. An account which qualifies for separate treatment as a case but which provides coverage on a multi-state basis, may be considered in its entirety if the insurer so chooses excluding experience used for deviation purposes in any state, states or group of states.

(15) ACCOUNTING AND UNDERWRITING EXPERIENCE. Each insurer shall maintain records of premiums, losses and expenses of Wisconsin business separately for credit life insurance and credit accident and sickness insurance on a calendar year basis or on a policy year basis. Such underwriting experience shall be maintained for each form of policy, creditor, and class of creditor. This information shall be subject to call annually by the commissioner.

(16) FINANCIAL STATEMENT MINIMUM RESERVES. (a) Each insurer shall show, as a liability in any financial statement or report required under section 601.42, Wis. Stats., its policy or unearned premium reserve in an amount not less than as computed in paragraphs (b), (c) and (d). If a credit insurance policy provides any combination of life insurance benefits, disability benefits and accident and sickness insurance benefits, a reserve must be established separately for the life insurance benefits, for the disability benefits and for the accident and sickness insurance benefits.

(b) The reserve for individual credit life insurance policies shall be not less than 130% of the Commissioner's 1958 Standard Ordinary Mortality Table at 3½% annual interest.

(c) The reserve for group credit life insurance policies shall be not less than 130% of the Commissioner's 1960 Standard Group Mortality Table at 3½% annual interest.

(d) The reserve for credit accident and sickness insurance policies and for disability benefits in credit life insurance policies shall be not less than the greater of 130% of the Commissioner's 1964 Disability Table at 3½% annual interest or the pro rata unearned premium reserve.

(17) EFFECTIVE DATE. (a) This rule shall become effective September 1, 1972.

(b) Each insurer subject to this rule shall file with the commissioner on or before October 1, 1972, a listing of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates pertaining thereto which have been heretofore approved and which the insurer intends to issue or use in Wisconsin after the effective date of this rule.

(18) PENALTY. Violations of this rule shall subject the insurer or agent to section 601.64, Wis. Stats.

(19) SEPARABILITY. If any provision or clause of this ruling or the application thereof to any person or circumstance is, for any reason held invalid, the remainder of this ruling and the application of such provision to other persons or circumstances shall not be affected thereby.

Note: It is the intent of this rule that it shall apply prospectively to the review for approval of policy and other forms of credit life and credit accident and sickness insurance and to the rates applicable to such forms that are submitted for filing after the effective date. Individual hearings will be held to consider whether credit life and credit accident and sickness insurance contract forms and rate levels presently in use provide benefits that are reasonable in relation to premium charges.

History: Cr. Register, August, 1972, No. 200, eff. 9-1-72.

Ins 3.26 Unfair trade practices in credit life and credit accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to assist in the maintenance of a fair and equitable credit life insurance and credit accident and sickness insurance market. This rule interprets, including but not limited to, the following Wisconsin statutes: 201.045; 201.53 (2), (4), (7) and (8); 206.41 (10); 207.03; 207.04 (1) (d), (f), (g), (h), and (j); 209.04 (9); 601.01 (3) (a), (b), (c), (g) and (h); and 601.41 (1), (2) and (3).

(2) SCOPE. This rule shall apply to the transaction of credit life insurance as defined in section 201.04 (3c) and 206.63, Wis. Stats., and the transaction of credit accident and sickness insurance as defined in section 201.04 (4a), Wis. Stats.

(3) UNFAIR TRADE PRACTICES DEFINED. The following acts, whether done directly or indirectly, in consideration of or in connection with a policy issued or proposed to be issued are defined to be prohibited unfair trade practices in the transaction of insurance described in subsection (2) above:

(a) The offer or grant by an insurer of any special favor or advantage, or any valuable consideration or inducement not set out in the insurance contract. The payment of agents' commissions, reported

annually in Schedule 24S, shall not be a violation of this paragraph but the acts cited in paragraphs (b), (c), (d), (e) and (f) may not in any way be construed as agents' commissions.

(b) The offer to deposit or the deposit with a bank or other financial institution, money or securities of the insurer or of any affiliate of the insurer with the design or intent that the deposit offset or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(c) The deposit with a bank or other financial institution of money or securities without interest or at a lesser rate of interest than is currently being paid other depositors on similar deposits with such bank or other financial institution. This shall not be construed to prohibit the maintenance by an insurer of such demand deposits as are reasonably necessary for use in the ordinary course of business of the insurer.

(d) The offer to sell or the sale of any capital stock or other security or certificate of indebtedness of the insurer or affiliated person.

(e) The offer to pay or the payment of any part of the premium for any insurance on the life, health or property of any creditor or any employee or other person affiliated with the creditor.

(f) The extension to the creditor of credit for the remittance of premium beyond the grace period of a group policy or for more than 45 days from the effective date of an individual policy.

(4) PENALTY. Violations of this rule shall subject the insurer or agent to section 601.64, Wis. Stats.

History: Cr. Register, October, 1972, No. 202, eff. 11–1–72.