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 3.04 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 3.07 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:

(1) Mutual insurance companies operating on a post mortem assessment plan cannot limit assessments to a specified amount.

(2) Nonassessable policies of mutual companies.

(3) Policy, inspection and similar fees.

Ins 3.09 Mortage guaranty insurance. (1) PURPOSE. This rule implements and interprets, including but not limited to, sections

201.04 (19), 611.02, 611.24, 618.01, 618.21, 620.02 and 623.04, Wis. Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) SCOPE. This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by section 201.04 (19), Wis. Stats.

(3) DEFINITIONS. (a) 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.

(b) As used in this rule, "person" means any individual, corporation, association, partnership or any other legal entity.

(4) DISCRIMINATION. No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the applicant's sex, marital status, race, color, creed or national origin.

(5) LIMITATION OF TOTAL LIABILITY ASSUMED. A mortgage guaranty insurer shall not at any time have outstanding a total liability under its aggregate insurance policies, computed on the basis of its election to limit coverage and net of reinsurance assumed and of reinsurance ceded to an insurer authorized to transact such reinsurance in this state, exceeding 25 times the sum of its contingency reserve established under subsection (14) and its surplus as regards policyholders.

(6) LIMITATION ON INVESTMENT. A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) LIMITATION ON ASSUMPTION OF RISKS. A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by a single risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to transact such reinsurance in this state. "Contiguous" for the purpose of this subsection means not separated by more than one-half mile.

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts in any assuming insurer authorized to transact mortgage guaranty insurance in this state, except it shall not enter into reinsurance arrangements designed to circumvent the compensation control provisions of subsection (15) or the contingency.

(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 for $100 of initial amount of insured indebtedness repayable in equal monthly instalments are 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, but no individual policy of credit accident and sickness insurance or group policy of credit accident and sickness insurance shall be delivered or issued for delivery if the benefits are payable after a waiting period of less than 14 days, regardless of whether the payment of benefits are retroactive to the first day of disability.

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
54	3.41	2.21
60	3.55	2.29
Basic permissable loss ratio	59%	52%

Original Number of Equal Monthly Instalments	14 Days	30 Days
	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
54	3.70	2.57
60	3.84	2.65
Basic permissible loss ratio	60%	57%

(b) The rate standards applicable for premiums payable on the basis of monthly outstanding balances shall be computed under the formula described in subdivision 1 below except as provided in subdivision 2:

1. For credit accident and sickness insurance benefit plans issued on an individual or a group basis the premiums payable 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 paragraph (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.

2. For credit accident and sickness insurance benefit plans issued on a group basis, a composite monthly outstanding balance premium rate schedule may be used in lieu of the rate procedure described in subdivision 1 above for each benefit plan, to apply to all outstanding balances each month under such plan, irrespective of the type or duration of loan making up such outstanding balances. Such composite monthly outstanding balance premium rate schedule will be approved for use only if the actuarial consistency of such composite rate with the prima facie maximum credit accident and sickness insurance premium rate standards and basic permissible loss ratios in paragraph (a) above is established, and the reasons for this use in lieu of the rate standard in subdivision 1 above are documented.

3. The rate deviation procedure outlined in subsection (14) shall be applied separately to any business written under subdivision 2 above, and the insurer shall maintain all pertinent data on such business separately.

(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 6 months preceding the effective date of the debtor's coverage and which caused loss within the 6 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 less than age 18 at the time the indebtedness is incurred, or

b. Debtors age 65 or over at the time the indebtedness is incurred, or

c. 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.

5. Provides for benefits to be payable in the event of disability resulting from bodily injury or sickness, which disability commences while the debtor is insured hereunder and prevents the insured debtor from engaging in any gainful occupation for which he is reasonably qualified by reason of education, training or experience, except that during the initial 12 months of disability the inability of the insured to engage in his own occupation shall be the only test.

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= [(Adjusted case ratio—1) × 1.25 × 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 limits 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-adjusted case ratio × 1.25 × Basic Permissible Loss Ratio]

Plan of Benefit	*Limit*
14 days Retroactive Elimination Period	.55
14 days Non-Retroactive Elimination Period	.59
30 days Retroactive Elimination Period	.67
30 days Non-Retroactive Elimination Period	.89

$$\text{Limit} = \frac{.5\ (1\text{-}1.25 \times \text{Basic Permissible Loss Ratio})}{\text{Basic Permissible Loss Ratio}\ (1\text{-}.5 \times 1.25)}$$

(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 the deviation factor h, and the prima facie rate in subsection (13) where

h=(Adjusted Case Ratio × Basic Permissible Loss Ratio × 2)

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

h= (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 contiune 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.)

c. 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 whithin 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) SUBMISSION OF POLICY FORMS AND RATE SCHEDULES IN USE. (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; cr. (2) (c), (6) (h) and (8) (h); am. (4) (b), (5), (8) (f), (12), (13) (a), (14) (e), and r. (17) (a), Register, February, 1973, No. 206, eff. 3-1-73; am. (4), (5), (6) (a) 6, (6) (h), (8) (f), (12) (g) 2, (13) (c) 3, (14) (c) and (d) and cr. (6) (i) and (13) (c) 5, Register, April, 1975, No. 232, eff. 5-1-75; am. (13) (b), Register, June, 1975, No. 234, eff. 7-1-75.

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 reasonable necessary for use in the oridinary 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 employe 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.

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physical condition itself, to originate after the effective date of coverage shall be administered in accordance with subparagraph 1 of this paragraph (b).

3. An insurer shall not exclude or limit benefits, using the pre-existence defense, a waiting period, a benefit maximum or other policy limitation, where the claimant's medical records indicate a reasonable basis for distinguishing between a condition or conditions which necessitated the hospital confinement or the medical or surgical treatment for which claim is made or which resulted in the disability for which the claim is made and a concurrently existing condition or conditions which did not contribute to the need for the confinement or treatment or did not contribute to the disability.

(c) Where the group or group type plan is issued to trustees of a fund as described by section 204.321 (1) (c), Wis. Stats., use the plan's provisions regarding individual eligibility for coverage and individual termination of coverage to deny liability for or to defend against a claim only if the certificate issued pursuant to the plan, under an appropriate caption or captions, includes the applicable requirements regarding an individual's eligibility for coverage and the conditions under which an individual's coverage terminates under the plan.

(4) BLANKET INSURANCE. An insurer issuing insurance under section 204.322, Wis. Stats., shall

(a) Include in an enrollment form used in connection with such insurance no question relating to the medical history or other matter concerning the insurability of the person or persons to be insured and

(b) Be subject to the following: 1. A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition, as distinguished from the cause of such disease or physical condition and manifested itself prior to such date. Such manifestation may be established by evidence of medical diagnosis or treatment of such disease or physical condition prior to the effective date or the existence of symptoms of such disease or physical condition prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care, or treatment.

2. Coverage which contains wording which requires the cause of the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with subparagraph 1. of this paragraph (b).

3. An insurer shall not exclude or limit benefits, using the pre-existence defense, a waiting period, a benefit maximum, or other policy limitation, where the claimant's medical records indicate a reasonable basis for distinguishing between the condition or conditions which necessitated the hospital confinement or the medical or surgical treatment for which claim is made or which resulted in the disability for which claim is made and a concurrently existing condition or conditions which did not contribute to the need for the confinement or treatment or did not contribute to the disability.

(5) EFFECTIVE DATE. This rule shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after December 1, 1974, except that subdivisions (3) (a) 4. a. and b. shall apply to coverage issued after said date and subdivisions (3) (a) 3. d., e. and g. shall apply to such activities after February 1, 1975.

History: Cr. Register, November, 1974, No. 227, eff. 12-1-74.

Ins 3.35 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner of insurance to promulgate a plan to provide health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or to call upon the insurance industry to prepare plans for his approval.

(b) Health care liability insurance for physicians, surgeons and osteopaths is not readily available in the voluntary market.

(c) A facility for providing such health care liability insurance should be enacted pursuant to chapter 619, Wis. Stats.

(d) Health care liability insurance for nurses and hospitals may not be readily available in the voluntary market in the near future.

(e) The facility created to provide health care liability insurance for physicians, surgeons and osteopaths should prepare plans to provide health care liability insurance to nurses and hospitals in the event such coverage were not readily available in the voluntary market.

(2) PURPOSE. This rule is intended to implement and interpret chapter 619, Wis. Stats., for the purpose of establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage for eligible physicians and surgeons and osteopaths on a self-supporting basis. This rule is also intended to encourage the improvement in reasonable loss prevention measures and to encourage the maximum use of the existing voluntary market.

(3) SCOPE. This rule shall apply to all insurers authorized to transact in this state on a direct basis insurance against liability resulting from personal injuries, except for Town Mutuals authorized to transact insurance under chapter 612, Wis. Stats.

(4) DEFINITIONS. (a) The *Wisconsin Health Care Liability Insurance Plan,* hereinafter referred to as the Plan, means the statutory, nonprofit, unincorporated association established by this rule to provide for the issuance of health care liability insurance at adequate rate levels for risk sharing subject to the right of recoupment and to assist qualified applicants in securing health care liability insurance.

(b) Insurance against liability resulting from personal injuries means all insurance coverages against loss by the personal injury or death of any person for which loss the insured is liable. It includes the personal injury liability component of multi-peril policies, but it does not include steam boiler insurance authorized under section 201.04 (6), Wis. Stats., workmen's compensation insurance authorized under section 201.04 (16), Wis. Stats., or coverage authorized under section 201.04 (18), Wis. Stats.

(c) Health care liability insurance means insurance against loss, expense and liability resulting from errors, omissions or neglect in the

performance of any professional service by any person authorized to practice medicine, surgery or osteopathy under the provisions of chapter 448, Wis. Stats.

(d) Premiums written means gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to insurance against liability resulting from personal injuries covering insureds or risks resident or located in this state excluding premiums on risks insured under the Plan.

(e) Servicing company means an insurer which services policies issued on behalf of the Plan.

(5) INSURANCE COVERAGE. (a) All authorized physicians, surgeons and osteopaths who are equitably entitled to but otherwise unable to obtain health care liability insurance in the voluntary market shall be eligible to apply for insurance under this Plan.

(b) The maximum limits of coverage for the type of health care liability insurance defined in subsection (4) (c) which may initially be placed under the Plan are $200,000 per claim and $600,000 aggregate for all claims in any one policy year.

(c) In the event that such coverage does not prove sufficient for an applicant's needs, the Plan shall offer assistance to applicants in obtaining further coverage in the voluntary market.

(d) The commissioner may establish higher or lower maximum limits of coverage in accordance with section 619.01 (1) (b) and section 619.01 (7), Wis. Stats.

(e) The coverage shall be provided and the policies issued on a modified claims made basis, under forms approved by the commissioner, subject to a provision in the policy that:

1. In event of death of an individual insured, the insured's estate shall not be required to pay additional premium to obtain coverage for all future claims arising out of incidents which occurred during the time when a Plan policy was in force and at the same limits of the previous policy;

2. In event of total and permanent disability of an individual insured who is therefore unable to engage in any gainful employment and who has not yet reached his 65th birthday, the insured shall not be required to pay additional premium to obtain coverage for all future claims arising out of incidents which occurred during the time when a Plan policy was in force and at the same limits of the previous policy;

3. In the event of termination of coverage under the Plan for any reason other than non-payment of premium, the insured shall be guaranteed the right to purchase coverage upon payment of a single premium to protect him for all future claims arising out of incidents which occurred during the time when a Plan policy was in force and at not less than the same limits of the previous policy;

4. In response to changing conditions and circumstances, the Plan may, subject to the approval of the commissioner and consistent with section 619.01 (1) (b), Wis. Stats., modify the coverage it affords.

(f) Coverage may include such ancillary coverages as are customarily offered in the voluntary market.

(6) MEMBERSHIP. (a) Every insurer, subject to subsection (3) shall be a member of this Plan.

(b) An insurer's membership terminates when the insurer is no longer authorized to write personal injury liability insurance in Wisconsin, but the effective date of termination shall be the last day of the fiscal year of the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this rule until it completes all of its obligations under the Plan.

(c) Subject to the approval of the commissioner, the governing committee may charge a reasonable membership fee, not to exceed $50.00.

(7) ADMINISTRATION. (a) This Plan shall be administered by a governing committee, subject to the supervision of the commissioner.

(b) The governing committee shall consist of 8 members, each of whom shall serve for a period of one year or until a successor is designated. Each shall have one vote.

1. The following associations shall appoint or elect:

American Insurance Association—one member
American Mutual Insurance Alliance—one member
National Association of Independent Insurers—one member
Wisconsin Insurance Alliance—three members

2. The commissioner shall appoint 2 members to represent other insurers not members of the associations in subparagraph 1.

3. Not more than one insurer in a group under the same management or ownership shall serve on the governing committee at the same time.

4. All members of advisory committees established under subsection (8) (g) shall be non-voting ex officio members of the governing committee.

(8) DUTIES OF THE GOVERNING COMMITTEE. (a) The governing committee shall meet as often as may be required to perform the general duties of the administration of the Plan or on the call of the commissioner. Five members of the committee shall constitute a quorum.

(b) The governing committee shall be empowered to invest, borrow and disburse funds, budget expenses, levy assessments, cede and assume reinsurance, and perform all other duties provided herein as necessary or incidental to the proper administration of the Plan. The governing committee may appoint a manager or one or more agents to perform such duties as may be designated by the committee.

(c) The governing committee shall develop rates, rating Plans, rating and underwriting rules, rate classifications, rate territories, and policy forms in accordance with sections 619.01 (1) (c) 2 and 625.12, Wis. Stats.

(d) The governing committee shall cause all policies written pursuant to this Plan to be separately coded so that appropriate

records may be compiled for purposes of calculating the adequate premium level for each classification of risk, and performing loss prevention and other studies of the operation of the Plan.

(e) The governing committee shall determine, subject to the approval of the commissioner, the eligibility of an insurer to act as a servicing company. If no qualified insurer elects to be a servicing company, the governing committee shall assume such duties on behalf of member companies.

(f) The governing committee shall enter into agreements and contracts as may be necessary for the execution of this rule consistent with its provisions.

(g) The governing committee shall appoint 2 advisory committees, the first consisting of no more than 4 health care representatives selected after nomination by appropriate professional societies, and the second consisting of no more than 4 representatives of insurance agents and the health care consumer, to advise the committee in the fulfillment of its duties and functions, and to serve as non-voting ex officio members of the governing committee.

(h) The governing committee may appoint additional advisory committees of interested persons not limited to members of the Plan, to advise the committee in the fulfillment of its duties and functions.

(i) The governing committee shall be empowered to develop, at its option, an assessment credit Plan, subject to the approval of the commissioner, wherein a member of the Plan receives a credit against an assessment levied, based upon the Wisconsin voluntarily written health care liability insurance premiums.

(j) The governing committee shall prepare such procedures, policy forms, underwriting rules, rates and rating Plans as would be necessary to provide health care liability insurance under the Plan to nurses and hospitals in the event such coverage were not readily available in the voluntary market.

(k) The governing committee of the Plan shall be authorized to take such actions as are consistent with law to provide the state medical examining board or other health care licensing bodies with such claims information as may be appropriate.

(9) ANNUAL REPORT TO MEMBERS. By May 1 of each year, the governing committee shall make a report to the members of the Plan summarizing the activities of the Plan in the preceding calendar year.

(10) APPLICATION FOR INSURANCE. (a) Any person authorized to practice medicine, surgery or osteopathy under chapter 448, Wis. Stats., may submit an application for insurance by the Plan either directly or through any licensed agent.

(b) The Plan may bind coverage.

(c) The Plan shall, within 8 business days from receipt of an application, notify the applicant of the acceptance, rejection or the holding in abeyance of the application pending further investigation. Any individuals rejected by the Plan shall have the right to appeal that judgment within 30 days to the governing committee in accordance with subsection (16).

(d) If the risk is accepted by the Plan, a policy shall be delivered to the applicant upon payment of the premium. The Plan shall remit any commission to the licensed agent designated by the applicant; if no licensed agent is so designated, such commission shall be retained by the Plan.

(11) ASSESSMENTS AND PARTICIPATION. (a) In the event that sufficient funds are not available for the sound financial operation of the Plan, and pending recoupment pursuant to section 619.01 (1) (c) 2, Wis. Stats., all members shall, on a temporary basis, contribute to the financial needs of the Plan in the manner prescribed in paragraph (b). When such assessment contribution is recouped, it shall be reimbursed to members as their total share of the assessment contribution bears to the aggregate outstanding contributions.

(b) All members of the Plan shall participate in all premiums, other income, losses, expenses, and costs of the Plan in the proportion that the premiums written of each such member [excluding that portion of premiums attributable to the operation of the Plan and giving effect to any assessment credit Plan under paragraph (8) (i)] during the preceding calendar year bears to the aggregate premiums written in this state by all members of the Plan. Each member's participation in the Plan shall be determined annually on the basis of such premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the commissioner of insurance.

(12) RATES. All rates shall be on an actuarially sound basis and shall be calculated to be self-supporting. Any deficit incurred by the Plan in any one year shall be recouped by rate increases applicable prospectively. Any surplus over the loss reserves of the Plan in any one year shall be distributed by rate decreases applicable prospectively.

(13) VOLUNTARY BUSINESS—CANCELLATION AND NONRENEWAL. Any member cancelling or not renewing voluntarily written health care liability insurance covering any risk eligible under this Plan shall inform the policyholder of the availability of insurance under the Plan. Any such notice of cancellation or nonrenewal shall allow ample time for application to the Plan and for the issuance of coverage. A copy of such cancellation or non-renewal notice shall be filed with the office of the commissioner of insurance.

(14) PLAN BUSINESS—CANCELLATION AND NONRENEWAL. (a) The Plan shall not cancel or refuse to renew a policy issued under the Plan except for:

1. Nonpayment of premium; or

2. Facts as confirmed by inspection which would have been grounds for nonacceptance of the risk under the Plan had they been known to the Plan at the time of acceptance; or

3. Changes in the physical or mental condition of the risk or other changed conditions as confirmed by investigation that makes the risk uninsurable under the Plan.

(b) No action shall be taken under paragraph (a) 2 and 3 until the health care representatives advisory committee has been notified of

that prospective action and has been offered 5 working days in which to review and comment upon that action.

(c) Notice of cancellation or nonrenewal under paragraph (a), containing a statement of the reasons therefor, shall be sent to the insured with a copy to the Plan. Any cancellation or nonrenewal notice to the insured shall be accompanied by a conspicuous statement that the insured has a right of appeal as provided in subsection (16).

(15) COMMISSION. (a) Commission to the licensed agent designated by the applicant shall be $50.00 per new and renewal policy issued. The agent need not be licensed by the servicing company.

(b) Paragraph (a) shall be reviewed by the governing committee after this rule has been in effect for 6 months. If a determination is made that a larger commission is required, the governing committee may authorize such commission as may be appropriate, but in no case may such commission exceed 5% of the policy premium.

(c) In the event of cancellation of a policy, or if an endorsement is issued which requires premium to be returned to the insured, the agent shall refund ratably to the Plan commissions on the return premium at the same rate at which such commissions were originally paid.

(16) RIGHT OF APPEAL. Any affected person may appeal to the governing committee within 30 days after notice of any final ruling, action, or decision of the Plan. If the appeal involves rejection of an application, or cancellation or nonrenewal of a policy, the health care representatives advisory committee shall be notified of such appeal and given 5 working days in which to review and comment upon the appeal and make a recommendation to the governing committee. The governing committee must consider the appeal and render a decision promptly after receipt of any such appeal. Any decision of the governing committee may be further appealed to the commissioner within 30 days after notice thereof. Orders of the commissioner shall be subject to review pursuant to chapter 227, Wis. Stats.

(17) REVIEW BY COMMISSIONER. The governing committee shall report to the commissioner the name of any member or agent which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the governing committee or to pay within 30 days any assessment levied.

(18) INDEMNIFICATION. Each person serving on the governing committee or any subcommittee thereof, each member of the Plan, and the manager and each officer and employe of the Plan shall be indemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the governing committee, or a member or manager or officer or employe of the Plan except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful misconduct in the performance of his or its duties as a member of such governing committee, or a member or manager or officer or employe of the Plan. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the Plan.

Indemnification hereunder shall not be exclusive of other rights to which the member, manager, officer, or employe may be entitled as a matter of law.

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