Chapter Ins 6
GENERAL

Ins 6.01 Foreign company to operate 2 years before admission. Experience has demonstrated that until a company has engaged in the business of insurance for at least 2 years there is not a sufficient basis upon which to form a judgment as to whether its methods and practices in the conduct of its business are such as to safeguard the interests of its policyholders and the people of this state. Therefore, no application of a foreign insurance company or mutual benefit society for a license to transact business in Wisconsin will be considered until it has continu-

ously transacted the business of insurance for at least 2 years immediately prior to the making of such application for license.

Ins 6.02 Company to transact a kind of insurance 2 years before admission. (1) Experience has demonstrated that until a company has engaged in a kind of insurance or in another kind of insurance of the same class for at least 2 years, there is not a sufficient basis upon which to form a judgment as to whether its methods and practices in the conduct of its business in such kind of insurance or another kind in the same class of insurance, are such as to safeguard the interests of its policyholders and the people of this state. Therefore, no application of a foreign insurance company or mutual benefit society for a license to transact a kind of insurance business in Wisconsin will be considered until it has continuously transacted that kind of insurance, or another kind of insurance in the same class of insurance as that for which it makes such application; for at least 2 years immediately prior to making such application. For the purposes hereof, insurance is divided into kinds of insurance according to the provisions of s. Ins 6.75 each subsection setting forth a separate kind, and into classes of insurance upon the basis of and including the said kinds as follows:

(a) Fire insurance includes the kinds in s. Ins 6.75 (2) (a).

(b) Life insurance includes the kinds in s. Ins 6.75 (1) (a) and (b) but excluding all insurance on the health of persons other than that authorized in s. 627.06, Stats., and s. Ins 6.70.

(c) Casualty insurance includes the kinds in s. Ins 6.75 (2) (c) through (n).

(2) Provided, however, that nothing herein shall preclude consideration of an application to transact the kind of insurance in Ins 6.75 (1) (e) or (2) (c) if the applicant company has transacted any of the kinds of insurance in Ins 6.75 (1) (a) and (b) or (2) (d), (e), (k) and (n) continuously for 2 years immediately prior to the making of application for license to transact the kind of insurance in Ins 6.75 (1) (e) or (2) (c).

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76; am. Register, March, 1979, No. 279, eff. 4-1-79.

Ins 6.05 Filing of property and casualty insurance forms. (1) PURPOSE. This rule is intended to implement and interpret s. 631.20, Stats., for the purpose of establishing filing procedures for certain property and casualty insurance policy forms.

(2) SCOPE. The requirements of this rule shall apply to insurance forms as defined in s. 600.03 (21), Stats., to be used to provide any of the lines or classes of insurance listed in Ins 6.75 (2) (a), (d), (e), (f), (g), (h), (i), (j), (l), (m) and (n).

(3) DEFINITIONS. In this rule, unless the context otherwise requires, the following words and terms shall have the following meanings:

(a) "Filing" shall mean:

1. Any matter submitted under this rule.

2. The act of filing such matter.

(b) "Basic policy forms" shall mean the basic insurance contracts used by any insurer including coverage parts or forms necessary to complete the contracts, amendatory endorsements needed to effect statu-

(c) Property insurance—as described in s. Ins 6.75 (2) (a) and (b);

(d) Casualty insurance—as described in s. Ins 6.75 (2) (d) through (n);

(e) Credit life and credit accident and sickness insurance as described in ss. Ins 6.75 (1) (a) 1. and (1) (c) 1. or (2) (c) 1.;

(g) Automobile insurance—as described in s. Ins 6.75 (2) (e);

(h) Title insurance—as described in s. Ins 6.75 (2) (h);

(i) Town mutual non-property insurance—as described in s. 612.31 (3), Stats.

History: Cr. Register, December, 1967, No. 144, eff. 1-1-68; r. and recr. (3) (d), Register, November, 1971, No. 191, eff. 12-1-71; am. (2) (e), Register, February, 1973, No. 206, eff. 3-1-73; am. (2) (h), Register, September, 1973, No. 213, eff. 10-1-73; cr. (2) (o), Register, May, 1975, No. 233, eff. 6-1-75; emerg. am. (1), (2), (3) (a) and (c), eff. 6-22-76; am. (1), (2), (3) (a) and (c), Register, September, 1976, No. 249, eff. 10-1-76; r. and recr., Register, August, 1977, No. 260, eff. 9-1-77; r. (2) (f), Register, October, 1981, No. 310, eff. 11-1-81.

Ins 6.51 Group life and disability coverage termination and replacement. (1) PURPOSE. This section is intended to promote the fair and equitable treatment of group policyholders, insurers, employes and dependents, and the general public by setting out procedures to be followed when a group life or disability insurance policy is terminated or replaced, and to interpret ss. 632.79 and 632.897, Stats.

(2) SCOPE. This section shall apply to all group life and group disability policies covering employes or employes and dependents, issued by insurers providing insurance as defined in s. Ins 6.75 (1) (a) or (c) or (2) (c). It shall apply to blanket policies only if they provide 24-hour coverage for both injury and sickness; any blanket policy, covering any type of group, which provides for renewal shall be subject to subs. (4) and (5); any blanket policy covering students of a college or university, regardless of whether it provides for renewal, shall be subject to subs. (6) and (7). Subsection (4) (a) shall apply only to group policies as defined in sub. (3) (c) 2.

(3) DEFINITIONS. (a) "Blanket policy" has the meaning in s. 600.03 (35) (c), Stats.

(b) "Employe" means an employe of an employer or a member of a union or association or a student of a college or university.

(c) "Group policy:" 1. Means a policy or contract covering employes issued by an insurer to an employer, labor union, association or trust fund or, in the case of a blanket policy, a college or university, or a group type plan, except that;

2. In sub. (4) (a), means only a policy or contract issued by an insurer or a s. 185.981, Stats., co-operative or a group type plan issued by a ch. 613, Stats., corporation, providing hospital, surgical or medical expense coverage to or on behalf of an employer.

(d) A "group policy providing medical expense coverage" does not include a policy providing coverage for dental, vision care, hearing care or prescription drug expense coverage only.

(e) "Group policyholder" means an employer, labor union, association, trust fund or other entity respnsible for making group policy premium payments to an insurer.

(f) "Group type plan" means an insurance plan using individual policies which meets the following conditions:

1. Coverage is provided to classes of employes defined in terms of conditions pertaining to employment or membership.

2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's connection with a particular organization or group,

3. Premiums are paid by the group policyholder to the insurer on behalf of covered employes, and

4. An employer, union, association or trust fund sponsors or authorizes the plan.

(g) "Individual policy" means an individual or family policy or subscriber contract issued by an insurer.

(h) "Insurer" means an insurance company subject to chs. 631 and 632, Stats., or a service insurance corporation subject to ch. 613, Stats.

(i) "Premium" means a policy premium or a subscriber contract subscription fee.

(j) "Pre-existing condition" means a disease or physical condition including pregnancy which manifested itself prior to the effective date of coverage through medical diagnosis or treatment or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment.

(k) "Validity covered" means that the individual involved was covered and met all policy requirements regarding eligibility for coverage, as opposed to an individual who was covered without having met all such requirements.

(4) EFFECTIVE DATE OF TERMINATION FOR NON-PAYMENT OF PREMIUM; NOTICE OF TERMINATION; LIABILITY OF INSURER. (a) A group policy subject to s. 632.79, Stats., as defined in sub. (3) (b) 2. may not be terminated by the insurer unless it has provided the termination notices required by s. 632.79 (2), Stats., except as provided in s. 632.79 (5), Stats. The insurer shall be liable for valid claims for covered losses as provided in s. 632.79 (3), Stats.

(b) Under a group policy other than one subject to s. 632.79, Stats., the insurer shall be liable for valid claims for covered losses incurred prior to the end of the grace period provided in the policy. This provision does not prevent a group policyholder from giving written notice of termination of the group policy, prior to the termination date, in accordance with the group policy terms, to reduce or eliminate the grace period.

(c) 1. The insurer shall also be liable for valid claims for covered losses beginning prior to the effective date of written notice of termination to the group policyholder if, after the end of the grace period provided in the policy:

a. It continues to recognize claims subsequently incurred for which recognition is not required by an applicable extension of coverage provision, or

b. It fails to request that the group policyholder notify covered employes of the termination and, except for life and disability income coverages, describe their rights, if any, upon termination.

2. The effective date of termination shall not be prior to midnight at the end of the third scheduled work day after the date on which the notice is delivered.

3. This paragraph shall not apply if a group policy is terminated and immediately replaced by another group policy providing similar coverage.

(5) CONTENT OF NOTICE OF TERMINATION. (a) A notice of termination given by an insurer to a group policyholder in accordance with sub. (4) (a) or (c) shall include:

1. The date as of which the group policy will be terminated,

2. A request to notify covered employes of the termination and, except for life and disability income coverages, the rights, if any, available to them under the group policy,

3. A statement that, unless otherwise provided in the group policy, the insurer will not be liable for claims for losses incurred after the termination date, and

4. If the group policy involves employe contributions, a statement that, if the group policyholder continues to collect contributions for the coverage beyond the date of termination, the group policyholder may be held solely liable for the benefits with respect to which the contributions have been collected.

(b) At the same time, the insurer shall furnish to the group policyholder for distribution to covered employes a supply of a notice form indicating the termination, its effective date and the rights, if any, available to them upon termination, except that, for life and disability income coverages, the notice need only urge the covered employes to refer to their certificate or individual policy to determine what rights, if any, are available upon termination.

(6) EXTENSION OF COVERAGE. (a) A group policy shall, if a covered employe or dependent is totally disabled at the date of termination of the policy, provide an extension of coverage for the individual, beginning at the date of termination of the group policy and continuing during the period of total disability as provided in this subsection.

(b) Under a group life policy which contains a disability benefit extension of any type, such as premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability, the termination of the group policy shall not operate to terminate the extension.

(c) Under a group policy providing benefits for loss of time from work or a specific indemnity during hospital confinement, termination of the group policy during a period of total disability or confinement shall have no effect on benefits payable for the condition or conditions causing con-

tinuing total disability or continuing confinement. The extension of coverage provision for loss of time benefits may provide for the integration of Social Security disability or retirement benefit increases which occur after the date of termination of the group policy only if integration of these benefit increases is also applicable prior to termination of the group policy.

(d) Under a group policy providing hospital, surgical or medical expense coverages, the extension of coverage shall be at least 12 months under major medical or comprehensive medical coverage and at least 90 days under other hospital, surgical or medical expense coverage, subject to the following:

1. Coverage need not be extended beyond the date on which:

a. Total disability terminates,

b. The benefit period specified in the policy ends,

c. The maximum benefit is paid or

d. Coverage for the condition or conditions causing total disability is provided under similar coverage, other than temporary coverage under sub. (7) (b) 2., under the succeeding insurer's group policy.

2. Extended coverage need not cover dental or uncomplicated pregnancy expenses or a condition other than the condition or conditions causing total disability.

3. The extension of coverage is not required where the succeeding insurer agrees, or the prior and succeeding insurers agree, to provide coverage, for individuals who are totally disabled at the date of termination of the group policy, which is not less favorable to them than would otherwise be required by this paragraph.

4. After the termination of extended basic hospital, surgical or medical expense coverage, extended major medical expense coverage shall cover expenses eligible under the major medical expense coverage which are normally covered under the basic coverage, subject to subd. 1.

5. A policy providing hospital, surgical or medical expense coverage which covers only expenses in excess of those covered by basic hospital-surgical-medical expense coverage and major medical coverage or comprehensive medical coverage, issued to the same group policyholder, need not provide extended coverage if the underlying coverage provides extended coverage.

Note: The effect of sub. (6) (d), with respect to pregnancy expense coverage, is to require that extended coverage provide benefits only for pregnancy complication expense, to be consistent with Ins 6.55 (4) (b) 5. However, employers and insurers may wish to consider the provisions of federal public law 95-555 enacted October 31, 1978, which requires that employers subject to it provide benefits for pregnancy, including extended benefits, under employe benefit programs to the same extent that benefits are provided for injury and sickness. Also, the equal rights division of the Wisconsin department of industry, labor and human relations has taken the position, based on Wisconsin case law, that the Wisconsin fair employment act, ss. 111.31-.37, Stats., applies to temporary disability resulting from pregnancy and requires that employe benefit programs provide loss of time benefits for temporary disability resulting from pregnancy, including extended benefits, to the same extent that such benefits are provided for injury and sickness.

(e) A provision for extending coverage shall be contained in each group policy as well as in corresponding certificates.

(f) The benefits payable during any period of extended coverage shall be subject to the group policy's regular coverage limits. The extended coverage shall terminate at the end of a normal benefit period or when the maximum benefit amount has been paid.

(7) LIABILITY OF PRIOR INSURER AND OF SUCCEEDING INSURER. (a) Liability of prior insurer. The prior insurer shall be liable only to the extent of its extensions of coverage. Its liability shall be the same whether the group policyholder secures replacement coverage from another insurer, self-insures or declines to provide the group with insurance.

(b) Liability of succeeding insurer. The succeeding insurer shall be liable as provided in this paragraph where its group policy replaces another providing similar coverage:

1. *Regular coverage.* Regular coverage shall be provided under the succeeding insurer's group policy to:

a. Each employe who is eligible for coverage in accordance with the succeeding insurer's group policy provisions regarding classes eligible and actively at work requirements,

b. Each dependent who is eligible for coverage in accordance with the succeeding insurer's group policy provisions regarding classes eligible and non-hospital confinement requirements,

c. A dependent of a disabled employe if the dependent is eligible for coverage in accordance with the succeeding insurer's group policy provisions regarding classes eligible and non-hospital confinement requirements and if the disabled employe is covered under the succeeding insurer's group policy, and

d. Each terminated insured who has elected to continue coverage under s. 632.897 (3), Stats.

2. *Temporary coverage.* Each employe or dependent not covered under the succeeding insurer's group policy in accordance with subd. 1 shall be provided with temporary coverage by the succeeding insurer, for losses occurring or beginning under the replacement policy, subject to:

a. Temporary coverage need be provided only if the individual was validly covered under the prior group policy or the date of its termination and meets the requirements necessary to be a member of an eligible class under the succeeding insurer's group policy, other than requirements for working full time, part time or a stated number of hours.

b. The coverage to be provided by the succeeding insurer shall be the coverage of the prior group policy reduced by any benefits payable under such policy. The benefits of the succeeding insurer's group policy shall be determined after the benefits of the prior group policy have been determined.

c. Temporary coverage shall be provided by the succeeding insurer until the first of:

(i) The date of the individual becomes eligible under the coverage and under the circumstances described in subd. 1. above.

(ii) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding insurer's group pol-

icy provisions regarding individual termination of coverage, such as at termination of employment or when ceasing to be an eligible dependent.

(iii) For an individual who is totally disabled on the effective date of the succeeding group policy, under a type of coverage for which sub. (6) requires an extension of coverage, the end of any period of extended coverage required of the prior insurer or, if the prior insurer's group policy was not subject to sub. (6), would have been required of the prior insurer had its group policy been so subject.

(3) *Pre-existing conditions.* If the succeeding insurer's group policy contains a pre-existing condition limitation, the coverage for these conditions of persons becoming covered by the succeeding group policy under subd. 1 or 2, during the period the limitation applies under that group policy, shall be the lesser of:

a. The coverage of the succeeding group policy determined without application of the limitation and

b. The coverage of the prior group policy determined after application of any such limitation contained in the policy.

4. *Deductibles and waiting periods.* The succeeding insurer, in applying deductibles or waiting periods contained in its group policy, including pre-existing condition waiting periods, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under the prior group policy, to the extent that the prior and succeeding group policies provide similar coverage. Deductible provision credit shall be given for the same or overlapping benefit periods for expenses incurred and applied against the deductible provisions of the prior group policy during the 90 days preceding the effective date of the succeeding group policy, but only to the extent that these expenses are recognized under the succeeding group policy and are subject to a similar deductible provision.

5. *Determining of prior insurer's coverage.* Where a determination of the prior insurer's coverage is required by the succeeding insurer, the prior insurer, at the succeeding insurer's request, shall furnish a statement of the coverage available and a copy of pertinent group policy provisions to permit the succeeding insurer to verify the coverage statement or make its own coverage determination. Coverage of the prior group policy shall be determined in accordance with the definitions, conditions and covered expense provisions of that group policy rather than those of the succeeding group policy. The coverage determination shall be made as if coverage had not been replaced by the succeeding insurer.

(8) MORE FAVORABLE PROVISIONS PERMITTED. This section sets out minimum requirements. It does not prohibit a group policyholder and an insurer from agreeing to policy provisions which are more favorable to insured persons.

(9) EFFECTIVE DATE. As provided in s. 227.026 (1) (intro), this section shall take effect on the first day of the month following its publication.

History: Cr. Register, October, 1972, No. 202, eff. 11-1-72; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (1), (2) and (7) (c), Register, March, 1979, No. 279, eff. 4-1-79; r. and recr., Register, March, 1982, No. 315, eff. 4-1-82.

Ins 6.52 Biographical data relating to company officers and directors. (1) PURPOSE. This rule is intended to implement and interpret ss. 611.13 (2), 611.54 (1) (a), 611.57, 618.11 (4) and 618.21 (1) (b), Stats., for the purpose of setting standards for the reporting of biographical data relating to company officers, directors, promoters and incorporators, or other persons similarly situated.

(2) In a mutual company organized for the insurance or guaranty of depositors or deposits in banks or trust companies, the maximum single risk may be fixed at a higher amount by the bylaws. Any such company may effect reinsurance in any authorized or unauthorized company that complies with s. 627.23, Stats. Insurance in any unauthorized company shall be reported annually and the same taxes paid upon the premiums as are paid by authorized companies.

History: Emerg. cr. eff. 6-22-76; cr. Register, September, 1976, No. 249, eff. 10-1-76; r. and recr. Register, August, 1981, No. 308, eff. 9-1-81.

Ins 6.73 Reinsurance. (1) PURPOSE. The purpose of this section is to establish requirements for determining an authorized reinsurer under s. 627.23 (1), Stats., and to define the criteria that must be met to permit an insurer to include credit for reinsurance ceded in the annual statement blank filed with the commissioner of insurance. This rule does not limit or change the requirements set forth in ss. 612.31 and 612.33, Stats., for town mutuals.

(2) SCOPE. This section shall apply to all insurers authorized to transact business in this state under chs. 611 through 618, Stats., including the state life insurance fund.

(3) AUTHORIZED REINSURER. (a) A single reinsurer is authorized to assume reinsurance if it is in compliance with one of the following:

1. The reinsurer is authorized to transact business in Wisconsin under chs. 611, 612, 614 or 618, Stats.

2. The reinsurer is licensed to transact business in another jurisdiction of the United States and its capital and surplus meets or exceeds the maximum capital and surplus required under s. 611.19, Stats.

3. The reinsurer is an underwriter at Lloyds, London, the United States government or any agency of the United States government.

(b) A group or pool of reinsurers is authorized to assume reinsurance only to the extent of the aggregate of the liability assumed by each individual reinsurer member of the group or pool meeting the requirements of sub. (3) (a).

(4) CRITERIA REQUIRED TO PERMIT CREDIT FOR REINSURANCE. Credit for reinsurance ceded may be reported in the annual statement blank filed with the commissioner of insurance if the following criteria are met:

(a) The reinsurer is an authorized reinsurer under sub. (3).

(b) The ceding insurer can substantiate credit taken for reinsurance through evidence of an executed copy of the reinsurance agreement and reinsurance accounting documents.

(c) Each reinsurance agreement shall contain an acceptable insolvency clause which guarantees payment of the liability of the reinsurer under the reinsurance contract without diminution because of the insolvency of the ceding insurer.

(d) Each reinsurance agreement effected on or after January 1, 1980 which by its terms required payments to an intermediary shall contain a provision whereby the reinsurer assumes all credit risks of the intermediary related to payments to the intermediary.

(e) The ceding insurer has established adequate gross liabilities or reserves.

(f) If the reinsurer is not considered an authorized reinsurer under sub. (3), credit for reinsurance ceded may be taken to the extent that the balances due from the reinsurer are absolutely secured by express provision in the reinsurance contract by any or a combination of the following:

1. Funds withheld from the same reinsurer and under exclusive control of the ceding insurer.

2. Securities on deposit with and under exclusive control of the ceding insurer and valued in accordance with the valuation standards permitted or prescribed by the commissioner.

3. Funds held in trust in a bank or trust company that is subject to supervision by any state of the United States or by the Dominion of Canada or a province thereof, or that is a member of the federal reserve system, and subject to withdrawal by and under the control of the ceding insurer. The funds may include letters of credit but they must be clean, irrevocable, unconditional letters of credit, with a bank or trust company that is subject to supervision by any state of the United States or by the Dominion of Canada or a province thereof or that is a member of the federal reserve system, termed to be funds held subject to withdrawal by and under the control of the ceding insurer. The letters of credit should be for a period of not less than one year.

History: Emerg. cr. eff. 6-22-76; cr. Register, September, 1976, No. 249, eff. 10-1-76; r. and recr. Register, March, 1982, No. 315, eff. 4-1-82.