Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This section implements and interprets s. Ins 6.75 (2) (i) and (j) and ss. 601.42, 611.19 (1), 611.24, 618.21, 620.02, 623.02, 623.03, 623.04, 627.05 and 628.34 (12), 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 s. Ins 6.75 (2) (i) and (j).

(3) DEFINITIONS. (a) "Amount at risk" means the coverage percentage or the claim settlement option percentage multiplied by the face of amount of a mortgage or by the insured amount of a lease.

(b) "Annual statement" means the fire and casualty annual statement form specified in s. Ins 7.01 (5) (a).

(c) "Contingency reserve" means the reserve established for the protection of policyholders against the effect of losses resulting from adverse economic cycles.

(d) "Equity" means the complement of the Loan-to-Value.

(e) "Face amount" means the entire indebtedness under an insured mortgage before computing any reduction because of an insurer's option limiting its coverage.

(f) "Loan-to-value" means the ratio of the entire indebtedness to value of the collateral property expressed as a percentage.

(g) "Mortgage guaranty account" means the portion of the Contingency Reserve which complies with 26 U.S.C. s. 832 (e) as amended.

(h) "Mortgage guaranty insurance" means that kind of insurance authorized by s. Ins 6.75 (2) (i).

(i) "Mortgage guaranty insurer" means an insurer which:

1. Insures pursuant to Ins 6.75 (2) (i), or

2. Insures pursuant to s. Ins 6.75 (2) (j) against loss arising from failure of debtors to meet financial obligations to creditors under evidences of indebtedness secured by a junior lien or charge on real estate.

(j) "Mortgage guaranty insurers report of policyholders position" means the annual supplementary report required by s. Ins 7.01 (24) (t).

(k) "NAIC Ratio — Investment Yield" means net investment income earned after taxes from the annual statement divided by mean invested assets.

(l) "Person" means any individual, corporation, association, partnership or any other legal entity.

(m) "Policyholders position" includes the contingency reserve established under sub. (14), the deferred risk charge established under sub. (13) (b) and surplus as regards policyholders. "Minimum policyholders position" is calculated as described in sub. (5).

(n) "Surplus as regards policyholders" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

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

(5) MINIMUM POLICYHOLDERS POSITION. (a) A mortgage guaranty insurer shall maintain at all times a minimum policyholders position in the amount required by this section. The policyholders position shall be net of reinsurance ceded but shall include reinsurance assumed.

(b) If a mortgage guaranty insurer does not have the minimum amount of policyholders position required by this section it shall cease transacting new business until such time that its policyholders position is in compliance with this section.

(c) If a policy of mortgage guaranty insurance insures individual loans with a percentage claim settlement option on such loans, a mortgage guaranty insurer shall maintain a policyholders position based on: each $100 of the face amount of the mortgage; the percentage coverage; and the loan-to-value category. The minimum amount of policyholders position shall be calculated in the following manner:

1. If the loan-to-value is greater than 75%, the minimum policyholders position per $100 of the face amount of the mortgage for the specific percent coverage shall be as shown in the schedule below:

Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage
5	$0.20	55	$1.50
10	0.40	60	1.55
15	0.60	65	1.60
20	0.80	70	1.65
25	1.00	75	1.75
30	1.10	80	1.80
35	1.20	85	1.85
40	1.30	90	1.90
45	1.35	95	1.95
50	1.40	100	2.00

2. If the loan-to-value is at least 50% and not more than 75%, the minimum amount of the policyholders position shall be 50% of the minimum of the amount calculated under subd. 1.

3. If the loan-to-value is less than 50%, the minimum amount of policyholders position shall be 25% of the amount calculated under subd. 1.

(d) If a policy of mortgage guaranty insurance provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be:

1. If the equity is not more than 50% and is at least 20%, or equity plus prior insurance or a deductible is at least 25% and not more than 55%, the minimim amount of policyholders position shall be calculated as follows:

Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage
1	$0.30	50	$0.825
5	0.50	60	0.85
10	0.60	70	0.875
15	0.65	75	0.90
20	0.70	80	0.925
25	0.75	90	0.95
30	0.775	100	1.00
40	0.80		

2. If the equity is less than 20%, or the equity plus prior insurance or a deductible is less than 25%, the minimum amount of policyholders position shall be 200% of the amount required by subd. 1.

3. If the equity is more than 50%, or the equity plus prior insurance or a deductible is more than 55%, the minimum amount of policyholders position shall be 50% of the amount required by subd. 1.

(e) If a policy of mortgage guaranty insurance provides for layers of coverage, deductibles or excess reinsurance, the minimum amount of policyholders position shall be computed by subtraction of the minimum position for the lower percentage coverage limit from the minimum position for the upper or greater coverage limit.

(f) If a policy of mortgage guaranty insurance provides for coverage on loans secured by junior liens, the policyholders position shall be:

1. If the policy provides coverage on individual loans, the minimum amount of policyholders position shall be calculated as in par. (c) as follows:

a. the loan-to-value percent is the entire loan indebtedness on the property divided by the value of the property;

b. the percent coverage is the insured portion of the junior loan divided by the entire loan indebtedness on the collateral property; and

c. the face amount of the insured mortgage is the entire loan indebtedness on the property.

2. If the policy provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be calculated according to par. (d) as follows:

a. The equity is the complement of the loan-to-value percent calculated as in subd. 1;

b. The percent coverage is calculated as in subd. 1; and

c. The face amount of the insured mortgage is the entire loan indebtedness on the property.

(g) If a policy of mortgage guaranty insurance provides for coverage on leases, the policyholders position shall be $4 for each $100 of the insured amount of the lease.

(h) If a policy of mortgage guaranty insurance insures loans with a percentage loss settlement option coverage between any of the entries in the schedules in this subsection, then the factor for policyholders posi-

tion per $100 of the face amount of the mortgage shall be prorated between the factors for the nearest Percent Coverage listed.

(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) 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.

(b) A mortgage guaranty insurer shall not insure loans with balloon payment provisions unless the policy provides:

1. That liability for the balloon payment is specifically excluded; or

2. That at the time the lender calls the loan, the lender will offer new or extended financing at the then market rates; or

3. The scheduled maturity date of the balloon payment.

(7m) MINIMUM CAPITAL OR PERMANENT SURPLUS. The minimum amount of capital or permanent surplus of a mortgage guaranty insurer shall be $2 million for an insurer first authorized to do business in Wisconsin on or after January 1, 1982, or the amount required by statute or administrative order before that date for other insurers.

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts, except it shall not enter into reinsurance arrangements designed to circumvent the compensation control provisions of sub. (15) or the contingency, reserve requirement of sub. (14). The unearned premium reserve required by sub. (13) and the contingency reserve required by sub. (14) shall be established and maintained in appropriate proportions in relation to risk retained by the original insurer and by the assuming reinsurer so that the total reserves established shall not be less than the reserve required by subs. (13) and (14).

(9) ADVERTISING. No mortgage guaranty insurer or any agent or representative of a mortgage guaranty insurer shall prepare or distribute or assist in preparing or distributing any brochure, pamphlet, report or any form of advertising to the effect that the real estate investments of any financial institution are "insured investments", unless the brochure, pamphlet, report or advertising clearly states that the loans are insured by insurers possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, as the case may be.

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

(11) PREMIUM. (a) The total consideration charged for mortgage guaranty insurance policies, including policy and other fees or similar charges, shall be considered premium and must be stated in the policy and shall be subject to the reserve requirements of subs. (13) and (14).

(b) The rate making formula for mortgage guaranty insurance shall contain a factor or loading sufficient to produce the amount required for the contingency reserve prescribed by sub. (14).

(12) REPORTING. (a) The financial condition and operations of a mortgage guaranty insurer shall be reported annually on the annual statement.

(b) The total contingency reserve required by sub. (14) shall be reported as a liability in the annual statement. This liability may be reported as unpaid losses, mortgage guaranty account or other appropriately labeled write-in item. Appropriate entries shall be made in the underwriting and investment exhibit — statement of income of the annual statement. The change in contingency reserve for the year shall be reported in the annual statement as a reduction of or a deduction from underwriting income. If the contingency reserve is recorded as a loss liability the change in the reserve shall be excluded from loss development similar to fidelity and surety losses incurred but not reported. The development of the contingency reserve and policyholders position shall be shown in an appropriate supplemental schedule to the annual statement.

(c) A mortgage guaranty insurer shall compute and maintain adequate case basis loss reserves to be reported in the underwriting and investment exhibit, unpaid losses and loss adjustment expenses, of the annual statement. The method used to determine the loss reserve shall accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid, and for claims incurred but not reported, including estimated losses on:

1. Insured loans which have resulted in the conveyance of property to the insurer which remains unsold;

2. Insured loans in the process of foreclosure;

3. Insured loans in default for four months or for any lesser period which is defined as a default in the policy provision; and

4. Insured leases in default for 4 months or for any lesser period which is defined as a default in the policy provisions.

(d) In computing the case basis reserves required by par. (c), the following factors shall be considered together with the prospective adjustments reflecting historic data relative to prior claim settlements:

1. Prior to the exercise of the claim settlement option, the potential liability for which there must be a reserve shall consider the amount at risk or the potential claim amount minus the value of the real estate.

2. If the claim settlement option exercised results in recording the claim amount as the cost of acquisition of the property, the potential liability is the claim amount minus the value of the real estate unless the real estate is recorded at market value.

3. If the claim settlement option exercised results in the payment of amounts equal to the monthly loan payments or lease rents, the potential liability is the present value, utilizing the insurer's NAIC financial ratio-investment yield, of the claim amounts minus the present value of the real estate or current rental income.

(e) Any property acquired pursuant to the exercise of the claim settlement option shall be valued net of encumbrances; and an amount of such property may be held as is permitted for nonlife insurer investments pursuant to s. 620.22 (5), Stats.

(f) Expenses shall be recorded and reported in accordance with ss. Ins 6.30 and 6.31.

(g) Amounts released from the contingency reserve pursuant to sub. (14) shall be treated on a first-in-first-out basis.

(h) An insurer which writes mortgage guaranty insurance and any other class of insurance business shall establish a segregated account for mortgage guaranty insurance or an insurer which writes more than one class of mortgage guaranty insurance shall establish a segregated account for each class of mortgage guaranty insurance. The classes of mortgage guaranty insurance are those types of insurance defined in:

1. s. Ins 6.75 (2) (i) 1 a and c; or

2. s. Ins 6.75 (2) (i) 1 b and 2; or

3. s. Ins 6.75 (2) (i) 1 d and (j).

(i) Each segregated account established under par. (h) shall contain:

1. The loss reserves required by par. (c);

2. The unearned premium reserve required by sub. (13) or (18);

3. The contingency reserve required by sub. (14) or (18); and

4. Any surplus required by the commissioner.

(13) UNEARNED PREMIUM RESERVE. (a) A mortgage guaranty insurer shall compute and maintain an unearned premium reserve on an annual or on a monthly pro rata basis on all unexpired coverage, except that in the case of premiums paid in advance for any coverage issued with a term shown in the schedule below the annual unearned premium factor specified shall apply:

UNEARNED PREMIUM FACTOR TO BE APPLIED TO PREMIUMS IN FORCE ON VALUATION DATE

Contract Year Current at Valuation Date	2 Year Coverage Period	3 Year Coverage Period	4 Year Coverage Period	5 Year Coverage Period	6 Year Coverage Period	7 Year Coverage Period	8 Year Coverage Period
1	88.7%	93.9%	95.7%	96.5%	97.0%	97.3%	97.5%
2	38.7%	66.7%	76.4%	81.0%	83.7%	85.4%	86.5%
3		22.9%	45.2%	56.0%	62.2%	66.2%	68.8%
4			14.5%	31.3%	41.1%	47.4%	51.3%
5				9.8%	22.7%	31.0%	36.2%
6					7.1%	17.1%	23.3%
7						5.4%	12.5%
8							3.8%
9							
10							
11							
12							
13							
14							
15							

Contract Year Current at Valuation Date	9 Year Coverage Period	10 Year Coverage Period	11 Year Coverage Period	12 Year Coverage Period	13 Year Coverage Period	14 Year Coverage Period	15 Year Coverage Period
1	97.7%	97.7%	97.8%	97.8%	97.8%	97.8%	97.8%
2	87.3%	87.6%	87.9%	88.1%	88.1%	88.2%	88.2%
3	70.4%	71.3%	71.9%	72.3%	72.5%	72.6%	72.6%
4	53.8%	55.3%	56.1%	56.7%	57.1%	57.2%	57.3%
5	39.4%	41.3%	42.5%	43.2%	43.7%	43.9%	44.0%
6	27.2%	29.5%	30.9%	31.8%	32.3%	32.7%	32.8%
7	16.9%	19.6%	21.2%	22.1%	22.8%	23.2%	23.3%
8	8.6%	11.6%	13.3%	14.4%	15.1%	15.5%	15.7%
9	2.5%	5.6%	7.5%	8.6%	9.3%	9.9%	10.1%
10		1.6%	3.4%	4.6%	5.4%	6.0%	6.2%
11			0.9%	2.1%	2.9%	3.5%	3.7%
12				0.6%	1.3%	1.9%	2.1%
13					0.4%	0.9%	1.1%
14						0.3%	0.5%
15							0.1%

These unearned premium factors are calculated on the assumption that on the average a contract is written in the middle of the calendar year and that these factors are applied annually to groups of contracts segregated by term and expiration year. These factors include one-half of the earned premium applicable to the contract year current at the valuation date.

(b) On an annual premium plan that portion of the first year premium, excluding policy and other fees or similar charges, which exceeds twice the subsequent renewal premium rate, shall be considered a deferred risk charge and amortized in accordance with factors specified for a 10 year term coverage in par. (a) or in accordance with factors specified for a lesser term coverage in par. (a) as approved by the commissioner.

(c) On premiums paid in advance for coverage periods in excess of 15 years, the unearned portion of the premium during the first 15 years of coverage shall be the premium collected minus an amount equal to the premium that would have been earned had the applicable premium for 15 years' coverage been received. The premium remaining after 15 years shall be released from the unearned premium reserve pro rata over the remaining term of coverage.

(14) CONTINGENCY RESERVE. (a) Subject to sub. (8), there shall be an annual contribution to the contingency reserve which in the aggregate shall be the greater of:

1. 50% of the net earned premium reported in the annual statement; or

2. The sum of:

a. The policyholders position established under sub. (5) on residential buildings designed for occupancy by not more than four families divided by 7;

b. The policyholders position established under sub. (5) on residential buildings designed for occupany by 5 or more families divided by 5;

c. The policyholders position established under sub. (5) on buildings occupied for industrial or commercial purposes divided by 3; and

d. The policyholders position established under sub. (5) for leases divided by 10.

(b) If the mortgage guaranty coverage is not expressly provided for in this section, the commissioner may establish a rate formula factor that will produce a contingency reserve adequate for the risk assumed.

(c) The contingency reserve established by this subsection shall be maintained for 120 months. That portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.

(d) Subject to the approval of the commissioner, withdrawals may be made from the contingency reserve for incurred loss payments in any year exceeding the greater of 35% of the net earned premium or 70% of the amount contributed to the contingency reserve in that year. Funds used in this manner shall be accounted for on a first-in, first-out basis as provided in sub. (12) (g).

(e) The computations required by pars. (a) and (d) shall be made prior to increment or decrement because of contributions to the contingency reserve.

(15) CHARGES, COMMISSIONS AND REBATES. (a) Every mortgage guaranty insurer shall adopt, print and make available a schedule of premium charges for mortgage guaranty insurance coverages. The schedule shall show the entire amount of premium charge for each type of mortgage guaranty insurance coverage issued by the insurer.

(b) A mortgage guaranty insurer shall not knowingly pay, either directly or indirectly to an owner, purchaser, mortgagee of the real property or any interest therein or to any person who is acting as agent, representative, attorney or employe of such owner, purchaser, or mortgagee any commission, remuneration, dividend or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.

(c) In connection with the placement of any insurance, a mortgage guaranty insurer shall not cause or permit any commission, fee, remuneration, or other compensation to be paid to, or received by: any insured lender; any subsidiary or affiliate of any insured; any officer, director or employe of any insured; any member of their immediate family; any corporation, partnership, trust, trade association in which any insured is a member, or other entity in which any insured or any such officer, director, or employe or any member of their immediate family has a financial

interest; or any designee, trustee, nominee, or other agent or representative of any of the foregoing.

(d) A mortgage guaranty insurer shall not make any rebate of any portion of the premium charge shown by the schedule required by par. (a). A mortgage guaranty insurer shall not quote any premium charge to any person which is different than that currently available to others for the same type of mortgage guaranty insurancy coverage sold by the mortgage guaranty insurer. The amount by which any premium charge is less than that called for by the current schedule of premium charge is a rebate.

(e) A mortgage guaranty insurer shall not use compensating balances, special deposit accounts or engage in any practice which unduly delays its receipt of monies due or which involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employe of such owner, purchaser or mortgagee as a means of circumventing any part of this rule. Except for commercial checking accounts and normal deposits in support of an active bank line of credit, any deposit account bearing interest at rates less than is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this paragraph.

(f) A mortgage guaranty insurer shall make provision for prompt refund of any unearned premium in the event of termination of the insurance prior to its scheduled termination date. If the borrower paid or was charged for the premium, the refund shall be made to the borrower, or to the insured for the borrower's benefit, otherwise refund may be paid to the insured.

(g) This subsection is not intended to prohibit payment of appropriate policy dividends to borrowers.

(16) TRANSITION. Policyholders position, unearned premium reserves and contingency loss reserves shall be computed and maintained on risks insured after the effective date of this section as required by subs. (5), (13) and (14). Unearned premium reserves and contingency loss reserves on risks insured before the effective date of this rule may be computed and maintained either as required by subs. (13) and (14) or as required by this section as previously in effect.

(17) CONFLICT OF INTEREST. (a) If a member of a holding company system as defined in Ins 12.01 (3) (e), a mortgage guaranty insurer licensed to transact insurance in this state shall not, as a condition of its certificate of authority, knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate.

(b) A mortgage guaranty insurer, the holding company system of which it is a part or any affiliate shall not as a condition of the mortgage guaranty insurer's certificate of authority, pay any commissions, remuneration, rebates or engage in activities proscribed in sub. (15).

(18) LAWS OR REGULATIONS OF OTHER JURISDICTIONS. Whenever the laws or regulations of another jurisdiction in which a mortgage guaranty

insurer subject to the requirements of this rule is licensed, require a larger unearned premium reserve or a larger contingency reserve in the aggregate than that set forth in this rule, the establishment and maintenance of the larger unearned premium reserve or contingency reserve shall be deemed to be compliance with this rule.

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. r. and recr. Register, March, 1975, No. 231, eff. 4-1-75; emerg. am. (1), (2) and (3) (a), eff. 6-22-76; am. (1), (2) and (3) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1), (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79; r. and recr. (1), (3), (5), (12) and (14), am. (2), (4), (8), (13) (a) and (16), renum. (7) to be (7) (a) and cr. (7) (b) and (7m), Register, October, 1982, No. 322, eff. 11-1-82; correction in (14) (d) made under s. 13.93 (2m) (b) 7, Stats., Register, December, 1984, No. 348; am. (3) (m), Register, October, 1985, No. 358, eff. 11-1-85.

Ins 3.11 Multiple peril insurance contracts. (1) PURPOSE AND SCOPE. (a) This rule implements and interprets s. Ins 6.70 and chs. 625 and 631, 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 s. Ins 6.70, and which include a type or types of coverage or a kind or kinds of insurance subject to ch. 625, Stats.

(c) Types of coverage or kinds of insurance which are not subject to ch. 625, 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 2 or more types of coverage or kinds of insurance included in any one or more than one paragraph of s. Ins 6.75. 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 s. 625.12, 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 s. Ins 6.76 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; emerg. am. (1), (2), (3) (a) and (4), eff. 6-22-76; am. (1), (2), (3) (a) and (4), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) (a) and (b), (2) and (4), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.12 Filing procedures for disability insurance forms. History: Cr. Register, January, 1980, No. 289, eff. 2-1-80; r. Register, December, 1987, No. 384, eff. 1-1-88.

Ins 3.13 Individual accident and sickness insurance. (1) PURPOSE. This section 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 s. Ins 6.75 (1) (c) or (2) (c), and franchise type accident and sickness policies permitted by s. 600.03 (22), Stats. and s. Ins 6.75 (1) (c) and (2) (c). The requirements in subs. (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.

Next page is numbered 65

September, 1976, No. 249, eff. 10-1-76; r. (2), Register, January, 1980, No. 289, eff. 2-1-80; am. (1), Register, September, 1986, No. 369, eff. 10-1-86.

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 ch. 623, Stats., and for fraternal benefit society reserves as authorized by s. 623.15, Stats.

(2) SCOPE. This rule shall apply to the kinds of insurance authorized by s. Ins 6.75 (1) (c) or (2) (c), and shall also apply to fraternal benefit contracts subject to s. 632.94, Stats.

(3) ACTIVE LIFE RESERVES, INDIVIDUAL AND FRANCHISE POLICIES. Active life reserves are required for all in force policies issued subject to s. Ins 6.75 (1) (c) or (2) (c), ss. 600.03 (22), and 632.93, 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 subpar. 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 s. 600.03 (22), 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 s. 600.03 (22), Stats.

6. Commercial policies and other policies not falling within subds. 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 par. (a) 1 to 4 shall be an amount computed on the basis of 2-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 par. (a) 5 and 6 shall be the pro rata gross unearned premium reserve.

(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 pars. (b), (c), (d), and (e). 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 Form 22-41—or with the corresponding items of the Underwriting and Investment Exhibit of the Annual Statement—Fire and Casualty Insurance Companies, Insurance Department Form 22-11. (s. 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 s. 600.03 (4) and (23), Stats.

(a) The minimum active life reserve for such policies shall be the pro rata gross unearned premium reserve.

(b) An additional active life reserve shall be established for converted policies which may be issued under a conversion option for terminated employes. 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 employes.

(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 s. Ins 6.75 (1) (c) or (2) (c), s. 600.03 (22), or 632.93, Stats.

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

1. Maximum Interest Rate: 3½% compounded annually.

2. Morbidity of Other Contingency:

a. Disability due to accident and sickness: The 1964 Commissioners Disability Table (see sub. (3) (b) 4.b), 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. (s. 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 s. 600.03 (4) or (23), 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 sub. (3) (b) 4.b.), 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. (s. 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 filling 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: 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 health, 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.

Ins 3

TABLE I

YEARLY DEATH RATE PER 1000 (1000qx)

AMERICAN MEN ULTIMATE MORTALITY TABLE (AM*)

COMMISSIONERS 1941 STANDARD ORDINARY MORTALITY TABLE (1941 CSO)

COMMISSIONERS 1958 STANDARD ORDINARY MORTALITY TABLE (1958 CSO)

Age	1000qx			Age	1000qx		
	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 Male	Room and Board Benefit* 90 Day Maximum Female	Maternity Expense Benefit Female For $100 Max. Benefit
	For $10 Daily 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

	Surgical Expense Benefit*			Surgical Expense Benefit*	
	Male	Female		Male	Female
Attained Age	For $200 "Standard" Schedule		Attained Age	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
		6.50	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		
	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		

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; emerg. am. to (1) to (6), eff. 6-22-76; am. (1), (2), (3) (intro.), (3) (a), 4 and 5, (3) (e), (4) (intro.), (4) (a), (5) and (6), Register, September, 1976, No. 249, eff. 10-1-76; am. (2), (3) and (5), Register, March, 1979, No. 279, eff. 4-1-79; am. (3) (intro.), (a) 4. and 5. (4) (intro.), (5) (intro.) and (6) (intro.), Register, September, 1986, No. 369, eff. 10-1-86.

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 ch. 623, Stats., and s. 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; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor. (1) This rule implements and interprets ss. 204.321 (1) (d) and 206.60 (2), 1973 Stats., with regard to issuance of a group policy of acci-

dent 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 s. 206.60 (2) (a) and (c), Stats., [1973] 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.

History: Cr. Register, November, 1959, No. 47, eff. 12-1-59; am. Register, September, 1963, No. 93, eff. 10-1-63; r. (3), Register, February, 1973, No. 206, eff. 3-1-73; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles. (1) PURPOSE. In accordance with s. 204.49 (4), Stats., this rule is to accomplish the purpose and enforce the provisions of ch. 625, 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.

(h) 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 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, 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 indicate the limitation clearly.

(i) Conspicuous notice of the debtor's right to return the policy, certificate of insurance or notice of proposed insurance within 10 days of incurring the indebtedness and to receive a refund of any premium paid if the debtor is not satisfied with the insurance for any reason, as required by s. 424.203 (4), Stats., shall be given with the policy, certificate or notice of proposed insurance.

(j) Charges or premiums for credit life insurance or credit accident and sickness insurance may only be collected from debtors if the disclosure and authorization requirements of s. 422.202 (2s), Stats., are met. If 2 debtors are to be insured for credit life insurance each must receive the disclosure information and each one must request credit life insurance coverage. However, the individual policy or group certificate may be delivered to only one debtor.

(8) 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 to them 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, notice of proposed insurance and the premium rates to be used in this state.

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

(c) If the commissioner notifies the insurer that the form is disapproved, the insurer shall not issue or use the form. The notice shall specify the reason for the disapproval and state that a hearing will be granted not less than 10 nor more than 30 days after a request in writing by the insurer.

(cm) No policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until 30 days after it has been filed, unless the commissioner gives prior written approval.

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

The insurer shall not issue or use any form after the effective date of the withdrawal of the approval.

(9) 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 if the premium rate exceeds that established by the filed rate schedules of the insurer.

(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 the debtor that coverage will not be issued and shall promptly make an appropriate credit to the account of the debtor.

(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. If the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of indebtedness and a direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with the insurance charge, the creditor shall 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 these dividends may be deferred until 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 to the refund. The policy certificate may prescribe a minimum refund of $1 and no refund of a lesser amount need be made. The sum of the refunds due on all credit life insurance or credit accident and sickness insurance being terminated in connection with the indebtedness and all other credits due to the customer under chs. 421 to 427, Stats., shall be used to determine if a refund is due.

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

1. In the case of credit life or credit accident and sickness insurance for which premiums are payable other than by a single premium, and in the case of level term credit life insurance, the refund of premium shall be not less than the pro rata unearned gross premium. In the case of credit life or credit accident and sickness insurance paid by a single premium, the refund shall be not less than the amount computed by the "sum of digits" formula commonly known as the "Rule of 78."

2. In the case of credit life or credit accident and sickness insurance for which an amount is charged other than in a single sum, and in the case of level term credit life insurance, the refund of the amount charged to the debtor for insurance shall be equal to the pro rata unearned gross amount charged or to be charged. In the case of credit life and credit accident and sickness insurance for which the whole amount is charged in a single sum the refund shall be not less than the amount computed by the "sum of the digits" formula commonly known as the "Rule of 78."

3. Refunds shall be based on 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 16 days of a loan month has been earned, no charge may be made for that loan month, but if 16 days or more has been earned, a full month may be charged.

(h) If an insured's indebtedness is transferred to another creditor, any group credit life insurance or group credit accident and sickness insurance issued on that indebtedness may be continued, but the creditor policyholder shall advise the insurer of each transfer within 30 days of its effective date.

(i) Voluntary prepayment of indebtedness. If a debtor prepays the indebtedness other than as a result of death or through a lump sum disability payment:

1. Any credit life insurance covering this indebtedness shall be terminated and an appropriate refund of the credit life insurance premium shall be paid to the debtor; and

2. Any credit accident and sickness insurance covering this indebtedness shall be terminated and an appropriate refund of the credit accident and sickness insurance premium shall be paid to the debtor. If a claim under such coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit accident and sickness benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period.

(j) Involuntary prepayment of indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor or by a lump sum payment of a disability claim under a credit insurance policy covering the debtor, then it shall be the responsibility of the insurer to see that the following are paid to the insured debtor, if living, or the beneficiary, other than the creditor named by the debtor, or to the debtor's estate:

1. In the case of prepayment by the proceeds of a credit life insurance policy, or by the proceeds of a lump sum total and permanent disability benefit under credit life coverage, an appropriate refund of the credit accident and sickness insurance premium;

2. In the case of prepayment by a lump sum disability payment under credit accident and sickness coverage, an appropriate refund of the credit life insurance premium;

3. In either case, the amount of the benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges.

(10) CLAIMS AND EXAMINATION PROCEDURES. (a) All claims shall be reported to the insurer or its designated claim representative promptly, 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 a draft drawn upon the insurer or by a 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 another specified person.

(c) No plan or arrangement shall be used in which 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 but 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. This paragraph shall not 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 section.

(d) The insurer shall make a good faith examination of each credit life and credit accident and sickness 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 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 shall maintain records of examinations for 2 years.

(11) CHOICE OF INSURER. When credit life insurance or credit accident or 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 the debtor or of procuring and furnishing the required coverage through any insurer authorized to transact insurance business within this state.

(12) CREDIT INSURANCE PREMIUM RATE FILINGS. (a) Every credit insurer shall file with the commissioner every maximum premium rate schedule applicable to credit life or credit accident and sickness insurance in this state at least 30 days before the proposed effective date.

(b) The benefits provided under a credit life or credit accident and sickness insurance form shall be presumed to be reasonable in relation to the premium rate charged if the premium rates filed do not exceed the prima facie premium rate standards set forth in subs. (14) and (15) and if the forms provide benefits which are no more restrictive than the coverage standards enumerated in subs. (14) and (15).

(c) Nothing in this subsection 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 credible mortality or morbidity actually experienced or reasonably anticipated.

(13) USE OF PRIMA FACIE PREMIUM RATES GENERALLY. (a) An insurer that files rates or has rates on file that are not in excess of the prima facie rates may use those rates without further proof of their reasonableness.

(b) The initial prima facie premium rates are as shown in subs. (14) and (15) for the plans and benefits described in these subsections and shall remain in effect through December 31, 1989.

(c) On or before October 1, 1989, and each three years after that, the commissioner shall give written notice to all authorized insurers specifying the prima facie premium rates to be effective for the three-year period beginning on the next January 1. Such rates shall be determined based on experience data submitted by all insurers pursuant to sub. (19) for the immediately preceding 3 calendar years and shall be calculated as follows:

1. For each category of coverage specified in Appendix B, total prima facie earned premium and total incurred claims shall be calculated for each year for all insurers.

2. If, for any category of coverage, the prima facie premium rate in effect at any time during the three-year period differs from that in effect at the end of of the three-year period, prima facie premiums for that category of coverage shall be adjusted to reflect what the prima facie premium would have been if the prima facie premium rate in effect at the end of the three-year period had been in effect throughout the full three-year period;

3. For each category of coverage, the resulting data are summed separately for the total 3 years for prima facie earned premium and for incurred claims;

4. The credit life insurance adjustment factor is determined as follows:

a. Total credit life insurance data are computed by summing the data for single life coverage and joint life coverage separately for prima facie earned premium and for incurred claims;

b. Total credit life insurance incurred claims are divided by total credit life insurance prima facie earned premiums to determine the credit life insurance loss ratio at prima facie rates, rounded to 3 decimal places; and

c. The credit life insurance loss ratio at prima facie rates is divided by the basic loss ratio for credit life insurance. The quotient, rounded to 2 decimal places, is the credit life insurance adjustment factor;

5. The credit accident and sickness insurance adjustment factor is determined using the same procedure specified in subd. 4., except that:

a. Data for the specifically described categories of credit accident and sickness insurance are summed spearately for prima facie earned premium and for incurred claims;

b. A composite credit accident and sickness insurance basic loss ratio is computed as the average of the basic loss ratio for each category of cover-

age weighted by the corresponding proportionate amount of prima facie earned premium for that category of coverage; and

c. If the quotient of the credit accident and sickness loss ratio at prima facie rates divided by the composite credit accident and sickness basic loss ratio is greater than .95 and less than 1.05, the credit accident and sickness adjustment factor shall be 1.00.

6. For single premium uniformly decreasing single life credit life insurance coverage, the new prima facie premium rate per $100 of initial indebtedness per year equals the prima facie premium rate then in effect multiplied by the credit life insurance adjustment factor, rounded to the nearest cent. This new prima facie premium rate is then multiplied by the following factors to derive the new prima facie premium rate for the indicated plan:

a. 1.85 for the single premium rate per $100 per year for level coverage on a single life, rounded to the nearest cent; or

b. 1.54 for the monthly premium rate per $1,000 outstanding balance coverage, rounded to the nearest one-tenth cent.

7. For credit accident and sickness coverage, the new prima facie premium rate per $100 initial coverage for each category of coverage and for each duration equals the then currently effective prima facie premium rate per $100 for the same category of coverage and duration multiplied by the credit accident and sickness insurance adjustment factor, rounded to the nearest cent.

(d) The basic loss ratio for credit life insurance shall be .50. The basic loss ratio for credit accident and sickness insurance shall vary by plan as follows:

1. 14 days retroactive waiting period — .60

2. 14 days nonretroactive elimination period — .59

3. 30 days retroactive waiting period — .57

4. 30 days nonretroactive elimination period — .52

(e) If a form provides for plans or benefits that differ from those described in subs. (14) and (15), the insurer shall demonstrate to the satisfaction of the commissioner that the premium rate or schedule of premium rates applicable to the form will or may reasonably be expected to achieve the applicable basic loss ratio or such other loss ratio as may be determined by the commissioner to be consistent with s. 424.209, Stats., or that the rate or rates are actuarially consistent with the prima facie premium rates.

(14) PRIMA FACIE CREDIT LIFE INSURANCE PREMIUM RATES. (a) If premiums are payable monthly on the outstanding insured balance basis for term insurance on a single insured debtor, the initial prima facie premium rate shall be $0.616 per month per $1,000 of outstanding insured indebtedness.

(b) If premiums are payable on a single premium basis for straight-line decreasing term insurance on a single insured debtor, the initial prima facie premium rate shall be $0.40 per annum per $100 of initial insured indebtedness.

(c) If premiums are payable on a single premium basis for level term insurance on a single insured debtor, the initial prima facie premium rate shall be $0.74 per annum per $100 of initial insured indebtedness.

(d) The prima facie premium rate for credit life insurance providing coverage on two lives with respect to a single indebtedness shall be 150% of the corresponding single life prima facie premium rate until December 31, 1989, and shall be 167% of the corresponding single life prima facie premium rate on and after January 1, 1990.

(e) The prima facie rates shall apply to all policies providing credit life insurance which are offered to all debtors.

1. If evidence of individual insurability is not required, the policy shall contain no exclusion for pre-existing conditions except for those conditions which manifested themselves to the insured debtor by requiring medical advice, diagnosis, consultation or treatment, or would have caused a reasonably prudent person to have sought medical advice, diagnosis, consultation or treatment, within 6 months preceding the effective date of coverage and which causes loss within 6 months following the effective date of coverage. Under open-end credit plans, the effective date of coverage applies separately with respect to each purchase or loan to which the coverage relates.

2. Whether or not evidence of insurability is required the policy shall contain:

a. No suicide exclusions other than suicide within one year of the effective date of coverage. Under open-end credit plans, the effective date of coverage applies separately with respect to each purchase or loan to which the coverage relates;

b. Either no age restrictions, or age restrictions making ineligible for coverage debtors 65 or over at the time indebtedness is incurred or debtors who will have attained age 66 on the maturity date of the indebtedness. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance, classes of debtors determined by age, and may provide for the cessation of the insurance or a reduction in the amount of insurance upon attainment of not less than age 65;

c. At the option of the insurer and in lieu of a pre-existing condition exclusion, for monthly outstanding balance premium coverage on open-end credit transactions, a provision limiting the amount of insurance payable on death due to natural causes to the balance of the loan as it existed 6 months prior to the date of death if there have been one or more increases in the outstanding insured balance of the loan during such 6 months period and if evidence of individual insurability is not required at the time of the increase in the amount of insurance.

(f) Evidence of insurability may be based either on questions relating to specific health history or based on an objective test such as active full-time work.

(15) PRIMA FACIE CREDIT ACCIDENT AND SICKNESS PREMIUM RATES. (a) The initial credit accident and sickness prima facie premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uni-

formly by the amount of the monthly installment paid, shall be as set forth in subs. 1. and 2. below:

1. As set forth in Appendix A, if premiums are payable on a single premium basis for the duration of the coverage; or

2. If premiums are paid on the basis of a premium rate per month per $1,000 of outstanding insured indebtedness, these premiums shall be computed according to a formula approved by the commissioner as producing a rate or rates actuarially consistent with the single premium prima facie premium rates.

(b) The prima facie rates shall apply to policies providing credit accident and sickness insurance which are issued with or without evidence of insurability, and which are offered to all debtors.

1. If evidence of individual insurability is not required there shall be no exclusion for pre-existing conditions, except for those conditions which manifested themselves to the insured debtor by requiring medical advice, diagnosis, consultation or treatment, or would have caused a reasonably prudent person to have sought medical advice, diagnosis, consultation or treatment, within 6 months preceding the effective date of coverage and which causes loss within 6 months following the effective date of coverage. Under open-end credit plans, the effective date of coverage applies separately with respect to each purchase or loan to which the coverage relates;

2. Whether or not evidence of insurability is required the policy shall contain:

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

b. Either no age restrictions, or age restrictions making ineligible for coverage debtors age 65 or over at the time the indebtedness is incurred, or debtors who will have attained age 66 on the maturity date of the indebtedness. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance classes of debtors determined by age, and may provide for the cessation of the insurance or a reduction in the amount of insurance upon attainment of not less than age 65.

c. A provision which defines disability as the inability to perform any occupation for which the debtor is reasonably fitted by education, training or experience after the period of disability has lasted for 12 consecutive months. During the first 12 consecutive months of disability, the definition must relate the disability to the occupation of the debtor at the time the disability occurred.

(c) No individual 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 is retroactive to the first day of disability.

(16) USE OF RATES HIGHER THAN PRIMA FACIE RATES. (a) An insurer may file for approval and use rates that are higher than the prima facie

rates if it can be reasonably expected that the use of these higher rates will result in a ratio of claims incurred to premiums earned that is not less than the applicable basic loss ratio.

(b) These higher rates may be:

1. Applied uniformly to all applicable credit insurance of the insurer; or

2. Applied according to a case-rating procedure on file with and approved by the commissioner.

(c) An insurer electing to file a case rating procedure may either file its own plan for approval by the commissioner or may use the standard case rating procedure specified in sub. (17).

(17) STANDARD CASE RATING PROCEDURE. (a) An insurer, by written notice to the commissioner of its election to do so, may file and use rates determined by the standard case rating procedure. If elected, the procedure shall be used by the insurer to rate all of its credit insurance in this state.

(b) The case rate shall be the prima facie premium rate if the life years exposure is less than the minimum life years exposure shown below:

Plan of Benefits	Minimum Life Years Exposure
Life - Single	1,900
Life - Joint	1,200
Accident and Sickness:	
14 Day Non Retroactive	100
14 Day Retroactive	100
30 Day Non Retroactive	200
30 Day Retroactive	200

(c) If the life years exposure is not less than the minimum life years exposure, the case rate for a plan of benefits shall be calculated as the product of the deviation factor determined in par. (d) and the prima facie premium rate in effect at the end of the experience period. The case rates shall be rounded to the nearest cent per $1000 indebtedness for single premiums payable on the basis of monthly outstanding balances.

(d) Deviation factor determination. The deviation factor shall be determined using the following worksheet:

Ins 3

Plan of Benefits	Prima Facie Incidence	Basic Loss Ratio
Life - Single	0.00369	.50
Life - Joint	0.00554	.50
Accident and Sickness:		
14 Day Non Retroactive	0.05200	.59
14 Day Retroactive	0.05980	.60
30 Day Non Retroactive	0.03081	.52
30 Day Retroactive	0.03543	.57

Basic Data Entry:

Plan of Coverage	_____
Actual Earned Premium	_____
Prima Facie Earned Premium	_____
Incurred Claims	_____
Number of Years in Experience Period	_____
Life Years Exposure	_____

All calculations below shall be taken to five decimal places:

Line Number	Description of Item	Value
1	Prima Facie Incidence	_____
2	Life Years Exposure	_____
3	Prima Facie Loss Ratio	_____
4	Basic Loss Ratio	_____
5	Line 3 Divided by Line 4	_____
6	Line 5 Times Line 1	_____
7	Line 6 Minus Line 1	_____
8	Line 2 Times Line 7	_____
9	Line 8 Times Line 7	_____
10	One Minus Line 1	_____
11	Line 10 Times Line 1	_____
12	Line 9 Minus Line 11	_____

IF LINE 12 IS GREATER THAN ZERO, GO ON TO LINE 13. IF LINE 12 IS LESS THAN OR EQUAL TO ZERO, THE DEVIATION FACTOR IS ONE AND THE CASE RATE IS THE PRIMA FACIE RATE BASIS CURRENTLY IN EFFECT.

13	Line 2 Times Line 6	_____
14	One Plus Two Times Line 13	_____
15	One Plus Line 2	_____
16	Line 13 Times Line 6	_____
17	Line 14 Squared	_____
18	Line 15 Times Line 16 Times Four	_____
19	Line 17 Minus Line 18	_____
20	Square Root of Line 19	_____
21	Two Times Line 15	_____
22	Line 14 Divided by Line 21	_____
23	Line 20 Divided by Line 21	_____
24	Line 22 Plus Line 23	_____
25	Line 22 Minus Line 23	_____

IF LINE 12 IS LESS THAN OR EQUAL TO ZERO, LINE 26 EQUALS LINE 1; OTHERWISE, IF LINE 5 EXCEEDS ONE, LINE 26 EQUALS LINE 25, AND IF LINE 5 IS LESS THAN ONE, THEN LINE 26 EQUALS LINE 24

26	Credibility Adjusted Incidence	_____
27	Deviation Factor The greater of 1 or Line 26 Divided by Line 1	_____

(e) The period of time for which a case rate may be used by an insurer may not exceed the length of the experience period on which the rate is based. However, the period may not be less than one year nor more than 3 years.

(18) CHANGE OF INSURERS. (a) If a creditor changes insurers, the case rate applicable to that creditor's coverage may be used by the replacing insurer under the same terms and conditions that apply to the replaced insurer;

(b) If the case rate is higher than the prima facie premium rate on the date of change, the replacing insurer shall furnish notice of the change of insurers to the commissioner within 30 days following the date of change. The notice shall include the identity of the creditor and of the replaced insurer, the approved case rate applicable to the creditor's coverage and the rate to be charged by the replacing insurer, and shall request that the commissioner inform the replacing insurer of the termination date of the case rate applicable to the creditor's coverage. In no event shall the replacing insurer charge a rate higher than that approved for use by the replaced insurer for the remainder of the case rate period or, if sooner, until a new case rate for that creditor's coverage is approved by the commissioner.

(19) FILING OF EXPERIENCE INFORMATION. Every insurer having credit life insurance or credit accident and sickness insurance in force in this state shall report Wisconsin experience data annually in the form of Appendix B. The experience data for each calendar year shall be submitted on or before June 30 of the next succeeding year and shall be accompanied by the following:

(a) Written certification by an officer of the insurer that the report fully complies with this reporting requirement and is prepared according to the instructions in sub. (21) except as may be noted and explained in such certification; and

(b) An actuarial description specifying the basis of calculation of unearned premium reserves and claim reserves and liabilities for each category of business, signed by a qualified actuary as defined in s. Ins 6.12.

(20) FINANCIAL STATEMENT MINIMUM RESERVES. (a) Each insurer shall show, as a liability in any financial statement or report required under s. 601.42, Stats., except for the report required to be filed under sub. (19), its policy or unearned premium reserve in an amount not less than as computed in pars. (b) through (f). 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 minimum mortality and interest standards for active life reserves for individual credit life insurance policies shall be not less than 100% of the commissioners 1958 standard ordinary mortality table at 4½% annual interest.

(c) The minimum mortality and interest standards for active life reserves for group credit life insurance policies shall be not less than 100% of the commissioners 1960 standard group mortality table at 4½% annual interest.

(d) In no event shall the active life reserves for credit life insurance be less than the unearned premium.

(e) The minimum morbidity and interest standards for active life reserves 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 commissioners 1964 disability table at 4½% annual interest, or the unearned premium reserve.

(f) With the approval of the commissioner, a company may, for valuation purposes, use any appropriate mortality or morbidity table, in lieu of those specified in pars. (b), (c) and (e), that is based on credible credit life or disability experience.

(g) Unearned premium shall be computed according to the method prescribed in sub. (21) for use in completing Appendix B.

(21) INSTRUCTIONS FOR COMPLETING APPENDIX B. (a) Data shall be provided for all coverage in force at any time during the calendar year, excluding coverage for which no indentifiable charge is made to insured debtors.

(b) Unearned premiums shall be reported consistently as of the beginning and the end of each year, and shall be based on the premium that would be charged for the remaining amount and term of coverage using the premium rate or schedule of premium rates in effect at the time the coverage became effective. The following calculation bases shall be deemed to comply with this requirement in lieu of a precise calculation:

1. For single premium uniformly decreasing credit life insurance coverage, the "sum of the digits" method, commonly know as the "Rule of 78";

2. For single premium credit accident and sickness coverage with substantially equal monthly benefits and with coterminous coverage and benefit periods, the arithmetic mean of the unearned premium calculated according to the "sum of the digits" method and the pro rata unearned premium calculated as the original premium multiplied by the ratio of the remaining coverage term to the original coverage term;

3. For premiums payable on a monthly outstanding balance basis, single premium level life coverage or any other coverage where the benefit amount remains constant throughout the remaining coverage period, the pro rata unearned premium calculated as the original premium multiplied by the ratio of the remaining coverage term to the original coverage term;

4. For decreasing credit life insurance coverge provided for the full term of the indebtedness where the benefit is equal to the actual or scheduled net amount necessary to liquidate the indebtedness, the unearned premium calculated as the original premiums multiplied by the ratio of the scheduled remaining dollar-months of coverage to the scheduled initial dollar-months of coverage. Dollar-months of coverage may be approximated using an assumed interest rate that is reasonably representative of the interest rates applicable to all indebtedness with respect to which coverage is provided on this basis;

5. For credit life insurance coverage providing a combination of level and decreasing benefits, or providing a truncated coverage period or pro-

viding full-term coverage of an indebtedness that requires a balloon payment, an appropriate combination of methods described in this paragraph; or

6. Any other reasonable approximation method approved by the commissioner.

7. In this paragraph, a "dollar-month of coverage" means one dollar of coverage for one month.

(c) Unearned premium for partial months may be calculated on an exact daily basis, on a basis assuming that the valuation date occurs in the middle of each installment period or using the method commonly known as the "15 day 16 day rule" in which the value at the beginning of the month is used if less than 16 days have elapsed in the current month and the value at the end of the month is used if more than 15 days have elapsed in the current month. For the purpose of the "15 day-16 day rule," the current month shall be deemed to begin on the day following the most recent payment due date of the indebtedness and end on the next succeeding payment due date. The valuation date shall be counted as a full day.

(d) Claim reserves and liabilities shall be reported on a consistent basis from year to year. Any change in the basis of calculation shall be disclosed, together with a recalculation of all items as of the end of the preceding calendar year according to the revised basis.

(e) Prima facie earned premium shall be reported as the premium that would have been earned if all coverage had been written at the prima facie premium rates in effect as of the last day of the calendar year for which the experience is submitted. Thus, an adjustment to actual premium will be required for all coverage written at other than the prima facie rate and for any business written at a prima facie rate that differs from the corresponding prima facie rate in effect on the last day of the calendar year for which the experience is submitted.

(22) PENALTY. Violations of this section shall subject the violator to ss. 601.64 and 601.65, Stats.

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; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (4) and (11) (d), cr. (12) (h) and (13) (d), Register, March, 1977, No. 255, eff. 4-1-77; am. (1), (2) and (14) (c), Register, March, 1979, No. 279, eff. 4-1-79; am. (12) (b) to (e), Register, September, 1981, No. 309, eff. 10-1-81; r. (19) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; reprinted to correct printing errors in (13) (b), (14) (c) and (f), Register, June, 1986, No. 366; r. and recr. Register, November, 1987, No. 383, eff. 1-1-88; am. (8) (c) and (17) (d), Register, November, 1988, No. 395, eff. 12-1-88.

Appendix A

GROUP CREDIT DISABILITY INSURANCE SINGLE PREMIUM RATES PER $100 OF INITIAL INSURED INDEBTEDNESS

	BENEFITS PAYABLE AFTER:			
	the 14th day of disability		the 30th day of disability	
Original number of equal monthly installments	Retroactive to first day	Non-retroactive	Retroactive to first day	Non-retroactive
6	1.74	1.39	1.10	.69
7	1.84	1.56	1.30	.80
8	1.94	1.66	1.40	.89
9	2.02	1.74	1.49	.97
10	2.10	1.82	1.58	1.05
11	2.17	1.89	1.63	1.12
12	2.23	1.95	1.68	1.18
13	2.29	2.01	1.72	1.24
14	2.35	2.07	1.75	1.30
15	2.41	2.13	1.79	1.35
16	2.46	2.18	1.82	1.40
17	2.51	2.23	1.86	1.45
18	2.56	2.27	1.89	1.50
19	2.60	2.32	1.91	1.54
20	2.65	2.36	1.94	1.59
21	2.69	2.40	1.97	1.62
22	2.73	2.44	1.99	1.64
23	2.77	2.48	2.02	1.67
24	2.81	2.52	2.04	1.69
25	2.85	2.56	2.06	1.71
26	2.88	2.60	2.09	1.73
27	2.92	2.63	2.11	1.75
28	2.95	2.67	2.13	1.77
29	2.99	2.70	2.15	1.79
30	3.02	2.74	2.17	1.82
31	3.06	2.77	2.19	1.83
32	3.09	2.80	2.21	1.85
33	3.12	2.83	2.23	1.87
34	3.15	2.86	2.25	1.89

Appendix A — Group Credit Disability Insurance (continued)

BENEFITS PAYABLE AFTER:

Original number of equal monthly installments	the 14th day of disability		the 30th day of disability	
	Retroactive to first day	Non-retroactive	Retroactive to first day	Non-retroactive
35	3.18	2.90	2.27	1.91
36	3.21	2.93	2.29	1.93
37	3.24	2.96	2.30	1.94
38	3.27	2.99	2.32	1.96
39	3.30	3.01	2.34	1.98
40	3.33	3.04	2.35	1.99
41	3.36	3.07	2.37	2.01
42	3.39	3.10	2.39	2.03
43	3.41	3.13	2.40	2.04
44	3.44	3.15	2.42	2.06
45	3.47	3.18	2.44	2.08
46	3.50	3.21	2.45	2.09
47	3.52	3.23	2.47	2.11
48	3.55	3.26	2.48	2.12
49	3.57	3.29	2.50	2.14
50	3.60	3.31	2.51	2.15
51	3.62	3.34	2.53	2.16
52	3.65	3.36	2.54	2.18
53	3.67	3.39	2.56	2.19
54	3.70	3.41	2.57	2.21
55	3.72	3.43	2.58	2.22
56	3.75	3.46	2.60	2.24
57	3.77	3.48	2.61	2.25
58	3.79	3.51	2.63	2.26
59	3.82	3.53	2.64	2.28
60	3.84	3.55	2.65	2.29
61	3.88	3.58	2.68	2.30
62	3.91	3.60	2.69	2.32
63	3.93	3.62	2.70	2.33
64	3.95	3.64	2.72	2.34
65	3.97	3.67	2.73	2.35
66	4.00	3.69	2.74	2.37
67	4.02	3.71	2.76	2.38

Appendix A — Group Credit Disability Insurance (continued)

BENEFITS PAYABLE AFTER:

Original number of equal monthly installments	the 14th day of disability		the 30th day of disability	
	Retroactive to first day	Non-retroactive	Retroactive to first day	Non-retroactive
68	4.04	3.73	2.77	2.39
69	4.06	3.75	2.78	2.40
70	4.08	3.77	2.79	2.42
71	4.11	3.80	2.81	2.43
72	4.13	3.82	2.82	2.44
73	4.15	3.84	2.83	2.45
74	4.17	3.86	2.84	2.47
75	4.19	3.88	2.85	2.48
76	4.21	3.90	2.87	2.49
77	4.23	3.92	2.88	2.50
78	4.25	3.94	2.89	2.51
79	4.27	3.96	2.90	2.52
80	4.29	3.98	2.91	2.54
81	4.31	4.00	2.92	2.55
82	4.33	4.02	2.94	2.56
83	4.35	4.04	2.95	2.57
84	4.37	4.06	2.96	2.58
85	4.39	4.08	2.97	2.59
86	4.41	4.10	2.98	2.60
87	4.43	4.12	2.99	2.61
88	4.45	4.14	3.00	2.63
89	4.47	4.16	3.01	2.64
90	4.49	4.18	3.03	2.65
91	4.51	4.20	3.04	2.66
92	4.52	4.21	3.05	2.67
93	4.54	4.23	3.06	2.68
94	4.56	4.25	3.07	2.69
95	4.58	4.27	3.08	2.70
96	4.60	4.29	3.09	2.71
97	4.62	4.31	3.10	2.72
98	4.64	4.32	3.11	2.73
99	4.65	4.34	3.12	2.74
100	4.67	4.36	3.13	2.75

Appendix A — Group Credit Disability Insurance (continued)

BENEFITS PAYABLE AFTER:

Original number of equal monthly installments	the 14th day of disability		the 30th day of disability	
	Retroactive to first day	Non-retroactive	Retroactive to first day	Non-retroactive
101	4.69	4.38	3.14	2.76
102	4.71	4.40	3.15	2.77
103	4.73	4.41	3.16	2.78
104	4.74	4.43	3.17	2.79
105	4.76	4.45	3.18	2.80
106	4.78	4.47	3.19	2.81
107	4.80	4.49	3.20	2.82
108	4.81	4.50	3.21	2.84
109	4.83	4.52	3.22	2.84
110	4.85	4.54	3.23	2.85
111	4.86	4.55	3.24	2.86
112	4.88	4.57	3.25	2.87
113	4.90	4.59	3.26	2.88
114	4.92	4.61	3.27	2.89
115	4.93	4.62	3.28	2.90
116	4.95	4.64	3.29	2.91
117	4.97	4.66	3.30	2.92
118	4.98	4.67	3.31	2.93
119	5.00	4.69	3.32	2.94
120	5.02	4.71	3.33	2.95

Formula 1.25 × Claim Cost + $.60 (subject to a maximum of 2 × Claim Cost)

Appendix B

CREDIT LIFE AND ACCIDENT AND HEALTH EXPERIENCE EXHIBIT

For the year ended December 31, 19.....

Of the ..... Insurance Company

Address (City, State and Zip Code) .....

NAIC Group Code ..... NAIC Company Code .....

To be filed on or before June 30

Direct Business in the State of .....

PART 1—CREDIT LIFE INSURANCE

	Single	Joint	Total
1. Earned Premiums:			
A. Gross written premiums			
B. Refunds on terminations			
C. Net written premiums (A – B)			
D. Premium reserves, start of period			
E. Premium reserves, end of period			
F. Actual earned premiums (C + D – E)			
G. Earned premiums at prima facie rates			
2. Incurred Claims:			
A. Claims paid			
B. Unreported claim reserve, start of period			
C. Unreported claim reserve, end of period			
D. Claim reserves, start of period			
E. Claim reserves, end of period			
F. Incurred claims (A – B + C – D + E)			
3. Loss Ratio:			
A. Actual loss ratio (2F/1F)	%	%	%
B. Loss ratio at prima facie rates (2F/1G)	%	%	%
4. Mean insurance in force			
5. Losses per $1,000 mean insurance in force ((1,000 × 2F)/4)			

PART 2—CREDIT ACCIDENT AND HEALTH INSURANCE

	7 Day Retro	14 Day Retro	14 Day Non-Retro	30 Day Retro	30 Day Non-Retro	Other	Total
1. Earned Premiums:							
A. Gross written premiums							
B. Refunds on terminations							
C. Net written premiums (A – B)							
D. Premium reserves, start of period							
E. Premium reserves, end of period							
F. Actual earned premium (C + D – E)							
G. Earned premiums at prima facie rates							
2. Incurred Claims:							
A. Claims paid							
B. Unreported claim reserve, start of period							
C. Unreported claim reserve, end of period							
D. Claim reserves, start of period							
E. Claim reserves, end of period							
F. Incurred claims (A – B + C – D + E)							
3. Loss Ratio:							
A. Actual loss ratio (2F/1F)	%	%	%	%	%	%	%
B. Loss ratio at prima facie rates (2F/1G)	%	%	%	%	%	%	%