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, 1990.

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(c) On or before October 1, 1990, and each 3 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:

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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

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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;

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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 coverage 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.

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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, 1990, and shall be 167% of the corresponding single life prima facie premium rate on and after January 1, 1991.

(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;

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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.

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(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 uniformly by the amount of the monthly installment paid, shall be as set forth in subds. 1. and 2.

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 cov-

erage 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:

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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 as specified in the instructions to the annual statement 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 (e). 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) 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.

(e) 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 (d), that is based on credible credit life or disability experience and either explicitly or implicitly has adequate margins for the present value of all future unaccrued liabilities.

(f) Unearned premium reserve shall be computed according to the method for calculating unearned premiums prescribed in sub. (21) for use in completing Appendix B.

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(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 identifiable charge is made to insured debtors.

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(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 known 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 coverage 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 providing full-term coverage of an indebtedness that requires a balloon pay-

ment, 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; r. and recr. (9) (g), am. (13) (b) and (c) (intro.), (14) (d), (19) (intro.), (20) (a) and Appendix B, r. (20) (d), renum. (20) (e) to (g) to be (20) (d) to (f) and am. (20) (e) and (f), Register, November, 1989, No. 407, eff. 12-1-89, except (9) (g) eff. 4-1-90.

Ins 3.25 Appendix A

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

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
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
35	3.18	2.90	2.27	1.91

Appendix A — Group Credit Disability Insurance (continued)

Original number of equal monthly installments	BENEFITS PAYABLE AFTER: the 14th day of disability		the 30th day of disability	
	Retroactive to first day	Non-retroactive	Retroactive to first day	Non-retroactive
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
68	4.04	3.73	2.77	2.39

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
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
101	4.69	4.38	3.14	2.76

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
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)

Ins 3.25 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 ..... Employer's I.D. Number .....

To be filed on or before MAY 1

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)	%	%	%	%	%	%	%

Revised 1988

Ins 3.26 Unfair trade practices in credit life insurance and credit accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to assist in the maintenance of a fair and equitable credit life insurance and credit accident and sickness insurance market. This rule interprets, including but not limited to, the following ss. 601.04; 601.01 (1), (2), (3), (7) and (8); 601.41 (1), (2) and (3) and ch. 628, Stats.

(2) SCOPE. This rule shall apply to the transaction of credit life insurance as defined in s. Ins 6.75 (1) (a) 1. and 632.44 (3), Stats., and the transaction of credit accident and sickness insurance as defined in s. Ins 6.75 (1) (c) 1. or (2) (c) 1.

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

(a) The offer or grant by an insurer of any special favor or advantage, or any valuable consideration or inducement not set out in the insurance contract. The payment of agents' commissions, reported annually in Schedule 24S, shall not be a violation of this paragraph but the acts cited in pars. (b), (c), (d), (e) and (f) may not in any way be construed as agents' commissions.

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

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

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

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

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

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

History: Cr. Register, October, 1972, No. 202, eff. 11-1-72; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79; correction in (1) made under s. 13.93 (2m) (b) 7, Stats., Register, April, 1992, No. 436.

Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance. (1) PURPOSE. The interest of prospective purchasers of

refer an enrollee, or initiates disenrollment proceedings, the preferred provider plan shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(c) A preferred provider plan shall resolve all grievances within 30 calendar days of receiving the grievance. If the preferred provider plan is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the preferred provider plan notifies, in writing, the person who filed the grievance that the preferred provider plan has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The preferred provider plan shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Preferred provider plans shall develop a separate grievance procedure for urgent care situations. This procedure shall require a preferred provider plan to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(f) Preferred provider plans shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each preferred provider plan shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the preferred provider plan.

2. Each provider contract and administrative services agreement entered into between a preferred provider plan and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the preferred provider plan for recording and resolution.

3. Each preferred provider plan shall submit the grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances that were formally reveiwed by a grievance panel of the preferred provider plan during the previous calendar year. For purposes of this report, the preferred provider plan shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefits denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each preferred provider plan shall keep together in a central location of the preferred provider plan all records on complaints and grievances resolved before a formal review by a grievance panel is completed

or in which the enrollee does not pursue a resolution. Preferred provider plans shall make these records available for review during examination by or on request of the commissioner.

(g) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from preferred provider plans. The report shall also summarize complaints involving preferred provider plans that were received by the office during the previous calendar year.

Note: A copy of the grievance experience report form required under sub. (7) (f) 3, OCI 26-004, may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707-7873.

History: Cr. Register, June, 1984, No. 342, eff. 7-1-84; r. (7) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; am. (1) and (4) (a), r. (6), Register, September, 1986, No. 369, eff. 10-1-86; renum. (2) to (5) to be (3) to (6), cr. (2) and (7), Register, October, 1989, No. 406, eff. 1-1-90.

Ins 3.49 Wisconsin automobile insurance plan. (1) PURPOSE. This section interprets s. 619.01 (6), Stats., to continue a plan to make automobile insurance available to those who are unable to obtain it in the voluntary market by providing for the equitable distribution of applicants among insurers and outlines access and grievance procedures for such a plan.

(2) DEFINITIONS. In this section:

(a) "Committee" means the governing committee of the Wisconsin Automobile Insurance Plan which is the group of companies administering the Plan.

(b) "Plan" means the Wisconsin Automobile Insurance Plan, an unincorporated facility established by s. 204.51 [Stats., (1967)] and continued under s. 619.01 (6), Stats.

(3) FILING AND ACCESS. The committee shall submit revisions to its rules, rates and forms for the Plan to the commissioner. Prior approval by the commissioner of the documents is required before they may become effective. The documents shall provide:

(a) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise and their assignment to insurers;

(b) Rates and rate modifications applicable to such risks which shall not be excessive, inadequate or unfairly discriminatory;

(c) The limits of liability which the insurer shall be required to assume;

(d) A method by which an applicant to the Plan denied insurance or an insured under the Plan whose insurance is terminated may request the committee to review such denial or termination and by which an insurer subscribing to the Plan may request the committee to review actions or decisions of the Plan which adversely affect such insurer. The method shall specify that such requests for review must be made in writing to the Plan and that the decision of the committee in regard to such review may be appealed by the applicant, insured, or company to the commissioner of insurance as provided for in ch. Ins 5. A review or appeal does not operate as a stay of termination.

Note: These requirements reflect former s. 204.51 (2), Stats.

(e) The commissioner shall maintain files of the Plan's approved rules, rates, and forms and such documents must be made available for public inspection at the office of the commissioner of insurance.

History: Cr. Register, November, 1984, No. 347, eff. 12-1-84.

Ins 3.50 Health maintenance organizations. (1) PURPOSE. This section establishes financial and other standards for health maintenance organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements which apply to health maintenance organizations.

(2) SCOPE. This section applies to all insurers writing health maintenance organization business in this state.

(3) DEFINITIONS. In this section:

(b) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(c) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a health maintenance organization which is expressed in writing by or on behalf of a plan enrollee.

(d) "Health maintenance organization" means a health care plan as defined in s. 609.01 (2), Stats.

(e) "Health maintenance organization insurer" has the meaning provided under s. 600.03 (23c), Stats. "Health maintenance organization insurer" does not include a limited service health organization.

(4) FINANCIAL REQUIREMENTS. (a) *Capital.* Unless otherwise ordered by the commissioner the minimum capital or permanent surplus of:

1. A health maintenance organization insurer first licensed or organized on or after July 1, 1989, is $750,000;

2. A health maintenance organization insurer first licensed or organized prior to July 1, 1989, is $200,000;

3. Any other insurer writing health maintenance organization business, is the amount of capital or required surplus required under the statutes governing the organization of the insurer.

(b) *Compulsory surplus.* An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer shall maintain compulsory surplus as follows, or a greater amount required by order of the commissioner:

1. Prior to January 1, 1991, at least the greater of $500,000 or an amount equal to the sum of:

a. 10% of premium earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (a) 3, Stats.; plus

b. 3% of all other premium earned in the previous 12 months.

2. In calendar year 1991, at least the greater of $500,000 or an amount equal to the sum of:

a. 10% of premium earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (3) (a) 3, Stats.; plus

b. 3% of other premiums earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 4.5% of other premium earned in the previous 12 months.

3. Beginning on January 1, 1992, at least the greater of $750,000 or an amount equal to the sum of:

a. 10% of premiums earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (3) (a) 3, Stats.; plus

b. 3% of other premium earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 6% of other premiums earned in the previous 12 months.

(c) *Risks.* Risks and factors the commissioner may consider in determining whether to require greater compulsory surplus by order include, but are not limited to, those described under s. 623.11 (1) (a) and (b), Stats., and the extent to which the insurer effectively transfers risk to providers. A health maintenance organization insurer may transfer risk through any mechanism including, but not limited to, those provided under sub. (5) (d).

(d) *Security surplus.* An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization insurance business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a health maintenance organization insurer shall be at least the greater of:

1. Compulsory surplus plus 40% reduced by 1% for each $33 million of premium in excess of $10 million earned in the previous 12 months; or

2. 110% of its compulsory surplus.

(e) *Insolvency protection for policyholders.* Each health maintenance organization insurer is required to either maintain compulsory surplus as required for other insurers under s. Ins 14.02 or to demonstrate that in the event of insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or pre-existing limitation requirements.

(f) *Setting greater amounts.* The commissioner may set greater amounts under pars. (a) to (d) on finding that the financial stability of the organization requires it.