CHAPTER 610

INSURERS IN GENERAL

Cross−reference: See definitions in ss. 600.03 and 628.02.
NOTE: Chapter 260, laws of 1971, which created this chapter, contains explanatory notes.

610.001 Purposes. The purposes of chs. 611 to 616 are:

(1) To provide an orderly procedure by which insurers may be created, governed and dissolved;

(2) To provide for procedures to merge, consolidate or convert various kinds of insurers;

(3) To provide for structure and management that will maximize democratic participation in the operation of insurers; and

(4) To prevent or control self−dealing by management in order to protect the interests of shareholders, policyholders, members, subscribers and the public.

History: 1971 c. 260; 1979 c. 102 s. 237; 1979 c. 261.

610.01 Definitions. In chs. 610 to 620 and 644, unless the context requires otherwise:

(1) "Director" includes "trustee".

(2) "Officer" does not include "director".

(3) "Promoter stock" means shares issued by a domestic stock corporation under ss. 611.18 (2) (a) 2. and 611.32 (1), and shares issued within 5 years after the initial issuance of the certificate of authority, to incorporators, directors, principal officers, members of the families of any of these persons, and to any corporations controlled by, or any trustee acting in behalf of, any of these persons.

(4) In any provision of ch. 180 or 181 made applicable by any section of chs. 600 to 646, "department" shall be read "commissioner of insurance".

History: 1971 c. 260; 1979 c. 102, 177; 1983 a. 189; 1995 a. 27; 1997 a. 227.

610.11 Qualified insurers. No person may do an insurance business as defined in s. 618.02 (2) on the person's own account in this state, either in person, or through agents or brokers, or through the mail or any other method of communication, except:

(1) An insurer authorized to do business in this state, within the limits of its certificate of authority; or

(2) An insurer doing business under s. 618.41.

History: 1971 c. 260; 1991 a. 316.

610.21 Other business. (1) PROHIBITION FOR DOMESTIC INSURERS. No domestic insurer may engage, directly or indirectly, in any business other than insurance and business reasonably incidental to its insurance business, except as specifically authorized by s. 611.26 (4), 611.26 (4) as incorporated by s. 614.24 (1), or s. 613.26 or any other provision of chs. 600 to 646;except that a domestic insurer not restricted under s. 620.03 may engage directly in any activity to the extent it is authorized to do so through a subsidiary.

(2) PROHIBITION FOR NONDOMESTIC INSURERS. No nondomestic insurer may engage in this state in any business forbidden to a domestic insurer, nor may the insurer engage in such business elsewhere if:

(a) The law of the insurer's domicile forbids an insurer to engage in such business; or

(b) The statutes of this state specifically prohibit a nondomestic insurer to engage in such business elsewhere; or

(c) The commissioner orders it to cease doing such business upon finding that doing such business is not consistent with the interests of its insureds, creditors or the public in this state; or that it gives the insurer a substantial competitive advantage in relation to domestic insurers.

(3) INCIDENTAL BUSINESS. "Incidental business" includes:

(a) The business of preparing and selling abstracts of title and related documents, if done by an insurer authorized to transact title insurance;

(b) Business that could be done through ancillary subsidiaries authorized under s. 611.26 (3), or, in the case of a nondomestic insurer, through corporations that would be so authorized if the insurer were domestic.

(4) ANNUITIES. For purposes of this section, "insurance" includes "annuities".

History: 1971 c. 260; 1975 c. 373; 1979 c. 102, 177; 1981 c. 307.

610.23 Power to hold property in other than own name. An insurer shall hold all investments and deposits of its funds in its own name except that:

(1) CUSTODIAL OR TRUST ARRANGEMENTS. Securities kept under a custodial agreement or trust arrangement with a bank or banking and trust company may be issued in the name of a nominee of the bank or banking and trust company; and

(2) BEARER SECURITIES. Any insurer may acquire and hold securities in bearer form.

History: 1975 c. 373.

Legislative Council Note, 1975: This section continues s. 201.24 (4), made applicable to all insurers. The power certainly exists under ss. 180.04 (17) and 181.04 (16) as incorporated in ss. 611.07 (1), 612.03 and 614.07 (1), but this section places it beyond doubt for all insurers and permits the repeal of s. 201.24 (4). [Bill 643−S]

610.24 Insurers as fundholders. All assets shall be held, invested and disbursed for the use and benefit of the insurer and no policyholder, member or beneficiary may have or acquire individual rights in such assets or become entitled to any apportionment or the surrender of any part of such assets, except as provided in the contract. An insurer may create, maintain, invest, disburse and apply any special funds necessary to carry out any purpose permitted by the laws of this state and the articles and bylaws of the insurer.

History: 1979 c. 102.

610.40 Continued effect of transitional provisions. Sections 610.41 to 610.53, 1981 stats., continue to apply to insurers affected by those sections before April 27, 1984.

History: 1983 a. 215.

610.50 Vital records. An insurer or an employee, agent or attorney of an insurer is not subject to s. 69.24 (1) (a) for copying a certified copy of a vital record for the insurer's own internal administrative use in connection with the payment of insurance claims or benefits if the copy is marked "FOR ADMINISTRATIVE USE" and is retained in the files of the insurer or attorney.

History: 1987 a. 247.

610.61 Duty of life insurers to report abandoned property. An insurer doing a life insurance business shall report under s. 177.17 any property presumed abandoned under s. 177.07.
History: 1979 c. 102; 1983 a. 408 s. 16.

610.65 Uniform claim processing form. Beginning no later than July 1, 2004, every insurer shall use the uniform claim processing form developed by the commissioner under s. 601.41 (9) (b) when processing a claim submitted by a health care provider, as defined in s. 146.81 (1) (a) to (p).
History: 2001 a. 109; 2009 a. 28.

610.70 Disclosure of personal medical information. (1) DEFINITIONS. In this section:

(a) "Health care provider" means any person licensed, registered, permitted or certified by the department of health services or the department of regulation and licensing to provide health care services, items or supplies in this state.

(b) "Individual" means a natural person who is a resident of this state. For purposes of this paragraph, a person is a state resident if his or her last−known mailing address, according to the records of an insurer or insurance support organization, was in this state.

(c) 1. "Insurance support organization" means any person that regularly engages in assembling or collecting personal medical information about natural persons for the primary purpose of providing the personal medical information to insurers for insurance transactions, including the collection of personal medical information from insurers and other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

2. Notwithstanding subd. 1., "insurance support organization" does not include insurance agents, government institutions, insurers or health care providers.

(d) "Insurance transaction" means any of the following involving insurance that is primarily for personal, family or household needs:

1. The determination of an individual's eligibility for an insurance coverage, benefit or payment.

2. The servicing of an insurance application, policy, contract or certificate.

(e) "Medical care institution" means a facility, as defined in s. 647.01 (4), or any hospital, nursing home, community−based residential facility, county home, county infirmary, county hospital, county mental health center, adult family home, assisted living facility, rural medical center, hospice or other place licensed, certified or approved by the department of health services under s. 49.70, 49.71, 49.72, 50.02, 50.03, 50.032, 50.033, 50.034, 50.35, 50.52, 50.90, 51.04, 51.08, or 51.09 or a facility under s. 45.50, 51.05, 51.06, or 252.10 or under ch. 233, or licensed or certified by a county department under s. 50.032 or 50.033.

(f) 1. "Personal medical information" means information concerning an individual that satisfies all of the following:

a. Relates to the individual's physical or mental health, medical history or medical treatment.

b. Is obtained from a health care provider, a medical care institution, the individual or the individual's spouse, parent or legal guardian.

2. "Personal medical information" does not include information that is obtained from the public records of a governmental authority and that is maintained by an insurer or its representatives for the purpose of insuring title to real property located in this state.

(2) DISCLOSURE AUTHORIZATION. (a) Any form that is used in connection with an insurance transaction and that authorizes the disclosure of personal medical information about an individual to an insurer shall comply with all of the following:

1. All instructions and other information contained in the form are presented in plain language.

2. The form is dated.

3. The form specifies the types of persons that are authorized to disclose information about the individual.

4. The form specifies the nature of the information that is authorized to be disclosed.

5. The form names the insurer, and identifies by generic reference representatives of the insurer, to whom the information is authorized to be disclosed.

6. The form specifies the purposes for which the information is being obtained.

7. Subject to par. (b), the form specifies the length of time for which the authorization remains valid.

8. The form advises that the individual, or an authorized representative of the individual, is entitled to receive a copy of the completed authorization form.

(b) 1. For an authorization under this subsection that will be used for the purpose of obtaining information in connection with an insurance policy application, an insurance policy reinstatement or a request for a change in policy benefits, the length of time specified in par. (a) 7. may not exceed 30 months from the date on which the authorization is signed.

2. For an authorization under this subsection that will be used for the purpose of obtaining information in connection with a claim for benefits under an insurance policy, the length of time specified in par. (a) 7. may not exceed the policy term or the pendency of a claim for benefits under the policy, whichever is longer.

(3) ACCESS TO RECORDED PERSONAL MEDICAL INFORMATION. (a) If, after proper identification, an individual or an authorized representative of an individual submits a written request to an insurer for access to recorded personal medical information that concerns the individual and that is in the insurer's possession, within 30 business days after receiving the request the insurer shall do all of the following:

1. Inform the individual or authorized representative of the nature and substance of the recorded personal medical information in writing, by telephone or by any other means of communication at the discretion of the insurer.

2. At the option of the individual or authorized representative, permit the individual or authorized representative to inspect and copy the recorded personal medical information, in person and during the insurer's normal business hours, or provide by mail to the individual or authorized representative a copy of the recorded personal medical information. If the recorded personal medical information is in coded form, the insurer shall provide to the individual or authorized representative an accurate written translation in plain language.

3. Disclose to the individual or authorized representative the identities, if recorded, of any persons to whom the insurer has disclosed the recorded personal medical information within 2 years prior to the request. If the identities are not recorded, the insurer shall disclose to the individual or authorized representative the names of any insurance agents, insurance support organizations or other entities to whom such information is normally disclosed.

4. Provide to the individual or authorized representative a summary of the procedures by which the individual or authorized representative may request the correction, amendment or deletion of any recorded personal medical information in the possession of the insurer.

(b) Notwithstanding par. (a), an insurer may, in the insurer's discretion, provide a copy of any recorded personal medical information requested by an individual or authorized representative under par. (a) to a health care provider who is designated by the individual or authorized representative and who is licensed, registered, permitted or certified to provide health care services with respect to the condition to which the information relates. If the insurer chooses to provide the information to the designated

health care provider under this paragraph, the insurer shall notify the individual or authorized representative, at the time of disclosure, that the information has been provided to the health care provider.

(c) An insurer is required to comply with par. (a) or (b) only if the individual or authorized representative provides a reasonable description of the information that is the subject of the request and if the information is reasonably easy to locate and retrieve by the insurer.

(d) If an insurer receives personal medical information from a health care provider or a medical care institution with instructions restricting disclosure of the information under s. 51.30 (4) (d) 1. to the individual to whom the information relates, the insurer may not disclose the personal medical information to the individual under this subsection, but shall disclose to the individual the identity of the health care provider or a medical care institution that provided the information.

(e) Any copy of recorded personal medical information provided under par. (a) or (b) shall include the identity of the source of the information if the source is a health care provider or a medical care institution.

(f) An insurer may charge the individual a reasonable fee to cover the costs incurred in providing a copy of recorded personal medical information under par. (a) or (b).

(g) The requirements for an insurer under this subsection may be satisfied by another insurer, an insurance agent, an insurance support organization or any other entity authorized by the insurer to act on its behalf.

(h) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.

(4) CORRECTION, AMENDMENT OR DELETION OF RECORDED PERSONAL MEDICAL INFORMATION. (a) Within 30 business days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in the insurer's possession, an insurer shall do either of the following:

1. Comply with the request.

2. Notify the individual of all of the following:

a. That the insurer refuses to comply with the request.

b. The reasons for the refusal.

c. That the individual has a right to file a statement as provided in par. (c).

(b) An insurer that complies with a request under par. (a) shall notify the individual of that compliance in writing and furnish the correction, amendment or fact of deletion to all of the following:

1. Any person who may have received, within the preceding 2 years, the recorded personal medical information concerning the individual and who is specifically designated by the individual.

2. Any insurance support organization for which insurers are the primary source of personal medical information and to which the insurer, within the preceding 7 years, has systematically provided recorded personal medical information. This subdivision does not apply to an insurance support organization that does not maintain recorded personal medical information concerning the individual.

3. Any insurance support organization that furnished to the insurer the personal medical information that has been corrected, amended or deleted.

(c) If an insurer refuses to comply with a request under par. (a) 1., the individual making the request may file with the insurer, an insurance agent or an insurance support organization any of the following:

1. A concise statement setting forth the information that the individual believes to be correct, relevant or fair.

2. A concise statement setting forth the reasons why the individual disagrees with the insurer's refusal to correct, amend or delete the recorded personal medical information.

(d) If the individual files a statement under par. (c), the insurer shall do all of the following:

1. File any statement filed by the individual under par. (c) with the recorded personal medical information that is the subject of the request under par. (a) in such a manner that any person reviewing the recorded personal medical information will be aware of and have access to the statement.

2. In any subsequent disclosure by the insurer of the recorded personal medical information, clearly identify any matter in dispute and provide any statement filed by the individual under par. (c) that relates to the recorded personal medical information along with the information.

3. Furnish any statement filed by the individual under par. (c) to any person to whom the insurer would have been required to furnish a correction, amendment or fact of deletion under par. (b).

(e) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.

(5) DISCLOSURE OF PERSONAL MEDICAL INFORMATION BY INSURERS. Any disclosure by an insurer of personal medical information concerning an individual shall be consistent with the individual's signed disclosure authorization form, unless the disclosure satisfies any of the following:

(a) Is otherwise authorized by the individual, or by a person who is authorized to consent on behalf of an individual who lacks the capacity to consent.

(b) Is reasonably related to the protection of the insurer's interests in the assessment of causation, fault or liability or in the detection or prevention of criminal activity, fraud, material misrepresentation or material nondisclosure.

(c) Is made to an insurance regulatory authority or in response to an administrative or judicial order, including a search warrant or subpoena, that is valid on its face.

(d) Is otherwise permitted by law.

(e) Is made for purposes of pursuing a contribution or subrogation claim.

(f) Is made to a professional peer review organization, bill review organization, health care provider or medical consultant or reviewer for the purpose of reviewing the services, fees, treatment or conduct of a medical care institution or health care provider.

(g) Is made to a medical care institution or health care provider for any of the following purposes:

1. Verifying insurance coverage or benefits.

2. Conducting an operations or services audit to verify the individuals treated by the health care provider or at the medical care institution.

(h) Is made to a network plan that is offered by an insurer in order to make arrangements for coordinated health care in which personal medical information concerning an individual is available for providing treatment, making payment for health care under the plan and undertaking such plan operations as are necessary to fulfill the contract for provision of coordinated health care.

(i) Is made to a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurer's operations or services. Disclosure may be made under this paragraph only if the disclosure is reasonably necessary for the group policyholder to conduct the review or audit.

(j) Is made for purposes of enabling business decisions to be made regarding the purchase, transfer, merger, reinsurance or sale of all or part of an insurance business.

(k) Is made for purposes of actuarial or research studies or for accreditation or auditing. With respect to a disclosure made under this paragraph, any materials that allow for the identification of an individual must be returned to the insurer or destroyed as soon as reasonably practicable, and no individual may be identified in any actuarial, research, accreditation or auditing report.

(L) Is made to the insurer's legal representative for purposes of claims review or legal advice or defense.

(6) IMMUNITY. (a) A person is not liable to any person for any of the following:

1. Disclosing personal medical information in accordance with this section.

2. Furnishing personal medical information to an insurer or insurance support organization in accordance with this section.

(b) Paragraph (a) does not apply to the disclosure or furnishing of false information with malice or intent to injure any person.

(7) OBTAINING INFORMATION UNDER FALSE PRETENSES. (a) Any person who knowingly and willfully obtains information about an individual from an insurer or insurance support organization under false pretenses may be fined not more than $25,000 or imprisoned for not more than 9 months or both.

(b) Any person who knowingly and willfully obtains information about an individual from an insurer or insurance support organization under false pretenses shall be liable to the individual for actual damages to that individual, exemplary damages of not more than $25,000 and costs and reasonable actual attorney fees.

History: 1997 a. 231; 1999 a. 9, 79; 2005 a. 22; 2007 a. 20 s. 9121 (6) (a).

Cross−reference: See also ch. Ins 25, Wis. adm. code.