Wisconsin Office of the
COMMISSIONER
OF INSURANCE

Intermediary Guide to Wisconsin Insurance Law

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Contents

Intermediary Guide to Wisconsin Insurance Law 1
INTRODUCTION 3
CHAPTER I 5
POWERS AND DUTIES OF THE COMMISSIONER 5
GENERAL POWERS 5
EXAMINATION POWERS AND DUTIES 7
ENFORCEMENT PROCEDURES 9
CHAPTER II 13
INSURANCE MARKETING 13
WHAT ARE THE TYPES OF INTERMEDIARIES? 14
COMPENSATION OF INTERMEDIARIES 36
CHAPTER III 39
INSURANCE CONTRACTS GENERALLY 39
GENERAL RULES 39
USE OF POLICY FORMS 47
SPECIFIC CLAUSES IN CONTRACTS 49
INSURANCE CLAIMS 54
CHAPTER IV 59
DISABILITY (ACCIDENT & HEALTH) INSURANCE 59
DISABILITY (ACCIDENT & HEALTH) 62
CHAPTER V 99
LIFE INSURANCE AND ANNUITIES 99
LIFE INSURANCE POLICIES 99
LIFE INSURANCE MARKETING 104
CHAPTER VI 120
PROPERTY AND CASUALTY INSURANCE 120
RATES 120
PROPERTY INSURANCE 122
LIABILITY INSURANCE 124
LEGAL EXPENSE INSURANCE 130
TITLE INSURANCE 132
WORKER'S COMPENSATION 133
PUBLIC ADJUSTER 136
CHAPTER VII 139
RISK-SHARING PLANS 139

INTRODUCTION

This guide will help you prepare for insurance exams, and it provides Wisconsin insurance law information. It is a summary of select laws and rules and therefore is not a complete review of all relevant insurance laws.

Intermediaries can obtain a complete copy of the Wisconsin Administrative Code and the Statutes from our website (oci.wi.gov) or from:

Department of Administration, Document Sales and Distribution
2310 Darwin Rd
Madison, WI 53704-3108
(608) 243-2441 or (800) 362-7253
docsales.wi.gov
DOADocumentSalesInformation@wi.gov

The Wisconsin Insurance Laws are also available from:

NILS Publishing Company
20675 Bahama Street
P. O. Box 2507
Chatsworth, CA 91311

Applicants for intermediary licenses must pass certain written examinations. You will be responsible for knowing the material covered in chapters I, II, III, and VI, in addition to all other chapters that specifically apply to the lines of insurance authority for which you wish to be licensed.

The guide presents material in a question-and-answer format; please read it carefully and thoroughly. Efforts have been made to simplify complex statutory language.

If an answer seems confusing, misleading, or incorrect, you should consult the applicable insurance statute or rule. Most answers include numbers in brackets "[ ]" that cite to a specific state statute and/or administrative rule.

A statute is a state law passed by the Wisconsin Legislature. In this guide, statutory references have an "s." or a "ch." before them, as in "s. 628.34" or "ch. 628." This refers the reader to a section or chapter of the Wisconsin Statutes (Wis. Stat.). An insurance rule implements the general requirements of the law. In this guide, insurance rule references have an "s. Ins" before them, as in "s. Ins 3.27," which refers the reader to s. Ins 3.27 of the Wisconsin Administrative Code (Wis. Adm. Code). The commissioner promulgates insurance rules under authority delegated to the commissioner by the Wisconsin Legislature.

Some of the examples in the general material of chapters I, II, and III use fact situations that pertain to a particular line of insurance. These examples illustrate certain points only and do not mean that a person applying for one type of insurance license is expected to be knowledgeable in other insurance lines.

The guide is updated periodically, but you should not rely solely on the material in this guide to stay informed about statute and rule changes. OCI also maintains several electronic mailing lists to announce the issuance of bulletins and press releases. Readers may subscribe to one or more of OCI's electronic mailing lists online at oci.wi.gov/Pages/AboutOCI/ListServe.aspx.

CHAPTER I

POWERS AND DUTIES OF THE COMMISSIONER

Wisconsin law gives the commissioner broad powers and duties to protect the public and to ensure that the insurance industry meets the insurance needs of Wisconsin citizens responsibly. These powers and duties are exercised in accordance with procedures designed to ensure due process and judicial safeguards.

The commissioner has broad rule-making authority, limited only by the proposed rule's relevance to the related statutes and by general legal and constitutional restraints. The commissioner supplements statutory law by interpreting that law through the formal processes of rulemaking and adjudication, and by informal executive decisions.

Rulemaking builds a body of insurance regulation that is a guide to regulated entities and the public. The rulemaking procedure includes the publishing of proposed rules and an invitation for comment at scheduled hearings. This procedure permits people to express their opinions about the proposed rule's impact on their businesses, activities, and interests. It further helps the commissioner formulate rules based on sound public policy considerations.

The commissioner's broad power to issue orders to enforce the statutes and rules enables the commissioner to negotiate settlements and induce compliance in many cases without taking formal disciplinary action. The commissioner will use enforcement powers if the situation demands it and has the full administrative power of investigation exercised through investigatory, educational, or multi-purpose hearings.

GENERAL POWERS

What are the commissioner's general duties and powers?

The commissioner is responsible for administering and enforcing the insurance laws of Wisconsin. The commissioner must act as promptly as possible on all matters placed before the office.

The commissioner and the office possess all the powers specifically granted or reasonably implied by the statutes. This enables the office to perform the duties necessary to enforce the law, including the adoption of rules.

[s. 601.41]

May the commissioner issue orders?

The commissioner is empowered to issue all prohibitory, mandatory, and other orders as necessary to secure compliance with the law.

At the request of any person who would be affected by an order, the commissioner may issue a declaratory order to clarify the person's rights and duties under Wisconsin law.

No rule or order may be issued because of a hearing unless the statutory requirements for administrative procedures are met.

[s. 601.41(4)]

May the commissioner require persons to submit reports and other material?

"Persons" as used in this context include intermediaries, individuals, insurers, navigators, public adjusters, agencies, and other corporate entities.

Yes. The commissioner has the authority to require the following from any person subject to regulation under Wisconsin insurance law:

- statements, reports, answers to questionnaires, and other information in whatever reasonable form the commissioner designates and at such reasonable intervals as the commissioner may choose; and
- full explanation of the programming of any data processing system, computer, or any other information storage system or communication system in use.

The commissioner may prescribe forms for the reports and specify who must execute or certify them. The commissioner may require verification of any report. The commissioner may prescribe reasonable data handling standards and techniques to ensure that timely, reliable information will be available.

[s. 601.42]

Who is required to reply to the commissioner's requests for information?

The following persons are required to reply promptly in writing or any other designated form, to any written inquiry from the commissioner requesting a reply:

- any officer, manager, or general agent of any insurer, authorized to do or doing any insurance business in Wisconsin;
- any person controlling or having a contract under which they have a right to control such an insurer, whether exclusively or otherwise;
- any person with executive authority over the affairs of an insurer; and
- any insurance intermediary or other person seeking licensure or licensed under the insurance laws.

Failure to reply may result in penalties.

[s. 601.42(4)]

EXAMINATION POWERS AND DUTIES

What power of examination does the commissioner have?

The commissioner has the power to examine the affairs and condition of the persons listed below whenever the commissioner deems it necessary to be informed about any matter related to the enforcement of the insurance laws. These persons include:

- any licensee under insurance laws (including insurers, intermediaries, navigators, corporations, etc.);
- any applicant for a license or registration;
- any person or organization transacting, or in the process of organizing to transact, the insurance business in this state;
- any advisory organization serving any of the above in Wisconsin; and
- any prelicensing school, continuing education provider, course, or instructor.

The commissioner may determine the scope of each examination and must consider all relevant factors, including but not limited to:

- length of time the examinee has been doing business;
- length of time the examinee has been licensed in Wisconsin;
- nature of the business being examined;
- nature of the accounting records available; and
- the nature of the examinations performed elsewhere.

The examination of an insurer domiciled in another country is limited to insurance transactions and assets in the United States unless the commissioner orders otherwise after finding that extraordinary circumstances necessitate a broader examination.

[s. 601.43]

Does the commissioner have any duty to examine?

Yes. The commissioner is required to examine every domestic insurer (an insurer created and organized under Wisconsin law) and every licensed rate service organization.

[s. 601.43(2)(a)]

What information must the examinee make available to the commissioner?

On demand, every examinee must make available to the commissioner any of its accounts, records, documents, or evidence of transactions as well as the accounts, records, documents, and evidence of transactions of any persons who may be examined collaterally.

Failure to comply is deemed concealment of records, a possible ground for liquidation of the business of the examinee. However, if the examinee is unable to obtain the accounts, records,

documents, or evidence of transactions from other persons, failure will not be deemed concealment if the examinee immediately terminates its relationship with such persons.

[s. 601.43(1)(c)]

Who pays the cost of examinations conducted by the commissioner?

For domestic insurers, the costs of examination are apportioned among all domestic insurers based on a formula related to premiums written in the state.

For nondomestic and town mutual insurers, reasonable costs of the examination are paid by the examinee unless the commissioner finds that payment would place an unreasonable burden on the examinee.

Prelicensing schools and continuing education providers may be billed for reasonable costs of an examination.

The costs include the salaries and expenses of the examiners, as well as any other expenses that may be directly attributable to the examination. Payment is due 10 days after the examinee has been served a detailed account of the costs.

[s. 601.45, ss. Ins 16.01, 26.10(3), 28.10(3)]

What about collateral examinations?

As far as reasonably necessary for an examination, the commissioner may examine the accounts, records, documents, or evidence of transactions of:

- any officer, manager, general agent, employee, or person in charge of any segment of the examinee's affairs;
- any person controlling or having the right to control the examinee, whether exclusively or with others;
- any person under the control of the examinee; or
- any person under the control of a person who controls or has a right to control the examinee whether exclusively or with others.

[s. 601.43(1)(b)]

Does the commissioner have access to any other records during the examination process?

The commissioner's office has access to the records of any agency of the state government or any political subdivision.

[s. 601.49]

ENFORCEMENT PROCEDURES

When are hearings required?

The commissioner must hold a hearing before issuing an order or rule whenever the insurance laws or the administrative procedure requirements expressly provide for a hearing. Unless the insurance laws prescribe special procedures, all hearings must comply with the procedures set out in ch. 227, Wis. Stat., and ch. Ins 5, Wis. Adm. Code. These statutes provide for the summary suspension of an intermediary's or navigator's license if the commissioner finds that public health, safety, and welfare require emergency action.

If the intermediary or navigator fails to pay a fee when due or fails to comply with continuing education requirements, the commissioner may revoke the license without a hearing. Also, a license must be revoked if the intermediary or navigator is liable for delinquent taxes or unemployment insurance contributions as certified to the commissioner by the Wisconsin Department of Revenue or the Wisconsin Department of Workforce Development.

If the commissioner and the intermediary or navigator agree, an intermediary or navigator may consent to a revocation without a hearing. Otherwise, the commissioner may revoke, suspend, or limit a permanent license of an intermediary or navigator only after a hearing and an opportunity for judicial review.

The commissioner must hold a public hearing before adopting any rule unless the rule is procedural rather than substantive, is an emergency rule, or is an exception listed under s. 227.03 of the Administrative Procedure Act.

The commissioner may hold informal hearings and public meetings for the purposes of investigation, determining public sentiment, or informing the public.

[ss. 601.41, 601.62, 628.10, ch. 227]

Does an applicant for an intermediary license have a right to a hearing after the commissioner's decision to not issue a license to the applicant?

Before being granted an original license for a line of insurance, the applicant must show the commissioner that they are competent and trustworthy. Applicants have the right to a hearing to appeal the commissioner's decision not to issue a license. Such hearing and appeal must comply with the procedures outlined in ch. 227, Wis. Stat.

When an order is issued without a hearing, any aggrieved person may demand a hearing within 30 days after the mailing of the order. Failure to demand a hearing within 30 days constitutes a waiver of the right to a hearing. The demand for a hearing must be made in writing and then served to the commissioner directly or left at the commissioner's office. The commissioner must hold the

requested hearing not less than 10 days or more than 60 days after delivery of the request for a hearing.

[s. 601.62, s. Ins 6.59]

May a person request a rehearing of a previous hearing decision?

After a final order is entered, any aggrieved person may request a rehearing within 20 days. The filing of a petition for rehearing does not suspend or delay the effective date of the order unless the petition is granted or the order is superseded, modified, or set aside as provided by law.

The commissioner may grant a rehearing only if there was a material error of law or fact, or if new evidence is discovered that merits reversing or modifying the order. If the commissioner has not acted on the petition within 20 days after its filing, the petition is considered to have been denied.

[s. 227.42]

Is a person required to testify and give evidence at a hearing?

No person is excused from attending, testifying, or giving evidence on the grounds that the testimony or evidence required from the person may tend to incriminate the person or subject the person to a penalty or forfeiture. After claiming the privilege against self-incrimination and being forced to testify, a person may not be criminally prosecuted for any act upon which the person is compelled to testify or produce evidence. A person is not exempt, however, from prosecution and punishment for perjury, false swearing, or contempt committed in testifying.

[s. 601.62(5)]

What enforcement sanctions are available to the commissioner?

Whenever a person fails to comply with an order, the commissioner may start legal action directing the person to comply with the commissioner's order and restraining that person from further noncompliance. In addition, forfeitures; license revocation, suspension, or other limitations; civil penalties; and criminal sanctions may be levied by the commissioner.

[s. 601.64]

What is a compulsive forfeiture?

After a person has failed to comply with an order, the commissioner may give notice of intent to proceed with a compulsive forfeiture. If the person fails to comply with the order within two weeks after the notice is given, the commissioner may start a legal action for a compulsive forfeiture in the amount a court would consider fair. Such forfeiture cannot exceed $5,000 for each day the violation continues between the commencement of the action and the time the court renders its judgment.

No compulsive forfeiture will be imposed if the person complied with the order by the time the action was started. If any violation of the order occurred while any proceeding for judicial review of

the order was pending, a compulsive forfeiture will not be imposed unless the court certifies that the claim of invalidity or non-applicability of the order was frivolous or a sham. If the person refuses to obey the order after a judgment is rendered, the commissioner may begin a new action for a compulsive forfeiture and may continue commencing such actions until the person complies with the order.

[s. 601.64(2)]

What about forfeitures and civil penalties?

Any person who violates an effective order or any insurance statute or rule may be required to forfeit to the state, in addition to any other forfeiture imposed, twice the amount of any profit gained from the violation.

Any person who violates an order after proper notice may be required to forfeit to the state not more than $1,000 for each violation. Each day the violation continues constitutes a separate offense.

Any person who violates an insurance statute or rule may be required to forfeit to the state not more than $1,000 for each violation. If the statute or rule imposes a duty to make a periodic or recurring report to the commissioner, each week of delay in complying with the duty constitutes a new violation.

Any person who violates an insurance statute or rule specifically involving a consumer who is an adult at risk, as defined in s. 55.01 (1e), or an individual who is at least 60 years of age, or where the violation involves or constitutes fraud or misrepresentation, shall forfeit to the state not more than $5,000 for each violation.

[s. 601.64(3)]**v**

Forfeiture of up to $1,000 may be levied against intermediary firms for violations by an insurance agent of a provision of an insurance statute or rule if the violation is in connection with an insurance policy or group certificate obtained or to be obtained through the firm if:

- the firm regularly utilizes the insurance agent to market insurance policies or group certificates;
- the primary insurance marketing activities of the insurance agent are in connection with insurance policies or group certificates obtained or to be obtained through or from the firm; or
- the insurance agent is employed by or is under contract with the firm to market insurance policies or group certificates.

A “firm” means a person that markets insurance but does not include an insurer.

[s. 601.65]

A person who is ordered to pay a forfeiture may demand a hearing. If the person fails to request a hearing, the order is conclusive as to the person's liability. The scope of review for forfeitures is as specified under s. 227.57, Wis. Stat.

[s. 601.64(3)(d)]

What about criminal penalties?

A person who:

- intentionally violates;
- intentionally permits any person over whom they have authority to violate; or
- intentionally aids any person in violating

any insurance statute or rule of this state or any effective order issued by the commissioner may be fined not more than $5,000 or imprisoned for a period not to exceed three years or both. A corporation may be fined not more than $10,000. These penalties apply unless a specific penalty is provided elsewhere in the statutes. "Intentionally" means that the person acting intends to do something or cause a specific result or believes an act will cause a specific result.

[s. 601.64(4)]

What is the Insurance Security Fund?

The Insurance Security Fund was established to provide certain protections to insureds in the event of an insurer's liquidation. Money in the fund comes from assessments against all insurers, with limited exceptions, licensed to transact business in the state. The fund is administered by a board of directors including the attorney general, the state treasurer, and the commissioner of insurance.

The primary duty of the board is to oversee the adjudication process of unpaid claims in cases where a court has issued an order of liquidation against an insurer authorized to do business in the state.

[ch. 646]

CHAPTER II

INSURANCE MARKETING

Chapter 628, Wis. Stat., on insurance law has four main parts:

1. the licensing of insurance intermediaries
2. regulation of insurance marketing practices
3. compensation of insurance intermediaries
4. regulation of navigators

Under the statutes, the term "intermediary" is used to include all the varieties of agency representation of either policyholders or insurance companies in the marketing of insurance. The different classes of "intermediaries" are intermediary (including navigators), intermediary-partnerships and corporations, intermediary-surplus lines agents and brokers, managing general agents, reinsurance intermediary brokers and managers, and life settlement brokers.

Wisconsin law places some restrictions on combining different intermediary roles in the same transaction.

The licensing of intermediaries is concerned solely with the qualifications of the person applying for the insurance license. The essential requirement is that the insurance intermediary be trustworthy and competent. The competence includes a basic understanding of fundamental insurance law as well as knowledge concerning specific statutes and rules.

Wisconsin insurance statutes outline and define the general requirements that the insurance intermediary must follow. In addition, the insurance intermediary must understand and follow the administrative code which has been adopted by the commissioner. General statutory language is expanded and clarified—by rule in the administrative code—by describing for intermediaries and companies the practices that are allowed and prohibited. The standards of professional conduct are set out in the statutes and these rules are strictly enforced by the commissioner.

What is an intermediary?

"Intermediary" means an agent, navigator, broker, or producer and any person, partnership, or corporation requiring a license.

[ch. 628, Wis. Stat.]

A person is an "intermediary" if the person does or assists another in any of the following:

- soliciting, recommending, negotiating, or placing insurance or annuities on behalf of an insurer or a person seeking insurance or annuities; or
- advising other people about insurance needs and coverages.

The following persons, however, are not considered "intermediaries" under Wisconsin law:

- a regular salaried officer, employee, or other representative of an insurer or licensed intermediary, who devotes substantially all working time to activities other than those listed immediately above and does not receive any compensation that is directly dependent upon the amount of insurance business obtained;
- a regular salaried officer or employee or a person seeking to procure insurance, who receives no compensation that is directly dependent upon the amount of insurance coverage procured;
- a person who gives incidental advice in the normal course of a business or professional activity other than insurance consulting. Neither the person nor the person's employer may receive compensation directly or indirectly on account of any insurance transaction that results from such advice;
- a person who, without special compensation, performs incidental services for another at another's request without providing advice or technical or professional services of the kind normally provided by an intermediary;
- a holder of a group insurance policy, or any other person involved in mass marketing, with respect to the person's administrative activities in connection with the policy. Such a person may not receive any compensation for the administrative work beyond actual expenses which can be estimated on a reasonable basis;
- a person who provides information, advice, or service for the principal purpose of reducing loss or risk;
- a person who gives advice or assistance without compensation, directly or indirectly;
- a travel retailer, or an employee or authorized representative of a travel retailer, that offers and disseminates travel insurance;
- a vendor, or an employee or authorized representative of a vendor selling or offering portable electronics insurance; or
- a person whose activities are limited to marketing, selling, or offering for sale a warranty contract, maintenance agreement, or service contract.

[s. 628.02(1) **and** s.628.347(1)(b)**]**

WHAT ARE THE TYPES OF INTERMEDIARIES?

Intermediary-Insurance Agent

An intermediary is an insurance agent if the intermediary acts as an intermediary other than as a broker.

[s. 628.02(4)]

Intermediary-Broker

An intermediary is an insurance broker if the intermediary acts in the procuring of insurance on behalf of an applicant for insurance or an insured. An insurance broker does not act on behalf of the insurer except by collecting premiums or performing other ministerial acts.

[s. 628.02(3)]

Intermediary-Surplus Lines Agent or Broker

A surplus lines agent or broker is one separately licensed to place insurance with unauthorized (non-licensed) insurers.

[s. 628.02(5), s. 618.41]

Intermediary-Corporations and Partnerships

Partnerships and corporations in the insurance business in Wisconsin may be licensed.

[s. 628.04, s. Ins 6.58(2)]

Reinsurance Intermediary-Broker

A reinsurance intermediary-broker places ceded reinsurance in this state and has an office or does business in this state and has an office outside this state unless it is licensed under a similar law in another state.

[Ch. Ins 47]

Reinsurance Intermediary-Manager

A reinsurance intermediary-manager has significant authority regarding the assumed reinsurance of an insurer and acts as its agent.

[Ch. Ins 47]

Managing General Agent

A person who manages all or part of the insurance business of an insurer or manages a separate division, department, or underwriting office; acts as an agent for the insurer; AND with or without the authority, either separately or together with affiliates, directly, or indirectly: a) produces and underwrites in any one quarter or year an amount of gross direct written premium equal to or more than 5% of the policyholder surplus as reported in the last annual statement of the insurer; and b) adjusts or pays claims in any one quarter or year in excess of 3% of the policyholder surplus as reported in the last annual statement of the insurer, or negotiates reinsurance on behalf of the insurer, or both.

[s. Ins 42.01, s. 628.49]

What are the required contract provisions between managing general agents and insurers?

No person may act as a managing general agent for an insurer unless the person first enters and subsequently complies with a written contract between the parties which sets forth the responsibilities of each party and, where both parties share responsibility for a particular function, specifies the division of the responsibilities, and which contains the following minimum provisions:

- the insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;
- the managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis;
- all funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a financial institution that is a member of the federal reserve system. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months of estimated claims payments and allocated loss adjustment expenses. The managing general agent will maintain separate records of business written by the managing general agent for the insurer. The insurer and the commissioner shall have access to, and the right to copy, all accounts and records related to its business in a form usable by the insurer and the commissioner;
- the managing general agent may not assign the contract in whole or in part;
- appropriate underwriting guidelines include, but are not limited, to a) the maximum annual premium volume; b) the basis of the rates to be charged; c) the types of risks which may be written; d) maximum limits of liability; e) applicable exclusions; f) territorial limitations; g) policy cancellation provisions, and h) the maximum policy period;
- the insurer may cancel or not renew any policy of insurance subject to the applicable laws and rules;
- if the contract permits the managing general agent to settle claims on behalf of the insurer the managing general agent: a) shall report all claims to the insurer in a timely manner; and b) shall send a copy of the claim file to the insurer at its request or as soon as it becomes known that the claim has equaled or exceeded or has the potential to equal or exceed an amount which is 0.5% of the insurer's policyholder surplus as of December 31 of the immediately preceding calendar year or exceeds the limit set by the insurer, whichever is less; involves a coverage dispute; may exceed the managing general agent claims settlement authority; is open for more than six months; or is closed by payment of an amount equal to or greater than 0.5% of the insurer's policyholder surplus as of December 31 of the immediately preceding calendar year or an amount set by the insurer, whichever is less;
- all claim files will be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, the files shall become the sole property of the insurer or its estate. The contract may provide that the managing general agent may have reasonable access to and the right to copy the files on a timely basis;
- any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination;
- the managing general agent will timely transmit to the insurer appropriate data from electronic claims files;

- if the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified as required by law; and
- the managing general may not: a) bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules; b) commit the insurer to participate in insurance or reinsurance syndicates; c) appoint any subproducer without assuring that the subproducer is lawfully licensed to transact the type of insurance for which the subproducer is appointed; d) without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed 1% of the insurer's policyholder surplus as of December 31 of the last completed calendar year; e) collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer; f) permit its subproducer to serve on the insurer's board of directors; g) jointly employ an individual who is employed by the insurer; or h) appoint a submanaging general agent.

[s. Ins 42.03, s. 628.49]

What is a life settlement broker?

Life settlement brokers replaced the licensing requirements for viatical settlement brokers. A life settlement broker is a person who, on behalf of an owner of a life insurance policy or certificate, and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and one or more providers, or one or more brokers. Life settlement brokers must apply for a license annually, maintain professional liability insurance, and have completed an initial training course relating to life settlements of not less than eight hours, and not less than four hours every 24 months thereafter reported at a rate of no less than two hours each 12 months of each compliance period.

[s. 632.69(1)(b)]

What is a life settlement provider?

Life settlement providers replaced the licensing requirements for viatical settlement providers. With some specified exceptions, a life settlement provider means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner. Life settlement providers must

apply for a license annually and demonstrate evidence of financial responsibility through either a surety bond, or a deposit of cash, certificates of deposit, or securities in the amount of $250,000.

[s. 632.69(1)(c) and (p)]

When is an intermediary required to get a license?

A person may not solicit, negotiate, sell, or advertise any service as an intermediary in Wisconsin unless the person obtains a license. No person may use the services of another as an intermediary if the person knows or should know that the other person does not have a license as required by law.

The commissioner may by rule exempt certain classes of persons from the requirements of obtaining a license. Persons may be made exempt if the functions they perform do not require special competence or trustworthiness or the regulatory surveillance made possible by licensing, or if other existing safeguards make regulation unnecessary.

An insurance contract is valid even if sold or serviced by an unlicensed intermediary.

[s. 628.03]

EXAMPLES

Do the following persons need to be licensed under Wisconsin law?

- *An employee or a collection agency that collects insurance premiums from delinquent policyholders.*

  No. This is a purely administrative function that does not require the special qualifications of an insurance intermediary and does not come under s. 628.02, Wis. Stat.

- *A person who incidentally advises other persons about insurance needs and coverages during the normal course of their noninsurance-related business, and who receives no direct or indirect compensation on account of any transaction which results from the advice.*

  No. This person comes under the exceptions in s. 628.02, Wis. Stat., and is not an intermediary.

- *A person who places insurance for an insurance company on a door-to-door basis.*

  Yes. Under s. 628.02, Wis. Stat., this person is an insurance marketing intermediary and is required to obtain a license.

- *A person who advises other persons about insurance needs and coverages and is directly compensated by an insurance company or the insured.*

  Yes. Under s. 628.02, Wis. Stat., the person is an insurance marketing intermediary and is required to obtain a license.

What requirements must a person meet to be issued a license?

A person must qualify on their own merits. The commissioner must issue a license to act as an intermediary to any person, corporation, or partnership that pays the applicable fee and satisfies the commissioner that such person or entity meets the statutory requirements.

The applicant must have the honest intention to do business as an intermediary. A corporation or partnership must have this intention spelled out in its articles of incorporation or association. The applicant must be competent and trustworthy. If the applicant is a corporation or partnership, its principal partners, officers, or directors must be competent and trustworthy.

A competent and trustworthy intermediary must be well-informed on the kinds of insurance the intermediary is qualified to write. The intermediary must be able to analyze the insurance needs of clients and be able to recommend the type of insurance best suited to their respective needs. The intermediary may make no false statements or any misrepresentations by omission of facts, inference, or subterfuge in any relations with clients, insurance companies, or other intermediaries. The intermediary must take all reasonable steps to inform clients of the extent and limitations of coverage provided by their contracts.

Intermediaries must manage agency financial affairs in accordance with the high standards applicable to a fiduciary. The intermediary must conform to all applicable insurance statutes and rules.

[ss. 628.04, 628.34, s. Ins 6.59]

The commissioner considers, but is not limited to, the following criteria when assessing the trustworthiness and competence of intermediaries:

- criminal record and convictions;
- regulatory actions;
- accuracy of application;
- violation of orders of any state insurance commissioner;
- misrepresentation or fraud in the application process or insurance practice;
- owing delinquent taxes or child support; or
- using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business.

[s. 628.04, s. Ins 6.59]

No intermediary may receive any compensation from an insurer for effecting insurance upon the intermediary's property, life, or other risk unless during the preceding 12 months the intermediary had affected other insurance with the same insurer with aggregate premiums exceeding the premiums on the intermediary's risks.

[s. 628.51]

What additional requirements are there for surplus lines agents or brokers?

The commissioner may issue a license to an agent or broker authorized to place surplus lines insurance if the applicant shows to the satisfaction of the commissioner that they have the competence necessary to deal with the problems of surplus lines insurance. The commissioner may by rule require an agent or broker authorized to place surplus lines insurance to supply a bond not larger than $100,000, conditioned upon the proper performance of the person's obligations as a surplus lines' agent or broker.

[s. 628.04(2)]

What are the requirements for intermediary licensing examinations?

The commissioner has the power to define classifications of intermediaries and can require different standards of competence, different examinations, and different educational requirements for each class. When possible, a single license is issued to each qualified intermediary for a single fee.

Individual intermediaries, as opposed to corporations and partnerships, need to take exams for licensing. Each examination tests the applicant's basic knowledge and understanding of the applicable laws and regulations.

Prelicensing education is required of candidates who apply for an original resident license, and those requesting additional major lines. Those candidates applying for an exam in the limited line of title or credit, and those who have completed a two-year Wisconsin vocational school degree in insurance, or a four-year college degree in business with an insurance emphasis are exempt from the prelicensing education requirement.

[s. Ins 26.04]

An applicant who submits an application that meets the competence and trustworthiness standards outlined in the preceding sections pays the required fee, submits fingerprints and background check, completes the prelicensing education requirements, and obtains a passing grade on the written examination, will be issued an individual intermediary license for those lines of insurance for which the applicant is qualified. A licensed agent may act as an agent or a broker.

[s. 628.04(1), (1m)**,** s. Ins 6.59**]**

The examination is given in two parts. Unless the candidate is exempt from the product knowledge portion of the examination, they must pass both parts in one sitting to qualify for licensing. Application for a permanent resident agent license or adding a new line of authority shall be made online. All prelicensing education must be completed prior to sitting for a required examination. A completed application consists of the following items:

- agent's name and the current address for the residence of the applicant;
- an original exemption form as required under ch. Ins 26, if required by s. Ins 26.04 (3);

- an electronic confirmation of prelicensing education completion for the specific lines of authority;
- an electronic confirmation of criminal history provided by the FBI;
- an electronic confirmation of criminal history provided from the Wisconsin department of justice, crime information bureau, completed not more than 180 days prior to the test date;
- payment of the fees to the testing vendor;
- an electronic photograph of the applicant taken by the test service at the time of testing;
- confirmation of previous license in another state, if applicable; and
- any documentation required in answer to questions on the application.

Applicants who fail an exam may repeat the exam as often as necessary.

[s. Ins 6.59(4)(a)]

A person engaged in soliciting insurance exclusively for town mutuals is not subject to the licensing requirements of s. 628.03 (1), Wis. Stat.

[s. 628.05]

Are resident intermediaries required to complete continuing education?

Yes. Resident intermediaries holding any one of the major lines of life, accident & health, property, casualty, personal lines P&C, or in the limited line of automobile must complete 24 credit hours in each biennium, three of the 24 hours must cover ethics in insurance. All credits must be banked by the license expiration date and prior to being able to pay for the renewal licensing fee. A credit hour is defined as not less than 50 minutes of classroom instruction by an approved provider. Correspondence, self-study, and online courses may be completed if they are approved by meeting criteria under current law and include successful completion of a certified proctored examination.

[s. Ins 28.04(1)(a), 28.08]

Are any intermediaries exempt from the requirements?

Yes. Intermediaries who hold ONLY a limited line insurance license for credit, legal expense, miscellaneous limited line, managing general agent, crop, surety, travel, or title are exempt from continuing education requirements.

[s. Ins 28.04(2)(a), (b)]

Does a nonresident intermediary have to satisfy Wisconsin's continuing education requirements if the intermediary has satisfied the requirements in the state where the resident license is issued?

No. Continuing education requirements do not apply to the following:

- any intermediary exclusively holding a limited line insurance license in the following lines: credit insurance, crop insurance, legal expense insurance, miscellaneous limited line, managing general agent, surety insurance, title insurance, or travel insurance; or

- a nonresident intermediary whose state of residence grants similar exemptions to Wisconsin residents.

However, nonresidents must comply with training requirements applicable to long-term care insurance, annuities, flood insurance, and life settlements if the intermediary is engaged in these types of business in Wisconsin.

[s. 628.347, 632.69(3), Ins 2.18(4), 3.46(26), 70 Fed. Reg. 52217]

What happens if intermediaries fail to meet continuing education requirements?

The commissioner will notify each intermediary by email at least 60 days before the expiration date. The notice provides the intermediary with guidance and instruction if the intermediary fails to renew their license and steps to reinstating the license.

[s. Ins 28.04(1)(f)]

Can an intermediary reapply without completing prelicensing education and taking an examination?

Yes. Any resident individual intermediary whose license is revoked for failing to pay renewal fees, failing to complete required continuing education, or failing to pay delinquent taxes may, within 12 months, reinstate for the same license without completing prelicensing education or passing a written examination.

Resident licensees who are required to complete continuing education must have all previous requirements met prior to reinstating. If a license has been revoked for more than 12 months, the intermediary shall, to be relicensed, satisfy the examination and licensing requirements established by s. Ins 6.59.

[s. Ins 6.63(3)]

What changes in the status of intermediaries must be reported?

Every change in the name, mailing, residence, or business address must be reported in writing to the commissioner within 30 days.

Every change in the membership of a partnership or the principal officers of a corporation licensed as an intermediary must be reported to the commissioner, as well as every significant change in the management powers of either.

Every change in status and relationships relating to the competency and trustworthiness of the intermediary must be reported to the commissioner within 30 days.

All reports must comply with the reporting forms and procedures set by the commissioner.

[s. 628.08, s. Ins 6.61]

EXAMPLES

The following status changes must be reported to the commissioner within 30 days:

- change in name, mailing address, residence address, or business address;
- change from resident to nonresident, nonresident to resident, or nonresident to nonresident status;
- dissolution of a partnership or the taking on of new partners;
- initial pretrial hearing date related to any criminal prosecution (either misdemeanor or felony);
- conviction of a crime (either misdemeanor or felony);
- administrative action taken by any state agency that licenses individuals for any occupational activity; or
- a lawsuit filed alleging misrepresentation, breach of fiduciary duty, fraud, theft, or embezzlement (individual or business).

Are there temporary licenses?

The commissioner may issue a temporary license as an intermediary for a period of not more than one year. A temporary license may be issued only to a personal representative of a deceased or mentally or physically disabled intermediary:

- to give time for the sale of the goodwill of a business owned by the intermediary;
- for the recovery or return of the intermediary to the business; or
- to provide the training and licensing of new personnel for the intermediary's business.

Temporary licenses may also be issued to personal representatives of an intermediary for the same purposes if the intermediary has entered active duty in the U.S. armed forces.

[s. 628.09]

What is the legal status of a temporary licensee?

A temporary licensee is a fully qualified intermediary for all purposes other than the process of licensing, the duration of the license, and the limits mentioned in the preceding section.

[s. 628.09(6)]

What are the limitations on intermediary temporary licenses?

The commissioner may, by order, limit the authority of a temporary licensee in any way they deem necessary to protect the insureds and the public.

The commissioner may, by order, revoke a temporary license permit if the interests of the insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

[s. 628.09(4)]

What is a navigator?

Navigator means a natural person or an entity that supervises or employs a natural person, who does all the following:

- performs any of the activities and duties identified in and on behalf of the exchange; and
- receives funding to perform any of the activities and duties identified and on behalf of the exchange.

Navigator does not include a person acting as an insurance intermediary, but an insurance intermediary may apply to be licensed as a navigator.

[s. 628.90]

What are the requirements for a navigator license?

- individuals must be at least 18 years of age;
- reside in this state and maintain their principal place of business in Wisconsin;
- has completed the training and course of study requirements mandated by the exchange;
- has successfully passed a written examination and submitted a full set of fingerprints including a criminal background check;
- has identified the entity with which they are, or will be, affiliated and by which they will be supervised, if any; and
- has paid the applicable licensing fee.

[s. 628.92]

What records must be maintained by an intermediary?

Each intermediary must maintain records for three years of cash receipts (monies received in connection with insurance), cash disbursements (monies paid out in connection with insurance), commission statements (commissions and fees allocated to the intermediary for insurance transactions), policyholder records (all records, applications, requests for changes, claims, and complaints of a policy generated by or through the intermediary), business checking accounts, and personnel records. These records must be updated at reasonable intervals or as necessary. Financial records must be kept in accordance with accepted accounting principles.

Each intermediary must maintain records for three years, giving the effective date of the coverage on all newly issued contracts, and records indicating that the necessary suitability inquiry and replacement procedures were followed for each individually issued life (including annuities) and accident & health contract written or replaced. Intermediaries shall retain policyholder records for at least three years after termination or lapse of the policy. Special reporting requirements apply to intermediaries who are or are an affiliate or are employed by an affiliate of a title insurance producer.

[s. Ins 6.61]

Records must be kept at the intermediary's business address recorded with the commissioner or at another location provided the intermediary supplies the commissioner with written notice of the location. The intermediary must notify the commissioner within 30 days of any change in the intermediary's business or residence address or change in the location of the records.

Each intermediary must notify the commissioner within 30 days of any felony conviction, misdemeanor (other than those related to a violation of a fish or game regulation), or any formal disciplinary action taken by any state's insurance regulatory agency or other regulatory agency that licenses the intermediary for any occupational activity. By written agreement, an insurer may assume the responsibility to maintain these records for an intermediary if the records can be made immediately available to the commissioner.

Each intermediary who is employed by or is an affiliate of a producer of title insurance shall maintain records for three years for each application or order for title insurance accepted in this state. The records shall state whether the application or order was directly or indirectly referred as provided by s. Ins 3.32 (5), Wis. Adm. Code, by a producer of title insurance that is an affiliate as defined by s. Ins 3.32 (3) (a), (bm), and (c), Wis. Adm. Code, and the name of each producer of title insurance who is an affiliate and acts as broker, agent, lender, representative, or attorney in the transaction that resulted in the application or order. Each intermediary who is an affiliate of a producer of title insurance shall maintain a record of gross revenue from operations in this state from title insurance by quarter calendar year that shall separately show gross revenues from operations in this state derived from applications or orders for title insurance directly or indirectly referred by the affiliate.

[s. 601.42, s. Ins 6.61]

Are there special requirements for the disposal of personal medical information?

Yes. Insurers and intermediaries/agents that obtain information from an insured or an individual seeking coverage pertaining to the person's physical or mental health, medical history, or medical treatment must take specific steps to ensure that personally identifiable information is shredded, erased, modified, or otherwise handled so that no unauthorized person has access to the information.

[s. 134.97(2)]

What is home solicitation selling?

Home solicitation selling means the solicitation or the offering for sale of insurance where the solicitation or sale is made by an agent at the residence or place of business or employment of the buyer or away from the agent's regular place of business. Home solicitation selling includes solicitations made directly or indirectly by telephone, person-to-person contact, or by written or printed communication, other than general advertising that indicates an intent to sell insurance or services at a regular place of business.

[s. Ins 20.01(3)(c)]

Are there certain disclosures that must be made by an agent engaged in home solicitation selling?

Yes. When engaged in home solicitation selling, every seller shall, at the time of initial contact or communication with an actual or prospective purchaser of insurance, clearly and expressly disclose the seller's name, the name of the business firm or organization represented, a statement that insurance is being sold or solicited, the identity of the insurer, if the solicitation is primarily for a single insurer, and the type of insurance being solicited.

A seller means a person, insurance agent, representative, insurance intermediary, or organization engaged in home solicitation selling, advertising, or offering services in home solicitation selling, or providing or exercising supervision, direction, or control over sales practices used in home solicitation sales.

A seller who receives a check or cash shall give the buyer a receipt or other document of the transaction that includes the date of the sale, a description of the type of policy applied for, the price paid, the name of the seller, and the name and mailing address of the insurer issuing the policy.

Persons engaging in home solicitation selling shall not:

- represent directly or by implication that the seller is making an offer to specially selected persons unless such representations are true and the specific basis for such representations is stated at the time the representation is made;
- represent that the seller is conducting a survey, test, or research project or engaged in a contest or other venture to win a cash award, scholarship, vacation, or similar prize when the principal objective is to make an insurance sale or obtain information to help identify sales prospects; or
- use any false, deceptive, or misleading representations to induce a sale, or use any plan, scheme, or ruse which misrepresents that the person making the call is selling insurance or fail to leave the premises promptly when requested to do so.

[s. Ins 20.01]

What are the restrictions on personal financial transactions?

Agents are prohibited from engaging in personal financial transactions with persons with whom they have conducted insurance business within three years prior to the transaction. Transactions with relatives and bona fide business transactions with customers are allowed if there are sufficient safeguards to protect the customer's interests.

[s. Ins 6.60]

What is the definition of a personal financial transaction?

"Personal financial transaction" includes a transaction in which the agent or an affiliate borrows money, property, or securities from a customer; loans money, property, or securities to a customer; acts as custodian for money, property, or securities of a customer; obtains power of attorney over

money, property or securities of a customer; obtains a guarantee of any loan from a customer; shares directly or indirectly in profits or losses with a customer; or without furnishing equal consideration obtains title to or ownership of any property of a customer. "Personal financial transaction" does not include transactions conducted by an agent or affiliate in the normal course of doing an insurance business such as holding an insurance policy for analysis or servicing, or receiving an insurance premium from a customer provided the transaction is properly recorded on the records of the agent or affiliate as required by including the name of the insurer for whom the premium was received, and the agent or affiliate immediately issues a written receipt to the customer for the policy or premium.

[s. Ins 6.60(1)(d)]

What activities are considered unfair trade practices by agents?

The following are considered unfair trade practices:

- effecting or attempting to affect a personal financial business transaction with a customer;
- knowingly being listed as a beneficiary of any proceeds of a life insurance policy or annuity issued to a customer unless the agent or affiliate has an insurable interest in the life of the customer;
- engaging in transactions with a customer in violation of the Wisconsin uniform securities law, the Wisconsin franchise investment law, the U.S. Securities Act of 1933, the U. S. Securities Exchange Act of 1934, the U. S. Investment Company Act of 1940, or any rules or regulations promulgated under any of such laws;
- making misleading statements to a customer regarding or otherwise misrepresenting one's qualifications or services. This includes using terms such as "financial," "investment" or "retirement" in conjunction with terms such as "planner," "planning" or "consulting" when, under the circumstances, the statements, representations, or use of these terms do not accurately describe the nature of the services offered or the qualifications of the person offering the services; and
- selling, soliciting the sale, or assisting the sale of health coverage that is provided by a person who is not licensed as an insurer in this state; and represented to be authorized under, or exempt from, state insurance regulation under the Federal Employee Retirement Income Security Act.

[s. Ins 6.60(2)]

Must an insurance company appoint its intermediaries with the commissioner of insurance?

Prior to or within 15 days after the earlier of the date the agent contract is executed or the first insurance application is submitted, the agent must be properly appointed with the insurer and entered into the OCI licensing system in a format specified by the commissioner.

Exception for insurers that sell long-term care insurance or annuity products:

- if the insurer sells long-term care insurance, the agent must hold a license, must be appointed, and must have completed the required long-term care training before the agent can solicit, negotiate, or sell long-term care insurance; or
- if the insurer sells annuities, the agent must complete the insurer-specific annuity product training and have completed the required four-hour annuity training before soliciting the sale of any annuity product.

The annual appointment renewal invoice will be made available to insurers every year. The invoice is for every individual intermediary serving as an agent for the insurer. Payment is required once a year in March from each insurer.

When the appointment of an individual agent is terminated, the insurer must notify the Office of the Commissioner of Insurance, electronically, no later than 30 days after the termination date. The insurer must also notify the intermediary in writing, prior to or within 15 days of filing the termination notice with the commissioner, that they are no longer appointed as a company representative, that they may not act as its representative, and that all materials that indicate an agency relationship with the company must be returned.

[s. 628.11, s. Ins 6.57]

What regulation charges must a licensed intermediary pay?

The biennial regulation amount to be paid by each licensed individual intermediary is $35.00 for a resident intermediary and $70.00 for a nonresident intermediary. Notification of the biennial regulation charge (renewal fee) will be emailed to the business email address on file with the commissioner at least 60 days prior to the expiration date. If the fee is not paid by the expiration date, the intermediary's license is revoked.

[s. 601.31, s. Ins 6.63]

How long does an intermediary's license remain in effect?

An intermediary's license remains in effect until it is revoked, suspended, or limited by the commissioner; until it is voluntarily surrendered by the intermediary; until the death of the intermediary; until a court's finding that the intermediary is mentally incompetent; or until the commissioner finds, after a hearing, that the person, corporation, or partnership is no longer qualified to act as an intermediary.

[s. 628.10(1)]

When can an intermediary's license be revoked, suspended, or limited?

The license of an intermediary who fails to pay a fee or fails to complete continuing education requirements when due is revoked as of the date due if the commissioner gave the intermediary reasonable notice. The intermediary may be relicensed only after satisfying all requirements under s. 628.04, Wis. Stat.

Likewise, an intermediary's license must be revoked if the intermediary or navigator is liable for delinquent taxes or unemployment insurance contributions as certified to the commissioner by the Wisconsin Department of Revenue or the Wisconsin Department of Workforce Development. An intermediary license must be suspended if an intermediary fails to pay child or family support. The intermediary may be reinstated only after satisfying all requirements under s. 628.10 Wis. Stat.

After a hearing, the commissioner may revoke, suspend, or limit an intermediary's license if:

- the intermediary repeatedly or knowingly violated an insurance statute, code regulation, or an enforcement order of the commissioner;
- the intermediary's business methods and practices endanger the legitimate interests of customers and the public;
- the intermediary's financial resources are inadequate to safeguard the legitimate interests of customers and the public;
- the intermediary provides false information in a statement on a licensing application or at the time of license renewal; or
- the intermediary is unqualified as an intermediary or is not competent or trustworthy.

[ss. 628.04(1)(b)2, 628.10(2)]

If a license has been revoked, when can the intermediary reapply?

If a license is revoked for nonpayment of fees or failure to comply with continuing education requirements, the intermediary may reinstate it immediately upon the payment of fees or compliance with the continuing education requirements.

When the commissioner revokes an intermediary's license for any of the other reasons mentioned in the preceding section, the commissioner may specify a period of five years or less during which the intermediary may not apply for a new license. If the commissioner does not specify a period, the intermediary may not apply for five years.

[s. 628.10(3)]

EXAMPLES

Does the commissioner have the power to take disciplinary action in the following cases?

- *A licensed intermediary continually used unlicensed employees who were paid to advise other persons about their insurance needs.*

  Yes. Under s. 628.02, Wis. Stat., the employees are insurance marketing intermediaries who must be licensed. This is a repeated violation of a state statute regulating the insurance business. Under s. 628.10 (2), Wis. Stat., the commissioner may act against any intermediary who repeatedly or knowingly violates an insurance statute.

- *A licensed intermediary failed to obey an order of the commissioner regarding that intermediary's violation of an administrative code regulation.*

Yes. Under s. 601.41 (4), Wis. Stat., the commissioner may issue orders to secure compliance with the law. Failure of a licensed intermediary to follow the order's directives is a violation of s. 628.10 (2), Wis. Stat.

- *A licensed intermediary failed to pay a required fee on time.*

Yes. Failure to pay a necessary fee when required is grounds for license revocation under s. 628.10 (2), Wis. Stat.

- *When training prospective intermediaries, a licensed intermediary corporation promoted an unfair marketing practice as a sales technique to be used by intermediaries.*

Yes. This is a violation of s. 628.10 (2), Wis. Stat. The commissioner may take disciplinary action against a licensed intermediary whose methods or practices in the conduct of its business endanger the legitimate interests of its customers and the public.

- *When selling a health insurance policy, a licensed individual intermediary failed to ask about the applicant's present insurance to determine whether the recommended insurance is suitable for the prospective buyer.*

Yes. This is an express violation of s. Ins 3.27 (7), Wis. Adm. Code. An intermediary should not recommend the purchase of any individual policy to a prospective buyer without reasonable grounds to believe that the recommendation is unsuitable for the applicant. Under s. 628.10 (2), Wis. Stat., the commissioner has the power to revoke, suspend, or limit the intermediary's license.

What are the prohibited practices during license revocation or surrender?

When an intermediary is disciplined by the Office of the Commissioner of Insurance, the disciplinary period begins on the effective date of the termination of the license and ends on the date on which a new license is issued. During the disciplinary period, the commissioner can discipline a person for using the services of a disciplined intermediary as well as the disciplined intermediary who provides the service.

[s. 628.345]

EXAMPLES

- *Who is a disciplined person?*

A disciplined person includes any intermediary whose license was revoked or surrendered under a stipulation, any affiliate of this disciplined agent, any estate in which this disciplined agent owns 10% or more of the stock, and any employee of the disciplined agent.

[s. 628.345(1)(b)]

- *Can a disciplined intermediary continue to be employed by, act as an intermediary for, or be affiliated with a person engaged in the business of an insurance intermediary?*

No. A disciplined intermediary may not serve in any of these capacities during the disciplinary period.

[s. 628.345(2)]

- *Can a person pay a disciplined intermediary for services performed as an agent?*

No. No person may pay consideration to, or expenses of, a disciplined intermediary that directly or indirectly relates to services performed during the disciplinary period. This does not apply to obligations incurred before the effective date of the discipline.

[s. 628.345(3)(a)]

- *Can a person seek information from a disciplined intermediary during the disciplinary period?*

No. No person may seek to obtain information from, or use information directly or indirectly from, a disciplined intermediary during the disciplinary period for the purpose of assisting in the sale of insurance.

[s. 628.345(3)(d)]

- *Can a disciplined intermediary be present during solicitation of the sale of insurance, or can a person knowingly solicit the sale of insurance with the assistance of a disciplined intermediary?*

No. During the disciplinary period, this is not allowed, regardless of whether the disciplined person acts as an intermediary.

[s. 628.345(3)(e)]

- *Can a person use or refer to an endorsement or referral by a disciplined intermediary for the purpose of soliciting the sale of insurance?*

No. During the disciplinary period of a disciplined intermediary, this practice is not allowed.

[s. 628.345(3)(f)]

What marketing practices are unfair?

Unfair marketing practices include misrepresentation; unfair inducements; unfair discrimination; restraint of competition, unfair restriction of contracting parties' choice of insurer; extra charges; attempt to unduly influence employers; and unfair use of official position.

[s. 628.34, ss. Ins 6.54, 6.55]

What is misrepresentation?

It is a violation for intermediaries and their employees or those acting on their behalf to make any written or oral communication about any insurance contract, the insurance business, any insurance company, or any intermediary which contains false or misleading information. This includes:

- information which is misleading because of incompleteness;

- filing a report with the intent to deceive the person examining that report;
- making a false entry in a record;
- failure to make a proper entry in a record for the purpose of concealing information; and
- using the name, slogan, emblem, or related device that will or is likely to cause an intermediary to be mistaken for another intermediary in the insurance business. If an insurance intermediary distributes cards or documents, exhibits signs, or publishes advertisements, including, but not limited to, social media posts, which include misrepresentations and contain a reference to a particular insurer that the person represents as an intermediary, the intermediary's violation carries a presumption that the violation was also committed by the insurer.

[s. 628.34(1)]

What is unfair inducement?

No insurance company, employee, or intermediary may influence another person to buy an insurance policy or terminate an existing insurance policy by offering benefits or making agreements that are not specified in the policy. Offering unfair inducements, sometimes referred to as "rebating," does not apply to reducing the amount of premiums because of expense savings, including commission reductions, resulting from any form of mass marketing.

No intermediary, broker, or insurer may absorb the premium tax for unauthorized insurance purchased under s. 618.43, Wis. Stat., for which the policyholder is responsible.

[ss. 628.34(2), 618.43(2)]

What is unfair discrimination?

No insurance company may charge different policyholders different premiums or provide different terms of coverage unless the differences are based on classifications which relate to the nature and degree of risk covered or the expenses involved. Rates do not discriminate unfairly if they are averaged among the persons covered under a group, blanket, or franchise policy. Terms of a group or blanket policy are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

[s. 628.34 (3), ss. Ins 6.54, 6.55, 6.67, 6.68]

What is restraint of competition?

It is illegal for any of the following persons to commit or agree to take part in any act of boycott, coercion, or intimidation that tends to unreasonably restrain the business of insurance, or which tends to create a monopoly in the insurance business:

- a person who is or should be licensed in Wisconsin;
- a person who is an employee or agent of the person who is or should be licensed in Wisconsin;

- a person whose main interest is to compete in the same business as those persons who are or should be licensed in Wisconsin; or
- a person who acts on behalf of those persons mentioned in the preceding sections.

[s. 628.34(4)]

May a person's choice of insurer be restricted by another?

No one who requires insurance coverage as a condition for concluding a contract or for exercising any right under a contract may restrict the choice of an insurer of the person buying the coverage. The person who is requiring the coverage may reserve the right to disapprove, on reasonable grounds, the policy or insurance company selected. The form of the corporate organization of the insurance company is not reasonable ground for disapproval.

[s. 628.34(5)]

What about "extra charges?"

No person may make any charge other than premiums and premium financing charges for the protection of property or protection of a security interest in property when the charge is a condition for the financing of a purchase of the property or the lending of money on the security of an interest in the property.

[s. 628.34(6)]

What about restrictions on the use of official positions to influence the purchase of insurance?

No one holding a position in government may use decision-making power to coerce a person to purchase an insurance policy from a particular intermediary or insurance company. Affected positions include elective, appointive, or civil service positions in federal, state, or local governments.

[s. 628.34(8)]

What about influencing employers?

No insurance company or intermediary or employee or agent may, in connection with an insurance transaction, influence or attempt to influence any employer not to hire a person or to fire a person arbitrarily or unreasonably.

[s. 628.34(7)]

Must an intermediary return indicia of agency (business cards, letterhead, or any materials, etc.) which indicate that the intermediary represents a particular insurer?

Yes. No agent may refuse or fail to return all indicia of agency promptly to any insurance company they represent whenever the company demands it.

[s. 628.34(9)]

Are there additional rules defining unfair marketing practices?

Yes. The commissioner may define by administrative rule specific unfair trade practices after finding that the practices are misleading, deceptive, unfairly discriminatory, provide an unfair inducement, or restrain competition unreasonably.

Some current rules that define unfair trade practices are:

- Section Ins 2.07, Wis. Adm. Code, replacement of life insurance policies or annuity contracts disclosure requirements;
- Section Ins 2.08, Wis. Adm. Code, special policies and provisions prohibitions, regulations, and disclosure requirements;
- Section Ins 2.09, Wis. Adm. Code, separate and distinct representations of life insurance;
- Section Ins 2.12, Wis. Adm. Code, exceptions to unfair discrimination;
- Section Ins 2.14, Wis. Adm. Code, life insurance solicitation;
- Section Ins 2.15, Wis. Adm. Code, annuity benefit solicitations;
- Section Ins 3.26, Wis. Adm. Code, unfair trade practices in credit life/credit accident and health insurance;
- Section Ins 3.27, Wis. Adm. Code, advertisements of and deceptive practices in accident and health insurance;
- Section Ins 3.29, Wis. Adm. Code, replacement of accident and sickness insurance;
- Section Ins 3.39, Wis. Adm. Code, standards for disability insurance sold to Medicare eligible;
- Section Ins 3.46, Wis. Adm. Code, standards for long-term care insurance and coverage;
- Section Ins 6.09, Wis. Adm. Code, prohibited acts by captive agents of lending institutions and others;
- Section Ins 6.54, Wis. Adm. Code, prohibited classification of risks for rating purposes;
- Section Ins 6.55, Wis. Adm. Code, discrimination based on sex—unfair trade practice;
- Section Ins 6.60, Wis. Adm. Code, prohibited business practices;
- Section Ins 6.67, Wis. Adm. Code, unfair discrimination in life and disability insurance based on physical or mental impairment or sexual orientation;
- Section Ins 6.68, Wis. Adm. Code, unfair discrimination based on geographic location or age of risk; and
- Section Ins 20.01, Wis. Adm. Code, home solicitation selling.

[s. 628.34]

EXAMPLES

Are the following cases unfair marketing practices?

- *An agent licensed to sell accident and health insurance in Wisconsin sold a policy to a 77-year-old man. During the course of the agent's sales presentation, the agent told the man that his company offers a Medicare supplement policy that pays every expense not covered by Medicare. According to the agent, the policy would "fill all the gaps" in Medicare coverage.*

Yes. Under s. 628.34 (1), Wis. Stat., the intermediary violated the law by telling the man that the insurance policy completely supplemented the coverage provided by Medicare. No supplement policy pays every expense not covered by Medicare. The statute applies because the intermediary was licensed, the information given to the man was false and misleading, and the information communicated concerned an insurance contract. Under s. 628.34 (11), Wis. Stat., the commissioner has defined additional unfair trade practices in the insurance code regulations. The intermediary's false statement about this policy filling "all the gaps" in Medicare was also a violation of s. Ins 3.27 (9) (n), Wis. Adm. Code. (See also s. Ins 3.39, Wis. Adm. Code, for Medicare supplement regulations.)

- *A licensed intermediary sent his customer a message on Facebook that her present accident and health insurance coverage was "almost worthless," that the company was financially unsound, and its agents were "crooks".*

Yes. Under s. 628.34 (1), Wis. Stat., this amounts to a flagrant violation, assuming that the allegation is unprovable. These unfair disparaging remarks are a specific violation of s. Ins 3.27 (23), Wis. Adm. Code.

- *A licensed intermediary, after identifying himself as a representative from the Social Security Administration, told the customer that he was there to explain Medicare when he was really there to sell insurance.*

Yes. Under s. 628.34 (1), Wis. Stat., this information is false and misleading. The false information concerning identification is a specific violation of s. Ins 3.27 (12) (c), Wis. Adm. Code.

- *An individual intermediary licensed to sell automobile liability insurance handed out business cards identifying herself as an agent for an insurance company that she did not represent.*

Yes. This is a violation of s. 628.34 (1), Wis. Stat. No intermediary may use any business name, slogan, emblem, or related device that is misleading or likely to cause the intermediary to be mistaken for another intermediary or insurer already in business.

- *A licensed intermediary informed a customer that the fire insurance policy he was selling had been endorsed by the governor and the state.*

Yes. This is a clear violation of s. 628.34 (1), Wis. Stat.

- *An intermediary licensed to sell life insurance told a customer that his company had taken over the customer's present insurance company and that now the customer must purchase new whole life insurance.*

Yes. This is a clear violation of s. 628.34 (1), Wis. Stat. While there may be replacement of life insurance policies under s. Ins 2.07, Wis. Adm. Code, the above remarks are false and misleading because an insurer cannot cancel all of its whole life policies.

- *An individual intermediary licensed to sell accident and health policies represented to the customer that her company's disability policy "guarantees your income".*

Yes. This is misleading under s. 628.34 (1), Wis. Stat., and is forbidden under s. Ins 3.27 (9) (n), Wis. Adm. Code. However, such statements may be preceded by other words such as "help."

What effect does the intermediary's appointment have on the insurer?

Every insurer is bound by an act of its agent performed in Wisconsin that is within the scope of the agent's authority. The insurance company remains bound while the agency contract is in force or until the insurance company has made reasonable efforts to recover from the agent its policy forms and other indicia of the agency. Reasonable efforts shall include a formal demand in writing for the return of the indicia and notice provided to the commissioner if the agent does not comply with the demand promptly.

[s. 628.40]

COMPENSATION OF INTERMEDIARIES

May an intermediary receive compensation for insuring himself or his property (controlled business)?

No intermediary may receive any compensation from an insurer for procuring insurance upon the intermediary's own property, life, or other risk unless during the prior year the intermediary sold other insurance with the same insurance company with total premiums exceeding the premiums on the intermediary's own risks.

[s. 628.51]

May an intermediary charge a fee to an insured for the purchase of insurance or for rendering advice on insurance needs and coverages?

Yes, an agent may charge a fee under these circumstances. However, before the insured incurs an obligation to pay compensation, the agent must clearly and conspicuously disclose to the applicant in writing:

- the amount of compensation to be paid by the insured (other than a commission payment made by the insurer); and
- the fact, if applicable, that compensation will be paid by another source.

[s. 628.32]

Is sharing of commissions allowed?

No intermediary or insurance company may pay any commission or reimburse out-of-pocket expenses to any person for services performed within Wisconsin as an intermediary if the intermediary or insurance company knows or should know that the person getting paid is not licensed.

No person may accept compensation for services performed as an intermediary unless the person is licensed under Wisconsin law.

An intermediary may direct that their commissions be paid to a partnership or corporation of which the intermediary is a member, officer, employee, or agent.

The law does not prohibit the payment of deferred commissions to formerly licensed agents or brokers or their assignees. The law also does not prohibit the proper exchange of business between intermediaries and brokers lawfully licensed in Wisconsin.

[s. 628.61]

May an agent be compensated for referring business to another intermediary (proper exchange of business between intermediaries)?

Proper exchange of business means the forwarding of insurance business from one agent to another because the forwarding agent cannot place the business with any of the companies for which the agent is listed due to capacity problems, the refusal of the company to accept the risk, or the onerous conditions it imposes on the insured. The agent forwarding the business is entitled to split the commission involved, but "referral fees" are not allowed.

An agent may properly exchange business with another agent or broker only if:

- the agent forwarding the business is licensed in the same line of business that is being exchanged;
- the agent who receives the business and agrees to place it is licensed in the line of insurance involved in the exchange; and
- the agent forwarding the business and the agent who places the business with the insurer both sign the insurance application or if no application is completed, the names of both agents involved in the transaction appear on the policy.

An agent is presumed to have exceeded the allowed exchange of business if they place more than five insurance risks per calendar year with any single insurer with which they are not listed as an agent, or exchanges in total more than 25 insurance risks per calendar year.

[s. Ins 6.66]

USE OF SENIOR-SPECIFIC DESIGNATIONS

Is an intermediary prohibited from using a senior-specific certification or professional designation in an advertisement, during the solicitation of a life or health insurance policy, or when providing advice in connection with life or health insurance?

An intermediary may not use a senior-specific certification or professional designation that indicates or implies that the intermediary has special certification or training when:

- the intermediary has not actually earned or is ineligible to use the certification or designation;
- the certification or designation is nonexistent or is self-conferred;
- the certification or designation implies a level of occupational expertise obtained through education, training, or experience that the intermediary does not have; or
- the certification or designation was obtained from an organization that is primarily engaged in sales and marketing instruction, does not have reasonable standards for assuring the competency of its students or for monitoring or disciplining its students for unethical conduct, or does not have reasonable continuing education requirements for its students in order to maintain the certification or designation.

[s. Ins 6.90]

CHAPTER III

INSURANCE CONTRACTS GENERALLY

This chapter covers insurance contracts in general. The state statutes affecting this material (chs. 631 and 632, Wis. Stat.) set out minimum standards for regulating the terms of insurance contracts. Control over policy forms and provisions is necessary for the adequate protection of Wisconsin policyholders. The approach of these statutes is to establish explicit standards within which the intermediary and the insurer will have sufficient freedom to develop contract terms and alternatives that fill the needs of individual consumers.

GENERAL RULES

Do chs. 631 and 632, Wis. Stat. (the "contracts" chapters), apply to all kinds of insurance?

The laws and regulations in these chapters apply to all insurance policies delivered or issued for delivery in this state on:

- persons residing in Wisconsin when the policy or group certificate is issued;
- property ordinarily located in Wisconsin; or
- business operations in Wisconsin.

[s. 631.01(1)]

Are there exceptions?

Unless otherwise specified by order or rule, chs. 631 and 632, Wis. Stat., do not apply to:

- death and disability benefits provided by an organization the principal purpose of which is not to provide such benefits but to seek unrelated charitable, educational, social, or religious objectives if the organization does not incur a legal obligation to pay a specified amount;

  [s. 600.01(1)(b)2]

- group or blanket insurance covering risks in Wisconsin if both the policyholder and the group do not exist primarily to procure insurance, the policyholder is not a Wisconsin resident and does not have its principal office in Wisconsin, fewer than 25% of the insureds are Wisconsin residents, and certain legal requirements are met;

  [s. 600.01(1)(b)3]

- transactions independently procured through negotiations involving direct placement of insurance with unauthorized insurers in compliance with s. 618.42, Wis. Stat.;

  [s. 600.01(1)(b)6]

- business operations in Wisconsin if the contract is negotiated outside this state and if the operations in Wisconsin are incidental or secondary to operations outside Wisconsin;

  [s. 631.01(1)(b)]

- reinsurance and ocean marine insurance except for certain specific statutes; and

[s. 631.01(2), (3)]

- group policies and annuities for eleemosynary institutions (that is, educational, research, religious, or charitable organizations licensed under ch. 615).

[s. 631.01(4)]

The commissioner may by rule exempt any class of insurance or insurance company from any or all provisions of chs. 631 and 632, Wis. Stat., if the interests of Wisconsin policyholders, creditors, or the public do not require such regulation.

[s. 631.01(5)]

Are binders and oral contracts for insurance valid?

Yes. The insurance laws of Wisconsin do not forbid oral contracts of insurance or issuance of a written promise to provide coverage. The insurance company must issue a policy as soon as reasonably possible after negotiation of an oral contract or issuance of any binder.

[s. 631.05]

May a policy be issued to a person who does not have an "insurable interest" in the subject matter insured?

No insurance company may knowingly issue a policy to a person who does not have an insurable interest in the subject of the insurance.

A person has an insurable interest if the person suffers a disadvantage or loss, especially a monetary loss, if an event should occur for which insurance is being purchased. For example, the owners of a farm would have an insurable interest in their own property, but not normally in their neighbor's.

[s. 631.07(1)]

May a life or disability (accident & health) policy be issued to anyone other than the person whose life or health is being insured?

Except in certain cases, an insurance company may only issue an individual life or disability (accident & health) insurance policy to the person whose life or health is being insured, unless the person who is being insured gives written consent to the policy being issued to another person. Consent is shown when the insured signs the insurance application with the knowledge it concerns insurance coverage on themselves. Consent may also be expressed in any other reasonable way.

[s. 631.07(2)]

May a charitable organization purchase or own a life insurance policy on the life of an individual?

A charitable organization is deemed to have an insurable interest and may be the applicant, owner, or beneficiary of a life insurance policy, an endowment policy, or annuity issued on the life of any individual. For policies issued on or after March 1, 1994, a charitable organization has an insurable

interest only if it obtains the consent of the individual in writing or by other means authorized by common law or by statute.

[s. Ins 2.45]

Are there cases where the insured's consent to life or disability (accident & health) insurance is unnecessary?

A life or health disability (accident & health) policy may be taken out by a third party without consent in the following cases:

- a person may obtain insurance on a dependent who does not have legal capacity;
- a creditor at the creditor's own expense may obtain a life or disability (accident & health) policy on the debtor in an amount reasonably related to the amount of the debt;
- a person may obtain a life or disability (accident & health) policy on family members who live with the person or qualify as their dependents;
- a person may obtain a disability (accident & health) policy on others that would only cover expenses that the policyholder would be legally or morally obligated to pay; or
- the commissioner may make rules permitting policies for a limited period on the life or health of a person serving the federal government outside the continental United States, provided the policyholder is closely related by blood or by marriage to the person who is being insured.

[s. 631.07(3)(a)]

Are there cases where consent may be given by another?

Consent may be given by another in the following cases:

- a parent, guardian, or a person having legal custody as defined in the statutes, may consent to the issuance of a policy on a dependent child;
- a grandparent may consent to the issuance of life or disability (accident & health) coverage on a grandchild; or
- a court of general jurisdiction may consent when the facts shown are sufficient to justify such insurance.

[s. 631.07(3)(b)]

What happens when a policy is issued where there is no insurable interest or consent?

No insurance policy is invalid because the policyholder lacks an insurable interest or because consent was not given. A court can order the policy's proceeds paid to someone other than the person who was to receive the proceeds. The court may order payment to a person who is equitably entitled to the proceeds. The court may also order the proceeds to be put in a constructive trust that would be subject to the remaining terms and conditions of the policy.

[s. 631.07(4)]

EXAMPLES

May an insurance company issue an insurance policy in the following examples?

- *A and B are partners in a business. B is not a dependent of A, nor is A a creditor of B. May an insurance company issue A a policy on B's life without B's consent?*

  No. Under s. 631.07 (1), Wis. Stat., there is an insurable interest because of their business relationship. A has a reasonable expectation of monetary benefit from the continued life of B. However, written consent to the issuance of the policy is necessary, and B failed to give such consent.

- *An insurance company knowingly issued a fire insurance policy to A on B's house. On just these facts should the policy have been issued?*

  No. There is no indication of insurable interest.

- *A is issued a disability (accident & health) policy on B. B is the husband of A. On these facts alone, may A be issued the policy?*

  Yes. Under s. 631.07 (3), Wis. Stat., there is an insurable interest. Consent is generally required for issuance of a life or disability (accident & health) policy on the life of another person. However, since B is a member of A's family, consent would not be required so long as B is living with A.

What is the legal effect of a mistake in an insurance contract?

In most circumstances, unless otherwise provided, general contract law applies to mistakes in insurance contracts.

In property insurance, a mistake in designating the person to whom the insurance is payable does not void the policy. Such a mistake does not constitute a defense for the insurance company unless the mistake was due to misrepresentation or concealment by the owner of the property or by someone representing the owner in getting the policy, or unless the company would not have issued or continued the policy if it had known the truth.

[s. 631.08]

Is an insurance company responsible for information known to its agents?

Yes. An insurance company is deemed to know any fact material to the risk or that violates a condition of the policy.

If the insurance company's agent who bound the company, issued the policy, or transmitted the application to the insurer knew the fact at the time they acted; or if afterward any of the company's agents learned of the fact during the course of dealing with the policyholder as an agent and knew that the fact pertained to the policy.

[s. 631.09(1)]

What if the insured fails to perform a required act due to the acts of the agent?

If a policyholder or insured failed to perform a required act in the prescribed time or manner because of the agents' actions or statements, the failure does not affect the insurance company's obligations under the policy. This is the case whether or not the agent was acting within the actual scope of the agent's authority.

[s. 631.09(2)]

Is notice to an agent notice to the insurance company?

Yes. The insurance company has been notified if the company's authorized agent has been notified by or on behalf of the policyholder or insured and provided with sufficient information to identify the policy in question.

[s. 631.09(3)]

How is the insurer protected from collusion between the policyholder and agent?

If the agent and policyholder or insured acted together to deceive or defraud the insurance company, s. 631.09 (1) and (2), Wis. Stat., do not apply. The two sections also do not apply if the policyholder or the insured knew the agent was acting beyond the scope of the agent's authority.

[s. 631.09(4)]

What is a representation by an applicant?

Representations are oral or written statements made by an applicant. Insurance coverage is issued based on the applicant's representations.

[Common Law, s. 631.11]

What is misrepresentation by an intermediary?

Misrepresentation by an intermediary is the use of written or oral statements that incorrectly describe the terms or benefits of any policy.

Misrepresentation by an intermediary also involves making or causing to be made any communication relating to an insurance contract, the insurance business, any insurers, or any intermediary that contains false or misleading information, including information that is misleading because of incompleteness. Filing a report with intent to deceive, making a false entry in a record, or willfully refraining from making a proper entry are considered communications under Wisconsin statutes.

[Common Law, ss. 628.34, 631.11]

What is a material misrepresentation by an applicant?

A material misrepresentation is an untrue statement made by an applicant that would influence a prudent insurer in determining whether to accept the risk or in fixing the amount of the premium in the event of such acceptance.

[Common Law, s. 631.11]

What is a warranty?

A warranty is a statement made in an insurance contract by the insured when the validity of the insurance contract depends on the literal truth of the statement. The parties to the contract mutually intend that the policy will not be binding unless the statement is true.

[Common Law, s. 631.11]

What is an affirmative warranty?

An affirmative warranty is a positive representation (implied or express) in the policy that verifies a fact at the time the policy goes into effect.

[Common Law, s. 631.11]

What is a promissory warranty?

A promissory warranty is a warranty that certain things will be done or not be done after the policy has taken effect.

[Common Law, s. 631.11]

When does a statement, representation, or warranty affect the insurer's obligations under a policy?

No statement, representation, or warranty made by a person other than the insurer or an agent of the insurer in the negotiation for an insurance contract affects the insurance company's obligations under the policy unless it is stated in any of the following:

- the policy;
- a written application signed by the person provided that a copy of the written application is made a part of the policy by attachment or endorsement; or
- a written communication provided by the insurer to the insured within 60 days after the effective date of the policy.

[s. 631.11(1)(a)]

What is the effect of misrepresentation or breach of an affirmative warranty on the insurer's obligations?

No misrepresentation and no breach of an affirmative warranty that is made by a person other than the insurer or an agent of the insurer in the negotiation for, or procurement of, an insurance contract

constitutes grounds for rescission of, or affects the insurer's obligations under, the policy unless the person knew or should have known that the representation was false, and unless any of the following applies:

- the insurer relies on the misrepresentation or affirmative warranty and the misrepresentation or affirmative warranty is either material or made with intent to deceive; or
- the fact misrepresented or falsely warranted contributes to the loss.

[s. 631.11(1)(b)]

What effect does the insurer's knowledge have on its obligations?

No misrepresentation made by or on behalf of a policyholder and no breach of an affirmative warranty or failure of a condition constitutes grounds for rescission of or affects an insurer's obligations under an insurance policy if at the time the policy is issued the insurer has either constructive knowledge of the facts [under s. 631.09 (1), Wis. Stat.] or actual knowledge. If the application is in the handwriting of the applicant, the insurer does not have constructive knowledge under s. 631.09, Wis. Stat., merely because of the agent's knowledge.

[s. 631.11(4)(a)]

If after issuance of an insurance policy an insurer acquires knowledge of sufficient facts to constitute grounds for rescission of the policy under this section or a general defense to all claims under the policy, the insurer may not rescind the policy and the defense is not available unless the insurer notifies the insured within 60 days after acquiring such knowledge of its intention to either rescind the policy or defend against a claim if one should arise, or within 120 days if the insurer determines that it is necessary to secure additional medical information.

[s. 631.11(4)(b)]

Must a copy of the application be made available to the insured?

Yes. The policyholder under a life and disability (accident & health) insurance policy and any person whose life or health is insured under the policy may request in writing a copy of the application if they did not receive the policy or a copy of it. The request may also be made if the policy has been reinstated or renewed without attachment of a copy of the original application. If the insurance company does not deliver or mail a copy as requested within 15 working days after the company or its agent receives the request, nothing in the application may affect the insurance company's obligations under the policy to the person making the request. The same conditions and results apply where a group policy certificate holder is not informed by the insurer how such a person may inspect the policy and application during normal business hours at a place reasonably convenient to the certificate holder.

[s. 631.11(4m)(a)]

Can separate agreements or other materials be "incorporated by reference" into a policy?

No. An insurance contract may not contain any agreement or incorporate any provision unless the provision is fully set forth in the policy, application, or document which is attached to and made part of the policy at the time of delivery. There are limited exceptions relating to rates and complex contracts.

[s. 631.13]

What are the privacy protections under Wisconsin insurance law?

Wisconsin consumers are provided with privacy protection for medical and financial information. These laws correspond with the requirements under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Gramm-Leach-Bliley Act (GLB) enacted in 1999. Chapter Ins 25, Wis. Adm. Code addresses insurance agents' responsibilities when sharing consumer and customer private personal financial and health information with third parties. The administrative code requires that a licensee provide written notice of its privacy policies and practices. It also establishes requirements for privacy notices.

Insurance agents may, for the most part, rely on the insurance companies with which they are listed to provide the required notices and disclosure. However, insurance agents who perform activities in addition to marketing products for insurance companies or who share a client's personal information may be responsible for obtaining authorization and providing notice to clients who meet the definition of consumers and customers.

[ch. Ins 25]

What are the medical records privacy protections under Wisconsin insurance law?

Wisconsin enacted a statute that regulates the disclosure of personal medical information. It places restrictions on both insurers and the persons that regularly assemble or collect personal medical information for the primary purpose of providing the personal medical information to insurers for the determination of an individual's eligibility for insurance coverage, benefit, or payment or for the servicing of an insurance application, policy, or certificate. The law delineates the form that is to be used in obtaining authorization for the release of personal medical information, the timeframe for which such information may be requested and maintained, how and to whom the information may be released to other entities or health care providers, notice requirements to individuals or insureds and the right of the individual to request a correction, amendment or deletion of personal medical information that is in the insurer's possession.

[s. 610.70]

What are the privacy protections regarding non-public personal financial information under Wisconsin insurance law?

Wisconsin enacted rules that require insurance companies and agents to provide written notice of their privacy policies and practices. The rule describes the conditions under which insurance companies and their agents may disclose nonpublic personal financial information. The rule also establishes requirements for privacy notices.

The rule also establishes restrictions on the sharing of health information. However, as Wisconsin has a separate statute regarding Medical Records Privacy, the provisions of the rule apply primarily to health information relating to claimants against worker's compensation or commercial liability insurance policies.

[ch. Ins 25]

When are agents required to provide privacy notices?

Agents can rely on the notice procedures of the insurance companies they represent as long as the agent does not share nonpublic personal information as provided by the rule. If the agent shares the information with third parties in activities that are not excepted by the rule, the agent will be required to issue the same type of notices required of the insurer.

[ch. Ins 25]

Disposal of Records Containing Personal Information

Wisconsin statutes include provisions regarding the proper disposal of personal medical information. The law is often referred to as the "dumpster diving law."

It requires that insurers that obtain information from an insured, or an individual seeking coverage, pertaining to the individual's physical or mental health, medical history, or medical treatment take specific steps to ensure that this personally identifiable information is shredded, erased, modified, or otherwise handled so that no unauthorized person has access to the information.

[s. 134.97]

USE OF POLICY FORMS

May any insurance policy form be used in Wisconsin?

No. Unless specifically exempt under the statutes, no policy form may be used in Wisconsin unless it has been filed with the commissioner.

Wisconsin insurance laws were amended to allow insurance companies to use certain policy forms if the companies file the forms with the commissioner 30 days prior to use and certify that the forms comply with Wisconsin insurance statutes and regulations. This process is called "file and use."

File and use does not apply to health care liability, worker's compensation, Medicare supplement, long-term care insurance (including nursing home and home health care) policy forms, service contracts, and warranty contracts. These forms must be submitted prior to use to the commissioner for review and approval.

Policy forms that are subject to prior approval are deemed approved if not disapproved within 30 days after filing or within a 30-day extension of that period ordered by the commissioner prior to the expiration of the first 30 days.

[s. 631.20]

May a filed policy form be disapproved subsequently?

Yes. After a hearing and a finding that a previously filed, approved, or deemed approved form would be disapproved for one of the reasons set out in s. 631.20 (2), Wis. Stat., if newly filed, the commissioner may order the use of the form discontinued or the appropriate changes made.

[s. 631.20(3)]

What is the Interstate Insurance Product Regulation Compact?

The Interstate Insurance Product Regulation Compact is a contract between member states that established the Interstate Insurance Product Regulation Commission (IIPRC). The IIPRC provides insurers with a single point of filing for the review and approval of certain insurance policy forms instead of submitting the forms to each state where they intend to use the policy forms.

[ss. 601.58, 14.82]

What insurance policy forms can be submitted to the IIPRC?

The Interstate Insurance Product Regulation Commission (IIPRC) has developed uniform national standards for insurance policy forms in the lines of life, annuities, disability income, long-term care insurance, as well as long-term care insurance advertisements.

Has Wisconsin joined the Compact?

Yes. Wisconsin was the 31st state to join the Compact, effective March 28, 2008. Insurers who submit policy forms to the IIPRC, intending to use the forms in Wisconsin, and who receive approval from the IIPRC, will be able to use the forms in Wisconsin provided the insurer has a certificate of authority in Wisconsin for the appropriate line of insurance.

Are the Compact's uniform product standards the same as Wisconsin's laws?

No. The uniform product standards were developed by the IIPRC with input from state insurance departments, insurers, and legislative as well as consumer representatives to ensure high-level standards. By joining the Compact, member states agree to have the Compact's uniform product

standards apply to forms submitted to the IIPRC even though certain product standards may differ from a member state's own insurance laws and regulations.

SPECIFIC CLAUSES IN CONTRACTS

When is mid-term cancellation of policies permissible by insurers?

Except for new policies and umbrella or excess liability policies and the war risks coverage in an aircraft policy as defined in s. Ins 6.77, Wis. Adm. Code, no insurance policy may be canceled by the insurer prior to the expiration of the agreed term or one year from the effective date of the policy or renewal, whichever is sooner, except for:

- failure to pay a premium when it is due;
- grounds for cancellation stated in the policy, which are included within the following classes:
- material misrepresentation;
- substantial change in the risk assumed, except to the extent that the insurer should have reasonably foreseen the change or contemplated the risk in writing the contract;
- substantial breaches of contractual duties, conditions, or warranties; or
- attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice accompanied by a pro rata return of the premium.

[s. 631.36(2)(a)**,** ss. Ins 6.77**,** 21.01(4)(a)**]**

What kind of notice is required for mid-term cancellation?

No cancellation based on the grounds listed in the above section is effective until at least 10 days after the first-class mailing or delivery of a written notice to the policyholder. Seven days' notice is required for the war risks coverage in an aircraft policy.

For worker's compensation insurance, no cancellation based on the grounds listed in the above section is effective until at least 30 days after the first-class mailing or delivery of a written notice to the policyholder and receipt by the Wisconsin Compensation Rating Bureau of at least 30 days' notice. However, the cancellation is effective whether or not the notice has been given to the policyholder upon the effective date of replacement insurance coverage obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[s. 631.36(2)(b)**,** ss. 102.31(2)(a)-(b)**,** ss. 102.315(10)(a)3, (10)(b)3**,** ss. Ins 21.01(4)(b), (8), (10)**]**

What are the regulations for mid-term cancellation of new policies?

The permissible grounds for mid-term cancellation and the notice requirements listed above do not apply to any new insurance policy that has been in effect less than 60 days at the time the notice of cancellation is mailed or delivered. No cancellation is effective until at least 10 days after the first-

class mailing or delivery of a written notice to the policyholder. This cancellation notice need not contain information about the grounds for cancellation unless it is a health insurance policy.

For worker's compensation insurance, no cancellation is effective until at least 30 days after the first-class mailing or delivery of a written notice to the policyholder and receipt by the Wisconsin Compensation Rating Bureau of at least 30 days' notice. However, the cancellation is effective whether or not the notice has been given to the policyholder upon the effective date of replacement insurance coverage obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[s.631.36(2)(c), ss. 102.31(2)(a)-(b), ss. 102.315(10)(a)3, (10)(b)3, ss. Ins 21.01(4)(c), (8), (10)]

What notice is required for "anniversary" cancellations?

A policy may be issued for a term longer than one year or for an indefinite term with a clause providing for cancellation by the insurer by giving notice 60 days prior to the anniversary date. The notice must comply with the statutory requirements for nonrenewals.

[s. 631.36(3), ss. 102.31(2)(a)-(b), s. Ins 21.01(5)]

What notice is required if a policy is not renewed?

Subject to the statutory requirements for mid-term and anniversary cancellations, a policyholder has the right to have their policy renewed, on the terms then being applied by the insurer to similar risks, for an additional period of time equal to the last term if the last term was a year or less, or for one year if the last term was longer than one year. The policy must be renewed unless at least 60 days before the expiration date, a notice of intent not to renew the policy is mailed or delivered to the policyholder. To be effective, the notice of nonrenewal must state with reasonable precision the fact(s) on which the insurer's decision is based.

To effectively terminate coverage at renewal because the policyholder did not pay the renewal premium on time, the insurer must give written notice to the policyholder between 10 and 75 days before the premium is due and the notice must clearly state the effect of nonpayment of premium by the due date. For worker's compensation insurance, the insurer must give written notice to the policyholder between 30 and 75 days before the premium is due, and the notice must clearly state the effect of nonpayment of premium by the due date.

This provision does not apply if the policyholder is insured elsewhere, has accepted replacement coverage, has requested, or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable. For worker's compensation insurance, no nonrenewal is effective until 60 days after the insurance company has given written notice of the nonrenewal to the Wisconsin Compensation Rating Bureau. However, a nonrenewal is effective whether or not the notice has been given to the

policyholder upon the effective date of replacement insurance obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[ss. 631.36(4), (6), ss. 102.31(2)(a)-(b), ss. 102.315(10)(a)3, (10)(b)3, ss. Ins 21.01 (6), (8) – (10)]

What happens when an insurer offers to renew with altered terms?

If the insurance company offers to renew a policy, other than a personal lines property & casualty policy, on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer sent by first-class mail or delivered to the policyholder notice of the new terms or rates at least 60 days prior to the expiration date. If the insurer notifies the policyholder within 60 days prior to the renewal date, the new terms or rates do not take effect until 60 days after the notice is mailed or delivered, in which case the policyholder may elect to cancel the renewal policy at any time during the 60-day period. If the insurer does not notify the policyholder of the new premiums or terms prior to the renewal date, the policy must be renewed under the terms of the expiring policy. Return premiums or additional premium charges shall be calculated proportionately based on the old rates. This section does not apply if the only change is a rate increase of less than 25% that is either generally applicable to the business class to which the policy belongs or results from a classification change based on the altered nature or extent of the risk insured against.

If the insurance company offers to renew personal lines property and casualty policies, an insurer may alter the terms or premium of a policy issued for a term longer than one year or for an indefinite term on the anniversary date only if notice of less favorable terms or premiums is sent by first-class mail or delivered to the policyholder at least 45 days prior to the anniversary date. If the insurer notifies the policyholder within 45 days prior to the anniversary date, the new terms or premiums do not take effect until 45 days after the notice is mailed or delivered, in which case the policyholder may elect to cancel the policy at any time during the 45-day period. The notice shall include a statement of the policyholder's right to cancel. If the policyholder elects to cancel the policy during the 45-day period, return premiums or additional premium charges shall be calculated proportionately based on the old premiums.

[s. 631.36(5)]

For motor vehicle liability insurance, the insurer is prohibited from issuing or renewing a policy that is less favorable to the insured or canceling or nonrenewing a policy because of any accident that occurs during the insured's business or employment unless the policy covers the insured for liability that arises in the course of their employment or business.

[ss. 632.36(1), (2)]

Can an insurance company choose not to renew a policy solely because of the termination of an insurance marketing intermediary's contract with the insurer?

No. An insurer may refuse to renew or cancel a policy, subject to the statutory requirements for nonrenewals and anniversary cancellations, only if the notice of nonrenewal or cancellation contains an offer to continue to renew the policy with the insurer if the insurer receives a written request from the policyholder prior to the cancellation or renewal date. The insurer will continue or renew the policy if a timely request is received unless the policyholder does not meet normal underwriting criteria. For worker's compensation insurance, the cancellation or nonrenewal is effective whether the notice contains an offer to continue or renew the policy upon the effective date of replacement insurance obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[ss. 631.36(4)(am), (4m), ss. Ins 21.01(6)(b), (7)]

What information must notices of nonrenewal and mid-term cancellation contain?

A notice of nonrenewal must state with reasonable precision the facts on which the insurer's decision was based. If a risk-sharing plan exists for the kind of coverage being canceled, the notice of nonrenewal is not effective unless it contains adequate instructions to the policyholder on how to apply for coverage in the plan.

This requirement does not apply if the grounds for cancellation or nonrenewal is nonpayment of the premium or if the policy is in a mandatory health care liability risk-sharing plan.

[ss. 631.36(6), (7), (8), s. 102.31(2)(a). ss. 102.315(10)(a)3, 4, ss. Ins 21.01(8) – (10)]

Is there any liability for making statements or providing information relating to the reasons for termination?

There is no liability on the part of and no cause of action arises against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing information relating to the reasons for cancellation or nonrenewal made to comply with s. 631.36, Wis. Stat., and Ins 21.01, Wis. Adm. Code.

[s. 631.36(9), s. Ins 21.01(11)]

EXAMPLES

- *An insurance company notified policyholder "B" at least 60 days before the policy's date of expiration that the homeowner's policy would not be renewed. The notice only informed "B" that the policy would not be renewed. Was the cancellation effective?*

  No. Under s. 631.36 (6) and (7), Wis. Stat., the company must inform "with reasonable precision the facts on which the insurer's decision is based" and contain information on how to apply to the Wisconsin Insurance Plan.

What happens when two or more policies indemnify against the same loss?

When two or more policies promise to indemnify an insured against the same loss, the total protection of the insured will be the lesser of the actual insured loss suffered by the insured or the total indemnification promised by the policies if any "other insurance" provisions are ignored.

The policies may define which is primary and which is excess. If the policies contain inconsistent terms on that point, the insurers are jointly and severally liable to the policyholder on any coverage where the terms are inconsistent, each to the full amount of coverage it provided. Settlement among the insurers does not alter any rights of the insured. This does not affect the right of the insurance company to defend against a claim under the policy on the grounds of fraudulent misrepresentation.

[s. 631.43(1)]

What are nonwaiver clauses in policies?

An insurance company may insert in any insurance policy a provision that no change in the policy is valid unless the change is approved by an executive officer of the insurance company and endorsed on the policy or attached to it. A provision may also be inserted specifying that an agent has no authority to change the policy or waive any of its provisions. These clauses do not preclude a person claiming a right under a policy from relying on waiver or estoppel in an appropriate case.

[s. 631.48]

What notice and proof of loss requirements apply to the insured?

If proof of loss is furnished to the insurer as soon as reasonably possible and within one year after the time it was required by the policy, failure to furnish such notice or proof within the time required by the policy does not invalidate or reduce a claim unless the insurer is harmed as a result, and it was reasonably possible to meet the time limit.

The notice or proof of loss is sufficient if it is properly mailed or delivered to the insurer within the time prescribed. The commissioner may expressly approve clauses requiring more prompt and efficient methods of notice where that is reasonable.

The acknowledgment by the insurer of the receipt of notice, the furnishing of forms for filing proof of loss, the acceptance of such proofs, or the investigation of any claim are not alone sufficient to waive any of the rights of the insurer in defense of any claim arising under the insurance contract.

[s. 631.81]

INSURANCE CLAIMS

Are there standards for insurance claim settlement practices?

Wisconsin law regulates insurance claim settlement practices to promote the fair and equitable treatment of policyholders, claimants, and insurers by defining certain claim adjustment practices as unfair business methods and practices in the insurance business.

[s. 628.46, s. Ins 6.11]

Are there standard forms that providers and insurers must use when submitting and paying health insurance claims?

Yes. The Wisconsin Administrative Code requires individual and institutional providers to use standardized billing forms for health care services. When an insurer pays a claim to a health care provider, the insurer is required to use a standardized remittance advice form and the claim disposition codes of the American National Standards Institute. Although there is no standard format for explanation of benefits forms sent to insureds, insurers are required to include certain minimum information on such forms. Insurers are not required to provide an explanation of benefits if the insured has no liability for payment or is liable only for a copayment unless one is requested by the insured.

[ss. Ins 3.65, 3.651]

How promptly must claims be paid?

Unless otherwise provided by Wisconsin law, subject to interest payment, an insurer must promptly pay most insurance claims. A covered claim is overdue if not paid within 30 days after the insurer is furnished with a written notice of the fact of covered loss and the amount of loss.

If the written notice of the entire claim is not sent to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days. A payment is not overdue if the insurer has reasonable proof to establish that the insurer is not responsible for the payment, even when written notice has been furnished to the insurer.

The date of payment is the date a check or payment was properly mailed or, if not mailed, the date of delivery of the payment. All overdue payments are charged simple interest at the rate of 7.5% per year.

The payment of a claim is not overdue until 30 days after the insurer receives the proof of loss required under the policy or equivalent evidence. Also, a delay in payment may be justified if the insurer cannot determine to whom the claim should be paid.

[s. 628.46]

What are some examples of unfair claim settlement methods and practices?

Any of the following done without just cause and with such regularity as to indicate a general business practice, constitutes an unfair method and practice:

[s. Ins 6.11(3) for additional examples]

- failure to promptly acknowledge pertinent communications with respect to claims arising under insurance policies;
- failure to promptly provide the necessary claim forms, instructions, and reasonable assistance to insureds and claimants;
- failure to attempt in good faith to effectuate fair and equitable settlements of claims in which liability has become reasonably clear; or
- knowingly misrepresenting to claimants pertinent facts or policy provisions.

[s. Ins 6.11]

Is sex discrimination an unfair trade practice?

Yes. The Wisconsin Administrative Code forbids the act of denying benefits or refusing coverage on the basis of sex and seeks to eliminate unfair discrimination in underwriting criteria based on sex. In addition, the code seeks to eliminate differences in rates based on sex that cannot be justified by credible supporting information. The following prohibitions apply to all insurance contracts delivered or issued in Wisconsin and are prohibited as unfair trade practices:

- the insurer may not refuse or cancel coverage or deny benefits on the basis of the sex of the applicant or insured; and
- the insurer may not restrict, modify, or reduce the benefits, term, or coverage on the basis of the sex of the applicant or insured.

[s. Ins 6.55]

EXAMPLES

The following are examples of unfair trade practices due to sex discrimination:

- denying coverage to females gainfully employed at home, employed part-time, or employed by relatives when coverage is offered to males similarly employed;
- denying benefits offered by policy riders to females when the riders are available to males;
- treating complications of pregnancy differently from any other sickness under a contract;
- restricting, reducing, modifying, or excluding benefits payable for treatment of the genital organs of only one sex;
- offering lower maximum monthly benefits to women than to men in the same underwriting, earnings, or occupational classifications under a disability income contract;
- offering more restrictive benefit periods and more restrictive definitions of disability to women than to men in the same underwriting, earnings, or occupational classifications under a disability income contract; and

- establishing different conditions by sex under which the policyholder may exercise benefit options contained in the contract

[s. Ins 6.55(4)(b)]

Surplus lines and unauthorized insurance

(In this section note the difference between an "unauthorized insurer" and "unauthorized insurance.")

What is surplus lines insurance?

Generally, surplus lines insurance is insurance placed with unauthorized (not licensed) insurers by an intermediary licensed to transact surplus lines business in Wisconsin. The license required is in addition to the property and casualty license. The license fee is $100.00 annually.
An insurer without a certificate of authority to do business in Wisconsin may negotiate and make insurance contracts with persons in Wisconsin on risks in Wisconsin subject to the following limitations and requirements.

A nondomestic insurer (that is, an insurer domiciled in another state) is not permitted to advertise or solicit business in Wisconsin without a certificate of authority. However, the commissioner has prescribed by rule the manner in which intermediaries may advertise the availability of their services in procuring, on behalf of persons seeking insurance, contracts with insurers not holding a certificate of authority. Such advertisements may not refer to any particular unauthorized insurer or insurers.

The nondomestic unauthorized insurer may also inspect risks to be insured, collect premiums, and adjust losses, and do all other acts reasonably incidental to a legally issued contract.

The unauthorized insurer and the intermediary are obligated promptly to furnish the policyholder with a proposal form which includes a statement that the insurer has not obtained a certificate of authority to do business in Wisconsin and is not state-regulated except for s. 618.41, Wis. Stat. The proposal is set forth in s. Ins 6.17, Wis. Adm. Code. The policyholder must pay the 3% premium tax required under s. 618.43, Wis. Stat. The agent is required to keep all taxes collected in a separate bank account and not commingled with other funds.

Nothing in the law prohibits proper exchange of business in accordance with s. Ins 6.66, Wis. Adm. Code, between licensed intermediaries. A regular licensed intermediary may procure surplus lines policies through a licensed surplus lines intermediary and the surplus lines intermediary may share commissions with the regular agent, as spelled out in s. Ins 6.66, Wis. Adm. Code.

Note: 2017 Wisconsin Act 16 authorizes domestic insurance corporations to provide surplus lines insurance in Wisconsin, subject to certain requirements, and specifies the application of various laws and requirements to surplus lines insurance policies provided by domestic surplus lines insurers.

[ss. 611.02, 611.20, 618.40, 618.41, 618.43, ss. Ins 6.17, 6.66]

What is "direct placement" of insurance with unauthorized insurers?

Generally, direct placement is accomplished when there is no Wisconsin intermediary or broker involved and negotiations occur primarily outside Wisconsin. It should be noted that the law provides that negotiations occur within Wisconsin if a letter regarding the insurance is sent to or from an address in Wisconsin.

Every policyholder who procures or renews insurance from any insurer not authorized to do business in Wisconsin, other than insurance procured under surplus lines insurance law and the renewal of guaranteed renewable insurance lawfully issued outside Wisconsin, must report within 60 days after the procurement or renewal to the commissioner on the form required by s. Ins 6.19, Wis. Adm. Code. In addition, the policyholder must pay the tax as set out in 618.43, Wis. Stat.

A Wisconsin intermediary or broker need not be greatly concerned with directly placed insurance except to recognize that the law does permit Wisconsin residents to purchase insurance from any insurer, regardless of the reliability or authority of the insurer, provided the transaction takes place primarily outside the state of Wisconsin.

[ss. 618.42, 618.43, s. Ins 6.19]

What is "unauthorized insurance"?

Unauthorized insurance is insurance placed with an unauthorized insurer illegally; in other words, not placed as a surplus lines transaction and not as a proper "direct placement" as explained above.

A person may not perform insurance business in Wisconsin if the person knows or should know that the result is or might be the illegal placement of insurance with an unauthorized insurer or the subsequent servicing of an insurance policy illegally placed with an unauthorized insurer.

Any person who violates the above paragraph is personally liable to any claimant under the policy for any damage caused by the person's violation. That damage may include damage resulting from the necessity of replacing the insurance with an authorized insurer or the failure of the unauthorized insurer to adhere to the contract.

[s. 618.39, 618.40(11)]

What are the regulations regarding solicitation and placement with risk purchasing and risk retention groups?

A risk purchasing group is a group of members who engage in businesses or activities that expose the members to similar risks, form a group, and purchase liability insurance for the group.

An agent may not solicit, negotiate, or obtain liability insurance for a risk purchasing group from an unauthorized insurer unless the agent holds an active surplus lines license in Wisconsin.

[s. 618.41(7m)]

A risk retention group is an insurance company comprised of members who engage in businesses or activities that expose the members to similar risks, which provides liability insurance to its members.

An agent may not place insurance with or solicit the purchase of insurance from an unauthorized risk retention group if:

- the group is financially unsound, engages in unfair business practices, or is otherwise substandard;
- the agent fails to give the applicant written notice of the insurer's deficiencies; and
- the agent knows of or fails to investigate adequately the insurer's financial condition and general reputation.

[s. 618.41(8)]

Before taking an application for liability insurance under a policy issued by an unauthorized risk retention group, the agent must inform the applicant of the insurer's deficiencies, that the insurer is not regulated by the state, that the risk is not protected by the security fund, and any other information required by the commissioner by rule.

[s. 618.415]

Must insurers notify policyholders of their right to file a complaint?

Yes. Insurers are required to notify their insureds of their right to file a complaint with the Office of the Commissioner of Insurance regarding problems they may have with their insurance. Notice is required once for each policy or certificate issued by an insurer.

[s. 631.28, s. Ins 6.85]

Is electronic delivery of notices or other documents allowed?

Yes. Notice to a party, and any other document that is required under applicable law in an insurance transaction or that serves as evidence of insurance coverage may be stored, presented, and delivered by electronic means, as long as the notice or other document meets the requirements of subchapter II of ch. 137, Wis. Stat.

[s. 610.60(2), ch. 137, subch. II]

CHAPTER IV

DISABILITY (ACCIDENT & HEALTH) INSURANCE

Disability (accident & health) insurance is generally defined as any type of insurance that covers policy claims involving: (1) medical and surgical expenses; (2) indemnities for loss of income due to accident or health; (3) accidental death and disability; (4) hospital care; and (5) long-term care.

Most disability policies offer a wide range of coverage and limits. The commissioner has the authority to regulate the terms of insurance contracts to protect the policyholder. The insurance laws establish statutory standards, explicit enough to protect the insured and to give the commissioner authority to set specific standards and provisions through rule-making powers.

What is the Affordable Care Act (ACA)?

The federal Affordable Care Act (ACA), also called PPACA (Patient Protection and Affordable Care Act), Health Care Reform or Obamacare, was enacted in March 2010. It addresses quality of care, cost of care, accessibility, and gaps in insurance coverage. Some of the health insurance reforms began in 2010 and some reforms did not begin until 2014. Examples of the reforms include prohibiting lifetime dollar limits and annual dollar limits on essential health benefits (EHBs), required coverage of specific preventive services with no cost-sharing, guaranteed issue of health insurance policies, and prohibiting preexisting condition limitations.

What is the health insurance exchange or marketplace?

The ACA provided for the 2014 implementation of health insurance exchanges, also called health insurance marketplaces, a federal website that allows consumers to purchase qualified health plans (QHPs) and determine their eligibility for federal premium tax credits and cost-sharing subsidies. The federal government uses the term health insurance “marketplace” instead of “exchange.”

What is a Qualified Health Plan (QHP)?

Under the Affordable Care Act (ACA), an insurance plan sold on the health insurance exchange/marketplace must be certified by the health insurance exchange/marketplace and once certified it becomes a qualified health plan (QHP). QHPs provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. QHPs are only available on the health insurance exchange/marketplace and are the only plans that provide premium tax credits and cost-sharing subsidies for eligible individuals.

What are Essential Health Benefits (EHBs)?

Essential health benefits (EHBs) are a set of health care service categories that must be covered as of 2014 by all comprehensive individual and small group health plans subject to the ACA, whether on or off the exchange. Essential health benefits must include items and services within at least the following 10 categories:

1. ambulatory patient services
2. emergency services
3. hospitalization
4. maternity and newborn care
5. mental health and substance use disorder services, including behavioral health treatment
6. prescription drugs
7. rehabilitative and habilitative services and devices
8. laboratory services
9. preventive and wellness services and chronic disease management
10. pediatric services, including oral and vision care

EHBs also include all Wisconsin mandated benefits. Mandated benefits are Wisconsin laws that require health coverage for specific treatments for medical conditions.

What is the Wisconsin EHB Benchmark Plan?

The ACA provides that each state establishes an essential health benefits benchmark benefit package to serve as the minimum standard for plans required to offer essential health benefits (EHBs) in the state. Wisconsin’s plan is called the Wisconsin EHB Benchmark Plan.

What is minimum essential coverage?

The ACA requires that all Americans have health insurance that qualifies as minimum essential coverage. Comprehensive individual and small group health plans, most employer-sponsored plans, and governmental plans such as Medicare, all qualify as minimum essential coverage. Short-term health policies and limited benefit plans such as specified disease, hospital indemnity, and other limited policies, are not considered minimum essential coverage. Currently, there is no longer a penalty for not having coverage that qualifies as minimum essential coverage.

What are metal levels or metal tiers?

The ACA provides that comprehensive individual and small group health plans be categorized into one of four different metal tiers. The tiers represent the average portion of expected costs a plan will cover for an average population. The percentages the plans will spend on average are 60% (Bronze),

70% (Silver), 80% (Gold), and 90% (Platinum). Catastrophic health plans are another category of ACA plans available to eligible individuals who are under age 30 or who qualify for a hardship exemption.

What are grandfathered plans?

Grandfathered plans are health insurance plans that were in place before March 23, 2010, when the ACA was signed into law. These plans are allowed to continue and are not required to meet ACA requirements as long as no major changes are made to plan provisions.

What are navigators?

Navigators are individuals who help individuals determine their eligibility for public assistance programs using the health insurance exchange/marketplace website. Navigators cannot legally provide advice to consumers about which health insurance plan to choose and are not permitted to sell insurance. Navigator roles are funded by the federal government.

What are Certified Application Counselors (CACs)?

Certified Application Counselors (CACs) are individuals who help individuals apply for public assistance programs and compare health insurance plans sold on the health insurance exchange/marketplace. CACs work in settings such as hospitals, local health departments, and health care provider offices.

What are premium tax credits?

The ACA provides a federal tax credit to help individuals and families afford health coverage purchased through the health insurance exchange/marketplace. The premium tax credit can be taken in advance or in the form of a refund at the end of the year. Those choosing the advanced premium tax credit, commonly referred to as APTC, will pay a reduced monthly premium. The tax credit amount that offsets the premium amount the consumer pays is sent directly from the federal government to the insurer. Those claiming the premium tax credit as a refund will pay the full health insurance premium each month and will subtract their premium tax credit amount from taxes owed at the end of the year.

What is a cost-sharing reduction?

Cost-sharing reduction is a type of financial assistance available under the ACA. It is based on an individual’s income and paid directly to the insurance company. It helps to lower the amount individuals will have to pay out-of-pocket for deductibles, coinsurance, and copayments.

A deductible is the specified dollar amount an enrollee pays for covered health care services before the insurance plan pays.

Coinsurance is the percentage of allowed charges an enrollee pays for covered health care services after the enrollee pays the deductible.

Copayment is a fixed amount an enrollee pays to the doctor, hospital, pharmacy, or other health care provider at the time of service for covered health care services.

The cost-sharing reduction is only available through the health insurance exchange/marketplace for individuals with incomes below certain levels, and who choose a health plan from the silver metal tier plan category. The cost-sharing reduction doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Any change in an individual's or family's income will affect the amount of cost-sharing reduction.

DISABILITY (ACCIDENT & HEALTH)

Does a policyholder with an individual disability (accident & health) insurance contract have a "right to return" the policy once it has been issued?

An individual disability (accident & health) policy is required to include a right to return policy to allow for returning the policy within 10 days of receipt. If the policyholder returns the policy within the 10-day period, the insurance contract is invalid, and all payments made under the contract must be refunded.

Persons who purchase a Medicare supplement policy or Medicare Select policy, or a long-term care policy have the right to return the policy or certificate within 30 days of receipt and receive a full premium refund.

The "right to return" notice must be printed on or attached to the first page of each policy.

This "right to return" does not apply to single premium nonrenewable policies issued for terms not greater than six months, except short-term medical policies, or to accident-only policies.

[s. 632.73; ss. Ins 3.13(2)(j)3, 3.39(22)(e), 3.46(5)(b)2]

EXAMPLE

- *A policyholder decided that she did not need a disability (accident & health) insurance policy that she purchased nine days before. The next day, the 10th day, she mailed the individual policy back to the insurance company. Is the policy still valid, and is the policyholder obligated to pay premiums that come due?*

  No. Under s. 632.73 (1), Wis. Stat., the policyholder has a right to return the policy within 10 days after receiving the policy. Since the policyholder returned the policy by mail within the 10-day period, she complied with the statute. The return of the policy invalidates the contract and the

policyholder is not liable for any premiums due under the policy. In addition, any premiums already paid must be refunded to the policyholder by the insurance company.

May an insurer contest a disability (accident & health) policy on the grounds that the insured made a misrepresentation?

Disability (accident & health) policies are incontestable once they have been in force for two years. This means that statements made by an applicant in an application attached to an individual disability (accident & health) insurance policy may not be the basis for voiding a policy or denying a claim for loss incurred or disability beginning after coverage has been in effect for two years. The contract may provide for a shorter period of contestability. Fraudulent misrepresentation constitutes valid grounds for voiding the policy, regardless of the length of time the policy has been in effect. The policy may provide for incontestability even with respect to fraudulent misstatements.

[s. 632.76(1), s. Ins 3.46(20)]

May an insurer refuse or reduce a claim on the ground of a "preexisting condition"?

Beginning January 1, 2014, comprehensive individual and group health policies subject to the Affordable Care Act (ACA) have been prohibited from imposing preexisting condition limitations on individuals insured under the plans. Policies not subject to the ACA may continue to have preexisting condition limitations subject to the following:

- For an individual disability (accident & health) insurance policy not subject to the ACA, no claim or loss incurred or disability commencing after 12 months from the date of issue of a policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss. For a limited benefit insurance policy, such as a hospital indemnity or accident policy, the preexisting condition limitation can apply for up to two years from the date of policy issue.
- An insurer may not void coverage or deny a claim on the ground that the application did not disclose information material to the risk if the application did not clearly require the disclosure of such information. If an application does not contain any question concerning the applicant's health or medical history, the insurer may use the preexisting condition defense only for those losses incurred within one year after the effective date of coverage. This time limitation is not applicable if the disease or physical condition causing the loss is excluded from coverage by name or specific description effective on the date of loss.
- For other than group health or comprehensive individual health policies subject to the ACA, if a policy has been in effect for a least two years, any claim for loss or disability that occurs after the two-year period may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage. The only exception is when the policy contains a provision effective on the date of loss that excludes the condition from coverage by name or specific description.

[s. 632.76(2)(ac), s. Ins 3.28]

What types of disability (accident & health) policies are allowed to have preexisting condition limitations?

As of January 1, 2014, health insurance policies subject to the ACA may not exclude coverage due to a preexisting condition. Short-term health, specified disease, hospital indemnity, and other limited benefit policies may include preexisting condition limitation policy provisions.

[s. 632.76(2)]

May Medicare supplement and long-term care insurers refuse or reduce a claim on the grounds of a "preexisting condition?"

Medicare supplement policies, Medicare cost and Medicare Select policies, and long-term care policies may not have a waiting period of more than six months after policy issuance for preexisting conditions for which medical advice was given or treatment was recommended or received within six months prior to the effective date of coverage. If a Medicare supplement, Medicare cost or Medicare Select policy or certificate replaces another Medicare supplement, Medicare cost or Medicare Select policy or certificate, the replacing insurer must waive any time periods applicable to preexisting condition waiting periods in the new Medicare supplement, Medicare cost or Medicare Select policy or certificate for similar benefits to the extent time was satisfied under the original policy or certificate.

Refer to the Medicare section in this guide for more information on Medicare supplement policies.

[s. 632.76(2)(b); ss. Ins 3.28(6)(a), 3.39(4t)(a)2, (8)(c) & (27), 3.46(5)(b)]

If a long-term care policy or certificate replaces another long-term care policy or certificate, the replacing insurer must waive any time periods applicable to preexisting condition waiting periods, elimination periods, and probationary periods in the new long-term care policy or certificate for similar benefits to the extent that similar exclusions were satisfied under the original policy or certificate.

[s. Ins 3.46(14)]

What are some of the responsibilities an intermediary (agent) or insurer has regarding an application for disability (accident & health) insurance?

The application form, which is part of the insurance contract, can only require that statements made by the applicant are true to the best of the applicant's knowledge and/or belief. The applicant may be required to state that the applicant's answers are true and complete to the best of the applicant's knowledge and/or belief.

An insurance agent must review with the applicant all questions contained in each application. The agent or representative must record on each application all material information disclosed by the applicant.

If an insurer issues coverage for a person without having resolved patently conflicting or incomplete statements in the application or fails to consider information gathered in connection with processing the application, then it cannot use these statements or information to void coverage or deny a claim.

When an application for insurance contains questions relating to medical history or other matters relating to the insurability of the applicant and will be part of the insurance contract, an insurer must notify the policyholder or certificate holder to check the application for omissions or misstatements that might invalidate a claim. This notice may be printed in contrasting color on the first page of the policy or certificate or in the form of a sticker, letter, or other form attached to the first page. The notice may also be furnished in a separate letter or other form that is mailed or made available electronically to the policyholder within 10 days after issuing or amending a policy or contract.

The insurer cannot void coverage or deny a claim on the grounds that the application did not disclose certain information considered material to the risk if the application did not clearly require the disclosure of such information.

After coverage for a person has been issued and an insurer receives information regarding that person which would reasonably be considered a sufficient basis to avoid that person's coverage, the insurer must void the coverage within a reasonable time, or else the insurer will be held to have waived its rights to such action.

[s. 632.76(1); ss. Ins 3.28, 3.46(20)]

What grace periods are required in individual disability (accident & health) insurance policies for late premium payments?

Every disability (accident & health) insurance policy with weekly premiums must contain a provision for a grace period of at least seven days. Policies with monthly premiums must provide for a grace period of at least 10 days. All other policies require a 31-day grace period. These grace periods apply only to the premiums that follow the initial premium payment. A policy continues in effect during the grace period.

[s. 632.78]

EXAMPLE

- *A policyholder of an individual disability (accident & health) insurance policy with an annual premium payment failed to make her payment for the second year's coverage on time. She then mailed in the premium payment two months after the due date. Is the policy still effective?*

No. Under s. 632.78 (1), Wis. Stat., such policies have a 31-day "grace period" during which payment can still be made and the policy is still in effect. Since the payment, in this case, was made after the 31-day period had expired, the insurance company has the discretion of whether to reinstate the policy or regard the policy as void.

The Affordable Care Act (ACA) provides that individuals who purchase coverage on the health insurance exchange/marketplace and who qualify for advanced premium tax credits (APTC) have a 90-day grace period to pay outstanding premiums. The 90-day grace period starts the first month a policyholder fails to pay the premium even if they make payments for the following months. If the initial missed payment is not made within 90 days, coverage will be lost retroactively to 31 days after the grace period begins.

EXAMPLE

- *A policyholder fails to make their premium payment for May. The policyholder submits payments for June and July but still hasn't paid for May. Their grace period ends July 31st (90 days from May 1st). If the policyholder hasn't paid their May premium by July 31st, they lose coverage* ***retroactive to the last day of May.***

Can an insurer exclude coverage for a work-related injury?

Yes. Most individual and group health insurance policies include specific exclusions regarding work-related injuries. The worker's compensation program was designed specifically to cover work-related injuries for a specified annual premium. Most Wisconsin employers are required to provide worker's compensation coverage for employees. Some individuals who are self-employed choose not to pay premiums for worker's compensation coverage. Agents should determine at the time of application whether an individual or family member has coverage for work-related activity. Agents should encourage self-employed individuals to purchase worker's compensation coverage, a rider to their health insurance policy or occupational accident policies that provide some protection in the event of work-related injuries.

[s. 631.20]

What are the disclosure requirements relating to health care claim settlements?

The disclosure requirements set out minimum standards for health insurance policies that provide benefits based on a specific claim payment methodology such as "usual, customary, and reasonable" or "prevailing" charges. It also applies to HMOs and managed care plans and to the mandated benefits in Medicare supplement policies to the extent such plans make claim settlement determinations for out-of-plan services.

Insurers must include a notice on the first page of the policy or certificate stating that a provider's billing may not be paid in full.

Insurers are required to disclose, upon request of the insured, the amount allowable under the insurer's guidelines for the determination of the eligible amount of a provider's charges for a specific health care procedure in a given geographical area. The insurer is required to disclose its specific

eligible amount only if the provider's charge exceeds the allowable charge under the insurer's guidelines. The insurer's estimate may be in the form of a range of payment or maximum payment.

An insurer is not bound by a good faith estimate of allowable charges in its response to a request.

If an insurer pays less than the billed amount of a claim based on its specific methodology, it must furnish the insured or the provider with a telephone number at the company that may be used to obtain further information, including information on the insurer's specific methodology, on the payment determination.

Note: The No Surprises Act supersedes the Wisconsin Administrative Code in instances where the two laws conflict.

[s. Ins 3.60(6), (7)]

What is a grievance?

A grievance is any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including:

- provision of services;
- determination to reform or rescind a policy;
- determination of diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; and
- claim practices.

[s. Ins 18.01(4)]

What type of health policies must develop an internal grievance procedure?

All insurers that issue health benefit plans must develop an internal grievance procedure. Health benefit plans do not include accident only or disability income insurance. Insurers are required to file with OCI an annual grievance report.

[ss. 632.745(11), 632.83; ss. Ins 3.39(4t)(a)12, 18.02(1), 18.03(1)(a) & (3)]

What is an independent review?

The independent review process provides an insured with an opportunity to have medical professionals with no connection to their health plan review a dispute. The independent review organization (IRO) assigns the dispute to a clinical peer reviewer who is an expert in the treatment of the disputed medical condition. The IRO has the authority to determine whether the treatment should be covered by the health plan.

[s. 632.835, s. Ins 18.01(6), 18.11; 45 CFR 147.136]

What types of disputes can be decided through independent review?

The dispute must involve a medical judgment. An insured can request an independent review whenever the health plan denies coverage for treatment because it maintains that the treatment is not medically necessary or that it is experimental, including a denial of a request for out-of-network services when the insured believes that the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under the insurance contract.

An insured can also request an independent review of the health plan's denial based on a preexisting condition exclusion or the plan's rescission of the policy.

[s. 632.835**,** ss. Ins 18.10, 18.105**]**

Is there a cost to the insured?

No. There is no cost to the insured. The health plan is required to pay the IRO's total fees.

[s. 632.835(3)(a)]

Can the insurer refuse to pay for some professional health care services?

No insurer may refuse to provide or pay for benefits for health care services because they were not rendered by a physician if the health care professional holds a license or certificate of registration from the appropriate medical examining board unless the policy provides otherwise, such as clearly excluding services by such providers.

The law prohibits health insurance policies (other than managed care plans) from excluding or otherwise limiting coverage for prescription drugs or devices provided by any pharmacist selected by the insured if the pharmacist agrees to abide by the terms of the policy and at the same costs as a pharmaceutical mail order plan.

[s. 632.87]

Must insurers provide coverage for nurse practitioners?

Insurers, self-funded municipalities, or self-funded school districts cannot refuse to provide coverage for certain specified medically necessary tests, examinations, or associated laboratory fees when performed by a nurse practitioner if the policy would provide coverage for the same services when performed by a physician.

[s. 632.87(5)]

Must insurers provide coverage for optometrists?

Insurers may not, under a contract or plan covering vision care services or procedures, refuse to provide coverage for such medically necessary services provided by an optometrist if the contract or

plan includes coverage for the same medically necessary services or procedures when provided by another health care practitioner.

[s. 632.87(2)]

Must insurers provide coverage for chiropractic benefits?

Insurers must include coverage of medically necessary services by a licensed chiropractor for diagnosis and treatment of a condition or complaint within the scope of the chiropractor's professional license if the policy covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath. Medicare supplement policies must independently evaluate whether the services provided by a chiropractor are medically necessary regardless of whether Medicare covers the claim. Insurers are prohibited from:

- restricting or terminating chiropractic coverage on the basis of an examination or evaluation other than by a chiropractor or peer review panel containing a chiropractor;
- establishing underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers;
- refusing to provide coverage to an individual because the individual has been treated by a chiropractor; or
- excluding or restricting health care coverage of a health condition solely because the condition may be treated by a chiropractor.

Claims for chiropractic services are overdue if not paid within 30 days after the insurer receives clinical documentation from the chiropractor unless, on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for treatment.

[s. 632.87(3), s. Ins 3.39(5t)(d)9]

What standards apply to coverage of emergency medical services?

An insurer that provides coverage of any emergency medical services may not deny coverage for emergency services that a reasonably prudent person would consider an emergency, and that are required to evaluate or stabilize the patient. An insurer can also not require prior authorization for emergency services.

The Affordable Care Act (ACA) provides that emergency services are essential health benefits (EHBs). Health plans issued on or after January 1, 2014, in the comprehensive individual and small group markets are required to cover emergency services.

[s. 632.85]

What restrictions apply to insurers who only provide coverage of certain prescription drugs and devices?

Insurers that use a formulary or other list of preapproved drugs and devices must have a process to permit a physician to request an individual exception for coverage of a drug or device not normally covered under the plan.

[s. 632.853, s. Ins 3.67(2)]

What requirements pertain to coverage for experimental treatment?

Insurers that limit coverage for experimental treatment must disclose such limitations in their policies and certificates and have a procedure for handling requests for prior authorization of an experimental procedure. Insurers must issue a coverage decision on a request for experimental treatment within five working days of receiving the request. Insurers must also have a procedure to allow an insured to appeal a denial of coverage for an experimental treatment.

[s. 632.855, s. Ins 3.67(3)]

Are there special rights for disabled ("handicapped") children covered by disability (accident & health) policies?

Hospital or medical expense policies that cover the dependent children of an insured may end coverage when the child reaches age 26. However, coverage of a dependent child cannot be ended while the child continues to be both:

- incapable of self-sustaining employment because of intellectual disability or physical disability ("handicap"); and
- chiefly dependent upon the person insured under the policy for support and maintenance.

[s. 632.88]

What coverage must be provided for dependents of an applicant or insured?

Insurers that offer group health benefit plans to employers must offer coverage to all the employer's eligible employees and their dependents. An employee's dependent includes the employee's spouse.

Insurers, self-funded municipalities, or self-funded school districts must offer and, if requested by an applicant or an insured, provide coverage for an adult child as a dependent of the applicant or insured if the child is over 17 but less than 26 years of age.

The coverage requirement also applies to an adult child who is a full-time student and called to federal active duty in the National Guard or a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and under the age of 27 when called to federal active duty.

[ss. 632.746(10), 632.885]

What benefits must be provided for alcoholism, drug abuse, and mental and nervous disorders?

Wisconsin's mental disorders, alcoholism, and other diseases mandate provides that policy exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limitations; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; limitations regarding referrals to non-physician providers and treatment programs; and duration or frequency of coverage limits under the plan may be no more restrictive for coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan. Group health policies are required to provide coverage for transitional mental health, alcohol, and other drug abuse treatment arrangements, such as day hospitalization.

HMOs, in addition to covering the mental health services described above, are required to provide certain benefits for outpatient treatment of nervous and mental disorders, alcoholism, and other drug abuse to a dependent student who is attending a school of higher education located in this state but outside the HMO's service area, if the HMO would have provided benefits for such services by a selected provider within the service area.

[ss. 609.05(3), 609.655]

The Affordable Care Act (ACA) provides that mental health and substance use disorder services including behavioral health treatment are essential health benefits (EHBs). Health plans issued on or after January 1, 2014, in the comprehensive individual and small group markets, are required to cover mental health and substance use disorder services including behavioral health treatment.

[s. 632.89]

What benefits must be provided for home care?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, providing coverage of expenses incurred for inpatient hospital care must provide coverage for no less than 40 home health care visits in any 12-month period for each person covered under the policy. Home health care means the care and treatment of an insured under a plan of care established by the attending physician, which may include intermittent home nursing care, home health aide services, various types of medically necessary therapy, medical supplies and medication prescribed under the home care plan, and nutrition counseling. If an insurer provides disability (accident & health) insurance, or if two or more insurers jointly provide disability (accident & health) insurance, to an insured under two or more policies, home health care coverage is required under only one of the policies.

Insurers may not deny coverage of a home health care claim based solely on Medicare's denial of benefits.

Insurers offering Medicare supplement policies, Medicare cost and Medicare Select policies must offer optional coverage of supplemental home care visits to produce an aggregate coverage of 365 home care visits per policy year.

Insurers must disclose and clearly define the home care benefits and limitations in a disability (accident & health) insurance policy, certificate, and outline of coverage.

[s. 632.895(2), s. Ins 3.54]

What benefits must be provided for skilled nursing care?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, that covers hospital expenses must provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility. Coverage may be limited to care that is certified as medically necessary by the attending physician. A disability (accident & health) insurance policy other than a Medicare supplement, Medicare cost or Medicare Select policy may limit coverage to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a hospital to receive continued care that is for the same condition as treated in the hospital.

[s. 632.895(3), s. Ins 3.39(5t)(d)7]

What benefits must be provided for kidney disease treatment?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, that covers hospital expenses must provide coverage for hospital inpatient and outpatient treatment of kidney disease, which may be limited to dialysis, transplantation, and donor-related services. The coverage is not required to duplicate Medicare benefits and may be subject to the same limitations that apply to other covered health conditions.

[s. 632.895(4), s. Ins 3.39(5t)(d)7]

Must a disability (accident & health) insurance policy provide coverage for newborn infants?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident- only policy, must provide coverage for a newly born child of the insured from the moment of birth. The newborn has the same coverage as the policy provides for any children covered or eligible for coverage under the policy, except that waiting periods do not apply. Coverage for newly born children must treat congenital defects and birth abnormalities as an injury or sickness under the policy. The disability (accident & health) policy must cover functional repair or restoration of any body part when necessary to achieve normal body functioning. Coverage is not required for “cosmetic” surgery performed only to improve appearance.

[s. 632.895(5), s. Ins 3.38]

What if an additional premium is required to provide coverage for a newborn infant?

If the payment of a specific premium is required to provide coverage for a child, the policy may require that notification of a child's birth and payment of the required premiums or fees be furnished to the insurer within 60 days after the date of birth. The insurer may refuse to continue coverage beyond the 60 days if such notification is not received, unless within one year after the birth of the child the insured makes all past due payments with interest at the rate of 5.5% per annum.

If the payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished.

The Affordable Care Act (ACA) provides that individuals who purchase coverage on the health insurance exchange/marketplace and qualify for premium tax credits have a 60-day special enrollment to add a newborn dependent. However, the ACA does not include language that allows for one year to pay past due payments with interest because of tax credit subsidies.

[s. 632.895(5)]

Must a disability (accident & health) insurance policy provide coverage for adopted children?

Yes. Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, that provides coverage for dependent children of the insured must provide coverage for children who are adopted or placed for adoption. This includes health maintenance organizations, preferred provider plans, and limited-service health organizations.

[ss. 609.75, 631.07(3)(a)3m., 632.896]

Must grandchildren be covered?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, that provides coverage for a dependent child of the insured must provide the same coverage for children of the dependent child until the dependent child is age 18.

[s. 632.895(5m)]

What benefits must be provided for the treatment of diabetes?

Every disability (accident & health) policy, other than a hospital indemnity, income continuation, or accident-only policy, that provides coverage of expenses incurred for the treatment of diabetes must provide coverage for expenses incurred by the installation and use of an insulin infusion pump and provide coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes. Policies must also provide coverage of diabetic self-management education programs.

Coverage may be subject to the same deductible and coinsurance as other covered expenses. Insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

Prescription medication coverage for the treatment of diabetes is not available under a Medicare supplement policy, Medicare cost or Medicare Select policy issued after January 1, 2006, because the coverage is available under Medicare Part D.

[s. 632.895(6)]

Must maternity benefits be provided for dependent children?

Every group disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, that provides maternity coverage must provide maternity coverage for all persons covered under the policy. If a group policy provides maternity coverage for the insured or the insured's spouse, the maternity coverage must also be provided for any dependent children covered under the policy.

[s. 632.895(7)]

What benefits must be provided for mammograms?

Every disability (accident & health) policy, other than a hospital indemnity, income continuation, accident-only, specified disease, Medicare supplement, Medicare replacement, or long-term care policy that provides coverage for a woman aged 45 or older, must provide coverage for periodic mammography. Coverage is required regardless of whether the woman shows any symptoms of breast cancer. The policy may not apply exclusions or limitations that do not apply to other radiological examinations covered under the policy.

[s. 609.80**,** 632.895(8)**]**

What benefits must be provided for lead poisoning screening?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident-only policy, specified disease, Medicare supplement, Medicare replacement, or long-term care policy, must provide coverage for blood lead tests for children under six years of age, which are conducted in accordance with any recommended lead screening methods and intervals contained in any rules endorsed by the department of health and social services. Lead poisoning screening may also be covered for children over six years of age if the services are determined to be medically necessary based on credible scientific evidence.

[s. 632.895(10)]

What benefits must be provided for temporomandibular joint disorders?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident-only, dental, Medicare supplement and Medicare replacement policy, but

including self-funded municipalities or self-funded school district plans, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue must provide coverage for diagnostic procedures and medically necessary surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ) disorders.

[s. 632.895(11)]

What benefits must be provided for hospital and ambulatory surgery center charges and anesthetics for dental care?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident-only or dental policy, but including self-funded municipalities or self-funded school district plans, must cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care if any of the following applies:

- the individual is a child under the age of five;
- the individual has a chronic disability that meets all the conditions in s. 230.04 (9r) (a) 2. a., b., and c., Wis. Stat; or
- the individual has a medical condition that requires hospitalization or general anesthesia for dental care.

Hospital or ambulatory surgery center charges incurred, and anesthetics provided in conjunction with dental care may also be covered for children over the age of five if the services are determined to be medically necessary based on credible scientific evidence.

[s. 632.895(12)]

What benefits must be provided for breast reconstruction?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, but including self-funded municipalities or self-funded school district plans, that provides coverage for a mastectomy must provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

[s. 632.895(13)]

What benefits must be provided for immunizations for children?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident-only, specified disease, hospital/surgical, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, that provides coverage for a dependent of an insured, must provide coverage of appropriate and necessary immunizations, from birth to the age of six years, for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. Some immunizations may be covered for children over age six

and adults when included in the federal Center for Disease Control's (CDC) Recommended Adult Immunization Schedule.

[s. 632.895(14)]

What benefits must be provided for treatment for autism spectrum disorders?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident-only, specified disease, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, must provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by a professional qualified to provide intensive-level services or non-intensive level services.

[s. 632.895(12m)]

What benefits must be provided for hearing aids, cochlear implants, and related treatment for infants and children?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident-only, specified disease, limited-scope dental or vision, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, must provide coverage of the cost of hearing aids and cochlear implants that are prescribed for a child covered under the policy who is under 18 years of age and who is certified as deaf or hearing impaired by a physician or by an audiologist.

Hearing aids, cochlear implants, and related treatment may also be covered for individuals over 18 years of age if the services are determined to be medically necessary based on credible scientific evidence.

[s. 632.895(16)]

What benefits must be provided for colorectal cancer screening?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident-only policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of any diagnostic or surgical procedures must provide coverage of colorectal cancer examinations and laboratory tests for insureds and enrollees who are 45 years of age or older and for insured or enrollees under age 45 and at high risk for colorectal cancer. Colorectal cancer screening services may not be subject to cost-sharing when the services are determined to be preventive services.

[s. 632.895(16m), s. Ins 3.35]

What benefits must be provided for prescription eye drops?

Every disability (accident & health) insurance policy, including self-funded municipalities and self-funded school district plans, that provides coverage of prescription eye drops must cover a refill of the prescription when 75% of the days have elapsed from the date of the last distribution if a refill is allowed by the prescription.

[s. 632.895(16t)]

What benefits must be provided for contraceptives and services?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident-only policy, specified disease, limited-scope dental or vision, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices must provide coverage of all the following:

- contraceptives prescribed by a health provider; and
- outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, if covered for any other drug benefits under the policy or plan.

[s. 632.895(17)]

What benefits must be provided for cancer clinical trials?

No policy, plan, or contract may exclude coverage for the cost of any routine patient care that is administered to an insured in an approved cancer clinical trial satisfying the specific criteria described in the regulation. The policy, plan, or contract is not required to reimburse services by a nonparticipating provider at the same rate as a participating provider.

[s. 632.87(6)]

What benefits must be provided for oral and injected chemotherapy?

Every disability (accident & health) policy, other than a hospital indemnity, income continuation, or accident-only policy, including self-funded municipalities or self-funded school district plans, that provides coverage of injected or intravenous chemotherapy and oral chemotherapy may not require a higher copayment, deductible, or coinsurance amount for oral chemotherapy than it requires for injected or intravenous chemotherapy, regardless of the formulation or benefit category determination by the policy or plan.

[s. 632.867]

What is a rider or endorsement?

A rider is an instrument signed by one or more officers of the insurer that is attached to and forms part of a policy issued by the insurer. If the rider reduces or eliminates coverage of the policy, signed acceptance of the rider by the insured is necessary. However, signed acceptance of the rider is not necessary when the rider is attached at the time of the original issuance of the policy if proper notice of such rider is contained in contrasting color on the policy's front page and filing back.

An endorsement differs from a rider only in that it is printed or stamped on the policy. If the endorsement reduces or eliminates coverage of the policy, signed acceptance of the endorsement by the insured is necessary. Signed acceptance of the endorsement is not necessary when it is affixed at the time of the original issuance of the policy if proper notice of such endorsement is contained in contrasting color on the policy's front page and filing back.

[s. 600.03(35), s. Ins 3.13(3)]

What are the requirements for premium rates and rate increases?

Wisconsin insurance statutes and regulations require that premium rates and changes in rates be filed for Medicare supplement, long-term care, and credit disability insurance policies, including anticipated loss ratios for these lines of insurance. Loss ratio is a calculation of the amount an insurance company pays for claims and expenses compared to the premiums it collects.

Initial premium rates and rate changes for comprehensive individual and small employer group health insurance must be filed at least 30 days prior to the effective date of the rates contained in the filing.

Initial premium rates and rate changes for all other lines must be filed with OCI within 30 days after they become effective.

[s. 625.13]

What standards apply to advertisements for disability insurance?

Prospective buyers of disability insurance must be provided with clear and unambiguous statements, explanations, advertisements, and written proposals concerning policies offered to them.

Section Ins 3.27, Wis. Adm. Code, outlines the minimum standards and guidelines for the advertising and selling of disability policies.

Advertisements and representations must be truthful, not misleading, and must accurately describe the policy to which they apply.

Advertisements for Medicare supplement policies must include specific disclosures, including prominently identifying the insurer, the fact that the document is an advertisement for insurance,

and the fact that any information or materials offered may be delivered in person by a representative of the company.

In addition, the content, form, and method of dissemination of all advertisements, regardless of whom designed, created, written, printed, or used, are the responsibility of the insurer whose policy is advertised. Insurers must require agents to submit all proposed disability advertising to them prior to use.

[s. 628.34, s. Ins 3.27]

Special rules apply to Medicare supplement and long-term care advertisements. Prior to use, an insurer must file a copy of any advertisement used in connection with the sale of its Medicare supplement or long-term care policies with the commissioner's office. If an agent intends to use any Medicare supplement advertisement that does not reference a particular issuer or Medicare supplement policy, the agent must file the advertisement with the commissioner's office prior to using it.

[s. Ins 3.39(15), s. Ins 3.46(22)]

What is an advertisement?

An advertisement means printed as well as oral representations. This includes:

- printed and published material, audio visual material, and descriptive material and literature of an insurer used in the media, including the internet and web pages, except for advertisements prepared for the sole purpose of obtaining employees, intermediaries, or agencies;
- social media pages, including social networking websites;
- descriptive literature and sales aids of all kinds issued by an insurer or agent for presentation to members of the public; or
- prepared sales talks, presentations of material used by intermediaries and representations made by agents in accordance with these talks and presentations, except for materials to be used solely by the insurer for the training and education of its employees or intermediaries.

[s. 628.34, s. Ins 3.27(5)(a)]

Who is responsible for determining the "suitability" of a policy for a prospective buyer?

Before an agent or insurer can advise a prospective buyer to buy an individual policy, the agent or insurer must have reasonable grounds to believe that the recommendation is not unsuitable for the applicant.

The agent or insurer must ask such questions as are necessary to determine that the purchase of such insurance is not unsuitable for the prospective buyer.

This rule does not apply to an individual policy issued on a group basis.

[s. 628.34, s. Ins 3.27(7)]

Special rules apply to long-term care insurance solicitations. Insurers are required to develop suitability standards for their long-term care insurance products. Both insurers and agents are required to develop procedures that take into consideration financial information, goals or needs, and values, benefits, and costs in order to determine whether the applicant meets the standards developed by the insurer. Agents must use the suitability standards developed by the insurer in marketing its long-term care policies and must complete a long-term care insurance personal worksheet.

[s. Ins 3.46]

Must an advertisement identify the insurance company?

The identity of the insurer must be made clear in all advertisements. An advertisement may not use a trade name, insurance group designation, name of the parent company of the insurer, name of a government agency or program, name of any other organization, service mark, slogan, or symbol or any device that has the capacity and tendency to mislead or deceive as to the identity of the insurer.

An advertisement may not use any combination of words, symbols, or materials that, by their content, phraseology, shape, color, nature, or other characteristics, is so similar to any materials used by federal, state, or local government agencies that it tends to confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with the government agency.

[s. 628.34, s. Ins 3.27(12)]

What requirements must advertisements meet regarding testimonials, endorsements, or commendations by third parties?

A testimonial means any statement made by a policyholder, or certificate holder that promotes the insurer and its policy by describing such person's benefits, favorable treatment, or other experience under the policy.

An endorsement means any statement promoting the insurer and its policy made by an individual, group of individuals, society, association, or other organization that makes no reference to the endorser's experience under the policy.

The testimonial or endorsement must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. An advertisement may not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organization, unless it is a fact. An advertisement may not state or imply that a government publication has commended or recommended the insurer or its policy.

An advertisement may not contain a testimonial, endorsement, or other statement concerning the insurer, its policies, or activities by any person who receives direct or indirect compensation from the

insurer in connection with the testimonial, endorsement, or statement, unless the advertisement discloses that the person giving the testimonial or endorsement is being paid. The rules of this paragraph do not apply if the person making the testimonial, endorsement, or statement holds a Wisconsin insurance intermediary license, or if the person is a radio or television announcer that is employed or compensated on a salaried or union wage scale basis.

[s. 628.34, ss. Ins 3.27 (5), (13)]

Are advertisements allowed to contain disparaging comparisons and statements?

An advertisement may not directly or indirectly make unfair or incomplete comparisons of policies or benefits. An advertisement may not falsely or unfairly disparage, discredit, or criticize competitors, their policies, services, or business methods or competing marketing methods.

[s. 628.34, s. Ins 3.27(23)]

What is the method of disclosure of required information?

All information required to be disclosed to the prospective buyer by s. Ins 3.27, Wis. Adm. Code, must be set out clearly, conspicuously, and in close proximity to the statements related to the information. Required information can also be set out under appropriate captions of such prominence that it is readily noticed and not minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

[s. 628.34, s. Ins 3.27(24)]

What other standards must be met when an advertisement contains statements about an insurer?

An advertisement may not contain statements that are untrue or are by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, experience, or relative position in the insurance business.

[s. 628.34, s. Ins 3.27(22)]

Are there certain words and phrases that should not be used in advertisements?

The words and phrases "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills," "this policy will fill the gaps under Medicare and your present insurance," "this policy will replace your income," or similar words and phrases may not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as to fairly describe a benefit.

An advertisement may not state that the insurer "pays hospital, surgical, medical bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," "pays for financial needs," "provides for replacement of your lost paycheck," "guarantees your paycheck," "guarantees your income," "continues your income," "provides a

guaranteed paycheck," "provides a guaranteed income," "fills the gaps in Medicare" or use similar words or phrases unless the statement is literally true. Where appropriate, these or similar words or phrases may properly be used if preceded by the words "help," "aid," "assist," or similar words.

An advertisement may not contain the expressions "extra cash," "cash income," "income," "cash," or similar words or phrases in such a way as to imply that the insured will receive benefits in excess of their expenses while being sick, injured, or hospitalized.

[s. 628.34, s. Ins 3.27(9)]

What is an outline of coverage?

An outline of coverage means an appropriately and prominently captioned part of a printed advertisement or separate statement that contains:

- a summary of benefits provided;
- a designation of the type or types of coverage involved;
- any exceptions, reductions, and limitations that affect the basic provisions of the policy; and
- any provisions relating to renewability, cancellability, termination, and modification of benefits, losses covered, or premiums because of age or other reasons.

[s. 628.34, s. Ins 3.27(5)(L)]

Who is responsible for providing an outline of coverage to the applicant?

Every agent must furnish an applicant with an outline of coverage at the time of taking an application for an individual policy.

Every advertisement that constitutes an invitation to apply for a specific individual policy or policies must include an outline of coverage.

The requirement for an outline of coverage does not apply to an advertisement or the taking of an application for an individual policy issued on a group basis.

[s. 628.34, s. Ins 3.27(8)]

What is the replacement of disability (accident & health) insurance?

Wisconsin law seeks to safeguard the interests of persons covered under disability (accident & health) insurance policies who consider the replacement of their insurance by giving them information regarding replacement. Such information reduces the possibility of misrepresentation and other unfair practices and methods of competition in the business of insurance.

This rule on replacement applies to most disability (accident & health) policies issued in Wisconsin. (There are some exceptions listed in s. Ins 3.29, Wis. Adm. Code.)

Replacement is any transaction in which new disability (accident & health) insurance is to be purchased, and it is known to the agent or company at the time of application that existing disability (accident & health) insurance has been or is to be lapsed or the benefits substantially reduced.

An application for insurance must contain a question as to whether the insurance to be issued is to replace any insurance presently in force. A supplementary application or other form signed by the applicant may be used for this purpose.

If the sale involves replacement, an agent must give the applicant the proper notice, as defined in the next section, and leave a copy of this notice with the applicant. A signed copy of this notice must be kept by the insurer.

[s. 628.34, s. Ins 3.29]

What notice is necessary when a disability (accident & health) policy is replaced?

Proper notice requires certain facts regarding replacement must be pointed out to the applicant. Proper notice includes written warnings that:

- health conditions the applicant might already have may not be covered under a new policy;
- questions in the application must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits under the new policy may be voided;
- the new policy will be issued at a higher age than was the applicant's present policy, and the cost of the new policy, depending upon benefits, may be higher than the applicant is presently paying;
- the renewal provisions of the new policy should be reviewed by the applicant; or
- it may be advantageous for the applicant to secure the advice of their present insurer or agent regarding the replacement of the applicant's present policy.

[s. 628.34, s. Ins 3.29]

The notice required when a Medicare supplement policy or long-term care insurance policy is being replaced must also contain an introductory statement regarding the right to return the new policy under s. 632.73, Wis. Stat., for a refund.

What is Medicare?

Medicare is the federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) for those who are 65 years of age or over, for some persons under 65 who are disabled, for people with permanent kidney failure, also known as End-Stage Renal Disease (ESRD), and for people with ALS, also known as Lou Gehrig's Disease. Medicare has two components: hospital insurance (Part A) and medical insurance (Part B).

Medicare Part A is "hospital insurance." It helps pay for inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Most people do not have to pay a premium for Part A.

Under Medicare Part A, hospital inpatient coverage (which includes semi-private room and board, general nursing, and miscellaneous hospital services) Medicare provides 60 days of hospitalization after an initial deductible per benefit period. It provides partial coverage from the 61st to the 150th day per calendar year. After the 150th day, it provides no coverage.

Medicare Part B is "medical insurance." It helps pay for medical services, such as physicians, ambulance transportation, outpatient therapy, and a wide range of other services, equipment, and supplies not covered by Part A. Part B is optional and individuals must pay a premium. Under the medical coverage (Part B), physician's fees, outpatient hospital services, surgeon's fees, inpatient medical services, home health care, and other eligible outpatient services and supplies are covered. The recipient pays an annual deductible and 20% of the Medicare-approved charges, with Medicare covering the remaining 80% of the Medicare-approved charges. Medicare determines what dollar amount is the maximum allowable charge for a particular service and pays the recipient based on this amount.

Medicare Part B does not cover prescription drugs that are self-administered or over-the-counter drugs. Medicare does not pay for hearing aids, routine medical check-ups, and confinement for custodial reasons. Coverage for psychiatric care is subject to limitations.

Detailed information about Medicare is provided in the *Medicare & You* handbook published by the Social Security Administration and at medicare.gov/medicare-and-you.

What outpatient prescription drugs are covered by Medicare?

Individuals with Medicare Part A and Medicare Part B can enroll in Medicare outpatient prescription drug plans, which are referred to as Medicare Part D. Medicare has contracted with private companies to offer this drug coverage. Medicare Part D has an annual enrollment period that occurs between October 15 and December 7, with enrollment effective January 1 of the following year.

Medicare Part D is an optional program with an annual premium. Lower-income beneficiaries who meet Medicare income limit guidelines may be eligible for assistance with premiums or coverage costs.

What is Medicare Advantage?

Medicare Advantage plans are an option under the Medicare program and take the place of original Medicare coverage in that private insurance companies contract with the federal government to provide Medicare benefits. Medicare pays the Medicare Advantage plan a set amount of money; in return, the Medicare Advantage plan provides the coverage that was provided by the Medicare program and any supplemental benefits. Medicare Advantage plans may include deductibles and

coinsurance amounts called out-of-pocket expenses. Medicare Advantage plans are not subject to the same benefit standards that apply to approved Wisconsin Medicare supplement policies.

What about insurance plans that "supplement" Medicare?

Medicare supplemental insurance, also known as Medigap, is designed to provide coverage for some of the "gaps" left by Medicare. Because Medicare may not cover all the services needed and because Medicare requires recipients to pay deductibles, coinsurance, and copayments, many people purchase Medicare supplement policies to help pay for some of those extra services and costs. Medicare supplement policies are offered by private health insurance issuers.

Wisconsin received a waiver for standardized regulations A through N of the Medicare supplement insurance. This means that policies sold in Wisconsin are somewhat different from those available in other states and include Wisconsin-mandated benefits. All policies currently sold in Wisconsin are guaranteed renewable for life. The insurance company may raise the premium but only if it raises the premium for all individuals who have the same policy.

No private insurance policy will cover everything that Medicare will not. For example, supplemental policies usually cover only "reasonable and necessary" charges or services as defined by Medicare. It is unlawful to claim that a Medicare supplement policy "fills the Medicare gap" or "pays everything Medicare does not" because none do so entirely. Section Ins 3.27, Wis. Adm. Code, prescribes advertising standards applicable to Medicare supplements and requires fair representations of both the private insurance being sold and the Medicare program. This includes a prohibition against an agent describing themselves as connected in any way with the Medicare program.

Not everyone needs individual Medicare supplement coverage. Some retired persons are eligible to convert from their group health coverage or retain previous coverage with changed benefits. Persons with comprehensive group coverage do not need to purchase individual policies. Persons on Title 19, the federal Medical Assistance program also known as Medicaid, should not purchase a supplemental policy because this program covers most health care expenses. (If individuals have Medicare supplement insurance and later become eligible for Medicaid, they can request that benefits and premiums be suspended for up to two years while they are covered by Medicaid.)

Insurers may sell only one individual Medicare supplement, one Medicare Select (HMO), one Medicare cost, and one group Medicare supplement insurance policy form in Wisconsin. There are additional standardized benefit riders that insurers may offer. Those riders include benefits for the Part A deductible, excess charges, foreign travel emergency, 365 days of home care, Medicare 50% Part A deductible, and Medicare Part B copayment or coinsurance. Insurers may not sell Medicare supplement coverage with benefits other than those contained in s. Ins 3.39, Wis. Adm. Code. Every individual policy that is sold as a supplement to Medicare or as a Medicare replacement plan must be appropriately labeled. Individual policies that do not qualify may not be sold or described as

Medicare supplements. Separate long-term care policies, hospital confinement indemnity policies, and specified disease policies may not be described as "Medicare supplements."

All Medicare supplement and Medicare Select insurance policies must contain a provision allowing for mid-term cancellation at the request of the insured and providing for a prorated premium refund if the policyholder cancels a policy mid-term. Insurers must also provide a prorated premium refund to the insured's estate if the insured dies during the term of the policy.

Medicare Select, which may be offered by insurance companies and health maintenance organizations (HMOs), is the same as standard Medicare supplement insurance in nearly all respects. The only difference between Medicare Select and standard Medicare supplement insurance is that Medicare Select policies will only pay full supplemental benefits if covered services are obtained through plan providers selected by the insurance company or HMO. Each issuer of a Medicare Select policy makes arrangements with its own network of plan providers.

Medicare supplements, Medicare Select, and Medicare costs must include an appeal procedure to respond to denied claims.

Section Ins 3.39, Wis. Adm. Code, places a responsibility on insurance companies and intermediaries to deliver a copy of the publication *Wisconsin Guide to Health Insurance for People with Medicare* with every solicitation for a policy covered by this rule whether or not an application is actually completed. The publication is also available from the commissioner's office online at oci.wi.gov.

Outlines of coverage and replacement notices must be provided in the appropriate situations. An agent who sells disability (accident & health) insurance to a person with the knowledge that the person receives medical assistance, or fails to inquire about receipt of medical assistance, may violate the requirements of s. Ins 3.27 (7), Wis. Adm. Code, regarding suitability.

Intermediaries should not replace existing coverage simply because it "isn't up to date," but should only recommend a new policy if the existing policy is inadequate for that policyholder's insurance needs.

[ss. 628.34, 632.84, ss. Ins 3.27, 3.39]

Are there special regulations concerning long-term care insurance?

Three types of health insurance policies qualify as long-term care policies:

- a long-term care policy that provides institutional (such as nursing home or assisted living facility) and community-based (such as home health care and adult day care) benefits;
- a nursing home policy that provides institutional benefits; and
- a home health care policy that provides community-based benefits.

Each of these types of policies includes their own specific caption. Wisconsin has minimum standards for these three types of policies. Long-term care policies must cover Alzheimer's disease and other types of irreversible dementia. Policies must offer a nonforfeiture benefit option that provides paid-up insurance if the policy lapses and must describe the benefit appeal process.

Life and annuity insurance policies may also include long-term care coverage as an endorsement or rider to a life or annuity insurance policy.

HIPAA (Health Insurance Portability and Accountability Act) allows for certain federal income tax advantages for long-term care policies that are designated as tax-qualified or qualified. Beginning with the January 1998 taxable year, the State of Wisconsin began allowing premiums paid for long-term care policies to be subtracted from Wisconsin income tax. The Wisconsin tax law provision applies to both policies designated for federal income tax purposes as tax-qualified and policies that are non-tax-qualified.

Long-term care benefits provided as riders to life or annuity insurance policies are tied directly to the amount of life or annuity insurance in force. These benefits will be reduced by any loans or withdrawals against the policy. Using the long-term care benefits will also reduce life or annuity insurance coverage under the policy.

All policies currently sold in Wisconsin are guaranteed renewable for life. The insurance company may raise the premium but only if it raises the premium for all individuals who have the same policy.

Insurers and intermediaries must provide an outline of coverage and the *Guide to Long-term Care* to all prospective purchasers of long-term care insurance.

Insurers are required to set and maintain rates and benefits so that the loss ratio is at least 65% for individual policies, 65% for group policies issued through the mail, and 75% for other group policies.

Insurers are required to provide a prorated premium refund if the policyholder requests cancellation. Insurers must also provide a prorated premium refund to the insured's estate if the insured dies during the term of the policy. A provision describing these mid-term cancellation rights must be included in all long-term care insurance policies.

[s. 632.825, s. Ins 3.46]

What is the Long-Term Care Partnership Program?

The Long-Term Care (LTC) Partnership Program allows individuals who purchase certain long-term care policies to protect some or all of their assets and still qualify for Medicaid if their LTC needs extend beyond the period covered by their qualified LTC Partnership insurance policy.

LTC Partnership policies provide covered individuals access to Medicaid under special eligibility rules that include a special feature called asset disregard. This allows covered individuals to keep assets that would otherwise not be allowed if they need to apply, and if they qualify, for Medicaid in order to receive additional long-term care services. The amount of assets covered individuals can disregard, or keep, is equal to the amount of the benefits they receive under their LTC Partnership policy. For example, if an individual purchases and uses a Partnership-qualified long-term care insurance policy that pays $100,000 in benefits, the covered individual can apply for Medicaid and retain $100,000 worth of assets over and above the state's Medicaid asset threshold. Wisconsin LTC Partnership policies offer reciprocity with other states regarding Medicaid eligibility and benefits.

[s. Ins 3.465]

What are the training requirements for agents who sell long-term care insurance?

Any agent who solicits, negotiates, or sells LTC insurance policies in Wisconsin must complete an approved LTC training program. The LTC training requirements include:

- initial training that is not less than eight hours; and
- ongoing training after the initial training of not less than four hours per session every 24 months by the date of the agent's next license renewal cycle.

Insurers providing LTC insurance are required to obtain from agents selling LTC insurance policies verification that the agents comply with the training requirements, maintain records related to the training verifications, and to make these training records available to OCI upon request.

[s. Ins 3.46(26)]

What are the continuation privileges of insureds under group health insurance policies?

Wisconsin has a continuation law for both group and individual health insurance policies. It does not apply to limited-scope dental or vision or other types of specified disease or limited policies.

The major provisions are:

- insurers must permit people who have been insured for at least three months under a group contract to continue group coverage if the group coverage ends because of divorce, annulment, death, or any other reason except discharge for misconduct;
- the rate for continued group coverage cannot be more than the group rate (including the employer's contribution);
- employers must continue to accept premiums from these insureds; and
- insurers or group policyholders must notify eligible insureds of their continuation option when their group coverage terminates.

There is also a federal law relating to continuation. This law (COBRA) applies to most employers with 20 or more employees. There are some differences between the state and federal law. The federal Department of Labor enforces the COBRA law.

[s. 632.897, ss. 3.41, 3.42, 3.43, 3.44, 3.45, 3.455]

What is a small employer?

A small employer means an individual, firm, corporation, partnership, limited liability company, or association that is actively engaged in a business enterprise in Wisconsin, including a farm business, and that employs an average of at least two but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ at least two but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year and employs at least two employees on the first day of the plan year. All persons treated as a single employer under the Internal Revenue Code of 1986 must be treated as one employer.

[s. 635.02(7)]

Are there special provisions relating to the sale of group or individual health insurance policies to small employers?

Yes. The law requires small employer insurers that offer group health benefit plans in the small group market to accept any small employer in the state that applies for such coverage and to accept any eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health benefit plan.

[ch. 635, ch. Ins 8**]**

Are there exceptions to the requirement that small employer insurers accept any small employer that applies for coverage?

Yes. Small employer insurers may establish minimum participation rules and requirements for the offering of a group health benefit plan in the small group market.

A small employer insurer that offers a group health benefit plan in the small group market through a network plan may limit the small employers that may apply for such coverage to those with eligible individuals who reside, live, or work in the service area of the network plan.

A small employer insurer may also deny coverage to small employers if it can demonstrate to OCI that it either does not have the capacity to deliver services adequately to additional groups (network plans) or does not have the financial reserves necessary to underwrite additional coverage. A small employer insurer that denies coverage in such instances may not offer coverage in the small group market for 180 days or until the insurer demonstrates to OCI that it has sufficient financial reserves to underwrite additional coverage, whichever is later.

[s. 635.19]

What are the solicitation and disclosure requirements for the sale of group or individual health insurance policies to small employers?

Before completing an application for a policy, an agent is required to provide the small employer with a form explaining the following information:

- the insurer's right to increase premium rates and the factors limiting the amount of the increase;
- the extent to which benefit design characteristics affect premium rates;
- the extent to which rating factors and changes in benefit design characteristics and case characteristics affect changes in premium rates;
- the small employer's renewability rights; and
- the small employer's right to ask for information concerning the policy's benefits and premiums under all other health insurance coverage that the insurer offers, for which the small employer is qualified.

The agent is required to sign and date the form certifying that the above information was made available to the small employer prior to completing the application and obtain the signature of the small employer acknowledging receipt of the information. The agent must give one copy of the form to the small employer and the agent, or the insurer must retain one copy of the completed form.

[s. 635.11, s. Ins 8.48]

What are the fair marketing standards for small employer health insurance plans?

Small employer insurers must actively market health benefit plan coverage to small employers in the state.

Insurers may not discourage a small employer from applying for coverage or encourage the small employer to seek coverage from another insurer because of health status, claims experience, industry, occupation, or geographic location of the small employer. Insurers and intermediaries may provide information about established service areas or restricted network provisions of the small employer insurer.

Insurers may not enter into a contract with an agent that provides for or results in compensation that varies according to the health status, claims experience, industry, occupation, or geographic location of the small employer or its employees.

Insurers may not terminate or limit a contract entered into or renewed with an agent based on the health status, claims experience, industry, occupation, or geographic location of the small employers or their employees placed by the agent with the insurer.

Insurers or agents may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage. If an insurer denies an application for coverage of a small employer, it must deny the application in writing and state the reasons for denial.

Insurers are prohibited from conditioning the offer or sale of a health benefit plan to a small employer by requiring that the small employer purchase or qualify for any other insurance product, service, or a health benefit plan that includes coverage other than health insurance.

A small employer insurer must establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health benefit plans and how to apply for coverage. The toll-free line does not have to be dedicated for this purpose.

[s. 635.18, s. Ins 8.68]

What are the minimum participation requirements that can be used by an insurer in determining whether to provide coverage under a group health benefit plan to an employer?

Insurers must apply minimum participation requirements uniformly among all employers. They may vary minimum participation and contribution requirements only by the size of each employer group.

Insurers may increase the minimum participation requirements once per calendar year only if the requirements are applied uniformly to all employers applying for coverage and to all renewing employers effective on the date of renewal.

Insurers may establish separate participation requirements that uniformly apply to all employers that provide a choice of coverage to employees or their dependents. Insurers may also establish separate uniform requirements based on the number or type of choice of coverage provided by the employer.

[s. 632.746(9)]

Are there prohibited coverage practices relating to employer group health benefit plans?

Yes. An insurer that offers a group health benefit plan to an employer must offer coverage to all of the employer’s eligible employees and their dependents.

Insurers may not offer coverage to only certain individuals in the group or to only part of the group, except for an eligible employee who has not yet satisfied a waiting period, if any.

An eligible employee means an employee who works on a permanent basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership, and a member of a limited liability company if such a person is included as an employee under a health benefit plan of an employer. The term does not include an employee who works on a temporary or substitute basis.

An insurer that provides coverage under a group health benefit plan must provide coverage to eligible employees and their dependents who become eligible for coverage after the commencement of the employer's coverage, regardless of their health conditions or claims experience, if the employee has satisfied any applicable waiting period and the employer agrees to pay the premium required for coverage of the employee under the plan.

An insurer may not establish rules for the eligibility of any individual to enroll or remain enrolled under a group health benefit plan that are based on any of the following factors:

- health status;
- medical condition, including both physical and mental illnesses;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability, including conditions arising out of acts of domestic violence; or
- disability.

Rules for eligibility to enroll under a group health benefit plan include rules defining any applicable waiting periods for enrollment.

An insurer may not require an individual to pay, based on any health status-related factor, a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled under the plan.

[ss. 632.746(10), 632.747, 632.748]

Must insurers offer coverage to late enrollees?

Yes. Insurers offering a group health benefit plan must permit an employee, or a participant's or employee's dependent, who is not enrolled but who is eligible for coverage, to enroll for coverage if all the following apply:

- the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;
- the employee or dependent stated in writing at the time coverage was previously offered that having other coverage was the reason the individual was declining coverage under the insurer's group health benefit plan. This applies only if the insurer required such a statement and provided the employee with notice of the requirement and the consequences of the requirement at the time coverage was previously offered; and
- the employee or dependent is currently covered under the other coverage, or the employee or participant requests enrollment under the group health benefit plan no later than 30 days after the date on which the other coverage is exhausted or terminated.

[s. 632.746(6)]

Must insurers offer special enrollment periods?

Yes. An insurer offering a group health benefit plan must provide for a special enrollment period during which:

- a person who marries and who is otherwise eligible for coverage may be enrolled under the plan as a dependent of the employee;
- a person who is born to, adopted by, or placed for adoption with an insured may be enrolled under the plan as a dependent of the insured;
- a person who has met any waiting period under the plan, who is eligible to be enrolled under the plan, and who failed to enroll during a previous enrollment period, or the individual's spouse, or both, may be enrolled under the plan if all of the following apply:
    - the group health benefit plan makes coverage available for dependents of participants under the plan;
    - the individual is a participant under the plan, or the individual has met any waiting period under the plan, and is eligible to enroll under the plan, but failed to enroll during a previous enrollment period; and
    - a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

The special enrollment period must be not less than 30 days and must begin on the date dependent coverage is made available under the group health benefit plan, or the date of the marriage, birth, adoption, or placement for adoption, whichever is later.

If an individual enrolls a dependent during a special enrollment period, coverage for a person who becomes a dependent through marriage must become effective no later than the first day of the first month beginning after the date on which the completed request for enrollment is received. Coverage for a person who becomes a dependent through birth must become effective at the date of birth. Coverage for a person who becomes a dependent through adoption or placement for adoption must become effective on the date of adoption or placement for adoption.

[s. 632.746(7)]

Are there special regulations regarding the termination or nonrenewal of individual health benefit plans?

Yes. Except as otherwise permitted below, an insurer that provides individual health benefit plan coverage must renew such coverage or continue such coverage in force at the option of the insured individual and, if applicable, the association through which the individual has coverage. An insurer may modify an individual health benefit plan coverage policy form at the time of renewal, as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

An insurer may nonrenew or discontinue the individual health benefit plan coverage of an individual only for the following reasons:

- nonpayment of premium;
- fraud;
- the insurer ceases to offer individual health benefit plan coverage;
- in the case of network plans, the individual no longer resides, lives, or works in the service area. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual; or
- the individual is eligible for Medicare and the commissioner by rule permits coverage to be terminated.

An insurer may discontinue offering a particular type of individual health benefit plan coverage in this state if all the following apply:

- the insurer provides, at least 90 days before the date coverage will be discontinued, notice to each individual for whom the insurer provides coverage of this type, and if applicable, the association through which the individual has coverage;
- the insurer offers to each individual for whom the insurer provides coverage of this type, and if applicable, the association through which the individual has coverage the option to purchase any other type of individual health insurance coverage that the insurer offers for individuals; and
- the insurer must act uniformly without regard to any health status-related factor of individuals who may become eligible for coverage.

An insurer may discontinue offering in this state individual health benefit plan coverage only if all the following apply:

- the insurer provides notice of the discontinuance to the commissioner, and to each individual for whom the insurer provides individual health benefit plan coverage in this state and, if applicable, to the association through which the individual has coverage at least 180 days before the date coverage will be discontinued;
- all individual health benefit plan coverage issued or delivered for issuance in this state is discontinued and coverage under such plans is not renewed; and
- the insurer does not issue or deliver for issuance in this state any individual health benefit plan coverage before five years after the day on which the last individual health benefit plan coverage is discontinued.

An insurer is not required to renew individual health benefit plan coverage that is marketed and designed to provide short-term coverage as a bridge between coverages.

[s. 632.7495]

What constitutes unfair discrimination in disability insurance?

It is unfair discrimination and an unfair marketing practice for insurers to refuse to insure, refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual or charge a different rate for the same coverage solely because of physical or mental impairment except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

It is unfair discrimination to refuse to insure, refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or to charge an individual a different rate for the same coverage solely because of blindness or partial blindness.

An insurer may not use sexual orientation in the underwriting process or the determination of insurability, premium, terms of coverage, or nonrenewal.

[s. 628.34(3), s. Ins 6.67]

What are the special disclosure requirements for the sale of cancer insurance?

Insurers and intermediaries who sell cancer insurance must give each prospective buyer a copy of *A Shopper's Guide to Cancer Insurance,* found in s. Ins 3.47, Wis. Adm. Code, at the time the prospect is contacted with an invitation to apply.

This rule does not apply to solicitations in which the booklet, *Wisconsin Guide for Health Insurance for People with Medicare,* is given to applicants as required by Ins 3.39, Wis. Adm. Code.

[s. 628.34, s. Ins 3.47]

Are there any special requirements relating to HIV?

An accident & health insurance policy is prohibited from containing any exclusions or limitations for coverage of the treatment of HIV infection or any affiliated condition unless the same exclusions or limitations apply to all other conditions.

[s. 631.93]

All disability (accident & health) policies, other than a hospital indemnity, income continuation, or accident-only policy, specified disease, limited-service health organization, Medicare supplement, Medicare cost and Medicare Select policies that provide coverage for prescription medications are required to provide coverage for FDA-approved drugs including phase three clinical investigational drugs for the treatment of HIV infection or related illnesses.

[s. 632.895(9)]

Non-grandfathered private health insurance plans must provide coverage for any FDA-approved Pre-Exposure Prophylaxis (PrEP) prescription drug for the prevention of HIV for individuals at high risk of contracting HIV without limitation or cost-sharing. This includes laboratory and other diagnostic procedures associated with the use of such drugs, clinical follow-ups, and monitoring.

[42 U.S. Code s. 300gg–13, Sect. 2713]

Are there any special requirements relating to genetic testing?

An insurer offering a group health benefit plan may not treat genetic information as a preexisting condition without a diagnosis of a condition related to the information.

[s. 632.746(2)]

Are there special regulations for managed care plans?

Yes. A managed care plan is defined as any health benefit plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract with the insurer offering the health benefit plan.

Wisconsin statutes define three different types of managed care plans. They are health maintenance organizations, preferred provider plans, and limited-service health organizations. A "defined network plan" (managed care plan) is a health benefit plan that requires or creates incentives for an enrollee to use providers that are managed, owned, under contract with or employed by the insurer.

A "health maintenance organization" is a managed care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

A "limited-service health organization" is a managed care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers selected by the organization.

A "preferred provider plan" (PPP) or "preferred provider organization" (PPO) is a managed care plan that pays a specific level of benefits if plan providers are used and a lesser amount if non-plan providers are utilized. A PPP offers financial incentives to use network providers through the use of coinsurance and deductible amounts.

In addition, some health maintenance organizations (HMOs) offer point-of-service plans, which require that enrollees designate a network primary care physician and allow for a referral approved by the plan to an out-of-network provider.

[ch. 609, ch. Ins 9]

What are prohibited insurance practices involving domestic abuse?

Insurers writing individual or group disability (accident & health) insurance may not exclude or limit coverage of, or deny a claim for, health care services related to the treatment of injury or disease resulting from domestic abuse on the basis that the person has been or is a victim of domestic abuse.

[s. 631.95]

What are short-term health policies?

Short-term health policies, also called short-term, limited-duration insurance, are temporary solutions that can provide a low-cost safety net in case of illness or injury that might develop during the coverage period.

Insurers can refuse to issue a second policy. Others might offer the insured another policy, but they can treat any injuries or illnesses that occurred during the previous short-term policy as preexisting conditions and will not cover treatment related to such conditions.

Most insurers only sell short-term health policies to people under the age of 65. Each short-term health policy has its own application with numerous questions. Additionally, applicants must meet medical underwriting guidelines.

[s. 632.7495(4)]

What are health benefit purchasing cooperatives?

The purpose of the health benefit purchasing cooperatives is to provide health care benefits to the employees, members, and officers of the members of each cooperative and their dependents. The health care benefits provided by a cooperative must be provided in a single group health care policy or plan. The contract under which the benefits are provided is between the cooperative and the insurance company, rather than between members of the cooperative and the insurer.

Health benefit purchasing cooperatives are organized in geographic areas designated by the commissioner, after a consultation with the Wisconsin Federation of Cooperatives. A geographic area may overlap with one or more geographic areas. Each cooperative may establish membership criteria, but membership in a cooperative is generally open to any business entity, trade or labor organization, municipality, or self-employed individual doing business in, or residing in, the designated area of the cooperative. A health benefit purchasing cooperative may limit the membership of self-employed individuals through its membership criteria, but such criteria must be applied in the same manner to all self-employed individuals.

The contract between the health benefit purchasing cooperative and an insurer has a term of three years. If a member withdraws from the health benefit purchasing cooperative before the end of the contract term, the health benefit purchasing cooperative may retain, as a penalty, an amount specified by the health benefit purchasing cooperative that is not less than the member’s applicable premium for the 36th month of coverage under the contract.

Members who are also employers are not considered small employers if the cooperative provides health care benefits for more than 50 individuals. A small employer, for the purpose of insurance coverage under group health benefits plan, is generally defined as an employer with between two and 50 employees.

[s. 185.99]

What are Association Health Plans (AHPs)?

Association Health Plans (AHPs) are group health plans that employer groups and associations offer to provide health coverage to employees, including self-employed working owners. Federal laws regarding AHPs also allow small employers to band together to purchase coverage. If the employer members of the association have in total more than 50 employees, the association can negotiate for coverage in the large group market and would only be subject to those provisions of the ACA that apply to large groups, not small employer groups. A bona fide association must have been formed and maintained for purposes other than obtaining insurance. An association may not condition membership on any health status-related factor and must make its health insurance coverage available to all members regardless of any health status-related factor.

[s. 632.745(3)]

Are there special regulations for multiple employer trusts?

Yes. State law requires a multiple employer trust or association, or agent, to file an informational report with OCI before soliciting Wisconsin residents if:

- it is defined as a multiple employer welfare arrangement under federal law;
- it is, or purports to be, subject to the Federal Employee Retirement Income Security Act (ERISA) and exempt from state insurance regulation; or
- it is established outside this state and is not domiciled in the U.S.

The filing must include a copy of any insurance policy or contract covering benefits offered by the organization, a copy of the trust or association's organizational documents, and a statement that the benefits are fully insured or a description of the extent to which they are not fully insured. The organization must update the filing within 15 days of any change or whenever the information previously provided is no longer accurate.

A multiple employer trust or association not subject to this rule is one that provides coverage subject to a collective bargaining agreement, that is fully insured by a Wisconsin-licensed insurer, that provides coverage to a governmental unit, that is an individual, or that is exempted by the commissioner.

[s. Ins 6.62]

CHAPTER V

LIFE INSURANCE AND ANNUITIES

The basic purpose of life insurance is the financial protection of the insured's beneficiaries/ dependents if the insured should die. Upon the death of the insured, the insurer is legally obligated to pay a previously agreed amount to the designated beneficiary.

Prospective purchasers of life insurance have several options to choose from. The development of these different options and more complex policy forms demands that prospective purchasers be fully informed as to the coverage and benefits necessary to provide adequate insurance protection for their needs.

Wisconsin law attempts to protect consumers by requiring that intermediaries provide clear and unambiguous information during their sales presentations. In addition, the policies must meet certain statutory requirements to be sold in this state.

LIFE INSURANCE POLICIES

What are some of the provisions which are required in all life insurance policies?

- separate benefits— Every life insurance policy must specify each benefit promised in the policy; and
- grace period— Every life insurance policy must contain a provision entitling the policyholder to a grace period of not less than 31 days for the payment of any premium except the first. During the grace period, the policy continues in force.

[ss. 632.44, 632.56]

EXAMPLE

- *The holder of an individual term life insurance policy failed to make the second premium payment by the due date. Two weeks later the insured mailed the payment to the insurance company. Is the policy still in effect?*

Yes. Under s. 632.44 (2), Wis. Stat., every life insurance policy must contain a "grace period" of not less than 31 days. Since the premium payment was submitted within 31 days after the due date, the policy will continue in effect.

What is a variable contract?

The term "contract on a variable basis" or "variable contract" means any policy or contract that provides for insurance or annuity benefits that may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract, as provided for in the contract.

[s. 632.45(1), Wis. Stat.]

Any contract using separate accounts that provides for payment of benefits in variable amounts must contain a statement of the essential features of the procedures the insurer will follow in determining the dollar amount of the variable benefits. It must contain appropriate nonforfeiture benefits in lieu of those under the standard nonforfeiture law.

Any individual variable contract must state that the dollar amount of benefits may decrease or increase.

Any individual variable contract must conspicuously display on its first page a statement that its benefits are on a variable basis, with a statement showing exactly where in the contract the details of the variable provisions can be found.

Any variable contract must state whether it may be amended as to investment policy, voting rights, and conduct of the business and affairs of any segregated account. Subject to any preemptive provision of federal law, any such amendment is subject to filing with the commissioner and approval by a majority of the policyholders in the segregated account.

Variable contracts may be issued only according to the terms of a general marketing plan approved by the commissioner. The marketing plan must be designated to protect the interests of the policyholders regarding any voting rights and operations of the segregated account and amendment of the contract.

Any intermediary selling or offering for sale a variable contract must hold a valid variable life/variable annuity line of authority and hold a Series 6 or Series 7 registration with the Financial Industry Regulatory Authority (FINRA).

[s. 632.45, s. Ins 2.13(12m)]

When can the insurer contest individual life insurance policies?

No individual life insurance policy may be contested after it has been in force for two years from the date of issue except for nonpayment of premiums or misstatement of age.

Disability coverage and additional accident benefits included in a life insurance contract may be contested at any time on the ground[s] of fraudulent misrepresentation.

[s. 632.46]

What happens if the application for insurance contains a misstatement of age?

If the age of the person whose life is at risk is misstated in a life insurance application and the error is not adjusted during their lifetime, the amount payable under the policy is what would be paid if the age had been stated correctly. The insurer is not liable for death benefits if the insured was older than the age limit designated by the insurer for issuance of the policy.

[s. 632.46 (3)]

EXAMPLES

- *The holder of an individual term life insurance policy was killed in an automobile accident. The insured was under the maximum age limit designated by the insurance company. The insured's wife, who was named as the beneficiary, filed a claim with the insurance company for the death benefits. The company refused to honor the claim on the ground that the insured misstated his age in the application. Can the insurance company refuse payment?*

No. Under s. 632.46 (3), Wis. Stat., if the age of the insured is misstated on the application for the policy and the error is not adjusted during his lifetime, the amount payable under the policy is what the premiums paid would have purchased if the age had been stated correctly.

- *The holder of an individual term life insurance policy suffered a fatal heart attack four years after the policy was issued. The contract contained a two-year incontestability provision. At the time of application for insurance, the insured had mistakenly answered in writing that he had no prior physical problems with his heart, although he had been treated for minor coronary ailments including high blood pressure. Can the insurance company now refuse to pay the claim on the ground that the insured had made a material misrepresentation which allowed the company to void the policy?*

No. Under s. 632.46 (1), Wis. Stat., once the policy has been in effect for two years, the insurance company may not contest the policy.

May rights under a life insurance policy be assigned to another person?

Yes. The owner of any rights under an individual life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary. An assignment which is valid under general contract law vests the assigned rights in the assignee (the person to whom the assignment is made) subject to any provision in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.

The rights of the beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee unless the beneficiary was effectively designated as an irrevocable beneficiary prior to the assignment.

Assignment may be expressly prohibited by a group contract providing annuities as retirement benefits, and by an annuity that is subject to transferability restrictions under any federal or state tax, employee benefit, or securities law.

[s. 632.47]

EXAMPLES

- *The owner of an individual whole life insurance policy notified the company that the rights to the death benefits were being assigned to her sister. There is no provision in the policy which restricts the policyholder's right to assign the rights under the policy. The assignment was done in writing and the owner received something of value from her sister in return. Assuming that the insured's sister was not the beneficiary under the policy, is the company obligated to pay the benefits to the sister-assignee?*

  Yes. The assignment is valid under general contract law and vests the assigned rights in the sister-assignee. Under s. 632.47, Wis. Stat., the rights of the sister-assignee to receive the death benefits take priority over the rights of the beneficiary.

- *The holder of an individual annuity contract assigned the rights to the annuities to his friend who was not the beneficiary under the policy. The assignment was in writing and made in exchange for something of value. The policy contains a provision which expressly stated that the designation of beneficiary was irrevocable. The insured died and the friend-assignee claimed the death benefits under the assignment contract. Is the insurance company obligated to pay the benefits to the friend-assignee?*

  No. Under an assignment under s. 632.47, Wis. Stat., the friend-assignee takes effective rights to the death benefits unless the beneficiary was "effectively designated as an irrevocable beneficiary prior to the assignment." Since the prior policy contains such a restriction on the assignment, the assignment to the friend-assignee is subordinate to the beneficiary. The death benefits go to the designated beneficiary.

What rights exist regarding the designation of the beneficiary?

Subject to the relative rights of the assignee and the beneficiary, the policyholder of a life insurance policy or annuity contract has the unrestricted right to designate an irrevocable beneficiary or change the beneficiary if not irrevocable.

The policyholder may, at any time, make an irrevocable designation of the beneficiary effective at once or at some time in the future. If the designation of the beneficiary is not explicitly irrevocable, the policyholder may change the beneficiary without the consent or knowledge of the previously designated beneficiary.

Subject to statutory requirements as to changing the beneficiary by the will of the policyholder, any act of the policyholder that unequivocally indicates an intention to make the change in beneficiaries is sufficient to affect it.

An insurer may prescribe formalities to be complied with for the change of beneficiaries which may be only for its own protection. The insurer discharges its obligation under the insurance policy if it pays a properly designated beneficiary unless it has actual notice of either the assignment or an

unequivocal act by the policyholder which indicates an intention to change beneficiaries. The insurer has actual notice if the policyholder has complied with its prescribed formalities.

[s. 632.48]

EXAMPLES

- *A holder of an individual whole life insurance policy originally named his daughter as beneficiary. The policy contained no explicit restrictions on the right to change the beneficiary. After the policy had been in effect for six months, the policyholder decided to change the beneficiary to his oldest son. After the policyholder's death, his daughter told the insurance company that she was entitled to receive the death benefits as the first beneficiary instead of the son. Is the daughter entitled to the benefits?*

  No. Under s. 632.48 (1) (b), Wis. Stat., if the designation of beneficiary is not explicitly irrevocable, the policyholder may change the beneficiary without the consent of the previously designated beneficiary. Assuming that the insured did not make a valid assignment of the right to the death benefits to the daughter after changing beneficiaries, the son is entitled to the benefits and not the daughter.

- *A holder of an individual term life insurance policy changed the beneficiary by replacing the name of his mother with his daughter's name. The policyholder failed to notify the insurance company of the change as required by the policy. After the policyholder died, the insurance company paid the benefits to the mother, who was the original beneficiary. The daughter claimed that the insurance company should have made payment to her under the policy. Was the insurance company correct in making payment to the original beneficiary?*

  Yes. Although the policyholder is free to change beneficiaries, under s. 632.48, Wis. Stat., the insurance company may require the policyholder to properly notify the company of any change of beneficiary. Since the policyholder failed to provide adequate notification under the terms of the policy, the insurance company discharged its obligation under the contract when it paid the properly designated beneficiary.

What is a life settlement?

A life settlement is a transaction in which the owner of a life insurance policy sells the policy for an amount less than the death benefit.

[s. 632.69(1)(j)]

Are there requirements for life settlement contracts and the providers and brokers arranging for such contracts?

Yes. Life settlement contract forms and disclosure statement forms are subject to prior approval by the commissioner and must allow the owner a right to rescind the contract before the earlier of 30 calendar days after the contract is executed by all parties or 15 calendar days after the life settlement proceeds have been paid to the owner. Providers and brokers are required to be licensed, give

proper disclosures to owners, purchasers, and insurers, and follow statutory standards for truthful advertising and fair marketing practices.

[s. 632.69]

What is stranger-originated life insurance (STOLI) and is it permissible?

Stranger-originated life insurance (STOLI) is the initiation of a life insurance policy for the benefit of a third-party investor who has no insurable interest in the insured. STOLI is considered a fraudulent life settlement act and is prohibited.

[s. 632.69]

Are there any special requirements relating to HIV?

Under current Wisconsin law, insurers writing individual life insurance in Wisconsin may require applicants for insurance to be tested for the presence of the antibody to HIV and reveal whether they have obtained a test or the results of such a test. Applicants for group insurance may not be required to take a test or reveal whether they have obtained a test or the results of such a test. Insurers may only use or inquire about FDA-licensed tests.

Insurers are prohibited from denying or limiting benefits solely because the insured's death is caused by HIV infection. An insurer may not require or request any individual to reveal whether they have undergone a test at an anonymous counseling and testing site or used a home test kit.

[s. 631.90, s. Ins 3.53]

What are prohibited insurance practices involving domestic abuse?

Insurers are prohibited from:

- refusing to provide, renew, or cancel a person's coverage under an individual or group policy or certificate on the basis that the person or a member of the person's family has been or is a victim of domestic abuse;
- refusing to provide, renew or cancel an employer's or other group's coverage on the basis that an employee or other group member or a member of their family has been or is a victim of domestic abuse; and
- rating an individual or group policy on knowledge or suspicion that a person has been or is a victim of domestic abuse.

Individual or group life insurers also may not deny or limit benefits under an individual or group life insurance policy in the event the insured's death results from domestic abuse.

[s. 631.95]

LIFE INSURANCE MARKETING

What is replacement of life insurance or annuities?

If the intermediary, or insurer when no intermediary is involved, knows or should have known that a consumer has an existing policy or contract that has been or will be terminated, converted, assigned, or otherwise reduced in value for any reason upon acquisition of a new policy or contract, the sale is considered a Replacement. If the reason for termination is surrender, a surrender charge may apply. The surrender charge is usually a percentage of the cash value of the life policy or of the accumulated value of the contract, the premiums paid, or the portion withdrawn. Surrender charges usually apply to surrenders or withdrawals taken during a certain number of years after the purchase of the policy or contract. Surrender charges may gradually decrease each year the policy or contract remains in force.

[s. 628.34, s. Ins 2.07(3)(i)]

What is the purpose behind replacement procedures and disclosure requirements?

The interest of life insurance and annuity policyholders must be protected by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of such policies. Policyholders are protected because the opportunity for misrepresentation in replacement situations is reduced. The replacement and disclosure requirements apply to most individual life insurance and annuity contracts sold in Wisconsin.

[s. 628.34, s. Ins 2.07]

What are the duties of an intermediary regarding replacement and disclosure?

An intermediary who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by the applicant and the intermediary as to whether the applicant has any existing individual life insurance policies or annuity contracts in force. If there is a policy or contract in force, the intermediary must present and read to the applicant not later than the time of taking the application, a notice regarding replacements. The notice must be signed by both the applicant and the intermediary, stating that the notice was read aloud, or that the applicant did not wish the notice to be read aloud and a copy left with the applicant.

[s. 628.34, s. Ins 2.07(4)]

What must intermediaries do if replacement is involved or proposed in the transaction?

Where replacement is involved or proposed, the intermediary must:

- list on the replacement notice, all life insurance policies or annuities proposed to be replaced, including the name of the insurer, the name of the insured or annuitant, the policy or contract number if available, and a statement as to whether each policy or contract will be replaced or used as a source of financing for the new policy or contract;

- leave with the applicant at the time of application, the original or a copy of all sales material. With respect to electronically presented sales material, it must be provided to the policyholder in printed form no later than at the time of policy delivery; and
- submit to the insurer to which the applicant is applying for coverage, a copy of the replacement notice, a statement identifying any preprinted or electronically presented company-approved sales materials or individualized sales materials including any illustrations that were used during the sale.

[s. 628.34, s. Ins 2.07(4)]

What must the replacing insurer do if replacement is involved or proposed in the transaction?

When a replacement is involved in a transaction, the replacing insurer must:

- verify that all required forms are completed and received with the application;
- notify any existing insurer that may be affected by the proposed replacement within five business days of receipt of the application, and mail a copy of the available illustration, policy summary, or disclosure document for the proposed policy or contract within five business days of a request from an existing insurer;
- be able to produce copies of the replacement notice for at least five years or until the conclusion of the next regular examination conducted by the Office of the Commissioner of Insurance, whichever is later.
- provide to the policy or contract owner notice of the right to return the policy or contract within 30 days of the delivery for an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy or contract. This is also referred to as a free-look period; and
- in transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract.

[s.628.34, s. Ins 2.07(6)]

What must the existing insurer do when notified that replacement is involved or proposed in the transaction?

When notified that replacement is involved in the transaction, the existing insurer must:

- retain and be able to produce all replacement notifications received, indexed by the replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the Office of the Commissioner of Insurance, whichever is later;

- send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values and provide the information within five business days of receipt of a request for the information from the policy or contract owner; and
- upon receipt of a request to borrow, surrender, or withdraw any policy values, send a notice, advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount, or surrender value of the policy from which the values are released.

[s. 628.34, s. Ins 2.07(7)]

Are insurers required to monitor the replacement activity of intermediaries?

An insurer must maintain a system of supervision and control to ensure compliance with the replacement requirements in s. Ins 2.07. An insurer must inform its agents of replacement requirements, monitor each agent's life insurance policy and annuity contract replacements for the insurer, and be able to produce records showing the percentage of each agent's replacements to total annual sales, percentage of lapses of policies to total annual sales, as well as the number of unreported replacements detected by the insurer's monitoring system.

[s. 628.34, s. Ins 2.07(5)]

Do individual agents have to maintain records regarding suitability inquiries and replacement procedures?

Yes. Each individual agent must maintain records for a three-year period giving the effective date of the coverage on all newly issued contracts and indicating that the necessary suitability inquiry and replacement procedures required by ss. Ins 2.07, 2.14 (5) (f), 2.15 (9) (f), 2.16 (6), 3.27 (7), and 3.29, Wis. Adm. Code, were followed for each individual life, individual annuity, and accident & health contract written or replaced. In addition, an agent must maintain records of the information collected from a consumer that is used in making a recommendation that results in the purchase or exchange of an annuity for six years after the transaction.

[ss. 601.42, 628.347(7), s. Ins 6.61]

May policies be dated back to a lower insurance age?

An insurance company may not issue any life insurance policy with an effective date more than six months before the date of application when the earlier date results in a lower premium than that which would have been payable based on the birthday nearest the date of application. The date of application will be the date on which the application or the medical examination is complete, whichever is later.

The exchange, alteration, or conversion of life insurance policies as of the original date of such policies is not prohibited if the amount of insurance provided under the new policy does not exceed the amount of insurance under the original policy or the amount of insurance which the premium

paid for the original policy would have purchased if the new policy had been originally applied for. This section does not prohibit the exercise of any conversion privilege contained in any policy or contract.

[s. Ins 2.03]

What are the standards for life insurance sold in connection with a mutual fund or other security?

Section Ins 2.09, Wis. Adm. Code, applies to the solicitation of life insurance or annuities when it is known to the insurer or the intermediary that the sale of any mutual fund or other security has been, may become, or is a part of any transaction.

Minimum standards are set out for the form of proposals and statements used to solicit, service, or collect premiums for life insurance or annuities sold in connection with a mutual fund or other security. Any bill, statement, or representation sent or delivered to any prospect or policyholder must show the premium charge and any other information mentioned concerning the life insurance or annuity separately from any other charges or values shown in the same billing.

An insurer or intermediary must provide the prospective purchaser or policyholder with a copy of a clear and unambiguous written proposal, as defined in the following section, not later than the time the solicitation or proposal is made.

[s. 628.34, s. Ins 2.09]

What must be included in the required proposal for life insurance and annuities sold in connection with a mutual fund or other security?

Any proposal under s. Ins 2.09, Wis. Adm. Code, must be dated and signed by the intermediary or by the insurer if no agent is involved. It must state the name of the company, be accurate and complete, contain no misrepresentation or false, deceptive, or misleading statements, and show the premium charge for the life insurance or annuity separately from any other charge.

In addition, the proposal must:

- show the value of the life insurance or annuity separately from any other values if the values that may accrue prior to the death of the insured are involved in the presentation;
- show the amount of the death benefit for the life insurance separately from any other benefit that may accrue upon the death of the insured if it is involved in the presentation;
- set forth all matters pertaining to life insurance or annuities separately from any matter not pertaining to life insurance or annuities; and
- contain only such representations as will accurately reflect the actual conditions applicable to the proposed insured.

[s. 628.34, s. Ins 2.09(6)]

What are the disclosure requirements for the sale of life insurance?

The interests of prospective purchasers of life insurance must be safeguarded by providing persons with clear and unambiguous statements, explanations, and written information concerning the life insurance contracts offered to them. Section Ins 2.14, Wis. Adm. Code, specifies that certain information must be disclosed to prospective purchasers. The purpose of the rule is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for their needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration, and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

The insurer must provide a Policy Summary upon delivery of the policy only if the insurer does not provide a basic illustration. The policy summary may describe or illustrate only the guaranteed elements of the policy. Dividends and other non-guaranteed elements cannot be shown. The policy summary must show the annual premiums, guaranteed amount payable upon death, and guaranteed cash surrender values, for the first 20 policy years and at least one age from 60 through 65 or maturity, whichever is earlier.

At the time the application is taken, the insurer shall provide a copy of the *Life Insurance Buyer's Guide* to all prospective purchasers of life insurance policies subject to the rule. An insurer not marketing policies through an intermediary may provide the *Buyer's Guide* at the time the policy is delivered, provided the policyholder is guaranteed a 30-day right to return the policy for a full refund of premium.

Prior to beginning a life insurance sales presentation, an intermediary must inform a prospective purchaser that they are acting as a life insurance intermediary and inform the prospective purchaser of the full name of the insurer that the intermediary is representing. Where an intermediary is not involved, the insurer must identify its full name.

[s. Ins 2.14]

What is a policy summary?

A Policy Summary means a written statement, in substantially the same format for all companies, which describes only the guaranteed elements of the life insurance policy, including but not limited to:

- the title of Statement of Policy Cost and Benefit Information;
- name and address of the intermediary and insurer;
- generic name of the basic policy and each rider;
- amounts, where applicable, for the first 20 policy years and at least one age from 60 through 65 or maturity, whichever is earlier, the annual premium for the basic policy, annual premium for each optional rider, guaranteed amount payable upon death, total guaranteed cash

surrender values, and guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values;
- effective policy loan interest rate, stated as an annual percentage; and
- date on which the Policy Summary is prepared.

A policy summary is not required if the insurer uses a basic illustration that complies with s. Ins 2.17.

[s. Ins 2.14]

What is a life insurance illustration?

Illustration means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years. A basic illustration means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

[s. Ins 2.17(3)(i)]

What are the requirements for the use of life insurance illustrations?

This rule provides requirements for life insurance policy illustrations that will protect consumers and foster consumer education. The rule provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations. The illustration rule applies to all group and individual life insurance policies and certificates except:

- variable life insurance;
- individual and group annuity contracts;
- credit life insurance; and
- life insurance policies with no illustrated death benefits on any individual exceeding $10,000.

[s. Ins 2.17(2)]

What must be included in an illustration?

An illustration must be clearly labeled "life insurance illustration" and must contain all of the following basic information:

- name of insurer;
- name and business address of agent or insurer's authorized representative;
- name, age, and sex of the proposed insured;
- underwriting or rating classification upon which the illustration is based;
- generic name of the policy, the insurer's product name and form number;
- initial death benefit; and
- dividend option election or application of non-guaranteed elements, if applicable

[s. Ins 2.17(5)(a)]

What is an insurer or agent prohibited from doing when using illustrations in the sale of a life insurance policy?

Insurers and agents shall not:

- represent the policy as anything but life insurance;
- use or describe non-guaranteed elements in a manner that is misleading;
- state or imply that payment of a non-guaranteed element is guaranteed;
- use an illustration that does not comply with the Life illustrations rule, s. Ins 2.17;
- use an illustration that at any policy duration depicts results more favorable than that produced by the illustrated scale of the insurer whose policy is being illustrated;
- provide an applicant with an incomplete illustration;
- represent that premium payment will not be required for each year of the policy in order to maintain the illustrated death benefits unless such representation is fact;
- use the terms "vanish," "vanishing premium," or similar language which implies that a policy will become paid up based on the use of non-guaranteed elements to pay premiums;
- use an illustration that is "lapse-supported" unless illustrating a policy that can never develop nonforfeiture values;
- use an illustration that is not "self-supporting"; or
- illustrate an interest rate that is greater than the earned interest rate underlying the disciplined current scale.

[s. Ins 2.17(5)(b)]

What are the requirements for delivery of illustrations and record retention?

If a policy is marketed with an illustration, a signed copy of the illustration must be provided to the applicant and must be submitted to the insurer at the time of policy application. If the policy is issued other than as applied for, a new basic illustration entitled "Revised illustration" conforming to the policy as issued shall be sent to the policyholder with the policy. The revised illustration shall be signed and dated by the applicant or policy owner and the agent no later than the time the policy is delivered.

The insurer shall maintain copies of all signed illustrations for a minimum of three years after the policy is no longer in force.

[s. Ins 2.17(8)]

When are annual reports to policyholders required and what is required in the report?

If an insurer uses an illustration in selling a policy, the insurer shall provide the policyowner with an annual report on the status of the policy that must contain at least the following information:

- the beginning and end date of the current report period;
- the policy value at the end of the previous report period and the end of the current report period;

- premiums paid;
- current death benefit;
- current cash surrender value;
- current dividends and application of current dividend; and
- amount of outstanding loans.

Policy owners will also receive information as to how to obtain an in-force illustration.

[s. Ins 2.17(8, 9)]

What other requirements must be met when selling life insurance?

- each insurer must maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to s. Ins 2.14, Wis. Adm. Code. The file must contain one copy of each authorized form for a period of three years following the date of its last authorized use;
- prior to any life insurance sales presentation, an intermediary shall inform the prospective purchaser that they are a life insurance intermediary and provide the full name of the insurance company which the intermediary is representing to the buyer;
- terms such as "financial planner," "investment adviser," "financial consultant," or "financial counseling" may not be used in such a way as to imply that the insurance intermediary is generally engaged in an advisory business in which compensation is unrelated to sales unless this is actually the case;
- any reference to policy dividends must include a statement that dividends are not guaranteed;
- no sales presentation may state or imply that life insurance arrangements are the same as savings accounts or deposits in banking or saving institutions, nor can terms such as "investment," "investment plan," "deposit," "profit sharing," "interest plan," "savings," or "savings plan," or other similar terms be used in a context or under circumstances that would have the capacity or tendency to mislead a purchaser or prospective purchaser to believe that they will receive something other than a life insurance policy or will receive some benefit not available to other persons of the same class and equal expectation of life;
- the purchase or replacement of any life insurance contract or annuity may not be recommended by any insurer or intermediary without reasonable grounds to believe that the recommendation is not unsuitable or in the best interests of the applicant based on information furnished by the applicant after the insurer or intermediary has made whatever reasonable inquiry is necessary under the circumstances concerning the prospective buyer's insurance and annuity needs and means;
- a system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments may not be used for comparing the cost of two or more life insurance policies.

[s. Ins 2.14, 2.15, 2.16]

Except for an illustration as defined in s. Ins 2.17, no presentation of benefits may display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately in close proximity to each other and with equal prominence.

[s. Ins 2.14]

Are there specific requirements relating to advertisements, representations, solicitations, and marketing of life insurance and annuities?

Yes. Major requirements include, but are not limited to, the following:

- advertisements may not contain deceptive words, symbols, or illustrations if they exaggerate, overstate, understate, or contain incomplete information regarding a life insurance or annuity product;
- advertisements, including, but not limited to, social media communications and posts, must clearly identify the insurer and may not use words or symbols that imply government sponsorship of the insurer;
- advertisements must disclose whether the person giving an endorsement is being paid for doing so. This does not apply if the person making the testimonial, endorsement, or statement holds a Wisconsin Insurance intermediary license, or if the person is a radio or television announcer that is employed or compensated on a salaried or union wage scale basis. Testimonials, endorsements, appraisals, or analysis used in advertisements, including, but not limited to, social media posts, shall also be genuine, represent the current opinion of the author, apply to the policy advertised, and be accurately reproduced;
- advertisements must disclose if a product has non-level premiums or if the insurer may change the amount of premium due during the policy term; and
- advertisements may not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed.

[s. Ins 2.16]

What are the disclosure requirements for sales of annuities?

Insurers are required to give applicants for deferred annuity contracts or deposit funds or riders sold in conjunction with insurance policies or annuity contracts, information that helps them evaluate the relative benefits of similar plans.

Insurers and intermediaries must give annuity buyers covered by the rule a copy of the current edition of the *Buyer's Guide to Annuities* and a Preliminary Contract Summary or a Contract Summary prior to accepting the applicant's initial consideration for the annuity contract. In the case of a rider, these items must be given prior to accepting the applicant's initial premium.

These regulations do not apply to:

- variable annuities;

- contracts registered with the Federal Securities and Exchange Commission;
- group annuity and pure endowment contracts purchased under a retirement plan or plans of deferred compensation established or maintained by an employer or employee organization;
- immediate annuity contracts;
- policies issued in connection with employee benefit plans covered by ERISA;
- individual retirement accounts;
- single advance payment of specified premiums equal to the discounted value of such premiums;
- a policyholder's deposit account established solely to facilitate payment of regular premiums; or
- settlement options under life insurance or annuity contracts.

[s. Ins 2.15]

What must the preliminary contract summary include?

The Preliminary Contract Summary must include:

- the title, contract summary, and an identification of the arrangement to which the statement applies;
- the name and address of the insurance intermediary or a statement of the procedure to be followed in order to receive responses to inquiries;
- the name and home office or administrative office address of the insurer;
- a statement as to whether the arrangement provides any guaranteed death benefits during the deferral period;
- a prominent statement that the contract does not provide cash surrender values, if that is the case;
- a statement that the contract may result in loss if kept for only a few years, if that is the case;
- any minimum or maximum premium limitations;
- a prominent description of all fees, charges, and loading amounts that are or may be deducted from initial or subsequent considerations paid or that may be deducted from the contract or fund values prior to or at contract maturity; and
- in the event any sales presentation illustrates values or annuity payments which are based on dividends or current annuity rates, a statement that these values and annuity amounts are illustrations only and are not guaranteed.

[s. 628.34, s. Ins 2.15]

Are there annuity training requirements for insurance intermediaries?

Yes. Before an intermediary can solicit the sale of any annuity product (fixed, indexed, variable, or contingent deferred annuities), they must complete a one-time four-hour training course and must complete the insurer-specific annuity product training. The training must include information on the different types and primary uses of annuities, how various contract provisions can affect consumers, tax considerations, appropriate sales practices, and replacement and disclosure requirements.

An intermediary who has completed an annuity training course approved by the commissioner prior to October 1, 2022, shall, within six months of October 1, 2022, complete any of the following:

- a four-credit training course approved by the commissioner; or
- an additional one-time one-credit training course approved by the commissioner and provided by an education provider, who is approved by the commissioner, on appropriate sales practices and replacement and disclosure requirements.

[s. 628.347(4m)(b)(1)(a) and (b)(3) and (b)(10)]

Does the training requirement apply to nonresident agents?

Yes. It applies to nonresident agents soliciting annuity products in Wisconsin. A nonresident agent who satisfies the training requirement of another state that is substantially similar to Wisconsin's law will be deemed compliant with Wisconsin's requirement.

[s. 628.347(4m)]

Is an intermediary permitted to recommend the purchase or exchange of an annuity to a consumer without first considering if the recommendation is in the best interest of the consumer?

No. When making a recommendation of an annuity, an insurance intermediary shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the financial interest of the intermediary or insurer ahead of the consumer's interest. An insurance intermediary has acted in the best interest of the consumer if the intermediary has satisfied the (2b) Care Obligation, the (2c) Disclosure Obligation, the (2d) Conflict of Interest Obligation, and the (2e) Documentation Obligation as outlined under section 628.347(2), Wisconsin Statutes.

[s. 628.347(2)(a)]

What consumer profile information must be considered before recommending the purchase or exchange of an annuity to a consumer?

An intermediary, or insurer if no intermediary is involved, must consider information that is reasonably appropriate to determine the suitability of a recommendation, including all the following:

- age;
- annual income;
- financial situation and needs, including the financial resources used for the funding of the annuity;
- financial experience;
- financial objectives;
- intended use of the annuity;
- financial time horizon;
- existing assets, including investment and life insurance holdings;

- liquidity needs;
- liquid net worth;
- risk tolerance; and
- tax status.

The factors generally relevant in determining whether an annuity effectively addresses the consumer's financial situation, insurance needs, and financial objectives shall be the consumer profile information, characteristics of the insurer, and product costs, rates, benefits, and features. The level of importance of each factor may vary depending on the facts and circumstances of a particular case, and no factor may be considered in isolation.

[s. 628.347(1)(ag) and 628.347(2b)(d)]

What must an intermediary do before giving advice to an individual consumer that results in the purchase or exchange of an annuity in accordance with that advice?

In making a recommendation, an insurance intermediary shall exercise reasonable diligence, care, and skill to do all of the following:

- know the consumer's financial situation, insurance needs, and financial objectives;
- understand the available recommendation options after making a reasonable inquiry into the options available to the intermediary;
- have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs, and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and
- communicate the basis or bases of the recommendation to the consumer.

[s. 628.347(2b)(a)]

What if a consumer refuses to provide the intermediary with pertinent financial information?

If a consumer refuses to provide consumer profile information, obtain a signed statement from the consumer, on a form substantially similar to Appendix B of the National Association of Insurance Commissioners Annuity Suitability Model Regulation that shall be posted on the Office's Internet site, that documents all of the following:

- a consumer’s refusal to provide consumer profile information; and
- a consumer’s understanding of the ramifications of not providing their consumer profile information or of providing insufficient consumer profile information.

[s. 628.347(2e)((b)]

Are there other requirements that must be met before recommending the purchase or exchange of an annuity to a consumer?

Yes. Prior to the recommendation or sale of an annuity, an insurance intermediary shall prominently disclose to the consumer, on a form substantially similar to Appendix A of the National Association

of Insurance Commissioners Annuity Suitability Model Regulation that shall be posted on the Office's Internet site, all of the following information:

- the terms of the intermediary's relationship with the consumer and the role of the intermediary in the transaction;
- an affirmative statement on whether the intermediary is licensed and authorized to sell annuities, life insurance, mutual funds, stocks, bonds, and certificates of deposit;
- an affirmative statement describing the insurers for which the intermediary is authorized, contracted, and appointed;
- a description of the sources and types of cash compensation and noncash compensation to be received by the intermediary, including commission as part of a premium received from the insurer or another intermediary, or by consulting services; and
- a notice of the consumer's right to request additional information regarding cash compensation.

[628.347(2c)(a)]

Are there other requirements that must be met at the time of sale of an annuity?

Yes. An insurance intermediary shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts related to an ownership interest; and at the time of making a recommendation or sale of an annuity, shall do all the following, as applicable:

- make a written record of any recommendation and the basis for the recommendation subject to this section;
- if an annuity is not recommended, obtain a signed statement from the consumer, on a form that shall be posted on the office's Internet site, that acknowledges an annuity transaction is not recommended; and
- if a consumer refuses to provide consumer profile information, obtain a signed statement from the consumer, that shall be posted on the office's Internet site and documents the following:
    - a consumer's refusal to provide consumer profile information; and
    - a consumer's understanding of the ramifications of not providing their consumer profile information or of providing insufficient consumer profile information.

[s.628.347(2)]

Do the consumer best interest requirements apply to variable annuities?

Yes. The best interest requirements apply to any fixed, indexed, variable, or contingent deferred annuity whether it is an individual or group contract, *except* for certain direct response solicitations, contracts used to fund employee pension or welfare benefit plans covered by ERISA, deferred compensation plans, government or church plans, prepaid funeral plans, and settlements associated with personal injury litigation or any dispute or claim resolution process. Sales made in compliance

with FINRA requirements pertaining to suitability and supervision of annuity transactions satisfy the requirements for the recommendation of annuities.

[s. 628.347(4) and (8)]

What action can the commissioner take to resolve a consumer's best interest complaint?

The commissioner may order an insurer, an intermediary, a general agent, or an independent agency that employs or contracts with an intermediary to take reasonably appropriate corrective action for any consumer harmed by a violation of the law relating to the consumer's best interest of an annuity recommendation to a consumer by the intermediary and may impose any appropriate penalties or sanctions.

[s. 628.347(5)]

Does an insurer have a supervisory responsibility to ensure that intermediaries are complying with the consumer's best interest requirements?

An insurer must establish a supervision system that is reasonably designed to ensure the best interest of annuity recommendations by informing its insurance intermediaries of best interest requirements, establishing standards and providing product-specific training on its annuity products to its insurance intermediaries, maintaining procedures for review of each recommendation before issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that the recommendation is in the best interest of the consumer, and maintaining reasonable procedures to detect recommendations that are not in a consumer's best interest. If an insurer contracts with a third party to perform a supervision function, the insurer must monitor and conduct audits to ensure that the contracted function is properly performed.

[s. 628.347(3)]

What is the State Life Insurance Fund?

The State Life Insurance Fund (Fund) is a state-sponsored, nonprofit, mutual program that offers low-cost life insurance to the residents of the state of Wisconsin. The Fund does not use licensed intermediaries, does not advertise, and is exempt from federal income tax. Policies can be bought through the Wisconsin Office of the Commissioner of Insurance. Evidence of insurability must be provided. This is not automatic coverage. The Fund is required to operate in a manner consistent with private insurers regarding policy coverage, medical examinations, and underwriting procedures.

The Fund issues term and whole life policies. The maximum coverage available under the Fund is $10,000.

[ch. 607]

What are the insurer requirements relating to unclaimed life and annuities?

Effective May 1, 2019, insurers are required to perform a comparison of in-force policies and contracts against the Social Security Administration death master file on at least a semi-annual basis. Insurers must complete a good faith effort to confirm potential matches and to locate beneficiaries where a match has been confirmed.

[s. 632.63]

CHAPTER VI

PROPERTY AND CASUALTY INSURANCE

Property and casualty insurance may generally be said to include all kinds of insurance other than life and disability (accident & health). Specifically, it includes but is not limited to, fire, other perils, inland marine and ocean marine, flood, liability, steam boiler, fidelity, surety, credit, title, burglary, robbery, theft, glass breakage, worker's compensation, automobile liability and physical damage, mortgage guaranty, legal expense, and other miscellaneous lines.

RATES

Do rates have to be filed?

Yes. Every authorized insurer and every rate service organization (licensed under Wisconsin law and designated by the insurer for the filing of rates) must file with the commissioner all rates, all supplementary rate information, and all changes and amendments to the rates made by it for use in Wisconsin within 30 days after the rates become effective. Except for worker's compensation rates and the rates used by the Wisconsin Automobile Insurance Plan and the Wisconsin Insurance Plan, no prior approval of rates for property and casualty insurance is required. However, the commissioner may call a hearing to disapprove rates.

[ss. 625.13**,** 625.22**,** 626.13**,** ss. Ins 3.49(3)**,** 4.10(7)(g)**]**

What about general rate standards for property and casualty insurance?

Except for those cases cited in the previous section, companies must file the rates they are using. The commissioner's office does not approve rates for policies sold in this state but does have the authority to disapprove rates if they are excessive, inadequate, or unfairly discriminatory.

Rates are presumed to be not excessive if a reasonable degree of price competition exists at the consumer level with respect to the class of business to which they apply. If such competition does not exist, rates are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to the services rendered.

A rate is inadequate if, together with the investment income attributable to it, it is clearly insufficient to sustain projected losses and expenses in the class of business to which it applies.

A rate is unfairly discriminatory in relation to another in the same class if it clearly fails to equitably reflect the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as the rate reflects the differences with

reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise, or blanket policy.

[s. 625.11]

Are there any exceptions to the general rate standards and rate filing requirements?

Yes. Inland marine risks, risks written on a consent-to-rate basis or individually rated and certain title insurance rates are exempt from the rate filing requirements. Worker's compensation insurance is totally exempt from the general rate standards and rate filing requirements because there is a separate rate law for worker's compensation insurance in Wisconsin.

Although worker's compensation rates shall not be excessive, inadequate, or unfairly discriminatory, the worker's compensation rate law is a prior approval law, and the rates used in Wisconsin are uniform. All insurers writing worker's compensation insurance in Wisconsin must be members of the Wisconsin Compensation Rating Bureau (WCRB), and by law, they must use the rates and the forms filed by WCRB without exception or deviation. Rates are filed by WCRB and must be approved by the commissioner prior to use.

[ss. 626.11, 626.13, 626.25, ss. Ins 4.08, 6.78]

What classification of risks are prohibited for rating purposes?

Section Ins 6.54, Wis. Adm. Code, applies to all contracts issued, renewed, or amended that provide automobile coverage, coverage for loss or damage to real property used for residential purposes for not more than four living units, or coverage for loss or damage to personal property used for residential purposes.

An insurance company may not refuse, cancel, or deny insurance coverage to a class of risk solely on the basis of any of the following factors (taken individually or in combination), nor may it place a risk in a rating classification based on any of the following factors without credible information supporting such a classification and demonstrating that it equitably reflects differences in past or expected losses and expenses:

- the applicant's or insured's past criminal record;
- the applicant's or insured's physical condition or developmental disability;
- the applicant's or insured's past mental disability;
- the applicant's or insured's age;
- the applicant's or insured's marital status;
- the applicant's or insured's sexual preference; or
- the applicant's or insured's "moral" character.

However, none of the above factors includes as a prohibited practice any of the following:

- denying, canceling, or nonrenewing automobile or property insurance of a person convicted of an offense directly related to the risk to be insured;
- establishing a classification system merely for the purpose of developing statistical data;
- underwriting only a class of risks which are specified in the insurer's articles of incorporation;
- establishing a rate based on the record of all drivers of an insured automobile; or
- establishing a rate based on the number of people residing in the household.

In addition, an insurer may not require an applicant or insured to undergo a physical examination to obtain or continue coverage unless the cost of the examination is borne by the insurer.

[s. 628.34, s. Ins 6.54]

Do forms have to be filed?

Generally, under Wisconsin law, any form which becomes a part of an insurance contract must be filed with the commissioner of insurance 30 days prior to its use by an insurer.

[s. 631.20, s. Ins 6.05]

PROPERTY INSURANCE

What must property insurance forms contain?

Property insurance was traditionally based upon what is known as the "standard fire policy." This standard fire policy was entirely set out in the statutes and provided coverage only for fire, lightning, and removal from the premises of property endangered by a covered peril. However, broader coverage against other dangers and kinds of loss could be provided by the attachment of various endorsements to the standard fire policy.

Thus, every policy that included fire coverage, alone or in connection with other coverage, was required by law to include the complete standard fire policy, even if its standard terms were inconsistent with conditions and terms of other endorsements. In 1976, the "standard fire policy" was removed from the statutes, to allow for the gradual development of other types of property insurance forms.

To assist this development, s. Ins 6.76, Wis. Adm. Code, was promulgated. This regulation sets out characteristics and authorized provisions for property insurance forms.

Any fire, inland marine, or other property insurance form may be disapproved as misleading, deceptive, or obscure by the commissioner if it does not clearly state the perils covered, the limitations, and the conditions; if it contains provisions contrary to the law, or if it does not include clauses covering the following provisions when appropriate:

- location and description of the property covered;
- effect of other insurance on the coverage provided;

- conditions suspending, restricting, or voiding the coverage provided;
- termination of the contract;
- mortgagee interests and obligations; and
- obligations in case loss occurs.

[s. 628.34, s. Ins 6.76]

What if there is a total loss?

Whenever any policy insures real property which is owned and occupied by the insured as a dwelling and the property is wholly destroyed without criminal fault on the part of the insured, the amount of the loss shall be taken conclusively to be the policy limits of the policy insuring the property.

The following properties are subject to the above:

- seasonal dwellings;
- multi-family units if at least one unit is occupied by the owner and there are no more than four dwelling units on the property;
- combined commercial and residential properties if owner-occupied as a dwelling; or
- owner-occupied real property partially destroyed but ordered destroyed under a fire ordinance or similar law.

The following properties are not subject to the above:

- outbuildings insured under the same policy as an owner-occupied dwelling;
- mobile homes; or
- property under construction unless the property is completed and occupied by the owner of the dwelling.

[s. 632.05(2), s. Ins 4.01]

May replacement cost coverage be issued?

In a property insurance policy, an insurer may agree to indemnify the insured for the amount it would cost to repair, rebuild, or replace the damaged or destroyed insured property with new materials of like size, kind, and quality.

[s. 632.05(1)]

May a lender require property insurance in excess of replacement value?

A lender may not require a borrower, as a condition of receiving or maintaining a loan secured by real property, to insure the property against risks to improvements on the real property in an amount that exceeds the replacement value or market value of the improvements, whichever is greater.

[s. 632.07]

What are mortgage clauses?

A provision for payment to a mortgagee (person or entity who lends the money) or another owner of a security interest in property may be contained in or added by endorsement to any property insurance policy. If the provision is contained in an endorsement and the insurance covers real property, any loss not exceeding $500 must be paid to the insured mortgagor (person taking out the mortgage) unless the mortgagee is a named insured.

[s. 632.08]

What are the limitations on denying a claim involving domestic abuse?

Property and liability insurers are prohibited from taking the following actions:

- Under property insurance policies that exclude coverage for loss or damage resulting from intentional acts, insurers may not deny claim payment to an innocent insured for property loss or damage that resulted from an act of abuse or domestic abuse, if that insured did not cooperate in or contribute to the loss or damage and the person who committed the act is criminally prosecuted.

[s. 631.95(2)(f)]

What are the limitations on using or disclosing information about domestic abuse?

Persons employed by or contracted with an insurer may not use, disclose, or transfer information relating to whether a person is or has been a victim of domestic abuse, and may not disclose or transfer that person's telephone number or address, except for a purpose related to the provision of health care services or for a valid business purpose, including disclosure or transfer of information to a reinsurer, the insurer's attorney, medical, and underwriting or claims personnel under contract with the insurer, the policyholder's assignee, in response to a legal process, or as required by court order or by order of OCI. An insured or applicant may also obtain their own insurance records from an insurer.

[s. 631.95(5)]

LIABILITY INSURANCE

May liability policies contain "appraisal" or "arbitration" provisions?

An insurance policy may contain a provision for independent appraisal and compulsory arbitration, provided that the provision meets the statutory requirements for approval of forms under s. 631.20, Wis. Stat., and is approved by the commissioner. If an approved policy provides for application to a court for the appointment of a disinterested appraiser, arbitrator, or umpire, any court of record in Wisconsin except the Court of Appeals or the Supreme Court may be requested to make an appointment.

Upon appropriate request, the court is required to make the appointment of a disinterested person promptly.

[s. 631.85]

What provision on bankruptcy or insolvency is required in liability insurance policies?

Every liability insurance policy must provide that the bankruptcy or insolvency of the insured will not diminish any liability of the insurer to third parties. Insolvency of the insured does not excuse the insurer from payment. If execution of a judgment by the injured party against the insured is returned unsatisfied, legal action may be maintained against the insurer to the extent that the liability is covered by the policy.

[s. 632.22]

May an injured third party maintain a "direct" legal action against the insurer under a liability policy issued in Wisconsin?

Any bond or insurance policy covering liability to others for negligence makes the insurer liable to persons entitled to recover against the insured for the death or injury to persons or property. The insurer is liable up to the amounts stated in the bond or policy, irrespective of whether the liability has already been established, or is dependent upon a final judgment against the insured.

[s. 632.24]

What notice provisions are required for liability insurance policies?

Every liability insurance policy must contain a provision that notice given by the policyholder to any authorized agent of the insurer in Wisconsin, with enough specific information to identify the insured, constitutes proper notice to the insurer.

If the contract contains a provision concerning failure by the policyholder to give any notice within the time specified, the provision does not invalidate the insured's claim if it is shown that it was not reasonably possible to give notice within that timeframe and that notice was given as soon as reasonably possible.

[s. 632.26(1)]

What coverage provisions are required for automobile liability policies?

Every liability policy issued or delivered in Wisconsin to the owner of a motor vehicle must provide that:

- any coverage provided to the named insured must also apply to any person using any motor vehicle described in the policy when the use is for purposes and in the manner described in the policy. This coverage extends to any person legally responsible for the use of the motor vehicle; and

- the policy may limit the coverage to instances in which the riding, use, or operation is with the permission of the named insured, or when the insured is an individual with the permission of an adult member of the insured's household other than a chauffeur or domestic servant.

[s. 632.32(3), (5)(a)]

What coverage is required under the "uninsured motorist" provision in automobile liability insurance policies?

Every policy of insurance newly issued or renewed effective on or after November 1, 2011, which:

- is delivered or issued for delivery in Wisconsin on any owned motor vehicle registered or principally garaged in Wisconsin; and
- insures against loss resulting from liability imposed by law for bodily injury or death suffered by persons arising out of the ownership, maintenance, or use of a motor vehicle.

Shall contain provisions such that:

- The insurer must provide in the policy, or supplemental to the policy, uninsured motorist coverage for bodily injury or death in the amount of at least $25,000 per person and $50,000 per accident under provisions filed with the commissioner. This provision is for the protection of injured persons who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, or death.

[s. 632.32(2)(f)-(g), (4)(a)1]

What coverage is required under the "underinsured motorist" provision in automobile liability insurance policies?

For every policy of insurance newly issued or renewed effective on or after November 1, 2011, underinsured motorist coverage is optional. Underinsured motorist coverage provides protection for injured persons who are legally entitled to recover damages from owners or operators of underinsured motor vehicles because of bodily injury, sickness or disease, or death.

For new policies that do not contain underinsured motorist coverage, the insurer must include a separate notice of the availability of underinsured motorist coverage and provide a brief description of the coverage along with the delivery of the policy. The insurance customer may reject underinsured motorist coverage. If purchased, underinsured motorist coverage must have limits of at least $50,000 per person and $100,000 per accident.

[s. 632.32(2)(d), (4m)]

What coverage is required under the "medical payments" provision in automobile liability insurance policies?

Every policy of insurance newly issued or renewed effective on or after November 1, 2011, that:

- is delivered or issued for delivery in Wisconsin on any owned motor vehicle registered or principally garaged in Wisconsin; and
- insures against loss resulting from liability imposed by law for bodily injury or death suffered by persons arising out of the ownership, maintenance, or use of a motor vehicle.

Shall contain provisions such that:

- the insurer must provide in the policy, or supplemental to the policy, coverage to indemnify for medical payments or chiropractic payments or both for the protection of all persons using the insured motor vehicle from losses resulting from bodily injury or death in the amount of at least $1,000 per person. Coverage may be written as excess coverage over any other source of reimbursement to which the insured person has a legal right; and
- the named insured may reject medical payments coverage. If rejected, it need not be provided in a subsequent renewal policy issued to such person by the same insurer unless the insured requests it in writing. The insurer is subrogated to the rights of its insured to the extent of its payments.

[s. 632.32(2)(am), (4)(a)2, (bc), (c)]

What uses may not be excluded by motor vehicle liability policies?

No policy may exclude from the coverage afforded or benefits provided:

- persons related by blood, marriage, or adoption to the insured;
- any person who is a named insured or passenger in or on the insured vehicle. This does not apply to motorcycles or mopeds designed to carry only one person and which do not have a passenger seat;
- any person solely for reasons of age, if the person is of an age authorized to drive a motor vehicle; or
- any use of the motor vehicle for unlawful purposes, or transportation of liquor in violation of law, or while the driver is under the influence of intoxicating liquors or narcotics or any use of the motor vehicle in a reckless manner.

[s. 632.32(6)(b)]

Which types of policies are exempt from the requirements for uninsured motorist, underinsured motorist, and medical payments coverages?

Umbrella and excess liability policies are exempt from including uninsured motorist coverage and from offering underinsured motorist and medical payments coverage.

- an umbrella or excess liability policy means a policy providing at least $1,000,000 of liability coverage per person or per occurrence in excess of certain required underlying liability insurance coverage or a specified amount of self-insured retention.

A commercial liability policy, if the incidental coverage it provides for motor vehicles is limited to non-owned motor vehicles, is also exempt from including uninsured motorist coverage and from offering underinsured motorist and medical payments coverage.

- a commercial liability policy means any form of liability insurance policy, including a commercial or business package policy or a policy written on farm and agriculture operations, that is intended principally to provide primary coverage for the insured's general liability arising out of its business or other commercial activities, with incidental auto liability as only one component of the policy. "Commercial liability policy" does not include a worker's compensation policy or a commercial automobile liability policy.

If an exempted policy provides uninsured motorist, underinsured motorist, or medical payments coverage, the coverage must be written with at least the minimum limits required for a non-exempted policy.

[s. 632.32(2)(ac), (cm), (4)(d), (4m)(e)]

When is cancellation or nonrenewal of an automobile liability insurance policy prohibited?

No insurer may cancel or refuse to issue or renew an automobile insurance policy wholly or partially because of one or more of the following characteristics of any person: age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status, or occupation.

[s. 632.35]

What are the requirements for motor vehicle replacement parts?

The name or logo of the manufacturer of the replacement parts used in the repair of a motor vehicle must be affixed or inscribed on the replacement parts and must be visible to the extent possible after installation.

An insurer or the insurer's representative may not require the use of a non-original manufacturer replacement part in an insured's motor vehicle unless the insurer or the insurer's representative gives the insured prescribed notice. The notice must be in writing. If the notice is initially given over the phone, a written disclosure must follow the phone notification.

[ss. 100.44, 632.38]

Can DOT odometer data be used to adjust rates?

No. Odometer data collected by the Wisconsin Department of Transportation (DOT) during emission inspections and obtained by an insurer from DOT may not be used as a factor in setting rates or

premiums for a motor vehicle liability insurance policy or as a factor in altering rates or premiums during the term or at the renewal of such a policy. Such data may be used as a basis for investigating the number of miles the motor vehicle is usually driven.

[s. 632.365]

Are there special requirements for motor vehicle glass repair?

An insurer may not require that motor vehicle glass repairs or parts be supplied by a particular vendor or at a specific location. Lists supplied by an insurer of motor vehicle repair vendors or locations which function to limit the choice of a vendor to one named on the list are prohibited.

[s. 632.37]

What is the responsibility of the sponsor of a minor who operates a motor vehicle?

Any negligence or willful misconduct of a person under the age of 18 years when operating a motor vehicle on Wisconsin highways is the responsibility of the parents where both have custody of the minor and either parent signed as sponsor on the minor's application for a driver's license. In all other cases, any such negligence or willful misconduct is the responsibility of the adult sponsor who signed the application for the minor's license. The parents or the adult sponsor are jointly and severally liable with the minor for any damages caused by the minor's negligence or willful misconduct.

[s. 343.15]

What are the minimum liability limits required of insurance policies providing motor vehicle liability coverages?

For policies newly issued and renewed on or after November 1, 2011:

- $25,000 for bodily injury or death of one person in any one accident;
- $50,000 for bodily injury or death of two or more persons in any one accident; and
- $10,000 for injury to or destruction of property of others in any one accident.

[s. 344.01(2)(d)]

Is motor vehicle liability insurance mandatory in order to operate a motor vehicle on a Wisconsin highway?

With some exceptions, as of June 1, 2010, no person may operate a motor vehicle upon a highway in Wisconsin unless the owner or operator of the vehicle has a motor vehicle liability policy in effect covering the vehicle being operated.

[s. 344.62]

Are there limits on wrongful death actions?

Yes. State law limits wrongful death actions for loss of society and companionship. Judgment for damages for pecuniary injury from wrongful death may be awarded to any person entitled to bring a wrongful death action. The additional damages limit is $350,000 or $500,000 in the case of a deceased minor.

[s. 895.04(4)]

What are the notice requirements when a certified motor vehicle liability policy is canceled or terminated?

When an insurer has certified a motor vehicle liability policy as proof of financial responsibility, the certified insurance may not be canceled or terminated until at least 10 days after a notice of cancellation or termination of the certified insurance has been filed with the Wisconsin Department of Transportation, Division of Motor Vehicles. A certified insurance policy may not be canceled or terminated by the insurer on the grounds of failure to pay a premium when due prior to the expiration of 90 days from the effective date of certification.

A newly certified policy will, on the effective date of its certification, terminate any insurance previously certified. Any certification or recertification filed by the same insurer following cancellation must be accompanied by a $3.00 fee payable by the insurer.

[s. 344.34]

What are the limitations on the insurer's "defense of noncooperation" in motor vehicle liability policies?

If a policy of automobile liability insurance provides a defense to the insurer for lack of cooperation on the part of the insured, the defense may not be used against a third person making a claim against the insurer unless there was collusion between the third person and the insured or unless the claimant was a passenger in or on the insured vehicle. If the defense may not be used against the claimant, after payment the insurer is subrogated to the insured to the extent of the payment and is entitled to reimbursement by the insured.

[s. 632.34]

LEGAL EXPENSE INSURANCE

What is legal expense insurance?

Legal expense insurance is the contractual obligation to provide specific legal services or to reimburse for specific legal expenses in consideration of specified payment for an interval of time, regardless of whether the payment is made by the beneficiary individually or by a third person for

the beneficiary. Legal expense insurance does not include the provision of, or reimbursement for, legal services incidental to other insurance coverages.

[s. Ins 22.01(5)(c)]

Are all legal expense insurance plans subject to full regulation by the commissioner?

The commissioner finds that certain plans of legal expense coverage, although they may constitute insurance plans, do not require regulation by the commissioner.

[s. Ins 22.01(1)]

What is exempt from regulation by the commissioner?

The provisions of chs. 600 to 655, Wis. Stat., do not apply to:

- any lawyer referral service operated by the Wisconsin State Bar or a local bar association;
- the furnishing of legal assistance by labor unions or other employee organizations to their members for matters relating to employment or occupation;
- the furnishing of legal assistance to members or their dependents by a church, cooperative, education institution, credit union, or organization of employees where the organization is established primarily for purposes other than to obtain insurance or to provide legal assistance or both, the organization contracts directly with a lawyer or law firm for the provision of legal services, and the administration and marketing of the legal services are conducted wholly by the organization and solely to individuals who are members of the organization; or
- employee welfare benefit plans to the extent that state laws are superseded by the Employee Retirement Income Security Act of 1974, 29 USC 1144, if evidence of exemption from state laws is shown to the commissioner.

[s. Ins 22.02]

What types of legal expense insurance plans are subject to limited regulation?

Legal expense insurance plans are subject only to limited requirements when the plans marketed comply with all the following provisions:

- the plan's legal services are limited to advice, consultation, preparation of a simple will or power of attorney or other simple, routine legal documents, and do not include representation in litigation (except those charged at predetermined or reduced rates which are not substantially below the usual charge by the same attorney for those services, but not less than 70% of the rate usually charged nonparticipants for the same services);
- the total annual cost including all fees, charges, or other considerations for one year of coverage under the plan does not exceed $200 per contract holder;
- legal services provided under the plan (other than advice, consultation, preparation of a simple will or power of attorney or other simple, routine legal documents), are charged at

predetermined or reduced rates that are not substantially below the usual charge by the same attorney for those services, but not less than 70% of the rate usually charged nonparticipants for the same services;

- a participant in the plan is not obligated to continue participation in the plan or to make further payments or to pay any fee or penalty to the plan if the participant wishes to withdraw from the plan at any time;
- a copy of the legal expense insurance contract and the form of agreement utilized under the following paragraph is filed with the commissioner; and
- all legal services are to be provided either by partners, members, or employees of the plan or by individuals who have a written agreement to provide legal services to plan participants, which agreement includes certain provisions.

[s. Ins 22.03(1)]

What plans are included as legal expense insurance plans?

Any legal expense insurance contract made by attorneys-at-law or law firms which are both promoted by mass-marketing techniques and charge a fee for the plan which is not based on an individual estimate of the nature, quantity, complexity, and amount of services to be provided each client are subject to regulation unless otherwise exempted by s. Ins 22.02, Wis. Adm. Code.

[s. Ins 22.04]

TITLE INSURANCE

May the title insurer ever charge a rate different from the title insurer's filed rate?

Yes, provided that the rate is not unfairly discriminatory [s. 628.34 (3), Wis. Stat.] and the modified rate is lower than the filed rate and the insurer keeps for at least five years after the inception of the policy:

- a record of the rate development;
- a record of the effective date of the policy, the location of the risk;
- the reason for the deviation; and
- a record of the deviated rate development.

Prior to entering into such insurance agreements, the insurer has notified the commissioner of its intention to do so identifying the contemplated rate deviation program.

[s. Ins 6.78(4)]

What are unfair practices?

Current law prohibits unfair practices in the transaction of the business of title insurance in Wisconsin. It contains a list of prohibited practices that constitute unfair marketing banned by ch.

628, Wis. Stat. The list prohibits offering free benefits, services, equipment, or space, and anticipates that the title agent will charge fees and premiums that relate to the service or insurance provided.

[ch. 628, s. Ins 3.32]

Can a title agent pay a realtor for their title referrals?

No. The rule prohibits title insurers and their agents from paying producers of title insurance and affiliates of producers of title insurance for referral of title insurance orders.

[s. Ins 3.32(4)(j)]

How are the terms "affiliate" and "affiliate producer" defined?

"Affiliate" of a person means any other person who controls, is controlled by, or is under common control with the first person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of persons manage the two corporations.

[s. 600.03(1)]

"Affiliate producer" is a title insurance term meaning any lender, real estate broker, or representative in a transaction that results in the application for title insurance. An "affiliate producer" is also any party that receives more than 40% of its title-related revenues from one title insurer, agency, or agent. An "affiliate producer" is a "producer of title insurance."

[s. Ins 3.32(3)(b)]

Who is a producer of title insurance?

A producer of title insurance means any owner or prospective owner of real or personal property; any lender or prospective lender; any agent, representative, attorney, or employee of any owner or prospective owner, or of any lender or prospective lender; or any affiliated producer.

[s. Ins 3.32(3)(c)]

May a title insurer advertise in publications distributed by lenders, real estate brokers, or attorneys?

Yes. Advertising is permitted if the consideration paid is reasonable and any title insurer may advertise.

[s. Ins 3.32(4)(l)]

WORKER'S COMPENSATION INSURANCE

What is worker's compensation?

Worker's compensation is protection mandated by state law for a worker and their dependents against injury and death occurring in the course of employment. Worker's compensation is not

health insurance and is not intended to compensate for disability other than disability caused by injury arising out of employment.

Wisconsin worker's compensation laws are administered by the Department of Workforce Development (DWD) Division of Worker's Compensation. The chief duty of the division is to ensure the prompt payment of benefits by private insurance companies and self-insured employers to workers who sustain work-related injuries or illnesses.

The purpose of worker's compensation system is to provide financial and medical benefits to the victims of "work-related" injuries and their families regardless of fault. The laws place the financial burden on the employer. This compensation is generally the exclusive remedy for the injured employee.

[ch. 102]

Who is an "employer" under the Worker's Compensation Act?

Under Wisconsin law, virtually all employers are required to have worker's compensation insurance. An employer is defined as any of the following:

- the state and each local governmental unit in this state;
- every person who at any time employs three or more employees for services performed in this state whether in one or more trades, businesses, professions, or occupations, and whether in one or more locations;
- every person who employs less than three employees, provided that the person has paid wages of $500 or more in any calendar quarter for services performed in Wisconsin. Such an employer becomes subject to the worker's compensation requirements on the 10th day of the first month of the next calendar quarter; and
- every person engaged in farming who on any 20 consecutive or nonconsecutive days during a calendar year employs six or more employees, whether in one or more locations. Such an employer must get worker's compensation insurance by the 10th day after the 20th day of employment.

[s. 102.04]

Who is an "employee" under the Worker's Compensation Act?

An employee is defined under Wisconsin law as any of the following:

- every person, including all officials, in the service of the state, or of any local governmental unit in Wisconsin;
- any peace officer during the performance of their duty;
- every person in the service of another under any contract of hire, and all helpers and assistants to employees if they are employed with the knowledge of their employer,

including minors. This does not include domestic servants, or any person whose employment is not in the course of a trade, business, profession, or occupation of an employer, unless the employer has elected to include such persons under the employer's worker's compensation coverage;

- persons who are members of volunteer fire departments or fire departments organized under Wisconsin law pertaining to firemen's associations; and
- every independent contractor who is injured while working is an employee of the person for whom they perform work unless the contractor meets all nine conditions specified in s. 102.07 (8).

[s. 102.07]

Who is covered by the Worker's Compensation Act?

- full-time and part-time employees, including family members and minors; and
- corporate officers—however, in closely held corporations, defined as a corporation with not more than 10 stockholders, no more than two officers may exclude themselves from coverage. If a closely held corporation has no more than two corporate officers and has no other employees, a worker's compensation policy is not required if both officers elect not to be subject to the Worker's Compensation Act by filing a Corporate Officer Option Notice with the Department of Workforce Development. If the corporation has other employees and/or officers, a worker's compensation insurance policy is required and the exclusion for officers must be specifically requested and made by an endorsement on the policy.

[s. 102.07, s. 102.076]

Who is not covered under worker's compensation?

Sole proprietors, partners, and members of a limited liability company are exempt from the worker's compensation statutes and coverage but may opt in by specifically requesting coverage on themselves by endorsement on the policy.

[s. 102.075]

What is the responsibility of the employer under the worker's compensation system?

An employer liable under Wisconsin law to pay worker's compensation must ensure payment of compensation by contracting for such coverage with an insurer authorized to insure such liability in Wisconsin, unless the employer is exempted by the Department of Workforce Development.

[s. 102.28]

Is there third-party liability under worker's compensation?

Filing a claim for worker's compensation against an employer or insurer for the injury or death of an employee does not affect the right of the employee, the employee's personal representative, or any

other person entitled to bring and maintain a legal action for such injury or death against a third party.

The filing of a claim against a third party for damages by reason of an injury that comes under conditions of liability does not affect the right of the injured employee or the employee's dependents to recover worker's compensation.

An employer or insurer may share in the proceeds collected in third-party suits.

[s. 102.29]

Can an employer purchase other liability insurance in addition to worker's compensation coverage?

Wisconsin law does not affect the organization of an insurer, nor the right of an employer to insure against such liability, or against the liability for compensation provided by worker's compensation, or to arrange with employees, or otherwise, for the payment of sickness, accident, or death benefits in addition to the compensation provided by worker's compensation.

[s. 102.30]

PUBLIC ADJUSTERS

What is a public adjuster?

Public adjuster means an individual who engages in adjusting services in this state and, in the case of an individual who is not a resident of this state, has registered with the commissioner under s. 629.02 (2), but does not include any of the following:

- an attorney admitted to practice in this state while acting in their professional capacity as an attorney;
- an individual who negotiates or settles claims arising under a life insurance policy, a policy of disability insurance, as defined in s. 645.675 (1) (h), or an annuity contract;
- an individual employed solely for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a public adjuster, including a photographer, estimator, private investigator, engineer, or handwriting expert;
- an individual who settles subrogation claims between insurers;
- an individual who is licensed as an intermediary under s.628.04 or 628.09 while acting in their professional capacity as an intermediary; or
- an individual who represents an insurer in negotiations for the settlement of a claim against the insurer arising out of the coverage provided by an insurance policy.

[s. 629.01]

What is a public adjusting service?

A public adjusting service means an act on behalf of an insured, in exchange for compensation, with the preparation, completion, or filing of a first−party claim, including by negotiating values, damages, or depreciation or by applying the loss circumstances to insurance policy provisions.

[s. 629.01]

Which chapter of the Wisconsin Statutes relates to the regulation of public adjusters?

Wis. Stat. ch. 629

Is registration with OCI required for public adjusters?

Wisconsin requires all non-resident public adjusters to register with OCI. Resident adjusters may register, but registration is not required for resident public adjusters. Licensure is not required, only registration. However, if a public adjuster registers in Wisconsin, the registration will appear in a database as a license for the purposes of reciprocity with other states.

[s. 629.02]

Is a public adjuster contract required to be filed with OCI?

Yes. The Wisconsin public adjuster law requires all public adjusters (resident or non-resident) to file a copy/template of their contract with OCI. A public adjuster may not perform any adjusting service for an insured prior to entering into a signed contract with the insured. The contract shall be in writing, be titled "Public Adjuster Contract," and be on a form filed with the commissioner.

[ss. 629.04 and 631.20(1m)]

Is there certain information required in a public adjuster contract?

Yes. The contract shall include all the following:

- the public adjuster's full name, state of residence, permanent principal business street address, telephone number, and, if applicable, the registration number assigned by the commissioner;
- the insured's full name, street address, insurer name, and policy number;
- a description of the loss and its location;
- the date and time the contract was signed by the public adjuster and the insured;
- an attestation by the public adjuster that they are fully bonded pursuant to state law;
- a disclosure of the compensation the public adjuster is to receive in accordance with s. 629.05;
- a provision allowing the insured to void the contract. At the insured's option, the insured may void a contract no later than five business days after the contract's execution. The insured

may void the contract by sending notice by registered or certified mail, return receipt requested, to the public adjuster at the address on the contract or by personally serving notice on the public adjuster at the place of business identified on the contract. The public adjuster shall return anything of value provided under the contract by the insured no later than 15 business days following receipt of the notice; and

- a statement that the contract shall constitute the entire agreement between the public adjuster and the insured.

[s. 629.04]

If a resident registers, will they be subject to all the compliance requirements for an out of state public adjusters?

Yes. Registering means that the resident public adjuster applies for an adjuster license and that includes taking the exam and continuing education.

[ss. 629.02, 629.03, and 629.11]

CHAPTER VII

RISK-SHARING PLANS

The commissioner may, by rule, establish mandatory risk-sharing plans for automobile, worker's compensation, and property insurance, if a demonstrated need for such plans exists. Such plans may also be set up voluntarily to meet market need. Four risk-sharing plans have been established in Wisconsin.

[s. 619.01]

What is the Wisconsin Automobile Insurance Plan?

The Wisconsin Automobile Insurance Plan (WAIP) is a risk-sharing plan which provides coverage for Wisconsin automobile owners who are unable to obtain automobile liability and physical damage coverages due to unfavorable driving records or other underwriting conditions.

The basic purpose of WAIP is:

- to make automobile liability insurance and other automobile insurance coverages available to those who cannot obtain it through the voluntary market in Wisconsin; and
- to establish a procedure for the equitable distribution of risks assigned to insurance companies.

WAIP is available to residents and nonresidents who have automobiles registered in Wisconsin.

[s. Ins 3.49(1)]

What coverage is available through WAIP?

For policies newly issued or renewed effective on or after November 1, 2011, automobile liability (including private passenger) coverage minimum limits for bodily injury are $25,000 per person and $50,000 per accident, and $10,000 for property damage. On request, coverage may be issued up to $100,000 per person and $300,000 per accident, and up to $100,000 for property damage. Uninsured motorist coverage is limited to $25,000 per person and $50,000 per accident and is mandatory. Medical payments are available in amounts from $1,000 to $5,000 per person.

Comprehensive and collision coverages are available on private passenger automobiles only, with deductibles of $100, $250 or $500.

May insurers assess a surcharge under WAIP?

If the hazard of a risk is greater than that contemplated by the rate normally available under WAIP, the insurer may ask the commissioner for a rate increase for that particular risk. Any rate increase approved by the commissioner includes any applicable additional charges.

What is the responsibility of an agent under WAIP?

The agent must determine that the applicant, within 60 days prior to the date of application, made an effort to obtain automobile insurance in Wisconsin through the voluntary market and that the applicant was unable to obtain such insurance.

The agent must make sure that the applicant has properly completed the WAIP application and that the appropriate deposit premium is submitted with the application. The agent is deemed to be the agent of the applicant and not an agent of WAIP and/or the insurance company assigned to service the applicant.

It is the duty of the agent to determine if the particular risk is eligible for coverage under WAIP. The intermediary should also obtain the applicant's driving record for the past three years from the Wisconsin Department of Transportation, Division of Motor Vehicles.

The agent must send to WAIP two copies of the application and the applicant's driving record along with the required fee. A deposit fee should be paid by check payable to the Wisconsin Automobile Insurance Plan. The check and the above information should be sent to:

Wisconsin Automobile Insurance Plan
PO Box 3080
Milwaukee, WI 53201-3080
1-800-827-5964
www.waip.org

What is the Wisconsin Worker's Compensation Insurance Pool?

The Wisconsin Worker's Compensation Insurance Pool (Pool) is a risk-sharing plan under Wisconsin law. Its purpose is to provide worker's compensation insurance to any employer who is unable to obtain such insurance in the private market due to unfavorable loss history or other underwriting conditions. The rates charged in the Pool are the same uniform rates charged by all insurers in the private market.

Who administers the Pool?

The Wisconsin Compensation Rating Bureau (WCRB) acts as administrator and trustee of the Pool. The WCRB is a licensed rate service organization for worker's compensation insurance in Wisconsin. It was created by Wisconsin law and is regulated by the Office of the Commissioner of Insurance.

What is the responsibility of an agent under the Pool?

It is the duty of the agent to assist the employer in meeting their obligations under the Wisconsin worker's compensation law. If worker's compensation insurance coverage cannot be obtained in the private market, coverage can be sought through the Pool. Agents must assist applicants who need to apply for Pool coverage, submit applications that meet the requirements, and follow the rules and procedures of the Pool.

The agent should make sure that the application has been properly completed and that all supplementary information required by the Pool is attached, including but not limited to payroll verification and the appropriate deposit premium.

The agent is deemed to be the agent of the applicant and not an agent of the Pool and/or the insurance company assigned to service the risk. The agent *cannot* bind coverage in the Pool. Coverage in the Pool cannot be backdated.

The agent should read and be familiar with the rules of the Pool as outlined in the Wisconsin Worker's Compensation Insurance Pool Handbook, which is available for public viewing on the WCRB's website.

Agents needing to place coverage through the Pool should contact the WCRB at:

Wisconsin Compensation Rating Bureau
P.O. Box 3080
Milwaukee, WI 53201-3080
(262) 796-4540
www.wcrb.org

[s. 619.01(3)]

What is the Wisconsin Insurance Plan?

The Wisconsin Insurance Plan (WIP) is a nonprofit unincorporated plan to provide basic property insurance, risk sharing, and assistance to Wisconsin residents in securing such insurance. All property insurance companies in Wisconsin participate in WIP and the plan is supervised by the Office of the Commissioner of Insurance.

WIP assists qualified property owners in obtaining actual cash value homeowner's coverage, fire, extended coverage, vandalism and malicious mischief, and burglary and crime insurance if they have difficulty in securing sufficient insurance protection in the voluntary market. Manufacturers, farm properties, and automobiles are not eligible.

Application forms are available from all insurance intermediaries, and brokers, or directly from WIP. Each Wisconsin insurer must require its licensed insurance intermediaries to cooperate fully in accomplishing the intent and purpose of WIP.

A free inspection service determines if the applicant's property meets the minimum insurance requirements and is physically sound. If the applicant's property is deemed to be insurable, a one-year policy is issued after payment of premium.

The maximum limits of coverage for basic property insurance on fire, extended coverage, and builder's risk endorsements for loss or damage are $350,000 on the dwelling, $175,000 on personal property for any habitational risk at one location and $500,000 on any other eligible property at one location.

The maximum limits for the Plan's modified homeowner's coverage are $350,000 on the dwelling, with the customary percentage limits for other structures, personal property, and loss of use. The maximum limit for personal liability is $100,000 and $1,000 medical payments to others for any risk at one location.

[ch. 619, s. Ins 4.10(4)]

What is the responsibility of an agent under WIP?

The agent must assist applicants who need to apply for coverage, submit applications that meet the requirements, and follow the rules and procedures of the Plan. The agent may not act as an agent for the Plan, bind coverage, alter, or change the Plan's policies, settle claims, act on behalf of the Plan, or commit the Plan to any course of action.

[s. 619.01, s. Ins 4.10 (19)]

The address of WIP is:

Wisconsin Insurance Plan
2115 10th Ave, Suite 201
South Milwaukee, WI 53172
(414) 291-5353
www.wisinsplan.com

What is the Wisconsin Health Care Liability Insurance Plan (WHCLIP)?

The commissioner has established a health care liability plan to provide coverage for medical professionals licensed under Wisconsin law. Those eligible include medical or osteopathic physicians, podiatrists, nurse anesthetists or nurse midwives, nurse practitioners, hospitals, and various public medical entities. Members of WHCLIP include all insurers authorized in Wisconsin to insure against liability resulting from personal injury or death, except that town mutuals are not included. In case WHCLIP loses money, the members are assessed.

Wisconsin Health Care Liability Insurance Plan
500 Third Street, Suite 700
Wausau, WI 54403
(715) 841-1680
https://wausaumms.com/

[ch. 619, s. Ins 17.25]