Form Filing Checklist – Individual & Group Medicare Select

TOIs: MS07I.012 & MS07G.012 - Medicare Select
MS07I.008, MS07I.009, MS07G.008 & MS07G.009 - Select Cost-Sharing
MS07I.006 & MS07G.006 - Select High Deductible

DISCLAIMER

The form filing checklists are intended only as guides for submitting various policy forms to the Office of the Commissioner of Insurance (OCI). The checklists are summaries, and are not intended as an OCI directive nor to interpret or address technical legal questions. Use of these checklists does not guarantee automatic approval of policy form submissions. Although efforts have been made to ensure that the checklists are current and accurate, information is subject to change on a regular basis without prior notice.

The cites in the second column reference Wisconsin statutes unless they begin with "Ins", which indicates an administrative code [regulation]

General Filing Requirements	Reference	Comments
Filing Description (SERFF)	Ins 6.05(4)(a)3a	Include a brief explanation of use and intent of the form filing, or that identifies amendments to prior policy form filing
Certificate of Compliance and Readability	Ins 6.05(4)(a)2 Ins 6.05 Appendix A Ins 6.07(4)(a)1	Submit certificate of compliance and readability substantially identical to Appendix A, s. Ins 6.05, Wis. Adm. Code, signed by an officer of the insurer which attests that the form meets the minimum Flesch score of 50.
Statement of Variability	Ins 6.05(4)(a)5	If a form contains variable material or language, a written description identifying the range of the variable material or language.
Text of Policy	Ins 3.39(4t)(a)11	Plainly printed in the size of which is uniform and not less than 10-point type.
Authorization to File on Insurers Behalf	631.20(1)(c) & Ins 6.05(3)	Medicare supplement policies must be filed and approved prior to use.
Actuarial Memorandum	Ins 3.39(4t)(e)	Actuarial demonstration that expected claims in relationship to premiums will comply with loss ratio standards. Memorandum should be specific to Wisconsin business.
Loss Ratio	Ins 3.39(4t)(e) & (16)(d)	65% for individual policies, 75% for group policies.
Commission Limitations	Ins 3.39(21)	Agent Commission Schedules.
Commission for Guaranteed Issue	Ins 3.39(21)(f)	Commission or compensation for guaranteed issue cannot be calculated on a different basis than commission for open enrollment.
Commission for Under-65 Sales	Ins 3.39(21)(e)	Commission or compensation for under age 65 sales cannot be less than commission for age 65-69 sales.
Rate Filing	Ins 3.39(4t)(e) & (16)(e)	May not use any premium rates for an individual or group Medicare select policy or certificate unless the rates, rating schedule, and supporting documentation have been filed.

Policy Form Requirements		
Face Page	**Reference**	**Comments**
Corporate Legal Name	631.20(2)(c), 631.31 & 631.64	Policy shall conspicuously display the name of the insurer on the first page and full address of its home office somewhere in policy.
Medicare Select Designation	Ins 3.39(30t)(i)8 or (r)1 or (s)1	Identifies policy as "Medicare Select Policy" or "Medicare Select Cost-Sharing Plan" in 18-point type and in close conjunction to caption.
Caption	Ins 3.39(30t) (i)9	Caption may include reference to policy or certificate, printed in 12-point type and in close conjunction to designation.
Right to Return Policy	Ins 3.13(2)(j)3 Ins 3.39(22)(e)	30 day "free look" period; right to return and have premiums refunded.
Guaranteed Renewable for Life	Ins 3.13(2)(c), (d) & (e), Ins 3.39(4t)(a)5	Shall disclose that the policy is guaranteed renewable for life.
Renewability	Ins 3.39(22)(a)	Shall include right to change premium and any automatic premium change due to age, and insurer's right to change premiums.
Preexisting Condition	Ins3.39 (4t)(a)2, (8)(a)3 & (c) & (22)(d)	If applies must be on face page of policy and limited to 6 months.
Important Notice Concerning Statements in the Application for Your Insurance	Ins 3.28(5)(d)	Notice required on front of policy, concerning statements made in the application [Individual policies & group certificates].
Term of Coverage	Ins 3.39(4t)(a)7	Clearly states the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed. Term is no less than 3 months.
Claim Methodology	Ins 3.39(6) & 3.60(5)	**Applies to mandated benefits**. Notice on first page of policy stating that insurer settles claim based on the usual, customary and reasonable charge as determined by the issuer for coverages.
Schedule of Benefits		
Term of Policy	Ins 3.39(4t)(a)7	Term is no less than 3 months. Include on face page or on schedule page.
List of Coverages, Annual Premiums & Modal Premium	Ins 3.39(4t)(d)	Include on the schedule of benefits page or the first page of the policy or certificate in format shown in sub. (10) of Appendix 2t.
General Contract		
Entire Contract	631.11	The policy shall state the forms or documents that constitute the entire contract.
Fraternal	614.19(3)(b)	Shall contain in each certificate of insurance it issues, a provision, that if the financial position of the fraternal becomes impaired, the board of directors or the supreme governing body may, on an equitable basis, apportion the deficiency among the members of the fraternal, the insured employees or the owners, or any combination thereof.
Incontestability	632.76	Policy is incontestable after 2 years, except for fraudulent misrepresentation.
Premium Increase	631.36(5)	60-day notice of premium increases greater than 25%.
Grace Period	632.78	Required grace period (7 day for weekly premium, 10 days for monthly, 31 days for all other policies).

Suspension of Coverage	Ins 3.39(4t)(a)18	Provision for up to 24 months suspension if policyholder becomes eligible for medical assistance.
Midterm Cancellation	Ins 3.39(4t)(a)15	Provision for midterm cancellation and pro rata refund of premium.
Ticket to Work	Ins 3.39(4t)(a)20	Provision for indefinite suspension if policyholder becomes eligible for group coverage.
Termination	Ins 3.39(4t)(a)6	Termination without prejudice to continuous loss.
Automatic Benefit Change	Ins 3.39(4t)(a)8	Statement that benefits change automatically as Medicare deductibles and copayments/coinsurances change.
Reinstatement Provision	632.74	Required reinstatement provision if policy terminates for nonpayment of premium [waiting periods for illness not allowed] .
Notice and Proof of Loss	631.81(1)	Notice or proof of loss is furnished as soon as reasonably possible & within one year of time required by policy.
Limitation of Actions	631.83(1)(b)	Action must be commenced within 3 years of when proof of loss was required to be furnished.
Subrogation	Case Law	Wisconsin case law (see Rimes v. State Farm Mutual Automobile Insurance Company, 106 Wis. 2d 263) has established that the insurer's recovery rights are limited to the amount remaining after the insured has been "made whole." There must be a positive statement to this effect in the policy.
Arbitration	631.20 631.85	An insurance policy may contain provision for independent appraisal and compulsory arbitration, subject to the provisions of 631.20. Form submissions containing such provisions will be deemed approved pursuant to s. 631.20(1)(a).
Mandatory Arbitration Prohibited	631.83(3)(c)	Policy may not provide that no action may be brought.
Grievance Procedure	632.83, Ins 3.39(4t)(a)12 & (30t)(k) Ins 18.03 (1)(a) & (3)	Grievance procedure **applies to Wisconsin mandated benefits.** May not require insured to exhaust grievance process prior to filing legal action.
Independent Review procedure (IRO)	632.835, Ins 18.12	IRO procedure **applies to Wisconsin mandated benefits** BULLETIN, April 26, 2002 http://oci.wi.gov/bulletin/0402iro.htm Bulletin, July 24, 2009 http://oci.wi.gov/bulletin/0709act28.htm
Standing Referral	609.22(4)	If policy requires referral.
Second Opinion	609.22(5)	Positive statement regarding 2nd opinion from participating provider.
Continuity of Care	609.24	Provision regarding continuity of care for provider that has left the plan.
Description of Network Providers	Ins 3.39(30t)(i) 3	Description of restricted network provisions, including coinsurance and deductibles when non-network providers are utilized.
Limitations on Referrals	Ins 3.39 (30t)(i)5.	A description of limitations on referrals to restricted network providers and to other providers.
Other Purchase Rights	Ins 3.39(30t)(i)6	Description of rights to purchase any other Medicare supplement policy otherwise offered by the insurer.
Quality Assurance Program	Ins 3.39(30t)(i)7	A description of the quality assurance program and grievance procedure.
Continuation	Ins 3.39 (30t)(n)	Continuation of coverage in the event the Secretary of DHHS determines that Medicare select policies issued should be discontinued.

Exclusions and Limitations		
Permitted Exclusions and Limitations	Ins 3.39(8)	Policy shall exclude expenses covered by Medicare and may contain a pre-existing waiting period, territorial limitations if HMO, etc.
No Limitations for Named Conditions	Ins 3.39(4t)(a) 14 & (8)(c)	Policy may not contain limitations for specifically named conditions after the effective date of the policy.
Preexisting Condition Exclusion	Ins 3.28(6)(a), 3.39(4t)(a)2 &(8)(c)	Policy may contain exclusion but must be limited to 6 months. If disclosed on application, pre-existence defense cannot be used
Duplication	Ins 3.39(4t)(a)17 & (8)(a)1	Provision that policy does not duplicate any Medicare benefit.
Coordination of Benefits	Ins 3.39(8)(a)	Policy must exclude expenses paid by Medicare; may limit benefits if insured has other insurance; no limitations more restrictive than Medicare.
Territorial Limitations	Ins 3.39(8) (a) 4	May include if policy is issued by HMO.
Military Service Related Conditions	Ins 3.39(8) (a) 5	May exclude if treatment provided by military or veterans hospital or facility contracted for or operated by national government or agency.
Exclusions and Limitations Contained in Medicare	Ins 3.39(8)(e)	May include exclusions and limitations which are not otherwise prohibited and are not more restrictive than those contained in Medicare.
Beneficiary Without Part B Coverage	Ins 3.39(8)(b)	May exclude coverage of Medicare Part B covered expenses if insured chooses not to enroll in Medicare Part B.
Managed Care Restrictions	Ins 9.38(2)	Restrictions on the selection of primary or referral providers; Restrictions on changing providers during the contract period; Out-of-pocket costs including copayments and deductibles.
Definitions		
Medically Necessary		Include definition if used to determine coverage for mandated benefits
Medicare Eligible Expenses	Ins 3.39 (3)(s)	Covered by Medicare Parts A and B and recognized as medically necessary and reasonable by Medicare.
Medicare	Ins 3.39(3)(q)	Definition of Medicare required.
Preexisting Condition	Ins 3.39(4t)(a)2	If applies, policy must include definition.
Managed Care Definitions	609.01, Ins 9.01 & 9.38(1)	Geographical service area, emergency care, urgent care, out-of-area service, dependent and primary providers.
Eligibility		
Medicare Eligible Persons	Ins 3.39(3)(t)	"Medicare eligible person" mean a person who qualifies for Medicare.
Newly Eligible	Ins 3.39(3)(ws)	Medicare eligible person who attains age 65 on or after January 1, 2020, or by reason of entitlement to benefits under Medicare Part A pursuant to Section 226(b) or 226A of the social security act, or who is deemed to be eligible for benefits under Section 226(a) of the social security act on or after January 1, 2020.
Guarantee Issue	Ins 3.39(34)	Definition guaranteed issue for eligible persons.
Open Enrollment	Ins 3.39(3r)(a)	6 month open enrollment period; special enrollment period for under age 65.
Application Acceptance	Ins 3.39(25)d	May not accept an application from an insured more than 3 months prior to the insured becoming eligible.

Benefit Description for Medicare Select		**Applies to Medicare Select & High Deductible, not Medicare Select Cost-Sharing**
High-Deductible Medicare Supplement Insurance	Ins 3.39(5m)(k) 3 & 4	**Not available to persons first eligible for Medicare on or after January 1, 2020**. High deductible shall consist of out-of-pocket expenses, other than premiums, and shall be in addition to any other specific benefit deductibles. Annual high deductible shall be adjusted annually to reflect the change in the CPI. (**Includes coverage of Medicare Part B medical deductible**.)
High-Deductible Medicare Supplement Insurance	Ins 3.39(5t)(k) 3 & 4	High deductible shall consist of out-of-pocket expenses, other than premiums, and shall be in addition to any other specific benefit deductibles. Annual high deductible shall be adjusted annually to reflect the change in the CPI. (**Does not include coverage of Medicare Part B medical deductible**)
Basic Medicare Select Coverage	Ins 3.39 (5t)(d) & (30t)(p)1	Basic benefits covered by Medicare supplement policies. For Medicare Select Cost-Sharing plans see Benefit Description for Cost-Sharing Plans section below.
Part A Deductible	Ins 3.39(5t)(e)1 & (30t)(p)2	Coverage for 100% of the Medicare Part A hospital deductible.
Part B Deductible	Ins 3.39(5m)(e)4 & (30m)(p)4	**Not available to persons first eligible for Medicare on or after January 1, 2020**. Coverage for 100% of the Medicare Part B medical deductible.
Home Health Care	Ins 3.39(5t)(e)3 & (30t)(p)3	Coverage for home health care for an aggregate of 365 visits per policy or certificate year.
Preventive Health Care Services	Ins 3.39(5t)(d)15 & (30t)(p)5	Coverage for preventive health care services.
Emergency Care Outside of the United States	Ins 3.39(5t)(e)7 & (30t)(p)6	Coverage for emergency care obtained outside of the United States.
New or Innovative Benefits	Ins 3.39(17)	Issuer may offer benefits that are appropriate to Medicare supplement that are new or innovative, are not otherwise available and are cost effective.
Emergency Services and Urgent Care	632.85	Description of coverage, and no restrictions on covered services by non-plan providers for emergency services
Experimental Treatment	632.855	Limitation on coverage of experimental treatment must state who is authorized to make decision.
No Prior Authorization for Emergency Room Use	632.85	Policies cannot require prior authorization for emergency room use.
Services Not Available by Network Providers	Ins 3.39(30t)(h)	Provide full coverage for services not available through network providers.
Managed Care Requirements	Ins 3.39(30t)(t)	Medicare select policies shall comply with subchs I & III of ch. Ins 9.
Benefit Description for Select Cost-Sharing Plans		**The Following Section Applies to Medicare Select Cost-Sharing Plans**
Part A Hospital Amount	Ins 3.39(30t)(r)2 & (s)2.	Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each day used from the 61st through the 90th day in any Medicare benefit period.

Lifetime Inpatient Reserve Days	Ins 3.39(30t)(r)3 & (s)3.	Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.
Exhaustion of Medicare Hospital Coverage	Ins 3.39(30t)(r)4 & (s)4	Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization.
Medicare Part A Deductible	Ins 3.39(30t)(r)5 & (s)5	Covers [25% or 50%] of Medicare Part A inpatient hospital deductible per benefit period until out-of-pocket limitation is met.
Skilled Nursing Facility Care	Ins 3.39(30t)(r)6& (s)6	Covers [25% or 50%] of coinsurance for 21st through 100th day in Medicare benefit period for post-hospital skilled nursing facility care under Part A until out-of-pocket limitation is met.
Hospice Care	Ins 3.39(30t)(r)7 & (s)7	Covers of [25% or 50%] of cost sharing for Medicare Part A eligible expenses and respite care until out-of-pocket limitation is met.
First 3 Pints of Blood	Ins 3.39(30t)(r)8 & (s)8	Covers [25% or 50%] under Medicare Part A or B of first 3 pints of blood.
Medicare Part B Deductible	Ins 3.39(30t)(r)9 & (s)9	Covers [25% or 50%] of cost sharing under Medicare Part B after policyholder pays Part B deductible until out-of-pocket limitation is met.
Preventive Services	Ins 3.39(30t)(r) 11 & (s) 11	Covers 100% of cost sharing for Medicare Part B preventive services after policyholder pays Part B deductible.
Out-of-Pocket Limitation	Ins 3.39(30t)(r) 12 & (s)12	Covers 100% of cost sharing under Medicare Parts A and B for balance of calendar year after individual reached out-of-pocket limitation.
Wisconsin Mandated Benefits		
Disclosure of Mandated Benefits	Ins 9.38(3)	Clear disclosure of all benefit mandates outlined in Wisconsin statutes.
Claim Methodology	Ins 3.39(6) & (30t)(p)1 &2, (r) 10 and (s) 10	**Applies to Wisconsin mandated benefits** for home care, chiropractic services and treatment of diabetes.
Mandated Coverages under 25% and 50% Cost-Sharing Plans	Ins 3.39(30t)(r) 10 & (s)10	Covers 100% of cost sharing for Wisconsin mandated benefits after policyholder pays Part A and B deductible and meets the out-of-pocket limitation is met. Those mandated benefits include: inpatient psychiatric hospital care; home health care; skilled nursing care; kidney disease treatment; chiropractic services; diabetic coverage; dental anesthetics and charges; and breast reconstruction.
Medicare Select Insurance-High Deductible Plans	Ins 3.39 (5t) (k)2	Covers 100% of cost sharing for Wisconsin mandated benefits after payment of the high-deductible. Those mandated benefits include: inpatient psychiatric hospital care; home health care; skilled nursing care; kidney disease treatment; chiropractic services; diabetic coverage; dental anesthetics and charges; and breast reconstruction.
Nurse Practitioner	632.87(5)	Coverage for papanicolaou test, pelvic exams, and associated laboratory fees performed by a nurse practitioner, if these services are covered when performed by a licensed physician.

Home Health Care	632.895 (2) Ins 3.39(5t)(d)6	Minimum of 40 home care visits per contract year Applies to cost-sharing plans.
Skilled Nursing Care	632.895(3) Ins 3.39(5t)(d)7	30 days per skilled nursing home confinement
Kidney Disease Treatment	632.895(4) Ins 3.39(5t)(d)76	Minimum of $30,000 annual kidney disease benefit (i.e., dialysis, transplantation, donor related services)
Mental Illness	632.89, Ins 3.39(5t)(d)8	Coverage for alcoholism, drug abuse, and mental/nervous disorders (Group policies only).
Chiropractic Services	632.87(3) Ins 3.39(5t)(d)9	Coverage of services received from a chiropractor
Evaluations Relating to Chiropractic Treatment	632.87(3)(b)1	Evaluation by a licensed chiropractor or a peer review committee that includes a licensed chiropractor regardless of Medicare's claim determination.
Diabetic Coverage	632.895(6) Ins 3.39(5t)(d)14	Policies that cover diabetes must cover installation and use of infusion pump, all other equipment and supplies for diabetes, including non-prescription insulin or any non-prescription equipment and supplies for treatment of diabetes and costs for test strips and lancet. Does not cover any outpatient prescription medications.
Facility Charges and Anesthetics for Certain Dental Care	632.895(12) Ins 3.39(5t)(d)16	Coverage of hospital or ambulatory surgery center charges and anesthetics provided in conjunction with dental care for individual with disability, or individual with medical condition hospitalization or anesthesia for dental care. Applies to cost-sharing plans.
Breast Reconstruction	632.895(13) Ins 3.39(5t)(d)17	Policies that cover a mastectomy shall provide coverage or breast reconstruction of the affected tissue incident to a mastectomy.
Cancer Clinical Trial	632.87(6)	No policy or certificate may exclude coverage for the cost of any routine patient care that is administered to an insured in a cancer clinical trial satisfying the criteria that would be covered under the policy or certificate if the insured were not enrolled in a cancer clinical trial.
Permissible Optional Riders		
Permissible Additional Coverage	Ins 3.39(5t)(e)	Permissible additional coverage may only be added as separate rider.
50% of Part A Deductible	Ins 3.39(5t)(e)2 & (30t)(q)1	Coverage for 50% of the Medicare Part A hospital deductible with no out-of-pocket maximum.
100% of Part B Deductible	Ins 3.39(5m)(e)5 & (30m)(q)2	**Not available to persons first eligible for Medicare on or after January 1, 2020**. Coverage for 100% of the Medicare Part B medical deductible subject to copayment or coinsurance.
Outline of Coverage	**Reference**	**Comments**
Readability	Ins 3.39(4t)(b)4	The designation in24 point type, and caption in 18 point type.
Format	Ins 3.39 (30t)(i)1.	Substantially the same format as Appendix 2t and 5t.
Title/Designation	Ins 3.39(30t)(i)8	Medicare Select Insurance or Medicare Select [25% or 50%] Cost-Sharing Plan on first page printed in bold print in 24-point type.
Caption	Ins 3.39 (30t)(i)8. and (r)1. & (s)1.	Printed in bold print in 18-point.
Summary of Coverage	Ins 3.39(4t)(b)7 Appendix 2t & 5t	Listing of required and optional coverages & annual premiums.

		Appendix 2t - Outline of Medicare Select Insurance or Medicare Select insurance – high deductible plan; Appendix 5t – Outline of Medicare Select 25% or 50% Cost-Sharing Plans
Limitations & Exclusions	Appendix 2t(4)	Must be listed under the caption "LIMITATIONS AND EXCLUSIONS" if benefits not provided.
Limitations & Exclusions Nursing Home Care	Appendix 2t(4)(a)	Beyond what is covered by Medicare and the 30-day skilled nursing mandated by 632.895(3), Wis. Stat.
Limitations & Exclusions Home Health Care	Appendix 2t(4)(b)	Above the number of visits covered by Medicare.
Limitations & Exclusions Charges Above Medicare's	Appendix 2t(4)(c)	Physician charges above Medicare's approved charge.
Limitations & Exclusions Outpatient Prescription Drugs	Appendix 2t(4)(d)	Outpatient prescription drugs.
Limitations & Exclusions Care Outside U.S.A.	Appendix 2t(4)(e)	Most care received outside of U.S.A.
Limitations & Exclusions Miscellaneous Stated Services Unless Eligible Under Medicare	Appendix 2t(4)(f)	Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.
Limitations & Exclusions Emergency & Urgent Care Coverage	Appendix 2t(4)(g)	Coverage for emergency care anywhere or for care received outside the service are if this care is treated differently than other covered benefits.
Limitations & Exclusions Preexisting Conditions	Appendix 2t(4)(h)	Waiting period for pre-existing conditions.
Limitations & Exclusions Choice of Providers	Appendix 2t(4)(i)	Limitations on the choice of providers or the geographical area serviced.
Limitations & Exclusions Usual & Customary	Appendix 2t(4)(j)	Define and explain usual, customary, and reasonable limitations.
Conspicuous Statements	Appendix 2t(5)	Conspicuous statement with reference to Medicare Handbook.
Renewability or Continuation of Coverage	Appendix 2t(6)	Description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premiums.
Out-Of-Area Claims	Appendix 2t(7)	Information on how to file a claim for services received from non-participating providers because of an emergency.
Restrictions of Choice	Appendix 2t(8)	If there are restrictions on the choice of providers, a list of providers available to enrollees shall be included with the outline.
Grievance Process	Appendix 2t(9)	**Applies to Wisconsin mandated benefits.** The definition of a grievance as stated in s. Ins 18.01 (4).

Application/ Enrollment Form	Reference	Comments
Acknowledgement	Ins 3.39(4t)(b)1	Requires written acknowledgement of receipt of outline.
Application Statements	Ins 3.39(23)(a)	Statements in application or supplementary form signed by the applicant and agent.
Application Questions	Ins 3.39(23)(a)	Questions in application or supplementary form signed by the applicant and agent.
Open Enrollment	Ins 3.39(23)(e)	Statement that health questions, including height & weight and any tobacco related question, should not be answered if the applicant is in the open-enrollment period.
Guaranteed Issue	Ins 3.39(23)(e)	Statement that health questions, including height & weight and any tobacco related question, should not be answered if the applicant applying during a guaranteed issue period.
Treatment History	631.20	"Planning to have treatment" language is misleading and obscure.
Genetic Testing	631.89, 632.748 & Ins 3.39(36)	May not deny or condition the issuance or effectiveness of policy or certificate on the basis of genetic information.
AIDS/HIV Questions	631.90, Ins 3.53(4)	Disclose that reporting of HIV test results limited to FDA-licensed test & consumer need not report results of tests conducted at anonymous counseling & testing site or through use of home test kit.
AIDS/HIV Disclosure	631.90 Ins 3.53	Disclose that AIDS/ARC must be diagnosed and/or treated by a member of the medical profession.
Personal Medical Information Disclosure Authorization	610.70(2)	If form authorizes disclosure of personal medical information, specific information must be included in disclosure authorization.
Other	**Reference**	**Comments**
Replacement Form	Ins 3.39 Appendix 7	Notice to be filed as shown in Appendix 7
Application or Service Fee	Ins 3.39(4t)(e)	Allowed if included in actuarial memorandum.
Electronic Signature	Ins 3.39(18)	Verification of the enrollment information shall be provided in writing to the applicant with delivery of the policy.
Application Form Available on the Internet		Internet applications must be filed unless the online view is identical to paper application.
Notice of Right to File a Complaint	631.28, Ins 6.85 (4)	Notice described under Appendix 1 or 2, s. Ins 6.85, Wis. Adm. Code.