

Clearinghouse Rule 10-068

STATE OF WISCONSIN

OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

★★★ NOTICE OF RULEMAKING HEARING ★★★

NOTICE IS HEREBY GIVEN that pursuant to the authority granted under s. 601.41(3), Stats., and the procedures set forth in under s. 227.18, Stats., OCI will hold a public hearing to consider the adoption of the attached proposed rulemaking order creating s. Ins 3.33, Wis. Adm. Code, relating to uniform questions and format for individual health insurance and affecting small business.

**HEARING INFORMATION**

**Date: July 22, 2010**

**Time: 1:00 p.m., or as soon thereafter as the matter may be reached**

**Place: OCI, Room 227, 125 South Webster St 2<sup>nd</sup> Floor, Madison, WI**

Written comments can be mailed to:

Julie E. Walsh  
Legal Unit - OCI Rule Comment for Rule Ins 333  
Office of the Commissioner of Insurance  
PO Box 7873  
Madison WI 53707-7873

Written comments can be hand delivered to:

Julie E. Walsh  
Legal Unit - OCI Rule Comment for Rule Ins 333  
Office of the Commissioner of Insurance  
125 South Webster St – 2<sup>nd</sup> Floor  
Madison WI 53703-3474

Comments can be emailed to:

Julie E. Walsh  
julie.walsh@wisconsin.gov

Comments submitted through the Wisconsin Administrative Rule Web site at: <http://adminrules.wisconsin.gov> on the proposed rule will be considered.

The deadline for submitting comments is 4:00 p.m. on the 14<sup>th</sup> day after the date for the hearing stated in this Notice of Hearing.

**SUMMARY OF PROPOSED RULE & FISCAL ESTIMATE**

For a summary of the rule see the analysis contained in the attached proposed rulemaking order. There will be no state or local government fiscal effect. The full text of the proposed changes, a summary of the changes and the fiscal estimate are attached to this Notice of Hearing.

## **INITIAL REGULATORY FLEXIBILITY ANALYSIS**

Notice is hereby further given that pursuant to s. 227.114, Stats., the proposed rule may have an effect on small businesses. The initial regulatory flexibility analysis is as follows:

- a. Types of small businesses affected:  
Insurance agents and intermediaries.
- b. Description of reporting and bookkeeping procedures required:  
None. No additional bookkeeping or reporting requirements other than are currently required.
- c. Description of professional skills required:  
None. No other professional skills other than are currently required.

## **OCI SMALL BUSINESS REGULATORY COORDINATOR**

The OCI small business coordinator is Eileen Mallow and may be reached at phone number (608) 266-7843 or at email address [eileen.mallow@wisconsin.gov](mailto:eileen.mallow@wisconsin.gov)

## **CONTACT PERSON**

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the OCI internet Web site at <http://oci.wi.gov/ocirules.htm> or by contacting Inger Williams, Public Information and Communications, OCI, at: [inger.williams@wisconsin.gov](mailto:inger.williams@wisconsin.gov), (608) 264-8110, 125 South Webster Street – 2<sup>nd</sup> Floor, Madison WI or PO Box 7873, Madison WI 53707-7873.

## **ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE**

To create s. Ins 3.33, Wis. Adm. Code, relating to uniform questions and format for individual health insurance.

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### **ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)**

#### **1. Statutes interpreted:**

ss. 600.01, 628.34 (12), 601.41 (10), Stats.

#### **2. Statutory authority:**

ss. 601.41 (3), 601.41 (10), Stats.

#### **3. Explanation of the OCI's authority to promulgate the proposed rule under these statutes:**

In accordance with s. 601.41 (10), Stats., the commissioner is required to prescribe by rule uniform questions and format of an application that is to be exclusively used by insurers authorized to offer individual major medical health insurance coverage. Further the commissioner has rule-making authority pursuant to s. 601.41 (3), Stats.

#### **4. Related Statutes or rules:**

Section 601.41 (8), Stats., authorized the commissioner to develop a uniform application for health insurance to be used in the small employer market. Section Ins 8.49, Wis. Adm. Code implemented the requirement for development of the uniform application for small employers. The commissioner used portions of the small employer application that is applicable to the individual health insurance application.

#### **5. The plain language analysis and summary of the proposed rule:**

The proposed rule was developed with the assistance of an advisory council charged with developing the uniform application questions and format to be used exclusively in the individual major medical health insurance market. The advisory council met six times between October 2009 and June 2010. The council members included intermediaries, public members, consumer advocates and representatives from the insurance industry.

As charged, the council recommended the proposed uniform application questions and format after reviewing applications used in the state for individual major medical health insurance and the model utilized by the State of Oregon.

The proposed rule requires insurers to develop policies and procedures to implement the new individual uniform application, restricts modifications, prescribes how the individual uniform application can be used when completed using internet access to the insurer or when the application is completed via telephone. The proposed rule prohibits insurers from automatically completing portion in the electronic version based on responses to various questions but does allow the insurer to rearrange the sequence as pull-down questions provided the printed form is in the required format as contained in Appendix 1.

Appendix 1 is the individual uniform application that once applicable, contains the only questions and format that can be used by insurers offering individual major medical health insurance.

Insurers will be permitted to add as separate forms that describe additional terms of the policy such as coinsurance, copayment and deductibles, payment mode, network selection. Additionally insurers will be permitted to add as a separate form the authorizations necessary to be compliant with Health Insurance Portability Accountability Act of 1996 (HIPAA) P.L. 104-191.

**6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

There is no existing or proposed federal regulation related to uniform questions and format of an application for individual health insurance. Recently, the federal government passed P.L. 111-148 and P.L. 111-152, federal health care reform, that will place restrictions on individual health insurance products but the laws do not prescribe uniform questions and format for individual health insurance.

**7. Comparison of similar rules in adjacent states as found by OCI:**

**Iowa:** None as to the uniform questions and format for individual health insurance.

**Illinois:** Recently enacted Public Act 95-857, requiring the development and use of uniform health applications for small group and individual health insurance. The applications are to be used beginning January 1, 2011. The applications are still being developed by the state.

**Minnesota:** None as to the uniform questions and format for individual health insurance.

**Michigan:** None as to the uniform questions and format for individual health insurance.

**8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

The commissioner in working with the advisory council sought the greatest common factor among insurers as to their current application and underwriting process to minimize changes that insurers will need to make to their underwriting process.

**9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

There are no insurers that offer health insurance that qualify as small businesses in accordance with s. 227.114 (1), Wis. Stat. Intermediaries that solicit individual health insurance will be required to use the new form but since it is available at no cost from the office, the effect will be minimal.

**10. If these changes may have a significant fiscal effect on the private sector, the anticipated costs to be incurred by private sector in complying with the rule:**

There will be no significant fiscal effect on the private sector as the proposed rules will assist individuals by utilizing one form when applying for individual major medical health insurance.

**11. Effect on Small Business:**

This rule will necessitate the use of the uniform questions and format for application for individual health insurance; however the effect is not significant.

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**The proposed rule changes are:**

**SECTION 1.** Section Ins 3.33 (1), is created to read:

Ins 3.28 **(1)** DEFINITIONS. For purposes of this section:

(a) "Individual uniform application" means the uniform questions and format for applications that are to be used by insurers offering individual major medical health insurance policies or certificates, including an individual major medical health insurance coverage provided through an association as individual coverage and underwritten on an individual basis and issued to individuals or families, as it appears in Appendix 1 as OCI form 26-503.

(b) "Individual major medical health insurance policies" means a comprehensive health care plan offered by an insurer authorized to write individual health or disability insurance for an individual or family. Individual major medical health insurance policies excludes limited-scope dental and vision policies, specified disease policies, hospital indemnity and other limited-benefit individual insurance products and policies issued by an association plan under a group policy that may be underwritten on an individual basis.

**(2) APPLICATION FORMAT.** (a) In accordance with s. 601.42 (10), insurers offering individual major medical health insurance policies or certificates shall use the questions in the same format as contained in Appendix 1, OCI 26-503 as the individual uniform application. The contents of the individual uniform application shall not vary, except as permitted in par. (3) (b), from the text or format including bold character, line spacing, the use of boxes around text and shall use a type size of at least 10 points.

Note: A copy of the individual uniform application form OCI 26-503 (c. 06/2010), required in par. (a), may be obtained at no cost from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707-7873, or at the Office's web address: [oci.wi.gov](http://oci.wi.gov).

(b) Insurers offering individual major medical health insurance policies or certificates shall implement procedures and policies necessary to implement and utilize the individual uniform application.

(c) Insurers offering individual major medical health insurance policies or certificates shall treat and accept a paper copy of the individual major medical health insurance application as an original.

**(3) WEB-BASED APPLICATIONS.** (a) Insurers offering individual major medical health insurance policies or certificates that permit applicants to complete the application through the insurer's website may not automatically populate or fill-in answers to health questions on the application. Each health question must be answered by the applicant and a paper copy of the completed application must be sent to the applicant with the notice required under s. Ins 3.28 (5) (d) and permitting return of the policy within 10 days as required by s. 632.73, Stats. The paper copy that is sent to the applicant must be in the same format as appears in Appendix 1.

(b) For the electronic, web-based application, insurers may change the order of questions but may not alter the content of any question from the individual uniform application. Insurers may not ask additional questions during the application process through its web-based application process. If the insurer has additional questions or clarifications that are not contained in the individual uniform application, insurers shall separately contact the applicant for response to inquiries. The additional information may not be considered part of the application and may not be used by the insurer to rescind a policy or certificate.

**(4) TELEPHONIC APPLICATIONS.** (a) Insurers offering individual major medical health insurance policies or certificates that permit applicants to complete the application verbally with an authorized, licensed intermediary or an employee of the insurer asking the insured the questions to the application. The intermediary or employee shall ask the applicant each question on the uniform individual applicant including each health question. The insurer must provide a paper copy of the completed application to the applicant with the notice required under s. Ins 3.28 (5) (d) and permitting return of the policy within 10 days as required by s. 632.73, Stats. The paper copy sent to the applicant must be in the same format as appears in Appendix 1.

(b) For the telephonic application process insurers may change the order of questions but may not alter the content of any question from the individual uniform application. Insurers may not ask additional questions during the application process. If the insurer has additional questions or clarifications that are not contained in the individual uniform application, insurers shall separately contact the applicant for response to inquiries. The additional information may not be considered part of the application and may not be used by the insurer to rescind a policy or certificate.

**(5) ADDITIONAL REQUIRED PROVISIONS.** (a) Insurers offering individual major medical health insurance policies or certificates shall include a statement on the first page of the policy that the policy is guaranteed renewable except for the reasons stated s. 632.7495 (2), Stats.

(b) Insurers shall include authorizations, releases and notices compliant with state and federal law filed with the office as separate forms that will be presented with the individual uniform application but not considered a part of the application.

(c) Insurers may file a separate form information or election options for the applicant to select deductible, copayment and coinsurance levels and elect, if applicable, provider networks. Additionally, insurers may include in the form premium payment options for the applicant to select.

**SECTION 2.** Section Ins 3.33 Appendix 1, is created to read:

**INDIVIDUAL UNIFORM APPLICATION  
FOR INDIVIDUAL MAJOR MEDICAL  
HEALTH INSURANCE**



**State of Wisconsin  
Office of the Commissioner of  
Insurance  
P.O. Box 7873  
Madison, WI 53707-7873  
(608) 266-3585  
Web Address: oci.wi.gov**

Ref: Section Ins 3.33, Wis. Adm. Code,  
and s. 601.41 (10), Wis. Stat.

*This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.*

**Instructions:** Please complete the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application, please attach, sign and date each page.

**I. INFORMATION**

**Primary Applicant/Insured Information:**

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height _____ Weight _____
Residential Address				
City		State	Zip Code	
Mailing Address, if different from residential address				
City		State	Zip Code	
Home Phone		Alternative Phone	Optional Email	
*If you have a Social Security Number.				
<b>The Primary Applicant is:</b>				
[ ] Single [ ] Married [ ] Under the age of 18**				
**If primary applicant is under the age of 18, please complete sections –II. C. and V.				
<b>Employment Information:</b>				
Primary job duties:				
Self-Employed: [ ] Yes [ ] No				

**II. ADDITIONAL APPLICANTS**

**A.** Please complete ONLY if your spouse and or children under the age of 27 are applying for coverage. Attach an additional family information sheet if necessary. **(Please sign and date the additional sheet.)**

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

\* If you have a Social Security number.



Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

\* If you have a Social Security number.

**B.** Does the child(ren) named within this application live with you at the address shown above?  
 Yes  No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant

City	State	Zip Code
Home Phone	Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child		

**C.** If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent

City	State	Zip Code
Home Phone	Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child		

**III. CURRENT AND PREVIOUS COVERAGE**

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

**Does anyone applying for coverage have current health coverage?**  
 Yes  No If "Yes," please indicate insurer and applicant \_\_\_\_\_.

**Has any applicant had health insurance coverage within the last 18 months?**

Yes  No If "Yes," please indicate insurer and applicant \_\_\_\_\_.

**If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?**

Yes  No

**Is any applicant enrolled in Medicare?**

Yes  No If "Yes," name of applicant \_\_\_\_\_. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

**Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?**

Yes  No If "Yes," name of applicant \_\_\_\_\_. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

#### IV. MEDICAL INFORMATION

##### NOTICE TO APPLICANT:

The insurance company does not use or collect genetic information for any Underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which you or any person applying for coverage if:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

**Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.**

##### WITHIN THE LAST FIVE (5) YEARS:

###### 1. Infectious and Parasitic Diseases

- a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and  Yes  No

you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.] .....	
b. Lyme's Disease .....	[ ] Yes [ ] No
c. Sexually transmitted disease(s).....	[ ] Yes [ ] No

**2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)**

a. Anemia/blood disorder .....	[ ] Yes [ ] No
b. Thyroid disease .....	[ ] Yes [ ] No
c. Diabetes/high or low blood sugar. .... (If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)	[ ] Yes [ ] No
d. Adrenal disorder .....	[ ] Yes [ ] No
e. Enlargement of lymph nodes .....	[ ] Yes [ ] No
f. Endocrine/gland/hormone system.....	[ ] Yes [ ] No

**3. Cancer, Cyst and Tumors**

c. Cancer. .... (If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)	[ ] Yes [ ] No
b. Tumors, cyst, lump, polyp.....	[ ] Yes [ ] No

**4. Mental/Nervous/Behavioral Disorders**

a. Alcohol/chemical/drug abuse/dependency .....	[ ] Yes [ ] No
b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs?.....	[ ] Yes [ ] No
c. Eating disorders such as, but not limited to, anorexia or bulimia.....	[ ] Yes [ ] No
d. Mental/emotional condition/depression.....	[ ] Yes [ ] No
e. Autism .....	[ ] Yes [ ] No
f. Suicide attempt .....	[ ] Yes [ ] No
g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years..... (if "Yes," record date of last session in on the Additional Medical Details page)	[ ] Yes [ ] No

**5. Brain and Nervous System**

a. Brain disease or injury/concussion.....	[ ] Yes [ ] No
b. Convulsion/seizures/epilepsy.....	[ ] Yes [ ] No
c. Chronic headaches/migraines.....	[ ] Yes [ ] No
d. Neurological condition/disease/injury .....	[ ] Yes [ ] No
e. Sleep apnea/chronic sleep disorder .....	[ ] Yes [ ] No
f. Stroke .....	[ ] Yes [ ] No
g. Multiple Sclerosis .....	[ ] Yes [ ] No
h. Paralysis.....	[ ] Yes [ ] No

**6. Skin Disorders**

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer .....	[ ] Yes [ ] No
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**7. Eyes, Ears, Nose**

a. Chronic ear/nose condition/disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Chronic eye condition/disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Cataracts/glaucoma .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

**8. Mouth, Throat or Jaw**

a. Chronic throat/tonsil/adenoid/disease/disorder .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. TMJ/jaw joint .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

**9. Heart or Circulatory System**

a. Blood/circulatory disorder .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Heart attack/chest pain/murmur/angina .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Elevated/High cholesterol .....	<input type="checkbox"/> Yes <input type="checkbox"/> No (if "Yes," record last reading and the date on the Additional Medical Details page)
d. Elevated/High or low blood pressure .....	<input type="checkbox"/> Yes <input type="checkbox"/> No (if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)
e. Phlebitis/blood clot .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Heart disease/disorder .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

**10. Respiratory System**

a. Asthma .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Emphysema/Chronic obstructive pulmonary disease (COPD) .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chronic respiratory/lung condition .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Pneumonia/bronchitis .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

**11. Digestive System**

a. Appendicitis/chronic abdominal pain .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Blood in stool .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Colon/rectum/intestine/bowel/Crohn's disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Ulcer/esophageal reflux .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Gallbladder .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Liver condition/hepatitis/pancreas .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

**12. Urinary System**

a. Bladder/urinary tract .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Kidney/kidney stones .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

**13. Male or Female Reproductive Systems**

a. Breast (lumps or masses).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Prostate/elevated PSA/prostatitis .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Reproductive system disorder/infertility/dysfunction.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Abnormal pap smear or mammography .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

**14. Pregnancy, Birth or Congenital Abnormalities**

a. Birth defect/congenital deformities .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
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b. Pregnancy complications .....	[ ] Yes [ ] No
c. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date _____.) .....	[ ] Yes [ ] No

**15. Muscular or Skeletal System**

a. Back/neck/spine disorder .....	[ ] Yes [ ] No
b. Bone/orthopedic disorder .....	[ ] Yes [ ] No
c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia .....	[ ] Yes [ ] No
d. Osteoarthritis/osteoporosis/osteopenia.....	[ ] Yes [ ] No
e. Rheumatoid arthritis.....	[ ] Yes [ ] No
f. Knee/shoulder/hip/joint surgery/disorder.....	[ ] Yes [ ] No
g. Hernia.....	[ ] Yes [ ] No

**16. Miscellaneous**

a. Cosmetic surgery/implants .....	[ ] Yes [ ] No
b. Use of prosthetic devices/limbs.....	[ ] Yes [ ] No
c. Had chronic fatigue.....	[ ] Yes [ ] No
d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities.....	[ ] Yes [ ] No
e. Any fluctuations in weight (+/- 20lbs) in the past 12 months .....	[ ] Yes [ ] No
f. Implantable devices/stents/shunts/pace maker .....	[ ] Yes [ ] No
g. Allergies.....	[ ] Yes [ ] No
h. Transplants .....	[ ] Yes [ ] No
18. Has any person on this application used tobacco products in any form within the last 12 months? .....	[ ] Yes [ ] No
If "Yes", name of person(s), amount of tobacco used and frequency:	

**17. Other Injury, Illness, Treatment or Condition**

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.) .....	[ ] Yes [ ] No
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**18. Tobacco Use**

a. Has any applicant used tobacco products in any form within the last 12 months?..	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:	

**19. Other Activities**

a. Has any applicant been involved in or participated in organized motorized racing or extreme activities? .....	[ ] Yes [ ] No
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If "Yes", provide the name of applicant(s), activity and frequency of the activity:

**ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.**

Please contact me at this phone number during business hours:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

**Additional Medical Details Page**

For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.

All additional pages must be signed and dated by the primary applicant.

<b>Question # or additional information</b>								
<b>Applicant Name</b>								
<b>Specific Diagnosis &amp; Type of Treatment</b>								
<b>Duration of Condition</b>	<b>Began mm/yy</b>		<b>Began mm/yy</b>		<b>Began mm/yy</b>		<b>Began mm/yy</b>	
	<b>End mm/yy</b>		<b>End mm/yy</b>		<b>End mm/yy</b>		<b>End mm/yy</b>	
<b>Name/ Dosage/ Frequency of medication &amp; Dates of Medication Use</b>	<b>Name of Rx</b>		<b>Name of Rx</b>		<b>Name of Rx</b>		<b>Name of Rx</b>	
	<b>Dose</b>		<b>Dose</b>		<b>Dose</b>		<b>Dose</b>	
	<b>Began mm/yy</b>	<b>End mm/yy</b>	<b>Began mm/yy</b>	<b>End mm/yy</b>	<b>Began mm/yy</b>	<b>End mm/yy</b>	<b>Began mm/yy</b>	<b>End mm/yy</b>
<b>Was surgery performed</b>								
<b>Description of surgery/ Procedures/ Tests/Result &amp; Dates</b>								
<b>Current Status/ O-Ongoing/ R-Resolved</b>								

Readings for Blood Pressure, Cholesterol & Diabetes	Date	Reading	Date	Reading	Date	Reading	Date	Reading
Physician/Hospital Name, City, State								

**V. TERMS AND CONDITIONS**

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

<b>Signature (or e-signature) of Primary Applicant</b> (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	<b>Date Signed</b>
<b>Signature (or e-signature) of Spouse</b>	<b>Date Signed</b>

**Signature (or e-signature) of each listed child who has attained the age of 18**

<b>Signature (or e-signature) of an Adult Child Applicant</b>	<b>Date Signed</b>
<b>Signature (or e-signature) of an Adult Child Applicant</b>	<b>Date Signed</b>
<b>Signature (or e-signature) of an Adult Child Applicant</b>	<b>Date Signed</b>

**Complete this section if someone assisted you in the completion of this Application**

The following person assisted me in completing the Application:

Please explain the assistant's relationship to you and your family:

**SECTION 3.** These changes will take effect on the first day of the first month after publication, as provided in s. 227.22(2) (intro.), Stats.

**SECTION 4.** These changes first apply to policies issued on or after July 1, 2011.

**SECTION 5.** This section may be enforced under s. 601.41, 601.64, 601.65, or 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

Dated at Madison, Wisconsin, this \_\_\_\_\_ day of, 2010.

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Sean Dilweg  
Commissioner of Insurance



**Office of the Commissioner of Insurance  
Private Sector Fiscal Analysis**

for section Ins 3.33 relating to uniform questions and format for individual  
health insurance

This rule change will have no significant effect on the private sector regulated by OCI.

### FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

ORIGINAL       UPDATED  
  
 CORRECTED       SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number <b>INS 333</b>

**Subject**  
uniform questions and format for individual health insurance

**One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):**  
**None**

Annualized Costs:	Annualized Fiscal impact on State funds from:	
	Increased Costs	Decreased Costs
<b>A. State Costs by Category</b>		
State Operations - Salaries and Fringes	\$ 0	\$ -0
(FTE Position Changes)	(0 FTE)	(-0 FTE)
State Operations - Other Costs	0	-0
Local Assistance	0	-0
Aids to Individuals or Organizations	0	-0
<b>TOTAL State Costs by Category</b>	<b>\$ 0</b>	<b>\$ -0</b>
<b>B. State Costs by Source of Funds</b>		
GPR	\$ 0	\$ -0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
<b>C. State Revenues</b> <small>Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)</small>	<b>Increased Rev.</b>	<b>Decreased Rev.</b>
GPR Taxes	\$ 0	\$ -0
GPR Earned	0	-0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
<b>TOTAL State Revenues</b>	<b>\$ 0 None</b>	<b>\$ -0 None</b>

**NET ANNUALIZED FISCAL IMPACT**

	<u>STATE</u>		<u>LOCAL</u>
NET CHANGE IN COSTS	\$ <u>None 0</u>		\$ <u>None 0</u>
NET CHANGE IN REVENUES	\$ <u>None 0</u>		\$ <u>None 0</u>

Prepared by: Julie E. Walsh	Telephone No. (608) 264-8101	Agency Insurance
Authorized Signature:	Telephone No.	Date (mm/dd/ccyy)

