State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Josephine W. Musser
Commissioner

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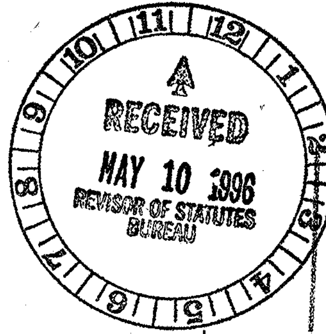
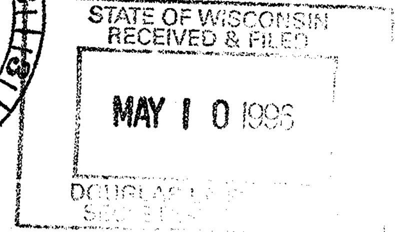


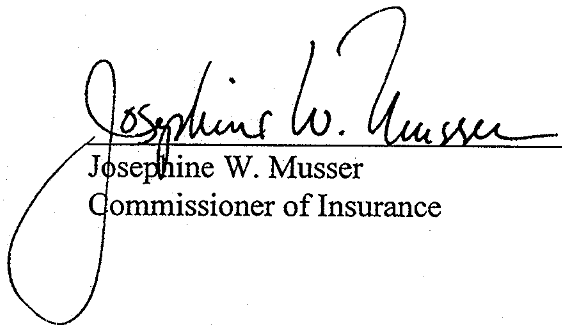


STATE OF WISCONSIN
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE

I, Josephine W. Musser, Commissioner of Insurance and custodian of the official records, certify that the annexed rule affecting Section Ins 3.455 and 3.46, Wis. Adm. Code, relating to the requirements for long term care insurance sold in Wisconsin, is duly approved and adopted by this Office on May 9, 1996.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 121 East Wilson Street, Madison, Wisconsin, on May 9, 1996.



Josephine W. Musser
Commissioner of Insurance

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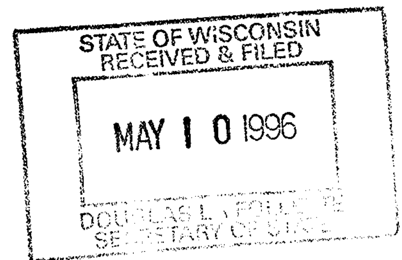


ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AMENDING AND CREATING A RULE

To renumber Ins 3.46(9)(intro), (9)(a) and (9)(b) to (9)(a), (9)(a)1. and (9)(a)2.; to amend Ins 3.46(4)(b) and (g); and to create s. Ins 3.455(9), 3.46(3)(cm), (4)(t), 9(b), (11m), (15), (16), (17), and Appendices 2, 3, and 4, Wis. Adm. Code, relating to the requirements for long-term care insurance sold in Wisconsin.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 600.01(2), 601.41(3), 601.42, 625.13(1), 625.16, 625.21(2), 628.34(12), 631.20, 632.73(2m), 632.76(2), 632.81, 632.82, 632.84 and 631.897, Stats.

Statutes interpreted: ss. 600.01, 625.16, 628.34(12), 631.20, 632.73(2m), 632.81, 632.84 and 632.897, Stats.

These revisions to the long-term care rule are mainly based on the new standards set in the National Association of Insurance Commissioners (NAIC) model rule for long-term care. The specific changes are as follows:

SECTION 1: For ages over 74 and with policies in effect for 10 years or more, the premium increase limit is 10%. Any premium rate increase after the first 3 year period is guaranteed for 2 years. If an insurer increases premiums more than 50% in any 3 year period, it must discontinue issuing long term care policies for 2 years.

SECTION 2: The term cognitive impairment is defined for the rule.

SECTION 3: The daily minimum coverage is increased from $30 to $60 and the benefit trigger is changed as indicated in s. (17).

SECTION 4: Policies are required to allow reinstatement in the event of lapse if reinstatement is requested within 5 months of the lapse and the lapse was due to the loss of functional capacity or cognitive impairment.

SECTION 6: A notice regarding the coverage and how it may duplicate Medicare must be given to the insured with the application. This is a requirement of federal law.

Minimum requirements for nonforfeiture benefits are set out when a policy terminates or lapses. The nonforfeiture benefit is a paid-up benefit period and equal to at least 100% of all premiums paid.

The insurer must attempt to obtain the name of another person to whom lapse or termination notice must be given in addition to the insured before the policy can lapse.

Suitability standards for the sale of long-term care insurance are required to be set by insurers based on the completion of a worksheet defined in the rule. Factors such as income, savings and other source of revenues must be considered.

Minimum standards for benefit triggers are defined to be a deficiency in at least 3 activities of daily living out of a list of 6. Insurers can define additional triggers.

SECTION 7: The formats for the disclosures required by the changes are set forth.

SECTION 8: The new requirements would apply to policies solicited, delivered or issued after September 1, 1996

SECTION 1. Ins 3.455(9) is created to read:

Ins 3.455(9) LONG-TERM CARE RATE INCREASE STANDARDS. (a) The initial premium rate schedule provided an insured covered by a long-term care policy may not increase during the initial 3 years in which the policy is in force.

(b) Except as provided in par. (d), any increase in the premium rate schedule provided an insured after the initial 3-year period is subject to the following:

1. Any premium rate increase after the initial 3-year period is guaranteed for at least 2 years after its effective date;

2. For those insureds age 75 or above and whose long term care policy(s) has been in force for at least 10 years, no rate increase shall exceed 10%;

3. If an insurer of any long-term care policy increases rates for a policy by more than 50% in any 3-year period, the insurer shall discontinue issuing all long-term care policies in this state for a period of 2 years from the effective date of such rate increase.

a. If an insurer issues both individual and group long-term care policies, the insurer shall discontinue issuing the type of coverage (individual and/or group) for which rates were increased more than 50% in a 3-year period.

b. All rate filings subject to this requirement shall include a past history of all previous rate increases and a certification of the maximum rate increase over the last thirty-five months including the current rate increase as a percent of the premium in the first month of the thirty-five month period.

c. This provision shall also apply to any replacing insurer which purchases or otherwise assumes a block of long-term care policies from a prior

insurer. For purposes of this provision, any rate increases of the prior insurer shall apply to the replacing insurer.

4. The premium charged to an insured may not increase due to either:

a. The increasing age of the insured at ages beyond 65; or

b. The duration the insured has been covered under the policy.

(c) Long-term care policies which provide for inflation protection shall be subject to the restrictions contained in pars. (a) and (b). However, the purchase of additional coverage may not be considered a premium rate increase for purposes of determining compliance with par. (b) at the time additional coverage is purchased. The premium charged for the purchase of additional coverage shall be subject to par. (b) for any subsequent premium rate increases.

(d) The commissioner may institute future rulemaking proceedings to amend the provisions in par. (b) in appropriate circumstances, including the following:

1. Applicable state or federal law is enacted which materially affects the insured risk.

2. Unforeseen changes occur in long-term care delivery, insured morbidity or insured mortality.

3. Judicial interpretations or rulings are rendered regarding policy benefits or benefit triggers resulting in unforeseen claim liabilities.

(e) Except as provided for in par. (f), the provisions of this subsection apply to all long-term care insurance policies and certificates issued on or after the effective date of this subsection [revisor inserts date].

(f) For certificates issued on or after the effective date of this subsection under a group long-term care insurance policy which is delivered or issued for delivery to:

1. One or more employers or labor organizations.

2. A trust or to the trustees of a fund established by one or more employers or labor organizations or a combination thereof for employes or former employes or a combination thereof or for members or former members or a combination thereof, of the labor organizations

where the group policy was in force at the time of the effective date of this paragraph [revisor inserts date], the provisions of this subsection do not apply

SECTION 2. Ins 3.46(3)(cm) is created to read:

Ins 3.46(3)(cm) "Cognitive impairment" means a deficiency in a person's short-term or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

SECTION 3. Ins 3.46(4)(b) and (g) are amended to read:

Ins 3.46(4)(b) Establish fixed daily benefit limits only if the highest limit is not less than ~~$30~~ $60 per day. This fixed daily benefit applies to the total long-term care insurance in force for any one insured.

(g) Provide coverage regardless of whether care is medically necessary. ~~If the form requires that care be provided according to a plan of care, that benefits are available only based on ability to perform activities of daily living, or that benefits are available or vary according to the level of care, the form shall also provide that, in the absence of fraud and collusion, the attending physician's certification of any of those matters is conclusive.~~ Coverage shall be triggered in conformance with the provisions contained in sub. (17) of this rule.

SECTION 4. Ins 3.46(4)(t) is created to read:

Ins 3.46(4)(t) Include a provision which allows for reinstatement of coverage, in the event of lapse, if the insurer is provided proof of cognitive impairment or the loss of functional capacity and if the reinstatement of coverage is requested within 5 months after termination and provision is made for the collection of past due premiums, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity to be used in evaluating an application for reinstatement may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

SECTION 5. Ins 3.46(9)(intro), (9)(a) and (9)(b) are renumbered (9)(a), (9)(a)1. and (9)(a)2.

SECTION 6. Ins 3.46(9)(b), (11m), (15), (16) and (17) are created to read:

(9)(b) The appropriate disclosure statement from s. 3.39 Appendix 8 shall be used on the application or together with the application for each coverage in pars. 3.39(9)(c) to (e). The disclosure statement may not vary from the text or format including bold characters, line spacing, and the use of boxes around text contained in s. 3.39 Appendix 8 and shall use a type size of at least 12 points.

(11m) SALE OF LONG-TERM CARE AND LIMITED BENEFIT POLICIES; REQUIRED OFFER OF NONFORFEITURE BENEFITS.

(a) No insurer may advertise, market or offer a long-term care, nursing home only or home health care only policy or certificate unless the insurer offers, at the time of sale, a shortened benefit period nonforfeiture benefit with the following standards:

1. Attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.

2. The nonforfeiture benefit shall provide paid-up long-term care, nursing home only or home care only insurance coverage after lapse. The amounts and frequency of benefits in effect at the time of lapse but not increased thereafter will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subd. 3.

3. The standard nonforfeiture credit shall be at least 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit may not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of par. (b).

4. No policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

a. The end of the tenth year following the policy or certificate issue date; or

b. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(b) All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status may not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium-paying status.

(c) There shall be no difference in the minimum nonforfeiture benefits as required under this subsection for group and individual policies.

(d) Premiums charged for a policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements contained in s. Ins 3.455 (5) treating the policy as a whole.

(e) This subsection does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(15) UNINTENTIONAL LAPSE; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES

(a) As part of the application process, an insurer shall obtain from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive a notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. Designation may not constitute acceptance of any liability by the third party for services provided to the insured. The written designation shall include the following:

1. Space for clearly listing at least one person.

2. The person's name and address.

3. In the case of an applicant who elects not to designate an additional person, the waiver shall state, "Protection against unintentional

lapse. I understand that I have a right to designate at least one person, other than myself, to receive notice of lapse or termination of this policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect **NOT** to designate any person to receive such notice."

(b) For those insureds who designate another person as provided in par. (a), the insurer, after the policy or certificate is issued shall send a letter to the designated person indicating that the insured has designated the person to receive notice of lapse or termination of the insured's long-term care, nursing home or home health care policy or certificate. The letter shall ask the person to correct any information concerning the name or address of the person. It shall also explain the rights and duties of the designated person.

(c) Not less than once every two years an insurer shall notify its policyholders of their right to designate a person to receive the notices contained in par. (a). The notification shall allow policyholders to change, add to or, in the case of those policyholders who elected not to designate a person, designate a person to receive the notices provided in par. (a).

(d) When an insured pays premium through a payroll deduction plan, the requirements contained in par. (a) need not be met until 60 days after the insured is no longer on a payroll deduction plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(e) No long-term care, nursing home, or home health care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those designated by the insured pursuant to par. (a) at the address provided by the insured for

purposes of receiving notices of lapse or termination. Notice may not be given until 30 days after a premium is due and unpaid.

(16) SUITABILITY; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES

(a) This subsection may not apply to life insurance policies that accelerate benefits for long-term care.

(b) Every insurer marketing long-term care insurance policies shall do all of the following:

1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

2. Train its agents in the use of its suitability standards.

3. Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) 1. To determine whether the applicant meets the standards developed by the insurer, the agent and insurer shall develop procedures that take the following into consideration:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

b. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

2. The insurer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subd. 1. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by

the insurer shall contain, at a minimum, the information in the format contained in Appendix 2, in not less than 12 point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the insurer's personal worksheet shall be filed with the commissioner.

3. A completed personal worksheet shall be returned to the insurer prior to the insurer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employes and their spouses.

4. The sale or dissemination outside the company or agency by the insurer or agent of information obtained through the personal worksheet in Appendix 2 is prohibited.

(d) The insurer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(e) Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance.

(f) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix 3, in not less than 12 point type.

(g) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application. In the alternative, the insurer shall send the applicant a letter similar to the sample letter in Appendix 4. However, if the applicant has declined to provide financial information, the insurer may use some other method to verify the applicant's

intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(h) The insurer shall maintain and have available for review by the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who, after receiving a suitability letter, indicated that the insurer should resume processing the application.

(17) STANDARDS FOR BENEFIT TRIGGERS; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES

(a) The following definitions apply to this subsection:

1. "Activities of daily living" includes at least bathing, continence, dressing, eating, toileting, and transferring.

2. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

3. "Cognitive impairment" means a deficiency in a person's short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

4. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

5. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

6. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

7. "Hands-on assistance" means physical assistance, either minimal, moderate or maximal, without which the individual would not be able to perform the activity of daily living.

8. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

9. "Transferring" means moving into or out of a bed, chair or wheelchair.

(b) A long-term care, nursing home only and home health care only policy or certificate shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits may not be more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the activities of daily living or the presence of cognitive impairment.

(c) 1. Activities of daily living shall include at least those contained in the definition in par. (a).

2. Insurers may use deficiencies to perform activities of daily living to determine when covered benefits are payable in addition to those contained in par. (a) as long as they are defined in the policy.

(d) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions may not restrict, and are not in lieu of, the requirements contained in pars. (b) and (c).

(e) For purposes of this section, the determination of a deficiency may not be more restrictive than any of the following:

1. Requiring hands-on assistance of another person to perform the prescribed activities of daily living.

2. If the deficiency is due to the presence of cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured and others.

(f) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(g) Long-term care, nursing home only and home health care only policies shall include a clear description of the process for appealing and resolving benefit determinations.

SECTION 7. Ins 3.46 - Appendices 2, 3 and 4 are created to read:

Ins 3.46 Appendix 2 **Long-Term Care Insurance Personal Worksheet**

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long-term care insurance can be expensive, and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

Premium

The premium for the coverage you are considering will be [$_______ per month, or $__________ per year,] [a one-time single premium of $________.]

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up by an average of _______%]. [The company has not raised its rates for this policy.]

Drafting Note: The insurer shall use the bracketed sentence or sentence applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage.

☐ [Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

Drafting Note: The insurer shall use the bracketed sentence unless the policy is fully paid up or is a noncancelable policy.

Income

Where will you get the money to pay each year's premiums?

☐ Income ☐ Savings ☐ Family members

What is your annual income? (check one)

☐ Under $10,000 ☐ $10-20,000 ☐ $20-30,000 ☐ $30-50,000 ☐ Over $50,000

Drafting Note: The insurer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Turn the Page

Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check (one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The information provided above accurately describes my financial situation.	☐ I choose not to complete this information.

Signed: ______________________ ______________________
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed: ______________________ ______________________
(Agent) (Date)

Agent's Printed Name: ______________________]

[**Note**: In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed: ______________________ ______________________]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employes and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Appendix 3

Things you Should know Before you Buy Long-Term Care

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete the above bullet; for noncancelable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does not pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a booklet called the "Guide to Long-Term Care." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state department on aging for more information about the senior health insurance counseling program in your state.

Appendix 4

Long-Term Care Suitability Letter

Dear [Applicant]:

Your recent application for [long-term care insurance] [insurance for care in a nursing home] [insurance for care at home or other community setting] included a "personal worksheet," which asked questions about your finances and your reasons for buying this coverage. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that insurance coverage you applied for may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Guide to Long-Term Care" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph and bracketed sentences in that paragraph that apply.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes**, [although my worksheet indicates that nursing home only or home health care insurance only insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No**, I have decided not to buy a policy at this time.

____ ________________________

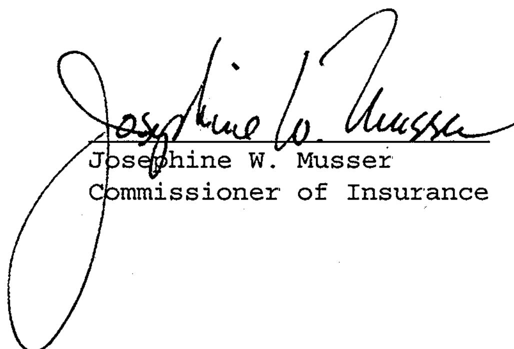
APPLICANT'S SIGNATURE DATE

Please return to [insurer] at [address] by [date].

SECTION 8. This rule applies to any policy solicited, delivered or issued after September 1, 1996. After the effective date but before September 1, 1996, the insurer may market policies under either the current rule or this rule, if a policy form conforming to this rule has been approved.

SECTION 9. This rule will take effect on the first day of the first month after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 9th day of May, 1996.



Josephine W. Musser
Commissioner of Insurance