Consumer's Guide To Insurance

For Small Business Owners

©

Guide Provides Information On:

- **Business Owner's Package Policy**
- **Auto Insurance**
- **Worker's Compensation Insurance**
- **Health Insurance**

State of Wisconsin
Office of the Commissioner of Insurance
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Madison, WI 53707-7873
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The mission of the Office of the Commissioner of Insurance . . .

Leading the way in informing and protecting the public

and responding to their insurance needs.

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

For information on how to file insurance complaints call:

(608) 266-0103 (In Madison)
or
1-800-236-8517 (Statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail
ocicomplaints@wisconsin.gov
(please indicate your name, phone number, and e-mail address)

OCI's World Wide Web Home Page
oci.wi.gov

For your convenience, a copy of OCI's complaint form is available at the back of this booklet. A copy of OCI's complaint form is also available on OCI's Web site. You can print it, complete it, and return it to the above mailing address.

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Small Employer Web Site

The Office of the Commissioner of Insurance (OCI) developed a Web site to help small employers become more knowledgeable insurance consumers. The Insurance Coverage for Small Employers Web page oci.wi.gov/smempins.htm assists Wisconsin small employers by providing information on the different types of insurance policies on the market, how much coverage to buy, and how to buy it wisely.

Few things in life are riskier than launching and running your own business. As a small business owner you need to deal with complex issues such as business plans, accounting sytems, payroll processes, employee recruitment, cash flow problems, marketing and risk management.

As a business owner you have to deal with a large array of insurance needs such as property, liability, auto, worker's compensation, health, or disability insurance. This brochure is designed to tell you about the different types of insurance available, how to buy the coverage you need and to let you know how to file a complaint with the Office of the Commissioner of Insurance (OCI).

Property and liability insurance are critical coverages a small business owner needs. Property insurance protects small business owners from losses due to damage to physical space or equipment and as a result of theft. Liability insurance protects a small business owner if someone falls while visiting your business premises or a customer is hurt by a product your business sells.

Property Insurance

Property insurance may be one of the most important types of insurance in terms of financially protecting the property and physical assets of your business. Types of property a business needs to insure include:

- Buildings and other structures, leased or owned
- Furniture, equipment, and supplies
- Leased equipment
- Inventory
- Money and securities
- Records of accounts receivable
- Improvements and betterments you made to the premises
- Machinery
- Boilers
- Data processing equipment and media, including computers
- Valuable papers, books, and documents
- Mobile property, such as automobiles, trucks, and construction equipment
- Satellite dishes
- Signs, fences, and other outdoor property not attached to a building
- Intangible property (goodwill, trademarks, etc.)

There are three types of property insurance plans. The basic property insurance form generally covers losses caused by fire or lightning and the cost of removing property to protect it from further damage (i.e., removing inventory or equipment from a damaged building so it won't be stolen).

The broad form includes basic coverage plus coverage for "extended perils," including windstorm, hail, explosion, riot and civil commotion, aircraft and vehicles that damage the property of the insured.

The special form includes basic and broad coverage and covers all direct physical losses except conditions specifically excluded as listed in the policy.

Liability Insurance

Liability insurance, also called Commercial General Liability (CGL), covers four categories of events for which you could be held responsible: bodily injury; damage to others' property; personal injury, including slander and libel; and false or misleading advertising. CGL coverage pays for the injured party's medical expenses. It excludes your employees, who are covered by worker's compensation.

There are three types of legal damages people may sue you for that are typically covered by a CGL policy:

Compensatory damages: financial losses suffered by the injured party and future losses they may suffer resulting from an injury they claim in the lawsuit.

General damages: nonmonetary losses suffered by the injured party, such as "pain and suffering" or "mental anguish."

Punitive damages: additional penalties and charges the defendant must pay.

I. BUSINESS OWNER'S POLICY

One package policy frequently purchased by small to mid-size businesses is the Business Owner's Policy or BOP. The BOP is a package policy designed to meet the insurance needs of small offices, stores, apartment houses, and certain types of small services and processing businesses.

The key to whether a business owner is eligible for the BOP is the size of the premises, the limits of liability required, the type of commercial operation it is, and the extent of its off-premises servicing and processing activities.

The BOP includes property insurance for buildings and their contents. The package policy may also cover loss of business income and extra expense resulting from a fire or similar insured peril. The liability section of the BOP includes coverage for bodily injury or property damage that a business may be liable for.

NOTE: The BOP does not cover professional liability (liability claims arising from wrongful practice by professionals), auto insurance, worker's compensation, health or disability insurance. These all need to be purchased separately.

A. Property Insurance Coverage

The BOP provides two basic property coverage forms: the standard form and the special form. Both forms cover buildings and most business property on a replacement cost basis. Replacement cost coverage is what it actually costs to replace or restore the item without deducting for depreciation. Do not confuse replacement cost with actual cash value. Actual cash value is usually figured out by taking the replacement cost of the item and subtracting depreciation. For example if your 7-year-old desk that cost $500 was damaged in a fire, it might have depreciated 50 percent. Therefore, you would be paid $250 for it.

Owners of older buildings for whom replacement cost coverage may be difficult or too expensive to obtain might consider the actual cash value option. Actual cash value is offered as an option for buildings.

The property coverage under BOP automatically includes other people's personal property to the extent that the business owner is legally liable for the damage.

B. Liability Insurance Coverage

Defending against a legal complaint, even a minor one, is costly. The liability coverage in the BOP protects the assets of your business when it is sued for something your business did (or failed to do) that caused injury or property damage to someone else.

Types of Claims Covered by Liability

The BOP liability covers claims in four basic categories of business liability:

- *Bodily injury* is damage to a person's body or physical well being.
- *Property damage* is damage to any type of real estate or personal property such as furniture.
- *Personal injury* (including Slander or Libel) is damage to a person's or business entity's reputation or basic rights, such as the right to be free from interference and to have privacy.
- *Advertising injury* refers only to liability for the harm caused as the result of the insured's advertising its goods or services, such as an advertisement that slanders another organizations products or services.

The liability coverage in the BOP also pays for medical expenses of persons, other than employees, who sustain injuries at the insured business or as a direct result of the operations of the insured business.

The liability coverage in the BOP covers liability claims that stem from ownership or control of premises, products and completed operations, and certain types of contracts. The term "premises" includes land, building and other property. This part of the policy, known also as owners', landlords' and tenants', covers claims due to the failure to avoid harming customers, salespeople or other people (even trespassers) who are on their premises.

"Products" coverage includes claims that stem not only from the manufacture of products but also from their distribution and sale. "Completed operations" is work that has been performed, such as the repairing of appliances, the cleaning of chimneys or the installation of plumbing.

However, liability insurance will not protect you against claims arising from nonperformance of a contract, wrongful termination of employees, sexual harassment, or race and gender lawsuits. This is another good reason to carefully read your policy.

Single Limit Liability Coverage

The BOP has a single limit for liability and medical expenses with a separate medical expenses limit per person injured. The BOP also has separate limits for

products/completed operations, that is, the work carried out and completed by the business, such as repairing electrical appliances, and for advertising and personal injury, as well as a general aggregate limit and limits per person injured and per occurrence, and limits on damage per fire.

The single limit in the BOP makes decisions on how much liability protection to purchase less complicated, but it also reduces flexibility. If your product has a higher than average product liability risk, such as toys, the BOP might not provide enough liability coverage.

For example, your business has chosen a $500,000 limit on liability and medical expenses and a $5,000 limit per person injured. If your store needed additional liability coverage, you could purchase higher limits or an umbrella or excess insurance policy.

Defense and Legal Costs

The BOP obligates the insurer to provide a defense and pay for various legal costs when there is a covered liability claim or lawsuit against the insured business owner and the claim is covered by the policy. This provision not only protects a business from legal expenses, but it also generally makes available a more expert defense than the business would be able to afford on its own.

Exclusions

The most important exclusion to note is the exclusion for injury and property damage that is intended or expected by the policyholder. For example, if you distributed a letter containing false negative information about a competitor in order to put him or her out of business, the policy would not cover the competitor's claim for damages.

The BOP policy excludes liability for exposures that would be covered under other insurance coverages such as worker's compensation and professional and auto liability insurance policies.

Also excluded are claims resulting from damage to the property of others in the business owner's care, custody and control. This is because coverage for such damage is covered under property policies.

Losses relating to contracts or agreements, injuries caused by exposure to nuclear radiation and liability for injury or property damage caused by substances that pollute the environment are excluded.

The BOP also excludes all coverage for pollution claims. However, to protect your interest in the property you own, and to prevent the pollutants from injuring others, the BOP property form provides $10,000 toward the cost of extracting the potentially polluting substances from the policyholder's own premises. If you need liability coverage for environmental pollution you must purchase a special policy.

Manufacturers of products subject to product recall, such as food items or toys, should consider purchasing a special policy to cover this exposure. Products are excluded from the BOP policy because of the costs incurred in a recall.

Coverage for administering certain kinds of professional services or failure to render such services may also be excluded from the BOP policy, depending on the extent of services provided.

Legal actions that do not involve a claim for bodily injury, property damage, personal injury, or advertising injury, are not covered. The BOP policy does not cover most contract disputes, actions by governmental agencies charging that a business has failed to abide by regulations or statutes, and charges of pollution.

A claim for back taxes or a penalty for failure to provide a safe workplace is not covered by the BOP policy.

It is important to ask your agent to explain anything about the policy you do not understand and to answer any other questions you might have. Among other matters, you should know what the policy does and does not cover, including any deductibles or coinsurance requirements, exclusions, exceptions, or limitations, how and when to make a claim and how claims are processed.

Specific Industry Coverage

Certain categories of small businesses, such as restaurants, wholesalers, florists, garages, etc., would not be eligible for a BOP, regardless of size, because they have specialized insurance needs. Many insurance companies offer specifically designed policies that usually include specialty coverage that is advantageous to those businesses. For more information contact your agent or members of your trade association.

C. Other Coverages

Business interruption insurance provides coverage if the business premises, vital business equipment, or other business property becomes unusable because of a fire, explosion, or similar covered property peril. As a result most businesses will suffer:

- loss of net profit that would have been earned, and
- payments for expenses that continue even though the business is not operating normally (e.g., debt payments, taxes, salaries, and employees).

These losses may be covered by business interruption insurance. The purpose of business interruption insurance is to provide the business owner with what the business itself would have done if there had been no loss. Business interruption insurance is included in the BOP but may also be purchased as an endorsement to the fire policy.

Extra expense insurance provides coverage for a business to continue operating regardless of the extent of damage to their property. Many businesses can resume operations fairly rapidly but may incur extra expenses by relocating to temporary facilities, buying or leasing replacement equipment, supplies, furniture, and machines, quickly getting in new merchandise, and notifying clients and customers of the move. Extra expense insurance provides coverage for these increased costs of resuming business.

D. Optional Coverages

Insurance companies have designed package policies for businesses so that all the major property and liability exposures are covered in a single policy. You can add a variety of coverages to the basic package for an additional premium through an endorsement which adds clauses to the insurance contract.

- Outdoor signs. The BOP covers only signs attached to the building itself. The optional coverage applies to signs located on other parts of the building.
- Exterior grade floor glass. The coverage for exterior grade floor glass refers to glass at ground or basement level with an exterior or outside exposure.
- Money and securities. The money and securities option provides all-risk coverage for valuables wherever they are, at the bank, at the business owner's or another person's home, on the business premises, or in transit between these places. You choose the coverage limits that you need.
- Crime insurance. Crime insurance protects businesses from theft and malicious damage, such as employee embezzlement.
- E-insurance or Internet business insurance. E-insurance covers Web-based businesses for damages caused by computer hackers and viruses.
- Employee dishonesty. The employee dishonesty option provides coverage for loss of business property, including money and securities, due to employee theft, embezzlement, fraud or any other criminal act on the part of an employee. You choose the coverage limits that you need.
- Mechanical breakdown. The mechanical breakdown option provides the same kind of protection available under a separate boiler and machinery policy. A boiler and machinery policy provides specialized coverage for machinery and power-producing equipment. Coverage is provided for losses resulting from the breakdown of mechanical, electrical and pressure equipment ranging from boilers to refrigeration systems, engines, compressors, pumps, motors, transformers and other machinery.
- Boiler and machinery policies cover both property and liability losses as well as the reasonable cost of making temporary repairs and expediting repair work. Property coverage is provided not only for the equipment, but also for other property of the policyholder that is directly damaged as a result of an accident.

  A boiler and machinery policy also may be endorsed to cover losses resulting from an interruption of business following an insured accident and losses due to spoilage of specified property, such as food and other perishables, from lack of power, heat, steam, light, or refrigeration resulting from an insured accident.
- Contingent Liability, Demolition Costs, and Increased Cost of Construction. Coverage for demolition costs and increased costs of

construction to comply with building codes protects the business owner from expenses to reconstruct property to comply with building ordinances.

An important consideration when selecting these coverages is how much of any damage you can afford to pay yourself without crippling your business's operations. The value of an outdoor sign, for example, may be so low and the likelihood of damage so minimal that it is not worth taking out insurance to cover it. In the same way, you can save money by taking higher deductibles on the coverages you do decide to purchase.

E. Buying Property and Liability Insurance—Things to Consider

Underwriting Process

Insurance companies decide the types of risks they will accept. This is referred to as "underwriting" and is the process by which an insurer selects and classifies risks according to their degree of insurability.

Premiums

The premiums charged for business insurance vary widely from company to company. It pays to shop around to obtain the best value for your insurance dollar. Insurance premiums are dependent on a number of factors, including location, age and type of building, use of building, local fire protection, choice of deductibles, application of discounts, and amount of insurance you purchase.

Deductibles

The cost of your insurance is directly linked to your policy's deductible amount. The deductible is the amount of money that you agree to pay as part of a claim, before your insurer pays the remaining amount toward that claim. Deductibles reduce costs because you pay the first $250 or $500 of every loss.

Since you are actually "self-insuring" for the deductible amount, you should ask if the savings is worth it. It is a good idea to get quotations for various deductibles, before making your selection. Deductibles may apply separately to each building covered or to personal property in each building, with an aggregate deductible for any one occurrence.

Building Insurance

What will it really cost to replace your building in the event of loss from a fire or tornado? Are there building upgrades that are required by law when you rebuild (i.e., fire sprinklers may need to be installed) and what will they cost? Does the policy you are considering cover the extra cost to meet current building code requirements?

Business Personal Property

Every business owns some personal property that could suffer a loss. What would it cost to replace all of your furniture, fixtures, inventory (minimum and maximum values during the year) and building upgrade (if you lease)?

Business Interruption Coverage

You need to consider how long it would take to restore your business operations in the event of a fire. Where would you temporarily resume operations? What expenses could you discontinue while repairs are being made?

Liability Coverage

You should check your lease and other legal contracts you have signed to see what and how much liability coverage the contracts require you to carry. You may want to get price quotes for limits of insurance beyond what you are required to purchase according to your contractual obligations, so you can see what higher amounts of coverage will cost. You may decide to either buy all the liability coverage you can afford or you may only want what is required. Many people buy what makes them comfortable for a price they can afford.

Report Your Loss History Accurately

Failure to accurately report past losses could allow an insurance company to legally deny your claim and not pay you for the loss. It is important to disclose any lawsuits in which you've been named as a party and for which insurance coverage was provided. Also, be sure to include any property claims you've had such as those for fires, thefts, or vandalism.

Discounts

Discounts may be available if you have sprinklers, burglar alarms, and security cameras. Make sure that you tell your agent about any upgrades or renovations done to the building, particularly to the roof, heating, electrical and plumbing systems.

Your Insurance Agent

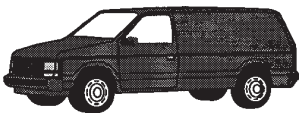
Your insurance agent should fully review the types of business property you own and use to discover what kinds of property insurance you need. There is no sure answer about how much liability insurance to buy for a particular business. You should consider the degree of risk in the business itself. Your insurance agent can help you determine a satisfactory limit of coverage for your specific business.

Ask your agent to explain anything about the policy you do not understand and to answer any other questions you might have. You should know what the policy does and does not cover, including any deductibles or coinsurance requirements, exclusions, exceptions, or limitations, how and when to make a claim and how claims are processed.

II. REQUIRED COVERAGES

Wisconsin law requires that all business owners purchase certain types of liability coverage or show proof of financial responsibility. What follows is a description of these required coverages.

A. Auto Insurance



Most businesses today operate with a motor vehicle. If the vehicles are damaged in an accident or stolen, the business has to repair or replace them. If there is an accident and the business is at fault, the business may be subject to large claims from people injured in the accident. A business auto insurance policy helps to cover both property and liability risks that businesses face because of the ownership or use of autos and trucks.

An auto is defined as any motor vehicle designed for primary use on the road. This includes all types of trucks and trailers pulled by trucks.

The insured is the person or entity who holds title to the vehicle. Owners of small businesses often use the same vehicles for both personal and business purposes. Problems may occur if the insurance is not written in the name of the person or entity with title to the vehicle. For example, John Smith owns the XYZ Company that owns the vehicle that Smith drives for both business and pleasure. Smith told his insurance agent that he owned the car so the agent put Smith's name on the auto insurance policy and not the company's name. Smith is involved in an accident. There may be problems when he attempts to collect on an insurance claim to repair the damage to the car because the insurance policy requires that the owner of the vehicle be the principal insured.

Financial Responsibility Auto Insurance Requirements

Wisconsin has a financial responsibility law. It is designed to make sure that any motorist licensed to drive in Wisconsin has insurance or enough money to pay for damages to others that may be caused by a motor vehicle. These requirements may be met through insurance, a surety bond, or self-insurance. Details are available at the Department of Transportation (www.dot.state.wi.us), Motor Vehicle Division, Hill Farms State Office Building, Madison, Wisconsin 53705.

If you buy insurance, your policy must provide the following minimum liability coverage:

- $25,000 for injury or death of one person
- $50,000 for injury or death of two or more people; and
- $10,000 for property damage.

The law also requires uninsured motorist coverage of $25,000/$50,000 for bodily injury only.

If you decide to satisfy the requirements of the Wisconsin Financial Responsibility Law by buying auto insurance, your policy must contain three major parts—liability insurance for bodily injury, liability insurance for property damage, and uninsured motorist coverage.

Bodily Injury Liability Insurance. Bodily injury liability insurance does not protect you or your car directly. If you cause an accident injuring other people, it protects you against their claims up to the stated amounts for medical expenses, lost wages, pain and suffering, and other losses. It will also usually pay if the accident was caused by a member of your family living with you or a person using your auto with your consent.

Property Damage Liability Insurance. Property damage liability insurance pays for any damage up to the stated amount you cause to the property of others such as a crushed fender, broken glass, or a damaged wall or fence. Your insurance will pay for

this damage if you were driving your auto or if it was being driven by another person with your consent.

Uninsured Motorist Coverage. Uninsured motorist coverage applies to bodily injury you, your family, and other occupants of your vehicle incur when hit by an uninsured motorist or hit-and-run driver. It also covers you and your family if injured as a pedestrian when struck by an uninsured motorist or hit-and-run driver. It protects you by making sure that money is available to pay for your losses that were caused by someone else.

Uninsured motorist coverage does not cover your property damage and does not protect the other driver. Your insurance company may sue the other driver for any money the company pays you because of the other driver's negligence.

Underinsured Motorist Coverage. This is an optional coverage that increases the personal injury protection to you and the people in your car up to the amount of coverage you purchase. It becomes effective when the party causing an accident has lower limits than you purchase and the accident costs more. The maximum dollars paid is then the difference between the two limits.

For example, assume the underinsured motorist (UIM) limits selected were $100,000 per person and the person causing the accident had limits of $50,000 per person. Under this scenario, you could collect up to $50,000 from the at-fault driver and up to an additional $50,000 (the difference in limits) under your own UIM coverage. UIM coverage typically does not "add" the amount you purchased to the amount available from the person causing the accident.

Insurers are required to notify policyholders who do not have UIM coverage of its availability. The limits of UIM coverage, if accepted after notification is $50,000 per person and $100,000 per accident.

Medical Payments. This provides medical or funeral expense for people injured or killed in your car. It also covers you and members of your family if hit by a car or injured while riding in another car. Medical expense coverage is usually sold as a single amount such as $1,000. Companies must offer this coverage but you do not have to buy it.

Physical Damage Coverage

There are three basic types of physical damage coverage for motor vehicles: collision, comprehensive, and specified perils.

Collision Coverage. This protects your car if your car collides with an object, including another car, or if it overturns. Your own insurer will pay for such damage even if the collision is your fault. Limits are based on the actual cash value of your car and it is usually written with a deductible of $100 or more.

Comprehensive Coverage. This protects your car against almost all damage except loss caused by collision. This includes fire, theft, missiles, glass breakage, falling objects, explosion, earthquake, civil commotion, or colliding with a wild bird or animal. It is based upon the actual cash value of the car and can be written with a deductible. Flood damage to your auto is covered if your auto insurance policy includes comprehensive coverage.

Specified Perils. Because comprehensive covers so many perils, it can be very expensive. For businesses that want this broad coverage, a less expensive alternative is specified perils coverage. This is sometimes called "fire, theft, and combined additional coverage" or "CAC." It covers many of the perils comprehensive covers, except windshield damage, but it does so on a named peril basis.

Coverage for your vehicle in an auto insurance policy is not based on replacement cost. The amount an insurance company will pay on an auto physical damage or theft claim depends on the "actual cash value" of the vehicle. The actual cash value of the vehicle is the replacement cost less depreciation, which most often is the current market value at the time of loss. Therefore, the company's obligation is to repair the car based upon its actual cash value not its replacement cost.

The insurance company may pay the business owner the value of the loss in money or, at its option, it may (1) repair or replace the damaged or stolen vehicle or (2) return a stolen vehicle to the business owner with payment for any damage caused by the theft.

If you borrow money from a bank or some other financial institution to buy your vehicle, the lender will probably require you to purchase physical damage coverage to protect both of your interests in the car.

Safety Responsibility Law

Wisconsin has a Safety Responsibility Law. The law requires that anytime a person is hurt or killed or someone's property is damaged over $1,000, it must be reported as soon as possible. You must also file a Driver's Report of Accident within 10 days with the Division of Motor Vehicles. If a police agency investigates the accident, you do not have to fill out the accident report, the police will.

If you are in an accident in Wisconsin, you should exchange insurance information with the other driver. Under the Safety Responsibility Law, uninsured motorists who are in reportable accidents must show they can pay for the damages and injuries they may have caused. The law takes away the driver's license and license plates of the uninsured motorist who cannot pay for damages or injuries they cause.

For more information, contact the Wisconsin Division of Motor Vehicles, Traffic Accident Section, Room 804, P.O. Box 7919, Madison, Wisconsin 53707-7919, or at (608) 266-1249.

Types of Auto Insurance Policies

Auto Insurance for a Home-Based Business

In most cases, home-based business owners can be covered by their personal auto insurance policy. However, depending on your particular use of your car, you may need to purchase higher coverage limits to protect yourself and your business.

In other cases, particularly if you are transporting people for any reason in the conduct of your business, you should consider a home-based business auto policy.

A home-based business auto policy is priced no differently than your regular auto policy. Insurance companies look at the number of miles you drive, who will be driving the vehicle, your driving record, and your claims history in order to set your premium.

The liability limits you choose and your comprehensive and collision deductibles are also major factors in how much you are going to pay. The higher your limits, the higher your premium. Lower deductibles are going to cost you more, too.

As a home-based business owner you need to pay attention to liability limits in order to protect both personal and business assets. If you cause an accident, the injured parties can go after you as an individual and as a business owner. In order to minimize financial risk, you might consider higher liability limits.

Many home-based businesses move equipment from job to job, like power washers and ladders for house painters, lawn mowers and other gardening equipment for landscapers. If you have a homeowner's or renter's insurance policy the equipment you haul from job site to job site is minimally covered. Your insurer will typically cover damages from $250 to $1,000, minus your deductible.

If you permanently affix a piece of equipment, like a generator, to your vehicle, the generator will not be covered unless you increase your insurance on your vehicle in order to cover items that are permanently attached.

Most importantly, if you are relying on either a personal auto insurance or personal umbrella liability policy to provide you with protection for your company's use of vehicles, look closely at the provisions, as business-related liability may be excluded.

Business Auto Insurance Policy

A business auto insurance policy covers both property and liability risks that a business owner faces because of ownership or use of autos and trucks. A policy covering a vehicle used in business also may cover your employees when they are operating their personal cars for your business.

The liability portion of the policy obligates the insurance company to pay because of bodily injury or property damage caused by an accident and resulting from the ownership, maintenance, or use of a covered auto up to the policy limits.

When there is an auto liability lawsuit against the insured business, where the loss is covered by the policy, the insurance company is obligated to defend the business owner or settle the lawsuit. The policy leaves the decision entirely up to the insurance company about whether to defend or settle a given claim. The insurance company's duty to defend or settle ends when the insurance policy limits have been exhausted by the payment of judgments or settlements.

There are three options for liability coverage under the business auto insurance policy: (1) autos owned by the business; (2) all autos owned, hired or leased; or (3) all autos, including those that are not owned, hired, or leased. Most business owners should buy the third type of coverage to protect themselves from liability when an employer or principal is driving a personal auto on company business.

When is the business liable?

An employer is generally liable for the acts of the employees when they are acting within the scope of their employment. So, when employees are driving vehicles on company business, regardless of who holds title to the vehicle, the employer probably will be liable.

For example if an employee takes a company-owned vehicle home at night, generally on the way to and from home, the employer is liable. However, if the employee takes that vehicle out later that night on personal errands, the employer will usually not be liable, because the employee is not acting within the scope of employment.

Controlling Auto Loss Exposures

The cause of most accidents is the driver. Employers should always check driving records of any employees who will drive on company business and never allow persons with a poor driving record to drive.

It should also be company policy that drivers always use seat belts. Driving safety should be frequently emphasized, and all vehicles should be well maintained.

Premiums

Premiums for the property coverage portion of the auto insurance policy are based on business use, radius or areas of use, and where there is a combination truck and trailer on gross vehicle weight (GVW) or gross combination weight (GCW).

The three types of business use are service, retail and commercial:

- Service use refers to vehicles used to transport people, tools, equipment, or supplies to and from a job location.
- Retail use refers to vehicles that pick up property from or deliver it to individual households.
- Commercial use is when it does not fit under the service and retail descriptions.

There are three radius classifications:

- Local—fewer than 50 miles from principal point of garaging.
- Intermediate—more than 50 and fewer than 200 miles.
- Long distance—more than 200 miles.

Fleet of Vehicles

Businesses that have a fleet of vehicles will of course have different needs than a business with one or two. Businesses need to be aware of how insurance policies are written for a fleet of vehicles. Some provide fleet coverage, which means the business does not have to notify the insurance company when a new vehicle is added; it is covered as part of the fleet. Other policies do require notice to the insurance company of a new vehicle. If the notice is not given, the new vehicle is not insured.

Underwriting Guidelines for Auto Insurance

Underwriting is the process insurance companies use to select and classify an applicant's risk. Insurers use their own underwriting standards to determine if your business is eligible for insurance and, if so, what price you should pay for the coverage.

When you apply for auto insurance, your driving record will not only affect your rates, it may also cause you to be denied insurance. Wisconsin law does not permit insurers to exclude drivers by endorsement. They are permitted to rate based on all members in the household regardless of whether they are related by blood or marriage.

Wisconsin law does not require insurance companies to extend a grace period for auto insurance premium payments. If payment is not received by the due date, the insurance company is permitted to cancel your auto insurance policy for nonpayment of premium.

When replacing your automobile policy with another company, be aware that the new company has 60 days to underwrite (examine, accept or reject) your application. This may include securing motor vehicle, credit and claim history reports, as well as verification of other information provided on the

application. Your policy can be canceled during the first 60 days for any adverse information, such as accidents, violations, suspensions or prior claims.

If You Are in an Accident

Call the police. A police report can help if you have an accident or if your car is stolen or damaged by vandals. What looks like a minor dent could be several hundred dollars' worth of damage.

Obtain information. Write down the names, addresses, telephone numbers, and license number of persons involved and of witnesses. Note the time, date, location, road conditions, make and year of vehicles involved, insurance information, apparent damage and injuries, and your version of what happened. Make a diagram of the accident. Your insurance company will need complete information about the account.

Call your agent. Phone your agent promptly, even if you are far from home. Have your policy number ready, plus all license numbers, phone numbers, and other information.

Ask your agent. Find out what documents, forms, and data you'll need. If you have any questions, your agent will be able to assist you in filling out the forms.

Cooperate and answer all questions fully. Your insurer may call you for more information or ask to examine your damaged vehicle. In order to determine the extent of damage, they must have access to the vehicle.

Take notes. Whenever you talk with insurance company employees, your agent, lawyers, police, or others, write down the date, times, names, and subjects you talked about. Include all decisions or promises made.

Save receipts. Your auto policy may pay for incidentals such as a car rental or a hotel room if your accident happens out of town. Save copies of all documents you send or receive.

Settling your claim. The claim should be paid promptly after the insurer has received adequate proof of loss. If the insurer rejects your claim or pays only part of it, you should be given an explanation for the decision.

B. Worker's Compensation Insurance

Worker's compensation is protection mandated by state law for a worker and his or her dependents against injury and death occurring in the course of employment. It is not health insurance and is not intended to compensate for disability other than disability caused by injury arising out of employment.

The purpose of the worker's compensation system is to provide financial and medical benefits to the victims of "work-related" injuries and their families regardless of fault. The laws place the financial burden on the employer and ultimately the consumer. This compensation is generally the exclusive remedy for the injured employee.

Benefits Payable Under Worker's Compensation Insurance

Worker's compensation benefits can provide the urgently needed medical care. And, it can provide the needed financial support for farmers and their families. Basic benefits include:

1) Coverage of all reasonable and necessary medical costs.

2) Benefits for temporary wage loss [Temporary Partial Disability (TPD) or Temporary Total disability (TTD)] sustained by an employee while recovering from an injury. Eligibility for temporary disability benefits are determined and must be documented by a doctor. Benefits for temporary wage loss due to disability are based on two-thirds of the employee's wage rate up to a specified maximum amount.

3) Benefits for permanent disability [Permanent Partial Disability (PPD) or Permanent Total Disability (PTD)] if the employee does not fully recover from the injury. Permanent disability is awarded for the potential, or actual, loss of earning capacity. The amount of benefit payment for permanent disability depends on the seriousness of the permanent disability.

4) Vocational rehabilitation and retraining. For information on job retraining or placement, call or write the Worker's Compensation Division.

5) If death occurs to an injured employee, death benefits and burial expense will be paid up to specific limits.

For more information on worker's compensation insurance, contact:

Wisconsin Worker's Compensation Division
Department of Workforce Development
www.dwd.state.wi.us

Madison Area Office:
Worker's Compensation Division
201 East Washington Avenue, Room C100
P.O. Box 7901
Madison, WI 53707
(608) 266-1340 Phone
(608) 267-0394 Fax

Milwaukee Area Office:
Worker's Compensation Division
State Office Building, Rm. 330
819 North Sixth Street
Milwaukee, WI 53203
(414) 227-4381 Phone
(414) 227-4012 Fax

Appleton Area Office:
Worker's Compensation Division
Fidelity Bank Bldg., Rm. 310
1500 North Casaloma Drive
Appleton, WI 54913-8200
(920) 832-5450 Phone
(920) 832-5355 Fax

Wisconsin law requires that a subject employer with employees working in Wisconsin must have a worker's compensation insurance policy with an insurance company licensed to write worker's compensation insurance in Wisconsin.

Each individual employer must provide a worker's compensation insurance policy for its employees. One employer cannot provide worker's compensation insurance coverage for another employer's employees even where or whether or not they voluntarily sign a contract to provide the coverage. Every employer, as described in s. 102.04 (1), Wis. Stat., is required under s. 102.28 (2), Wis. Stat., to have a worker's compensation insurance policy in the name of the employer/owner or in the name of the business entity.

An employer subject to the Act may not withhold or collect any money from employees or any other person, including independent contractors and subcontractors, to pay for worker's compensation insurance. To do so is illegal. Also, no agreement by an employee waiving rights to compensation is valid. [s. 102.16 (3) and 102.16 (5), Wis. Stat.]

Wisconsin Worker's Compensation Act

Most Wisconsin employers are required to have insurance or be licensed self-insurers under the Wisconsin Worker's Compensation Act (the Act). The law mandates compensation insurance for:

1) Any employer who usually employs three or more persons full- or part-time. This employer needs insurance immediately.

2) Any employer who has one or more full-time or part-time employees and has paid gross combined wages of $500 or more in any calendar quarter for work done in Wisconsin. This employer must have insurance by the 10th day or the first month of the next calendar quarter.

3) Anyone engaged in farming who employs 6 or more employees (at one or more locations) on the same day for 20 days (consecutive or nonconsecutive) during a calendar year. A calendar year is January through December. The farmer must have insurance within 10 days after the 20th day of employment. Some relatives of the farmer are not counted as employees.

(Sections 102.04 and 102.07, Wis. Stat.)

Wisconsin law requires that a subject employer with employees working in Wisconsin must have a worker's compensation insurance policy with an insurance company licensed to write worker's compensation insurance in Wisconsin.

Each individual employer must provide a worker's compensation insurance policy for its employees. One employer cannot provide worker's compensation insurance coverage for another employer's employees even where or whether or not they voluntarily sign a contract to provide the coverage. Every employer, as described in s. 102.04 (1), Wis. Stat., is required under s. 102.28 (2), Wis. Stat., to have a worker's compensation insurance policy in the name of the employer/owner or in the name of the business entity.

An employer subject to the Act may not withhold or collect any money from employees or any other person, including independent contractors and subcontractors, to pay for worker's compensation insurance. To do so is illegal. Also, no agreement by an employer waiving rights to compensation is valid. [s. 102.16 (3) and 102.16 (5), Wis. Stat.]

Who is covered by the Act? Are there exceptions?

Nearly all employers in Wisconsin are covered. This includes both public and private employers. In fact, when talking about worker's compensation, it is easier to discuss the exceptions. There are a few classes of workers who are covered by federal laws and are not covered by the Act. Employees of the federal government (such as postal workers, employees at a veterans administration hospital, or members of the armed forces) are covered by federal laws. People who work on interstate railroads are covered by the Federal Employers Liability Act. Seamen on navigable waters are covered by Merchant Marine Act of 1920, and people loading and unloading vessels are covered by the Longshoremen's and Harbor Worker's Compensation Act.

The only employee exceptions to the Act insurance requirement are domestic servants, some farm employees, volunteers, including volunteers of nonprofit organizations that receive money or other things of value totaling not more than $10 per week, and religious sect members that qualify and are certified for an exemption. Please contact the Worker's Compensation Division, Bureau of Insurance Programs at (608) 266-1340 for a detailed explanation of these exceptions. Virtually all other workers and employers are subject to the Act.

Are out-of-state employers who have employees working in Wisconsin required to have a worker's compensation insurance policy in Wisconsin?

Yes, out-of-state employers with employees working in Wisconsin must have a worker's compensation policy with an insurance company licensed to write worker's compensation insurance in Wisconsin.

Section 102.28 (2), Wis. Stat., requires that an employer subject to the Act with employees working in Wisconsin must have a worker's compensation insurance policy with an insurance company licensed to write worker's compensation insurance in Wisconsin. The policy must be endorsed to name Wisconsin as a covered state in section 3-A of the policy.

If an out-of-state employer has a worker's compensation insurance policy with an insurance company not licensed to write in Wisconsin, they must obtain a policy from a Wisconsin licensed insurance company to cover their Wisconsin exposure. The insurance company must file the properly endorsed policy with the Wisconsin Compensation Rating Bureau.

To obtain more information contact:

The Wisconsin Compensation Rating Bureau
Street Address
20700 Swenson Drive – Suite 100
Waukesha, WI 53186
(262) 796-4540 (Phone)
(262) 796-4400 (Fax)

Mailing Address
P. O. Box 3080
Milwaukee, WI 53201-3080

Internet Address
www.wcrb.org

Must employers purchase worker's compensation insurance?

The law requires that every employer subject to the Act must provide some way of assuring that it can pay benefits to its workers should they become injured. Most employers in Wisconsin provide this security by purchasing an insurance policy from a private insurance company. The insurance company then reports to the State of Wisconsin Department of Workforce Development (DWD) that it is providing coverage for the employer. Some employers, however, are "self-insured."

What is self-insurance?

Some employers who are financially sound (and usually quite large) are "self-insured." An employer can only be self-insured if it obtains permission from DWD.

DWD requires employers to demonstrate a very sound financial condition in order to be self-insured.

Where to Purchase Worker's Compensation Insurance

Open Marketplace

There are about 300 insurance companies licensed to write worker's compensation insurance in Wisconsin. Contact a local agent to assist you in applying for insurance to the company of your choice.

If an insurance company turns down your application for insurance, you should ask your agent to search the marketplace for another company. A list of Licensed Worker's Compensation Insurance Companies (oci.wi.gov/workcomp/wcliccos.htm) and a directory of licensed insurers that includes addresses and phone numbers is available on OCI's Web site at Company Lookup https://ociaccess.oci.wi.gov/CmpInfo/CmpInfo.oci. You can also find Company Lookup in the Quick Links section on OCI's home page at oci.wi.gov.

Wisconsin Worker's Compensation Pool

If coverage is not available in the open market, your agent should submit an application to the Wisconsin Compensation Rating Bureau (Bureau). The Bureau acts as administer and trustee of the Wisconsin Worker's Compensation Pool (Pool). The Pool is a risk-sharing plan created to provide worker's compensation insurance to any employer who is unable to obtain coverage in the open market and who is, in good faith, entitled to such insurance. Out-of-state employers with no Wisconsin operations and employers who owe the Pool monies from prior policies are not eligible for coverage from the Pool.

All insurers licensed to write worker's compensation insurance in Wisconsin must participate in funding the Pool, and are represented by eight insurance companies that have been designated as servicing carriers. The insurance company assigned to service a policy issued through the Pool writes the policy in its own name and provides claims, loss control, auditing, and other services, just as they would for their voluntarily written policyholders.

The Bureau will assign an insurer to write the policy for you. The premium cost is generally the same for assigned coverage. Your insurance agent can provide you with further information and forms.

For more information on the Pool, contact your agent or the Bureau at:

Street Address
Wisconsin Compensation Rating Bureau
20700 Swenson Drive, Suite 100
Waukesha, WI 53186

Mailing Address
Wisconsin Compensation Rating Bureau
P.O. Box 3080
Milwaukee, WI 53201-3080

Phone Number
(262) 796-4540

Internet Address
www.wcrb.org

Penalties for not Purchasing Worker's Compensation Insurance

There are severe penalties for the failure of an employer to provide worker's compensation coverage. First, if a worker is injured, the employer is personally liable.

Second, the Worker's Compensation Division actively enforces the Act. It has the authority to close down an employer until such time as proper worker's compensation insurance coverage is obtained.

By law, a penalty is imposed on an employer for failing to have worker's compensation insurance coverage where required. The normal penalty is twice the amount of premium not paid during an uninsured time period or $750, whichever is greater. An employer who has an illegal lapse in worker's compensation insurance of seven consecutive days or less, can be subject to a penalty of $100 for each day they are uninsured up to seven days, provided 1) the employer has not previously been penalized for not having worker's compensation insurance coverage; and 2) no injury that the employer is liable for under s. 102.03, Wis. Stat., occurred during the uninsured period. If the illegal lapse is greater than seven days, the normal penalty assessment will apply.

In addition to the penalty, uninsured employers are personally liable for benefits and do not have the normal exemptions of property from seizure and sale on execution of a judgment. Officers and directors of uninsured corporations are personally liable for benefits owed by the corporation. There are other penalties that may apply depending upon the situation. [Sections 102.82 (2) (a), 102.82 (2) (ag), and 102.28 (5), Wis. Stat.]

Cost of Insurance

The cost of insurance will vary depending on your payroll and the type of business you operate. Employers are classified for worker's compensation insurance purposes by the predominate business of the employer and not the specific job.

For example, in a manufacturing risk situation, the product manufactured determines the business of the insured employer. In other words, General Motors would be classified as an automobile manufacturer. There are many different kinds of jobs involved in the manufacturing of automobiles, some of which are more hazardous than others. Nonetheless, all of these jobs are being performed for an employer engaged in the business of manufacturing automobiles, and therefore, all of the employees' payrolls would be classified in the same classification.

Premium Rate Determination

The Bureau sets the premium rate for each class with the approval of the Commissioner of Insurance. If you feel that your business is not properly classified or the premium charged is not proper, you can appeal to the Bureau for review of your situation. If you are still not satisfied with the Bureau's decision, you may request, in writing, that the Commissioner of Insurance hold a hearing to review the Bureau's decision. [Section 626.31, Wis. Stat.]

Classification System in Worker' s Compensation Insurance

The object of the worker's compensation system is to group similar employers so that each classification reflects losses common to them. Since losses vary widely by business or industry of employers, charging the statewide average rates would result in some employers paying too high a premium, while employers in other businesses or industries would pay less than their fair share.

Accordingly, employers are classified by the business or industry in which they operate to reflect this variation in loss costs. Generally, similar businesses have similar exposures to occupational injury and disease, even though no two businesses are identical.

Each classification combines the payroll and losses of similar employers to develop a price for the insurance protection. Worker's compensation insurance uses approximately 600 separate business classifications for premium purposes.

Three occupations are common to so many businesses that special classifications have been established for them. These "standard exception" classifications cover clerical office employees, outside sales people, and drivers. The standard exception classes are the only classifications that are not related to the business of the employer. Instead, they are related to the job as these jobs are fairly common to all employers.

The Experience Rating Plan

The Experience Rating Plan offers a method for modifying the cost of insurance for all but the smaller employers to match the characteristics of an individual employer. Experience rating groups all insureds according to their business operations or classification, adds together the losses of the groups, and obtains an average cost for the groups.

In worker's compensation experience rating the actual losses of the individual employer are determined over a period of time, usually three years. The losses are capped which makes the frequency not severity of losses more important for determining experience rates. This experience is then compared or contrasted with the average as reflected by the rate or rates that apply to the employer's business. If the employer has better than average costs, then the employer is awarded a credit, while poorer than average experience carries a debit rating. Experience rating takes average loss experience (rates), and modifies it by the individual employer's own loss experience.

Legal Protections in the Event of Bankruptcy

There are two provisions in the law to protect workers in the event of bankruptcies.

Self-Insurers' Security Fund

The Self-Insurers' Security Fund is funded by assessments, on other self-insured employers. Should a self-insured employer go bankrupt, the Self-Insurers' Security Fund has the responsibility for making payments to injured workers. Should this occur, it is very important that the injured worker give notice of their claim to the Self-Insurers' Security Fund immediately. There is also a guaranty fund which assumes responsibility if an insurance carrier becomes bankrupt.

Wisconsin Insurance Security Fund

Every state has a safety net to protect insurance consumers from financial loss in the rare instance that a company becomes insolvent. This safety net is called a "guaranty fund." The guaranty funds are established by state law and are composed of

licensed companies in the state. They pay the claims of policyholders and other claimants of an insolvent insurance company. The money to pay the claims against the insurance company comes from assessments made against all of the insurance companies that are members of the guaranty fund.

In Wisconsin, the fund is called the Insurance Security Fund (Fund). The Fund is created by state law and is funded by assessments of insurers licensed to do business in Wisconsin. In general, the Fund protects residents for most claims of licensed insurers in liquidation. The Fund should not be relied upon to eliminate all risks of loss to insureds due to insurer insolvency. Some types of policies may not be fully covered and significant delays could occur in settling obligations in cases of liquidation.

Questions about the coverage and limitations of the Fund can be addressed to:

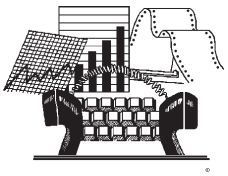
Wisconsin Security Fund
2445 Darwin Rd. #101
Madison, WI 53704
(608) 242-9473
www.wilifega.org

Where can I get more Information About Coverage Under the Act?

Questions often arise concerning the interpretation of the coverage and exclusion requirements of the law. Information and assistance concerning these issues is available from the Wisconsin Worker's Compensation Division, Bureau of Insurance Programs at (608) 266-1340.

Copies of the Worker's Compensation Act of Wisconsin (www.dwd.state.wi.us/wc/legal/default.htm) are available for purchase. Please call (608) 266-1340 for details.

III. INSURING YOUR HOME BUSINESS



If you operate a home business full-or part-time you might be uninsured and not realize it. Many home business owners believe that their homeowner's insurance policy covers all their home business needs. You should not assume that your homeowner's insurance policy will cover your home business. Your homeowner's policy may provide coverage but probably only to a maximum of $2,500 for business equipment in the home and $250 away from the premises.

Your homeowner's policy usually does not cover business-related liability, for example, if a customer or supplier is injured on your property. A homeowner's policy also does not insure your inability to collect your accounts receivable if your business records are damaged, and your policy will not replace lost income if you cannot operate your business due to damage to your home.

There are three ways you can buy home business coverage:

- Depending on your home business, you may be able to add an endorsement to your existing homeowner's insurance policy. For example, some insurers offer a home day care endorsement for people who operate a home day care service for pay in their home.

- You may also be able to buy several individual business insurance policies to provide the various coverages you need, such as business property, general liability and business income coverage.

- Some insurance companies have begun to offer what amounts to a mini-business owner's package policy specifically for home businesses. Some of these policies cover the loss or destruction of business property on or off premises; the loss of valuable papers and important business information; personal injury and advertising liability; accounts receivable up to $10,000; money lost on premises up to $5,000 and off premises up to $2,000.

The companies that offer these policies often require that you purchase your homeowner's and auto insurance policies from them. With these policies in place, your home business policy extends the amount of personal property and liability coverage you have on your home to your business. And if a fire or storm makes running your business impossible, your insurance will cover expenses and lost income for up to a year.

Discuss your home business insurance needs with your agent to buy the policy that best fits your needs.

IV. UMBRELLA LIABILITY INSURANCE

Umbrella policies cover all underlying liability policies. Umbrella policies are designed to cover large, infrequent losses such as the total cost of claims that may result from a collision with a school bus. To decide whether you need an umbrella policy, think of the most extreme situations like a roof caving in under the weight of a once in a 100-year snowstorm, and the total cost of the claims that such an accident would produce if there were many people in the vicinity; then compare the amount with the limits of your current liability policies.

Umbrella liability insurance provides two kinds of coverage:

- Payments of liabilities in excess of the policy limits for an insured's basic commercial general liability, or employers' liability coverage; and
- Liability for areas not covered in other liability policies.

An umbrella policy offers you extra liability insurance that pays for a loss when the limits of your underlying policy are reached. So, if you are responsible for someone's injury that required $150,000 of medical treatment and the liability limit in your underlying policy is $100,000, your umbrella policy will pay the additional $50,000. Also, there are some situations, such as libel and slander, that a standard policy does not cover. An umbrella liability policy enables people to protect themselves against catastrophic lawsuits in such situations.

Umbrella policies are sold with a variety of limits, commonly $1 million or $5 million. The underlying policies provide the first dollars in a liability claim and the umbrella is available to any remaining amounts until the amount paid by all policies reaches the umbrella limit.

Umbrella liability policy coverage usually protects policyholders wherever they travel. Many such policies will cover legal defense costs even if the charges are proved baseless. Umbrella liability coverage has come to be in high demand among individuals who have substantial assets and who may be especially vulnerable to lawsuits and costly judgments.

Keep in mind that most personal umbrella policies that are added to a homeowner's or personal auto insurance policy will cover liability stemming from business activities and business property only if covered by the basic policies. Always check your policy to see how it defines business and business property, or ask your agent.

V. RISK MANAGEMENT/LOSS CONTROL MEASURES

You may be able to reduce your premium through risk management. Risk management involves identifying and analyzing ways in which you may be found liable (your "exposure to liability") and selecting and implementing techniques to be used to handle the exposure. You can take steps to reduce the possibility of unforeseen losses and the impact of those that do occur, whether from fires, storms, thefts, lawsuits or injuries.

You can:

- Conduct safety inspections and programs for training employees in first-aid methods.
- Install a sprinkler system and an alarm that automatically notifies firefighters of a fire. This may make losses less likely or injuries less severe.
- Make sure the wiring in your building is in good shape.
- Train workers to lift heavy items properly and to wear safety masks and gloves when working with hazardous substances.
- Keep only a small amount of cash in the cash register and deposit the rest in a floor safe that cannot be opened by employees.
- Store inventory in two locations so if there is a loss, all the inventory will not be destroyed.
- If you lease out part of your premises, you might require your tenant to protect you from liability claims of people they allow in the building.
- Make sure that all your drivers have good driving records. The cause of most accidents is the driver. You should always check the driving records of any employees who will drive on company business and never allow a person with a poor driving history to drive.

This list is far from complete. You should ask your agent or insurance company if they have brochures or publications on loss control topics.

Impact of Implementing Loss Control Measures

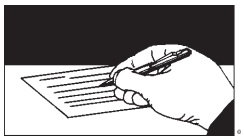
Implementing loss control measures may make it less likely that you will be found liable, or if you are found liable, that damage will be large. Because premiums are based on how much insurers pay out in claims, an increase in claim costs also means an increase in your premiums.

Businesses with very good loss control measures and claims histories will often pay lower insurance premiums than those with less effective loss control measures and practices. A business with a really poor loss control history may also have difficulty finding property insurance.

This, in turn, may make it less likely that you will be found liable, or if you are found liable, that damages will be large. You should talk to your agent about which risk management techniques you can use that may reduce your premiums.

VI. FILING A CLAIM

A. How to File a Property Damage Claim



If your business is hit by a fire, accident or theft, your insurance policy lists the steps you must take. The following tips will make it easier for you to go through the claims process.

1. When a fire, accident, or theft occurs, call your agent or insurance company at once. Report any burglary or theft to the police.

2. Take steps to protect your property from further damage.

3. If you need immediate repairs, save the damaged parts. The claims adjuster may be interested in examining them. If saving them is not practical, call the claims manager at your insurance company.

4. Get at least two bids for repairs. This will speed the processing of your claim. Get estimates on the cost to repair or replace the damaged property. Bids should include:

   - A list of parts that have to be replaced and the reason for replacing them;
   - Straight time labor costs;
   - Overtime labor costs. Don't forget to include any costs you or your employees incur while repairs are being made.

5. If you are filing a business interruption claim, you will have to show how much business you carried on, both before and after the loss. Keep detailed records of business activity and extra expenses during the interruption period. Keep current copies of these records off the business premises so they will not be destroyed by fire. Do everything you can to minimize the amount of loss.

6. If you need help, call your agent or your insurance company's claims manager.

B. How to File a Liability Insurance Claim

Business owners have a contractual obligation to inform the insurance company or agent as soon as they become aware that there is or could be a liability claim. The insurance policy contains a "reporting clause" that specifies the time an insured has to file a claim. With a standard general liability insurance policy, it is recommended that a claim be reported as soon as you know of a loss.

You should report all liability claims to the insurance company as soon as possible. Your report should include:

- The details of how, when and where the accident took place.
- The names and addresses of any injured persons and witnesses.
- All copies of any demands, notices, summonses or legal papers received in connection with the claim or suit to the insurance company as soon as possible.
- An authorization for the insurance company to obtain records and other information.

Your policy requires you to cooperate with the insurance company in the investigation, settlement or defense of the claim or suit.

Unless all of the terms set out in the policy have been fully complied with, you might not be able to collect from the insurance company.

C. How to File Your Motor Vehicle Claim

If your company car or truck is involved in an accident, if it is damaged by fire, flood or vandalism, or if it is stolen, follow these steps in filing a claim.

- Phone your agent or insurer as soon as possible. Ask what forms or documents will be needed to support your claim. Your insurer may require a "proof of loss" form, as well as documents relating to your claim, such as medical and repair bills and a copy of the police report.

- Supply the information your insurer needs. Cooperate with the investigation, settlement or defense of any claim, and provide copies of any legal papers you receive in connection with your loss. Your insurer will represent you if a claim is brought against you and defend you if you are sued for a claim covered by the policy.

- Keep records of expenses you may incur as a result of the accident. You may be reimbursed for them because of your policy. If the accident occurs while employees are conducting insurer-related business activities, your worker's compensation policy will cover the workers' medical expenses and loss of income.

- Keep copies of all paper work for your own files. You may need them later.

VII. FLOOD INSURANCE

If your business is located on a flood plain, you will need to purchase flood insurance. Flood insurance is available through the National Flood Insurance Program (NFIP). To qualify for the NFIP program, you must live in a designated community and comply with the government guidelines for flood prevention. Most areas in Wisconsin qualify. Your agent should be able to help you find out if you are eligible.

For general information on the flood insurance program, you may call or write:

Federal Emergency Management Agency (FEMA)
536 S. Clark St. - 6th Floor
Chicago, IL 60605
(312) 408-5500 (Phone)
1-888-379-9531 Toll-Free
1-800-424-5593 TTY
www.floodsmart.gov

VIII. HEALTH INSURANCE

No Wisconsin state or federal insurance law requires employers to offer or provide health insurance to employees. However, if an employer decides to offer group health insurance to employees, the insurance options available will often depend on the size of the group to be insured. Your insurance agent or broker should be able to advise you on the availability and cost of the coverage.

A. Types of Coverage

Group health insurance. Group health insurance provides coverage to individuals under a single master policy issued to the group policy owner. Certificates of insurance are provided to the individuals. The policy owner may be an employer, an association, a labor union, or other entity. Unless the group is small, no individual medical underwriting is performed. Instead, insurers require minimum employee or member participation levels and minimum employer contribution levels in order to assure that there are sufficient individuals in the group in good health to balance those in the group in poor health.

Group health insurance provides several advantages:

- The premium is often partly paid by an employer or union.

- The ratio of total benefits paid to total premiums received is usually quite high.

- You are automatically eligible if you are a group member, and there may or may not be additional screening for medical problems.

- Group premiums are typically lower than those for comparable individual policy coverage.

Individual health insurance. Individual health insurance provides coverage to a specific individual or to an individual and their family under a policy issued to that individual. In order to be considered for individual health insurance coverage, you will be asked to provide evidence of insurability that may require you to undergo a medical examination. This is called medical underwriting. The same requirements would apply to any dependents you may insure under the policy. Medical underwriting is discussed further on page 32.

Finding adequate coverage at an affordable price will take some effort. Start with a knowledgeable health insurance agent who will provide reliable service. Try to get a recommendation from family or friends. Otherwise check the yellow pages of the telephone book. If you are turned down by one company, try another. Insurers have different standards.

B. Finding the Right Coverage

The health insurance available to a group will depend upon several factors including:

- The size of the group;
- The age, sex, and marital status of employees;
- The number of the dependents;
- The health status of the employees and dependents; and
- The location and type of the business.

Factors that an employer needs to consider are:

- How much can the employer afford to contribute toward insurance for the employees? Should the employees contribute toward their own insurance? If so, what is a fair amount? Many insurers set minimum participation levels for eligible employees.
- What benefits should the policy cover? Because of the multitude of policies on the market, it is important for an employer to decide the minimum services he or she wants covered by a policy.
- Are the policy benefits realistic given the group's particular community and today's medical costs? For example, will the policy meet the group's needs if it only pays $250 for an appendectomy when the average cost in the area is five times the amount?
- Most policies do not cover experimental procedures. Many organ transplants are considered experimental, they are expensive. What organ transplants are covered by the policy?
- Are cost-containing incentives built into the policy? This includes incentives for outpatient rather than in-hospital surgery, generic rather than name-brand prescriptions, and managed care facilities.

Make sure that each covered employee understands the benefits covered and their responsibilities under the policy for cost-sharing and cooperating with managed health care procedures.

C. Cost Containment Features

There are several ways insurers and employers can use to hold down costs of medical benefit plans. There are two ways to shift costs to an employee. One is through the use of deductibles. The other is through copayments or coinsurance.

Deductibles, Copayments and Coinsurance. A **deductible** is the initial amount that an insured must pay before the policy benefits begin. It is usually a flat dollar amount. A **copayment** is a set dollar amount of the costs that the insured must pay and **coinsurance** is a certain percentage of the costs that the insured must pay after the deductible is met.

A policy containing a deductible, copayment and coinsurance provisions may have a $500 or higher deductible per family member per year, 80/20% coinsurance for expenses over the deductible, a $5 copayment for prescription drugs, and out-of-pocket expense cap of $1,000 per person or $2,500 per family.

Higher deductibles and copayments than those used in the above illustration are becoming more common.

IX. CHOOSING A PLAN

Choosing a health insurance plan is like making any other major purchase. You choose the plan that meets both your needs and your budget. For most people, this means deciding which plan is worth the

cost. Plans differ, both in how much you have to pay and how easy it is to get the services you need.

Health insurance plans are usually described as a fee-for-service health plan or a defined network health plan. A defined network plan is the term used in Wisconsin insurance law to refer to any health benefit plan that creates incentives for its enrollees to use network providers. A fee-for-service health plan allows you to use any doctor, hospital, or other provider you choose. Although these plans offer the greatest freedom to select any doctor, they are usually more expensive than plans that limit choices. Defined network health plans usually cost you less, but you give less freedom of choice.

Cost isn't the only thing to consider when buying health insurance. You also need to consider what benefits are covered. You need to compare plans carefully for both cost and coverage.

While fee-for-service and defined network plans differ in important ways, in some ways they are similar. Both cover an array of medical, surgical, and hospital expenses. Most offer some coverage for prescription drugs; and some include coverage for dentists and other providers. But there are many important differences that will make one or the other form of coverage the right one for you.

A. Fee-for Service Health Plan

Under a fee-for-service health plan, you are free to seek necessary medical care from any doctor and hospital you wish. The doctor often bills the insurance company directly for the services provided, and the insurance company pays for the items covered by the policy. In some cases you will have to fill out claim forms and send them to the insurance company. This type of health plan offers the most choices of doctors and hospitals.

Features of a Fee-for-Service Health Plan

The following section discusses how a fee-for-service health plan works.

Deductible

The deductible is the dollar amount that you must pay each year before the insurance company pays its share. The deductible may range from $500 or more per year per individual or $2,500 or more per year per family. For example, if you have a $500 annual deductible, you will pay for the first $500 of covered expenses for each person insured.

If you are buying coverage for your family, ask how the family plan works. Some plans may not require each family member to pay the deductible after two people in the family have paid it.

Read the policy carefully. Some policies require you to pay a deductible on a calendar year basis or on a per sickness or injury basis.

Coinsurance

Coinsurance is your share or the percentage of covered expenses you must pay in addition to the deductible. The most common coinsurance arrangement is for the insurance company to pay 80% and you pay 20% as coinsurance until a maximum out-of-pocket expense is reached. Coinsurance applies to each person and starts over again each year. Sometimes the policy will cover all expenses after a certain point. Look at the list of covered expenses for the policy to see how comprehensive it is.

Out-of-Pocket Limit

Many plans have an out-of-pocket limit. The out-of-pocket limit is the maximum dollar amount that you pay for covered services and supplies during a specified period, generally a calendar year. The maximum may be defined to include or exclude the deductible. Once the out-of-pocket maximum is paid, benefits are paid at 100% of the costs incurred after that time.

Lifetime Maximum

Your major medical policy puts a cap, such as $1 million, on the total amount the policy will pay toward your medical expenses. When the insurance company has paid that amount, the policy will be "used up" and no more benefits will be paid for your medical expenses. If you expect to have significant medical expenses, make sure to check the plan's lifetime maximum.

Medically Necessary

Every major medical policy contains a provision that allows insurance companies to evaluate whether a service or treatment is "medically necessary" in treating a patient and whether it could adversely affect the patient's condition if it were omitted. Insurance companies can deny payment for a

treatment that is not medically necessary. Most health benefit plans often require a review before certain medical procedures are done.

Usual, Customary, and Reasonable Charge

Most insurance companies do not use your actual bills to calculate their payments. Companies have their own fee schedule, often known as usual, customary, and reasonable (UCR) charges. The UCR charges are typical amounts paid for everything from a doctor's visit to heart surgery.

For example if your doctor charges $1,000 for an operation while most doctors in your area charge only $800, you will be billed for the $200 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, ask your doctor to accept your insurance company's payment as full payment, or shop around to find a doctor who will. Otherwise, you will have to pay the difference.

Exclusions and Limitations

There are some services that plans won't cover—usually because they are not considered medically necessary. In addition, some services, such as mental health and substance abuse treatment, may be limited. Review each plan's exclusions and limitations. Keep in mind that you have to pay the full cost of care that isn't covered.

B. Defined Network Health Plan

Some defined network plans will provide coverage only if the enrollee uses network providers and other plans will pay a larger portion of the charges if the enrollee uses network providers. HMOs, point-of-service plans and preferred provider plans are examples of defined network plans. This type of plan is sometimes referred to as a managed care plan.

Health Maintenance Organization (HMO)

An HMO is a health insurance plan that provides comprehensive, prepaid medical care. It differs from a traditional insurer in that it both pays for and provides the medical care. Persons insured by an HMO plan are referred to as enrollees. An HMO usually operates on a closed panel basis. This means the enrollees are required to seek care from a medical provider who is either employed by or under contract to the HMO.

HMOs limit care to a specific geographic area. Except for serious emergencies or the need for urgent care outside the service area, the HMO will probably not pay for care enrollees receive from a provider who is not affiliated with the HMO unless the HMO physician refers you to that provider.

HMOs are regulated as insurance companies by the OCI. To do business in the state, an HMO must meet certain financial requirements and abide by relevant insurance laws. OCI must approve policies before they are sold to ensure they comply with state laws.

Point-of-Service Plan (POS)

A POS plan is essentially an HMO that allows members to use services provided outside of the network without prior approval from a network doctor. POS plans offer lower deductibles and no coinsurance for visits to doctors inside the network. Visits outside the network normally require the payment of deductibles and coinsurance the same as a standard insurance policy.

Preferred Provider Plan (PPP)

A PPP is a form of managed care closest to an indemnity plan. A PPP has arrangements with doctors, hospitals, and other providers of care who have agreed to accept lower fees from the insurer for their services. A PPP pays a specific level of benefits if certain providers are used, and a lesser amount if non-PPP providers are utilized. A PPP must provide reasonable access to network providers in the service area. However, a PPP is not required to offer a choice of participating providers in each geographic area.

PPPs may require that enrollees pay coinsurance of up to 50% for services provided by nonparticipating providers. Enrollees should read their policies carefully before seeking services from nonparticipating providers.

A PPP operates in a certain geographic area, is limited to specific providers, and is regulated by OCI. A PPP that has a provider agreement with a hospital may not have an agreement with every provider who provides services at the hospital, such as anesthesiologists, pathologists, and radiologists.

Many insurers that offer standard health insurance policies also offer some type of preferred provider plan. You should ask your agent to provide you with information on preferred provider plans in your area.

Features of a Defined Network Health Plan

The following section discusses how a defined network health plan works.

Provider Directories

All defined network plans will provide an enrollee with a provider directory listing hospitals, primary care physicians, and specialty providers from whom the enrollee may obtain services. These directories are updated annually. However, the enrollee should inquire at the time of making an appointment as to whether the provider is currently a member of the defined network organization.

Continuity of Care

If a defined network plan represented a primary care physician (defined as a physician specializing in internal medicine, pediatrics, or family practice) as being available during an open enrollment period, it must make the physician available at no additional cost for the entire plan year. A specialist provider must be made available for the lesser of the course of treatment or 90 days. If an enrollee is in her second trimester of pregnancy, the provider must be available through postpartum care. The exceptions are for a provider who is no longer practicing in the defined network plan's service area or who was terminated from the plan for misconduct.

Referral Procedure

Some HMOs require a referral from a primary care physician before an enrollee can see another plan provider. All HMOs require the enrollee to have a referral that has been approved by the plan before going to a non-plan provider. The certificate booklet includes information on the procedure to follow and any notification requirements.

A defined network plan may not require a referral from a physician for services from a plan chiropractor. It must also allow a woman to receive obstetrical and gynecological services from a plan physician who specializes in obstetrics or gynecology without requiring a referral from her primary care provider.

Defined network plans must have a procedure allowing for standing referrals. A standing referral authorizes an enrollee to be seen by a specialist provider for a specific duration of time or specific number of visits without having to obtain a separate referral from the primary provider for each visit to the specialist.

If an enrollee goes to a non-HMO provider without an approved referral, the claim for those services will not be reimbursed by the HMO. Enrollees have the right to file a grievance when a referral is denied.

Second Opinions

Every defined network plan must cover a second opinion from another provider within the defined network plan provider network.

Disenrollment

An HMO must disclose in the policy and certificate any circumstances under which an enrollee may be disenrolled. Disenrollment proceedings may be initiated only for the following reasons:

- The enrollee has failed to pay required premiums by the end of the grace period.
- The enrollee has committed acts of physical or verbal abuse, which pose a threat to providers or other members of the organization.
- The enrollee has allowed a nonmember to use the HMO's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage.
- The enrollee has moved outside of the geographical service area of the organization.
- The enrollee is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care.

Enrollees have the right to file a grievance when a disenrollment proceeding is initiated.

Small employer health insurance is available in Wisconsin from several insurers and defined network plans. The OCI publishes a brochure that is meant to help small employers understand their options and to provide a comparison of premium rates available in the small health insurance marketplace. To obtain a copy, contact the OCI at 1-800-236-8517 and ask for a copy of *Health Insurance for Small Employers and Their Employees*. A copy is also available on OCI's Web site at oci.wi.gov/pub_list/pi-206.htm. OCI also publishes a Spanish version of *Health Insurance Insurance for Small Employers and Their Employees*. You can receive a copy of *Seguro de*

Salud para Pequeños Empleadores y sus Empleados by calling 1-800-236-8517. A copy is also available in pdf format on OCI's Web site at oci.wi.gov/spanish/sp_pub_list/pi-306.pdf.

C. Other Insurance Programs

Health Insurance Risk-Sharing Plan (HIRSP) (hirsp.org)

HIRSP offers health insurance to Wisconsin residents. The plan makes health insurance available to people who either are unable to find adequate health insurance coverage in the private market due to their medical conditions or who have lost their employer-sponsored group health insurance. Applicants are required to meet HIRSP eligibility criteria to qualify. For more information about HIRSP, including eligibility, covered services, and policy options write HIRSP Customer Service, 1751 W. Broadway, P.O. Box 8961, Madison, WI 53708-8961, or call (800) 828-4777 or (608) 221-4551.

BadgerCare Plus (New 05/2008) (www.dhs.wisconsin.gov/badgercareplus)

BadgerCare Plus is a new program for children under 19 years of age and families in Wisconsin who need and want health insurance.

BadgerCare Plus is for all children, regardless of income.

BadgerCare Plus is about more than just children. It also offers access to comprehensive, affordable health care to many families and pregnant women in Wisconsin.

BadgerCare Plus is designed for people who do not currently have access to health insurance. It is not designed to replace private insurance. For that reason, specific rules have been established that do not allow most people to drop their private insurance to participate in BadgerCare Plus.

If you would like more information about BadgerCare Plus call member services at 1-800-362-3002.

D. Other Types of Policies

There are several other types of policies on the market. These are not substitutes for basic or major medical coverage.

Vision and dental policies: These are policies that provide benefits only for vision or dental care. They should not be bought as substitutes for more comprehensive coverage.

Hospital confinement indemnity. This type of policy pays a fixed amount for each day in the hospital for a specified number of days. Sometimes benefits are not paid until you have been hospitalized for several days. These policies are often not a good buy unless the daily benefit is quite high.

Specified disease policies. These policies cover a specific disease or group of diseases. The most common type is cancer insurance. If you already have comprehensive coverage, this coverage is not necessary.

Any insurer selling cancer insurance must give the *A Shopper's Guide to Cancer Insurance* (oci.wi.gov/pub_list/pi-001.htm) to applicants. A copy of the guide is available by contacting the OCI at 1-800-236-8517.

Health discount cards. Be wary of health discount cards, which offer a reduced fee for doctor visits or other medical services. Health discount cards are NOT health insurance plans and are therefore not regulated by the OCI. Some discount cards have been the subject of numerous scams in recent years, so be sure to check these out carefully.

E. Requirements Applicable to All Health Benefit Plans

Emergency Care

Every health plan offered in Wisconsin that covers emergency care, including defined network plans, must cover services required to stabilize a condition that most people would consider to be an emergency, without prior authorization. Defined network plans are permitted to charge a reasonable copayment or coinsurance for this benefit.

Grievance Procedure

All health insurance plans, including all defined network plans are required to have an internal grievance procedure for those who are not satisfied with the service they receive. The procedure must be set forth in the insurance contract and must also be provided in written notice.

The defined network plan must provide each enrollee with complete and understandable information about how to use the grievance procedure. An enrollee has the right to appear in person before the grievance committee and present additional information.

Enrollees may wish to first contact the defined network plan with a question or complaint. Many complaints can be resolved quickly and require no further action. However, filing a complaint with the plan first is not required. An enrollee can file a complaint with the appropriate state agency instead of, before, or at the same time as filing with the defined network plan.

Defined network plans are required to have a separate expedited grievance procedure for situations where the medical condition requires immediate medical attention. The procedure requires defined network organizations to resolve an expedited grievance within 72 hours after receiving the grievance.

Defined network plans are required to file a report with the OCI listing the number of grievances they had in the previous year. A summary of this information for HMOs is included in *The Consumer's Guide to Managed Care Plans in Wisconsin*. To receive a copy of this brochure call the OCI at 1-800-236-8517. A copy is available on the OCI's Web site at oci.wi.gov/pub_list/pi-044.htm.

Independent Review

All insurance companies offering health benefit plans in Wisconsin are required to have an internal grievance process to resolve any complaint you may have with the plan. If you are not satisfied with the outcome of the grievance, you have an additional way to resolve some disputes involving medical decisions. You or your authorized representative may request that an Independent Review Organization (IRO) review your health plan's decision.

The independent review process provides you with an opportunity to have medical professionals who have no connection to your health plan review your dispute. You choose the IRO from a list of review organizations certified by the OCI. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The IRO has the authority to determine whether the treatment should be covered by your health plan.

The independent reviews are conducted by IROs that are certified by the OCI. In order to be certified the IRO must demonstrate that it is unbiased and that it has procedures to ensure that its clinical peer reviewers are qualified and independent.

In most cases, you will need to complete your health plan's internal grievance procedure. After you receive the insurer's final decision on your grievance, choose an IRO from the list provided by the insurer. Then send a written request for independent review to the insurance company.

Your health plan should provide you with information on your right to request an independent review in its written materials. You can also call the health plan at its toll-free number and request information on independent review.

For more information on the independent review process, call the OCI at 1-800-236-8517 and request a copy of *Fact Sheet on the Independent Review Process in Wisconsin*. A copy is also available on the OCI's Web site at oci.wi.gov/pub_list/pi-203.htm. OCI also publishes a Spanish version of the *Fact Sheet on the Independent Review Process in Wisconsin*. You can receive a copy of *Resumen informativo sobre el proceso de revisión independiente en Wisconsin* by calling 1-800-236-8517. A copy is also available in pdf format on OCI's Web site at oci.wi.gov/spanish/sp_pub_list/pi-303.pdf.

Mandated Benefits (Updated 05/2008)

Health insurance policies sold in Wisconsin often include "mandated benefits." These are benefits that an insurer must include in certain types of health insurance policies. Except for HMOs organized as cooperatives under ch. 185, Wis. Stat., HMOs are required to provide the same benefits as traditional insurers. Cooperative HMOs are subject to the mandates regarding chiropractors, optometrists, genetic testing, nurse practitioners, newborns, adopted children, HIV drugs, dentists, temporomandibular (TMJ) disorders, breast reconstruction, and hospital and ambulatory surgery center charges and anesthetics for dental care.

The mandated benefits required by Wisconsin state law include coverage for: professional health care services; adopted children; handicapped children; nervous and mental disorders, alcoholism, and other drug abuse; home health care; skilled nursing home care; kidney disease; mammography; new born infants; coverage for grandchildren born to dependent children under the age of 18 who are covered by the policy; diabetes, lead screening, and maternity coverage for all persons covered under the policy if it provides maternity coverage for anyone, genetic testing, drugs for treatment of HIV infection, TMJ disorders, hospital and ambulatory surgery center charges and anesthetics for dental care, breast reconstruction, coverage of certain health care costs in cancer clinical trials, and coverage of student on medical leave.

Insurer plans must provide at the least the minimum mandated coverage but may provide benefits that are greater than those mandated by law. Some mandated benefits apply only to group policies. Some apply both to policies sold to individuals and to groups. For more information on mandated benefits, call the OCI at 1-800-236-8517 and request a copy of *Fact Sheet on Mandated Benefits in Health Insurance Policies* (oci.wi.gov/pub_list/pi-019.htm).

The Health Insurance Portability and Accountability Act of 1996

Federal and state laws provide important consumer protections for those who have preexisting medical conditions and move from one job to another. Legislation passed during the 1997 legislative session brings Wisconsin insurance laws into compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA does not mandate that employers provide insurance. It does not require insurance plans to cover specific services (except in some limited situations) or regulate the premiums that may be charged by insurers. In general, most of the new laws cover group health plans only. Very few changes were made to individual health plans.

The OCI publishes a brochure designed to provide a general overview to the federal law as well as the changes made to state health insurance law.

You may request a copy of the *Consumer's Guide to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Wisconsin Insurance Laws* (oci.wi.gov/pub_list/pi-096.htm) by calling the OCI at 1-800-236-8517.

Continuation and Conversion

Both state and federal law give certain individuals who would otherwise lose their group health care coverage under an employer or association plan, the right to continue their coverage for a period of time. The two laws are similar in some ways, but also have provisions that are very different. Most employers that have 20 or more employees must comply with the federal law, while most group health insurance policies that provide coverage to Wisconsin residents must comply with the state law. When both laws apply to the group coverage, it is the opinion of the Office of the Commissioner of Insurance that where the federal and state laws differ, the law most favorable to the insured should apply. The state law also gives conversion rights to certain individuals who are covered under individual health insurance policies.

Federal Law (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows most employees, spouses, and their dependents who lose their health coverage under an employer's group health plan to continue coverage, at their own expense, for a period of time. This law applies to both insured health plans and self-funded employer-sponsored plans in the private sector and those plans sponsored by state and local governments. However, COBRA does not apply to certain church plans, plans covering less than 20 employees, and plans covering federal employees.

Under the federal law, employees who terminate employment for any reason other than gross misconduct, or who lose their eligibility for group coverage because of a reduction in work hours, and the covered spouses and dependents of the employees may continue the group coverage for up to 18 months. A spouse and dependents may continue coverage for up to 36 months if they lose coverage due to the death of the employee, divorce from the employee, loss of dependent status due to age, or due to the employee's eligibility for Medicare. If within the first 60 days of COBRA coverage an individual or dependent is determined to be disabled by Social Security, the disabled individual and other covered family members may continue coverage for up to 29 months.

Wisconsin Law (s. 632.897, Wis. Stat.)

Wisconsin's continuation law applies to most group health insurance policies that provide hospital or medical coverage to Wisconsin residents. The law applies to group policies issued to employers of any size. The law does not apply to employer self-funded health plans, or policies that cover only specified diseases or accidental injuries.

Where to go for Help

For questions about the Wisconsin continuation law, contact:

Office of the Commissioner of Insurance

P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103 (In Madison)
1-800-236-8517 (Outside Madison)
oci.wi.gov

For questions about the federal COBRA law, contact:

U.S. Department of Labor - Regional Office
Employee Benefits Security Administration (EBSA)
200 West Adams, Suite 1600
Chicago, IL 60606
(312) 353-0900
www.dol.gov/dol/topic/health-plans/cobra.htm

For more information on continuation and conversion, call the OCI at 1-800-236-8517 and request a copy of *Fact Sheet on Continuation and Conversion Rights in Health Insurance Policies* that describes both state and federal law. A copy is also available on the OCI's Web site at oci.wi.gov/pub_list/pi-023.htm. OCI also publishes a Spanish version of the *Fact Sheet on Continuation and Conversion Rights in Health Insurance Policies*. You can receive a copy of *Resumen informativo sobre los derechos de continuación y conversión de las pólizas de seguros de salud* by calling 1-800-236-8517. A copy is also available in pdf format on OCI's Web site at oci.wi.gov/spanish/sp_pub_list/pi-123.pdf.

F. How to File a Health Insurance Claim

Read your benefit booklet carefully before you have a claim. Understand what is and is not covered. Follow all procedures and deadlines for seeking treatment and filing complaints and appeals. The majority of insurance companies maintain a toll-free telephone information and complaint line, and some companies and HMOs provide special mediation or arbitration procedures for handling complaints.

Filing your claim

- It is important to find out if your provider submits the claim for you or if you need to do it. If you are insured through an HMO, you will rarely, if ever, see the actual bill for your health care services. Insurance companies pay claims for fee-for services differently.
- If you need to file the claim, review the information to be sure it is complete and correct.
- File it as soon as you get the bill from the provider.
- Send it to the right address.
- Keep a copy for your reference.

Processing your health claim

Allow a reasonable time for the company to process your claim. The company will inform you if it needs any additional information to complete the claim. The company may also request more information from the provider or return the claim form to you to get more information.

Once the insurance company receives the claim form, it reviews the claim and tells the provider what it will pay for the services. The insurance company also sends you, the insured, a form known as an "EOB" (explanation of benefits) that tells you the same thing about your claims.

It is very important for you to look at your EOBs and any doctors' bills you get. You should make sure the services listed on an EOB match the services you received. If a service is not covered, or is only partially covered (if, for example, you have to pay a 20% coinsurance), the EOB will help you understand what you will be billed by the doctor or hospital after the insurance company pays its share.

How the claim is paid

If you assigned benefits to the provider, the benefit check will be sent directly to the provider.

You will pay any deductibles and coinsurance.

If you did not assign the benefits, the check will come to you and you will need to pay your providers for the entire amount.

If your claim is denied

All health insurance plans, including all defined network plans are required to have an internal grievance procedure for those who are not satisfied with the service they receive. The procedure must be set forth in the insurance contract and must also be provided in written notice.

The defined network plan must provide each enrollee with complete and understandable information about how to use the grievance procedure. An enrollee has the right to appear in person before the grievance committee and present additional information.

If you are not satisfied with the outcome of the grievance, you have an additional way to resolve some disputes involving medical decisions. You or your authorized representative may request that an Independent Review Organization (IRO) review your health plan's decision.

In most cases, you will need to complete your health plan's internal grievance procedure. After you receive the insurer's final decision on your grievance, choose an IRO from the list provided by the insurer. Then send a written request for independent review to the insurance company.

Your health plan should provide you with information on your right to request an independent review in its written materials. You can also call the health plan at its toll-free number and request information on independent review.

To obtain a copy of the listing of organizations certified to perform independent review call the OCI and request a copy of *Independent Review Organizations Certified to Perform Independent Reviews in Wisconsin*. A copy is also available on OCI's Web site at oci.wi.gov/iroscert.pdf. OCI also publishes a Spanish version of the *Independent Review Organizations Certified to Perform Independent Reviews in Wisconsin.* You can receive a copy of *Independent Review Organizations certificadas para llevar a cabo revisiones independientes en Wisconsin* by calling 1-800-236-8517. A copy is also available in pdf format on OCI's Web site at oci.wi.gov/spanish/iroscertsp.htm.

For more information on the independent review process, call the OCI and request a copy of *Fact Sheet on the Independent Review Process in Wisconsin*. A copy is also available on the OCI's Web site at oci.wi.gov/pub_list/pi-203.htm. OCI also publishes a Spanish version of the *Fact Sheet on the Independent Review Process in Wisconsin*. You can receive a copy of *Resumen informativo sobre el proceso de revisión independiente en Wisconsin* by calling 1-800-236-8517. A copy is also available in pdf format on OCI's Web site at oci.wi.gov/spanish/sp_pub_list/pi-303.pdf.

If you do not resolve the matter, file a formal complaint with the OCI. For your convenience, a complaint form (oci.wi.gov/com_form.htm) is included in the back of this booklet. The OCI consumer complaint form is available in Spanish. You can obtain a copy by calling 1-800-236-8517. A copy is also available on OCI's Web site at oci.wi.gov/spanish/com_form_sp.htm.

G. Disability Income Insurance

Anyone who works probably needs disability income insurance to help replace income lost because of a long-term injury or illness. People of working age are more likely to become disabled than they are to die – making disability insurance at least as important as life insurance.

There are numerous types of disability insurance policies available. You have to be a wise consumer and look at the different products. You have to choose the product that best suits you.

Disability income policies have waiting periods before benefits become payable. The waiting period starts after you have become disabled for a covered disability. The longer the waiting period, the lower the premium will be. The period of time for which benefits are payable can also vary considerably. Benefit periods may depend on whether the disability was caused by an accident or illness. A long-term disability income policy may provide for lifetime accident benefits and illness benefits to the age of 65. The longer the benefit period, the higher the premium will be.

What it Covers

The amount of monthly benefit provided by a disability income policy may be stated as a

percentage of income or as a set dollar amount. The amount of benefit for which you can qualify is usually based on a percentage of your gross earnings, normally around 60%. A partial disability benefit may be provided, or may be available, on an optional basis.

Some policies may reduce your benefit by the amount you receive from social security or worker's compensation so your disability benefit and social security or worker's compensation benefits together will provide a specified income. Some companies will consider possible social security benefits when they decide the amount of benefits for which you qualify.

Occupational therapy and vocational rehabilitation benefits may also be provided by a disability income policy.

Things to be aware of regarding disability insurance

A disability income policy generally requires that you be totally disabled before benefits are paid. The definition of total disability varies from policy to policy. There are two different definitions used in disability policies. One definition is that you are unable to perform your own occupation. The other definition is much more comprehensive requiring that you are unable to perform any occupation (for which you are suited by education or experience). This distinction can be important for jobs that require very specialized physical skills such as surgeons or loggers.

Some points to check:

- What is the definition of disability? Does it cover both injury and sickness? Is it for partial or total disability? Is it defined as inability to perform your current occupation or as inability to perform any occupation of which you are capable?
- When does coverage begin? Is it different for injury and sickness?
- How long will benefits be paid? What is the weekly or monthly benefit?
- How much of your income will be replaced?
- What does it cost?
- Is it guaranteed renewable?
- Disability income policies may specify that income benefits will not be paid to a disabled person if the disability results from certain causes. Check the policy for any exclusions or limitations that might apply. If you have any questions, ask your agent.

H. Medical Underwriting

Before you can buy an individual health insurance policy you must give the insurance company information about your health. This process is called medical underwriting. The company uses medical underwriting information to predict what the likelihood is that you will file claims against the policy. Each company has its own underwriting standards, which means one company could reject your application but another may be willing to accept it.

The insurance company will get most of its underwriting information from these sources:

- Your application form
- Your past medical history
- The Medical Information Bureau

Underwriting Decisions

Insurance companies can accept your application and issue the policy as requested or they can do one of the following:

- Issue the policy with full protection but charge a higher premium. This might occur if you have a chronic disease such as diabetes.
- Modify the benefits, such as increase the deductible.
- Exclude a specific medical problem from coverage by adding an exclusion rider.
- Decide not to issue a policy—turn down your application for insurance.

If you are turned down or denied coverage:

- Find out why you were denied coverage. The company is required to provide you with that information in writing. If it is due to your medical

history, make sure the information the company received was correct.

- Try several other insurance companies or HMOs. Every company has its own underwriting guidelines. Some may view your situation differently.

- If you cannot find coverage from an insurance company, you may be eligible for benefits under the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP). More information on HIRSP is provided on page 27.

The Medical Information Bureau

When you sign the application form, you authorize the insurance company to obtain information about you from the Medical Information Bureau (MIB). The MIB is a private company that insurance companies use to share information about insurance applicants. If you are denied coverage based on medical history, you may want to find out if you have an MIB file and if so, is it correct? If your file contains incorrect information, you have the right to ask the MIB to correct it. You may obtain a copy of your report by calling or writing to:

Medical Information Bureau (MIB)
P.O. Box 105
Essex Station
Boston, MA 02112
(866) 692-6901
(866) 346-3642 TTY (for hearing impaired)
www.mib.com/

X. BUYING INSURANCE

For the most part insurance is sold directly through an insurance company or indirectly through an agent or broker. An independent agent may represent more than one, and sometimes several insurance companies. An exclusive or captive agent sells solely for one insurer or group of related insurers. Independent agents, as well as exclusive agents, may place business with another insurer if the insurer(s) he or she represents does not write the type of insurance needed. A broker represents you in your dealings with an insurance company.

When buying business insurance, you should:

- Contact several agents and insurance companies.

- Shop around.

- Understand what you are buying.

In buying insurance, price is certainly a big consideration. But your insurance agent also performs an important role. An agent makes sure that the insurance is up-to-date, reflecting the actual values of the business, such as additional or replacement equipment, new structure or expanded operations. It is important to discuss with your agent, at least once a year, any changes that have occurred during the year, any increases in values, and increases in payroll and receipts.

An agent can offer advice on the amount and types of business insurance you need. You may need to work with several agents to make sure that you are getting the needed coverage at the best available price.

To assure that you are dealing with a reliable agent, you may wish to talk with other business owners in your community to learn what agents they use and how satisfied they are with these agents. You should also discuss your needs with an agent who has experience with your particular type of business. If you are a landscape gardener, for example, the risks you face will be very different from those of the ice cream parlor and you may need an agent who specializes in your field to assist you.

All companies and agents doing business in Wisconsin are licensed by the OCI. To find out if an agent or company is licensed call 1-800-236-8517. Licensing information about agents and companies can also be found on OCI's home page in the Quick Links section under Agent/Agency Lookup (https://ociaccess.oci.wi.gov/ProducerInfo/PrdInfo.oci) and Company Lookup (https://ociaccess.oci.wi.gov/CmpInfo/CmpInfo.oci).

XI. BEFORE DISASTER STRIKES

Before a fire, theft, or an accident strikes, you will save time, money and anxiety by doing these important things now:

√ Study your insurance policies to see what is and is not covered. Make sure you understand your policies before you have a loss. For example, do you know the answers to these questions:

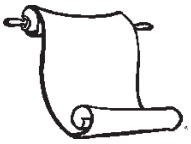
- ♦ How much liability insurance do you have?
- ♦ What are the financial responsibility requirements for your auto in your state?
- ♦ What deductibles do you have on your cars and trucks?

√ Ask your insurance agent to explain anything in the policy you do not understand.

√ Make sure you and your employees know what to do if you have a loss and need to submit a claim.

√ Keep an updated inventory of your business property with appropriate documentation. Remember to include leased property that is not specifically insured by the leasing company.

XII. LEGAL PROTECTIONS



Wisconsin has several laws to protect you before and after you purchase insurance. Some of these protections include:

- ♦ Insurance companies and agents may not misrepresent the terms of an insurance policy.
- ♦ Insurance companies may not unreasonably delay their claims investigations, fail to pay a legitimate claim within a reasonable time after proof of loss or engage in other unfair claims settlement practices.
- ♦ Insurance companies may not cancel a policy mid-term unless specific, limited reasons justify the cancellation.
- ♦ Insurance companies must provide a 60-day notice of nonrenewal. They also must give 60 days' notice of renewal on altered terms of an expiring policy when the companies increase rates by over 25% unless something you do causes the increase.
- ♦ Although an insurance company may cancel your policy for nonpayment of premium, you may be entitled to a grace period. A grace period is the period during which coverage continues even if the premium has not been paid. For individual life insurance policies it is 1 month. For health insurance it is 7 days for weekly premium policies, 10 days for monthly premium policies, and 1 month for all other policies. No grace period is required for auto or property insurance.
- ♦ If you believe that an insurance company has violated your rights, you should first complain to your agent or the insurance company. If this does not resolve the problem, you may want to file a complaint with the OCI. For your convenience a complaint form (oci.wi.gov/com_form.htm) is included in the back of this booklet. The OCI consumer complaint form is also available in Spanish. You can obtain a copy by calling 1-800-236-8517. A copy is also available on OCI's Web site at oci.wi.gov/spanish/com_form_sp.htm.

XIII. UNFAIR DISCRIMINATION

Insurers may not refuse, cancel, or restrict coverage on the basis of the sex of the applicant or insured.

Insurers may not refuse, cancel, or deny coverage for auto or property insurance solely because of a past criminal record, physical or developmental disability, past mental disability, age, marital status, sexual preference, or "moral" character.

Insurers may not refuse, cancel, or limit the amount of coverage for property or casualty insurance because of the geographic location of the risk unless required by law or for a legitimate business purpose.

No insurer may refuse or limit coverage or charge a different rate because of a mental or physical condition except when the refusal, limitation, or rate differential is based on either sound actuarial principles or actual or reasonably anticipated experience.

Small Employer Web Site

The OCI developed a Web site to help small employers become more knowledgeable insurance consumers. The Insurance Coverage for Small Employers Web page oci.wi.gov/smempins.htm assists Wisconsin small employers by providing information on the different types of insurance policies on the market, how much coverage to buy, and how to buy it wisely.

Worker's Compensation Questions? Here's Whom To Call

Worker's Compensation Division of the Department of Workforce Development (DWD) (www.dwd.state.wi.us)

201 East Washington Avenue
P. O. Box 7901
Madison, WI 53707
(608) 266-1340 (Phone)
(608) 267-0394 (Fax)

- All Questions Relating to the WI Worker's Compensation Act
- All Injury/Claim Questions
- Compliance Questions
- Corporate Officer Options Questions
- Enforcement Questions
- Penalty and Penalty Payment Plan Questions
- Self Insurance Questions
- Divided Insurance Questions
- Wrap-up Policy Questions
- Withdrawal Questions

Wisconsin Compensation Rating Bureau (WCRB) (www.wcrb.org)

P. O. Box 3080
Milwaukee, WI 53201-3080
(262) 796-4540 (Phone)
(262) 796-4400 (Fax)

- Wisconsin Worker's Compensation Insurance Pool Questions
- Rate Questions
- Inspection Questions
- Audit Questions
- Premium Charging Questions
- Classification Questions
- Experience Modification Questions
- All Questions Regarding the Proper Filing of Policies and Endorsements Pertaining to Wisconsin Coverage
- Insurance Company Filing Questions
- Endorsement Filing Questions
- Questions Regarding Appeal Rights Of A WCRB Decision
- Questions about Statistical Reporting

Office of the Commissioner of Insurance (OCI) (oci.wi.gov)

125 South Webster Street
P. O. Box 7873
Madison, WI 53707
1-800-236-8517 or (608) 266-0103 (Phone)
(608) 264-8115 (Fax)

- All Questions Relating to the Insurance Laws
- Questions Related to the Licensing & Regulation of Insurance Companies
- Unfair Claim Settlement Practices Questions
- Unfair Marketing Practices Questions
- Worker's Compensation Rate Regulation Questions
- Worker's Compensation Dividend Plans Questions
- Questions Related to the Licensing & Regulation of WCRB

Glossary of Insurance Terms

Actual cash value: The value of the property when it is damaged or destroyed. This is usually figured by taking the replacement cost and subtracting depreciation.

Adjuster: An insurance company representative who seeks to determine the extent of the firm's liability for loss when a claim is submitted.

Agent: A person licensed by a state insurance department who solicits, negotiates, or effects insurance contracts on behalf of one or more insurers.

All risks: The term "all risk" means there is coverage for all perils except those excluded. A particular exposure would be insured against economic loss by any peril that is not specifically excluded under the terms of the contract.

Auto insurance: A type of insurance that protects the policyholder against losses involving automobiles. Different coverages can be purchased depending on the needs and wants of the insured.

Binder: An agreement to provide immediate insurance coverage. May be oral or written and sets forth conditions of coverage. Often used during the interval between the coverage becoming effective and the time a formal policy is prepared and delivered. Normally it is issued for a limited period of time.

Broker: A marketing specialist who represents buyers of property and liability insurance and who deals with either agents or companies in arranging for the coverage required by the customer.

Captive agent: An agent who sells insurance for only one company, as opposed to an independent agent who represents several companies.

Claim: A request for reimbursement for a loss covered by the policy. For example, a claim for items stolen from the policyholder's business.

COBRA benefits: COBRA stands for "Consolidated Omnibus Budget Reconciliation Act of 1985," which requires companies with 20 or more employees to offer separating employees the option to continue their group health-care coverage at their own expense.

Coinsurance: A provision that requires the insured to share in the cost of covered services on a percentage basis. A typical coinsurance arrangement is 80% by the insurer and 20% by the insured.

Collision: An optional auto insurance coverage that pays for damage to the policyholder's car caused by its collision with another vehicle or object.

Comprehensive coverage or Other than Collision: Personal auto insurance policies use this term for physical damage coverage for losses by fire, theft, vandalism, falling objects and various other perils.

Conditions: Provisions of an insurance policy that state the rights and duties of the insured or the insurer. Typical conditions have to do with such things as the insured's duties in the event of loss, cancellation provisions, and the right of the insurer to inspect the property.

Copayment: A provision in insurance policies that requires the insured to pay a flat fee for certain medical expenses.

Coverage: The scope of protection provided under an insurance contract.

Deductible: The amount of an insured loss paid by the policyholder. For example, if you select a deductible of $250 for your auto insurance policy, you agree to pay the first $250 worth of damages to your car if you are in an accident.

Defined network plan: Any health benefit plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract with the insurer offering the plan. This type of plan is sometimes referred to as a managed care plan.

Depreciation: A decrease in the value of property over a period of time resulting from use, obsolescence, or wear and tear.

Disability insurance: A type of health insurance that pays a monthly income to the policyholder when he or she is unable to work because of an illness or accident.

Endorsement: An attachment to an insurance policy that amends and alters the coverage provided in the policy. In life and health insurance it is called a rider.

Exclusions: Specific situations, conditions, or circumstances that are listed in the insurance policy as not being covered.

Health insurance: A general term for insurance against loss by sickness or bodily injury. This usually includes coverage for medical expenses such as doctor visits and hospital stays and can cover normal and preventive care such as check-ups, prenatal care, and well-baby care.

Independent agent: An insurance agent who represents more than one insurer.

Insurance: A formal device for reducing the chance of loss by transferring the risks of several individual entities to insurance companies.

Insured: The party covered by an insurance arrangement, to whom an insurance company agrees to indemnify for losses, provide benefits, or render services.

Liability: Individual responsibility for causing, through negligence, injury to another person or damage to another person's property.

Managed care: (see Defined network plan)

Market value: This is a value placed on real or personal property which relates to its resale value in the market place. Since the object of most property insurance policies is to pay the insured the actual cash value or the cost to repair or replace the damaged or destroyed property, the "market" or "book" values are not used in loss settlements.

Medical payments insurance: A form of coverage, optional in various liability policies such as auto insurance, that provides for the payment of medical and similar expenses regardless of liability.

Named peril or specified peril: This is a peril indicated or identified in the contract as a cause of loss for which insurance is being provided. Under such contracts if a peril is not named or specified it is not covered.

Package policy: A single insurance policy that combines several coverages available separately. For example, business owner's insurance is a package policy, combining property, liability, and theft coverages.

Peril: A property insurance term referring to the possible cause of loss such as a fire or windstorm.

Personal property: All tangible property not classified as real property.

Policy: A written contract for insurance between the insurance company and the policyholder.

Premium: The amount of money an insurance company charges, based on a given rate, to provide the coverage described in the policy, or simply stated, the price of insurance protection for a specified risk for a specified period of time, typically one year.

Property/Casualty insurance: Property insurance covers damage to or loss of the policyholder's property. The terms "casualty" and "liability" insurance are often used interchangeably. Both cover the policyholder's legal liability for damages caused to other persons and/or their property.

Rate: The cost of a unit of insurance as determined by insurance companies and state regulators. The rate serves as the basis for the premium.

Real property: Land and most things attached to the land such as buildings and vegetation.

Replacement cost: The cost of replacing property without a deduction for depreciation.

Risk: This word has two meanings for insurers:
(1) the chance of loss such as from a peril; and
(2) the person or entity that is insured by a policy.

Theft: The act of stealing or taking the property of another.

Umbrella liability: A form of insurance protection against losses in excess of the amount covered by other liability insurance policies; also protects the insured in many situations not covered by the usual liability policies.

Underwriting: The process by which an insurance company selects and classifies risks according to their degree of insurability.

Underinsured motorist (UIM) coverage: A coverage in an automobile insurance policy under which the insurance company will pay damages to the insured for which another motorist is liable if the motorist causing an accident has lower bodily injury liability limits than your UIM limits. The maximum dollars paid is then the difference between the two limits.

Uninsured motorists (UM) coverage: A coverage in an automobile insurance policy under which the insurance company will pay damages to the insured for which another motorist is liable if that motorist is unable to pay because he or she is uninsured. This coverage applies to bodily injury damages only. Injuries to the insured caused by a hit-and-run driver are also covered.

Utilization review: A method of claims review whereby the insurance company analyzes a case, either prospectively, concurrently, or retrospectively to determine if the treatment given is necessary and appropriate.

Worker's compensation: A policy conforming to state law which pays benefits to an employee (or an employee's family) if the employee suffers a job-related injury (including death) or occupational injury.