

LONG-TERM INSURANCE ACT 52 OF 1998

REGULATIONS UNDER THE LONG-TERM INSURANCE ACT, 1998

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PART I
INTERPRETATION

1.1 Definitions

In these regulations “**the Act**” means the Long-term Insurance Act, 1998, and any word or expression to which a meaning has been assigned in the Act shall have the meaning so assigned to it, and unless a different meaning is assigned elsewhere in these regulations-
[Preamble substituted by GN 1437/2017 w.e.f. 1 January 2018]

“Companies Act” means the Companies Act, 2008 (Act No. 71 of 2008);
[Definition of “Companies” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“disability event” in respect of a –

(a) registered insurer, has the meaning assigned in section 1 of the Act; and

(b) licensed insurer, has the meaning assigned in section 1 of the Insurance Act;

Commented [IRFD1]: This term is used in more than one Part.

~~“effective date” means the date referred to in regulation 8.2;~~
[Definition of “effective date” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“fund” in respect of a –

Commented [IRFD2]: Definition deleted and moved to Part 9. Use of the term “effective date” in the definition of “representative” has been replaced with “1 January 2018”.

(a) registered insurer, has the meaning assigned to it in section 1 of the Act; and

(b) licensed insurer, has the meaning assigned to it in Schedule 2 of the Insurance Act;

“fund policy” in respect of a –

(a) registered insurer, has the meaning assigned to it in section 1 of the Act; and

(b) licensed insurer, means a policy underwritten under the fund risk or fund investment class of long-term insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“health event” in respect of a –

(a) registered insurer, has the meaning assigned to it in section 1 of the Act; and

(b) licensed insurer, has the meaning assigned to it in section 1 of the Insurance Act;

Commented [IRFD3]: These term are used in more than one Part.

“Insurance Act” means the Insurance Act, 2017 (Act No. 18 of 2017);

“insurer” means a long-term insurer;
[Definition of “insurer” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“juristic person” includes-

- (a) a company, close corporation or co-operative incorporated or registered in terms of legislation whether in the Republic or elsewhere;
- (b) an association, partnership, club or other body of persons of whatever description, corporate or unincorporated; or
- (c) a trust or trust fund;

[Definition of “juristic person” inserted by GN 1437/2017 w.e.f. 1 January 2018]

(i) ~~“Part”~~ means the applicable Part of these regulations; (iii)

“policy” means a long-term policy;

[Definition of “policy” inserted by GN 1437/2017 w.e.f. 1 January 2018]

~~“Policyholder Protection Rules” means the Policyholder Protection Rules made under section 62 of the Act;~~

(ii) ~~“SAFEX”~~

[Definition of “SAFEX” deleted by GN 1437/2017 w.e.f. 1 January 2018]

(iii) ~~“Schedule” means the applicable Schedule to the Act; (ii)~~

(iv) ~~“section”~~ means the applicable section of the Act. (i)

Commented [IRFD4]: These term are used in more than one Part.

Commented [IRFD5]: The term “Schedule” is only used in part 2 which is being repealed so there is no need to define this term.

PART 2 **LIMITATION ON ASSETS**

(Section 31)

Commented [IRFD6]: Part repealed as it relates to prudential matters.

2.1 Definitions

~~For the purposes of this Part and section 31 and, unless the context otherwise indicates-~~

~~“asset holding intermediary”, in relation to a long term insurer, means an undertaking, other than a company the shares of which are listed on a licensed stock exchange in the Republic-~~

(a) ~~which is a subsidiary of the long term insurer or would be its subsidiary if that insurer were a company;~~

(b) ~~the management of the investments of which is under de facto control of the long term insurer; and~~

(c) ~~which has assets which are regarded and dealt with, for all intents and purposes, as if they were the assets of the long term insurer;~~

~~“associated company” means a company-~~

(a) ~~which is an associate, as defined in section 26(5), of a long term insurer;~~

(b) ~~which exercises control, as defined in section 26(6), over a long term insurer; or~~

(c) ~~over which a long term insurer exercises control as defined in section 26(6);~~

other than a company which is an asset holding intermediary or a property company;

“call option” means an option contract under which the holder of the option contract has the right but not an obligation, in accordance with the terms of the contract, to purchase (or to make a cash settlement in lieu thereof) the quantity of the underlying asset covered by the call option contract;

“convertible debenture” means a debenture which is convertible into equity shares of a company;

“equity shares” in relation to a company, means shares, excluding any part thereof which, neither as respects dividends nor as respects capital, carries any right to participate beyond a specified amount in a distribution;

[Definition of “equity shares” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“linked policy” means a long term policy in relation to which the liabilities of the long term insurer are linked liabilities as defined in section 33(2);

“long position” means long position as defined in the rules of SAFEX;

“market value”, in relation to an asset, means—

- (a) — in the case of an asset which is listed on a licensed stock exchange and for which a price was quoted on that stock exchange on the date as at which the value is calculated, the price last so quoted;
- (b) — in the case of an asset which is a long term policy, the amount which on any day would be payable to the policyholder upon the surrender of the policy on that day;
- (c) — in any other case, the price which could have been obtained upon a sale of the asset between a willing buyer and a willing seller dealing at arm’s length, as estimated by the long term insurer, or by the Registrar if the Registrar is not satisfied with that estimate;

“multiple” means the futures contract’s unit of trading in its description;

“n.e.s.” means not elsewhere specified in this Part;

“net loans” means the positive amount (if any) by which the aggregate amount of loans made by a long term insurer to its asset holding intermediary, exceeds the aggregate amount of loans made to it by that asset holding intermediary;

“property company” means a company—

- (a) — whose ownership of

~~(i) — immovable property; or~~

~~(ii) all of the shares in a company~~

~~(aa) — whose principal business consists of the ownership of immovable property; or~~

~~(bb) — which exercises control, as defined in section 26(6), over a company whose principal business consists of the ownership of immovable property; or~~

~~(iii) — a linked policy, to the extent that the policy benefits thereunder are determined by reference to the value of immovable property, constitutes, in the aggregate, 50 per cent or more of the market value of its assets;~~

~~(b) — which derives 50 per cent or more of its income, in the aggregate, from—~~

~~(i) — investments in immovable property;~~

~~(ii) — investments in another company which derives 50 per cent or more of its income from investments in immovable property; or~~

~~(iii) — a linked policy to the extent that the policy benefits thereunder are determined by reference to the value of immovable property; or~~

~~(c) — which exercises control, as defined in section 26(6), over a company referred to in paragraph (a) or (b);~~

~~“put option” means an option contract under which the holder of the option contract has the right but not an obligation in accordance with the terms of the contract to sell (or to make a cash settlement in lieu thereof) the quantity of the underlying asset covered by the put option contract;~~

~~“rules of SAFEX” means rules issued by SAFEX in terms of section 10(2)(b) read with section 17 of the Financial Markets Act, 2012 (Act No. 19 of 2012);~~
~~[Definition of “rules of SAFEX” substituted by GN 1437/2017 w.e.f. 1 January 2018]~~

~~“SAFEX” means the South African Futures Exchange;~~
~~[Definition of “SAFEX” inserted by GN 1437/2017 w.e.f. 1 January 2018]~~

~~“shares” include share stock;~~

~~“short position” means short position as defined in the rules of SAFEX.~~

2.2 — General limitation on assets

~~For the purposes of section 31 (1), a long term insurer shall have as kinds specified in Schedule 1 having a market value which, when percentage of the aggregate value of the relevant liabilities of the long term does not exceed the percentage specified in column 2 of the Table to t relation to the particular kinds or categories of assets specified in column Table.~~

2.3 — Assets of asset holding intermediary

~~For the purposes of regulation 2.2 the assets of the kinds set out in Schedule 1 of an asset holding intermediary of a long term insurer, other than a claim against that long term insurer, shall be deemed to be assets of the long term insurer~~

~~(a) in place of the net loans made by it to the asset holding intern the extent determined in accordance with the formula~~

$$\frac{A \times C}{B}$$

~~(b) in place of its shares, other than equity shares, in the ass intermediary, to the extent determined in accordance with the~~

$$\frac{A \times D}{B}$$

~~(c) in place of its equity shares in the asset holding intermediate extent determined in accordance with the formula~~

$$\frac{E \times F}{G}$$

~~in which formulae-~~

~~A — represents the market value of each asset or kind or category of asset in column 1 of the Table to this Part of the asset holding intermediary)~~

~~B — represents the aggregate market value of all the assets of the ass intermediary~~

~~C — represents the amount of any claim arising from any net loans to the asset holding intermediary;~~

~~D — represents the value of shares, other than equity shares, held by the long term insurer in the asset holding intermediary, plus or minus the amount to be apportioned to those shares by virtue of the excess or shortfall of the assets of the asset holding intermediary over its liabilities;~~

E—represents A minus the sum of the amounts determined in accordance with the formulae referred to in paragraphs (a) and (b);

F—represents the value of the equity shares held by the long term insurer in the asset holding intermediary;

G—represents the aggregate value of all equity shares of the asset holding intermediary.

2.4—Liabilities of asset holding intermediary

~~For the purposes of regulation 2.2, the liabilities of an asset holding intermediary of a long term insurer, other than a claim of the long term insurer against that asset holding intermediary, shall be deemed to be liabilities of the long term insurer to the extent determined in accordance with the formula~~

$$\frac{A \times B}{C}$$

~~in which formula-~~

~~A—represents the aggregate value of those liabilities, plus the value of those of the shares, other than equity shares, in the asset holding intermediary concerned, which are not owned by the long term insurer concerned;~~

~~B—represents the value of the equity shares held by the long term insurer in the asset holding intermediary;~~

~~C—represents the aggregate value of all equity shares of the asset holding intermediary.~~

2.5—Deemed assets

~~For the purposes of regulation 2.2, there shall be deemed as assets of a long term insurer, or, where appropriate, its asset holding intermediary, in place of the market value of an asset thereof which is a linked policy, those assets of the particular kind or categories specified in Schedule 1 to the extent, in respect of each such particular kind or category, of an amount which bears the same proportion to the market value of the linked policy as each of those kinds or categories of assets by reference to the value of which the policy benefits are to be determined, is stated in terms of the policy (or, if not so stated, is estimated by the long term insurer which is liable under the policy), bears to the total of all of the assets to which the policy is linked.~~

2.6—Futures contracts

- ~~(1) For the purposes of regulation 2.2, a futures contract shall be deemed to be the asset or kind of asset to which the futures contract relates. The exposure in consequence of concluding a futures contract shall be included in the calculation of the overall exposure to the particular asset or category of assets concerned, and the assets of the kind specified in item 1, 2, 16(5)(d) or 18 of the Table to Schedule 1 shall be adjusted accordingly. The exposure arising from the use of a purchased futures contract (long position) shall be added, while assets of the kind specified in item 1, 2, 16(5)(d) or 18 of the Table to Schedule 1 shall be reduced, and the exposure arising from the use of a sold futures contract (short position) deducted from the particular asset or category of assets whilst the assets of the kind specified in item 1, 2, 16(5)(d) or 18 of the Table to Schedule 1 shall be increased.~~
- ~~(2) The balance of any margin deposit shall be deemed to be an asset of the kinds specified in items 2 and 16(5)(b) of the Table to Schedule 1.~~
- ~~(3) For the purposes of this regulation “exposure” means the number of contracts x multiple x current price, where the current price shall be the “mark to market” as defined in the rules of SAFEX on the reporting date.~~

2.7 — Option contracts

- ~~(1) For the purposes of regulation 2.2, an option contract shall be deemed to be the asset or kind of asset to which the option contract relates. The exposure in consequence of concluding an option contract shall be included in the calculation of the overall exposure to the particular asset or category of assets concerned and the assets of the kind specified in item 1, 2, 16(5)(d) or 18 of the Table to Schedule 1 shall be adjusted accordingly. The exposure arising from the use of an option contract that results in a positive holding shall be added to the particular asset or category of assets while assets of the kind specified in item 1, 2, 16(5)(d) or 18 of the Table to Schedule 1 shall be reduced. The exposure arising from the use of an option contract that results in a negative holding shall be deducted from the particular asset or category of assets, while assets of the kind specified in item 1, 2, 16(5)(d) or 18 of the Table to Schedule 1 shall be increased. A positive holding constitutes a call option bought (long call) and a put option sold (short put), and a negative holding constitutes a call option sold (short call) and a put option bought (long put).~~
- ~~(2) The balance of any margin shall be deemed to be an asset of the kinds specified in items 2 and 16(5)(b) of the Table to Schedule 1.~~
- ~~(3) For the purposes of this regulation “exposure” means the number of contracts x delta x the market value of the underlying asset or kind of assets where “delta” represents the change in option contract premium associated with one percentage point move in the market price of the underlying asset.~~

2.8 — Other derivatives

Any derivative in relation to which no basis for valuation has been provided in regulation 2.6 or 2.7 shall be—

- (a) — deemed to be the asset or kind of asset to which the derivative relates; and
- (b) — valued as determined by the Registrar.

Table
CATEGORIES OF ASSETS
(Regulation 2.2)

In this Table particular items or groups of items referred to in Schedule 1, or particular kinds of assets falling within the more general description of those categories in Schedule 1, are specified in column 1. The maximum permitted holding of those specified assets, calculated according to their market value and expressed as a percentage of the liabilities concerned, is specified in column 2.

Asset limitation number	Column 1 Relevant Schedule 1 item	Column 2 Percentage
01.	Ex item 1:	
01.01	Krugerrand coins in the aggregate	10
02.	Ex items 2 and 18	
02.01	In the aggregate in respect of any one institution	20
02.02	In the aggregate in respect of margin deposits held with SAFEX	2,5
03.	Item 3:	
03.01	In the aggregate	20
04.	Ex item 6:	
04.01	In the aggregate in respect of any one body, council or institution	20
05.	Item 7:	
05.01	In the aggregate	20
06.	Item 8:	
06.01	In the aggregate	20
07.	Item 9:	
07.01	In the aggregate	20
08.	Item 10:	
08.01	In the aggregate	20
09.	Item 11:	
09.01	In the aggregate	20
10.	Ex item 12:	
10.01	In the aggregate in respect of any one body corporate	20
11.	Item 13:	

11.01	In the aggregate	20
12.	Ex items 14, 16(1), (2), (3) and (4), 17, 19(a) and 20:	
12.01	Immovable property, units in a unit trust scheme in property shares, loans or mortgage bonds to or shares or debentures or depository receipts or linked units or loan stock issued by a property company; and linked policies linked thereto-	
12.01.01	In the aggregate	25
12.01.02	In the aggregate in respect of any one property or property development project or property company	5
13.	Ex item 15:	
13.01	Computer equipment – in the aggregate	5
13.02	Other assets – in the aggregate	2,5
14.	Ex items 16(1), (2), (3) and (4), 17 and 20(a):	
14.01	Shares, convertible debentures or depository receipts or linked units or loan stock, issued by a body corporate, other than an asset holding intermediary, n.e.s., and units in a unit trust scheme in securities other than property shares; and linked policies linked thereto-	
14.01.01	In the aggregate	75
14.01.02	In the aggregate of those which are not listed on a licensed stock exchange or financial market in the Republic or are listed in the Development or Venture Capital Sectors of such an exchange or market	5
14.01.03	In the aggregate of those which are listed on a licensed stock exchange or financial market in the Republic, otherwise than in the Development or Venture Capital Sectors thereof, and which are issued by any one body corporate which has a market capitalisation-	
14.01.03.01	not exceeding R2 000 million	10
14.01.03.02	exceeding R2 000 million	15
15.	Ex items 16(1) and (2), 19(a) and 20(b) and (c):	
15.01	Loans to, and claims against, or debentures, other than convertible debentures, issued by, associated companies – in the aggregate	5
16.	Ex item 20(a):	
16.01	Claims under long term policies other than linked policies-	
16.01.01	In the aggregate in respect of any one long term insurer	20
17.	Ex items 16(1) and (2), 19(a) and 20(b) and (c):	
17.01	Claims against individuals, and claims against, loans to or debentures, other than convertible debentures, issued by, bodies corporate, n.e.s.-	
17.01.01	In the aggregate	25
17.01.02	In the aggregate in respect of any one individual	0,25
17.01.03	In the aggregate in respect of any one body corporate	5
18.	Ex item 16(5):	

18.01	Securities, shares, credit balances, deposits, units, margin deposits-	
18.01.01	In the aggregate	15
18.01.02	Ex item 16(5)(b):	
18.01.02.01	In the aggregate	15
18.01.03	Ex item 16(5)(d):	
18.01.03.01	In the aggregate in respect of margin deposits	2,5
18.01.04	Ex item 16(5)(a)(i):	
18.01.04.01	In the aggregate	15
18.01.05	Ex item 16(5)(a)(ii) and (c)	
18.01.05.01	In the aggregate	15
18.01.05.02	In the aggregate of shares, convertible debentures or depository receipts or linked units or loan stock which are listed in a regulated market in a country other than the Republic which the Registrar has approved or are listed in the Development or Venture Capital Sectors of a stock exchange outside the Republic, which the Registrar has approved, and which are issued by any one body corporate incorporated outside the Republic; and linked policies linked thereto in the aggregate	5
18.01.05.03	In the aggregate of shares, convertible debentures or depository receipts or linked units or loan stock which are listed on a stock exchange outside the Republic, which the Registrar has approved, and which are issued by any one body corporate incorporated outside the Republic which has a market capitalisation; and linked policies linked thereto-	
18.01.05.03.01	not exceeding R2 000 million	10
18.01.05.03.02	exceeding R2 000 million	15
18.01.05.04	In the aggregate of securities, other than convertible debentures or depository receipts or linked units or loan stock, which are listed in a regulated market in a country other than the Republic or on a stock exchange outside the Republic, which the Registrar has approved, and which are issued by any one body corporate incorporated outside the Republic; and linked policies linked thereto in the aggregate in respect of any one body corporate	5
19.	Items 16(5)(d) and 18:	
19.01	In the aggregate in respect of margin deposits	2,5
20.	Ex items 14, 16(1), (2), (3), (4) and (5)(a)(ii) and (c) and 17:	
20.01	In the aggregate	90
21.	Ex items 14, 15, 16(1), (2), (3), (4) and (5)(a)(ii) and (c), 17, 19 and 20:	
21.01	In the aggregate	95
21.02	In respect of any one asset the kind of which is not subjected elsewhere in this Table to a specific limitation	2,5

**PART 3
REMUNERATION**

(Section 49)

[Heading of Part 3 substituted by GN 1437/2017 w.e.f. 1 January 2018]

**PART 3A
LIMITATION ON REMUNERATION FOR RENDERING SERVICES AS
INTERMEDIARY - POLICIES OTHER THAN POLICIES TO WHICH PART 3B
APPLIES**

[Heading of Part 3A inserted by GN R952/2008 and substituted by GN 1437/2017 w.e.f. 1 January 2018]

3.1 Application of this Part 3A, and definitions

[Heading substituted by GN R952/2008]

This Part 3A applies to policies, components and benefit components other than those to which Part 3B applies, and unless the context indicates otherwise-

[Sentence following heading substituted by GN R952/2008]

“**administrative work**” means work in connection with the handling of enquiries, maintaining administrative records and the receipt and processing of claims under a group scheme;

“**administrative work**”

[Proposed amendment: Definition of “administrative work” to be deleted by GN 1437/2017 w.e.f. 1 January 2019]

“**annualised premium**”, in relation to a group scheme or fund policy, means 12/m of the total premiums payable under the group scheme or fund policy during a scheme year, excluding transfer values inwards and credits arising in the group scheme or fund policy to employers of fund members in consequence of the withdrawal of members;

“**benefit component**” means each separately identifiable kind of policy benefit undertaken to be provided under a particular kind of policy;

“**component**” means a part of a policy, if any, where that part provides a policy benefit for which an identifiable, separate premium is payable;

[Definition of “component” inserted by GN R952/2008]

“**compulsory**”, in relation to an annuity, means that there is an obligation in terms of the rules of a fund to enter into a policy which provides the annuity;

“**credit scheme**” for purposes of Table 1 of Annexure 1 means a group scheme under which every life insured is indebted to or a surety of the policyholder whose insurable interest as policyholder arises solely from that indebtedness or suretyship;

“**fund member policy**” in respect of a –

(a) registered insurer means an individual policy-

(ai) of which a fund is the policyholder;

- (bii) under which a specified member of the fund (or the surviving spouse, children, dependants or nominees of the member) is the life insured; and
- (eiii) which is entered into by the fund exclusively for the purpose of funding that fund's liability to the member (or the surviving spouse, children, dependants or nominees of the member) in terms of the rules of that fund;

(b) licensed insurer means a policy with an individual as defined in Schedule 2 of the Insurance Act underwritten under sub-classes (a) to (d) of the Risk class, or the Life Annuity, Individual Investment or Income Drawdown classes of life insurance business as set out in Schedule 2 of Table 1 of the Insurance Act and –

- (i) of which a fund is the policyholder;
- (ii) under which a specified member of the fund (or the surviving spouse, children, dependants or nominees of the member) is the life insured; and
- (iii) which is entered into by the fund exclusively for the purpose of funding that fund's liability to the member (or the surviving spouse, children, dependants or nominees of the member) in terms of the rules of that fund;

“group of companies” has the meaning defined in section 1 of the Companies Act;
[Definition of “group of companies” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“group scheme” in respect of a –

(a) registered insurer, means a scheme or arrangement which provides for the entering into of one or more policies, other than an individual policy, in terms of which two or more persons without an insurable interest in each other, for the purposes of the scheme, are the lives insured;

(b) a licensed insurer, means a policy with a group as defined in Schedule 2 of the Insurance Act;

“immediate annuity” means an annuity that is paid under a policy, where the first payment period begins within 12 months after the policy has been entered into;
[Definition of “immediate annuity” inserted by GN R952/2008]

“independent intermediary” means a person, other than a representative, rendering services as intermediary;

“individual policy” means –

(a) in respect of a registered insurer, a policy under which a particular person is the life insured, or two or more particular persons having an insurable interest in each other are the lives insured jointly;

(b) in respect of a licensed insurer, a policy with an individual as defined in Schedule 2 of the Insurance Act;

“investment policy” means a policy other than a policy which is an ‘excluded policy’ as defined in Part 5;

[Definition of “investment policy” substituted by GN R952/2008]

“m” means the number of months in a scheme year;

“multiple premium policy” means a policy under which the premium is payable in two or more amounts;

“policy” means a long-term policy other than a reinsurance policy;

“policy benefit” has the meaning assigned to it in the Act, but excludes a loan in respect of the policy, or a consideration payable upon the full or partial surrender of the policy;

[Definition of “policy benefit” inserted by GN R952/2008]

Commented [IRFD7]: Policy benefit as defined in the Act already differentiates between registered and licensed insurers and therefore no further differentiation is required.

~~**“Policyholder Protection Rules”** means the Policyholder Protection Rules made under section 62 of the Act;~~

[Definition of “Policyholder Protection Rules” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“premium”, in relation to a premium period, means the premium which is payable under a policy in respect of every separately identifiable benefit component of that policy;

[Definition of “premium” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“premium-paying term”, in relation to a multiple premium policy, other than a group scheme or fund policy, means the whole period during which the several amounts of premium are payable, determined by reference to-

- (a) the longer of-
 - (i) 10 years; or
 - (ii) the number of complete years in the period extending from the date of commencement of the first premium period of the policy to a date-
 - (aa) in the case of a fund member policy, 66 years; or
 - (bb) in any other case, 75 years, after the date of birth of the life insured under the policy; or
- (b) if it is stated in or ascertainable from the written provisions of the policy at its commencement, and is a shorter period than that determined in accordance with paragraph (a), the shorter of-

- (i) the particular limited period for which those several amounts of premium are expressed to be payable; or
- (ii) the period during which those several amounts of premium must be paid before there shall or may-
 - (aa) be provided a policy benefit, otherwise than upon the death of, or upon the occurrence of a health event or a disability event in relation to a life insured under the policy; or
 - (bb) be paid, upon the surrender of the policy, consideration the amount of which is stated in or ascertainable from written provisions of the policy at its commencement;

“premium period”, in relation to a policy other than a group scheme or a fund policy, means one of a succession of periods of time, each of 12 months’ duration, the first of which commences on, and ends 12 months after, the date on which the policy is entered into or, if it is a later date, the date on which the obligation of the long-term insurer becomes operative;

“primary commission” means commission which is payable generally in respect of all policies in accordance with this Part other than secondary commission;

“rendering services as intermediary” means the performance by a person other than a long-term insurer or a policyholder, on behalf of a long-term insurer or a policyholder, of any act directed towards entering into, maintaining or servicing a policy or collecting, accounting for or paying premiums or providing administrative services in relation to a policy, and includes the performance of such an act in relation to a fund, a member of a fund and the agreement between the member and the fund;

“replacement investment event” means a causal event resulting in the levying of a causal event charge in excess of 15% of the investment value or materially equivalent value of a policy, where “causal event”, “causal event charge” and “investment value” have the meanings assigned to them in Part 5A and “materially equivalent value” means the value contemplated in sub-regulation 5.2(2)(b) of Part 5A;

[Definition of “replacement event” substituted by GN R952/2008 and GN 1437/2017 w.e.f. 1 January 2018]

“replacement investment policy” means a multiple premium policy which is an investment policy, where the policyholder is or was either the policyholder or the life insured in respect of any other investment policy, and where a replacement event occurs in respect of that other investment policy within a period of 4 months before or after the replacement investment policy is entered into;

[Definition of “replacement policy” substituted by GN 1437/2018 w.e.f. 1 January 2018]

“replacement risk policy” means an individual risk policy as defined in the Policyholder Protection Rules that is entered into as a result of a replacement as contemplated in the Policyholder Protection Rules;

[Definition of “replacement risk policy” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**representative**” means a person employed or mandated by a long-term insurer for the purpose of rendering services as intermediary only in relation to policies-

- (a) entered into or to be entered into by that insurer;
- (b) entered into or to be entered into by another insurer which is also part of the same group of companies that the insurer is part of;
- (c) entered into or to be entered into on or after ~~the effective date-1 January 2018~~ by another insurer which has a written agreement with that insurer in terms of which the person employed or mandated by that insurer may render services as intermediary in relation to-
 - (i) a class of policies of that other insurer which none of the insurers referred to in paragraphs (a) and (b) are registered to underwrite; or
 - (ii) a class or types of policies of that other insurer which the Registrar has determined by notice on the official web site; or
- (d) entered into prior to ~~the effective date-1 January 2018~~ by another insurer which concluded a written agreement with that insurer prior to 1 January 2017 in terms of which the person employed or mandated by that insurer may render services as intermediary in relation to that other insurer’s policies;

[Definition of “representative” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“**retirement annuity fund**” means a retirement annuity fund as defined in the Income Tax Act, 1962;

[Definition of “retirement fund annuity” inserted by GN R952/2008]

“**Scale A**” means the scale of commission set out in Annexure 2 to this Part;

“**secondary commission**” means commission which is payable, in addition to primary commission, in respect of certain policies only, as provided in and subject to this Part;

“**scheme year**”, in relation to a group scheme or a fund policy, means a period-

- (a) commencing on the later of-
 - (i) the date that the fund policy or group scheme is entered into with the long-term insurer concerned, or any anniversary of that date; or
 - (ii) the date of the appointment of an independent intermediary for the purposes of rendering services as intermediary in relation to the group scheme or fund policy;

Commented [IRFD8]: Definition of “effective date” has been removed.

Commented [IRFD9]: Definition of “effective date” has been removed.

- (b) and ending on the earlier of-
- (i) the day preceding the commencement of the next scheme year;
 - (ii) the date of termination of the group scheme or fund policy with that long-term insurer; or
 - (iii) the date of termination of the appointment of the independent intermediary rendering services as intermediary in relation to that group scheme or fund policy;

“**single premium policy**” means a policy under which the premium is payable in one amount only;

“**Table 1**” means ~~the Table 1 of set out in~~ Annexure 1 to this Part that applies to registered insurers only;

“**Table 2**” means Table 2 of Annexure 1 to this Part that applies to licensed insurers only;

“**term cover**” means a policy under which a long-term insurer undertakes to provide policy benefits only upon-

- (a) the life of a life insured having ended;
- (b) the life of a life insured having begun;
- (c) a health event occurring; or
- (d) a disability event occurring,

during a specified period only;

“**this Part**” means this Part 3A;
[Definition of “this Part” inserted by GN R952/2008]

“**tied**”, in relation to a compulsory annuity, means that there is an obligation to enter into the policy concerned with a particular insurer and no other.

3.2 General limitations

- (1) No consideration shall, directly or indirectly, be provided to, or accepted by or on behalf of, an independent intermediary for rendering services as intermediary, otherwise than by way of the payment of commission in monetary form.
- (2) Subject to sub-regulation 3.4(1A), no commission shall be paid or accepted otherwise than in accordance with this Part generally, and specifically as specified in the Table.

[Subreg. (2) substituted by GN 1582/2016 w.e.f. 1 April 2017]

- (3) Irrespective of how many persons render services as intermediary in relation to a policy, the total commission payable in respect of that policy shall not exceed the maximum commission payable in terms of regulation 3.4.
- (4) No secondary commission shall be paid or accepted-
- (a) in respect of a single premium policy;
 - (b) except in the case of a policy and benefit component of a kind specified in items 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of ~~the Table 1~~ or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa) and 6(a)(i) of Table 2;
[Para. (b) substituted by GN 1437/2017 w.e.f. 1 January 2018]
 - (c) if the policy concerned has terminated before the commencement of its second premium period.
- (4A) No remuneration or consideration shall, directly or indirectly, be provided to, or accepted by or on behalf of, a representative for rendering services as intermediary, otherwise than in accordance with the principle of “Equivalence of Reward”, in terms whereof the remuneration paid, whether in cash or in kind, must substantially be in accordance with this Part.
[Subr. (4A) inserted by GN 1437/2017 w.e.f. 1 January 2018]
- (5) The Registrar may for purposes of subregulation (4A) by notice on the official web site determine that particular forms of remuneration or consideration, whether in cash or in kind, comply or do not comply with the principle of “Equivalence of Reward”.
[Subr. (5) substituted by GN 1437/2017 w.e.f. 1 January 2018]

Commented [IRFD210]: Note that all references to “Registrar” will change to “Authority” (which will be defined in the LTIA).

3.3 Time of payment of commission

- (1) Primary commission shall not be paid or accepted before-
- (a) the first premium period has commenced; or
 - (b) the premium in respect of which it is payable has been received by the long-term insurer concerned, except that, in the discretion of that insurer-
 - (i) in the case of a policy and benefit component of a kind specified in items 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of ~~the Table 1~~ or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa) and 6(a)(i) of Table 2, primary commission may be paid and accepted in one or more amounts after the policy has been entered into;
[Subpara. (i) substituted by GN 1437/2017 w.e.f. 1 January 2018]

- (ii) in the case of a group scheme or fund policy, primary commission in respect of a particular scheme year may be paid and accepted in one or more amounts after the policy has been entered into; and
 - (iii) in any other case, primary commission in respect of a particular premium period may be paid in one or more payments and accepted after the commencement of that premium period.
- (2) Secondary commission may be paid and accepted in one or more amounts after the second premium period has commenced, at the discretion of the long-term insurer.
 - (3) If the full amount of primary or secondary commission is paid in more than one amount aggregating to that full amount, the long-term insurer concerned may pay interest at 15 per cent per annum, or such other rate of interest as may be prescribed by the Registrar from time to time, compounded annually from the earliest date on which the full amount could have been paid, on any outstanding amount, until the full amount has been paid.

3.4 Maximum commission payable

- (1) No primary commission shall exceed, in respect of each kind of policy and benefit component specified in column 2 of ~~the~~ Table 1 or Table 2, an amount arrived at by applying, in the case of-
 - (a) a single premium policy, other than a fund policy and a group scheme, the percentage specified in column 3 of ~~the~~ Table 1 or Table 2 to the amount of the premium concerned;
 - (b) a multiple premium policy, other than a fund policy and a group scheme, the percentage specified in column 4 of ~~the~~ Table 1 or Table 2 to the total amount of the premium payable during the premium-paying term, calculated as if the premium payable during the first premium period were payable at that level throughout the premium-paying term of the policy, which commission may be paid and accepted in one or more amounts at the discretion of the long-term insurer: Provided that such commission shall not exceed, in the case of a policy and benefit component specified in item 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of ~~the~~ Table 1 or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa) and 6(a)(i) of Table 2, an amount equal to the percentage specified in column 5 of ~~the~~ Table 1 or Table 2 of the premium payable during the first premium period of the policy; or
 [Para. (b) substituted by GN 4137/2017 w.e.f. 1 January 2018]
 - (c) a fund policy or a group scheme, an amount which shall not exceed 12/m of the aggregate commission on the annualised premium as provided for in Scale A.
- (1A) No commission shall exceed, in respect of a contract identified ~~as a health policy~~

in category 1 and 3 in the table under regulation 7.2(1) of the Regulations, the maximum commission specified in column two of the Scale below:

SCALE

Individual and group policy	
Column 1	Column 2
Monthly premium band	Maximum Commission Level
Above R1,200	5%
R601 to R1,200	10%
R300 to R600	15%
Less than R300	20%

[Subreg. (1A) inserted by GN 1582/2016 w.e.f. 1 April 2017]

- (2) No secondary commission shall exceed one-third of the amount of the primary commission paid in respect of the policy and benefit component concerned: Provided that if such commission is paid and accepted in more than one amount, the value thereof discounted at 15 per cent per annum, or such other rate of interest as may be prescribed by the Registrar from time to time, compounded annually to the beginning of the second premium period of the policy, shall not exceed one third of the value of the primary commission excluding interest.

3.5 Adjustment and refund of commission

- (1) If the provisions of a multiple premium policy are varied so that the total amount of the premium which was payable during the premium-paying term of the policy and which was used for the purpose of the calculation of commission in terms of regulation 3.4(1), is, for any reason-

[Words preceding para. (a) substituted by GN 1437/2018 w.e.f. 1 January 2018]

- (a) increased, the primary and secondary commission payable in relation to that increase shall be dealt with in terms of this Part as if-
- (i) the total amount of the increase payable during the remainder of the premium-paying term were the only premium payable under the policy; and
 - (ii) the premium period in which that variation becomes operative were the first premium period of the policy; or
- (b) reduced, with effect from a date before the end of the second premium period of the policy-
- (i) the primary commission previously calculated in terms of regulation 3.4(1)(b) to be payable shall be recalculated in accordance with this Part in relation to the total amount of premium as so reduced and any amount of commission which has been paid, or would have been payable had the

reduction not occurred, and which exceeds the amount payable in accordance with the recalculation, shall be determined by the insurer concerned; such part of that amount as exceeds the percentage in column A of the Table in subregulation (2) shall be reversed and, if already paid, shall be refunded to the insurer by the person to whom it was paid;

- (ii) the secondary commission previously calculated in terms of regulation 3.4(2) to be payable, shall be recalculated in accordance with this Part in relation to the total amount of primary commission as reduced in accordance with subparagraph (i) and any amount of commission which has been paid, or would have been payable had the reduction not occurred, and which exceeds the amount payable in accordance with the recalculation shall be determined by the insurer concerned; such part of that amount as exceeds the percentage in column B of the Table in subregulation (2) shall be reversed and, if already paid, shall be refunded to the insurer by the person to whom it was paid.

(2)

(a) If a premium or any part thereof is-

- (i) for any reason refunded by the long-term insurer or, in the case of a multiple premium policy which is not-
 - (aa) a fund policy, or
 - (bb) a fund member policy other than a fund member policy which funds a retirement annuity fund, or
 - (cc) a policy in respect of which commission has been paid only after each premium in respect of which it is payable has been received by the long-term insurer concerned (including but not limited to a replacement investment policy),

[Subsubpara. (cc) substituted by GN 1437/2017 w.e.f. 1 January 2018]

for any reason not paid on its due date, including that the policy has been made paid-up or surrendered, but excluding termination upon a health event, a disability event or the death of a life insured, during the first two premium periods in the case of a policy referred to in items 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of ~~the Table 1~~ or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa) and 6(a)(i) of Table 2 the commission payable in terms of this Part shall be recalculated by reference to the scale and shall not exceed the percentage of maximum commission in column A or B, respectively, and any amount of commission which has already been paid in excess of the commission as so recalculated, shall be reversed by the long-term insurer and refunded to it by the person to whom it was paid:

[Words following subsubpara. (cc) substituted by GN 1437/2017 w.e.f. 1 January 2018]

Premiums received with an equivalent value to monthly premiums for-	Column A Maximum percentage of primary commission payable	Column B Maximum percentage of secondary commission payable
0-6 months	Nil	not applicable
7 months	29,17	not applicable
8 months	33,33	not applicable
9 months	37,5	not applicable
10 months	41,67	not applicable
11 months	45,83	not applicable
12 months	50	not applicable
13 months	54,17	8,3
14 months	58,33	16,7
15 months	62,5	25
16 months	66,67	33,3
17 months	70,83	41,7
18 months	75	50
19 months	79,17	58,3
20 months	83,33	66,7
21 months	87,5	75
22 months	91,67	83,3
23 months	95,83	91,7
24 months	100	100

- (ii) in the case of any policy not mentioned in subparagraph (i), for any reason refunded by the long-term insurer, or for any reason not paid on its due date, any commission paid by the long-term insurer shall be reversed and refunded to it by the person to whom it was paid;
- (b) Subparagraphs (i) and (ii) of paragraph (a) shall-
 - (i) not apply to the extent that, and for so long as, payment of an unpaid premium is effected by means of the maintenance of the policy in force as contemplated in [Rules 15.11 and 15.12 of the Policyholder Protection Rules section 52\(2\) or \(3\)](#);
 - (ii) be deemed not to have been applicable if and to the extent that, any premium or part thereof which was unpaid is later paid to the long-term insurer, and in that event any reversed commission refunded to the long-term insurer may again be paid to the person by whom it was refunded.

3.6 Special provisions concerning fund and fund member policies

- (1) No commission shall be paid or accepted in relation to so much of the premium payable under a fund policy as has already borne commission under a prior, substituted fund policy.
- (2) The commission payable in respect of a fund policy or a fund member policy, as provided for in this Part shall be reduced by the value of any consideration provided by the fund concerned, or its members, for services rendered as intermediary in connection with the agreement whereby the fund assumed the obligation concerned to the member.

3.7 Commission when policy has different benefit components

- (1) If, in respect of a policy which comprises more than one benefit component, it is not specified in or ascertainable from the written provisions of the policy what portion of the total premium payable is attributable to the different benefit components, the commission payable in terms of this Part shall not exceed that which would have been payable had the policy comprised, and had the total premium been attributable to, only that benefit component which most closely reflects the main purpose of the policy to the exclusion of other subordinate purposes of the policy.
- (2) Despite sub-regulation (1), if, in respect of a policy which comprises more than one benefit component and one of the benefit components is a ~~contract~~health policy referred to in category 1 or 3 in the table under regulation 7.2(1) of the Regulations, it is not specified in or ascertainable from the written provisions of the policy what portion of the total premium payable is attributable to the different benefit components, the commission payable in respect of that policy shall not exceed the maximum commission allowable under ~~the~~ Scale in Regulation 3.4(1A).

[Reg. 3.7 substituted by GN 1582/2016 w.e.f. 1 April 2017]

3.8 Voidness of certain agreements

Any agreement, scheme or arrangement to provide consideration for the rendering of services as intermediary otherwise than in accordance with this Part shall be void.

3.9 Special provisions concerning replacement investment policies

- (1) Commission may only be paid in respect of a replacement investment policy as a level percentage of the premiums received, and may only be paid once the premium in respect of which it is payable has been received by the long-term insurer concerned, whether or not-
 - (a) the replacement investment policy comprises more than one benefit component; or
 - (b) the portion of the total premium attributable to the different benefit components of the replacement investment policy is specified in or ascertainable from the written provisions of the policy.

- (2)
- (a) The total amount of commission paid on a replacement investment policy may not exceed the total of the primary and secondary commission that would have been payable in terms of this Part in respect of a policy other than a replacement investment policy; and
 - (b) in determining such total amount, the long-term insurer concerned may include interest at 15 per cent per annum, or such other rate of interest as may be prescribed by the Registrar from time to time, compounded annually from the earliest date on which the full amount of primary or secondary commission could have been paid if the policy was not a replacement investment policy, until such full amount has been paid.
- (3) In the event of commission on a replacement investment policy being paid or accepted otherwise than in accordance with subregulation (1) or (2), whether due to the fact that the long-term insurer was not aware at the time of payment that the policy in question was a replacement investment policy, or for any other reason, then any commission paid by the long-term insurer in excess of the commission payable in accordance with subregulation (2), or paid earlier than permitted in subregulation (1), shall upon identification of the excess or early payment, be reversed and refunded to the long-term insurer by the person to whom it was paid.

[Reg. 3.9 substituted by GN 1437/2017 w.e.f. 1 January 2018]

3.9A. Special provisions concerning replacement risk policies

- (1) Notwithstanding regulation 3.4, a long-term insurer must either-
- (a) not pay any commission to any person in respect of a replacement risk policy unless and until the confirmation referred to in Rule 19 of the Policyholder Protection Rules, where required, has been provided; or
 - (b) where the long-term insurer does pay commission to a person in respect of a replacement risk policy, reverse such payment and ensure that the payment is refunded to the long-term insurer if the confirmation referred to in Rule 19 of the Policyholder Protection Rules, where required, is not provided within the time specified in that Rule.
- (2) In the event of commission on a replacement risk policy being paid or accepted otherwise than in accordance with subregulation (1), whether due to the fact that the long-term insurer was not aware at the time of payment that the policy in question was a replacement risk policy, or for any other reason, then any commission paid by the long-term insurer shall upon identification be reversed and refunded to the long-term insurer by the person to whom it was paid.

[Proposed amendment: Reg. 3.9A to be inserted by GN 1437/2017 w.e.f. 1 July 2018]

ANNEXURE 1

[Annexure 1 substituted by GN R952/2008 and amended by GN 1582/2016]

Table 1 – Registered insurers

Item	Kind of policy or benefit component	Maximum percentage			Notes	
		Single premium policy	Multiple premium policy		Up-front payment reg 3.3 (1) (b) (l) applicable	Secondary commission: reg 3.2 (4) (b) applicable
			Basic percentage	Limit per proviso to reg 3.4 (1) (b)		
	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
		%	%	%		
1	Individual policy, not elsewhere specified					
1.1	not immediate annuity	3.0	3.25	85.0	yes*	yes*
1.2	immediate annuity					
1.2.1	not compulsory	1.5	not applicable	not applicable	no	no
1.2.2	compulsory, not tied	1.5	not applicable	not applicable	no	no
1.2.3	compulsory, tied	nil	not applicable	not applicable	no	no
2	Fund member policy					
2.1	funding a retirement annuity fund					
2.1.1	upon entry, not a transfer	2.5	3.0	75.0	yes*	yes*
2.1.2	upon entry, a transfer from a fund other than a retirement annuity fund to					
2.1.2.1	a fund chosen by the member	1.5	not applicable	not applicable	no	no
2.1.2.2	a fund not chosen by the member	nil	not applicable	not applicable	no	no
2.1.3	upon entry, a transfer from another retirement annuity fund	nil	not applicable	not applicable	no	no
2.2	not funding a retirement annuity fund					
2.2.1	upon entry, not a transfer	2.5	3.0	75.0	yes*	yes*
2.2.2	upon entry, a transfer from another fund	1.5	not applicable	not applicable	no	no

3	Life policy					
3.1	other than term cover only					
3.1.1	incorporated into a group Scheme					
3.1.1.1	which is a credit scheme	7.5	7.5	not applicable	no	No
3.1.1.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	No
3.2	term cover only					
3.2.1	individual	7.5	3.25	85.0	yes	yes
3.2.2	incorporated into a group scheme					
3.2.2.1	which is a credit scheme	7.5	7.5	not applicable	no	no
3.2.2.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	no
4	Fund policy	Scale A	Scale A	not applicable	no	no
5	Health policy and disability policy					
5.1	Other than term cover only					
5.1.1	individual	3.0	3.25	85.0	yes	yes
5.1.2	incorporated in a group scheme					
5.1.2.1	which is a credit scheme	7.5	7.5	not applicable	no	no
5.1.2.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	no
5.2	Term cover only					
5.2.1	individual	7.5	3.25	nil	no	no
5.2.2	incorporated in a group scheme					
5.2.2.1	which is a credit scheme	7.5	7.5	not applicable	no	no
5.2.2.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	no
6	Sinking fund policy	3.0	3.0	nil	no	no
7	Assistance policy	-	-	-	no	no
Notes to Table 1 of Annexure 1:						
<ul style="list-style-type: none"> • An asterisk (*) denotes "excluding a replacement policy". • A dash (-) denotes that there is no limit. • "nil" denotes that no commission may be paid. 						

- A policy, other than one that provides an immediate annuity, that is a fund member policy or a fund policy falls under item 2 or 4, as the case may be irrespective whether it can fall also under another item. A policy that provides an immediate annuity that is a fund member policy or a fund policy attracts the commission referred to in item 1.2.
- Item 2.1.2.1 applies with effect from 1 March 2007.

Table 2 - Licensed insurers

In this Table –

“Credit Life” means a life insurance policy written under the Credit Life class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“credit provider policy” means a policy referred to in paragraph (a)(i) of the definition of “individual” as defined in Schedule 2 of the Insurance Act;

“death event” has the meaning assigned to such term in section 1 of the Insurance Act;

“employer policy” means a policy referred to in paragraph (a)(ii) of the definition of “individual” as defined in Schedule 2 of the Insurance Act;

“Fund” in item 3 means a fund policy;

“Fund Member” in item 4 means a fund member policy;

“Funeral” means a life insurance policy written under the Funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“Group Death” means a policy written under sub-class “e” of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“Group Disability” means a policy written under sub-class “g” or “h” of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“Group Health” means a policy written under sub-class “f” of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“Individual Death” means a policy written under sub-class “a” of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

Commented [IRFD11]: See document accompanying this document for an explanation in respect of credit provider and employer policies.

Commented [IRFD12]: See note accompanying this document for an explanation in respect of credit provider and employer policies.

“Individual Disability” means a policy written under sub-classes “c” or “d” of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“Individual Health” means a policy written under sub-class “b” of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“Individual Investment” means a life insurance policy, excluding a fund member policy, written under the Individual Investment class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

“life event” has the meaning assigned to such term in section 1 of the Insurance Act;

“Microinsurance” means a life insurance policy written by a microinsurer as defined in section 1 of the Insurance Act; and

“Risk” means a life insurance policy written under the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

Item	Class of insurance business		Maximum percentage			Notes		
			Single premium policy	Multiple premium policy				
Item	Column 2		Column 3	Column 4	Column 5	Column 6	Column 7	
			%	%	%			
1.	Policy not elsewhere specified	(a) not immediate annuity	3.0	3.25	85.0	yes*	yes*	
		(b) immediate annuity	(i) not compulsory	1.5	not applicable	not applicable	no	no
			(ii) compulsory, not tied	1.5	not applicable	not applicable	no	no
			(iii) compulsory, tied	Nil	not applicable	not applicable	no	no
2.	Individual Investment unrelated to a life event which undertakes to provide one or more sums of money, on a fixed or determinable future date, as policy benefits		3.0	3.0	nil	no	no	
3.	Fund		Scale A	Scale A	not applicable	no	no	

Commented [IRFD13]: The intention here is to capture the current “sinking fund policies”.

4.	Fund Member	<u>(a) funding a retirement annuity fund</u>	<u>(i) upon entry, not a transfer</u>		<u>2.5</u>	<u>3.0</u>	<u>75.0</u>	<u>yes*</u>	<u>yes*</u>
			<u>(ii) upon entry, a transfer from a fund other than a retirement annuity fund to</u>	<u>(aa) a fund chosen by the member</u>	<u>1.5</u>	<u>not applicable</u>	<u>not applicable</u>	<u>no</u>	<u>No</u>
				<u>(bb) a fund not chosen by the member</u>	<u>nil</u>	<u>not applicable</u>	<u>not applicable</u>	<u>no</u>	<u>no</u>
			<u>(iii) upon entry, a transfer from another retirement annuity fund</u>		<u>nil</u>	<u>not applicable</u>	<u>not applicable</u>	<u>no</u>	<u>no</u>
		<u>(b) not funding a retirement annuity fund</u>	<u>(i) upon entry, not a transfer</u>		<u>2.5</u>	<u>3.0</u>	<u>75.0</u>	<u>yes*</u>	<u>yes*</u>
			<u>(ii) upon entry, a transfer from another fund</u>		<u>1.5</u>	<u>not applicable</u>	<u>not applicable</u>	<u>no</u>	<u>no</u>
		5.	Risk	<u>(a) Individual Death</u>	<u>(i) Term cover only</u>	<u>(aa) Other than an employer policy</u>	<u>7.5</u>	<u>3.25</u>	<u>85.0</u>
<u>(bb) Employer policy</u>	<u>Scale A</u>					<u>Scale A</u>	<u>n/a</u>	<u>no</u>	<u>no</u>
<u>(ii) Other than term cover only</u>	<u>(aa) Other than an employer policy</u>				<u>3.0</u>	<u>3.25</u>	<u>85.0</u>	<u>yes*</u>	<u>yes*</u>
	<u>(bb) Employer policy</u>				<u>Scale A</u>	<u>Scale A</u>	<u>n/a</u>	<u>no</u>	<u>no</u>
<u>(b) Group Death</u>				<u>Scale A</u>	<u>Scale A</u>	<u>n/a</u>	<u>no</u>	<u>no</u>	
<u>(c) Individual</u>	<u>(i) Term cover only</u>			<u>(aa) Other than employer policy</u>	<u>7.5</u>	<u>3.25</u>	<u>nil</u>	<u>no</u>	<u>no</u>

		Disability and Individual Health		(bb) Employer policy	Scale A	Scale A	n/a	no	no	
			(ii) Other than term cover only	(aa) Other than employer policy	3.0	3.25	85.0	yes	yes	
				(bb) Employer policy	Scale A	Scale A	n/a	no	no	
		(d) Group Disability and Group Health			Scale A	Scale A	n/a	no	no	
6.	Credit Life	(a) Other than credit provider policy	(i) Death event		7.5	3.25	85.0	yes	yes	
			(ii) Disability event, Health event or event of unemployment, or other insurable risk that is likely to impair a person's ability to earn an income or meet credit obligations		7.5	3.25	nil	no	no	
		(b) Credit provider policy			7.5	7.5	n/a	no	no	
7.	Funeral				-	-	-	no	no	
8.	Microinsurance	(a) Risk and Funeral				-	-	-	no	no
		(b) Credit Life	(i) Other than credit provider policy	(aa) Death event	7.5	3.25	85.0	yes	yes	
				(bb) Disability event, Health event or event of unemployment, or other insurable risk that is likely to impair a person's ability to earn an income or meet credit obligations	7.5	3.25	nil	no	no	
			(ii) Credit provider policy		7.5	7.5	n/a	no	no	

Commented [IRFD14]: Commission in respect of the Funeral class will remain uncapped.

Commented [IRFD15]: In line with the Microinsurance Policy document which proposed caps on credit life offered by microinsurers.

Commented [IRFD16]: In line with the Microinsurance Policy document which proposed no caps for microinsurance with the exception of credit life.

Notes to Table 2 of Annexure 1:

- An asterisk (*) denotes "excluding a replacement policy".
- A dash (-) denotes that there is no limit.
- "nil" denotes that no commission may be paid.

- A policy, other than one that provides an immediate annuity, that is a fund policy or a fund member policy falls under item 3 or 4, as the case may be irrespective whether it can fall also under another item. A policy that provides an immediate annuity that is a fund policy or a fund member policy attracts the commission referred to in item 1(b).

ANNEXURE 1

[Annexure 1 substituted by GN R952/2008, amended by GN 1582/2016 and substituted by GN 1437/2017 w.e.f. 1 January 2019]

[Proposed amendment: Annexure 1 to be substituted by GN 1437/2017 w.e.f. 1 January 2019]

**ANNEXURE 2
SCALE A**

1. Normal commission

MAXIMUM COMMISSION AS PERCENTAGE OF ANNUALISED PREMIUM UNDER A GROUP SCHEME OR FUND POLICY	ANNUALISED PREMIUM OF WHICH THE AMOUNT-	
	EXCEEDS	DOES NOT EXCEED
%	R	R
7,5%		200 000
5,0%	200 000	300 000
3,0%	300 000	800 000
2,0%	600 000	2 000 000
1,0%	2 000 000	UNLIMITED

[Para. (1) substituted by GN 1437/2017 w.e.f. 1 January 2018]

Special commission

2. In addition to the normal commission contemplated in paragraph 1, there may be paid, once only and only in respect of the period of 12 months following the date on which the group scheme or fund policy is established, a special commission equal to the lesser of-

- (a) 7,5 per cent of the total premium payable during that period of 12 months; or
(b) R7 700.

[Subpara. (b) substituted by GN 1437/2017 w.e.f. 1 January 2018]

[Part 3 amended by GN R197/2000, GN R164/2002 and GN R1209/2003 and substituted by GN R186/2007]

PART 3B

LIMITATION ON REMUNERATION FOR RENDERING SERVICES AS INTERMEDIARY - INVESTMENT POLICIES THAT STARTED ON OR AFTER 1 JANUARY 2009

[Heading of Part 3B substituted by GN 1437/2017 w.e.f. 1 January 2018]

3.10 Application of this Part 3B, and definitions

- (1) This Part 3B applies to-

- (a) investment policies that started on or after 1 January 2009, but except only for purposes of regulation 3.15(4), does not apply to risk components of such investment policies; and
- (b) any variable premium increase (as defined in Part 5A) in respect of a policy to which Part 5A applies.

[Subr. (1) substituted by GN 1437/2017 w.e.f. 1 January 2018]

- (2) In this Part 3B, unless defined differently in this Part 3B or unless the context indicates otherwise, any word or expression to which a meaning has been assigned in Part 3A or 5B has the meaning assigned to it in that Part, and-

‘discount term’, in relation to a multiple premium policy, means the period that begins on the premium commencement date and:

- (a) in the case of a fund member policy, is a period of 25 years or, if it is shorter, the period for which the premium is to be paid specified in the policy, or determinable from its written provisions, as at the start of the policy; or
- (b) in the case of a policy other than a fund member policy, is a period of 15 years or, if it is shorter, the period for which the premium is to be paid specified in the policy, or determinable from its written provisions, as at the start of the policy;

‘fund member policy’ has the meaning assigned to it in Part 5A;

‘insurer’ means a long-term insurer;

‘investment policy’ has the meaning assigned to it in Part 5B;

‘member’ has the meaning assigned to it in Part 5A;

‘payment date’, in relation to a premium, means the date on which that premium must be paid in terms of the policy;

‘preservation fund’ means a pension preservation fund or a provident preservation fund, which terms have the meanings assigned to it in section 1 of the Income Tax Act, 1962 (Act No. 58 of 1962);

‘risk component’ means a component that on its own constitutes an excluded policy;

‘Table’ means the table accompanying this Part; and

‘this Part’ means this Part 3B.

3.11 General prescriptions

- (1) Remuneration for rendering services as intermediary may be paid by or on behalf of an insurer, and received by an independent intermediary-
 - (a) only in accordance with this Part;
 - (b) only after the policy has started; and
 - (c) only as commission in monetary form.
- (2)
 - (a) No remuneration or consideration shall, directly or indirectly, be provided to, or accepted by or on behalf of, a representative for rendering services as intermediary, otherwise than in accordance with the principle of “Equivalence of Reward”, in terms whereof the remuneration paid, whether in cash or in kind, must substantially be in accordance with this Part.
 - (b) The Registrar may for purposes of paragraph (a) by notice on the official web site determine that particular forms of remuneration or consideration, whether in cash or in kind, comply or do not comply with the principle of “Equivalence of Reward”.
[Subr. (2) substituted by GN 1437/2017 w.e.f. 1 January 2018]
- (3) The total commission per policy may not exceed the maximum prescribed by this Part, irrespective whether more than one independent intermediary or representative renders services in respect of that policy.
- (4) If a policy has two or more components, each component must for the purposes of this Part, and where applicable, for the purposes of Part 3A, be dealt with as if it were a separate policy.
- (5) If a policy (that does not have two or more components) or a component provides more than one type of policy benefit, and one or more of these benefits is a benefit other than a risk benefit, the maximum commission in respect of that policy or component must be determined in accordance with this Part.
- (6) Any agreement, scheme or arrangement to offer, provide, accept, pay, or receive remuneration, otherwise than in accordance with this Part, is void.

3.12 Maximum commission

- (1) The maximum commission that may be paid in respect of a multiple premium policy, is an amount equal to 5% of each premium.
- (2)
 - (a) Subject to paragraph (b), the maximum commission that may be paid in respect of a single premium policy is an amount equal to 3% of the premium.

- (b) The maximum commission that may be paid in respect of a single premium policy-
 - (i) of which the policy benefit is an immediate annuity, is an amount equal to 1.5% of the premium;
 - (ii) that is a fund member policy which funds a retirement annuity fund, upon a transfer from a fund other than a retirement annuity fund, is an amount equal to 1.5% of the premium;
 - (iii) that is a fund member policy which funds a retirement annuity fund, upon a transfer from a retirement annuity fund, is nil;
 - (iv) that is a fund member policy which funds a preservation fund, upon a transfer from a fund other than a preservation fund, is an amount equal to 1.5% of the premium;
 - (v) that is a fund member policy which funds a preservation fund, upon a transfer from a preservation fund, is nil;
 - (vi) that is a fund member policy, which does not fund a retirement annuity fund or a preservation fund, upon a transfer from another fund, is an amount equal to 1.5% of the premium.

3.13 Time of payment of commission

- (1) Commission in respect of a premium may be paid only on or after the payment date of that premium.
- (2) Despite subregulation (1), an insurer, at its discretion, may discount commission in respect of a multiple premium policy in terms of regulation 3.15, and pay the discounted commission at any time after the policy has started.
- (3)
 - (a) An insurer, at its discretion, may pay commission in two or more instalments, provided that the sum of the instalments, before any increase in terms of paragraph (b), does not exceed the maximum commission referred to in regulation 3.12.
 - (b) Where commission is paid in two or more instalments, the insurer, at its discretion, may increase any instalment at an annual effective rate of not more than 6% from the date the commission becomes payable to the date on which that instalment is paid.

3.14 Premium increases and additional premiums

If the premium is increased in accordance with the terms of the policy as at the start of the policy or as amended from time to time, or if an additional premium is paid, the discounted and undiscounted commission in respect of the increased portion of the premium or in respect of the additional premium must, except for the purpose of subregulation 3.15(4), be dealt with as if-

- (a) the increased portion of the premium, or the additional premium, were a premium payable or paid under a separate policy; and
- (b) that separate policy starts on the first or only payment date of the increased portion of the premium or the additional premium.

3.15 Discounting of commission

- (1) In the case of a multiple premium policy the insurer, at its discretion, may discount a portion of the commission in respect of every premium of which the payment date falls within the discount term: Provided that an insurer, at its discretion, may discount a portion of the commission in respect of every premium of which the payment date falls within a shorter period than the discount term, in which case that shorter period will be regarded as the discount term for purposes of that policy.
- (2) The maximum portion of the commission that may be discounted in respect of each premium is an amount equal to 2,5% of that premium, and the portion of commission that is discounted must be the same proportion of every premium.
- (3) The discounting must be done-
 - (a) once only and only at the start of the policy, and this may be done also at the payment of an additional premium and at the start of payment of an increased premium, as contemplated in regulation 3.14;
 - (b) from the payment date of each premium to the premium commencement date, at an annual effective rate of not less than 6%.
- (4) Despite subregulation (2), but subject to regulation 3.12(1), if the commission discounted for the policy, or where the policy at its start has two or more components the aggregate commission discounted for all the components (including risk components), comes to less than four hundred Rand, the insurer, at its discretion, may discount a larger portion of the commission in respect of all the premiums, at a level higher than 2,5% of each premium, to allow for a discounted commission for the policy, or an aggregate discounted commission for all the components of the policy (including risk components), of not more than four hundred Rand.
- (5) The discounting in terms of subregulation (4) may be done once only and only at the start of the policy, but not at the payment of an additional premium or at the start of an increased premium, as contemplated in regulation 3.14.

3.16 Redirecting of commission

- (1) A policyholder (excluding a person to whom the policy has been ceded as security) or member may at any time during the life of an investment policy instruct the insurer in writing to stop paying further discounted and undiscounted commission to an independent intermediary or a representative, provided that as part of that instruction the policyholder or member also must instruct the insurer-
 - (a) to pay the further commission to another independent intermediary, nominated by the policyholder or member in that instruction, who has a contract with the insurer for rendering services as intermediary in respect of policies of the insurer of the type of policy in question; or
 - (b) to pay the applicable portion of the further commission, in accordance with the principle of equivalence of reward referred to in regulation 3.11(2), to another representative of the insurer nominated by the policyholder or member in that instruction, who is approved by the insurer to render services as intermediary in respect of the policy in question; or
 - (c) to pay the applicable portion of the further commission, in accordance with the principle of equivalence of reward referred to in regulation 3.11(2), to another representative of the insurer to be appointed by the insurer to render services as intermediary to the policyholder or member in respect of the policy in question.
- (2) The insurer must, at no additional cost to the policyholder, comply with an instruction contemplated in subregulation (1).

3.17 Adjustment and refund of commission

- (1) If, within 5 years after the premium commencement date, the premium is stopped or decreased- for any reason other than where the policy ends on account of a disability event, a health event, or the death of a life insured- the insurer must reverse a proportion of any discounted commission payable or paid on premiums received.
- (2) The proportion of commission to be reversed based on premiums received as contemplated in terms of subregulation (1), must be calculated by applying the applicable adjustment percentage in column 2 of the Table to the ratio that the premium decrease bears to the premium in respect of which the discounted commission first was calculated.
- (3) If a premium or a part of it, of which the payment date falls within 5 years after the premium commencement date, is not paid to the insurer or is paid back by the insurer- for any reason other than where the premium is stopped or decreased, or where the policy ends on account of a disability event, a health event, or the death of

a life insured- the insurer must reverse any discounted commission payable or paid in respect of that premium or part of it.

- (4) If a premium or a part of it, whether its payment date falls within or after 5 years after the premium commencement date, is not paid to the insurer or is paid back by the insurer, the insurer must reverse any undiscounted commission paid in respect of that premium or part of it.
- (5)
 - (a) If discounted or undiscounted commission paid to an independent intermediary or a representative is reversed in terms of subregulation (1), (3) or (4), the independent intermediary or representative must pay it back to the insurer.
 - (b) If commission has been paid back to the insurer in terms of paragraph (a), and the premium in question or part of it is paid to the insurer thereafter, the insurer may again pay that commission to the independent intermediary or representative.
- (6) Subregulations (1) to (5) do not apply to the extent that, and for as long as, the policy is maintained in terms of [Rule 5.11 of the Policyholder Protection Rules section 52\(2\)](#), but not made paid-up.

3.18 Replacement investment policies

- (1) Commission may not be discounted in respect of a replacement investment policy.
- (2) In the event of commission in respect of a replacement investment policy having been paid otherwise than in accordance with this Part, whether because the insurer at the time of the payment was not aware that the policy in question was a replacement investment policy, or for any other reason, then any commission paid by the insurer in excess of the maximum that may be paid in accordance with this Part, or paid earlier than permitted in this Part, must, upon identification of the payment, be reversed and paid back to the insurer by the person to whom it was paid.

[Part 3B inserted by GN R952/2008 and substituted by GN 1437/2017 w.e.f. 1 January 2018]

Table
Regulation 3.17 (2)

<i>Column 1</i> <i>Premiums received with a value equivalent to monthly premiums for</i>	<i>Column 2</i> <i>Adjustment Percentage</i>	<i>Column 1</i> <i>Premiums received with a value equivalent to monthly premiums for</i>	<i>Column 2</i> <i>Adjustment Percentage</i>
0 months	100	31 months	48,33
1 months	100	32 months	46,67
2 months	100	33 months	45
3 months	100	34 months	43,33

4 months	100	35 months	41,67
5 months	100	36 months	40
6 months	100	37 months	38,33
7 months	88,33	38 months	36,67
8 months	86,67	39 months	35
9 months	85	40 months	33,33
10 months	83,33	41 months	31,67
11 months	81,67	42 months	30
12 months	80	43 months	28,33
13 months	78,33	44 months	26,67
14 months	76,67	45 months	25
15 months	75	46 months	23,33
16 months	73,33	47 months	21,67
17 months	71,67	48 months	20
18 months	70	49 months	18,33
19 months	68,33	50 months	16,67
20 months	66,67	51 months	15
21 months	65	52 months	13,33
22 months	63,33	53 months	11,67
23 months	61,67	54 months	10
24 months	60	55 months	8,33
25 months	58,33	56 months	6,67
26 months	56,67	57 months	5
27 months	55	58 months	3,33
28 months	53,33	59 months	1,67
29 months	51,67	60 months	0
30 months	50		

[Part 3B inserted by r 1.4 in GNR.952 of 5 September 2008.]

PART 3C LIMITATION ON REMUNERATION FOR BINDER FUNCTIONS

3.19 Application of this Part 3C, and definitions

- (1) This Part 3C applies to remuneration provided by an insurer or any person on its behalf to a person for a rendering binder function.

- (2) In this Part 3C unless the context indicates otherwise, any word or expression to which a meaning has been assigned in Part 6 has the meaning assigned to it in that Part, and —

“cell structure” has the meaning assigned to it in section 1 of the Insurance Act means an arrangement under which a person (cell owner)

~~(a) holds an equity participation in a specific class or type of shares of an insurer, which equity participation is administered and accounted for separately from other classes or types of shares;~~

~~(b) is entitled to a share of the profits and liable for a share of the losses as a result of the equity participation referred to in paragraph (a), linked to profits or losses generated by the insurance business referred to in paragraph (c); and~~

~~(c) places insurance business with the insurer referred to in paragraph (a), which business is contractually ring fenced from the other insurance business of that insurer for as long as the insurer is not in winding up.~~

3.20 General principles for determining remuneration for binder functions

- (1) When remuneration is provided by or on behalf of an insurer to any person for rendering a binder function -
- (a) such remuneration must be reasonable and commensurate with the actual cost of performing the binder function, taking into account the nature of the function and the resources, skills and competencies reasonably required to perform it;
 - (b) the payment of such remuneration must not result in the person being remunerated more than once for performing a similar function on behalf of the insurer and/or policyholder;
 - (c) any actual or potential conflicts between the interests of policyholders and the interests of the person receiving the remuneration must be effectively mitigated; and
 - (d) the payment of such remuneration must not impede the delivery of fair outcomes to policyholders.

3.21 Remuneration that may be offered or provided to a binder holder

- (1) An insurer may pay a binder holder a fee for services rendered under a binder agreement, if the fee is consistent with the principles referred to in regulation 3.20(1).

- (2) Despite subregulation (1), an insurer must not without the prior approval of the Registrar referred to in subregulation (3) pay a binder holder a fee for services rendered under a binder agreement that exceeds the value listed in the Table below, reflected as a percentage of the aggregate of the total premiums payable by policyholders in respect of the policies to which the binder function relates, if that binder holder is-
- (a) a non-mandated intermediary that is authorised to render “advice” as defined in the FAIS Act in respect of policies;
 - (b) a non-mandated intermediary that is an associate of another non-mandated intermediary that is authorised to render “advice” as defined in the FAIS Act in respect of policies.

TABLE

BINDER FUNCTION		MAXIMUM FEE PAYABLE
Enter into, vary or renew a policy - section 49A(1)(a) (“function (a)”)	Function (a) only	3.5%
Determine the wording of a policy - section 49A(1)(b) (“function (b)”) Determine premiums under a policy - section 49A(1)(c) (“function (c)”)	Function (a) and one or more of functions (b) - (d)	5%
Determine the value of policy benefits under a policy - section 49A(1)(d) (“function (d)”) Settle claims under a policy - section 49A(1)(e)	One or more of functions (b) - (d) only	0% 4%

[Editor’s note: See Regulation 8.3 for the commencement date of subr. (2)]

- (3) The Registrar, subject to such conditions as the Registrar may impose, may on application from an insurer grant approval to the insurer to pay a binder holder a fee in excess of the fees referred to in subregulation (2) if the Registrar is satisfied that the fee is consistent with the principles referred to in regulation 3.20.

[Editor’s note: See Regulation 8.3 for the commencement date of subr. (3)]

- (4) Any fee referred to under subregulation (1) payable to a non-mandated intermediary that may perform the service or function contemplated in section 49A(1)(e) of the Act under a binder agreement, may not constitute or be based on a percentage of the difference between an amount claimed or the maximum value of policy benefits payable under a policy and the policy benefits actually provided to a policyholder in settlement of a claim.

- (5) Any fee referred to under this regulation 3.21, payable to a non-mandated intermediary that is a binder holder, must be disclosed to a policyholder, which disclosure must be included in the disclosures contemplated under regulation 6.2(1)(g).

3.22 Participation by a binder holder in profits attributable to the policies referred to in a binder agreement

- (1) A non-mandated intermediary that is a binder holder, in respect of the services rendered under the binder agreement, may not directly or indirectly receive or be offered any share in the profits of the insurer attributable to the type or kind of policies referred to in the binder agreement.
- (2) Subregulation (1) does not prohibit a non-mandated intermediary that is a binder holder and entered into a cell structure with an insurer from receiving dividends in respect of shares held in that insurer as part of that cell structure.
- (3) An administrative FSP or underwriting manager, in respect of the services rendered under the binder agreement, may share in the profits of the insurer attributable to the type or kind of policies referred to in the binder agreement.

[Part 3C inserted by GN 1437/2017 w.e.f. 1 January 2018. See Regulation 8.3 for the commencement date of Regulation 3.21(2) and 3.21(3)]

PART 3D NOTIFICATION OF CERTAIN ARRANGEMENTS WITH INDEPENDENT INTERMEDIARIES OR REPRESENTATIVES

3.23 Definitions

In this Part 3D-

“**binder function**” has the meaning assigned to it in Part 6; and

“**independent intermediary**”, “**representative**” and “**rendering services as intermediary**” has the meaning assigned to such terms in Part 3A.

3.24 Notification of certain arrangements with independent intermediaries or representatives

An insurer must at least 30 days before entering into an arrangement to pay remuneration to an independent intermediary or representative for a service, function or activity which in the opinion of the insurer does not constitute rendering services as intermediary or a binder function notify the Registrar in writing and in the format determined by the Registrar of the arrangement to be entered into.

[Part 3D inserted by GN 1437/2017 w.e.f. 1 January 2018]

PART 4

LIMITATION ON PROVISIONS OF CERTAIN POLICIES

(Section 54)

4.1 Definitions

In this Part

“**excess premium**” means a premium which is received by, or which becomes due to, a long-term insurer during a premium period, and which-

- (a) by itself exceeds;
- (b) when aggregated with all premiums already received, and still to be received, during that premium period, exceeds; or
- (c) is the first of increased recurrent premiums which, if it had been received by the long-term insurer at that increased rate during that premium period, would have caused the total value of the premiums received by the long-term insurer during that premium period to exceed,

by a rate of more than 20 per cent, the higher of the total value of the premiums received by the long-term insurer during any one of the two premium periods immediately preceding that premium period: Provided that if a premium is increased during the second premium period, the percentage increase shall be determined in relation to the first premium period only;

[Definition of “excess premium” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“**extended restriction period**” means a restriction period-

- (a) which has not expired;
- (b) which includes every earlier restriction period any part of which runs concurrently with it; and
- (c) the commencement date of which, from time to time, is the commencement date of the earliest restriction period which runs concurrently with it;

“**free surrender value**” means the value of the consideration which the long-term insurer would provide if the policy is surrendered on the day preceding the date of commencement of an extended restriction period;

“**fund member policy**” ~~has the meaning assigned to it in Part 3A~~ ~~it in means a long term policy other than a fund policy-~~

- ~~(a) — of which a fund is the sole policyholder;~~

~~(b) under which a specified member of the fund (or the surviving spouse, child, dependent or nominee of the member) is the life insured; and~~

~~(c) which is entered into by the fund for the purpose of exclusively funding the fund's liability to that member (or the surviving spouse, children, dependants or nominees of the member) in terms of the rules of the fund;~~

[Definition of "fund member policy" substituted by GN 1437/2017 w.e.f. 1 January 2018]

"benefit fund" in section 1 of the Income Tax Act, 1962 (Act No. 58 of 1962), only in so far as provision is made therein for unemployment benefits;

"linked benefit" means a policy benefit, the value of which is not guaranteed by the long-term insurer and is determined solely by reference to the value of particular assets or particular categories of assets which are specified in the policy and which are actually held by or on behalf of the long-term insurer specifically for the purpose of the policy;

"policy" means a long-term policy, whether entered into before or after the commencement of this Act, excluding-

- (a) a reinsurance policy;
- (b) a fund policy;
- (c) a fund member policy, for as long as no right under the policy is transferred by the fund to a life Insured under the policy, or is transferred to any person except another fund for the direct or indirect benefit of a life insured under the policy; or
- (d) a living annuity as defined in section 1 of the Income Tax Act, 1962 (Act No. 58 of 1962);

[Definition of "policy" substituted by GN 1437/2017 w.e.f. 1 January 2018]

"policy benefit" ~~has the meaning assigned to it in the Act~~~~means one or more sums of money, services or other benefits, including an annuity, but excludes~~excluding a loan in respect of a policy or consideration upon the surrender of a policy;

~~"premium" has the meaning assigned in the Act~~~~means the premium which is stipulated in the policy, or otherwise agreed upon between the parties to the policy, to be provided to the long-term insurer, including any part of a premium;~~

Commented [IRFD217]: "Premium" is already defined in the Act and therefore this definition is not necessary.

"premium period" means one of a succession of periods, each of 12 months' duration, the first of which begins on, and ends 12 months after, the first day of the month in which the first premium, or any part thereof, is received by the long-term insurer or, if it is a later date, the first day of the month in which the undertaking of the long-term insurer to provide policy benefits under the policy, becomes operative;

"restricted amount" means an amount equal to-

- (a) the aggregate of the free surrender value, and the total value of the premiums received by the long-term insurer during the extended restriction period concerned, plus interest on the free surrender value and each premium at the rate of 5 per cent per annum compounded annually; less
- (b) the aggregate of all payments already made by the long-term insurer in respect of the policy, whether as a policy benefit (other than a policy benefit referred to in subregulation (2) of regulation 4.2) or upon the surrender of any part of the policy, during the extended restriction period concerned, plus interest on each payment at 5 per cent per annum compounded annually;

“restriction period” means a period of 5 years which commences, if the date concerned is 1 January 1994 or later-

- (a) on the date when the first premium period begins; or
- (b) during a premium period after the first such period, on the first day of the month in which an excess premium is received by the insurer.

4.1A Application of this Part

- (1) This Part does not apply to a policy that is a tax free investment contemplated in section 12T of the Income Tax Act, 1962 (Act No. 58 of 1962).
[Reg. 4.1A inserted by GN R170/2015 w.e.f. 1 March 2015]

4.2 Limitations on policies

- (1) Subject to subregulations (2), (3), (4) and (5), a long-term insurer, and any person who acts as intermediary between a long-term insurer and any person in respect of a policy or proposal for a policy, shall not undertake to provide, or provide
 - (a) a policy benefit under a policy during an extended restriction period;
 - (b) upon the full or partial surrender of a policy during an extended restriction period-
 - (i) if the policy has previously been partially surrendered during the extended restriction period concerned, any further consideration; or
 - (ii) if the policy has not been previously partially surrendered during the extended restriction period concerned, any consideration the value of which exceeds the restricted amount less the capital (excluding capitalised interest) of a loan already provided in respect of the policy during that extended restriction period:

Provided that where the policy is fully surrendered and the full value of the consideration to be provided thereupon exceeds the amount thus determined by not more than R10 000 the full consideration may be provided;

[Para. (b) substituted by GN 1437/2017 w.e.f. 1 January 2018]

- (c) a loan under or on security of a policy during an extended restriction period-
 - (i) if such a loan has previously been provided in respect of the policy during the extended restriction period concerned; or
 - (ii) if such a loan has not previously been provided in respect of the policy during the extended restriction period concerned, the amount of which exceeds the restricted amount; or
 - (d) directly or indirectly, by means of one or more policies, during an extended restriction period, any benefit (whether as policy benefits or loans in respect of policies or consideration upon the surrender of policies, or any combination thereto which achieves substantially the result that is achieved by an annuity, but which is not, and is not expressly stipulated in the policy or policies to be, an annuity.
- (2) Subregulation (1)(a) shall not apply to a policy benefit which is to be provided and is provided under the policy upon-
- (a) the life of a life insured having ended;
 - (b) the life of a life insured having begun;
 - (c) a health event occurring;
 - (d) a disability event occurring;
 - (e) loss of income occurring.
- [Subreg. (2) substituted by GN 1437/2017 w.e.f. 1 January 2018]
- (3) Subparagraph (1)(a) shall not apply to a policy benefit which is an annuity-
- (a) the payments of which are to be made, and are made, at intervals not exceeding 12 months;
 - (b) at least one of the payments of which is to be made and, except due to the prior death of the life insured, is made, within 31 days before the expiry of the extended restriction period concerned; and
 - (c) the total amount of the payments of which in any period of 12 months does not differ, by a rate of more than 20 per cent, from the total amount of the

payments thereof in the immediately preceding period of 12 months, except in the case of an annuity-

- (i) which constitutes a linked benefit, where the difference, during the period concerned, results solely from the determination of the value of the relevant assets;
 - (ii) payable in terms of a policy with two or more policyholders or lives insured and where the difference results solely from a reduction in the annuity payable during the period concerned consequent upon the death of one of those policyholders or lives insured; or
 - (iii) where the difference results solely from a reduction in the annuity payable during the period concerned consequent upon the surrender of a part of the policy.
- (4) Subregulation (1) shall not apply in the event of-
- (a) the death, placement under curatorship or sequestration of the estate of a policyholder who is a natural person; or
 - (b) the winding-up, liquidation, placement under curatorship or judicial management, by an order of Court, of a policyholder which is a juristic person.
- (5) Subregulation (1)(c) and (d) shall not apply to a premium advance made under non-forfeiture provisions in a policy.

4.2A. Maximum fees, penalties or any other charges on loans

- (1) Where the terms of a loan on the security of a long-term policy provide for the charging of interest at a stated fixed rate, whether simple or compound interest, an insurer may only apply such interest to the capital amount of the loan and not to any other cost or loss in respect of the loan.
- (2) Where the terms of a loan on security of a long-term policy do not provide for the charging of interest, an insurer may not impose any fees, penalties or other charges in respect of the loan in excess of an amount equal to the maximum causal event charge that the insurer would have been permitted to charge if the capital amount of the loan had been the amount surrendered in terms of a causal event referred to in paragraph (d) or (f) of the definition of causal event in Part 5A.

[Reg. 4.2A inserted by GN 1437/2017 w.e.f. 1 January 2018]

4.3 General exclusion

This Part shall not apply in respect of anything done, before or after the commencement of this Part, in relation to a policy entered into before the commencement of this Part if, from a date prior to 1 March 1993, the policy expressly provided, in writing, for it to be done.

**PART 5
REQUIREMENTS AND LIMITATIONS REGARDING THE VALUES AND BENEFITS
OF POLICIES**

(Section 54)

**PART 5A
POLICIES OTHER THAN POLICIES TO WHICH PART 5B APPLIES**

5.1 Application of this Part 5A, and definitions

[Heading substituted by GN R952/2008]

This Part 5A applies to policies other than policies to which Part 5B applies, and in this Part 5A, unless the context indicates otherwise-

[Sentence following heading substituted by GN R952/2008]

“**actuarial basis**”, in relation to a policy, means the underlying actuarial rules, specifications and formulae in terms of which the policy operates, which:

- (a) in compliance with the Act, are approved by the statutory actuary of the insurer, in particular for the purposes of sections 46 of the Act and Rules 15.9 to 15.12 of the Policyholder Protection Rules~~52~~; and
- (b) if and while the Insurance Act, 1943 applied to the policy, in compliance with that Act, were approved by the valuator of the insurer, in particular for the purposes of sections 34 and 62(2) of that Act;

“**basic premium**” means the premium, including a premium paid by virtue of a premium-waiver benefit, less charges (if any) deductible from the premium for rider-benefits;

“**basic risk benefit**” means a risk benefit for which the charge is determined periodically with reference to changes in factors pertaining to the risk, including but not limited to the age of the life insured, the amount of the risk cover, or the investment value of the policy, but excluding a rider benefit;

“**benefit**” means a policy benefit, including a consideration payable upon the full or partial surrender of a policy, but excluding a loan in respect of a policy;

“**causal event**”, in relation to a policy, means one of the following events:

- (a) the policy becomes fully paid-up;
- (b) the basic premium is reduced, without the policy thereby coming to an end or becoming fully paid-up;

- (c) the remaining policy term or the remaining premium-paying term is reduced, without the policy thereby coming to an end or becoming fully paid-up;
- (d) the policy is surrendered in part, other than for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956, or a part of the policy comes to an end for another reason (other than because risk cover under the policy has come to an end);
- (e) the policy, in the case of a fund member policy, is surrendered in part for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956;
- (f) the policy is surrendered in full, other than for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956, or the policy comes to an end for another reason (other than because the policy has reached its maturity date); or
- (g) the policy, in the case of a fund member policy, is surrendered in full for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956;

“causal event charge” means a charge, other than an administration charge contemplated in regulation 5.4A, occasioned by and pertaining to a causal event;

[Definition of “casual event charge” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“charge” means a charge stipulated in a policy or its actuarial basis, whether or not the actuarial basis has been expressly incorporated in the policy, which charge is deductible in respect of the policy in accordance with its terms or actuarial basis;

“come to an end” means that the final benefit under a policy has become payable, including in the case of a fund member policy for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956, or that the policy has lapsed without a benefit becoming payable;

“component” has the meaning assigned in Part 3A;

[Definition of “component” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“dependant” has the meaning assigned in section 1 of the Pension Funds Act, 1956;

“effective date” means 1 December 2006;

“excluded policy” in respect of a –

(a) registered insurer means:

- (ia) a fund policy;

- (ii) a reinsurance policy;
- (iii) a policy that provides risk benefits only;
- (iv) a whole-life policy that provides risk benefits and has an investment value or a materially equivalent value referred to in regulation 5.2(2)(b), and in respect of which policy, immediately before a causal event, the ratio of the aggregate of the sums insured of all basic risk benefits to the monthly basic premium (or the monthly equivalent where recurring premiums are not paid monthly) is greater than the threshold ratio in the table below:

Age next birthday of the life insured at the inception of the policy	Threshold ratio
Up to and including 30	480
31	468
32	456
33	444
34	432
35	420
36	408
37	396
38	384
39	372
40	360
41	348
42	336
43	324
44	312
45	300
46	288
47	276
48	264
49	252
50	240
51	228
52	216
53	204
54	192
55	180
56	168
57	156
58	144
59	132
60 and above	120

(ve) and any other policy that provides primarily risk benefits;

(b) licensed insurer means a policy as defined in section 1 of the Insurance Act:

(i) written under one or more of the following classes of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act: Risk, Fund Risk, Credit Life, Funeral, Fund Investment and Reinsurance only;

(ii) that is a whole-life policy written under both the –

(aa) Risk, Credit Life or Funeral classes of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act; and

(bb) Life Annuity, Individual Investment or Income Drawdown classes of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act; and

that has an investment value or a materially equivalent value referred to in regulation 5.2(2)(b), and in respect of which policy, immediately before a causal event, the ratio of the aggregate of the sums insured of all basic risk benefits to the monthly basic premium (or the monthly equivalent where recurring premiums are not paid monthly) is greater than the threshold ratio in the table below:

<u>Age next birthday of the life insured at the inception of the policy</u>	<u>Threshold ratio</u>
<u>Up to and including 30</u>	<u>480</u>
<u>31</u>	<u>468</u>
<u>32</u>	<u>456</u>
<u>33</u>	<u>444</u>
<u>34</u>	<u>432</u>
<u>35</u>	<u>420</u>
<u>36</u>	<u>408</u>
<u>37</u>	<u>396</u>
<u>38</u>	<u>384</u>
<u>39</u>	<u>372</u>
<u>40</u>	<u>360</u>
<u>41</u>	<u>348</u>
<u>42</u>	<u>336</u>
<u>43</u>	<u>324</u>
<u>44</u>	<u>312</u>
<u>45</u>	<u>300</u>
<u>46</u>	<u>288</u>
<u>47</u>	<u>276</u>
<u>48</u>	<u>264</u>
<u>49</u>	<u>252</u>

<u>50</u>	<u>240</u>
<u>51</u>	<u>228</u>
<u>52</u>	<u>216</u>
<u>53</u>	<u>204</u>
<u>54</u>	<u>192</u>
<u>55</u>	<u>180</u>
<u>56</u>	<u>168</u>
<u>57</u>	<u>156</u>
<u>58</u>	<u>144</u>
<u>59</u>	<u>132</u>
<u>60 and above</u>	<u>120</u>

(iii) and any other policy that provides primarily risk benefits;

“fund member policy” in respect of a –

(a) registered insurer means a policy-

(i~~a~~) of which a fund is or was the policyholder; and

(i~~b~~) which is or was entered into by the fund for the purpose of funding exclusively the fund’s liability to a particular member (or to the surviving spouse, children, dependants or nominees of the member) in terms of the rules of the fund;

(b) licensed insurer means a policy written under the Life Annuity, Individual Investment or Income Drawdown classes of life insurance business as set out in Schedule 2 of Table 1 of the Insurance Act and –

(i) of which a fund is or was the policyholder; and

(ii) which is or was entered into by the fund for the purpose of funding exclusively the fund’s liability to a particular member (or to the surviving spouse, children, dependants or nominees of the member) in terms of the rules of the fund;

“growth rate” means, over a given period, the positive or negative investment return declared for a portfolio, which investment return is net of those portfolio charges that are deducted before the declaration of the investment return, and in the case where a bonus is declared is inclusive of vested and non-vested bonuses;

“insurer”

[Definition of “insurer” deleted by GN 1437/2017 w.e.f. 1 January 2018]

“investment value” means the value of a policy;

- (a) calculated using a method commonly referred to as a back-end loaded basis, by accumulating the basic premium less deductions at the growth rate that applies to the policy, which deductions comprise:
- (i) benefits paid, excluding basic risk benefits and rider-benefits;
 - (ii) charges for basic risk benefits;
 - (iii) charges deducted when benefits are paid or the policy is altered;
 - (iv) charges stipulated as a fixed amount, which amount, over the full term of the policy, is designed to remain unchanged or is designed to be increased at a specified rate at regular intervals;
 - (v) charges stipulated as a percentage or proportion of premiums, which percentage or proportion is designed to remain unchanged over the full term of the policy; and
 - (vi) those portfolio charges that are deducted after the declaration of the growth rate, where, in the case of general portfolio charges deducted after the declaration of the growth rate, their percentage or proportion of the value of the portfolio is designed to remain unchanged over the full term of the policy;

provided that in determining the growth rate to be applied for the purposes of this calculation, the percentage or proportion of the value of the portfolio for general portfolio charges that are deducted before the declaration of the growth rate, is designed to remain unchanged over the full term of the policy; and

- (b) adjusted, where the growth rate that applies to the policy does not follow the fluctuation in the value of the portfolio on a daily basis, and where that is required by the terms or actuarial basis of the policy, by a market-adjustment factor to take into account the difference between the value of the policy so calculated and the value of the portfolio;

“member”, in relation to a fund member policy, means the member of the fund in respect of whom the fund had or has taken out the policy;

“nominee”, in relation to a member, means a nominee of the member contemplated in the rules of the fund;

“policy” means a long-term policy, whether entered into before or after the commencement of the Act;

“portfolio” means the one or more investment funds representing the underlying assets of a policy;

“**portfolio charges**” means charges deducted from a portfolio, being:

- (a) “specific portfolio charges”, namely charges for specific expenses, which expenses include but are not limited to taxes, statutory levies, investment expenses (including investment performance fees), and investment guarantees; and
- (b) “general portfolio charges”, namely management charges, capital charges and other stipulated general charges, which general portfolio charges are stipulated as a percentage or proportion of the value of the portfolio;

“**rider-benefit**” in respect of a –

(a) registered insurer, means a risk benefit for which the charge is a certain amount or a percentage of the premium or is otherwise fixed, which risk benefit excludes a basic risk benefit; and

(b) licensed insurer, has the meaning assigned to it in section 1 of the Insurance Act;

“**this Part**” means this Part 5A;

“**universal whole of life policy**” means a policy other than a fund member policy that is a whole-life policy that is not an excluded policy and-

- (a) that provides risk benefits and has an investment value or a materially equivalent value referred to in regulation 5.2(2)(b); and
- (b) in respect of which the underlying actuarial basis of the policy, whether or not the actuarial basis has been expressly incorporated in the policy, provides that, at inception of the policy, less than 40% of the total premium payable by the policyholder over the expected lifetime of the policy will be allocated towards the investment benefits;

[Definition of “universal whole of life policy” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**values**” means all values of a policy including, but not limited to, its investment value, its remaining value and other values contemplated in Rule 15.11 of the Policyholder Protection Rules section 52(2), and its maturity value;

[Definition of “values” amended by GN 1437/2017 w.e.f. 1 January 2018]

“**variable premium increase**” means an increase in an existing recurring premium payable by a policyholder under a policy, which increase is not a regular contractual premium increase provided for and determinable in the policy at the start of that policy.

[Definition of “variable premium increase” inserted by GN 1437/2017 w.e.f. 1 January 2018]

5.2 Basis for determination of values and benefits of policies

- (1) The values and benefits of a policy, and charges in respect of the policy, are determined, over the full term of the policy, in accordance with its terms and its

underlying actuarial basis, whether or not the actuarial basis has been expressly incorporated in the policy.

- (2) Notwithstanding anything to the contrary in the terms or actuarial basis of a policy which is not an excluded policy, and in respect of which a causal event has occurred on or after 1 January 2001, but subject to regulation 4.2;
 - (a) where the terms or actuarial basis of that policy make provision for the calculation of an investment value as described in the definition “investment value”, regulations 5.3 to 5.6 apply to that policy; or
 - (b) where the terms or actuarial basis of that policy do not make provision for the calculation of an investment value as described in the definition “investment value”, the values or benefits of that policy upon or immediately after the causal event must be, as certified by the insurer’s statutory actuary, materially equivalent to such values or benefits as determined in accordance with regulations 5.3 to 5.6 for a policy contemplated in paragraph (a).

5.3 Fund member policies

- (1) Where a causal event occurred in respect of a fund member policy on or after 1 January 2001, but before the effective date, and the insurer on account of that causal event deducted causal event charges which in total exceed the maximum prescribed in subregulation (2), the insurer must:
 - (a) if the policy has not come to an end before the effective date, within 6 months after the effective date credit the policy with the amount by which the total causal event charges deducted exceed the prescribed maximum (“the excess amount”) plus interest on the excess amount calculated in accordance with regulation 5.5; or
 - (b) if the policy has come to an end before the effective date, and if the amount by which the total causal event charges deducted exceed the prescribed maximum (“the excess amount”) is R150 or more, upon the written request of the member, or in the case of a deceased member upon the written request of the dependants or nominees of the member, which request in every case must be received by the insurer within three years after the effective date, within 6 months after having received the written request pay the excess amount plus interest on the excess amount calculated in accordance with regulation 5.6, less any tax that must be deducted, to the member or to the dependants or nominees of a deceased member.
- (2) The maximum deductible charges for purposes of subregulation (1) are:

- (a) where the causal event is one contemplated in paragraph (a), (c),(f) or (g) of the definition “causal event”, 35% of the investment value immediately before the causal event;
 - (b) where the causal event is one contemplated in paragraph (b) of the definition “causal event”, a percentage of the investment value immediately before the causal event equal to 35% multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;
 - (c) where the causal event is one contemplated in paragraph (d) or (e) of the definition “causal event”, 35% of the amount by which the investment value immediately before the causal event has been reduced.
- (3) Where a causal event occurs in respect of a fund member policy on or after the effective date but before 1 January 2018, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum prescribed in subregulation (4).
 [Subr. (3) substituted by GN 1437/2017 w.e.f. 1 January 2018]
- (4) The maximum deductible charges for purposes of subregulation (3) are:
- (a) where the causal event is one contemplated in paragraph (a), (c), (f) or (g) of the definition “causal event”, 30% of the investment value immediately before the causal event;
 - (b) where the causal event is one contemplated in paragraph (b) of the definition “causal event”, a percentage of the investment value immediately before the causal event equal to 30% multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;
 - (c) where the causal event is one contemplated in paragraph (d) or (e) of the definition “causal event”, 30% of the amount by which the investment value immediately before the causal event has been reduced.
- (5) Where a causal event occurs in respect of a fund member policy during a period referred to in column 1 of Table A below, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum percentage set out in the corresponding line in column 2 of Table A below.

Timing of causal event	Maximum if causal event is one contemplated in the following paragraph of the definition “causal event”:		
	for purposes of paragraph (a), (c), (f) or (g), the maximum percentage below of the investment value immediately before the causal event:	for purposes of paragraph (b), the maximum percentage of the investment value immediately before the causal event equal to percentage below	for purpose of paragraph (d) or (e), the maximum percentage below of the amount by which the investment value immediately before

		multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced:	the causal event has been reduced:
On or after 1 January 2018 but before 1 January 2019	20%	20%	20%
On or after 1 January 2019 but before 1 January 2020	18%	18%	18%
On or after 1 January 2020 but before 1 January 2021	16%	16%	16%
On or after 1 January 2021 but before 1 January 2022	14%	14%	14%
On or after 1 January 2022 but before 1 January 2023	12%	12%	12%
On or after 1 January 2023 but before 1 January 2024	11%	11%	11%
On or after 1 January 2024 but before 1 January 2025	10%	10%	10%
On or after 1 January 2025 but before 1 January 2026	9%	9%	9%
On or after 1 January 2026 but before 1 January 2027	8%	8%	8%
On or after 1 January 2027 but before 1 January 2028	7%	7%	7%
On or after 1 January 2028 but before 1 January 2029	6%	6%	6%
On or after 1 January 2029	5%	5%	5%

5.4 Policies other than fund member policies

- (1)
 - (a) Where a causal event occurred in respect of a policy other than a fund member policy on or after 1 January 2001, but before the effective date, and the insurer on account of that casual event deducted causal event charges which in total exceed the maximum prescribed in subregulation (2), the insurer must, if the policy has not come to an end before the effective date, within 6 months after the effective date credit the policy with the amount by which the total causal event charges deducted exceed the prescribed maximum (“the excess amount”) plus interest on the excess amount calculated in accordance with regulation 5.5.
 - (b) Despite paragraph (a), where a policy other than a fund member policy has come to an end before the effective date, no maximum is prescribed with regard to the deduction of causal event charges on account of a causal event.
- (2) The maximum deductible charges for purposes of subregulation (1) are:
 - (a) where the causal event is one contemplated in paragraph (a) or (c) of the definition “causal event”, 35% of the investment value immediately before the causal event;
 - (b) where the causal event is one contemplated in paragraph (b) of the definition “causal event”, a percentage of the investment value immediately before the causal event equal to 35% multiplied by the amount by which the basic

premium has been reduced divided by the basic premium before it was reduced;

- (c) No maximum is prescribed with regard to the deduction of causal event charges on account of a causal event contemplated in paragraph (d) or (f) of the definition “causal event”.
- (3) Where a causal event occurs in respect of a policy other than a fund member policy on or after the effective date but before 1 January 2018, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum prescribed in subregulation (4).
 [Subr. (3) substituted by GN 1437/2017 w.e.f. 1 January 2018]
- (4) The maximum deductible charges for purposes of subregulation (3) are:
- (a) where the causal event is one contemplated in paragraph (a) or (c) of the definition “causal event”, 30% of the investment value immediately before the causal event;
 - (b) where the causal event is one contemplated in paragraph (b) of the definition “causal event”, a percentage of the investment value immediately before the causal event equal to 30% multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;
 - (c) where the causal event is one contemplated in paragraph (d) of the definition “causal event”, 40% of the amount by which the investment value immediately before the causal event has been reduced;
 - (d) where the causal event is one contemplated in paragraph (f) of the definition “causal event”, 40% of the investment value immediately before the causal event.
- (5) Where a causal event occurs in respect of a policy other than a fund member policy, but that is not a universal whole of life policy, during a period referred to in column 1 of Table A below, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum percentage set out in the corresponding line in column 2 of Table A below.

Timing of causal event	Maximum in respect of a causal event contemplated in the following paragraph of the definition “causal event”:		
	for purposes of paragraph (a), (c), (f)), the maximum percentage below of the investment value immediately before the causal event:	for purposes of paragraph (b), the maximum percentage of the investment value immediately before the causal event equal to percentage below multiplied by the amount by which the basic premium has	for purpose of paragraph (d), the maximum percentage below of the amount by which the investment value immediately before the causal event has been reduced:

		been reduced divided by the basic premium before it was reduced:	
On or after 1 January 2018 but before 1 January 2019	20%	20%	20%
On or after 1 January 2019 but before 1 January 2020	18%	18%	18%
On or after 1 January 2020 but before 1 January 2021	16%	16%	16%
On or after 1 January 2021 but before 1 January 2022	14%	14%	14%
On or after 1 January 2022 but before 1 January 2023	12%	12%	12%
On or after 1 January 2023 but before 1 January 2024	11%	11%	11%
On or after 1 January 2024 but before 1 January 2025	10%	10%	10%
On or after 1 January 2025 but before 1 January 2026	9%	9%	9%
On or after 1 January 2026 but before 1 January 2027	8%	8%	8%
On or after 1 January 2027 but before 1 January 2028	7%	7%	7%
On or after 1 January 2028 but before 1 January 2029	6%	6%	6%
On or after 1 January 2029	5%	5%	5%

- (6) Where a causal event occurs in respect of a universal whole of life policy during a period referred to in column 1 of Table A below, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum percentage set out in the corresponding line in column 2 of Table A below.

Timing of causal event	Maximum in respect of a causal event contemplated in the following paragraph of the definition "causal event":		
	for purposes of paragraph (a), (c), (f)), the maximum percentage below of the investment value immediately before the causal event:	for purposes of paragraph (b), the maximum percentage of the investment value immediately before the causal event equal to percentage below multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced:	for purpose of paragraph (d), the maximum percentage below of the amount by which the investment value immediately before the causal event has been reduced:
On or after 1 January 2018 but before 1 January 2019	20%	20%	20%
On or after 1 January 2019 but before 1 January 2020	19%	19%	19%
On or after 1 January 2020 but before 1 January 2021	18%	18%	18%
On or after 1 January 2021 but before 1 January 2022	17%	17%	17%
On or after 1 January 2022 but before 1 January 2023	16%	16%	16%
On or after 1 January 2023	15%	15%	15%

5.4A Deduction of administration charge

- (1) The insurer may, in addition to causal event charges, deduct in respect of any causal event taking place after 31 December 2017, either during or after the charge term, an administration charge of not more than R500.
- (2) Despite paragraph (a), the administration charge must, if necessary, be reduced proportionally so that the investment value immediately prior to the causal event, less the causal event charge and administration charge, is not smaller than 70% of the investment value immediately before the causal event.

[Reg. 5.4A inserted by GN 1437/2017 w.e.f. 1 January 2018]

5.5 Interest on the excess amount

The interest on the excess amount contemplated in regulations 5.3(1)(a) and 5.4(1)(a) is:

- (a) calculated from and including the date the excess amount was deducted, to but excluding the date it is credited to the policy; and
- (b) at an annual interest rate equal to the growth rate (net of those portfolio charges that are deducted after the declaration of the growth rate) over this period, which annual interest rate is subject to a maximum effective rate of 10% and a minimum effective rate of 0%.

5.6 The interest on the excess amount contemplated in regulation 5.3(1)(b) is:

- (a) calculated from and including the date the causal event occurred, to but excluding the date the excess amount is paid to the member or to the dependants or nominees of a deceased member;
- (b) for the period from the date the causal event occurred, to and including the date the policy came to an end, at an annual interest rate equal to the growth rate (net of those portfolio charges that are deducted after the declaration of the growth rate) over this period, which annual interest rate is subject to a maximum effective rate of 10% and a minimum effective rate of 0%; and
- (c) for the period from and excluding the date the policy came to an end, to but excluding the date the excess amount is paid, at an annual effective rate of 5%.

5.7

[Reg. 5.7 deleted by GN 1437/2017 w.e.f. 1 January 2018]

5.8 Amendments to actuarial basis and values

- (1) An insurer must, before giving effect to an amendment made to the actuarial basis of a policy, where that amendment will have the effect of reducing the values or benefits of that policy, inform the Registrar of the amendment. The insurer must also provide the reasons for the amendment.

- (2) The Registrar may, if he or she is of the opinion that an amendment contemplated in subregulation (1) was affected to directly or indirectly reduce the impact on the insurer of complying with this Part, direct the insurer to review that amendment.
- (3) An insurer must keep a record of amendments contemplated in subregulation (1), which record must be made available to the Registrar on request.
[Reg. 5.8 substituted by GN 1437/2017 w.e.f. 1 January 2018]

5.9 Variable premium increases in respect of policies to which this Part applies

Despite anything contained in this Part or the regulations, any variable premium increase on or after 1 January 2018 in respect of-

- (a) a policy other than a universal whole of life policy to which this Part applies;
- (b) the investment component of a universal whole of life policy;

is subject to Part 3B and Part 5B and must be regarded as constituting a separate policy for purposes of the application of those Parts.

[Reg. 5.9 substituted by GN 1437/2017 w.e.f. 1 January 2018]

[Part 5 substituted by GN R1218/2006]

PART 5B INVESTMENT POLICIES THAT STARTED ON OR AFTER 1 JANUARY 2009

5.10 Application of this Part 5B, and definitions

This Part 5B applies to investment policies that started on or after 1 January 2009, and unless defined differently in this Part 5B or unless the context indicates otherwise, any word or expression to which a meaning has been assigned in Part 5A has the meaning assigned to it in that Part, and-

‘causal event charge’ means a charge, other than an administration charge contemplated in regulation 5.12(3), occasioned by and pertaining to a causal event;

‘charge’ means a charge stipulated in a policy, which charge is deductible in respect of that policy in accordance with its terms and its actuarial basis;

‘charge percentage’, in relation to an investment policy, means 15% reduced on a straight-line basis to 0% over the charge term;

‘charge term’ means the term during which the insurer may deduct a causal event charge, which term starts on the premium commencement date and is equal to:

- (a) in the case of a single premium policy the shorter of-
 - (i) 5 years; or

- (ii) the period until the date on which the policy will reach maturity;
- (b) in the case of a multiple premium policy-
 - (i) 10 years, if the premium term is 20 years or longer;
 - (ii) half of the premium term, if the premium term is 10 years or longer but shorter than 20 years;
 - (iii) 5 years, if the premium term is 5 years or longer but shorter than 10 years; or
 - (iv) the premium term, if the premium term is shorter than 5 years;

‘excluded policy’ in respect of a –

(a) registered insurer means a policy contemplated in paragraphs (a)(i), (ii), (iii) and (iv) of the definition “excluded policy” in Part 5A;

(b) licensed insurer means a policy contemplated in paragraphs (b)(i) and (ii) of the definition “excluded policy” in Part 5A;

‘investment policy’ means a single premium policy or a multiple premium policy, other than an excluded policy;

‘payment date’, in relation to a premium, means the date on which that premium must be paid in terms of the policy;

‘premium commencement date’ means the payment date of the only or first premium;

‘premium term’, in relation to a multiple premium policy, means the shorter of the following periods:

- (a) the period for which the premiums are to be paid in terms of the policy- which period, as at the start of the policy, is specified in the policy or is determinable from its written provisions; or
- (b) the period for which the premiums are to be paid before a policy benefit is to be provided- excluding where the policy benefit is to be provided on account of a disability event, a health event or the death of a life insured; or
- (c) the period for which the premiums are to be paid before a consideration must or may be paid upon the full or partial surrender of the policy- if the amount of the consideration, as at the start of the policy, is specified in the policy or is determinable from its written provisions; or

- (d) the longest of the following periods:
 - (i) 10 years; or
 - (ii) in the case of a fund member policy- the number of full years from the start of the policy to the 66th birthday of the life insured; or
 - (iii) the number of full years from the start of the policy to the 75th birthday of the life insured;

‘start’, in relation to a policy, means when the application for that policy is accepted by the insurer; and

‘this Part’ means this Part 5B.

5.11 Basis for determination of values and benefits of policies

- (1) The values and benefits of an investment policy, and charges in respect of the policy, are determined, over the full term of the policy, in accordance with its terms, which terms must be in accordance with its actuarial basis.
- (2) Notwithstanding anything to the contrary in the terms or actuarial basis of an investment policy, but subject to regulation 4.2, where a causal event has occurred in respect of that policy and that policy’s terms or actuarial basis do not make provision for the calculation of an investment value as described in the definition of “investment value” in Part 5A, the values or benefits of that policy upon or immediately after the causal event must be, as certified by the insurer’s statutory actuary, materially equivalent to such values or benefits as determined in accordance with regulation 5.12 for an investment policy of which the terms or actuarial basis do make provision for the calculation of an investment value as described in the definition “investment value”.

5.12 Maximum charges that may be deducted

- (1) Where a causal event occurs in respect of an investment policy, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum prescribed in subregulation (2).
- (2) The maximum deductible charges for purposes of subregulation (1) are:
 - (a) where the causal event is one contemplated in paragraph (a), (c), (f) or (g) of the definition “causal event”, the charge percentage (15% or less) of the investment value immediately before the causal event;
 - (b) where the causal event is one contemplated in paragraph (b) of the definition “causal event”, a percentage of the investment value immediately before the

causal event equal to the charge percentage (15% or less) multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;

- (c) where the causal event is one contemplated in paragraph (d) or (e) of the definition “causal event”, the charge percentage (15% or less) of the amount by which the investment value immediately before the causal event has been reduced.
- (3)
- (a) The insurer may, in addition to causal event charges, deduct in respect of any causal event, either during or after the charge term, an administration charge of not more than R500.
[Para. (a) substituted by GN 1437/2017 w.e.f. 1 January 2018]
 - (b) Despite paragraph (a), the administration charge must, if necessary, be reduced proportionally so that the investment value immediately prior to the causal event, less the causal event charge and administration charge, is not smaller than 70% of the investment value immediately before the causal event.

5.13 Disclosure

- (1) An insurer must ensure that-
- (a) when an investment policy is applied for, the prospective policyholder or member is within 30 days from the date of application provided in writing with the information referred to in subregulation (2);
 - (b) the summary to be provided to the policyholder or member in accordance with [Rule 11.5 of the Policyholder Protection Rules](#)~~section 48 of the Act~~ contains the information referred to in subregulation (2); and
 - (c) the policyholder or member is at least annually provided with the information referred to in subregulation (2) in writing, by telefax or any appropriate electronic communication reducible to printed form.
- (2) The information for purposes of subregulation (1) is-
- (a) a summary of the content of the provisions of this Part to the extent that those provisions may be or may become applicable to the policy;
 - (b) an explanation of what constitutes a causal event in respect of the policy in question;
 - (c) a statement, expressed as a percentage and, where a Rand value amount is determinable, also as a Rand value amount, of the maximum causal event charges that may be deducted; and

- (d) the administration charge that may be deducted when a causal event occurs.
[Part 5B inserted by GN R952/2008]

PART 5C
PRINCIPLES FOR CALCULATION OF CAUSAL EVENT CHARGES

5.14 Definitions

In this Part 5C any word or expression to which a meaning has been assigned in Part 5A and Part 5B, depending on the context in which this Part 5C is applied, has the meaning assigned to it in Part 5A and Part 5B, respectively.

5.15 General principles for the calculation of causal event charges

- (1) For purposes of compliance with Parts 5A and 5B, an insurer must consider all causal event charges that arose after 1 January 2001.
- (2) When calculating causal event charges in respect of policies referred to in Part 5A and Part 5B, an insurer must-
 - (a) take into account the cumulative effect on a policy's investment value of charges that have already been deducted in respect of previous causal events;
 - (b) on the occurrence of a second or subsequent causal event on a policy, determine the causal event charge for that second or subsequent event by taking into account the cumulative effect of that charge and all prior causal event charges on the policy's investment value;
 - (c) ensure that the cumulative effect of multiple causal event charges during the life of a policy does not result in the policy's investment value at any time being reduced by a greater portion than would have been the case if, at the time of the first causal event, the maximum causal event charge has been deducted.
- (3) For purposes of sub-regulation (2)(b), the calculation of the cumulative causal event charges and the impact on the policy's investment value may take into account the time value of money, but any simplification applied in the calculation methodology may not result in a reduced policy investment value.
- (4) For purposes of subregulation (2)(c), the maximum causal event charge means the lower of-
 - (a) the highest charge the insurer applies to any one causal event for the type of policy concerned according to the insurer's actuarial basis; and
 - (b) the highest causal event charge, at the time of the first causal event, provided for in Part 5A, Part 5B or for the type of policy concerned.

- (5) In applying the principles in subregulation (2), an insurer must apply the same method of calculation to all policies of the same type.
- (6) An insurer must, where the actuarial basis provides for a charge percentage that is less than the maximum prescribed charges, apply the lesser percentage in calculating causal event charges and in determining their cumulative effect.
- (7) An insurer must, prior to adjusting the actuarial basis for policies to ensure that these bases are not inconsistent with the minimum principles contained in this Part, inform the Registrar of the proposed amendment and the reasons therefore.
[Part C inserted by GN 1437/2017 w.e.f. 1 January 2018]

PART 6 BINDER AGREEMENTS

6.1 Definitions and interpretation

In this Part 6, unless the context indicates otherwise-

“administrative FSP” has the meaning assigned to it in the Codes of Conduct for administrative and discretionary FSPs published in Board Notice No. 79 of 8 August 2003, and amended from time to time, under the FAIS Act;

[Definition of “administrative FSP” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“associate” -

- (a) has the meaning assigned to it in the General Code of Conduct; and
- (b) in addition to paragraph (a), includes, in respect of a juristic person, -
 - (i) another juristic person that has a significant owner or member of its governing body that is also a significant owner or member of the governing body of the first mentioned juristic person; and
 - (ii) another juristic person that has a person as a significant owner or member of its governing body who is an associate (within the meaning of paragraph (a)) of a significant owner or member of the governing body of the first mentioned juristic person;

[Definition of “associate” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“binder agreement” means an agreement contemplated in section 49A of the Act;

[Definition of “binder agreement” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“binder function” means any of the functions contemplated in section 49A(1)(a) to (e) of the Act;

[Definition of “binder function” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**binder holder**” means a person with whom an insurer has concluded a binder agreement;

“**enter into**” means any act that results in an insurer becoming liable to provide policy benefits under a policy where the person performing the act may do so without the insurer becoming aware of the act until after the act has been performed;

“**FAIS Act**” means the Financial Advisory and Intermediary Services Act, 2002 (Act No. 37 of 2002);

[Definition of “FAIS Act” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**funeral and assistance policies**” in respect of a –

(a) registered insurer, means one or more -

(i) life policies where the policy benefits relate only to services or costs associated with funerals; or

(ii) assistance policies;

(b) licensed insurer, means one or more policies underwritten –

(i) under the Funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act; or

(ii) by a microinsurer as defined in section 1 of the Insurance Act;

[Definition of “funeral and assistance policies” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**General Code of Conduct**” means the General Code of Conduct for Authorised Financial Services Providers and Representatives as published in Board Notice No. 80 of 2003, and amended from time to time, under section 15 of the FAIS Act;

[Definition of “General Code of Conduct” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**governing body**” has the meaning assigned to it in section 1 of the Financial Sector Regulation Act, 2017 (Act No. 9 of 2017); ~~means a person or body of persons, whether elected or not, that manages, controls, formulates the policy and strategy of the financial institution, directs its affairs or has the authority to exercise the powers and perform the functions of the financial institution, and includes –~~

(a) ~~the general partners of an en commandite partnership or the partners of any other partnership;~~

(b) ~~the members of a close corporation;~~

(c) ~~the trustees of a trust; and~~

~~(d) — the board of directors of a company;~~
[Definition of “governing body” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**independent intermediary**” has the meaning assigned to it in regulation 3.1;

“**integration**” means policy and policyholder data is in a format that is readily recognisable and capable of being meaningfully utilised immediately by the core insurance systems and applications of the insurer;

[Definition of “integration” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**insurer**”

[Definition of “insurer” deleted by GN 1437/2017 w.e.f. 1 January 2018]

“**inter-related**” has the meaning assigned to in section 1 of the Companies Act;

[Definition of “inter-related” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“**mandated intermediary**” means an independent intermediary that holds a written mandate from a potential policyholder or policyholder that authorises that intermediary, without having to obtain the prior approval of that potential policyholder or policyholder, to perform any act, including termination, in relation to a policy, that legally binds that potential policyholder or policyholder, other than an act directed only at changing the underlying investment portfolio of a policy;

“**non-mandated intermediary**” means a representative or an independent intermediary, other than a mandated intermediary or an underwriting manager;

“**policy**” means a long-term policy other than a reinsurance policy;

[Definition of “policy” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“**qualifying stake**” means in respect of a person that-

- (a) is a company, that another person, directly or indirectly, alone or together with a related or inter-related person-
 - (i) holds at least 15% of the issued shares of the first mentioned person;
 - (ii) has the ability to exercise or control the exercise of at least 15% of the voting rights attached to securities of the first mentioned person;
 - (iii) has the ability to dispose of or control the disposal of at least 15% of the first mentioned person’s securities; or
 - (iv) holds rights in relation to the first mentioned person that, if exercised, would result in that other person, directly or indirectly, alone or together with a related or inter-related person-

- (aa) holding at least 15% of the securities of the first mentioned person;
 - (bb) having the ability to exercise or control at least 15% of the voting rights attached to shares or other securities of the first mentioned person; or
 - (cc) having the ability to dispose of or direct the disposal of at least 15% of the first mentioned person's securities;
- (b) is a close corporation, that another person, directly or indirectly, alone or together with a related or inter-related person, holds at least 15% of the members' interests or controls, or has the right to control, at least 15% of members' votes in the close corporation;
- (c) is a trust, means that another person has, directly or indirectly, alone or together with a related or inter-related person-
- (i) the ability to exercise or control the exercise of at least 15% of the votes of the trustees;
 - (ii) the power to appoint at least 15% of the trustees; or
 - (iii) the power to appoint or change any beneficiaries of the trust;
[Definition of "qualifying stake" inserted by GN 1437/2017 w.e.f. 1 January 2018]

"related" has the meaning assigned to in section 1 of the Companies Act;
[Definition of "related" inserted by GN 1437/2017 w.e.f. 1 January 2018]

"renew" means any act that results in the renewal or reinstatement of an insurer's liability to provide policy benefits under a policy where the person performing the act may do so without the insurer becoming aware of the act until after the act has been performed;

"representative" has the meaning assigned to it in regulation 3.1, but excludes any natural person;
[Definition of "representative" substituted by GN 1437/2017 w.e.f. 1 January 2018]

"settle a claim" means any act that results in-

- (a) the acceptance of partial or full liability under a claim for policy benefits or a part thereof;
- (b) the determination of the liability of an insurer under a claim for policy benefits; or
- (c) the rejection of or refusal to pay a claim for policy benefits or a part thereof;

where the person performing the act may do so without the insurer becoming aware of the act until after the act has been performed;

“significant owner” means a person that, directly or indirectly, alone or together with a related or inter-related person, has the ability to control or influence materially the business or strategy of another person. A person has the ability referred to in that subsection if-

- (a) the person, directly or indirectly, alone or together with a related or inter-related person, has the power to appoint 15% of the members of the governing body of the other person;
- (b) the consent of the person, alone or together with a related or inter-related person, is required for the appointment of 15% of the members of a governing body of the other person; or
- (c) the person, directly or indirectly, alone or together with a related or inter-related person, holds a qualifying stake in the other person;
[Definition of “significant owner” inserted by GN 1437/2017 w.e.f. 1 January 2018]

“this Part” means this Part 6;

“transformation in the insurance sector” has the meaning assigned to it in section 1 of the Insurance Act;

Commented [IRFD18]: Inserted to inform the insertion of regulation 6.3(1)(qA).

“underwriting manager” means a person that-

- (a) performs one or more binder function; and
- (b) if that person renders services as an intermediary as defined in Part 3A of the Regulations-
 - (i) does not perform any act directed towards entering into, maintaining or servicing a policy on behalf of an insurer, a potential policyholder or policyholder (including the performance of such an act in relation to a fund, a member of a fund and the agreement between the member and the fund); and
 - (ii) renders those services (other than the services referred to in paragraph (i) above) to or on behalf of an insurer only; and
- (c) does not have any relationship with an insurer (including the secondment of that person’s employees to an insurer or an associate of an insurer, the outsourcing of that person’s infrastructure to an insurer or an associate of an insurer, or any similar arrangement) which may result in that person or its employees de facto, directly or indirectly, performing any act directed towards entering into, varying or renewing a policy on behalf of an insurer, a potential policyholder or policyholder; and
[Definition of “underwriting manager” substituted by GN 1437/2017 w.e.f. 1 January 2018]

“vary” means any act that results in the variation, termination, repudiation or denial of an insurer’s liability to provide policy benefits under a policy where the person performing the

act may do so without the insurer becoming aware of the act until after the act has been performed, and includes any act declaring a policy void.

6.2 Requirements, limitations and prohibitions relating to binder holders

- (1) An insurer, subject to subregulations (1A) to (4) and regulation 6.5, may have a binder agreement with one or more of the following persons only-
 - (a) a non-mandated intermediary;
 - (b) an underwriting manager; or
 - (c) an administrative FSP.
- (1A) An insurer may only enter into a binder agreement with a person referred to in subregulation (1) if the outsourcing of a binder function to that person-
 - (a) is intended to promote the delivery of fair outcomes to customers;
 - (b) would not result in a duplication of administrative efforts or costs for the insurer; and
 - (c) would not impede the insurer's ability to on an ongoing basis identify, assess, manage and report on the risks of poor customer outcomes potentially arising from the manner in which the insurer conducts its business.
- (2) A non-mandated intermediary referred to under subregulation (1)(a) may not conduct any business with any mandated intermediary that is an associate of that non-mandated intermediary in relation to the same policy or policies of an insurer.
- (3) An underwriting manager referred to under subregulation (1)(b) may not conduct any business with a mandated or non-mandated intermediary, or a representative of a mandated or non-mandated intermediary, or an administrative FSP that is an associate of that underwriting manager in relation to the same policy or policies of an insurer.
- (4)
 - (a) An underwriting manager referred to under subregulation (1)(b) who is a binder holder of one insurer cannot also be a binder holder of other insurers in respect of the same class of policies defined in section 1 of the Act, unless all the relevant insurers have agreed thereto in writing.
 - (b) Paragraph (a) does not apply if an underwriting manager enters into a binder agreement with an insurer during a termination period referred to in regulation 6.3(1)(s) in respect of a binder agreement with another insurer and that

underwriting manager may not perform any binder functions on behalf of that other insurer during that termination period.

[Reg. 6.2 substituted by GN 1437/2017 w.e.f. 1 January 2018]

6.2A Governance and oversight requirements

- (1) An insurer must before entering into a binder agreement and at all times thereafter-
 - (a) have the necessary resources and ability to exercise effective oversight over the binder holder on an ongoing basis, particularly in respect of identifying, assessing, managing and reporting on the risks of poor customer outcomes arising from conducting insurance business through binder agreements;
 - (b) satisfy itself of the adequacy of the binder holder's-
 - (i) governance, risk management and internal control framework, including the binder holder's ability to comply with applicable laws and the binder agreement; and
 - (ii) fitness and propriety, including any specific technical expertise required to perform the function to which the binder agreement relate;
 - (c) have documented controls in place to ensure the validity, accuracy, completeness and security of any information provided by the binder holder; and
 - (d) have appropriate contingency plans in place to address any shortcomings it may identify that could lead to it not being satisfied as to the matters provided for in paragraph (b), including where the binder holder is unable to provide the insurer with the relevant data in the appropriate format.
- (2) An insurer must before entering into a binder agreement and at all times thereafter be satisfied that the binder holder has the operational ability to ensure integration between the information technology system of the insurer and the information technology system of the binder holder, which enables the insurer to have access to up-to-date, accurate and complete data held by the binder holder as and when requested by the Insurer and as required in terms of the binder agreement and any other regulatory requirements relating to data management, including the requirements in the Policyholder Protection Rules;
[Editor's note: See Regulation 8.3 for the commencement date of subr. (2)]
- (3) An insurer must regularly review and, where appropriate, act upon the information received from the binder holder to assess the appropriateness and suitability of the functions being performed in terms of the binder arrangement in delivering fair outcomes to policyholders on an ongoing basis.

[Reg. 6.2A inserted by GN 1437/2017 w.e.f. 1 January 2018. See Regulation 8.3 for the commencement date of Regulation 6.2A(2)]

6.3 Requirements, limitations and prohibitions relating to binder agreements

- (1) A binder agreement must, in addition to those matters provided for under section 49A(2)-
 - (a) specify if the binder holder is a non-mandated intermediary, an underwriting manager or an administrative FSP;
 - (b) specify the duration of the agreement;
 - (c) specify the level and standard of service that must be rendered to a policyholder, where relevant, and to the insurer;
 - (d) require that the binder holder at all times is fit and proper, and has appropriate governance, risk management, internal controls and information technology systems in place to render the services under the binder agreement;
[Para. (d) substituted by GN 1437/2017 w.e.f. 1 January 2018]
 - (e) require that the binder holder comply with applicable laws;
 - (f) specify the Rand value of the remuneration or consideration contemplated under Part 3C payable by the insurer to the binder holder or, if the Rand value is not fixed or determinable on entering into the agreement, the basis on which the remuneration or consideration payable will be calculated, in respect of each binder function performed under the binder agreement;
[Para. (f) substituted by GN 1437/2017 w.e.f. 1 January 2018]
 - (g) specify the disclosures that must be made and the information that must be provided to a policyholder, and the manner in which such disclosures or information must be made or provided when a binder holder-
 - (i) enters into, varies or renews a policy;
 - (ii) determines the wording of a policy;
 - (iii) determines premiums under a policy;
 - (iv) determines the value of policy benefits under a policy; or
 - (v) settles a claim under a policy;
 - (h) provide for the type and frequency of reporting by the binder holder on the services rendered under the binder agreement;
 - (i) provide for the manner in and the means by which an insurer will monitor the binder holder's performance under and compliance with the binder agreement;

- (j) provide for periodic performance reviews of the binder holder and the regular review of the binder agreement;
 - (k) specify that the insurer has a right to access any data held by the binder holder as and when such data is requested by the insurer;
[Para. (k) substituted by GN 1437/2017 w.e.f. 1 January 2018]
 - (l) address confidentiality, privacy and the security of information of the insurer and policy holders;
 - (m) address ownership of intellectual property;
 - (n) specify that the binder holder must take the necessary steps to allow the Registrar access to its business and information in respect of the functions performed under the agreement;
 - (o) include indemnity and liability provisions;
 - (p) provide for the intervals, which may not be longer than 90 days, at which the binder holder will update policyholder and policy information in the records of the insurer, which information must, at least, enable the insurer to identify the policyholders, contact the policyholders and assess its liability under the policies;
- (p) require the binder holder to provide the insurer with access to up-to-date, accurate and complete data (in accordance with regulation 6.2A(2)) to ensure that the insurer is able to comply with any regulatory requirements relating to data management, including any requirements provided for in the Policyholder Protection Rules, at the following intervals -
 - (i) daily, in respect of policies other than funeral and assistance policies;
 - (ii) monthly, in respect of funeral and assistance policies;

[Proposed amendment: Para. (p) to be substituted by GN 1437/2017 w.e.f. 1 January 2020]
- (q) set out any warranties or guarantees to be furnished and insurance to be secured by the binder holder in respect of its ability to fulfill its contractual obligations;
 - (qA) must provide for mechanisms and measures that will assist the insurer in meeting procurement, enterprise and supplier development targets relating to the transformation in the insurance sector;**
 - (r) provide for a dispute resolution process;

Commented [IRFD19]: Included to assist insurers in meeting transformation commitments.

- (s) provide for a termination period, irrespective of the circumstances under which the agreement is terminated (including the lapsing or non-renewal of the agreement), of at least 90 days, that will allow-
 - (i) the binder holder and insurer to comply with any legislative requirements relating to the policies referred to in the binder agreement; and
 - (ii) for the transfer or sharing of all electronic and paper-based records in respect of the policies referred to in the binder agreement, including the names and identity numbers of all policyholders, insured persons and beneficiaries; and
 - (t) provide for business contingency processes, including the continuity of service if the binder holder is placed under curatorship, business rescue, becomes insolvent, is liquidated or is for any reason unable to continue to render the services in accordance with the binder agreement.
- (2) Sub-regulation (1)(t) does not prohibit a binder agreement from providing that an insurer may-
- (a) limit or prevent a binder holder from performing certain or all binder functions during the termination period; or
 - (b) take reasonable measures to limit any risks it may be exposed to resulting from or associated with a binder agreement or its termination.
- (3)
- (a) A binder agreement may only provide for matters referred to in section 49A of the Act, this Part and matters incidental thereto, and may not regulate any other arrangement or relationship with the binder holder, irrespective of such other arrangement or relationship being dependent on the conclusion of a binder agreement or that the binder agreement is in addition to or consequential to such other arrangement or relationship.
 - (b) A binder agreement may not prohibit an insurer from communicating directly with its policyholders or any independent intermediary.
- (4) A binder agreement concluded with a non-mandated intermediary, in addition to the matters provided for under sub-regulation (1), must limit the discretion of the binder holder in respect of-
- (a) the maximum value of policy benefits that may be determined under each policy or the maximum value of any claim that may be settled by the binder holder under the policies to which the binder agreement relates;

- (b) the morbidity and mortality risk factors, where appropriate, that must be considered by the binder holder when entering into, varying or renewing a policy or determining the value of policy benefits under a policy;
 - (c) other parameters in accordance with which the binder holder must render the services provided for in the binder agreement; and
 - (d) any guarantee of policy benefits that may be provided for under an investment policy as defined in Part 3A of the Regulation.
- (5) A binder agreement concluded with a non-mandated intermediary may not authorise the binder holder to-
- (a) refuse to renew a policy;
 - (b) reject or refuse to pay a claim for policy benefits or a part thereof;
 - (c) terminate, repudiate or deny an insurer's liability to provide policy benefits under a policy; or
 - (d) declare a policy void.
- (6) An insurer must promptly take reasonable steps to rectify any non-adherence to a binder agreement.
[Subr. (6) inserted by GN 1437/2017 w.e.f. 1 January 2018]
- (7) An insurer must retain a copy of a binder agreement for a period of at least 5 years from the date on which a binder agreement is terminated.
[Subr. (7) inserted by GN 1437/2017 w.e.f. 1 January 2018]

6.4

[Reg. 6.4 deleted by GN 1437/2017 w.e.f. 1 January 2018]

6.5 Exemption

Despite regulation 6.2(2) or (3), the Registrar may on application from an insurer referred to in regulation 6.2(2) or (3) or an insurer that is the holding company or associate of more than one person referred to in regulation 6.2(2) or (3) exempt, subject to such conditions as the Registrar may impose, the insurer or such person from regulation 6.2(2) or (3), if the Registrar is satisfied that-

- (a) any actual or potential conflict of interest is effectively mitigated;
- (b) the delivery of fair outcomes to policyholders will not be impeded; and
- (c) the person has the operational and financial capability to perform the binder function or to conduct such business.

[Reg. 6.5 substituted by GN 1437/2017 w.e.f. 1 January 2018]

6.6 Reporting requirements

- (1) An insurer must, at least 30 days before entering into a binder agreement, notify the Registrar in writing and in the format determined by the Registrar of the proposed binder agreement,
- (2) An insurer must, at least 60 days before the expiry of the termination period referred to under regulation 6.3(1)(s), inform the Registrar in writing and in the format required by the Registrar-
 - (a) of the date on which the binder agreement will terminate;
 - (b) of the reasons for the termination of the binder agreement;
 - (c) how the policies to which the binder agreement relates will be dealt with;
 - (d) how any legislative requirements relating to the termination of the binder agreement or policies, if one or more policies to which the binder agreement relates will be terminated, will be complied with.

[Reg. 6.6 substituted by GN 1437/2017 w.e.f. 1 January 2018]

6.7

[Reg. 6.7 deleted by GN 1437/2017 w.e.f. 1 January 2018]

[Part 6 added by GN R1218/2006, substituted by GN R186/2007, amended by GN R952/2008 and substituted by GN R1077/2011]

PART 7

CONTRACTS IDENTIFIED AS HEALTH POLICIES UNDER SECTION 72(2A)(a) OF THE ACT

7.1 Definitions and interpretation

In this Part 7, unless the context indicates otherwise-

“condition-specific waiting period” means a period in which a policyholder is not entitled to claim policy benefits in respect of a specific condition for which medical advice, diagnosis, care or treatment was recommended or received within a period of 12 months preceding the day on which the policy was entered into;

“general waiting period” means a period in which a policyholder is not entitled to claim any, or may only claim certain, policy benefits;

Commented [IRFD20]: In accordance with Schedule 3 of the Insurance Act this Part must be regarded as having been issued under section 69 of the Insurance Act (which provides for the making of “demarcation” regulations). The Prudential Authority will deal with interpretation and alignment issues regarding the demarcation regulations through an interpretation ruling, if necessary.

“**hospitalisation**” means any admission for a procedure or administration of a therapeutic or diagnostic medical intervention wherein a person is expected to stay overnight in a facility;

“**insurer**” means a long-term insurer;

“**medical scheme**” has the meaning assigned under section 1 of the Medical Schemes Act;

“**member**” has the meaning assigned under section 1 of the Medical Schemes Act;

“**policy**” means a long-term policy;

“**product line**” in relation to a category and type of contract referred to in Regulation 7.2(1), means health policies that have the same or closely related contractual terms offered or entered into by an insurer;

“**relevant health service**” has the meaning assigned under section 1 of the Medical Schemes Act;

“ **rider benefit**” means an additional insurance obligation under a long-term policy which obligation is ancillary to the primary insurance obligations assumed under that policy;

“**this Part**” means this Part 7;

“**underwritten on a group basis**” means where the risks relating to a policy forming part of a product line are rated based on the characteristics of a group of people (other than characteristics that relate to or may result in specific health conditions) together as opposed to that of the individual to whom the policy relates.

7.2 Categories and types of contracts identified as health policies

- (1) The categories and types of contracts set out in the table below are identified as health policies. A contract will only be a health policy for purposes of this Part if it meets the contract description and requirements relating to policy benefits of a specific category and type of contract set out in the table below.

TABLE

Category	Contract Type	Contract description	Requirements relating to policy benefits
1.	Non-medical expense cover as a result of hospitalisation	A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits on the	Policy benefits- (a) Are a fixed sum of money which does not exceed R3 000.00

		happening of a health event that results in hospitalisation.	<p>(three thousand Rand) per insured per day or a maximum lump sum amount of R20 000.00 (twenty thousand Rand) per annum irrespective of the number of days in hospital;</p> <p>(b) does not require hospitalisation for a period of longer than 3 days before they become payable;</p> <p>(c) once it becomes payable, calculated from day 1 of hospitalisation; and</p> <p>(d) may not be paid or ceded to the provider of a relevant health service</p>
2.	Frail Care	<p>A contract-</p> <p>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event; and</p> <p>(b) the purpose of which is to cover the costs or expenses of assistance for activities of daily living.</p>	-
3.	HIV, Aids, tuberculosis or malaria testing and treatment	<p>A contract-</p> <p>(a) in terms of which a person, in return for a</p>	Policy benefits are provided as a rider benefit.

		<p>premium, undertakes to provide policy benefits if a health event relating to HIV, Aids, tuberculosis or malaria occurs; and</p> <p>(b) the purpose of which is to cover the costs or expenses of testing and treatment of HIV, Aids, tuberculosis or malaria.</p>	
4.	Medical emergency evacuation or transport	<p>A contract-</p> <p>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event; and</p> <p>(b) the purpose of which is to-</p> <p>(i) cover the costs of or provide emergency evacuation or transport to a medical treatment facility; or</p> <p>(ii) cover the cost of emergency medical treatment.</p>	Policy benefits are provided as a rider benefit.

- (2) All amounts referred to in sub-regulation (1) escalate annually, from the effective date of this Part, by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999)).

7.3 Limitations applicable to category 1 contracts

Prohibition of policy benefits that fully or partially indemnifies against medical expenses under category 1

- (1) A contract referred to in category 1 in the table under regulation 7.2(1) may not provide policy benefits that are fully or partially related to indemnifying the policyholder against medical expenses incurred in respect of a relevant health service.

Underwritten on a group basis and non-discrimination

- (2) A contract referred to in category 1 and 3 in the table under Regulation 7.2(1) must-
 - (a) be underwritten on a group basis; and
 - (b) not discriminate against a policyholder or potential policyholder on the basis of race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability, state of health or any similar grounds.
- (3) An insurer may not refuse to enter into a contract referred to in category 1 with a potential policyholder unless where that potential policyholder has previously committed a fraudulent act related to insurance.
- (4) Despite sub-regulation (2)(b), an insurer may in respect of contracts referred to in category 1 in the table under Regulation 7.2(1) require a policyholder that enters into a contract after a specific age to pay a higher premium than a policyholder that entered into the contract at a younger age, provided that the same higher premium is payable by all policyholders entering into a product line after a specific age.

Waiting periods

- (5) Despite sub-regulation (2), a contract referred to in category 1 and 3 in the table under Regulation 7.2(1) may provide for a-
 - (a) general waiting period of up to 3 months; and
 - (b) condition-specific waiting period of up to 12 months.
- (6) An insurer may not impose a condition-specific waiting period on a policyholder's health policy if that policyholder, for at least 90 days before entering into a health policy with the insurer, had a health policy with materially similar benefits and had completed the condition-specific waiting period in respect of that health policy;
- (7) Where a waiting period of a policyholder under a previous health policy referred to in sub-regulation (6) had not expired at the time that that policyholder enters into a new health policy with materially similar benefits, the insurer may only impose a

waiting period equalling the unexpired part of the waiting period in respect of that previous policy.

Variation of contracts

- (8) For the purposes of this Part, the variation of a contract includes premium adjustments under a contract, unless agreed to at the commencement of the contract and such adjustments are not inconsistent with sub-regulation 7.3(2)(b).
- (9) Despite sub-regulation (2), a contract referred to in category 1 and 3 in the table under Regulation 7.2(1) may be varied as a result of the health or claims experience of all policies forming part of a product line but may not be varied as a result of the health or claims experience of an individual policyholder.

Termination of contracts

- (10) A contract referred to in category 1 in the table under Regulation 7.2(1) may be terminated by an insurer only if-
 - (a) the policyholder-
 - (i) fails to pay (within the time allowed in the contract and subject to any legislative requirements) the premium under the contract;
 - (ii) submitted fraudulent claims; or
 - (iii) committed any fraudulent act; or
 - (b) the insurer will no longer be offering a specific product line as part of its long-term insurance business and the insurer has given all of that product line policyholders 90-day notice before termination.
- (11) For the purposes of this Part, termination of a contract includes the non-renewal of a contract by an insurer.

7.4 Contracts may not require medical scheme membership

A contract referred to in the table under Regulation 7.2(1) may not provide that the policyholder or insured person must be a member of a medical scheme.

7.5 Marketing and disclosures requirements

- (1) Any marketing activity or marketing material in respect of a contract referred to in category 1 and 3 in the table under regulation 7.2(1) must

- (a) not identify that contract by the term “medical”, “hospital” or any derivative thereof, except-
 - (i) where using the term “hospitalisation” to describe a contract, in which case the term must always be preceded by the words “non-medical expense cover as a result of”; or
 - (ii) where such terms are used in the contract itself to describe policy benefits;
- (b) not in any manner create the perception that the contract-
 - (i) is a substitute for medical scheme membership; and
 - (ii) in the case of a contract referred to in category 1 in the table under regulation 7.2(1), indemnifies a policyholder against medical expenses incurred as a result of a relevant health service; and
- (c) display the following statement in clear legible print in a prominent position: “This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.”

7.6 Reporting requirements

- (1) An insurer must, at least 1 month prior to marketing or offering a new product line, submit to the Registrar and Registrar of Medical Schemes a summary of the benefits, terms and conditions and marketing material of the health policy or policies forming part of the product line.
- (2) The Registrar may at any time request information on the benefits, terms, conditions and marketing material of a contract that, in the opinion of the Registrar or the Registrar of Medical Schemes, is or may be a contract referred to under regulation 7.2(1).
- (3) The Registrar of Medical Schemes may at any time advise the Registrar that the Registrar of Medical Schemes is of the opinion that the benefits, terms and conditions or marketing material relating to a contract under sub-regulation (1) or (2) is contrary to the objectives and purpose of the Medical Schemes Act and the principles referred to in sections 72(2A)(b)(i)(cc)(A) to (C) of the Act, and the reasons for this opinion.
- (4) The Registrar may at the Registrar’s own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to under sub-regulation (3), by notice to an insurer, object to any of the benefits, terms and conditions and marketing material of a health policy under sub-regulation (1) and (2), and instruct the insurer to-

- (a) stop marketing the health policy or policies;
- (b) stop offering or renewing the health policy or policies to the public and within 90-days of the date determined by the Registrar, terminate such health policy or policies; or
- (c) by a date determined by the Registrar, amend any of the benefits, terms and conditions and marketing material of a health policy or policies in accordance with the requirements of the Registrar.

7.7 Transitional arrangements

- (1) Contracts entered into before this Part took effect must comply with this Part as and when such contracts are varied or renewed subsequent to this Part becoming effective.

[Part 7 inserted by GN R1077/2011 and substituted by GN 1582/2016 w.e.f. 1 April 2017]

PART 8
AUTHORISATION OF AND REQUIREMENTS FOR COLLECTION OF PREMIUMS
BY INTERMEDIARIES
(SECTION 47A)

8.1 Authorisation

- (1) Any authorisation referred to in section 47A provided by an insurer to an independent intermediary to receive, hold or in any other manner deal with a premium payable under a policy of that insurer must be in writing and must, amongst other things -
 - (a) specify the duration of the authorisation and the functions that may be performed under the authorisation;
 - (b) specify the commission payable by the insurer to the independent intermediary for services rendered under the authorisation;
 - (c) specify the level and standard of services that must be rendered in terms of the authorisation;
 - (d) specify the operational requirements that the independent intermediary must meet at all times to render services under the authorisation;
 - (e) provide for the type and frequency of reporting by the independent intermediary on the services rendered under the authorisation; and

Commented [IRFD21]: Comments on transitional provisions relating to these requirement are requested.

- (f) provide for the manner in and the means by which an insurer will monitor the independent intermediary's performance under and compliance with the authorisation.
- (2) An independent intermediary may not delegate an authorisation that has been granted to it in accordance with section 47A.
- (3) An insurer may not authorise, as contemplated in section 47A, more than one independent intermediary to receive, hold or in any other manner deal with a premium in relation to the same policy.
- (4) An insurer must, before it authorises an independent intermediary under section 47A, and at all times thereafter, be satisfied that –
 - (a) the independent intermediary has the necessary operational ability to satisfactorily perform the functions or activities contemplated in the authorisation;
 - (b) such authorisation will not materially increase risk to the insurer; and
 - (c) such authorisation will not compromise the fair treatment of or continuous and satisfactory service to policyholders.
- (5) An insurer must on an ongoing basis monitor whether an independent intermediary authorised under section 47A receives, holds or in any other manner deals with premiums in accordance with the authorisation and in accordance with this Part.
- (6) An insurer must have appropriate contingency plans in place to address any shortcomings in the independent intermediary's performance of the authorised functions that identify through an assessment contemplated in subregulation (5) or otherwise become aware of.

8.2 Requirements relating to receiving premiums

- (1) An independent intermediary who receives premiums must account for such premiums properly and promptly and open and maintain one or more separate bank accounts designated for receiving and remitting premiums only.
- (2) All premiums received by an independent intermediary –
 - (a) through electronic means must be received into a bank account referred to in subregulation (1); or
 - (b) in cash must be deposited into a bank account referred to in subregulation (1) within 2 business days after a premium is received.

- (3) A premium received or deposited into a bank account in accordance with subregulation (2) may only be transferred to the insurer for whom the premium is intended and may not be utilised or transferred for any purpose other than remitting the premium to the insurer concerned.
- (4) An independent intermediary must within a period of 15 days after the end of every month, pay to the insurer concerned the total amount of the premiums received during that month.
- (5) Despite subregulation (4), an independent intermediary may, subject to the insurer's authorisation, prior to paying the total amount of the premiums received to the insurer reduce that amount by the value of –
- (a) any refund of premiums due and payable by the insurer to any policyholder or prospective policyholder represented by such independent intermediary; and
 - (b) any consideration payable to that independent intermediary by the insurer for rendering services as intermediary in respect of the policies concerned.

8.3 Returns

- (1) An independent intermediary who has been authorised under section 47A must in respect of every month in respect of which the authority is in force, furnish the insurer concerned with returns –
- (a) in the form required by that insurer;
 - (b) containing information relating to at least the premiums received, the commission payable to that intermediary and the amounts paid to the insurer; and
 - (c) within a period of 15 days after the end of the month concerned.

PART 98 TITLE AND COMMENCEMENT

98.1 These regulations are called the Regulations under the Long-term insurance Act, 1998.

98.2 The amendments to the Regulations, subject to subregulation 8.3, take effect on ~~1~~ 2 ~~January~~ July 2018.

98.3 Despite regulation 8.2 the following amendments made to the Regulations through Government Notice 1437 as published in Government Gazette 41334 on 15 December 2017 take effect as follows -

- (a) repeal of the definition of “administrative work” in regulation 3.1 in Part 3A takes effect 12 months after the effective date;
- (b) insertion in Part 3A of regulation 3.9A takes effect 6 months after the effective;
- (c) the amendment of item 5.2.2.1 and repeal of items 5.2.2.1.1 and 5.2.2.1.2 in the Table in Annexure 1 in Part 3A takes effect 12 months after the effective date;
- (d) insertion of subregulations (2) and (3) in regulation 3.21 in Part 3C takes effect-
 - (i) on the effective date for binder agreements entered into on or after the effective date;
 - (ii) for binder agreements entered into after 1 January 2017 but before the effective date, the earliest of-
 - (aa) 6 months after the effective date; or
 - (bb) the date on which any amendment to binder fees payable under such binder agreement is made;
 - (iii) for binder agreements entered into before 1 January 2017, the earliest of-
 - (aa) 12 months after the effective date; or
 - (bb) the date on which any amendment to binder fees payable under such binder agreement is made;
- (e) insertion of subregulation (2) in regulation 6.2A in Part 6 takes effect 24 months after the effective date; and
- (f) amendment to paragraph (p) in subregulation (1) in regulation 6.3 in Part 6 takes effect 24 months after the effective date.
[Part 8 inserted by GN 1582/2016 and substituted by GN 1437/2017 w.e.f. 1 January 2018]

9.4 For purposes of regulation 9.3 “effective date” means 1 January 2018.