# GOVERNMENT NOTICES

## NATIONAL TREASURY

### LONG-TERM INSURANCE ACT, 1998: AMENDMENT OF REGULATIONS MADE UNDER SECTION 72

I, Pravin Jamnadas Gordhan, Minister of Finance, under section 72(1)(d) and 72(2A)(a) of the Long-term Insurance Act, 1998 (Act No. 52 of 1998), hereby amend the Regulations made under section 72 of the Long-term Insurance Act and published under Government Notice R1492 in *Government Gazette* 19495 of 27 November 1998 (as amended from time to time) as set out in schedule A.

**PRAVIN JAMNADAS GORDHAN, MP**
**MINISTER OF FINANCE**

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## SCHEDULE A

**1. Amendment of Part 3A in the Regulations under the Long-term Insurance Act, 1998 as published in GN R.1492 of 1998 and amended by GN R.197 of 2000, GN R.164 of 2002, GN R.1209 of 2003, GN R.1218 of 2006, GN R.186 of 2007, GN R.952 of 2008 GN R.1077 of 2011 and GN R.170 of 2015:**

Part 3A of the Regulations is hereby amended by:

(a) The substitution of sub-regulation (2) in Regulation 3.2 of the Regulations for the following sub-regulation:

"(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.";

(b) The insertion after sub-regulation (1) in Regulation 3.4 of the Regulations of the following sub-regulation:

"(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 R 600 | 15% |
| Less than R300 | 20% |

(c) The insertion after the last note in the Notes to Annexure 1 to Part 3A of the following note:

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"a health policy under item 5 refers to a health policy other than a contract identified as a health policy in category 1 and 3 in the table under regulation 7.2(1) of the Regulations".

(d) The substitution of Regulation 3.7 for the following regulation:

"**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 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 Scale in Regulation 3.4(1A)."

**2. Substitution of Part 7 in the Regulations under the Long-term Insurance Act, 1998 as published in GN R.1492 of 1998 and amended by GN R.197 of 2000, GN R.164 of 2002, GN R.1209 of 2003, GN R.1218 of 2006, GN R.186 of 2007, GN R.952 of 2008, GN R.1077 of 2011 and GN R.170 of 2015:**

Part 7 of the Regulations is hereby substituted for the following Part:

**"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-

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**“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;

**“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 |
|---|---|---|---|

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| | | | |
|---|---|---|---|
| 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 happening of a health event that results in hospitalisation. | Policy benefits –<br>(a) Are a fixed sum of money which does do not exceed R3 000.00 (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;<br>(b) does not require hospitalisation for a period of longer than 3 days before they become payable;<br>(c) once it becomes payable, are calculated from day 1 of hospitalisation; and<br>(d) may not be paid or ceded to the provider of a relevant health service. |
| 2 | Frail Care | A contract -<br>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event; and<br>(b) the purpose of which is to cover the costs or expenses of assistance for activities of daily living. | - |
| 3 | HIV, Aids, tuberculosis or malaria testing and treatment | A contract –<br>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits if a health event relating to HIV, Aids, tuberculosis or malaria occurs; and<br>(b) the purpose of which is to cover the costs or expenses of testing and treatment of HIV, Aids, tuberculosis or malaria. | Policy benefits are provided as a rider benefit. |
| 4 | Medical emergency evacuation or transport | A contract –<br>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event; and<br>(b) the purpose of which is to –<br>(i) cover the costs of or provide emergency evacuation or transport to a medical treatment facility; or<br>(ii) cover the cost of emergency medical treatment. | Policy benefits are provided as a rider benefit. |

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(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.

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(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.

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### 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.

**3. Insertion of Part 8 in the Regulations under the Long-term Insurance Act, 1998 as published in GN R.1492 of 1998 and amended by GN R.197 of 2000, GN R.164 of 2002, GN R.1209 of 2003, GN R.1218 of 2006, GN R.186 of 2007, GN R.952 of 2008, GN R.1077 of 2011 and GN R.170 of 2015:**

Part 8 is hereby inserted after Part 7 of the Regulations:

"**PART 8**

**TITLE AND COMMENCEMENT**

8.1 These regulations are called the Regulations under the Long-term Insurance Act, 1998.

8.2(1) Regulations 1 to 4 came into operation on commencement of the Act.

(2) Regulation 3A and 5A came into operation on 1 December 2006.

(3) Regulation 3B and 5B came into operation on 1 January 2009.

(4) Regulation 6 came into operation on 1 January 2012.

(5) The amendments to Part 3A and Regulation 7 comes into operation on 1 April 2017.

(6) Any amendments to regulations 1 to 7 come into operation on the date of publication thereof in the Government Gazette or on such other date specified by the Minister in the Government Gazette or specified in a regulation."

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