FSCA

Financial Sector
Conduct Authority

PROPOSED AMENDMENTS TO THE POLICYHOLDER PROTECTION RULES MADE UNDER THE LONG-TERM INSURANCE ACT, 1998 AND SHORT-TERM INSURANCE ACT, 1998

Consultation Report

SEPTEMBER 2018

1. Summary of public consultation process

The predecessor to the Financial Sector Conduct Authority (FSCA), the Financial Services Board (FSB) on 2 March 2018 released, for public comment, the proposed amendments to the Policyholder Protection Rules (PPRs) made under the Long-term Insurance Act, 1998 (LTIA) and Short-term Insurance Act, 1998 (STIA) (proposed amendments). The envisaged effective date of the proposed amendments was initially aligned to the effective date of the Insurance Act, 2017 (Insurance Act), being 1 July 2018. However due to the interconnectedness between the proposed amendments and the amendments to the Regulations under the LTIA and STIA (the amendments to the Regulations) which was published by the Minister of Finance and consulted on during the same period, the decision was taken that the effective date of the proposed amendments and the amendments to the Regulations will be coordinated to take effect on the same date. The envisaged effective date of the proposed amendments and the amendments to the Regulations is 1 October 2018.

The legislative process employed in respect of amending the PPRs follows the prescripts of section 98 of the Financial Sector Regulation Act, 2017 (FSRA), despite the fact that the FSRA only took effect on 1 April 2018.

1.1 Documents published for public comment

Notice of the release of the proposed amendments for public comment was given by way of Board Notice 30 of 2018 (the Notice) which was published in Government Gazette No. 41473 on 2 March 2018.

The Notice advised of the publication of the proposed amendments for public comment and invited submissions in relation thereto. The Notice also stated where the documents were published and where, how and by when submissions were to be made.

The following documents were published on the website of the FSB:

- Board Notice 30 of 2018
- Annexure A – Draft amendments to the PPRs made under the LTIA
- Annexure B – Draft amendments to the PPRs made under the STIA
- Statement on the proposed amendments to the PPRs under the LTIA and STIA
- Track changes version of the proposed draft amendment to the existing LTIA PPRs
- Track changes version of the proposed draft amendment to the existing STIA PPRs

Comments on the draft amendments to the PPRs were due to the FSCA in writing on or before 13 April 2018, allowing a period of 6 weeks for public comment.

1.2 Notification to and workshops with stakeholders and interested parties

On 2 March 2018, the FSB circulated an email confirming the release of the PPRs for public comment, stating where the documents were published and where, how and by when submissions were to be made. The email was sent to the public officers of all insurers registered under the LTIA and STIA, industry representative bodies as well as interested stakeholders registered to receive such emails.

A similar notification was sent to all members of the FSB industry stakeholder committee and the Market Conduct Regulatory Framework Steering committee, which comprises of the industry representative bodies for insurers, banks, pension funds and intermediaries.

Two industry workshops on the proposed amendments were hosted at the offices of the FSCA on 3 and 4 April 2018. The workshops were attended by 139 representatives from regulated entities, industry associations and other interested parties.

1.3 Copies of documents published /provided to other financial sector regulators

Section 98(3) of the FSRA requires copies of the notice inviting submissions together with the statement explaining the need and the intended operation as well as the expected impact of the financial instrument to be provided to specific stakeholders. In accordance with this requirement, the draft PPRs and supporting documents were provided to the following institutions:

- National Treasury
- Prudential Authority
- South African Reserve Bank
- National Credit Regulator
- Council for Medical Schemes

1.4 Submission of regulatory instruments to Parliament

The proposed amendments were submitted for parliamentary scrutiny in terms of section 103 of the FSRA on 16 May 2018. The following documents were submitted to Parliament:

- Notice of amendment to the LTIA PPRs (draft regulatory instrument)
- Notice of amendment to the STIA PPRs (draft regulatory instrument)
- A statement explaining the need, the intended operation and expected impact of the proposed amendments as required in terms of section 98 of the FSRA
- A report on the consultation process followed as required in terms of section 104 of the FSRA
- A tracked changes version of the proposed amendments reflected on the existing LTIA PPRs
- A tracked changes version of the proposed amendments reflected on the existing STIA PPRs

The 30 day period referred to in section 103(1) of the FSRA expired on 15 June 2018.

2. General account of the issues raised in the submissions made during the consultation

2.1 Significant concerns were raised regarding the below listed proposals in the PPRs. The proposed approaches to alleviate the concerns are listed in the column next to the concern raised.

Primary concern raised	Response and approach taken to alleviate concern
○ The proposed application of the microinsurance product standards to funeral policies offered by traditional insurers;	The intention with applying the product standards to both microinsurance products and funeral products offered by traditional insurers is to ensure a level playing field between microinsurers and traditional insurers in respect of funeral policies and that all policyholders are afforded the same protections in terms of these Rules. The aim of the microinsurance framework is to facilitate financial inclusion and enterprise development by enabling small and medium enterprises to enter the "insurer market" and provide policies to the low income market without being subject to the onerous solvency requirements applicable to traditional insurers. If the product standards were not applicable to funeral policies offered by traditional insurers, traditional insurers would be at an unfair advantage to new microinsurers. The concerns regarding specific standards were however noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies and not to funeral policies offered by traditional insurers. The limitations on waiting periods were also addressed to further accommodate longer term policies offered by traditional insurers.
○ Limitation on a contract term of a microinsurance policy and funeral policy to a maximum of 12 months;	The limitation on a contract term to the maximum of 12 months will only apply to microinsurers. The 12 month limitation on microinsurance policies was proposed in line with the National Treasury's Microinsurance Policy Document ("Policy Document") released in July 2011, which is available on the National Treasury's website https://www.treasury.gov.za. The contract term is a critical component that justifies the specific prudential requirements that will be introduced by the Insurance Prudential Standards under the Insurance Act. This limitation is central to allowing a lighter regulatory regime for dedicated microinsurers and is included in the product standards to support the prudential framework for microinsurers. Should there be actuarial grounds to change the terms of, or cancel the contract, the limited contract term implies that the microinsurer is not locked into a contract or price beyond the 12 months prescribed maximum. This is not to say that longer-term products do not hold value to lower-income households, but the increased complexity of these longer-term products requires the more onerous regulatory regime currently applied to insurers. It is for this reason that the 12 month contract limitation will apply only to microinsurers. Microinsurers will however be encouraged to use a longer-term view for pricing even though they are allowed to adjust prices more frequently.
○ The limitation of the use of the	This limitation was introduced to ensure that policies

Primary concern raised	Response and approach taken to alleviate concern
term "funeral policy" in advertising to only life insurance policies underwritten under the funeral class of life insurance business;	cannot be marketed as providing funeral benefits unless it meets the description of the Funeral Class of business as set out in Schedule 2 of the Insurance Act and the insurer is authorised to offer such policies. The requirement was deemed necessary in order to avoid insurers circumventing the application of the microinsurance product standards by writing funeral type policies under the Risk (Death) class of business, as the microinsurance product standards would only apply to insurers when selling funeral type policies under the Funeral Class as was seen in respect of life versus assistance policies under the prevailing framework. We remain of the view that the microinsurance product standards should apply to traditional insurers selling funeral policies because funeral policies are significant in facilitating financial inclusion objectives and un-level playing field between microinsurers and traditional insurers in the funeral insurance market must be avoided. The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured, which will alleviate most of the concerns raised by insurers in respect of the cap. The prohibition on marketing polices to cover funeral costs has been amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers.
o Prohibition of surrender or investment value for funeral policies offered by traditional insurers;	This sub-rule has been removed from the product standards and will not apply to funeral products written by life insurers. The limitation will however continue to apply to microinsurers. In terms of definition of "microinsurance business" in the Insurance Act, a microinsurer can only conduct business in the following classes of life insurance business as referred to in Schedule 2 of the Insurance Act, subject to the insurance obligations (policy benefits) under such policies not exceeding the prescribed amounts: o Risk o Credit Life o Funeral o Reinsurance (in as far as it relates to the above life classes of insurance business) By virtue of this definition in the Insurance Act, microinsurers will not be able to offer policy benefits that have an investment / surrender value.
o Limitation on waiting periods to not exceed a quarter of the contract term;	The limitation on applying waiting periods will be amended to allow for waiting periods for the shorter of one quarter of the term of the policy, or a maximum of 6 months. Please refer to item 2.1.1(h) of the Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk

Primary concern raised	Response and approach taken to alleviate concern
	of adverse selection in situations where no individual underwriting occurs, against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.
o Prohibition on waiting periods for replacement policies; and	This remains a necessary limitation to protect policyholders. The wording of the prohibition will be revised to be less prescriptive. The period during which a new waiting period may not be applied upon reinstatement of a policy will be reduced from 6 months to 2 months.
o Exclusions for pre-existing health conditions for the credit life or funeral class of life insurance business.	Please refer to item 2.1.1(i) of Policy Document, which contains the initial proposal that a microinsurance policy may not impose any exclusion for a pre-existing health condition. In acknowledging that such blanket exclusion may drive up premiums and inhibit fair underwriting, the alternative was suggested that exclusion of pre-existing health conditions should only be prohibited for funeral policies underwritten by traditional insurers and microinsurers, and should not be applied for other microinsurance policies.
o The need for certain conduct of business related requirements that will be repealed from the STIA through Schedule 1 to the Insurance Act and inserted in Rules 7, 11 and 20 to apply to commercial lines business; and	The proposed repeal of Sections 51, 53, 54 of the STIA through the Insurance Act, 2017 will be deferred and these sections will not be provided for in the PPRs as was suggested in the initial draft published for public comment. This will be done to ensure that these requirements remain applicable to commercial lines business, which is currently the case. As the concern does not apply to the long-term insurance industry, these sections will be removed for purposes of the long-term PPRs.
o Detailed transitional arrangements required.	The table setting out the transitional arrangements for the effective dates of the various Rules were revised and simplified at the request of the industry to ensure legal certainty and effective implementation of the various rules. A transitional period of 2 years and 10 months has been included to allow for alignment of existing policies that offer funeral benefits to the product standards set out in Rule 2A of the LTIA PPRs. The period effectively allows for one year after the 2 year conversion of licensing period, as referred to in Schedule 3 of the Insurance Act, for insurers to align all existing policies that meet the description of funeral in schedule 2 of the Insurance Act.

3. Comments received through public consultation process / responses thereto

A total of 198 individual comments were received from 19 different commentators. A list of the commentators and relevant contact persons, as well as all comments received through the public consultation process and the FSCA's responses thereto are set out in the tables below.

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SECTION A – LIST OF COMMENTATORS

No	AGENCY / ORGANISATION	CONTACT PERSON
1	African Unity Life Limited	Johan Ferreira
2	Association For Savings & Investment SA (ASISA)	Anna Rosenberg
3	Assupol Life Limited	Bridget Mokwena-Halala
4	AVBOB Mutual Assurance Society	Kriben Gounden
5	Banking Association South Africa (BASA)	Adri Grobler
6	Clientele General and Clientele Life Assurance (Clientele)	Yurika Pistorius
7	Ms D Donnelly	Ms D Donnelly
8	Direct Marketing Association of South Africa (DMAS)	Wayne Mann
9	The Financial Intermediaries Association of Southern Africa	Ronald King
10	The Financial Planning Institute of Southern Africa	David Kop
11	Home Loan Guarantee Company NPC	Janet Abramowitz
12	Independent Actuaries & Consultants	Marcus Pillay
13	Investec Life Limited	Nthabiseng Mhlongo
14	Janice Angove	Janice Angove
15	KGA Life Ltd	Louw Kriegler
16	Nick Flowers	Nick Flowers
17	Ombudsman for Long-term Insurance (OLTI)	Jennifer Preiss
18	Outsurance Life	Neline Versfeld
19	South African Insurance Association (SAIA)	Easvarie Naidoo

SECTION B – COMMENTS AND RESPONSES ON THE PROPOSED AMENDMENTS TO THE PPRs UNDER THE SHORT-TERM INSURANCE ACT, 1998

No	Section/Rule	Commentator	Comment	Response
			CHAPTER 1: INTERPRETATION	
1.	Definition of credit life insurance	FIA	We at the FIA are not privy to the size of credit life insurance that was written by non-life insurers, but would like to ensure that the necessary analysis of the market impact of the prohibition has been done.	This proposed change is to ensure alignment between the PPRs and the Insurance Act, 2017. In terms of the Insurance Act, the class of "Credit Life Insurance" will only be allowed to be written by life insurers, authorised for the credit life class of business. This effectively means that non-life insurers will not be able to write credit life, but will be able to write consumer credit insurance as defined in Schedule 2 to the Insurance Act. The only class relating to cover for disability or death events that non-life insurers will be able to write will be the "Accident and health" class which can only cover costs or loss of income resulting from a disability or death event caused by an accident. For this purpose the definition of credit life insurance in the ST PPRs is now limited to registered insurers only. Table 2 of Schedule 2 to the Insurance Act sets out the classes and sub-classes of business for which non-life insurers may be authorised. These classes were developed as part of the consolidated legal framework for the prudential supervision of insurers contained in the Insurance Act. The development process of the Insurance Act was comprehensive and inclusive and with broad public consultation, which included an economic impact study. We therefore submit that the necessary analysis of the impact on the market was done as part of the development of the Insurance Act.
2.	Rule 2.1 Definition of *"insurer"*	SAIA	The SAIA proposes that the definition of 'insurer" should be extended to specifically define *"registered insurer"* and *"licensed insurer."*	See the preamble to the Definitions section in Chapter 1, under 2.1 which states that: "*In these rules "the Act" means the Short-term Insurance Act, 1998 (Act No. 53 of 1998), including the Regulations*

No	Section/Rule	Commentator	Comment	Response
				promulgated under section 70 of the Act, and any word or expression to which a meaning has been assigned in the Act bears, subject to context, that meaning unless otherwise defined,-…" This means that any word that is defined in the Act or Regulations has the same meaning in the PPRs – unless differently defined. Schedule 1 to the Insurance Act in turn amends the STIA by replacing the definitions section of the STIA. As of the effective date of the Insurance Act (envisaged for 1 July 2018), the definitions in the STIA will therefore be replaced. The new definition of "short-term insurer" in the STIA reads as follows: *"short-term insurer" means a registered insurer or a licensed insurer;* "registered insurer" and "licensed insurer" are also now defined for purposes of the STIA. Note the definition of "insurer" in the PPRs: "*insurer" means a short-term insurer.* Insurer in the short-term PPRs therefore means a short term insurer (as defined in the STIA), which in turn means a registered insurer or a licensed insurer (also as defined in the STIA). Extending the definition in the PPRs is therefore not necessary.
3.	Definition of repudiate	FIA	Would this also include a case where a client lodges a claim with an adviser, but the adviser informs the client that the claim is not covered and does not lodge the claim with the insurer?	Please refer to Rule.17.4.3. If the adviser has been mandated by the insurer to manage claims on its behalf, or if the adviser is a representative of the insurer, the claim is deemed to have been received by the insurer itself, in which case it will constitute repudiation by the insurer.

No	Section/Rule	Commentator	Comment	Response
CHAPTER 3: PRODUCTS				
RULE 2: PRODUCT DESIGN				
No comments received.				
RULE 2A: MICROINSURANCE PRODUCT STANDARDS				
4.	General comment	Clientele	Our understanding of the National Treasury policy document on Microinsurance in 2011 was not that the idea was to apply the microinsurance requirements on short-term insurance. We have noted that legal expenses insurance also falls within the realm of micro insurance (insofar as the cover amount falls below the threshold). As set out in more detail, we believe that many of the Rules cannot be effectively applied on legal expenses insurance.	We disagree. Please refer to the National Treasury's Microinsurance Policy Document ("Policy Document") released in July 2011, which is available on the National Treasury's website https://www.treasury.gov.za. Section 2.1.1 that specifically deals with Product features and standards does not anywhere limit the proposed product standards to life (long-term) insurance. Please also specifically see sub-paragraph (o) which refers to the development of minimum and maximum excess payments for asset microinsurance, which is a clear reference to non-life (short-term) cover. Legal expense is a dedicated class of non-life insurance business and listed as a class of micro-insurance business in the definition of micro-insurance business in the Insurance Act. It is unclear from the commentator's comment why policyholders of legal expense microinsurance policies should not be afforded the protections in the product standards.
5.	Rule 2A.4.1 & 2A.4.2	Clientele	Strictly speaking many short-term policies are month to month policies. Would the insurer then be required to comply with the disclosure requirements at the end of each month? Regardless of whether policies are annualised or month to month, in the lower LSM, contactibilty of policyholders is a big concern, as it is known in the lower LSM market that most of these policyholders have around 2 - 3 different cell phone numbers, as they do sim swaps due to data costs and airtime	If the policies are actually renewed every month, then the insurer would have to meet the disclosure requirements. Our understanding of these mentioned short-term policies is that they are month-to-month policies, meaning that they can be cancelled by the policyholder on 30 days' notice, but only annually renewable. In terms of the microinsurance product standards in Rule 2A, the terms, conditions or provisions of a microinsurance policy may not be changed or varied during the first 12

No	Section/Rule	Commentator	Comment	Response
			packages and can sometimes not be reached. Physical addresses are not available due to informal demarcation standard and poor postal service (registered mail and normal mail is returned).	months after inception of the policy. This aligns with the proposals in the National Treasury's Microinsurance Policy Document. Regarding the commentators concerns on "contactability" of the policyholder, the insurer has the responsibility in terms of Rule 13 of the PPRs on Data Management to ensure that it has the access to the names, identity numbers and contact details of all its policyholders and that the contact details are as complete as possible. Without this information the insurer will in any event not be able to meet the disclosure requirements in the PPRs.
6.	Rule 2A.4.1 & 2A.4.2	DMASA	Given that the duration of a microinsurance policy cannot exceed 12 months and that the terms and conditions cannot vary during that period of 12 months, we submit that it would be impractical to make the disclosures required in terms of Rule 11.6.6 on a policy that renews in periods shorter than the 12 months - for example on month-to-month policies. Furthermore, the intent of a term of no more than 12 months must please be clarified. If the reason is to ensure that clients are regularly informed of the benefits they have, the solution would be through a requirement that annual communication is sent to the insured prior to the anniversary of the policy.	✎See the amendments to the Rule. The 12 month limitation on microinsurance policies was proposed in line with the NT Policy Document released in July 2011, which is available on the National Treasury's website https://www.treasury.gov.za. Microinsurance policies will be automatically renewable as was also proposed in the policy document. The requirements relating to on-going disclosure as set out in Rule 11 will however remain as they are already applicable to all other insurance policies. The prohibition of variation during first 12 months after inception of the policy will also remain as it is intended to protect policyholders from insurers unilaterally increasing the premium soon after inception or changing the terms, conditions or limitations to the detriment of the policyholder.
7.	Rule 2A.4.1 & 2A.4.2	FIA	While we are not averse to the idea that, as per clause 2A.4.2, micro-insurance policies should be limited to a period of 12 months in principle, in practice this is likely to cause considerable complications, especially where, for example, the policy is taken out by someone in a rural area who works in the city and is not always available to discuss renewal annually and may not be easily	Noted. It is for this reason that a microinsurance policy will be automatically renewed upon expiry. The microinsurer will have to meet the disclosure requirements relating to the renewal of policies as set out in rule 11.6.5 should any of the terms conditions or limitations in the policy be changed, which is in the best interest of the policyholder.

No	Section/Rule	Commentator	Comment	Response
			contactable with communication in some cases	The microinsurer has the responsibility in terms of Rule 13 of the PPRs on Data Management to ensure that it has the access to the names, identity numbers and contact details of all its policyholders and that the contact details must be as complete as possible. The microinsurer will need this information to meet the disclosure requirements in the PPRs.
8.	Rule 2A.4.2 Structure of policy benefits	SAIA	The SAIA requests that the FSCA clarifies what the intention of this rule is. The SAIA submits that new system will be necessary developments for the requirements in this rule. Accordingly, we propose that a longer transitional period be considered for this rule.	The intention of this rule is to set out the structure of the policy benefits as proposed in the National Treasury's Microinsurance Policy Document. We note that it may require system development, but considering that the Rule will apply to microinsurance policies entered into by a microinsurer, and that microinsurers will only be licensed as such under the Insurance Act, such system developments will be required to set up a microinsurer. Once the microinsurer is ready to operate its business and licensed by the Prudential Authority, it may start offering microinsurance policies in the market, which policies much meet these standards. The standards will therefore only apply once the microinsurer is licensed.
9.	Rule 2A.4.3	FIA	Disallowing average significantly increases the risk of an asset deliberately being under-insured and the premium collected not correlated to the actual risk carried on the asset. Disallowing averaging would therefore result in significant increases in premiums.	Noted. Please bear in mind the policies are however capped at a maximum of R300 000 per insurance policy for non-life insurance (see draft Governance and Operational Standard for Microinsurers – Prudential Standard GOM available on the Prudential Authority's website. https://www.prudentialauthority.co.za/Pages/Documents-issued-for-Consultation.aspx) which lowers the risk of underinsurance. The proposal aligns with requirements of the category in the FAIS Fit and Proper requirements of 'short-term insurance personal A1' as set out in the FAIS Board Notice on

No	Section/Rule	Commentator	Comment	Response
				Determination of Fit and Proper requirements for FSPs, to which the product standards have been aligned. In addition it aligns to the principle in the NT insurance policy document that products must be designed in an appropriately simplified way, to support improved understanding of insurance products by consumers in the market. ✎Also note the amendments to the Rule regarding excesses and exclusions to mitigate the concerns raised in this regard.
10.	Rule 2A.5.1(a) Variation and renewal of a microinsurance policy	SAIA	The SAIA proposes that the word "or" be added at the end of the sentence.	Agree. ✎See the amendments to the Rule.
11.	Rule 2A.5.2 Variation and renewal of a microinsurance policy	SAIA	Please clarify whether the insurer is permitted to change the terms of the policy after the 12 month period as Rule 2A.5.1 applies *"regardless of whether a microinsurance policy has been renewed during the 12 month period referred to therein."*	The insurer may change or vary the policy after the first 12 months from inception of the policy. Rule 2A.5.2 is intended to clarify that the prohibition in 2A.5.1 applies, regardless of the length of the policy term, in other words, if the policy term is 3 months and the policy is then renewed, the insurer may still not vary or change the terms, conditions or provisions of the policy during the first 12 months unless it can demonstrate the requirements in (a)(i) or (ii).
12.	Rule 2A.5.3 Variation and renewal of a microinsurance policy	SAIA	Please refer to our query in point 7 above. If the terms of the policy may be changed after the 12 month period, please advise if this would also apply to the group policy referred to in Rule 2A.5.3.	Rule 2A.5.2 applies regardless of whether the microinsurance policy is underwritten on a group basis or as an individual policy. Also note that Rule 2A.5.3 applies to a group policy at all times, regardless how long the policy has been in force and regardless of when or whether it is renewed.
13.	Rule 2A.6.1	FIA	Due to the absence of underwriting on these policies, the market generally makes use of waiting periods that could be longer than 3 months. Imposing a 3-month limit on the waiting period will inevitably result in rates increasing considerably in many cases. This will be to the detriment of the	Noted ✎See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the policy, or 6 months. Please refer to item 2.1.1(h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on

No	Section/Rule	Commentator	Comment	Response
			market	waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.
14.	Rule 2A.6.2	Clientele	We propose that the Rule should clearly state that no waiting period may be imposed, provided that the accident occurred after the commencement of the policy. In its current form, the rule can be interpreted that policy benefits would be payable if the event (accident) happened prior to the commencement of the policy, but the death or disability as a result of the accident has not yet occurred.	Noted ✎See the amendments to the Rule.
15.	Rule 2A.6.4	Clientele	While we have noted that Legal Expense policies are included in the realm of microinsurers (providing that the cover limit falls below the threshold), we do not believe that the waiting period requirements in this Rule can be applied on Legal Expenses insurance. In many instances, the insurable event is not totally unexpected and a risk exists that anti-selection will take place.	Noted. ✎See the amendments to the Rule relating to waiting periods.
16.	Rule 2A.6.4	FIA	Would this also apply if the previous policy is not cancelled and the new policy becomes a second policy?	No.
17.	Rule 2A.6.5	Clientele	This rule creates a huge administrative burden on insurers, in the light that policyholder data is an issue in the lower LSM market. As previously stated a policyholder might not be contactable and where will the insurer then obtain such sophisticated data regarding previous insurers? There is currently no such central database available to check against and in most instances, the client will not be able to provide the new insurer with the policy documents or proof of previous cover (and its waiting period) from the previous insurer showing this.	Noted. ✎See the amendments to the Rule relating to waiting periods. Also see previous response regarding the microinsurer's responsibility in terms of Rule 13 of the PPRs on Data Management and ensuring that it has the access to the names, identity numbers and contact details of all its policyholders that are as complete as possible. The microinsurer will need this information to meet the disclosure requirements in the PPRs. The microinsurer cannot avoid responsibilities towards its policyholders based on the fact that the policyholder is

No	Section/Rule	Commentator	Comment	Response
				unsophisticated or difficult to contact. The insurer can contact the previous insurer directly to obtain the information if need be. If the insurer finds it too administratively burdensome to obtain the information, it simply cannot impose a new waiting period.
			We also do not believe that this Rule can effectively be applied on Legal Expenses insurance where the claim event is in many instances not a quick once-off event but in some instances (such as civil or labour litigation matters) could occur over years. The industry would run the risk that clients can "hop" between legal expense insurers while they have different ongoing legal matters. We propose that a standard waiting period be allowed for legal expenses insurance.	Regarding the comment specific to Legal Expenses insurance, regardless of the type of policy the intention is to limit waiting periods in microinsurance policies. Please refer to item 2.1.1(h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.
18.	Rule 2A.6.5 to 2A.6.8	DMASA	The majority of funeral policies are sold via direct marketing. The implication of these requirements is onerous. Clients often do not remember the underwriter as they may have bought the previous policy through their bank or other institution and are not clear on the underwriter. Has consideration been given to the process of identifying possible previous insurer in such cases? What if a customer does not know about a previous policy and assumes such policy is still active when in fact it is has lapsed? To do this effectively there should be a central repository of funeral policy holders across underwriters against which an applicant for cover can be checked before proceeding. The implications of implementing such a process and system, however, are extensive. In addition, what if the lives being insured under the new policy are not the same as the lives insured under the previous policy, should there still be no waiting period?	Non-life insurers will not be authorised to write policies under the funeral class of business, as funeral is limited to life insurance business. We therefore assume that this comment is limited to the LT PPRs. Please see our response under item 109 of this comment matrix.

No	Section/Rule	Commentator	Comment	Response
19.	Rule 2A.6.8 Waiting periods	SAIA	The SAIA submits that this rule could be problematic if the previous microinsurer's records are not up to date. Please advise whether the FSCA will oversee this requirement and hold such microinsurer liable for incorrect information that may result in negative consequences for the policyholder.	Noted. This comment is made on the assumption that a previous microinsurer may not have up to date records. We are of the view that this should be the exception to the rule and will depend on the facts of the specific matter at hand, which will be assessed as part of the supervision of the insurer. Such situations will be addressed through supervision.
20.	Rule 2A.7.1	Clientele	This Rule cannot apply to legal expenses insurance where specific legal causes of actions are excluded.	Disagree. The commentator did not provide any details of causes of action that will be excluded from the cover that do not fall within the exclusions set out in Rule 2A.7.1. We submit that a cause of action relating to unlawful conduct, which is typically excluded from cover under a legal expense policy, constitutes a permissible exclusion. A microinsurer can design its products respect of which the aggregate value of the policy benefits is R120 000 or less limited to the exclusions listed in Rule 2A.7.1(a) to (e). The proposal to limit exclusions aligns with requirements of the category in the FAIS Fit and Proper requirements of 'short-term insurance personal A1' as set out in the FAIS Board Notice on Determination of Fit and Proper requirements for FSPs, to which the product standards have been aligned. This is an existing category under FAIS and aligns to the principle in the NT policy document that products must be designed in an appropriately simplified way, to support improved understanding of insurance products by consumers in the market. Products with aggregate value between R120 000 and the R300 000 benefit cap as introduced by the Prudential Authority must comply with the requirements in Rule 2A.7.2.

No	Section/Rule	Commentator	Comment	Response
				✎See the amendments to the Rule relating to exclusions.
21.	Rule 2A.9.1(b)(i) Claims	SAIA	We propose that the word “or” be added at the end of the sentence.	Disagree. Rule 2A.9.1(b)(ii) contains the word “or”, which is interpreted to mean that the items listed under Rule 2A.9.1(b)(i) to (iii) are exclusive of one another. In other words it must be interpreted as, in addition to the other requirements under Rule 2A.9.1, a microinsurer must, within 48 hours after all required documents in respect of a claim under a microinsurance policy have been submitted - (b) (i) authorise payment of the claim; or (ii) repudiate the claim; or (iii) dispute the claim and notify the claimant of the dispute.
22.	Rule 2A.9.1	DMASA	Authorising and paying claims on accident and health or travel microinsurance policies within 48 hours of receiving the claim and required documentation, will expose insurers to risk. In this event, the insurers are likely to increase premium in order to mitigate their risk, to the detriment of policyholders.	Noted. In the absence of any reason why there will be an increased risk for accident and health microinsurance policies, it is not clear why the risks would necessarily be higher for these types of policies, as opposed to other microinsurance policies. In terms of the rule, the microinsurer may dispute a claim and investigate it further, should it identify any risks relating to the claim. ✎See the amendments to the Rule extending the requirement from 48 hours to 2 business days.
23.	Rule 2A.9.1	FIA	Please change the 48 hours to 2 business days to provide for public holidays and weekends. (The term “business day’ is defined anyway.)	Agreed. ✎See the amendments to the Rule extending the requirement from 48 hours to 2 business days.
24.	Rule 2A.9.2 Claims	SAIA	The SAIA submits that in the event of a dispute of the claim and the matter is being investigated internally, the matter may not be concluded within 14 days. The SAIA proposes that a 21 day period be considered.	Noted. ✎See the amendments to the Rule extending the requirement from 14 days to 14 business days.
25.	Rule 2A.9.3 Claims	SAIA	There are limitations on benefits placed with regard to group schemes. Please advise if those limitations should be disclosed prior to inception of the policy to members in a compulsory group scheme space.	The principle is that a microinsurer may not repudiate a claim based on information that it did not specifically request the policyholder to disclose before the inception of the policy.

No	Section/Rule	Commentator	Comment	Response
			This is often difficult as members do not complete an application form to be part of the group scheme. Please clarify how this will work practically and advise to what extent this can be used as part of the exclusion as opposed to misrepresentation by the policyholder.	This is based on the fact that a policyholder may not necessarily know which disclosures are relevant to the risk being underwritten, and if a microinsurer is of the view that information is relevant to the risk, it should ask the policyholder appropriate questions before the inception of the policy. This is an adapted version of the "non-contestable rule" which is applied in some other jurisdictions. It aligns to the proposal in the NT Microinsurance Policy Document under item 2.5.6 which deals with requirements for simplified disclosure. ✎See the amendments to the Rule limiting the requirement to non-disclosure by the policyholder to address concerns raised regarding compulsory group schemes. However the insurer will be responsible to ensure that that the policyholder is aware of the requirement and communicate accordingly to members of the group scheme.
26.	Rule 2A.10.1	DMASA	Insurers are less likely to consider reinstatement given the proposals, which is not necessarily in the best interests of policyholders. Reinstatement is often not readily considered due to policyholders reinstating based on their realisation that they may shortly have a claim or already have a claim. The ability to reinstate with waiting periods is essential to enable insurers to maintain prudentially sound risk pools.	✎See the amendments to the Rule reducing the period from 6 months to 2 months. This rule does not force a microinsurer to reinstate a policy. It merely sets out the requirements if the microinsurer chooses to reinstate the policy. The rule does not prohibit a microinsurer from choosing to rather not reinstate, and to enter into a new policy with the policyholder. It may well be that the policyholder does not have the money to reinstate, i.e. pay up the premiums which it has missed which caused the policy to lapse, in which case the insurer may choose not to reinstate the policy. The parties may by agreement then choose to enter into a new policy for which the premium may differ, but to protect the policyholder from the adverse effect of a new waiting period, the new policy may not impose a new waiting period if the policy lapsed less than 2 months ago.

No	Section/Rule	Commentator	Comment	Response
27.	Rule 2A.10.2	DMASA	This rule will discourage microinsurers from providing cover to recently lapsed (due to non-payment) policyholders. Due to the common payment method of debit orders, a premium might be unpaid due to insufficient funds in the policyholder's bank account, this might have been unintentional due to a change in banking details or dates on which salaries are paid into the account. Based on the DMASA's experience, the market segment most affected by these lapses, often change contact details and might not be aware of the bank rejection or the lapsed status of their policy. Insurers providing these products will typically communicate with the lapsed policyholders after the lapse, to see if their financial position has improved or circumstances have changed. On average, at least 20% of previously lapsed on cancelled policyholders will take up a new policy, like the previous policy. These retention strategies are definitely seen as valuable to the policyholders. This rule could increase the overall risk to the insurer and would either increase the premiums to cover the risk or simply not offer these products for at least 6 months, while the relationship with the policyholder and their contactibility declines and they remain without cover.	Please see the response directly above. The insurer can choose to reinstate or to enter into a new policy with the policyholder. The rule does not limit this right; it merely sets out the requirements in either of such instances.
28.	Rule 2A.10.2 Reinstatement	SAIA	The SAIA submits that this will expose microinsurers to anti-selection risk. This will have negative and high risk implications for microinsurers as it will mean policyholders are afforded a longer period to come back and reinstate policies where one previously lapsed and can keep doing it indefinitely. The SAIA proposes that the period referred to in this rule be limited to a quarter of the policy's term and should only be done once for such policyholder.	✎See the amendments to the Rule reducing the period from 6 months to 2 months. Bear in mind that the insurer can choose to reinstate or to enter into a new policy with the policyholder. The rule does not limit this right; it merely sets out the requirements in either of such instances. If the insurer chooses to reinstate, it must do so on the same terms and may not impose a waiting period. Nothing prohibits it to agree with the policyholder to recover the outstanding premium under the reinstated policy.

No	Section/Rule	Commentator	Comment	Response
				Alternatively the insurer may choose to enter into a new policy, but may not impose a new waiting period it the policy lapsed less than 2 months ago. This requirement is included to protect the policyholder from the adverse effect of a new waiting period if the policy recently lapsed. The rule does not limit the insurer's right to, in terms of its underwriting rules, limit that a reinstatement should only be done once for such policyholder.
29.	Rule 2A.11.1	FIA	While we support customer choice in this regard we are cognisant of the fact that bulk negotiations with suppliers such as electronic stores reduces the cost of replacement products and thereby reduces the premiums. This is similar to a medical scheme requiring use of their panel of medical practitioners. Care also needs to be given to cases where an insurer appoints a service provider to effect a replacement that the reimbursement is made to the service provider and not policyholder by the insurer.	Noted. ✎See the amendments to the Rule. The requirement will be removed for short-term.
30.	Rule 2A.12.1	DMASA	What is considered to be a new micro insurance or funeral product? Is it a product that the insurer previously did not have in their product basket or is it a product that is fundamentally different to the norm in the industry? If 100 insurers now start offering a funeral product that is very much standard and in line with the requirements, will they all have to submit to the Authority for approval? In addition, as the Authority may object at any time to the product, the ability for insurers to service and manage such products is inherently uncertain which will discourage investment and innovation in this space. What will the implication be for customers who have bought a product which is subsequently deemed to be unsuitable? The Authority should only be able to object within the 31 day notice period.	✎See the amendments to the Rule to clarify. A new microinsurance product is any product that the insurer previously did not have in their "product basket" (to use the wording of the commentator). It is not products that are 'new' to the industry only. It applies on individual insurer level. This rule goes to the appropriate design of microinsurance products. This aligns to the proposal in the National Treasury Microinsurance Policy Document relating to product regulation. Please see item 2.1.2 on page 15 - 16 of the policy document in this regard that proposes that product review will take place on a "file-and-use" basis. The policy document sets out a detailed explanation for the proposed approach to regulation of microinsurance products in this section.
31.	Rule 2A.12.1	FIA	We would appreciate some further clarity as to what	✎See the amendments to the Rule to clarify.

No	Section/Rule	Commentator	Comment	Response
			would constitute a new product as opposed to a variation of an existing product.	Please see the response directly above in explaining what will constitute a new microinsurance product.
RULE 3: CREDIT LIFE AND CONSUMER CREDIT INSURANCE				
32.			No comments	
RULE 7: VOID PROVISIONS				
33.			No comments	
CHAPTER 4: ADVERTISING AND DISCLOSURE				
RULE 10: ADVERTISING				
34.	General comment	FIA	We are unsure whether the same advertising and disclosure requirements could be made applicable to microinsurance. Although these products targets those clients that require the most protection, the nature of the market also limits the manner of advertising as well as the level of disclosure that can be made.	Noted. We however share the commentator's view that microinsurance products target those customers that require the most protection, also in relation to appropriate advertising and disclosure. In the absence of any specific examples or instances where the requirements in these rules are not appropriate to microinsurance products we submit that the PPRs are drafted in a sufficiently principle based manner in order for them to be applied proportionately.
35.	Rule 10.1 Definition of *"group of companies"*	SAIA	Please advise the rationale behind the substitution of the Companies Act with the Insurance Act, when the latter also makes reference to the Companies Act.	The definition of a 'group of companies' in the Insurance Act is broader than a group of companies as defined in the Companies Act, and the concept should be applied consistently by insurers for purposes of all insurance related legislation. This aligns to reasoning set out in the Statement supporting Tranche 2 amendments to PPRs March 2018 as published with the proposed amendments to the PPRs. The statement confirms that the amendments are necessary to align the PPRs with the Insurance Act, 2017 which will support consistency across the insurance regulatory framework in order to maintain legal certainty.
36.	Rule 10.3 and 10.4	DMASA	The definition of Advertising (Chapter 1, 2.1) states that any communication through any medium, must at all times adhere to Rule 10. In the process of direct marketing it has been common practice for insurers, either directly or through lead aggregators, to create awareness of its products typically within the market segment not ordinarily serviced by brokers, through either SMS, social media or other	Noted. However the definition of 'advertising' has not been changed since the replacement of the PPRs in December 2017. The definition has merely been moved to the main definitions section as the term is used in other rules, and no longer only in the rule on advertising. We understand the role that technology plays in marketing of products; however the interest of insurers to market their

No	Section/Rule	Commentator	Comment	Response
			digital media. These messages to potential policyholders to "find out more" fits the definition of "Advertising", but this invitation to obtain further information will not adhere to Rule 10 due to practicalities (maximum length of SMS, banners on websites) and will prevent the distribution of important cover to markets previously unaware of the importance or existence of these products. The cost of generating consumer awareness/interest is currently extremely high. The imposition of any additional requirements will negatively impact the commercial viability of these communication strategies, especially as it is often the start of an individual's journey with a financial services provider.	products in a cheap and easy way has to be balanced against the protection of policyholders and potential policyholders that receive these advertisements. We submit that the rule on advertising does not prohibit insurers to make use of sms, social media or other digital media. It sets out the principles to which advertisements must comply to ensure fair outcomes for policyholders. As there aren't any 'additional requirements' being imposed, and the development of the rule on advertising was widely consulted on as part of Tranche 1 before the replacement PPRs were made effective in December 2017, it is unclear what further negative impact this may have.
RULE 11: DISCLOSURE				
37.	General comment	FIA	We are unsure whether the same advertising and disclosure requirements could be made applicable to microinsurance. Although these products targets those clients that require the most protection, the nature of the market also limits the manner of advertising as well as the level of disclosure that can be made.	Noted. We however share the commentator's view that microinsurance products target those customers that require the most protection, also in relation to appropriate advertising and disclosure. In the absence of any specific examples or instances where the requirements in these rules are not appropriate to microinsurance products we submit that the PPRs are drafted in a sufficiently principle based manner in order for them to be applied proportionately.
38.	Rule 11.5.1.i	FIA	Risk acceptance criteria / data (such as information gathered under client needs analysis systems - like security arrangements and prior claims history) are not necessarily currently transferred (or in a format that is transferable) from underwriting systems into policy production systems. This type of information ranges from hard copy proposal forms to electronic data held in various formats some of which is re-keyed into policy systems. Some of this information may go back some years to the original inception of the policy that makes availability, accessibility and transferability even more problematic.	Noted. As the requirements in this sub-rule are not currently prescribed for short-term insurance, and have been inserted to align to the requirements in the Long-term Insurance PPRs, (which in turn are being transferred from s48 of LTIA to the LT PPRs), an appropriate transitional period will be afforded. ✎ Please see the table in Chapter 8 on administration in this regard.

No	Section/Rule	Commentator	Comment	Response
			This is a new requirement that introduces significant sourcing and formatting challenges and cannot be applied as early as 1 July 2018 in fact there are significant difficulties in accessing and providing this information even by 15 December 2018 being the date for the other information under the existing rule 11 (that is more generally achievable). Request – that the deadline for completion of 11.5.1(i) be 1 July 2019 (or one year after effective date of new regulations).	
39.	Rule 11.5.2	BASA	Rule 11.5.2 requires information to be provided to the policyholder, which is distinguishable from the policy. The information required refers to 'comprehensive details'. This may result in a lengthy 'summary' document attached to the policy wording, which the client may not pay attention to. We suggest that the Regulator consider providing a template summary document. Further, as these requirements have a document and system impact, we suggest that a transitional period may assist with implementation.	Noted. However considering the vast amount of different products and different features of products in the market, the format of the disclosure is best left to the insurer. This is in line with principle based regulation and we will not be prescriptive in this regard. It is up to the insurer to ensure that the information is in an appropriate format. ✎ Also please see the transitional period for implementation afforded in table in Chapter 8 on administration in this regard.
40.	Rule 11.5.2	DMASA	Please can you provide clarity on the purpose / rationale for this requirement to enable us to comment meaningfully. We respectfully submit, on the face of it, that there will be no difference in customer outcomes relative to what is already required under existing legislation. This requirement effectively amounts to unnecessary compliance and will increase costs for the policyholder. In this regard, direct marketers provide prospective customers with information to make an informed decision at sales stage, which is subject to further subsequent written confirmation and disclosures post the sale as you know.	The requirements in this sub-rule are not currently prescribed for short-term insurance, and have been inserted to align to the requirements in the Long-term Insurance PPRs, (which in turn are being transferred from s48 of LTIA to the LT PPRs). The proposed requirement in 11.5.2 does not impose any additional disclosure requirements, and merely sets out the principle that the information referred to in 11.5.1 (which is already required) must be clearly distinguishable from the rest of the information in the policy wording and the schedule. As this relates to information to be provided after the inception of the policy, it is not clear how this is any different for a direct marketer who is required to provide the information in terms of 11.5.1.

No	Section/Rule	Commentator	Comment	Response
				This does not detract from the principle that it is not a duplication of information already provided by the insurer in writing under Rule 11.4, which allows for a less 'compliance' based approach to disclosure, and a more principles based approach. As the requirements in this sub-rule are not currently prescribed for short-term insurance, an appropriate transitional period will be afforded. ✎ Also please see the transitional period for implementation afforded in table in Chapter 8 on administration in this regard.
41.	Rule 11.5.2	FIA	Please define what is clearly distinguishable from the policy The "policy" contract is defined in policy wordings as comprising the following documents - Proposal for insurance, Schedule of insurance and Policy wording. The disclosures referred to in 11.5.1. are usually contained within the schedule of insurance or the policy wording but are not necessarily grouped together under, say, "Material disclosures by policyholder". It is not clear what is meant by the "information must be provided in a format which is distinguishable from the policy"? The former wording in the STIA was "provided … with a copy of the document which embodies the contract of short-term insurance concerned". This, read with the definition in policy wordings (above), has been taken to mean that the information under 11.5.1 being included in the construct of the policy contract as defined above was acceptable. The change suggests that the information must be in a separate document.	This means that the disclosures must not be absorbed into the legal jargon in the policy wording, as this information is particularly relevant to the policyholders. This is to make sure that policyholders are given clear information and are kept appropriately informed before, during and after the time of entering into a policy, which is critical in ensuring the delivery of fair outcomes to which is one of the outcomes to achieve the fair treatment of policyholders. This does not necessarily require a separate document. It goes to the construct of the disclosures, rather than requiring specific separate documentation. We are of the view that the requirements are drafted in a sufficiently principle based manner in order for it to be applied proportionately. As the requirement in this sub-rule is not currently prescribed for short-term insurance, an appropriate transitional period will be afforded. ✎ Also please see the transitional period for implementation afforded in table in Chapter 8 on administration in this regard.

No	Section/Rule	Commentator	Comment	Response
			Request – please clarify whether the requirement for Material disclosures is for i) a separate document; ii) a separate section in existing policy documentation under the heading Material disclosures; iii) content comprising Material disclosures to be included throughout existing documentation but in a way that is "clear distinguishable". Can all three be acceptable methods, the test being that the Material disclosures be set out in such a way to be clear and apparent to the policyholder that the insurer has relied on the disclosures in entering into the policy?	The requirement is that the disclosures must be in a format which is clearly distinguishable from the main body of the policy itself. The FSCA will not be prescriptive on the format. The insurer will need to position the disclosures in a way that is appropriate for the product and the policyholder, and dependent on the volume and complexity of the information. The three options proposed by the commentator would all be acceptable as long as the outcome underpinning the rule has been achieved as described above.
42.	Rule 11.5.2 Disclosure after inception of policy	SAIA	Rule 11.5.2 refers to information that was provided by or on behalf of the policyholder to the insurer as part of the process to assess the risk under a policy. Material information that was considered in the risk assessment process must then be communicated to the policyholder along with information referred to in 11.5.1 (a-i). The information referred to in (a-h) generally forms part of the policy schedule. The SAIA submits that this information should not have to be provided in a format that will be distinguishable from the policy as it forms the basis of the policy. It could still form part of the policy schedule and the information referred to in (i) could be provided either in the policy schedule or separately.	Disagree. The intention is that the disclosures must not be absorbed into the legal jargon in the policy wording, as this information is particularly relevant to policyholders. This is to make sure that policyholders are given clear information and are kept appropriately informed before, during and after the time of entering into a policy which is critical in ensuring the delivery of fair outcomes to policyholders. It goes to the construct of the disclosures, rather than requiring specific separate documentation. We are of the view that the requirements are drafted in a sufficiently principle based manner in order for it to be applied proportionately which is consistent with an outcomes-based approach to regulation. As the requirement in this sub-rule is not currently prescribed for short-term insurance, an appropriate transitional period will be afforded. ✎ Also please see the transitional period for implementation afforded in table in Chapter 8 on administration in this regard.

No	Section/Rule	Commentator	Comment	Response
				The requirement is that the disclosures must be in a format which is clearly distinguishable from the main body of the policy document. The FSCA will not be prescriptive on the format. The insurer will need to position the disclosures in a way that is appropriate for the product and the policyholder, and dependent on the volume and complexity of the information.
43.	Rule 11.5.5	FIA	Is this in the format of a simple statement or does it necessitate restating all the disclosure information from 11.4.1(a) in 11.5.1? We suggest the issues around section 11 be discussed and resolved through a workshop at which SAIA and FIA members can engage directly with the drafter. This is a key section requiring significant implementation time and cost and ongoing operation and monitoring and requires absolute clarity to avoid interpretive variations and the risk of non-compliance.	This is not a new requirement as it was included in the replacement of the PPRs that came into effect on 1 January 2018. The comments matrix on draft amendments may not be the appropriate forum to settle interpretational concerns, and it is recommended that the commentator contact the FSCA to engage with the Authority and address any confusion or practicalities in interpreting existing legislation.
CHAPTER 7: NO UNREASONABLE POST-SALE BARRIERS				
RULE 17: CLAIMS MANAGEMENT				
No comments				
RULE 19: TERMINATION OF POLICIES				
No comments				
RULE 20: MISREPRESENTATION				
44.	Rule 20.2	Ms D Donnelly	Rule 20.2 The sub-rule omits the words “unless a reasonable prudent person would consider that” which appear in the LT PPR rule 21.2. Those words reflect the objective test of materiality currently contained in section 53(1) of the STIA (and 59(1) of the LTIA). Unless this omission is corrected, the change of wording implies an intention to change the effect of the provision. This would create two different standards for LT and ST policies and will give rise to confusion and litigation to the detriment of policyholders.	Noted. Please note that the proposed repeal of Sections 51, 53, 54 of the STIA through the Insurance Act, 2017 will be deferred and will not be provided for in the PPRs as was suggested in the initial draft published for public comment. Section 53 of the STIA will therefore remain as is in the STIA.
CHAPTER 8: ADMINISTRATION				
45.	Transitional	Clientele	Comment – There was a contradiction previously	Interpretational difficulty is noted.

No	Section/Rule	Commentator	Comment	Response
	timelines		with regards to the effective date. Government Gazette GG 41321 states that "This Notice comes into operation on 1 January 2018". This contradicts the reference to 15 December 2017 in Chapter 8. All presentations, including the FAIS Conference, have references to the effective date of PPR as 1 January 2018 and insurers have used this date for all planning and implementation during the transitional phase. It is requested that the date of publication referred to here which has now been amended to 15 December 2017 is changed to 1 January 2018.	The table in Chapter 8 will be amended to reflect the dates in the interest of simplicity and to accommodate the request from industry. ✎ Please see the revised table in Chapter 8 on administration in this regard.

SECTION C - GENERAL COMMENTS: SHORT-TERM PPRs

No.	Issue	Commentator	Comment/input	Response
46.	Rule 20	Ms D Donnelly	Rule 20 in the ST PPR and Rule 21 in the LT PPR are best placed in the Insurance Act where one test would apply to all types of policies and all policyholders. Incorporating the provisions in the PPR adversely affects juristic persons with a turnover over R2million (at the current threshold value) as such juristic persons are excluded from protection under the ST PPR (Rule 1.2 read with the definition of 'policy'). The repeal of section 53(1) of the STIA will revive the common law. Such juristic persons will thus no longer have any statutory protection for breach of affirmative warranties in a ST policy and will face the unresolved judicial controversy raised by the decision in *Qilingele v South African Mutual Life Assurance Society 1993 (1) SA 69 (A)* regarding the applicable legal test for misrepresentations.	Noted. The proposed repeal of Sections 51, 53, 54 of the STIA through the Insurance Act, 2017 will be deferred and these sections will not be provided for in the PPRs as was suggested in the initial draft published for public comment. Section 53 of the STIA will therefore remain as is in the STIA. As the concern does not apply to long-term insurance industry, the these sections will be moved for purposes of the long-term PPRs.
47.	General	BASA	Our overall concern is that the impact of suggested changes may have an unintended negative impact on the client as detailed above. Further the suggested amendments will require document, system and process changes and with the legislation currently being in draft format with an implementation date of 1 July, transitional phases will be required.	Noted. See the proposed changes to the drafts and transitional periods allowed in Chapter 8 to mitigate the concerns raised.

SECTION D – COMMENTS AND RESPONSES ON THE PROPOSED AMENDMENTS TO THE PPRs UNDER THE LONG-TERM INSURANCE ACT, 1998

No	Section/Rule	Commentator	Comment	Response
CHAPTER 1: INTERPRETATION				
48.	definition of "advertisement"	Janice Angove	Public interest generally refers to welfare of the general public. Different phrasing may be more appropriate – interest by the public	Agreed. ✎ See grammatical correction to the definition.
49.	2.1 definition of "beneficiary" (a)(ii)	Janice Angove	A word seems to me missing. May read better as "… or person otherwise …"	Agreed. ✎ See correction to the definition.
50.	2.1 definition of "intermediary"	FIA	Use of "a" and "an" after each other	Agreed. ✎See correction to the definition.
51.	2.1 Definition of registered and licensed insurer	FIA	While other definitions refer to the Act, these are not so defined	See the preamble to the Definitions section in Chapter 1, under 2.1 which states that: "In these rules "the Act" means the Long-term Insurance Act, 1998 (Act No. 52 of 1998), including the Regulations promulgated under section 72 of the Act, and any word or expression to which a meaning has been assigned in the Act bears, subject to context, that meaning unless otherwise defined,-…" This means that any word that is defined in the Act or Regulations has the same meaning in the PPRs – unless differently defined. Schedule 1 to the Insurance Act amends the LTIA by replacing the definitions section of the LTIA. As of the effective date of the Insurance Act (envisaged for 1 July 2018), the definitions in the LTIA will therefore be replaced. The new definition of "long-term insurer" in the LTIA reads as follows: "long-term insurer" means a registered insurer or a licensed insurer; "registered insurer" and "licensed insurer" are also now defined for purposes of the LTIA.

No	Section/Rule	Commentator	Comment	Response
				Including specific definitions in the PPRs are therefore not necessary.
52.	2.1 definition of "outsourcing"	ASISA	This definition refers to the definition in the Financial Sector Regulation Act ("FSR Act"). However, there is not a definition of "outsourcing" in the FSR Act. There is only a definition of "outsourcing arrangement" in the FSR Act. It is therefore submitted that the wording should be amended to reflect the definition in the Insurance Act which says: "outsourcing" means an outsourcing arrangement as defined in section 1 of the Financial Sector Regulation Act .	Agreed. ✎Definition amended to reflect the suggested approach.
53.	2.1 Definition of "repudiate"	FIA	Would this also include a case where a client lodges a claim with an adviser, but the adviser informs the client that the claim is not covered and does not lodge the claim with the insurer?	Please refer to Rule.17.4.3. If the adviser has been mandated by the insurer to manage claims on its behalf, or if the adviser is a representative of the insurer, the claim is deemed to have been received by the insurer itself, in which case it will constitute repudiation by the insurer.
54.	2.1 "repudiate" (b)	Janice Angove	May need to consider the grace period here.	Noted. However the definition of 'repudiate' has not been changed since the replacement of the PPRs in December 2017. The definition has merely been moved to the main definitions section as the term is used in other rules, and no longer only in the rule on claims. Please note that claim may not be repudiated due to non-payment of premiums while the grace period is still running.
55.	2.1 "service provider"	Janice Angove	The definition of service provider should also include service providers for "value added benefits" for example teledoctor services	Noted. However the definition of "service provider" already includes reference to "related services", and the term "related services" is defined in section 2.1 and can include such "value added services" as referred to in the comment if provided together with or in connection with any policy or policy benefit.
CHAPTER 3: PRODUCTS				
RULE 2: PRODUCT DESIGN				
56.	Rule 2.5 & 2.6 Option for payment of	ASISA	ASISA members are in support of the extension of this requirement in principle but	Noted.

No	Section/Rule	Commentator	Comment	Response
	policy benefits in money		there are some practical issues. Some benefits are not quantifiable before claims stage and some cannot be paid out in cash such as “premium holiday” benefits so allowance needs to be made for benefits that are not quantifiable. It also needs to be recognised that discounts available to the insurer due to bulk purchases or a special negotiated rate with a service provider will lead to a lower amount being paid in cash than if the customer takes a non-cash benefit e.g. the insurer could offer a R100 airtime voucher but the cash equivalent may be R50 as it only costs the insurer R50. The wording appears to say that the provision applies to all policies from the same dates and does not make it clear that the extension from assistance business policies to all life policies is not retrospective. Section 53 of the Long Term Insurance Act (LTIA) currently only applies to assistance policies and the understanding of ASISA members, as confirmed by the Financial Sector Conduct Authority (FSCA) at the industry workshop on 4 April 2018, is that it will only apply to other policies from the effective date of these amendments. However, as it currently reads, it applies to all policies retrospectively.	Please note that the requirement will be moved to Rule 2A and made applicable to assistance policies, microinsurance policies and funeral policies only. As this is an existing requirement in the LTIA applicable to assistance policies we are of the view that this will alleviate the concerns. Also note that the requirement in the LTIA applicable to terms of an assistance policy entered into before 1 June 2009 will remain applicable to assistance policies only. ✎See revised wording of the Rule, now in Rule 2A.4.
57.	Rule 2.5, 2.6(a) and (b) and 2.7 Option for payment of policy benefits in money	AVBOB	The effective date of 15 December 2017 cannot apply retrospectively in respect of this rule.	Noted. See response directly above.
58.	Rule 2.5 Payment of policy benefit in cash	BASA	Rule 2.5 refers to the option for payment of policy benefits in money, which has been extended from only assistance policies to all	Noted.

No	Section/Rule	Commentator	Comment	Response
			life policies. The LTIA, under which the clause was initially included, defines policy benefits as follows “means one or more sums of money, services or other benefits, including an annuity” We wish to establish how the PPRs will define policy benefits and whether value-added services will be termed policy benefits. At present certain added services are provided, such as repatriation benefits. As the service is provided by one service provider the service is provided at a competitive rate. Should the Regulator intend on applying this rule to the added services, time would be required by the business in order to comply with the requirements (which were previously limited to assistance policies only	Please note that the definition of “policy benefits” as defined in the LTIA will apply. See the preamble to the Definitions section in Chapter 1 in this regard. Also note that the requirement will be moved to Rule 2A and made applicable to assistance policies, microinsurance policies and funeral policies only. As this is an existing requirement in the LTIA applicable to assistance policies we are of the view that this will alleviate the concerns. Also note that the requirement in the LTIA applicable to terms of an assistance policy entered into before 1 June 2009 will remain applicable to assistance policies only. ✎See revised wording of the Rule, now in Rule 2A.4.
59.	Rule 2.5 Payment of policy benefit in cash	DMASA	Although we understand the reasoning behind this, it might not be practical to allocate a value to all the benefits, e.g. if a provider was contracted to provide a specific type of legal advice in terms of the Insurance Product, this benefit might not be available elsewhere/ in terms of any other Insurance Product, irrespective of the value. The concern is that this might not always be in the best interest of the policyholder or provide the beneficiaries with the benefits as envisaged by the policyholder (In terms of ‘Treating Customers Fairly ‘TCF’).	Noted. Please see the response directly above and the revised wording of the Rule, now in Rule 2A.4.
60.	Rule 2.5	FIA	We understand the fact that this is an existing requirement under the to be repealed s53 of the LTIA. We also understand the risks that this requirement seeks to address. A product supplier could, as an example, “pocket” the cash and	Noted. However please note that this is an existing requirement in the LTIA applicable to assistance policies. The potential for abuse by providers refusing to provide the benefits to the policyholder in cash outweighs the

No	Section/Rule	Commentator	Comment	Response
			provide an inferior product. There are, however, a number of instances where the insurer would wish to ensure that the product is delivered rather than cash provided to the family. These are the cases where the trust in the supplier to provide the product is higher than in the family, while there also may be ultimate cost savings/added quality benefits to the client where a dedicated service provider is used for the fulfillment. Although still open to manipulation the client could be required to specifically state that the family is not entitled to a cash equivalent.	potential for abuse by policyholders as per the opinion raised by the commentator. Also, in instances where there is more than one policy offering a funeral service on the same life insured, the policyholder should be entitled to receive the benefits in cash as only one funeral service can take place.
61.	Rule 2.6 (b)	ASISA	The cost of a policy benefit is not always known in advance so can't always be shown upfront in the policy as 2.6(b) requires. It is requested that this part be amended so that the actual cost should only have to be stated in the policy where this is possible. For example the cost of body repatriation benefits is dependent on the place of death relative to the place of burial, amongst other things.	Noted. ✎See revised wording of the Rule, now in Rule 2A.4.
62.	Rule 2.6 (b)	DMASA	How is it intended that existing policies and policy documents be updated with "state the amount of the policy benefit that is to be provided as a sum of money"? This is potentially not practical or feasible, especially for simple, low risk, low premium policies.	Please note that it will not apply to existing policies offered by registered insurers other than to assistance policies, which is an existing requirement. ✎See revised wording of the Rule, now in Rule 2A.4.
63.	Rule 2.5 to 2.7	Janice Angove	The sum of money equal to the value of the policy benefit that would have been provided by the insurer may be open to interpretation for funeral parlours. The value of the policy benefit may be interpreted as the cost of the providing the funeral by the funeral parlour or the cost of the funeral to the policyholder.	Noted. Please bear in mind that this is an existing requirement in terms of S 53 under the LTIA but currently only applies to assistance policies.
RULE 2A: MICROINSURANCE PRODUCT STANDARDS				
64.	General Comment	FIA	Is the intention that the term "assistance	Yes. The class of assistance policies will cease to exist

No	Section/Rule	Commentator	Comment	Response
			business" will be phased out and replaced by micro insurance?	under the Insurance Act. Only registered insurers will be able to offer assistance business, for the interim period until they are converted to licensed insurers. In order to offer microinsurance policies under the Insurance Act, an insurer will have to be licensed to conduct microinsurance business. Micro insurance policies may include such policies underwritten under the funeral class of business. In other words, policies in the funeral class of life insurance business can be written by both microinsurers and traditional insurers, if they are authorised for the funeral class of business by the Prudential Authority.
65.	Rule 2A	Clientele Life	Comment – Does this rule only apply to funeral policies, as defined, or does it also apply where a funeral benefit is added as a rider or included as a rider to another life policy?	✎See the amendment to the part on application in Rule 2A.2.1 to clarify. The rule will apply to any microinsurance policy and any funeral policy, and any rider benefit except where stated otherwise. This is in order to avoid regulatory arbitrage.
66.	Rule 2A.2.1	Clientele Life	Comment – Funeral policies, as well as a funeral policy as a rider on another life insurance policy, can't be treated the same as microinsurance. Funeral policies are designed for the needs of all income groups and not only the lower LSM.	Disagree. The rule will apply to any microinsurance policy and any funeral policy, and any rider benefit except where stated otherwise. This is in order to ensure consistency and level playing fields between insurers and microinsurers and avoid regulatory arbitrage.
67.	Rule 2A.2.1 & 2A.2.2	ASISA	As per our general comments the product standards in the proposed new Rule 2A policies should not apply to funeral policies.	Noted. See response to general concern as set out in item 181.
68.	Rule 2A.2.1 & 2A.2.2	FIA	Will it in future be possible to have funeral policies written under the micro-insurance class and also as a life insurance policy, with the treatment of these being different?	No. The rule will apply to any microinsurance policy and any funeral policy, and any rider benefit except where stated otherwise. This is in order to ensure consistency and level playing fields between insurers and microinsurers and avoid regulatory arbitrage.

No	Section/Rule	Commentator	Comment	Response
69.	Rule 2A.3.2 Use of terms and advertising	ASISA	3.2 says that the use of the term “funeral policy” or any suggestion to create the impression that policy benefits are intended to cover the costs associated with a funeral or a funeral service, other than for a funeral policy is prohibited. This will have the following impacts: • Funeral benefits which exceed the proposed R60 000 limit in the prudential standards (GOI 7) cannot be advertised as providing for a funeral in any way which will be detrimental to insurers as well as customers. The Prudential Authority (PA) stated in its published response to comments from some ASISA members on the need for this limit to be higher, that funeral policies with a higher amount can be written under the life risk class of business, but this section effectively prevents this.	Noted. The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured. The Insurance Act, 2017 introduces the classes of business as set out in Schedule 2 of the Act, in terms of which insurers will have to be authorised and report on to the Prudential Authority. The prohibition on advertising funeral benefits written as life insurance was introduced to ensure that policies cannot be marketed as providing funeral benefits unless it meets the description of the Funeral Class of business as set out in Schedule 2 of the Insurance Act, 2017 and the insurer is authorised to offer such policies and reports thereon to the Prudential Authority. The requirement was deemed necessary in order to avoid insurers circumventing the application of the microinsurance product standards by writing funeral type policies under the Risk (Death) class of business, as the microinsurance product standards would only apply to insurers when selling funeral type policies under the Funeral Class as was seen in respect of live versus assistance policies under the prevailing framework. We remain of the view that the microinsurance product standards should apply to traditional insurers selling funeral policies because funeral policies are significant in facilitating financial inclusion objectives and un-level playing field between microinsurers and traditional insurers in the funeral insurance market must be avoided.

No	Section/Rule	Commentator	Comment	Response
			• Combination policies or a policy with a funeral rider benefit cannot advertise these benefits. These types of policies reduce the need for policyholders to purchase multiple policies and provide them with more flexibility to change benefits in the policy as their needs change. Premiums may also be less than having separate policies as administration expenses are lower. They address the funeral cover needed and calling it something else will be confusing and misleading.	The prohibition on marketing polices to cover funeral costs has been amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers. The product standards will apply to any microinsurance policy and any funeral policy, and any rider benefit except where stated otherwise. This is in order to ensure consistency and level playing fields between insurers and microinsurers and avoid regulatory arbitrage.
			• It is important to be able to link funeral insurance to risk benefits overall to educate and inform customers that life insurance is generally needed for more than just covering the cost of a funeral. This assists in gaining customer understanding to think beyond burial costs and to plan for the financial burden of everyday costs following their death, which aids customer education and ultimately financial inclusion.	Noted. However our proposal does not prevent this. Insurers will be able to offer life insurance (death benefits) if so authorised by the Prudential Authority to plan for the 'every day' costs and referred to by the commentator.
			• Even if only the funeral portion of the insurance contract can be advertised as such and the remainder of the life cover cannot be referred to as funeral, it would be very complex for insurers to make that distinction in customer communications and would confuse customers who are expecting an amount at the happening of a death event. This is in cases where cover is offered under both the risk and funeral class of business, for instance if the total risk cover is R100, 000 which intends to partially cover burial costs.	This distinction will have to be made for purposes of reporting under the authorisation classes to the Prudential Authority. As per the comment made in the bullet directly above by the commentator, this is necessary to help customers understand the benefits which they can get from the cover which will support consumer education. It will also insure that products are appropriately marketed and sold.
			• Based on research, funeral policies are the most well-known type of policy in the	Noted. We are not disallowing use of the term "funeral". On the contrary, we are simply requiring a clearer

No	Section/Rule	Commentator	Comment	Response
			market and should the term “funeral” not be allowed to describe the purpose of the policy, insurers as well as potential customers will be disadvantaged. It is submitted that 3.2 should be deleted.	distinction between benefits specifically targeted for funeral costs and general death benefits in line with the classes of business under the Insurance Act.
70.	Rule 2A.3.2 Use of terms and advertising	AVBOB	This rule would exclude policies with limited payment periods and whole of life cover which is made paid-up.	Comment not understood. It is not clear how the limitation on advertising benefits as funeral benefits would impact these types of cover.
71.	Rule 2A 3.2	FIA	Some traditional life insurers provide a funeral rider benefit on their policies that allows a portion of the life cover to be paid out within 48 hours. Stating that these funds could be used for the funeral should be acceptable. We recommend that the paragraph only refers to the use of the term funeral policy. Would an insurer now require a micro-insurance licence to market a funeral policy or would it be possible to develop such a product under the normal licence as well?	Noted. This will not be prohibited. ✎The prohibition on marketing polices to cover funeral costs has been amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers. Funeral policies, by definition in the PPRs, are life insurance policies underwritten under the funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act, in other words, underwritten by traditional insurers. Micro insurance policies may include such policies underwritten under the funeral class of business. In other words, policies in the funeral class of life insurance business can be written by both microinsurers and traditional insurers, if they are authorised for the funeral class of business by the Prudential Authority.
72.	Rule 2A.3.2	Clientele Life	Comment – to call it anything else than what it is, will lead to consumer confusion, and consumers will be misled in terms of the product and benefits that they are receiving. This will also apply where funeral cover is included in the overall life policy, or added as a rider, and it would be very difficult to advertise the product and benefit correctly to	Noted. ✎The prohibition on marketing polices to cover funeral costs has been amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers. The Prudential Authority increased the limit prescribed for

No	Section/Rule	Commentator	Comment	Response
			the customer. Especially in the lower LSM, it needs to be clear to clients what the product is, and what the product covers. We would recommend to include the word funeral cover to avoid misleading marketing to customers. This speaks to the fact that traditional insurer selling funeral policies can't fall under the realm of micro insurance. It should further be noted that there is clearly a need in the market for funeral policies in excess of the maximum cover amount values proposed.	funeral policies to R100,000 per life insured, which will alleviate most of the concerns raised. The rules do not prohibit the offering of combined policies subject thereto that the insurer is authorised by the Prudential Authority to offer policies for which the description of the policies fall within the classes of business. This limitation was introduced to ensure that policies cannot be market as providing funeral benefits unless it meets the description of the Funeral Class of business as set out in Schedule 2 of the Insurance Act, 2017 and the insurer is authorised to offer such policies. The requirement was deemed necessary in order to avoid insurers circumventing the application of the microinsurance product standards by writing funeral type policies under the Risk (Death) class of business, as the microinsurance product standards would only apply to insurers when selling funeral type policies under the Funeral Class as was seen in respect of live versus assistance policies under the prevailing framework. We remain of the view that the microinsurance product standards should apply to traditional insurers selling funeral policies because funeral policies are significant in facilitating financial inclusion objectives and un-level playing field between microinsurers and traditional insurers in the funeral insurance market must be avoided.
73.	Rule 2A.3.2	Clientele Life	Comment - Currently Funeral policies with a Sum assured of less than R30,000 are classified as assistance and any funeral policy above that as a life policy, however both can be advertised as a funeral policy. There are customers who take out funeral policies in excess of R60,000, however these will now not be allowed to be called funeral policies, or advertised. So for example a policyholder can currently	Noted. The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured, which will alleviate most of the concerns raised. In terms of the new caps prescribed by the Prudential

No	Section/Rule	Commentator	Comment	Response
			get a funeral policy of R75,000. While this is classified as life policy it can be advertised as funeral. Under the new proposal all funeral benefits will be limited to R60,000. So even if a policy is used to cover the cost associated with a funeral, but the cover amount is R70,000 it can no longer be called a funeral policy or advertised as such? As stated, we believe that there is a need in the marker for funeral policies in excess of R60,000 and that traditional insurers should be allowed to market and sell policies as such.	Authority such policies will still be allowed.
74.	Rule 2A.3.2	DMASA	Unless a policy is defined as a "funeral policy" (max of R60k cover, 12month contract term), it cannot be advertised or sold as a funeral benefit or there cannot be any reference to funeral expenses. This is not practical and does not adhere to TCF principles, as there are existing Life Policies with funeral benefits as part of the policy to cover immediate funeral expenses, which are typically paid within 48 hours. This now means that a policyholder (and relevant Life Insurer) will have to re-structure their Life Policies to exclude the funeral benefit, then find and engage a microinsurer to purchase a separate funeral policy, which will result in additional administration and bank costs for the client and possibly the increase in premium relative to the reduction in the original Life Policy premium. Furthermore, the above benefit limits may not be in the best interests of policyholders. If a policyholder requires or wants more cover than R60k for funeral, this would then mean that they would need to potentially purchase more than one policy, which is likely to result in additional administrative costs, bank	Disagree with concern. A separately identifiable funeral benefit can still be added to a life risk policy as a rider benefit. The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured, which will alleviate the concerns raised. The prohibition on marketing polices to cover funeral costs has been amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers.

No	Section/Rule	Commentator	Comment	Response
			charges etc.	
75.	Rule 2A.3.2	FPI	This rule may be too restrictive. Many traditional insurance policies have an option to have a portion of the life assured paid out in 48 hours with minimal requirements. While not designed as a funeral policy the purpose of this benefit is to assist with immediate need that could include a funeral. As such an advertisement for this benefit could contain the fact that the benefit may be used for the costs of a funeral. We recommend that the clause state that an advertisement may not use the term funeral policy unless it falls under the funeral class as defined in the Insurance Act.	Agreed. ✎The prohibition on marketing polices to cover funeral costs has been amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers.
76.	Rule 2A.3.2	IAC	It is proposed that the prohibition on the use of the term “funeral policy” is removed. The prohibition on the term “funeral policy” unnecessarily restricts competition in the market. A similar prohibition does not exist in the short term insurance regulations. Other products may well include provision for the costs of funerals, and product providers should have the room to advertise this fact. Regulatory arbitrage should be seen in totality, i.e. including the prudential standards that would apply to non-microinsurers. It would be odd if a heavily regulated institution could not innovate around funeral benefits or funeral policies. If these institutions are able to come up with different designs they should have the freedom to do so, given the regulatory regime that applies to them. This rule therefore potentially reduces the choice offered to the consumer and could	Noted. However, it does not restrict the use of the term “funeral policy”; it merely prohibits policy benefits to be advertised as funeral benefits, unless it meets the description of the funeral class of business as defined in Schedule 2 of the Insurance Act. It is intended to ensure clear and appropriate marketing of funeral benefits and limit regulatory arbitrage. ✎The prohibition on marketing polices to cover funeral costs has been amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers.

No	Section/Rule	Commentator	Comment	Response
			contribute to market failures around competition.	
77.	Rule 2A.4 Structure of policy benefits	ASISA	Since this section deals with the composition and structure of microinsurance and funeral policies, reference should be made to the prudential standards that will prescribe the maximum cover amounts for policy benefits as no reference to maximum cover limits are made in the PPR. In the Prudential Standard GOI 7 (Miscellaneous Regulatory Requirements for Insurers), the PA prescribes the maximum amount payable in respect of the Funeral class of life insurance business in Table 1 of Schedule 2 of the Insurance Act, to be R60,000 escalated annually by the CPI from the date of commencement of the PPR. It is not mentioned on what basis this limitation must be applied but the intention as per the microinsurance policy document was that the R60, 000 limit should apply on a policy level per life insured. Comments on this as well as on the R60 000 limit will be made to the PA, but it is suggested that a cross reference to this standard is made. One ASISA member is of the view that the product standards for microinsurance should also include a premium cap. This will align with the approach for credit life insurance in the National Credit Act (NCA) regulations where there are prescribed caps. They are concerned that for a product that provides similar benefits, there are no real distinguishing pricing factors that give rise to the disparate levels of pricing seen in the market. In some cases the pricing is high	Noted. ✎ See amendment to include reference to the prudential standard and the maximum policy benefits as prescribed by the Prudential Authority. Noted. However, in order to introduce a premium cap extensive further technical work and industry consultation will be required, as the impact of this on insurers will be quite significant. Consideration will be given to this as a further phase of the development of microinsurance standards should supervisory experience indicate that this is required.

No	Section/Rule	Commentator	Comment	Response
			due to operational inefficiencies of the underlying provider. This reduces the actual value of the policy to the customer and is likely to also contribute to affordability strain in the largely lower income segment. They are willing to volunteer actuarial capacity to assist the FSB in developing industry price caps for microinsurance.	
78.	Rule 2A.4.1	ASISA	This limitation for microinsurance policies to only provide risk policy benefits without any surrender or investment value was part of the microinsurance policy document and was therefore expected for microinsurance products. It was envisaged in the policy document that broadening the product range to include savings and medical products would be looked at a later stage. ASISA has, in commenting on various occasions on the Retail Distribution Review (RDR), highlighted the need for a framework for the low income market as this has not been defined and we would like to reiterate that microinsurance and funeral policies should not be considered as encompassing the low income market. Savings and other non microinsurance risk benefits also need to be part of this. A number of funeral policies currently include	Noted. This sub-rule has been removed. In terms of definition of "microinsurance business" in the Insurance Act, a microinsurer can only conduct business in the following classes of life insurance business as referred to in Schedule 2 of the Insurance Act, subject to the insurance obligations (policy benefits) under such policies not exceeding the prescribed amounts: • Risk • Credit Life • Funeral • Reinsurance (in as far as it relates to the above life classes of insurance business) In terms of this definition in the Insurance Act microinsurers will not be able to offer policy benefits that have an investment / surrender value. Noted. This is indeed the intention of RDR Proposal TT and part of the developments under RDR. This will not be prohibited for traditional insurers, subject

No	Section/Rule	Commentator	Comment	Response
			a savings benefit as an option and these are very popular with customers. It allows them the opportunity to save in a cost effective way as the costs of the policy are lower than having a stand-alone savings policy and with the need to promote savings in South Africa. This should be encouraged as much as possible. Many funeral products have a premium refund or cash back benefit. If the intention of this rule is to disallow the provision of these benefits under a funeral policy there will be a significant erosion of value proposition to customers. We submit that this restriction is deleted for funeral policies. If the FSCA has a specific concern with the low income savings market then standards should be formulated in this regard.	thereto that the insurer is authorised by the Prudential Authority under the Insurance Act for the relevant investment related class of business. In as far as it relates to microinsurance policies, the Governance and Operational Standard for Microinsurers as prescribed by the Prudential Authority prohibits the offering of a policy that provides for a loyalty benefit, no-claim bonus or rebate in premiums, without the approval of the Prudential Authority. Please see the Prudential Standards in this regard. Agreed. The limitation will only apply to microinsurers and for prudential reasons.
79.	Rule 2A.4.1 Structure of policy benefits No surrender or investment value	AVBOB	This rule would invalidate a class of contracts and disqualifies policies that have surrender values to fund policies with limited payment periods and whole of life cover. In addition, clarity is required from a classification perspective in respect of what features would be excluded from a funeral policy e.g. would a cashback feature or disability benefit be excluded?	Noted. Please see response under item 78 above.
80.	Rule 2A.4.1	DMASA	This proposal is not reflective of the current market demand, specifically in the lower-income market, where there is a need for a simple savings product which encourages small monthly contributions (which are easy to maintain, while limiting administrative or banking costs). Existing funeral policies with a savings component will need to be amended, which is not in the best interests of	Noted. Please see response under item 78 above.

No	Section/Rule	Commentator	Comment	Response
			policyholders.	
81.	Rule 2A.4.1	DMASA	There is a need for combining a funeral policy with an additional small savings component. The life cover and savings component is not cross-subsidised, but would be sold as a consolidated product. The take up of the savings product would be significantly less if not attached to the funeral policy. Requiring additional licences and fit and proper requirements for such a small savings component would also limit financial inclusion. Fund limitations or similar could be introduced.	Noted. Please see response under item 78 above.
82.	Rule 2A.4.2	ASISA	Please refer to our general comments above and the concerns raised there about the unilateral application of the proposed microinsurance standards to funeral products. This does not align with National Treasury's stated policy in their micro insurance policy document referred to in our general comments and the fact that the 12 month contract term is directly linked to the lower prudential requirements for microinsurers. Limiting the term of funeral policies to 12 months is problematic from a customer value perspective on a number of fronts : • Many contracts today offer guaranteed rates for extended periods, and the capping of the term to 12 months removes the ability of the insurer to offer and meet the customer needs for such guarantees. • Linked to the above point, premiums increase over time as individuals age, and it could become prohibitively expensive for	Noted. The limitation of a funeral policy offered by a traditional insurer having a contract term of no more than 12 months will be removed. The intention with applying the product standards to both microinsurance products and funeral products offered by traditional insurers is to ensure a level playing field between microinsurers and traditional insurers in respect of funeral policies and that all policyholders will be afforded the same protections in terms of these Rules. The aim of the Microinsurance framework is to facilitate financial inclusion and enterprise development by enabling small and medium enterprises to enter the "insurer market" to provide policies to the low income market without being subject to the onerous solvency requirements applicable to traditional insurers. If the product standards were not applicable to funeral policies offered by traditional insurers, traditional insurers would be at an unfair advantage to new microinsurers. The concerns regarding the application of the contract limitation is noted, and the wording of the product

No	Section/Rule	Commentator	Comment	Response
			older customers to obtain funeral cover if a longer contract term or a whole of life term is not permitted. This will exclude certain “at risk” groups of the population, compromising their ability to obtain insurance. • There is already a vibrant market where there is healthy competition between 12 month term limit contracts and priced for life contracts. • Having a contract term of 12 months that is auto-renewable means that the cover will not increase annually unless the client elects to do so. In many cases, the clients do not make changes to their contracts under the current regulations, so requiring a client to now increase their cover regularly to ensure that it keeps up with some level of inflation will be cumbersome for the client. This change to a 12 month contract term will require immense change management with clients who are used to signing up for a long term contract. Many of the clients in the funeral market may not understand these changes, as the long term nature of a funeral policy is embedded in their culture and understanding of how funeral insurance works. • There are many combination long term risk policies which have funeral policy benefits. This rule will affect the ability to offer clients such “combinations” on a cost effective basis. • It will result in an increased administrative burden as even with the automatic renewal, the cost of reserving of assets is much higher and the impact will have to be passed on to consumers. With the implementation of IFRS the reserves	standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies and not to funeral policies offered by traditional insurers, as the limitation is primarily included to support the prudential framework for microinsurers. The requirement to be automatically renewable will also be limited to microinsurance policies, and will not apply to funeral policies offered by traditional insurers.

No	Section/Rule	Commentator	Comment	Response
			established for policies may not recognise cash flows beyond the contract boundary. By forcing a 12 month contract boundary the full acquisition costs of a funeral policy will have to be covered by charges within the first year (unless insurers commit to absorbing significant reported new business losses as the costs will be incurred without corresponding reserves to offset them against, which is unlikely). • This requirement could lead to poor customer outcomes and offers less protection for the policyholder as the insurer is now given the option of not renewing the policy if the insurer considers the client to be a high risk client. • Members currently have employer group schemes which provide whole life funeral policies to employees and upon retirement or resignation, such employees may convert the policy to an individual policy with no additional underwriting requirements, no waiting periods, no increased premiums and have the same level of cover as they had whilst employed. It will be to the detriment of these employees if such policies are no longer permitted. A set 12 month contract term for microinsurance credit life policies is problematic. Loan repayment periods differ and the longer the repayment period the lower the monthly instalments. The implications on loan providers and borrowers will be adverse due to the increased costs of the short credit life insurance period and risk to the lender should the credit life not be renewed yet the loan has not been repaid	

No	Section/Rule	Commentator	Comment	Response
			within the 12 month period.	
83.	Rule 2A.4.2 Structure of policy benefits Contract term – not more than 12 months	AVBOB	The rule is inconsistent with whole of life policies. In addition, it does not provide for multiple insured lives that are added or removed during the term of the policy.	✎The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies and not to funeral policies offered by traditional insurers.
84.	Rule 2A.4.2 &2A.4.3	Clientele Life	• Comment – Having a contract term of 12 months that is auto-renewable means that benefits and premium will not increase annually, unless the client undergoes the disclosures in terms of Rule 11. It will add an additional administrative burden to the client to increase their cover regularly and it will also add to an additional administrative burden on the insurer. • In the lower LSM, contactibilty of policyholders is a big concern, as it is known in the lower LSM market that most of these policyholders have around 2 - 3 different cell phone numbers, as they do sim swaps due to data costs and airtime packages and can sometimes not be reached. Physical addresses are not available due to informal demarcation standard and poor postal service (registered mail and normal mail is returned). • This proposed rule will have the adverse effect on customers and will lead to poor customer outcomes. • We recommend that the policy remain a long-term contract, where at stales stage, annual increase in terms of premium and benefits are explained upfront and that the customer is aware of the cancellation process in the event that they would like to cancel the policy. • We agree due to limited capital	Noted. ✎The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies and not to funeral policies offered by traditional insurers. However the limitation on variation and renewal of a microinsurance policy and a funeral policy in the first 12 months after inception of the policy will remain. In terms of the microinsurance product standards in Rule 2A, the terms, conditions or provisions of a microinsurance policy may not be changed or varied during the first 12 months after inception of the policy. This aligns with the proposals in the National Treasury's Microinsurance Policy Document. The application thereof on funeral policies offered by traditional insurers is required due to abuses identified through supervision. Regarding the commentator's concerns on "contactability" of the policyholder, the insurer has the responsibility in terms of Rule 13 of the PPRs on Data Management to ensure that it has the access to the names, identity numbers and contact details of all its policyholders and that the contact details are as complete as possible. Without this information the insurer will in any event not be able to meet the disclosure requirements in the PPRs.

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			requirements a micro insurer should be limited to 12 months contracts. However it should not apply to Funeral policies. As a fully licensed insurer should be able to provide policyholders with longer contracts, that provide guaranteed premiums. The proposed changes will negatively impact policyholders, and remove premium guarantees.	
85.	Rule 2A.4.2	DMASA	Given that the duration of a microinsurance policy cannot exceed 12 months and that the terms and conditions cannot vary during that period of 12 months, we submit that it would be impractical to make the disclosures required in terms of Rule 11.6.6 on a policy that renews in periods shorter than the 12 months - for example on month-to-month policies. Furthermore, the intent of a term of no more than 12 months must please be clarified. If the reason is to ensure that clients are regularly informed of the benefits they have, the solution would be through a requirement that annual communication is sent to the insured prior to the anniversary of the policy.	Noted. See response directly above.
86.	Rule 2A.4.2	Janice Angove	There are currently policies in the market sold as individual whole life policies that are currently marketed as funeral policies. Is it not possible for a licensed life insurer to sell funeral insurance policies that are whole life policies? The 12 month term limitation to simplify prudential requirements is not necessary for licensed life insurers.	Noted. See response directly above.
87.	Rule 2A.4.2 & 2A.4.3	FIA	While we are not averse to the idea that, as per clause 2A.4.2, micro-insurance policies should be limited to a period of 12 months in principle, in practice this is likely to cause considerable complications, especially	Noted. It is for this reason that a microinsurance policy will be automatically renewed upon expiry. The microinsurer will have to meet the disclosure requirements relating to the

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			where, for example, the policy is taken out by someone in a rural area who works in the city and is not always available to discuss renewal annually and may not be easily contactable with communication in some cases	renewal of policies as set out in rule 11.6.6 should any of the terms conditions or limitations in the policy be changed, which is in the best interest of the policyholder. The microinsurer has the responsibility in terms of Rule 13 of the PPRs on Data Management to ensure that it has the access to the names, identity numbers and contact details of all its policyholders and that the contact details must be as complete as possible. The microinsurer will need this information to meet the disclosure requirements in the PPRs.
88.	Rule 2A.4.3	ASISA	As per our comments above this should not apply to funeral policies as these should not be restricted to a 12 month term. It is submitted that for microinsurers the requirements for automatic renewal of the policy need to be condensed so that they can be complied with via SMS communication to the client. Rule 11.6.6 requires extensive information to be provided at least a month before renewal date to each policyholder. This is too detailed for an SMS and it should be sufficient to inform the policyholder that the policy is being renewed, their new and current premium, and insurer contact details for any questions.	Noted. See response under item 82 above. Please note that Rule 11 on disclosures already provide for the use of an appropriate medium, taking into account the complexity of the information being provided and is drafted in a sufficiently principle-based manner to allow SMS communication where appropriate. Please see rule 11.3.1 in this regard.
89.	Rule 2A.4.3 Structure of policy benefits - Automatically renewable or terminated	AVBOB	• Commission: This rule would result in commission being paid on an as-and-when basis. This will impact the distribution model as it is unsustainable for distribution networks. • Disclosure requirements: The written disclosure requirement will add to the administration cost of policies which in the case of a mutual model has an impact ultimately on the policyholder.	Commission for microinsurance polices will not be capped, and the structure thereof will not be prescribed. The 12 month contract period limitation and the automatic renewal requirement will be limited to microinsurance policies and will not apply to funeral policies offered by traditional insurers. Please note that Rule 11 on disclosures already provide for the use of an appropriate medium, taking into account the complexity of the information being provided and is drafted in a sufficiently principle-based manner to allow

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				SMS communication where appropriate. Please see rule 11.3.1 in this regard.
			• Termination: The rule provides for the unilateral termination of the policy by the insurer – this may place the policyholder worse off.	The insurer in any event has the right to terminate a policy subject to meeting the circumstances and the requirements as set out in Rule 20. This rule was introduced with the replacement of the PPRs in December 2017 and is not limited to microinsurance policies. Please see the consultation documents relating to the Tranche 1 proposals available on the FSCA's website.
90.	Rule 2A.4.3 a	DMASA	Refer Rule 11.6.6. The percentage of policy documents which are posted (which is still very prevalent in the low-income market) but returned to sender as undelivered is very high - and will presumably be higher after 12 months has elapsed. This proposal will not result in effective communication with policyholders. After a couple of months, a policyholder could easily claim that they did not receive the renewal notification and that they assumed the policy was no longer active and, although they enjoyed the cover during this period, they now expect all premiums during the renewal period to be repaid to them (potentially including banking charges). Dependent on the guideline, the application of this rule will be well complimented with continuous reference to the policy documents and ongoing consumer education to enhance the general understanding of the parties' roles and responsibilities.	Noted. Please note that this rule does not require a physical written document. Please see the definition of "writing" in Section 2. Also Rule 11 on disclosures already provide for the use of an appropriate medium, taking into account the complexity of the information being provided and is drafted in a sufficiently principle-based manner to allow SMS communication where appropriate. Please see rule 11.3.1 in this regard.
91.	Rule 2A.4.4	ASISA	ASISA members are unsure of the reason for this section and what is meant by the policy "must be defined on a sum assured basis". Therefore an explanation on the meaning of and need for this section is requested.	Please see page 7 of the NT Microinsurance Policy Document in this regard. This is a recommendation from the policy document. However we understand that life insurance by its nature always offers stated benefits. The requirement will accordingly be removed.
92.	Rule 2A.5.1	ASISA	It is very onerous for all the conditions in 5.1	Agree. ✎See the amendments to the Rule.

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			to be met in order to make any changes during the first 12 months, and it is submitted that it should be one of the three and therefore "and" after 5.1(b) should be replaced with "or". Clarity is sought as to whether "inception" means the original inception date or the renewal date. It should be the former as otherwise it means that, as a new policy is entered into every 12 months, no changes can be made over the lifetime of the policy unless these requirements are met.	"inception date" means the date on which the policy first incepts. It is not intended to include the renewal date.
93.	Rule 2A.5.3	ASISA	The explanation provided by the FSCA regarding the intention behind this section at the FSCA industry workshop on 4 April 2018 was that there shouldn't be selective non-renewal in a group policy so either all the policies must be renewed or cancelled. Whilst our members agree that this should be the case for a group policy, it should not apply to individual policies which are "underwritten on a group basis". The insurer should have the ability in these cases to renew or terminate a policy with the policyholder whether these are priced on a group basis or not. It is requested that this section be amended accordingly.	Disagree. Please see page 7 of the NT Microinsurance Policy Paper under item 2.1.1(e) Insurers should not be able to selectively cancel (that is, to refuse to renew) individual policies within the group. Should the insurer no longer find the level of risk acceptable it must decline to renew the policies for the whole group or increase the premiums for the whole group. Allowing selective decisions at individual level is inconsistent with the whole point of group level underwriting.
94.	Rule 2A.5.3	Janice Angove	Although this sub-rule does protect policyholders from being denied cover or charged higher premiums that the rest of the group as they age. The group age profiles and premiums for microinsurance and funeral insurance policies should be monitored. It may pose a risk to the industry if the group age profile for these products increases to the extent that premiums for the group increase and policies	Noted. See comment directly above under item 93.

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			become unaffordable to members of the group who have paid premiums for many years when they are older and need the cover most.	
95.	Rule 2A.6.1	African Unity Life	The linking of the waiting period with 2A 4.3 (the term) is particularly problematic in the group funeral insurance space. As we know funeral insurance is generally written as term insurance and comes to an end at the expiry of the agreed term but is customarily regarded as renewed by the insurer for as long as the premiums continue to be paid. The cancellation notice period in these agreements is normally 30 days – the same for premium increases. Although these polices are individual policies they are underwritten on a group basis with the waiting period the main type of underwriting (usually 6 months). If the waiting period is reduced to effectively a quarter of the term of the policy – the applicable waiting period would now be 7.5 days which would of course lead to anti-selection that can influence the entire group scheme negatively. Premiums in these groups would increase dramatically with these waiting periods which is in direct conflict with financial inclusion. It is also extremely unpractical to do the whole renewal process on a monthly basis through these funeral group schemes. It is safe to say that the FSCA did not consider the impact these changes would have on these group schemes (maybe the FSCA can explain the thinking behind the 12 month terms cover and the 3 month waiting period?). In most cases funeral parlours would enter into *stipulatio alteri* arrangements with the	Noted ✎See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the policy, or 6 months. Please refer to item 2.1.1(h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders. Also ✎The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies and not to funeral policies offered by traditional insurers. Note these product standards were developed with input from the Prudential Authority from a prudential perspective.

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			insurers. These schemes can then cancel a master policy and move to alternative insurers by providing 30 days' notice – this is an industry norm and in almost all the cases premiums are only guaranteed on a month to month basis. The suggested changes would have a huge influence on the industry and would impact negatively on specifically the premiums these policyholders pay. We do request a formal meeting to discuss the impact of these changes with the FSCA as from a prudential point of view to impact on writing policies with a term longer than 30 days would a huge SCR impact on the insurer.	
96.	Rule 2A.6.1	ASISA	This section which restricts a waiting period to one quarter of the term of the policy, read with 4.2 above means that with a contract term of 12 months, the maximum waiting period is 3 months. This may be appropriate for a microinsurance policy with a 12 month term but as set out in our comments on section 4.2 ASISA members do not agree that funeral policies should be restricted to a 12 month contract term and that for these policies a maximum waiting period of 6 months is appropriate. Waiting periods are the main type of underwriting used by funeral insurers and help to avoid anti-selection. The funeral industry is subjected to significant attacks from criminal syndicates and a decrease in the maximum waiting period would only assist these syndicates with their activities. A member has advised that an analysis of their short-term claims show a claim spike around 4-8 months and these claims would	Agreed. ✎See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the policy, or 6 months. Please refer to item 2.1.1(h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders. This comment refers to imposing a waiting period where a previous waiting period under a similar policy has been served. The intention is for the insurer to take previous waiting periods into account. Rule 2A.7.5(a) to (c) refers to a "previous policy with another insurer". The meaning of policy would be as defined for purposes of the PPRs, being a long-term policy as defined in the LTIA. This is not limited to licensed insurers, and will

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			not be excluded by a 3-month waiting period. If a 3 month period has to be applied insurers would need to do a repricing exercise due to worse expected claim experience. This would mean increased premiums for customers which make financial services less affordable and less accessible, opposing the industry's aim to make financial services more available, particularly in this market. It is suggested that the wording can be amended to state that "a microinsurance policy or a funeral policy may not impose a waiting period exceeding the shorter of one quarter of the term of the policy or 6 months, in respect of…" There is some uncertainty about how this section would be applied during the transition period i.e. when a customer moves from one insurer to the next and one insurer is a Licensed Insurer and the other is a Registered Insurer and vice versa as the section would apply to a licensed insurer but not a registered insurer. Please can this be clarified.	include policies for both licenced and registered insurers as defined in the LTIA.
97.	Rule 2A.6.1 Waiting periods A waiting period may not exceed one quarter of the term of the policy	AVBOB	• This rule would result in higher claims costs, as a waiting period is an effective form of underwriting, as well as increased anti-selection.	✎See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the policy, or 6 months. Please refer to item 2.1.1 (h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.

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98.	Rule 2A.6.1	Clientele Life	• Comment – If the proposed rule as stated above is to become effective, this would mean on a maximum policy term up to 12 months implies a maximum waiting period of 3 months. This introduces a high risk of anti-selection, which will in effect have an effect on the pricing of the policy and will affect the customer. • We do agree that insurers must not impose unreasonable waiting periods, however 3 months is not reasonable and we would recommend a waiting period of 6 months. • In the funeral space, insurers are confronted with syndicates which exploits such waiting periods, and the risk will increase for syndicates if a shorter waiting period becomes effective. • We are of the view that funeral policies can still be offered as whole of life policies and that a 6 month waiting period is reasonable for a long-term contract.	Noted. ✎See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the policy, or 6 months. Please refer to item 2.1.1 (h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.
99.	Rule 2A.6.1	FIA	Due to the absence of underwriting on these policies, the market generally makes use of waiting periods that could be longer than 3 months, especially for extended family members. Imposing a 3-month limit on the waiting period will inevitably result in rates increasing considerably in many cases. This will be to the detriment of the market	Noted. ✎See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the policy, or 6 months. Please refer to item 2.1.1 (h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.
100.	2A.6.1 – Waiting periods	KGA Life	The proposed rule restricts waiting periods in respect of policy benefits payable on the occurrence of a death, disability or health	Noted. ✎See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the

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			event resulting from natural causes on Microinsurance and Funeral Insurance products to a maximum of three (3) months. The initial product rules for Microinsurance released by the Treasury in 2011, referred to a maximum of a six (6) month waiting period for policyholders younger than 65 years upon entry. Currently, the majority of funeral insurance policies apply a six (6) month waiting period for policyholders younger than 65 years upon entry and may apply higher waiting periods for policyholders older than 65 years at entry. Reducing the waiting period to three (3) months will have a significant impact on the cost of providing funeral insurance cover. Microinsurance policies are aimed at the lower income market to enable them so assess insurance products. The target market has less disposable income and therefore product design is aimed at reducing the cost of the products (to ensure that the products remain affordable). Funeral insurance policies offered to the lower income market generally do not include significant amounts of initial underwriting (e.g. medical test, blood test, etc.) in an attempt to reduce the cost. Due to the limited initial underwriting there is however a need to reduce the possible anti-selection that could occur as a result of limited initial underwriting. One of the methods to reduce the anti-selection is the application of a waiting period.	policy, or 6 months. Please refer to item 2.1.1 (h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.

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			ASISA has reported an increase in irregular claims reported between 2015 and 2016, these also included criminally originated claims. In the extreme we have already picked up cases where policies have been taken out and the lives insured murdered in order to receive the benefit. Shortening the waiting period could further accelerate that process and thus inadvertently result in a potential increase in such cases. A reduction in the waiting period will likely result in an increase in the number of claims under funeral insurance policies. The exact extent of the increase may be difficult to determine where historic experience does not include products with shorter waiting periods. Therefore the products will likely become more expensive to provide due to: 1. the increase in expected claims; and 2. the need for additional margins in pricing where there is uncertainty relating to the exact impact of a reduction in waiting period. These increased cost will be passed on to policyholders and the products will therefore become more expensive to provide. The target market does however not have significant amounts of disposable income and increases in prices may affect their ability to purchase the products. Therefore, the proposed legislation may negatively impact this segment of the market and may fail to provide the additional protection envisaged by these rules.	
101.	Rule 2A.6.2	ASISA	There are some exclusions for accidental death e.g. when the person is under the	The intention is to avoid exclusions that are complex or difficult to understand. This is to ensure fair outcomes for

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			influence of alcohol which should still be permitted so it is requested that allowance is made for these.	customers through appropriate product design. Microinsurance policies must be simple and easy to understand and introducing exclusions would result in the policies becoming complex and require additional explanations, which is inconsistent with simple product design philosophy underpinning microinsurance products.
102.	Rule 2A.6.2	Clientele Life	Comment – We propose that the Rule should clearly state that no waiting period may be imposed, provided that the accident occurred after the commencement of the policy. In its current form, the rule can be interpreted that policy benefits would be payable if the event (accident) happened prior to the commencement of the policy, but the death or disability as a result of the accident has not yet occurred.	Noted ✎See the amendments to the Rule.
103.	Rule 2A.6.3	ASISA	Not allowing any waiting period for a microinsurance credit life policy is not aligned to the Credit Life Regulations in the NCA as these do provide for waiting periods. ASISA members submit that the standards in 2A for a microinsurance credit life policy should not conflict with the NCA regulations and it is in fact imperative that they are aligned. In addition it is unreasonable not to allow any waiting periods for these credit life policies. Policyholders may take out a credit life policy knowing that they may do have to serve any waiting periods. This will create opportunities for increased fraud, anti-selection and claims. This could be financially unsound for microinsurers as they may have to take on risks they have not reserved for.	Noted. ✎See proposed amendment to the rule on waiting periods to align to the NCA Credit Regulations.
104.	Rule 2A.6.3	Clientele Life	Comment – We would like confirmation that	See response directly above.

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			this rule is aligned with the new credit life regulations, seeing that the new credit life regulations do provide for waiting periods (even though only for disability benefits and unemployment benefits). If no waiting periods are imposed on credit life, it might have an adverse effect in that policyholders might take out policies, knowing that they may not have to undergo any waiting period, and it can lead to the increase in fraud, anti-selection and ultimately claims. We propose that the waiting periods for credit life policies be aligned with the credit regulations.	
105.	Rule 2A.6.5 – 2A.6.9	ASISA	It is submitted that the requirements on insurers in 6.5 to 6.9 are not practically possible and that the cost for insurers to try and comply with these which will need to be passed on to the customer through an increase in premiums will outweigh any benefits for the customer. The time and resources required to do the checks before signing on a policyholder are unreasonable and unrealistic. No allowance for waiting periods on replacements or where a policy has lapsed will mean that the risk to the new insurer will need to be priced for in that the client has served a waiting period or part of a waiting period, but with another insurer, so there is a risk to the new insurer of anti-selection and the client not living long enough to cover the cost of the insurance with no waiting period. Pricing will have to be very conservative under this structure, to the detriment of the majority of more healthy customers. It is proposed that the objective behind these requirements can be met in a simpler and	Disagree. Please refer to item 2.1.1 (h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders. The microinsurer cannot avoid responsibilities towards its policyholders by merely wanting to move the disclosure requirements to the policyholder, especially in the microinsurance market where the policyholder may be at a disadvantage if it does not understand that serving a previous waiting period will have been beneficial. We remain of the view that this requirement is not unreasonably onerous on insurers. The insurer can contact the previous insurer directly to obtain the information if need be. If the insurer finds it administratively burdensome to obtain the information, it simply cannot impose a new waiting period. Also See the amendments to the Rule reducing the

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			much more cost effective way by placing the onus on the customer to provide the policy information to the new insurer in order for them to assess whether the policy benefits under their previous policy were materially similar to benefits under the new policy. It should be made clear that the policyholder will only be entitled to take out one insurance policy without a waiting period for every one insurance policy that ended. A policyholder should for example not be allowed to cancel one insurance policy and then take out five new insurance policies. It is our understanding that for group policies, it should only be required to determine the information in 6.7 from the policyholder as requesting this from each member will result in a delay in implementation. Any new member joining the group will have to comply with the waiting periods imposed if the scheme has already been implemented.	period from 6 months to 2 months. Noted. We are of the view that this is an extreme example, and it has to be taken into account that in such an instance the policyholder will have to pay 5 premiums instead of one. The insurer can appropriately engage the policyholder or potential policyholder and obtain the information in that way. Logically if the insurer asks the information from the policyholder when entering into the policy and there is no evidence of a previous policy or a previous waiting period being served then 2A.6.5 would not apply. It is also not clear how it is suggested that such potential behaviour by the policyholder can be prohibited by regulation in the PPRs which is not enforceable against policyholders. Agreed. ✎ See amendments to the Rule. This will not go down to member level. This needs to be managed between the insurer and the group policyholder. Insurers who wish to offer scheme policies must be aware of the potential risks inherent in these and manage them accordingly through the contractual/policyholder relationship.
106.	Rule 2A.6.5 Waiting period – previous policy	AVBOB	• Materially similar benefits: Clarity is required in respect of what materially similar benefits mean as there will be a significant cost implication associated with the analysis of market products.	This means where the policy benefits under the previous policy is significantly similar to the benefits offered under the new policy in as far as it relates to the nature, value and type of the benefits offered under the policy, including but not limited to the sum assured where applicable.

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				As suggested in the NT microinsurance policy document, these products must be designed in an appropriately simplified way, to support improved understanding. We are therefore of the view that it should not require complicated over analysis of the benefit for the new insurer to understand. This requirement is based on principle, and will be measured against the outcome achieved for the policyholder.
			• Previous policy: Does reference to previous policies mean existing policies or replacement polices?	✎See proposed amendment to the wording in the rule to clarify.
			• Waiting period: The waiting period will require premium rates because of different underlying risks and would have the effect of two sets of premium rates in this regard. In addition, not imposing a waiting period would expose insurers to significant anti-selection.	It refers to a replacement of a previous policy. The term previous implies that that it is in the past and no longer exists / will no longer exist. Noted. Please see the response above on waiting periods and the proposed risk of anti-selection. ✎ Also see the amendments to the Rule reducing the period from 6 months to 2 months to mitigate the risks
107.	Rule 2A.6.5	FIA	Would this also apply if the previous policy is not cancelled and the new policy becomes a second policy?	No.
108.	Rule 2A.6.6	Clientele Life	Comment – This rule creates a huge administrative burden on insurers, in the light that policyholder data is an issue in the lower LSM market. As previously stated a policyholder might not be contactable and where will the insurer then obtain such sophisticated data regarding previous insurers? There is currently no such central database available to check against and in most instances, the client will not be able to provide the new insurer with the policy documents or proof of previous cover (and its waiting period) from the previous insurer showing this.	Noted. ✎See proposed amendment to the wording in the rule to clarify. See previous response regarding the microinsurer's responsibility in terms of Rule 13 of the PPRs on Data Management and ensuring that it has the access to the names, identity numbers and contact details of all its policyholders that are as complete as possible. The microinsurer will need this information to meet the disclosure requirements in the PPRs. The microinsurer cannot avoid responsibilities towards its policyholders based on the fact that the policyholder is

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				unsophisticated or difficult to contact. The insurer can contact the previous insurer directly to obtain the information if need be. If the insurer finds it to administratively burdensome to obtain the information, it simply cannot impose a new waiting period.
109.	Rule 2A.6.5 to 6.8	DMASA	The majority of funeral policies are sold via direct marketing. The implication of these requirements is onerous. Clients often do not remember the underwriter as they may have bought the previous policy through their bank or other institution and are not clear on the underwriter. Has consideration been given to the process of identifying possible previous insurer in such cases? What if a customer does not know about a previous policy and assumes such policy is still active when in fact it is has lapsed? To do this effectively there should be a central repository of funeral policy holders across underwriters against which an applicant for cover can be checked before proceeding. The implications of implementing such a process and system, however, are extensive. In addition, what if the lives being insured under the new policy are not the same as the lives insured under the previous policy, should there still be no waiting period?	The commentator did not provide any substantiation or evidence to confirm the assertion that the majority of funeral policies are sold via direct marketing. The insurer can appropriately engage the policyholder or potential policyholder and obtain the information in that way. Logically if the insurer asks the information from the policyholder when entering into the policy and there is no evidence of a previous policy or a previous waiting period being served then 2A.6.5 would not apply. We remain of the view that this requirement is not unreasonably onerous on insurers. On this question, if the lives being insured under the new policy are not the same as the lives insured under the previous policy, one would need to consider if the policy benefits under the new policy is actually materially similar to benefits under the previous policy. The rule does not require waiting periods should be waived on completely different lives. An insurer would be able to impose new waiting periods on new lives. ✎See proposed amendment to the wording in the rule to clarify.
110.	Rule 2A.6.5 to 6.9	IAC	It is suggested that these rules are deleted. Given that the waiting period is restricted to a quarter of the contract term, the potential for loss to the policyholder is limited, compared to the administrative burden of obtaining	Disagree. ✎See proposed amendment to the wording in the rule to clarify and change in the requirements relating to waiting periods.

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			information on past policies, dates of termination, and communication with other insurers. This process is difficult to police or to penalise for non-compliance, and passive non-compliance is a strong likelihood. It is submitted that the cost of compliance with these rules outweighs the purported benefit of the rules.	The insurer can appropriately engage the policyholder or potential policyholder and obtain the information in that way. Logically if the insurer asks the information from the policyholder when entering into the policy and there is no evidence of a previous policy or a previous waiting period being served then 2A.6.5 would not apply. Please refer to item 2.1.1(h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders.
111.	Rule 2A.6.6-6.9	Janice Angove	Although this provision is consistent with fair treatment of customers, it may be onerous and costly to microinsurers.	Noted. ✎See proposed amendment to the wording in the rule to clarify and change in the requirements relating to waiting periods. The insurer can appropriately engage the policyholder or potential policyholder and obtain the information in that way. Logically if the insurer asks the information from the policyholder when entering into the policy and there is no evidence of a previous policy or a previous waiting period being served then 2A.6.5 to 2A.6.9 would not apply.
112.	Rule 2A.6.7 Waiting periods Confirmation of previous policy and completion of waiting period – by potential policyholder/member	AVBOB	• It would be impossible to validate whether there is a comparative policy in force at the point of sale. In addition, this approach will not work where there are multiple lives insured. Further, the rule would have a significant impact in respect of the administration burden and delay the process of issuing policies which will ultimately impact the policyholder.	✎See proposed amendment to the wording in the rule to clarify and change in the requirements relating to waiting periods.
113.	Rule 2A.6.7(b)	Janice Angove	The microinsurer will also need to know the unexpired period of the waiting period.	Agreed. The insurer can choose to confirm this with the policyholder or the previous insurer. But the PPRs allow for this in principle, and do not make it compulsory. ✎See proposed amendment to the wording in the rule to

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				clarify and change in the requirements relating to waiting periods.
114.	Rule 2A.6.9	BASA	Rule 2A6.9 potentially adds another layer of cost.	Noted. ✎See proposed amendment to the wording in the rule to clarify and change in the requirements relating to waiting periods.
115.	Rule 2A.7	FIA	Could the suicide exclusion not work similarly to the waiting period in 2A.6.5? We are also of the belief that insurers should look to define the suicide clause as being applicable to the principle member only rather than any other family members covered under the policy as "abuse" would be unlikely in cases other than the principle member.	Noted, but such a limitation should then only apply if the principle member is also a life insured under the policy.
116.	Rule 2A.7.1	ASISA	Please refer to our comments above on 6.3. In terms of the Credit Life Regulations exclusion for pre-existing conditions is allowed. This limitation read with 6.3 (no waiting period), really affords little protection to the insurer in respect of underwriting, and is likely to result in higher premiums for customers, or the product not being offered at all.	Noted. ✎See proposed amendment to the rule on waiting periods to align to the NCA Credit Regulations. Please refer to item 2.1.1(i) of the National Treasury Microinsurance Policy Document, page 12. The initial proposal in the MI policy document was that a microinsurance policy may not impose any exclusion for a pre-existing health condition. In acknowledging that such blanket exclusion may drive up premiums and inhibit fair underwriting the alternative was suggested that exclusion of pre-existing health conditions should only be prohibited for funeral policies underwritten by traditional insurers and microinsurers. Also see the proposed changes to the requirements relating to waiting periods.
117.	Rule 2A.7.1	BASA	Exclusion of a pre-existing health condition for a 'micro credit policy' Clarity is required on whether "micro credit policy" will apply to ALL credit life policies OR just credit life policies sold by a Micro-Insurer?	Application to credit life policies was removed. ✎See proposed amendment to the rule on waiting periods to align to the NCA Credit Regulations.
118.	Rule 2A.7.1	IAC	It is proposed that limited pre-existing conditions exclusions are allowed.	Noted.

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			This is necessary to combat anti-selection in respect of conditions or diseases of a long term nature. Competitive pressures may result in the removal of these clauses through industry practice. An example of a limited pre-existing conditions clause is one that applies only during the first year or 2 years after policy inception. The exclusion could be further limited to conditions arising in a fixed period prior to taking out the policy, e.g. 1 or 2 years. The use of pre-existing conditions clauses assists in the operation of the market by compensating for an information asymmetry between the insurer and the insured, and thus protects consumers and firms in the market for funeral insurance against abuse. In the case of lightly regulated firms, this protection becomes more important. It is desirable that consumers of funeral insurance participate in a market that is substantially free of abuse.	Please see the response directly above and the amendments to the rule relating to exclusions.
119.	Rule 2A.7.2	ASISA	This rule will negatively impact upon the pricing of the funeral policy as it is much shorter than the current standard waiting period of 24 months for suicide. The current practice to pay claims subject to a 2 year “waiting period”, where the death is as a result of a suicide is in fact a concession by insurers (as causing the event for which you are insured against makes the claim inadmissible under basic principles of insurance) and not an exclusion. It is suggested that a 12 month period is appropriate for microinsurance policies and 24 months for funeral policies because as	Disagree with the proposal to increase the exclusion period from 12 months to 24 months. The intention is that microinsurance policies must be simple and easy to understand and complex exclusions should be avoided.

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			submitted their contract term should not be limited to 12 months as proposed.	
120.	Rule 2A.7.2	BASA	**Suicide exclusion proposed is 12 months from inception** We are concerned that this may have a negative pricing impact overall across the industry. It may not be in everyone's best interest to increase pricing to accommodate the suicide class of policy holders. Currently industry practice applies a 24-month waiting period to suicide.	See response directly above.
121.	Rule 2A.7.2	Clientele Life	• Comment – The current industry norm is 24 months, seeing that a moral hazard risk exists, in the event that the exclusion period is reduced. • The pricing of the funeral products will also be affected, seeing that the standard for suicide is 24 months. This will have a negative impact on the policyholders and also the insurers.	Noted. See response directly above.
122.	Rule 2A.7.3	Outsurance Life	The section is not clear on whether the suicide exclusion may be renewed at the annual renewal or if it falls away *in toto* after the first 12 months after inception. Please provide clarity.	No it cannot be renewed – 2A.7.2 limits it to 12 months from the inception date of the policy. Rule 2A.7.3 is intended to clarify that the prohibition in 2A.7.2 applies, regardless of the length of the policy term, in other words, if the policy was renewed during the 12 months from inception of the policy, the insurer may not impose a new 12 month exclusion for suicide.
123.	Rule 2A.8.1	ASISA	Although the industry norm is to pay funeral claims within 48 hours this is not always possible due to various factors such as IT downtime. The 48 hour period could also fall over a weekend. It is suggested that this paragraph should be amended to say that claims must be paid "within two business days or as soon thereafter as reasonably possible" to make it clear that the period runs during business days and that the insurer will	Partially agreed. ✎See the amendments to the Rule extending the requirement from 48 hours to 2 business days.

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			not be in breach if they are unable to pay within that time for unforeseen reasons. It is requested that in order to make it clear that the requirement to pay the claim within the prescribed period will not start until all the requirements are received, "required documents" should be changed to "required documentation and reasonable insurer requirements". This will include for example blood alcohol test results which may be required to establish if an alcohol exclusion is applicable.	Partially agreed. ✎See proposed change from "submitted" to "received".
124.	Rule 2A.8.1 Claims 48 hours after all required documents in respect of a claim under a microinsurance policy or a funeral policy have been submitted	AVBOB	• The 48 hour rule should apply from when all the claim documents have been received and verified.	Partially agreed. ✎See proposed change from "submitted" to "received".
125.	Rule 2.8.1	FIA	Please change the 48 hours to 2 business days to provide for public holidays and weekends, etc. (The term "business day" has already been defined anyway.)	Partially agreed. See proposed change from "submitted" to "received".
126.	Rule 2A.8.1 and 2A.8.2	IAC	It is proposed that the limitation of 48 hours is removed. It is accepted in the Statement that industry practice already supports a 48-hour turnaround of claims. The need for the rule is thus unclear, since there is no deficiency in the market that needs to be remedied. It should be remembered that Rule 17.6.1 remains in effect for microinsurers. There may also be practical reasons that necessitate longer turnaround times in	Disagree. Please note that this aligns to the current requirements for assistance business, and the intention is for the requirements under the microinsurance frameworks to align. In this regard, please see the NT Microinsurance Policy Document on page 51 under item 4 relating to Consequential Amendments And Intergovernmental Coordination. Also abuses in the market in this regard have been picked up through supervision.

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			specific instances, such as difficulties in obtaining the death certificate.	✎See the amendments to the Rule extending the requirement from 48 hours to 2 business days.
127.	Rule 2A.8.1	Investec	The proposed amendments reads "Subject to rule 2A.8.2, an insurer must, within 48 hours after all required documents in respect of a claim under a microinsurance policy or a funeral policy have been submitted - (a) assess and make a decision whether or not the claim submitted is valid, and (b) (i) authorise payment of the claim; (ii) repudiate the claim; or (iii) dispute the claim and notify the claimant of the dispute. We support the 48 hour turnaround time, however, this may pose a challenge where all the documents are received on the last working day of the week i.e. Friday. From an administrative and process point of view, it is not always practical to make payment outside the normal working hours. We propose that the turnaround time be changed to 2 business days.	Noted. ✎See the amendments to the Rule extending the requirement from 48 hours to 2 business days.
128.	Rule 2A.8.1	Janice Angove	Although it is market practice to settle claims in 48 hours or less for funeral business. It may not be appropriate to set a 48 hour time to pay claims for all classes of business. 17.6.1 is a principles-based rule that accommodates fair treatment of customers in this regard.	Noted. Please note that this aligns to the current requirements for assistance business, and the intention is for the requirements under the microinsurance frameworks to align. In this regard, please see the NT Microinsurance Policy Document on page 51 under item 4 relating to Consequential Amendments And Intergovernmental Coordination. ✎See the amendments to the Rule extending the requirement from 48 hours to 2 business days.
129.	Rule 2A.8.2	ASISA	This section appears to require the insurer to make a decision within 14 days regardless of	Agreed.

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			whether or not they have the information available to establish if it is a valid claim e.g. the example under 8.1 regarding the blood alcohol results. If 8.1 is changed as suggested then 14 days should be sufficient, but this should be 14 business days.	✎See the amendments to the Rule extending the requirement from 14 days to 14 business days.
130.	Rule 2A.8.2 Claims Investigation to be concluded within 14 days	AVBOB	• This rule may result in increased disputes and repudiation of claims as most investigations take longer than 14 days specifically in remote areas.	Please note that this aligns to the current requirements for assistance business, and the intention is for the requirements under the microinsurance frameworks to align. In this regard, please see the NT Microinsurance Policy Document on page 51 under item 4 relating to Consequential Amendments And Intergovernmental Coordination. ✎See the amendments to the Rule extending the requirement from 14 days to 14 business days.
131.	Rule 2A.8.3	DMASA	The reasonable man test will be used to assess the validity of any non-disclosure, but the onus is on the insurer to ensure they ask for all potentially relevant information. Within the context of microinsurance seeking to provide simple and effective cover, the application and binding process may prove to be cumbersome within the context of a sales execution model – and as "assumed" risks increase, premiums are also likely to increase. Again, the concern is the impact of this proposal on TCF and increasing access to financial services.	The principle is that a microinsurer may not repudiate a claim based on information that it did not specifically request the policyholder to disclose before the inception of the policy. This is based on the fact that a policyholder may not necessary know which disclosures are relevant to the risk being underwritten, and if a microinsurer is of the view that information is relevant to the risk, it should ask the policyholder appropriate questions before the inception of the policy. This is an adapted version of the "non-contestable rule" which is applied in some other jurisdictions. It aligns to the proposal in the NT Microinsurance Policy Document under item 2.5.6 which deals with requirements for simplified disclosure. ✎See the amendments to the Rule limiting the requirement to non-disclosure by the policyholder to address concerns raised regarding compulsory group schemes. However the insurer will be responsible to

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				ensure that that the policyholder is aware of the requirement and communicate accordingly to members of the group scheme.
132.	Rule 2A.8.3	IAC	The non-contestability rule should be retained only if limited pre-existing conditions exclusion is retained. If no pre-existing conditions clause is retained, then the non-contestability clause further limits the ability of the insurer to manage its portfolio. It may also have the undesirable effects of additional costs at underwriting stage or lengthy lists of underwriting questions. The non-contestability rule together with the absence of a pre-existing conditions exclusion and the short waiting period may impair the functioning of the market under normal conditions by weakening risk selection by product providers. This would increase the cost of this Rule beyond its intended impact of policyholder protection.	Agree. Please note that the clause relating to exclusions for pre-existing conditions relating to funeral policies in Rule 2A.7.1 will be retained.
133.	Rule 2A.9	KGA Life	We agree with the spirit of the rule as unfortunately in some cases lapses are due to short term financial difficulties experienced by policyholders and as such product designs to accommodate such cases should be encouraged. However cognisance should be given to the cost of forcing all products to conform to these requirements which may result in less affordable products on offer. For example, a policyholder could use the six (6) month rule to gain access to insurance when they feel it is most needed. The policyholder would only be required to take out the policy for the initial waiting period where after the policy could be lapsed due to	✎See the amendments to the Rule reducing the period from 6 months to 2 months. This rule does not force a microinsurer to reinstate a policy. It merely sets out the requirements if the microinsurer chooses to reinstate the policy. The rule does not prohibit a microinsurer from choosing to rather not reinstate, and to enter into a new policy with the policyholder. It may well be that the policyholder does not have the money to reinstate, i.e. pay up the premiums which it has missed which caused the policy to lapse, in which case the insurer may choose not to reinstate the policy. The parties may by agreement then choose to enter into

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			non-payment. The policyholder would only need to reinstate cover for one month every six months in order to ensure that they have guaranteed insurability for the following six months (in order to cover themselves for deaths due to illness). Such behaviour could negatively impact on the cost of providing the product and increased costs would likely have to be passed on to policyholders and affect the affordability of these products. It may also have an impact on operational management as insurers will have to make provision for this requirement in its systems in order to track such expiry dates. This may also result in an increase in the cost of providing cover and impact the affordability of these products.	a new policy for which the premium may differ, but to protect the policyholder from the adverse effect of a new waiting period, the new policy may not impose a new waiting period it the policy lapsed less than 2 months ago.
134.	Rule 2A.9.1 to 2A.9.3	ASISA	These requirements on reinstatements significantly increase the scope for anti-selection by customers. A customer can, by paying only 2 months' premiums per year, maintain the "option" to take out insurance when he/she is terminally ill and could facilitate almost continuous cover by following this approach in conjunction with a policy that only provides accidental cover. It will also create a big administrative burden for insurers. Whilst ASISA members would prefer to reinstate a policy, not being permitted to include a waiting period if the reinstatement is done within 6 months of the policy having lapsed, will deter them from doing so. We propose that the 6 month period is shortened to 1 month.	Noted. See the amendments to the Rule reducing the period from 6 months to 2 months, and the comments under item 133 above.
135.	Rule 2A.9.1 and	AVBOB	• The rule may lead to anti-selection	Noted. See the amendments to the Rule reducing the

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	2A.9.2 Reinstatement		and increased costs as well as that new policies may be issued instead of reinstated which is not in the policyholder's interest.	period from 6 months to 2 months, and the comments under item 133 above.
136.	Rule 2A.9.1	Clientele Life	Comment – this will create additional risk to insurers, clients decide to reinstate when they realise they have a condition or illness. This rule would leave insurers with no other option that to re-price the policies and the cost will be borne by the policyholder.	Noted. ✎See the amendments to the Rule reducing the period from 6 months to 2 months, and the comments under item 133 above.
137.	Rule 2A.9.1	DMASA	Insurers are less likely to consider reinstatement given the proposals, which is not necessarily in the best interests of policyholders. Reinstatement is often not readily considered due to policyholders reinstating based on their realisation that they may shortly have a claim or already have a claim. The ability to reinstate with waiting periods is essential to enable insurers to maintain prudentially sound risk pools.	Noted. ✎See the amendments to the Rule reducing the period from 6 months to 2 months, and the comments under item 133 above.
138.	Rule 2A.9.1 and 2A.9.2	IAC	This Rule is supported. The high lapse rates in this market segment means that consumers are at risk of loss of continuity of cover, and this requires measures to address this problem. The requirement to reinstate on same terms and not to impose waiting periods should assist in the remedy.	Noted. ✎See the amendments to the Rule reducing the period from 6 months to 2 months, and the comments under item 133 above.
139.	Rule 2A.9.1	Outsurance Life	We hold the opinion that where reinstating a policy may not incur a waiting period the risk will be high for anti-selection which may have an impact on the affordability of policies.	Noted. ✎See the amendments to the Rule reducing the period from 6 months to 2 months, and the comments under item 133 above.
140.	Rule 2A.9.2	Clientele Life	Comment – This increases anti-selection from customers. We believe that the proposed 6 months is excessive and should be shortened to not more than 1 month.	Noted. ✎See the amendments to the Rule reducing the period from 6 months to 2 months, and the comments under item 133 above.
141.	2A.10: General	BASA	**Product standards for Life and non-life policies**	

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			Clarity is needed whether this applies to new sales, new products and/or existing products from 1 July 2018.	The standards will apply to all microinsurance policies and funeral policies written by insurers under the funeral class of insurance business referred to in Table 1 of Schedule 2 to the Insurance Act. It will therefore apply to all new policies written by microinsurers and licensed insurers. Existing policies will have to be varied or amended to align with the product standards as part of the conversion of registrations to licenses under the Insurance Act.
142.	Rule 2A.10.1	ASISA	ASISA members agree that the policyholder should be able to choose whether the benefits are paid to the beneficiary or to a service provider. It appears from the FSCA statement on the proposed amendments (pg. 7at 3.3.10) that this is the intention but the wording needs to be clearer. Some of the reasons why payment directly to a service provider may be preferred is because payment to the beneficiary will result in a delay in the payment of service providers as the money first needs to clear in the beneficiaries' account before they can pay the service provider, which will in turn result in a delay in the delivery of the funeral service. The beneficiary may not have a bank account. There may also be cases where a policyholder elects payment to the service provider as they are worried that their family members will not use the money from the policy towards the funeral and will keep it for themselves.	Noted. ✎See the amendments to the Rule to clarify the intention. Please note that the requirement in Rule 2A.10.1 specifically prohibits that a policy provide that the policy benefit is payable directly to the service provider. In other words it may not be at the instance of the insurer. This does not limit the insurer to at claims stage on the instruction of or by agreement with the policyholder pay the policy benefits directly to a service provider. It merely states that payment directly to a service provider it may not be prescribed by the insurer in the policy.
143.	Rule 2A.10.1 General Policy benefit payable as a sum of money cannot be paid directly to a service provider	AVBOB	• The mutual agreement and freedom of contract, where the free will of the policyholder is expressed through consent that a sum of money be provided to a service provider to conduct the funeral, should be the overriding factor. This rule will impact on the	Noted. ✎See the amendments to the Rule to clarify the intention and response under item 142 directly above.

No	Section/Rule	Commentator	Comment	Response
			policyholder's freedom of contract.	
144.	Rule 2A.10	DMASA	The risk of the Authority objecting to new products may discourage new entrants into this market, especially during the initial phases where there will be uncertainty regarding the application of this rule. The easiest remedy for microinsurers will be to increase the assumed risk and increase the premium.	This aligns to the proposal in the National Treasury Microinsurance Policy Document relating to product regulation. Please see item 2.1.2 on page 15 - 16 of the policy document in this regard that proposes that product review will take place on a file-and-use basis. The policy document sets out a detailed explanation for the proposed approach to regulation of microinsurance products in this section.
145.	Rule 2A.10.1	FIA	While we support customer choice in this regard we are cognisant of the fact that some benefits (such as where groceries are provided for) are provided specifically to provide for beneficiaries where the policyholder may feel that the funds would otherwise be wasted. This limitation also doesn't take into consideration that 2A.10.2 has in effect the same effect in that the insurer itself now acts as the product supplier. Also refer to our comments under 2.5 above. In many cases the insured specifically selected the service provider and would not want family members to change this or access the funds.	Noted. ✎See the amendments to the Rule to clarify the intention and response under item 142 above.
146.	Rule 2A.10	FPI	While we support customer choice in this regard we are cognisant of the fact that some benefits (such as where groceries are provided for) are provided specifically to provide for beneficiaries where the policyholder may feel that the funds would otherwise be wasted. Under a larger rick policy this protection could be obtained by setting up a trust to administer the benefits. He wishes of the policy holder in this regard must be considered.	Noted. ✎See the amendments to the Rule to clarify the intention and response under item 142 directly above.
147.	Rule 2A.10.2	BASA	It will be helpful to provide a definition for 'non-monetary benefits'.	Please consider the context of the wording "When providing a service or other non-monetary benefit…"

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				It means benefits other than benefits payable in cash.
148.	Rule 2A.11	DMASA	What is considered to be a new micro insurance or funeral product? Is it a product that the insurer previously did not have in their product basket or is it a product that is fundamentally different to the norm in the industry? If 100 insurers now start offering a funeral product that is very much standard and in line with the requirements, will they all have to submit to the Authority for approval? In addition, as the Authority may object **at any time** to the product, the ability for insurers to service and manage such products is inherently uncertain which will discourage investment and innovation in this space. What will the implication be for customers who have bought a product which is subsequently deemed to be unsuitable? The Authority should only be able to object within the 31 day notice period.	✎See the amendments to the Rule. A new microinsurance product is any product that the insurer previously did not have in their "product basket" (to use the wording of the commentator). It is not products that are 'new' to the industry only. It applies on individual insurer level. This rule goes to the appropriate design of microinsurance products. This aligns to the proposal in the National Treasury Microinsurance Policy Document relating to product regulation. Please see item 2.1.2 on page 15 - 16 of the policy document in this regard that proposes that product review will take place on a "file-and-use" basis. The policy document sets out a detailed explanation for the proposed approach to regulation of microinsurance products in this section.
149.	Rule 2A.11	FIA	We would appreciate some further clarity as to what would constitute a new product as opposed to a variation of an existing product.	Please see the response directly above in explaining what will constitute a new microinsurance product.
150.	Rule 2A.11	IAC	It is proposed that this Rule is deleted. Currently pre-approval of products is not a feature of the South African regulatory approach and there is no reason why this should be different for the microinsurance licensees. The unintended negative impact on innovation arising from the need for pre-approval is an important consideration (the "chilling effect"). Additional costs are imposed on the insurer due to the Authority's ability to object to product features at any time, rather than only at pre-approval stage. Further, the ability of the Authority to object to product terms is not limited to the requirements set	Disagree. This aligns to the proposal in the National Treasury Microinsurance Policy Document relating to product regulation. Please see item 2.1.2 on page 15 - 16 of the policy document in this regard that proposes that product review will take place on a file-and-use basis. Note that this is not a "pre-approval" basis. The policy document sets out a detailed explanation for the proposed approach to regulation of microinsurance products in this section. The intention is for these products to have appropriate oversight to ensure that microinsurance products are appropriately designed and marketed in order to ensure fair outcomes for a particularly vulnerable segment of

No	Section/Rule	Commentator	Comment	Response
			out in the PPR. These unintended consequences, and especially the chilling effect on insurers, harm consumers by resulting in lower levels of innovation that would benefit consumers by meeting their needs in new and better ways. The reduction in competition which arises reduces the choices that consumers have and their ability to change providers to products that could be better suited to their needs. The objective of the Rule is stated as the "facilitation of effective supervision". This objective can be reached in a less costly manner through annual reporting of compliance of products with the PPR requirements. In the event of non-compliance with the PPR, specific remedies can be proposed that are directly related to the non-compliant activity. The advantage of this approach is that it does not slow down or inhibit the normal functioning of market participants in product design and development and provides a predictable interaction with the Authority once a year on the PPR compliance.	customers. The approach enables the supervisor to proactively monitor product development trends in this vulnerable market, and to pre-emptively identify potential risks of unsuitable product design practices. ✎See the amendments to the Rule. A new microinsurance product is any product that the insurer previously did not have in their "product basket" (to use the wording of the commentator). It is not products that are 'new' to the industry only. It applies on individual insurer level. This rule goes to the appropriate design of microinsurance products. This aligns to the proposal in the National Treasury Microinsurance Policy document relating to product regulation. Please see item 2.1.2 on page 15 - 16 of the policy document in this regard that proposes that product review will take place on a "file-and-use" basis. The policy document sets out a detailed explanation for the proposed approach to regulation of microinsurance products in this section. To supervise these products on an annual reporting basis would be reactive and not in line with the risk-based approach to supervision which supports fair outcomes for customers.
151.	Rule 2A.11.1 Reporting a new product Submission of information to the Authority	AVBOB	• Clarity is required in respect of what information will be requested (for e.g. information in respect of variation, premium rate change, addition of a feature, improvement on a product).	✎Please see the amendments to the rule to clarify what would constitute a new product.
152.	Rule 2A.11.1	Clientele Life	• Comment – The requirement places and administrative burden which could amount to overregulation of a non-complex product such as a funeral policy. The	Noted. This comment is contrary to the views raised by other commentators who have suggested that funeral policies are not as simple or homogenous as sometimes perceived. We do not share the concern regarding stifling

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			requirement could stifle innovation due to the administrative burden. All advertising material could possibly also not be ready as long as 31 days prior to the launch date which could delay the release of innovative new products to the market.	innovation. Note that product review will take place on a file-and-use basis, not a pre-approval basis.
153.	Rule 2A.11.1	Janice Angove	Consider removing funeral policies from this rule. Funeral policies provided by licensed insurers that are more strictly supervised could be treated in the same way as other products offered by these insurers. There should be requirements for fully licensed insurers to have robust product oversight procedures that would justify that the same approach for the insurer to introduce new products for all types of policies.	Noted. However the intention of the "file-and-use' requirements are to ensure supervisory oversight and additional checks on the extent to which prescribed product features are complied with and interpreted in practice and to monitor trends. We are therefore of the view that the supervisory rationale applies equally to funeral policies offered by traditional insurers and microinsurance products.
154.	Rule 2A.11.2 Reporting of a new product Action by the Authority	AVBOB	• Whilst we support consumer protection, we are strongly of the view that the application of this rule should be limited to market conduct and not pricing (as such would be anti-competitive). Commercial decisions should remain the domain of the Board.	Noted. The proposals in this rule align to the proposal in the National Treasury Microinsurance Policy Document relating to product regulation. The proposed approach did not suggest price regulation. The intention is that products must meet the microinsurance standards and must not undermine consumer protection. To ensure effective monitoring, it is important that the FSCA be aware of all product features – at the time of licensing but also on an ongoing basis, should new products be launched. This is in the interest of fair treatment of policyholders by ensuring that microinsurers design their products appropriately. Note too that the PPRs as a whole do impose obligations to ensure fair pricing of all insurance policies.
155.	Rule 2A.11.4 and 11.5	Janice Angove	Consider adding: commission and fees/remuneration, written disclosures	Please see Rule 2A.11.1(b) that refers to commission payable and the intended structure of the commission payable.

No	Section/Rule	Commentator	Comment	Response
RULE 3: CREDIT LIFE INSURANCE				
No comments				
RULE 7: VOID PROVISIONS				
156.	Rule 7.1.f	FIA	Is this to be read that an insurer will be responsible for any actions of PSA workforce as well as RFAs even if they have acted fraudulently?	No. This means that a provision in a policy is void if it provides expressly or by implication that a long-term insurer is exempted from liability for the actions, omissions or representations of a person acting on its behalf in relation to a long-term policy.
CHAPTER 4: ADVERTISING AND DISCLOSURE				
RULE 10: ADVERTISING				
157.	Rule 10.3 and 10.4	DMASA	The definition of Advertising (Chapter 1, 2.1) states that any communication through any medium, must at all times adhere to Rule 10. In the process of direct marketing it has been common practice for insurers, either directly or through lead aggregators, to create awareness of its products typically within the market segment not ordinarily serviced by brokers, through either SMS, social media or other digital media. These messages to potential policyholders to "find out more" fits the definition of "Advertising", but this invitation to obtain further information will not adhere to Rule 10 due to practicalities (maximum length of SMS, banners on websites) and will prevent the distribution of important cover to markets previously unaware of the importance or existence of these products. The cost of generating consumer awareness/interest is currently extremely high. The imposition of any additional requirements will negatively impact the commercial viability of these communication strategies, especially as it is often the start of an individual's journey with a financial services provider.	Noted. However the definition of 'advertising' has not been changed since the replacement of the PPRs in December 2017. The definition has merely been moved to the main definitions section as the term is used in other rules, and no longer only in the rule on advertising. We understand the role that technology plays in marketing of products; however the interest of insurers to market their products in a cheap and easy way has to be balanced against the protection of policyholders and potential policyholders that receive these advertisements. We submit that the rule on advertising does not prohibit insurers to make use of sms, social media or other digital media. It sets out the principles to which advertisements must comply to ensure fair outcomes for policyholders. As there aren't any 'additional requirements' being imposed, and the development of the rule on advertising was widely consulted on as part of Tranche 1 before the replacement PPRs were made effective in December 2017, it is unclear what further negative impact this may have.
158.	General comment	FIA	Although we agree with the requirement placed on insurers, we are of the belief that	Noted. We however share the commentator's view that microinsurance products target those customers that

No	Section/Rule	Commentator	Comment	Response
			extending the requirements of advertising and disclosure to all forms of promotional material may well present considerable complications to many of the funeral parlours and marketers of assistance business who are not that literate and whose clients aren't as well. While the protection of these clients is paramount, we believe it might require a different set of rules with regards to micro-insurance and funeral policies.	require the most protection, also in relation to appropriate advertising and disclosure. In the absence of any specific examples or instances where the requirements in these rules are not appropriate to microinsurance products we submit that the PPRs are drafted in a sufficiently principle based manner in order for them to be applied proportionately.
159.	Rule 10.14.1	ASISA	A member has requested that as the purpose of this section is to allow fair and informed comparisons to be made by comparing different present values it would be better to prescribe explicitly a reference rate. Their concern is that using different inflation rates over long projection periods could yield different results, despite good arguments existing at the outset for both projected rates and that at the very least the assumptions used in the calculation should need to be disclosed.	Noted. We hold the view that the Rule should not be too prescriptive with regard to the calculation of loyalty benefits, and the aim is to ensure appropriate advertising regarding loyalty benefits, no-claim bonuses or rebates in premium. The Authority will consider issuing guidance in due course should our supervisory experience indicate a need for this.
160.	Rule 10.14.1 - 10.14.4	Janice Angove	The information required to be disclosed in an advert seems complicated for radio or television advertising. It might be helpful to simplify the requirements for advertising for loyalty benefits and to include these requirements in disclosures.	Please see Rule 10.4.6 to accommodate practicalities due to the nature of the medium used for an advertisement.
161.	Rule 10.16.5	Janice Angove	The information required to be disclosed on restrictions etc. seems complicated for radio or television advertising. It might be helpful to simplify the requirements for advertising for tax and to include these requirements in disclosures. The advert can indicate where these disclosure of information on restrictions etc. can be found.	See comment directly above.

No	Section/Rule	Commentator	Comment	Response
			RULE 11: DISCLOSURE	
162.	Rule 11.4 and 11.5	Janice Angove	It would be helpful to include a list of simplified disclosures for microinsurance policies. A consistent list of minimum implied disclosures will help to create a common understanding of policies and allow customers to compare policies more easily.	Noted. The rule on disclosures is drafted in a principle based manner in order for it to be applied proportionately. The Authority will consider issuing guidance in due course should our supervisory experience indicate a need for this.
163.	Rule 11.5.1(i)	FIA	Risk acceptance criteria / data (such as information gathered under client needs analysis systems - like security arrangements and prior claims history) are not necessarily currently transferred (or in a format that is transferable) from underwriting systems into policy production systems. This type of information ranges from hard copy proposal forms to electronic data held in various formats some of which is re-keyed into policy systems. Some of this information may go back some years to the original inception of the policy that makes availability, accessibility and transferability even more problematic. This is a new requirement that introduces significant sourcing and formatting challenges and cannot be applied as early as 1 July 2018 in fact there are significant difficulties in accessing and providing this information even by 15 December 2018 being the date for the other information under the existing rule 11 (that is more generally achievable). Request – that the deadline for completion of 11.5.1(i) be 1 July 2019 (or one year after effective date of new regulations).	Noted. However these are existing requirements in the LTIA, adapted from S 48 of the LTIA as being repealed by the Insurance Act. The appropriate processes and systems should already be in place as there is already a requirement on long-term insurers to issue the s48 summary. As the requirements in this sub-rule are not currently prescribed for short-term insurance, and have been inserted to align to the requirements in the Long-term Insurance PPRs, (which in turn are being transferred from s48 of LTIA to the LT PPRs), an appropriate transitional period will be afforded for purposes of the ST PPRs.
164.	Rule 11.5.2 and 11.5.3	DMASA	Please can you provide clarity on the	The requirements in this sub-rule are currently required

No	Section/Rule	Commentator	Comment	Response
			purpose / rationale for this requirement to enable us to comment meaningfully. We respectfully submit, on the face of it, that there will be no difference in customer outcomes relative to what is already required under existing legislation. This requirement effectively amounts to unnecessary compliance and will increase costs for the policyholder. In this regard, direct marketers provide prospective customers with information to make an informed decision at sales stage, which is subject to further subsequent written confirmation and disclosures post the sale as you know.	under S 48 of the LTIA, which is being repealed by the Insurance Act. Please see the statement supporting the amendments as published with the PPRs for context in this regard. The proposed requirement in 11.5.2 does not impose any additional disclosure requirements, and merely sets out the principle that the information referred to in 11.5.1 (which is already required) must be clearly distinguishable from the rest of the information in the policy wording and the schedule. As this relates to information to be provided after the inception of the policy, it is not clear how this is any different for a direct marketer who is required to provide the information in terms of 11.5.1. This does not detract from the principle that it is not a duplication of information already provided by the insurer in writing under Rule 11.4, which allows for a less 'compliance' based approach to disclosure, and a more principles based approach.
165.	Rule 11.5.2	FIA	Please define what is clearly distinguishable from the policy The "policy" contract is defined in policy wordings as comprising the following documents - Proposal for insurance, Schedule of insurance and Policy wording. The disclosures referred to in 11.5.1. are usually contained within the schedule of insurance or the policy wording but are not necessarily grouped together under say "Material disclosures by policyholder". It is not clear what is meant by the "information must be provided in a format which is distinguishable from the policy"? The former wording in the STIA was "provided … with a copy of the document which embodies the contract of short-term insurance concerned". This, read with the	This means that the disclosures must not be absorbed into the legal jargon in the policy wording, as this information is particularly relevant to the policyholders. This is to make sure that policyholders are given clear information and are kept appropriately informed before, during and after the time of entering into a policy, which is critical in ensuring the delivery of fair outcomes to which is one of the outcomes to achieve the fair treatment of policyholders. This does not necessarily require a separate document. It goes to the construct of the disclosures, rather than requiring specific separate documentation. We are of the view that the requirements are drafted in a sufficiently principle based manner in order for it to be applied proportionately.

No	Section/Rule	Commentator	Comment	Response
			definition in policy wordings (above), has been taken to mean that the information under 11.5.1 being included in the construct of the policy contract as defined above was acceptable. The change suggests that the information must be in a separate document. Request – please clarify whether the requirement for Material disclosures is for i) a separate document; ii) a separate section in existing policy documentation under the heading Material disclosures; iii) content comprising Material disclosures to be included throughout existing documentation but in a way that is "clear distinguishable". Can all three be acceptable methods, the test being that the Material disclosures be set out in such a way to be clear and apparent to the policyholder that the insurer has relied on the disclosures in entering into the policy?	Disagree. The requirement is that the disclosures must be in a format which is clearly distinguishable from the main body of the policy itself. The FSCA will not be prescriptive on the format. The insurer will need to position the disclosures in a way that is appropriate for the product and the policyholder, and dependent on the volume and complexity of the information. The three options proposed by the commentator would all be acceptable as long as the outcome underpinning the rule has been achieved as described above.
166.	Rule 11.5.3 Disclosure after inception of policy	ASISA	It is suggested that for consistency and clarity the wording in 11.5.3 should be changed from "must issue and deliver a copy of the policy", to "must provide a copy of the policy" as the other parts of Rule 11 refer to providing the policyholder with the necessary disclosures. In addition a requirement to ensure delivery of the policy to the policyholder is too onerous. The obligation on the insurer can only be to show that it has been sent to the policyholder.	Agreed. ✎See proposed change in the wording of Rule 11.5.3.
167.	Rule 11.5.3 Disclosure Insurer required to issue and deliver copy of policy	AVBOB	• Delivery must include electronic methods.	Noted. In our view delivery does include electronic methods. ✎However see the proposed change in wording to Rule 11.5.3

No	Section/Rule	Commentator	Comment	Response
168.	Rule 2A.11.5.3	Clientele Life	• Clarification is required on the word "issued" and "delivered". The word issue is where the system "issues" the policy, but for the policy to be "sent" and "delivered", requires further action from the insurer. • Comment – the requirement to prove delivery in the lower LSM is too onerous on insurers, the obligation of the insurer must include that the insurer can prove that the policy document was in fact "sent" to the policy holder.	Noted. ✎See proposed change in the wording of Rule 11.5.3.
169.	Rule 11.5.5	FIA	Is this in the format of a simple statement or does it necessitate restating all the disclosure information from 11.4.1(a) in 11.5.1? We suggest the issues around section 11 be discussed and resolved through a workshop at which SAIA/ASISA and FIA members can engage directly with the drafter. This is a key section requiring significant implementation time and cost and ongoing operation and monitoring and requires absolute clarity to avoid interpretive variations and the risk of non-compliance.	This is not a new requirement as it was included in the replacement of the PPRs that came into effect on 1 January 2018. The comments matrix on draft amendments may not be the appropriate forum to settle interpretational concerns, and it is recommended that the commentator contact the FSCA to engage with the Authority and address any confusion or practicalities in interpreting existing legislation.
170.	Rule 11.6.4(a)(b)	Janice Angove	This sub-rule should refer to "premiums" and "charges"	Agreed. ✎See proposed change in the wording of Rule 11.6.4
171.	Rule 11.6.5	ASISA	It is suggested that the period is also changed from 60 days to 31 days to align with 11.5.1 and 11.5.3.	Agreed. ✎Please see amendment from 60 days to 31 days.
RULE 12: ARRANGEMENTS WITH INTERMEDIARIES AND OTHER PERSONS				
172.	Rule 12.2.2	ASISA	Although this section has not been changed it is requested that this should specifically provide for such an agreement to apply to all insurers in a group so that an agreement with one insurer in the group can also be on behalf of another insurer in the group. This can be done in a similar way as the definition of "representative" in Part3A of the LTIA	Partially agreed. However the concern will be addressed by amendment to the definition of intermediary agreement in Rule 12, in order to make interpretational and drafting sense. ✎See change to the definition of "intermediary services".

No	Section/Rule	Commentator	Comment	Response
			regulations which refers to another insurer "which is also part of the same group of companies".	
CHAPTER 6: PRODUCT PERFORMANCE AND ACCEPTABLE SERVICE				
RULE 15A: PAYMENT OF PREMIUMS				
173.	Rule 15.A	AVBOB	There is no effective date provided for Rule 15A.	Agreed. Table in Chapter 8 on Administration corrected with a proposed effective date of 1 July 2018.
174.	Rule 15.A	Janice Angove	Simplified provisions for the grace period for microinsurance and funeral insurance business are appropriate given that there is no savings element to these policies.	Noted. ✎See addition of the words "where applicable" in rule 15A.2.
175.	Rule 15.A.1	OLTI	1. The provision only makes reference to a 'policy' remaining in force. Should make reference to / provision for 'cover' as well 2. Whilst the section requires the insurer to give notice when a premium is in arrear, it prescribes no sanction for non-compliance. It should set out the consequences for non-compliance.	Agreed. ✎See addition as suggested in Rule 15A.1 If the insurer does not meet the requirements in any of the PPRs, it will be in contravention which means that it may attract regulatory action. The sanctions would therefore be similar to any other contravention of the PPRs.
176.	Rule 15.A.2	OLTI	Section should end with 'if applicable'	Noted. ✎See addition of the words "where applicable" in rule 15A.2
177.	Rule 15.A.3	BASA	Kindly provide clarity whether this section applies to Funeral and Credit Life policies.	Yes. This rule currently applies in terms of the LTIA. It has merely been moved here. It therefore currently applies to existing policies, and will apply to all new policies, regardless of the class of business it is written under.
RULE 17: CLAIMS MANAGEMENT				
178.	Rule 17.11.1 Claims received during periods of grace	ASISA	The requirement relates to the claimant submitting the claim within the period of grace. Isn't the intention that if the claimable event, not the submission of the claim, occurs in the grace period that it can still be regarded as a valid claim?	Agreed. ✎See amendment to the wording to clarify the intention.
RULE 20: TERMINATION OF POLICIES				
179.	Rule 20	AVBOB	• The implementation date of Rule 20 is	Noted. However, making the Rule on terminations

No	Section/Rule	Commentator	Comment	Response
			noted as 15 December 2019, however, in terms of Rule 2A an insurer would be able to terminate a policy, in force for a period of 12 months, calculated from the effective date of Rule 2A which is 1 July 2018. The termination provision should therefore be effective from an earlier date for enforceability.	effective earlier would have an unfair impact on the insurance industry that has been afforded 24 months to align their systems and operations to comply with the rule on termination. Rule 2A will be amended to not reference Rule 20. Effectively this will mean that for the time being, the insurer will have to comply with Rule 6 Part V: Rules on Cancellations of policies and Cooling-Off, and when it is replaced with Rule 20, then with Rule 20.
180.	Rule 20.4	BASA	It may be helpful to provide examples or clarity as to what may constitute “other appropriate communication channels”.	It is up to the insurer to establish which communication channels would be appropriate, depending on the level of sophistication of the policyholders, and dependent on the volume and complexity of the information.
RULE 21: MISREPRESENTATION				
181.	Rule 21	Nick Flowers	The amendment is intended to ensure that the common law test of materiality applies. At common law two tests exist, one objective and one subjective, depending on whether there has been a representation or non-disclosure. In removing the wording of a 'reasonable, prudent person', the possibility of a court adopting the subjective test is introduced, which will run contrary to the intended aims of the policyholder protection rules and the TCF Principle. The amended wording has removed the clarity regarding the timing of the representation or non-disclosure - especially as far as non-disclosure is concerned because an insured has a duty to inform an insurer of any material change to the risk. The reference to the time of the policy's issue, variation or renewal was important because it provides clear indication to an insured when the risk is assessed and disclosure is required. The proposed	Noted. Please however note that a reference to a reasonable, prudent person has been included in Rule 21.1 which means that the test will still be an objective one. The wording of this section in the Act has long been the topic of much academic debate. The attempt to clarify and streamline the wording in this clause has been rejected by the commentator. In the interest of not delaying the proposed amendments given the imperative to align the amendment of the PPRs with the effective date of the Insurance Act, the wording will be changed back to the original wording in the Act, which refers to the risk under the policy concerned at the time of the issue or time of any variation thereof.

No	Section/Rule	Commentator	Comment	Response
			amended wording is contrary to the TCF Principle.	
CHAPTER 8: ADMINISTRATION				
182.	2.2 These rules will come into operation as follows: Chapter 1: Interpretation	ASISA	It is requested that the date of publication referred to here which has now been amended to 15 December 2017 is changed to 1 January 2018. • Government Gazette GG 41321 states that "This Notice comes into operation on 1 January 2018". This contradicts the reference to 15 December 2017 in Chapter 8. • All the presentation slides on the replacement PPR from the FSCA have references to the effective date of PPR as 1 January 2018 and it is this date that insurers have been working with in respect of implementing the various rules with transitional periods. • Retaining the 15 December 2017 date results in the transitional period end dates being 15 June 2018, 15 December 2018 etc. which create unnecessary complexity and members strongly request that the date should be 1 January 2018. • The amendments to the LTIA Regulations which were done at the same time as the replacement PPR refer to the effective date (1 January 2018) and not the publication date. These results in a discrepancy in some cases e.g. both of these include requirements for replacements of risk policies which should be effective on the same date but will now have two different effective dates. It is stipulated in Chapter 8 that rule 11 will come into operation on 15 December 2018,	Interpretational difficulty is noted. The table in Chapter 8 will be amended to reflect the dates in the interest of simplicity and to accommodate the request from industry. ✎ Please see the revised table in Chapter 8 on administration in this regard.

No	Section/Rule	Commentator	Comment	Response
			except for rule 11.5.1(j) and rules 11.5.2 to 11.5.4, which will come into operation on 1 July 2018. Does this mean that policyholders from 1 July 2018 until 14 December 2018 only have to be provided with the information as set out in rule 11.5.1(j), and that the other information as set out in rule 11.5.1 only has to be provided from 15 December 2018? Drafting error - This section refers to the commencement date of Rules 15.9 to Rule 15.12. This should be to Rule 15A (1-4). Please see our comments in section C regarding the effective date of these amendments.	
183.	2A	Clientele Life	The proposed effective date of 1 July 2018 will not be achievable, for the new rule 2A, especially if funeral policies are included in the micro insurance policy framework, this will include a redesign of marketing material, policies and IT systems developments and changes will be required. A transitional period of 24 months should be provided from the 1st of July 2018.	Noted. Please see the proposed changes to Rule 2A, and the response to the main issues as set out at the beginning of this consultation report. These product standards will only apply to microinsurance policies offered by a microinsurer once registered as such under the Insurance Act, 2017, and insurers registered under the LTIA and STIA, whose licenses have been converted in terms of Schedule 3 of the Insurance Act. The Insurance Act allows for a period of 2 years after the effective date of the Insurance act for licenses to be converted. The Prudential Authority will, through the license conversion process, engage the insurer on how existing policies should be aligned to legislated requirements. This will be done in cooperation with the FSCA. We therefore submit that there will be sufficient time allowed for insurers to align existing policies to the new product standards.
184.	2.2	Clientele Life	Comment – There was a contradiction previously with regards to the effective date. Government Gazette GG 41329 states that "This Notice comes into operation on 1	Interpretational difficulty is noted. The table in Chapter 8 will be amended to reflect the dates in the interest of simplicity and to accommodate the

No	Section/Rule	Commentator	Comment	Response
			January 2018". This contradicts the reference to 15 December 2017 in Chapter 8. All presentations, including the FAIS Conference, have references to the effective date of PPR as 1 January 2018 and insurers have used this date for all planning and implementation during the transitional phase. It is requested that the date of publication referred to here which has now been amended to 15 December 2017 is changed to 1 January 2018.	request from industry. ✎ Please see the revised table in Chapter 8 on administration in this regard.

SECTION E - GENERAL COMMENTS: LONG-TERM PPRs

No.	Issue	Commentator	Comment/input	Response
185.	Funeral insurance business	African Unity Life	Does the FSCA still plan to do something separate for the funeral parlour type businesses?	Work remains underway to focus on an appropriate regulatory framework for funeral parlours. The proposals will be consulted on with industry stakeholders.
186.	Application of product standards in 2A to funeral policies	ASISA	<u>General comments on the product standards in 2A</u> Product standards for microinsurance products have been expected since the finalisation of the National Treasury policy document on Microinsurance in 2011, which was published in July 2011 and is titled "The South African Microinsurance Regulatory Framework" and therefore, despite the long period of time which has passed, they do not come as a surprise and are more or less what ASISA members expected. There has however been no prior consultation or any indication given by the policymaker or regulator prior to the release of these	Noted. Please see responses to each of the bullet points below.

			"Tranche 2 PPR amendments" about including funeral policies in the product standards for microinsurance policies. The reasons given by the FSCA in their statement on the proposed amendments is that funeral policies are generally not complex and in many instances are taken up by low income earners; that it will ensure a level playing field between microinsurers and traditional insurers in respect of funeral policies and that all policyholders will be afforded the same protections. ASISA members' view is that these reasons do not warrant the inclusion of funeral policies in the microinsurance product standards because: • Policies which include funeral benefits can be more complex as they may include savings benefits as well as other risk benefits and funeral benefits are often provided as a rider benefit on risk policies. The rules on advertising in section 4.2 will effectively curtail these combination policies or funeral rider benefits and having to provide a funeral policy as a stand-alone policy is not in all customers' interests, because these types of policies reduce the need for policyholders to purchase multiple policies and provide them with more flexibility to change benefits in the policy as their needs change. Premiums may also be less than having separate policies as administration expenses are lower. • Funeral benefits, although a relatively	Noted. Traditional insurers will be allowed to write rider benefits as prescribed by the Prudential Authority in Governance and Operational Standards (GOI7). The Insurance Act, 2017 introduces the classes of business as set out in Schedule 2 of the Act, in terms of which insurers will have to be authorised and report on to the Prudential Authority. The rules do not prohibit the offering of combined policies subject thereto that the insurer is authorised by the Prudential Authority to offer policies for which the description of the policies fall within the classes of business. This limitation was introduced to ensure that policies cannot be market as providing funeral benefits unless it meets the description of the Funeral Class of business as set out in Schedule 2 of the Insurance Act, 2017 and the insurer is authorised to offer such policies. The requirement was deemed necessary in order to avoid insurers circumventing the application of the microinsurance product standards by writing funeral type policies under the Risk (Death) class of business, as the microinsurance product standards would only

			simple product, are not only designed for low income earners; nor are they sold to, or aimed at, only low income earners. Funeral provision is a universal need, and funeral products are sold to all income segments, including middle to affluent customers. Funeral products are developed after research has been conducted to meet the needs of specific policyholders. Including all funeral policies in Rule 2A does not appear to take into account that these policies must be developed to meet and address different needs and that this is a requirement under Rule 1.4(b) of the PPR which requires insurers to give effect to the following TCF outcome: "(b) products are designed to meet the needs of identified types, kinds or categories of policyholders and are targeted accordingly".	apply to insurers when selling funeral type policies under the Funeral Class as was seen in respect of live versus assistance policies under the prevailing framework. We remain of the view that the microinsurance product standards should apply to traditional insurers selling funeral policies because funeral policies are significant in facilitating financial inclusion objectives and un-level playing field between microinsurers and traditional insurers in the funeral insurance market must be avoided. The prohibition on marketing polices to cover funeral costs will be amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers. We agree that funeral benefits are not only intended to serve the low income market. However, the rationale for having a separate class for funeral was also informed by conduct of business supervisory concerns. Similar caps are appropriate as funeral insurance is an inclusion product and, primarily the first insurance policy that most consumers purchase / enter into, irrespective of the fact that the policy is underwritten by a microinsurer or another type of insurer. The additional protections afforded to this class of insurance business through these product standards are therefore necessary. The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured, which will alleviate most of the concerns raised.
			• One of the particular areas of concern with the product standards is the proposal that microinsurance and funeral insurance policies should have a contract term of not more than 12 months. The Microinsurance policy	The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies and not to funeral policies offered by traditional insurers, as the limitation is

			document referred to above says on page 9 that the intention is to include a maximum term for "*microinsurance policies*" and specifically states as follows: "*As contract term is one of the primary drivers of the level of prudential risk, this limitation is central to allowing a lighter regulatory regime for dedicated microinsurers. This is not to say that longer-term products do not hold value to lower-income households, but the increased complexity of these longer-term products requires the more onerous regulatory regime currently applied to insurers.* The product standards for microinsurance products go hand in hand with significantly reduced prudential requirements and other less onerous regulatory requirements for mircroinsurers as well as the ability to pay uncapped commission. The thinking has always been that these would enable microinsurers to effectively compete with traditional insurers (who have to incur the costs of full prudential requirements) so it is not understood why the same product standards must now apply to funeral policies offered by traditional insurers in order to level the playing fields. ASISA members do not think that it is appropriate to use a measure that was intended to address a prudential risk to address market conduct risk concerns. • The policy document on pg. 60 also says that *"the microinsurance*	primarily included to support the prudential framework for microinsurers. The aim of the Microinsurance framework is to facilitate financial inclusion and enterprise development without being subject to the onerous solvency requirements applicable to traditional insurers. If the product standards were not applicable to funeral policies offered by traditional insurers, traditional insurers would be at an unfair advantage to new microinsurers. In the absence of any specific examples or instances where the requirements in these rules are not appropriate to microinsurance products we submit that the PPRs are drafted in a sufficiently principle based manner in order for them to be applied proportionately. Also see responses to comments in the body of the matrix above.

			proposals... cement a rules-based approach to prudential regulation (with a degree of product regulation) that differs fundamentally from the principles-based direction that insurance supervision for the traditional market is heading". It is not clear why the principles-based approach as followed in the PPR is not considered sufficient for the regulation of traditional insurers. Including funeral policies in the product standards that were always consulted on and drafted specifically for microinsurance products is a very disruptive change and will seriously impact ASISA members as well as customers. If some product standards for funeral policies offered by traditional insurers are considered necessary in order to address market conduct concerns, then ASISA members are firmly of the view that while in a few cases the same product standards for microinsurance products and funeral policies may be appropriate, in a number of cases they need to be different. The need for these differences is set out in our specific comments below. ASISA members suggest a separate set of product standards for funeral policies, as appropriate and where necessary, to address market conduct concerns.	Noted. Work remains underway to focus on an appropriate regulatory framework for funeral parlours. The proposals will be consulted on with industry stakeholders. That said, the imperative to include product standards for microinsurance at this point in time is vital to ensure an appropriately functioning regulatory framework. We are of the view that the amendments made based on the comments received will appropriately and sufficiently mitigate the risks as set out in your comments.
187.	Consultation and comment period	ASISA	ASISA members appreciate the explanatory document provided by the FSCA and the version provided of the proposed amendments with tracked changes and comments. Whilst members are aware of the time constraints of the FSCA to finalise and publish the amendments by 1 July 2018 to	Noted. We would appreciate any data and statistics that the commentator may have to substantiate the concerns raised.

			coincide with the proposed effective date for the Insurance Act the time allowed has not been sufficient as it has been during a period with numerous public holidays and school holidays. The inclusion of funeral policies in the product standards was totally unexpected and a completely new development and further consultation on this inclusion is necessary. ASISA would like to provide some statistics from members showing the number of funeral policies currently written under their life licences (versus their assistance business licence) but there hasn't been sufficient time to do this. However, ASISA members are currently undertaking this exercise, and these will be provided to the FSCA as soon as possible.	
188.	Effective date and transition periods	ASISA	An effective date of 1 July 2018 or once a registered insurer becomes a licenced insurer will not be achievable for the following proposed amendments: Rule 2A for funeral policies as a redesign of these will be necessary as well as IT developments and changes. The transition period needed will depend on the content of the final amendments and we would like an opportunity to give input on this to the FSCA once these are known, but at this stage request that a transitional period of 24 months is provided irrespective of when an insurer moves from being a registered insurer to a licensed insurer.	These product standards will only apply to microinsurance policies offered by a microinsurer once registered as such under the Insurance Act, 2017, and insurers registered under the LTIA and STIA, whose licenses have been converted in terms of Schedule 3 of the Insurance Act. The Insurance Act allows for a period of 2 years after the effective date of the Insurance Act for licenses to be converted. The Prudential Authority will, through the license conversion process, engage the insurer on how existing policies should be aligned to the requirements in legislation. This will be done in cooperation with the FSCA. We therefore submit that there will be sufficient time allowed for insurers to align existing policies to the new product standards. Also see the transitional period of 2 years and 10 months allowed in Rule 2A.2.2 to allow for alignment of existing policies that offer funeral benefits to the product standards set out in Rule 2A of the LTIA PPRs. The period effectively allows for one year after the 2 year conversion of licensing period, as referred to in Schedule 3 of the Insurance Act, for insurers to align all existing policies that meet the description of funeral

			Section 2.5 & 2.6 for funeral policies- an effective date of 1 January 2019 is proposed.	in schedule 2 of the Insurance Act. Noted, however the requirements are existing requirements for assistance polices, and will only apply to policies written under the funeral class of business once existing insurer's licenses have been converted in terms of Schedule 3 of the Insurance Act. The requirement has been amended and will no longer apply to all life polies, but only to assistance policies, and policies written in the funeral class of business by life insurers and microinsurers.
189.	Effective date of 15 December 2017	AVBOB	Tranche 1 PPR provided that the applicable sections would come into effect from the date of publication of the Notice in the Government Gazette, however, the Notice came into operation on 1 January 2018. It is our view that the effective date of 15 December 2017 cannot have application before the Notice came into operation.	Interpretational difficulty is noted. The table in Chapter 8 will be amended to reflect the dates in the interest of simplicity and to accommodate the request from industry. ✎ Please see the revised table in Chapter 8 on administration in this regard.
190.	Definition of "Days"	AVBOB	Is the reference to days – business or calendar days?	The requirements in the Microinsurance product standards have been amended to business days as defined in section 2 of Chapter 1 of the PPRs.
191.	• Restrict the funeral insurance market's access to appropriate and good-value insurance products; and • Place the protection of consumers at risk.	ASSUPOL	**1. Restricting the funeral insurance market's access to appropriate and good-value insurance products** The following aspects of the Proposed Tranche 2 PPRs in our view limit the ability to provide comprehensive access to the full range of appropriate and good value insurance products to the wider funeral insurance market, namely: • Restricting the use of the term "funeral policy" to products that fall within the	Noted. Please see responses to each of the bullet points below. The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured, which will alleviate most of the concerns raised. The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month

			narrowly defined microinsurance and funeral policy product standards[1]; and • The requirement that "funeral policies" should be limited to a term of 12 months[2]. In this regard we would like to note the following points: • Clients should continue to have the same access to the full and comprehensive range of funeral products, not simply to those provided under the auspices of the Proposed Tranche 2 PPRs. Not allowing life insurers to brand products that are specifically designed to meet the funeral needs of their customers as funeral policies because they fall outside the proposed new narrowly defined microinsurance and funeral policy product standards (including, for example, whole of life funeral products, etc.) would ultimately prevent access to a set of products that have proven their worth beyond doubt. • It is not only the lower income market that requires funeral products. Every person regardless of class will need a funeral policy. Reserving the use of the word “funeral” for the narrowly defined proposed funeral class only would not be in the interest of the middle income and higher income consumers who require funeral cover outside the ambit of the restrictions	limitation on a contract term will only apply to microinsurance policies and not to funeral policies offered by traditional insurers, as the limitation is primarily included to support the prudential framework for microinsurers. This limitation was introduced to ensure that policies cannot be market as providing funeral benefits unless it meets the description of the Funeral Class of business as set out in Schedule 2 of the Insurance Act, 2017 and the insurer is authorised to offer such policies. The requirement was deemed necessary in order to avoid insurers circumventing the application of the microinsurance product standards by writing funeral type policies under the Risk (Death) class of business, as the microinsurance product standards would only apply to insurers when selling funeral type policies under the Funeral Class as was seen in respect of live versus assistance policies under the prevailing framework. We remain of the view that the microinsurance product standards should apply to traditional insurers selling funeral policies because funeral policies are significant in facilitating financial inclusion objectives and un-level playing field between microinsurers and traditional insurers in the funeral insurance market must be avoided. The prohibition on marketing polices to cover funeral costs will be amended and moved to the general rule on advertising (Rule 10), as it will apply to all insurers and not only microinsurers.

[1] Draft Rule 2A.3.2
[2] Draft Rule 2A.4.2

			contained in the proposed Rule 2A. Consumers also often have a need for rider benefits, such as premium cash back and premium waiver features. Furthermore, it is not clear if rider benefits such as premium waivers would be permissible under Proposed Tranche 2 PPRs, but if it is not, we submit that this is a critical benefit to the market.	
			• Life policies offered often includes the option to add funeral benefits for the spouse, children, parents and other family members. Not allowing this will mean that separate policies will have to be taken out for this very real need.	Traditional insurers will be allowed to write rider benefits as prescribed by the Prudential Authority in Governance and Operational Standards (GOI7). Add-on funeral benefits are not prohibited, but will be required to meet the product standards as set out in Rule 2A.
			• The access to funeral products, equally so in the lower income markets, is to a large extent facilitated by the various intermediaries (mostly insurance sales representatives) operating in the market. Although there are areas in which the provision of advice could be improved, we fundamentally believe that on the whole clients are significantly better off if they have access (or at least the choice of having access) to appropriate face-to-face advice and guidance.	Comments regarding access to advice noted. It is unclear what the concern is here, as commission for funeral policies and microinsurance policies will be uncapped.
			• The current Proposed Tranche 2 PPRs, in particular insofar as the ability to appropriately remunerate sales representatives to provide such advice, would prevent the objective of	The product standard does not in any way restrict the use of intermediaries or access to advice. The product standards are also not prescriptive on commission structures.

			providing wide and cost-effective access being achieved. This is especially true in most rural areas. • In this regard, the 12-month term limitation, restricts the life insurer's ability to appropriately remunerate sales representatives to provide such advice, as 12 months' premiums are inadequate to fund the costs of providing insurance cover as well as funding the expenses associated with the distribution activities. For this reason, face-to-face advice is arguably more suitable when selling whole life policies. **2. Placing consumer protection at risk** We believe that the introduction of Rule 2A as contained in the Proposed Tranche 2 PPRs and in particular the product standards would not necessarily result in an improvement of the protection of customers, in fact there are some aspects that would generally operate to the detriment of customers. • One aspect that is specifically concerning is the effect of the provision that limits the duration of funeral policies to 12 months[3] on premium patterns and product structures. Given that funeral policies are	The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies. This limitation was introduced to ensure that policies cannot be market as providing funeral benefits unless it meets the description of the Funeral Class of business as set out in Schedule 2 of the Insurance Act, 2017 and the insurer is authorised to offer such policies. The requirement was deemed necessary in order to avoid insurers circumventing the application of the microinsurance product standards by writing funeral type policies under the Risk (Death) class of business,

[3] Draft Rule 2A.4.2

				proposed to have a contract term of not more than 12 months[4] (albeit renewable) and that there are no obligations on the insurer to hold long term reserves in respect of the funeral business, there are two potential ways that funeral products can be priced and managed, namely: • Premium rates increase with age. The Proposed Tranche 2 PPRs make no allowance for the long-term liabilities that arise in traditional level premium business due to the upward sloping mortality curve (i.e. premiums in the early years of the policy term fund expected claims as the policy ages and expected claims increase). Consequently, as the policyholder ages, the premium will have to rise and in extremis will become unaffordable, especially since income tends to fall after retirement. • Alternatively, life insurers will rely on new business to keep average premium rates lower. In this case, new and younger policyholders will keep the average age and hence mortality / risk of the book of business stable. Interestingly this is the dynamic underpinning most business written on a group basis.	as the microinsurance product standards would only apply to insurers when selling funeral type policies under the Funeral Class as was seen in respect of live versus assistance policies under the prevailing framework.

[4] Draft Rule 2A.4.2

			Both alternatives are feasible, however it does give rise to some interesting dynamics. In the scenario where the life insurer structures its premium rates to increase as the policyholder ages, it is highly likely that for the reasons highlighted above, lapse or termination rates will increase dramatically as the policyholder ages. This is likely to result in inequitable outcomes for policyholders, more so in the funeral space than in the traditional life insurance market. We say this because, a funeral policy, is as its name suggests is bought to fund the cost of a funeral (which everyone can be quite confident will be necessary at some point), yet under the scenario we have just articulated, older policyholders who have contributed premiums for a long time may lose their cover because of the inexorable increase in premiums that is an outcome of the term limit placed on microinsurance and funeral policies (and the associated prudential standards). While traditional life cover is often only needed temporarily (to repay debt or to meet future education liabilities), it should be possible to also sell funeral business on a whole of life basis, as under these circumstances all our policyholders know they are going to have a funeral that will be funded from somewhere. It is therefore our considered view that by limiting the term of funeral business to one year and not also allowing whole of life policies, some policyholders will	

				inevitably be prejudiced if they live long enough that their premiums become unaffordable. This, we believe, is unlikely to be an outcome the regulators intended. Where a life insurer relies on new entrants to keep the average age and hence mortality experience of its policyholder book stable, the increase in premiums we have just articulated could probably be avoided. It is however inevitable that some life insurers will not be able to source enough new business, which will ultimately give rise to the scenario we articulated above. Furthermore, those that fail to attract sufficient new business could arguably end up increasing premiums, making it more difficult to attract new business and likely that younger (and profitable) policyholders will leave, resulting in a "death spiral." In short, policyholders in this scenario will be dependent on the new business success of the life insurer they are joining to ensure that their premiums do not rise to a level that becomes unaffordable. Traditional whole of life funeral business addresses the aforementioned concerns by setting aside reserves to cater for the increase in mortality risk. In aggregate therefore we would argue, that it is not in the interests of the public to sell funeral business on a 12-month term basis only, as both of	We remain of the view that the microinsurance product standards should apply to traditional insurers selling funeral policies because funeral policies are significant

			the scenarios we have articulated above result in the industry failing to deliver (for all or at the very least some policyholders) what the client actually wants, which is a dignified funeral which they have paid for themselves. In the former scenario, many if not most older policyholders will not be able to afford funeral premiums at a time when they arguably need a funeral policy most, and in the latter scenario, the Regulator can expect to be faced with the certainty that some policyholders will have been prejudiced by the failure of their life insurer to generate sufficient new business. We specifically submit that traditional insurers should be allowed to continue to provide funeral policies on a whole of life basis, and not only on a 12-month term cover basis. We note from the National Treasury Policy document that this restriction was included to limit the nature of products that microinsurers can issue because of the less onerous capital requirements and regulatory regime. Traditional insurers would however not benefit from the lighter regulatory regime and should therefore not be restricted from writing whole of life funeral policies. • In addition, the proposal that a microinsurance policy or a funeral policy may not impose a waiting period exceeding one quarter of the	in facilitating financial inclusion objectives and un-level playing field between microinsurers and traditional insurers in the funeral insurance market must be avoided. See the amendments to the Rule allowing waiting periods for the shorter of one quarter of the term of the policy, or 6 months. Please refer to item 2.1.1(h) of the National Treasury Microinsurance Policy Document, which sets out the rationale for restricted waiting periods. The limitation on waiting periods is intended to balance the risk of adverse selection in situations where no individual underwriting occurs against the risk of unreasonably lengthy waiting periods which could adversely affect policyholders. The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies. See the amendments to the Rule allowing waiting periods for the shorter of either one quarter of the term of the policy, or 6 months.

				term of the policy (effectively three months)[5] could have a significant impact on the ability of microinsurers and funeral insurers to sustainably provide affordable and appropriate cover to its clients, which in turn also lessens the protection that clients are likely to receive under the currently proposed microinsurance and funeral policy regime. Assupol's mortality investigations indicate that reducing the waiting period from the current industry standard of six months, will increase the cost of mortality significantly. 15% of all of Assupol's claims (across the entire book of business) arise from policies that are less than six months old. This indicates high levels of anti-selection. All other things being equal, it is our considered view that a reduction of the waiting period from six months to three months would require life insurers to either materially increase their premium rates and / or render the products on a potentially unprofitable manner. We fully support the concept of a "no waiting period on replacement"[6]. In our experience, the most important problem by far on the replacement of a policy, is the waiting period of the new policy. An unhappy policyholder, or one faced with the opportunity to	

[5] Draft Rule 2A.6.1
[6] Draft Rule 2A.6.5

				obtain a cheaper policy is currently caught between a rock and a hard place. The policyholder can't replace their provider without a six-month gap in cover for death from natural causes. (The only way to avoid a six-month long reduction in cover is to pay double premiums for six months.) This situation is clearly undesirable. This concept of having portable guaranteed insurability option is socially desirable and in the interests of the industry, as is the case with the medical scheme industry. However, we believe that the first (lifetime once-off) waiting period should be sensible to avoid anti-selection (not so much to protect insurers, because they will price for it, but to remove the moral hazard and the temptation and opportunity for fraud). Given that the waiting period will be applied only once in a lifetime, allowing six months instead of three months will avoid many pitfalls without being onerous or unfair for any individual. We understand and agree that a six-month waiting period on a 12-month policy is not appropriate, but the problem lies in the 12-month policy term and not in the six-month waiting period. Rule 2A.6.5 also requires an amendment to ensure that the guaranteed insurability transfer	

			happens from a specific replaced policy to only one other replacing policy (i.e. a policyholder should not be able to replace one policy with multiple others on the strength of the initial policy's insurability "certification"). **3. Conclusion** In conclusion, we respectfully submit that, in order for the Proposed Tranche 2 PPRs to fully achieve all of its stated objectives, the FSCA should give serious consideration to the following, namely: 1. We believe that the 12-month term requirement relating to funeral policies has many unintended consequences that negatively impact the value that consumers are likely to enjoy from the insurance sector generally. Consequently, we would propose that consideration is given to allowing whole of life funeral policies to be written by life insurers within the funeral product classification. 2. A combination of the proposed reduction in the waiting period, the introduction of portable insurability and the proposed reinstatement rights will increase the cost of cover significantly thus reducing consumers' access to affordable cover. Retaining a six-month waiting period would allow the introduction of insurance portability without increasing cost significantly. Assupol would sincerely appreciate the	

			opportunity to present our comments in person and our Group CEO and Life CEO would avail themselves at dates and times suitable to you, to do so. Assupol is a fully-transformed successful insurer with an enviable track record of providing affordable products for the market under consideration. As a well-transformed entity, we believe that Assupol is well-placed to play a constructive role in achieving the objectives of transformation, access and policyholder protection as envisaged in the Proposed Tranche 2 PPR's. Thank you once again for the opportunity to provide you with comments on the Proposed Tranche 2 PPRs in order for it to fully achieve the noble objectives it has set out to achieve.	Noted thank you.
192.	Microinsurance and funeral	BASA	The larger question remains as to why funeral has been included in the requirements for microinsurance. Microinsurance, being a new concept, will allow businesses to develop products and systems in line with the requirements. The inclusion of the funeral product will result in changes being necessary to the status quo, resulting in the issues highlighted below: a. Currently, businesses allow potential policyholders to take out funeral policies with benefits exceeding the suggested R60 000.00 cap. This does not curtail an insurer from offering policyholders benefits in excess of the cap, as the policy may be classed under the life category. However, the term 'funeral' may not be used. This may create confusion for the policyholder who currently holds a 'funeral' policy or requests one in future.	The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured, which will alleviate most of the concerns raised.

			Although it is noted that the source of the confusion results from the draft GOI standard. b. Clarity is sought as to the reason for the restriction of the term of the policy. Although protection is provided to the client in terms of the automatic renewal, this may result in confusion to the client who is under the impression that the policy terminates after 12 months. 12 month contract is more akin to short term insurance c. The waiting period and exclusion restrictions creates a serious impact on the way the policies are priced. At present our policies are priced on a 6 month waiting period and should the period be decreased to a maximum period of the 3 months, the premium will undergo a significant increase. Industry standards and even private arrangements like Stokvels are 6 months. d. There is disconnect between the requirements imposed by the CCI regulations and the requirements imposed under microinsurance. CCI allows for certain restrictions, however provides a premium cap. The PPRs do not allow for certain exclusions. The result being that the likelihood of the product meeting both sets of restrictions is less. e. 7.3 seems unfairly penal on an insurer	The concerns regarding the application of the contract limitation is noted, and the wording of the product standards were revised to specify that the 12 month limitation on a contract term will only apply to microinsurance policies. Noted. See the amendments to the Rule allowing waiting periods for the shorter of either one quarter of the term of the policy, or 6 months. Noted. See amendment to the rule on waiting periods to align to the NCA Credit Regulations
193.	Microinsurance Maximum Limits	BASA	Maximum Limits From our experience with our policyholders, a benefit cap of R 60 000 may not always be sufficient to cater for funerals. Policyholders	The Prudential Authority increased the limit prescribed for funeral policies to R100,000 per life insured, which will alleviate most of the concerns raised.

			vary in the way they structure funeral policy to accommodate variety of their needs. This is not always capped at R 60 000. On the other hand the Accident and Health (A&H) maximum limit of R 120 000. Clarity is sort on whether both risk events are allowed on one Microinsurance policy to accommodate the needs of the policyholder.	
194.	Microinsurance Waiting Periods	BASA	Waiting Periods Clarity is sort whether the waiting period will be applied the same way as in the Demarcation Regulation i.e. if the insured has proof of serving a waiting period at another insurer we cannot enforce a further waiting period. We therefore propose that the policyholder serve the balance of the waiting period.	The application of the micro insurance standards comes down to the same principle. See amended Rule 2A.7 in this regard.
195.	Microinsurance Reporting	BASA	Reporting Clarity is sort on whether this is a filing procedure that insurers need to comply with or will they prevent insurers from launching the product. From our understanding non-submission would imply non-compliance. We therefore advise FSCA to clearly stipulate timelines for insurers to either remove the product, or be allowed to make changes to the product to ensure compliance	This aligns to the proposal in the National Treasury Microinsurance Policy Document relating to product regulation. Please see item 2.1.2 on page 15 - 16 of the policy document in this regard that proposes that product review will take place on a file-and-use basis. Note that this is not a “pre-approval” basis. The policy document sets out a detailed explanation for the proposed approach to regulation of microinsurance products in this section. The intention is for these products to have appropriate oversight to ensure that microinsurance products are appropriately designed and marketed in order to ensure fair outcomes for a particularly vulnerable segment of customers. The approach enables the supervisor to proactively monitor product development trends in this vulnerable market, and to pre-emptively identify potential risks of unsuitable product design practices.
196.	Microinsurance and funeral	Clientele Life	The inclusion of funeral policies in the product standards is most unexpected to us, and we would like to require further consultation on this inclusion.	Noted. Please note that the revised draft standards have removed application of the product standards to funeral policies based on the comments received. We remain of the view that some of the standards should

			The lower LSM market conditions remains an important factor and the lower LSM policyholder should not be prejudiced in terms of financial inclusion, seeing that they don't have access to data or airtime to renew a contract or in the event that they are not contactable. We support the micro insurance framework, but not to the detriment of policyholders and the South Africa economy which is supported by Insurers. The freedom of choice must still remain with the policyholders, in terms of the policies suitable for their needs.	equally apply to funeral policies in the interest of affording equal protection to policyholders regardless of their sophistication or affluence. Microinsurance policies will be automatically renewable. The Microinsurance product standards will not impede on policyholders freedom of choice, and rather ensure fair outcomes for a particularly vulnerable segment of customers.
197.	Microinsurance	DMASA	We respectfully submit that there is no evidence that enough consideration has been given to specific distribution channels (direct marketing and sales execution) and the practical implications of the Rules governing these activities, to ensure effective and appropriate regulation of these products.	Noted. We however hold the view that the changes introduces based on the public consultation process sufficiently addressed the concerns. Also, the disclosure requirements in the PPRs have been drafted through the Tranche 1 amendments with extensive input from the industry. The requirements are drafted in an appropriately principle based manner as to cater for all the different distribution models. If there are any specific requirements that would have unintended consequences for a specific business model, information in this regard will be considered.
198.	General Comment on Microinsurance	FPI	A July 2008 FSA report, Financial Capability: A Behavioural Economics Perspective, argued that people's financial behaviour may primarily depend on their intrinsic psychological attributes rather than information or skills or how they choose to deploy them. The report suggested two modes of financial capability could be promising: (a) directing people to a particular financial action and (b) active intervention by a counsellor and/or individualized advice. As governments shift responsibility for financial	Noted. Detailed comments received through the public comment process will inform the final PPRs. The caution on a possible impact on costs is duly noted and will be balanced against ensuring that appropriately designed products are placed in the market to ensure fair outcomes for customers. Although a product approval programme may achieve broad regulatory oversight, the costs and impact of such a programme without having the appropriate systems and resources in place to consider and

			wellbeing to consumers, and financial products increase in number and complexity, an increased level of financial capability is needed to balance the asymmetry of information among consumers and financial services providers and practitioners. **What's in the Product?** FPI supports the TCF principles which require that products and services marketed and sold should be designed to meet the needs of identified consumer groups and targeted accordingly. Consumers should receive clear information and be kept appropriately informed before, during and after the point of sale. Consumers should be provided with products that perform as product providers have led them to expect, and the associated service should be of an acceptable standard and as the consumers have been led to expect. Finally, consumers should not face unreasonable post-sale barriers imposed by product providers to change product, switch providers, submit claims or make a complaint. South Africans should be able to assume that all financial product manufacturers/providers would ensure that financial products are "true to purpose" and are provided to customers along with documentation indicating the product's purposes and risks. Similarly, financial advisers should have a reasonable expectation that a product will perform as expected for the client. Mis-selling of these products often arises when there is an insufficient duty of care afforded to the customer by those whose personal interests	approve such products before they are introduced in the market, are not ideal. The suggested file-and-use system is submitted as a viable alternative to product pre-approval, with less risk of disruption to businesses.

			or external obligations conflict with public expectations and customer needs of the products. There is a role for regulators to develop mechanisms to evaluate the "safety" of financial products for the retail market, and provide guidance related to their sale and use. FSCA has a good understanding of which financial products currently, or soon to become, available in South Africa carry greater levels of risk, particularly those with applications in the retail market. By adopting a form of product approval, regulators could ensure that the financial products being sold in the retail market were appropriate for that segment and accompanied by sufficient documentation and disclosures to customers. Given the effort and cost required for such a program, it would make sense to focus on those products already proven to have caused the most damage in the retail market, as well as future generations of those products planned for release in the retail market. **We support the product standards in so far as, they meet the principles above. Based on the discussions in the workshops run by the FSCA the products standards must carefully be considered and not lead to a higher cost for the consumer.**	

199.	2A Microinsurance Product Standards	Janice Angove	Some of the proposals microinsurance product features from the National Treasury Policy document are not included in the microinsurance product standards: • Grace period of 30 days • Simplified disclosure	Noted. Any deviations to the suggestions in the policy document, was done in consultation with National Treasury. Both the mentioned areas are addressed in the PPRs.
200.	Complexity of the principles-based requirements for the implementation of the Treating Customers Fairly principles for microinsurers	Janice Angove	Although these provisions are important for microinsurance and funeral insurance it may be difficult for microinsurers to interpret and implement many of the rules implementing the Treating Customers Fairly framework. It might be helpful to facilitate compliance with the regulatory environment to express these requirements in simpler terms and consider the proportionate application of these requirements.	Noted. As the PPRs are drafted in a primarily principle based manner, it lends itself to a risk based proportionate regulation thereof. The FSCA will take such a proportionate approach in supervising microinsurers.
201.	Assistance products sold prior to the implementation of the new Microinsurance and Funeral Insurance product rules	KGA Life	Is it correct to assume that assistance assurers who convert to either a Microinsurance or an Insurance Class 4 (Funeral Insurance) license would be allowed to run-off existing books of business where products no longer conform to Microinsurance or Funeral Insurance product definitions?	As the conversion of existing licenses will be done by the Prudential Authority, we recommend that the commentator engage with this Authority as the responsible Authority for licensing. Details on how existing policies are dealt with will form part of the licence conversion process. See specifically Item 6(5) of Schedule 3 to the Insurance Act, 2017, in this regard. Also see the transitional period of 2 years and 10 months allowed in Rule 2A.2.2 to allow for alignment of existing policies that offer funeral benefits to the product standards set out in Rule 2A of the LTIA PPRs. The period effectively allows for one year after the 2 year conversion of licensing period, as referred to in Schedule 3 of the Insurance Act, for insurers to align all existing policies that meet the description of funeral in schedule 2 of the Insurance Act.
202.	Capping of funeral policies for traditional insurers	Outsurance Life	It does not make sense to have the same cap for a micro insurer and a fully-fledged insurer. The insurer has more onerous capital and other requirements and should not be subjected to the same cap as a micro insurer. It is not clear why there would be a cap of R60 000 in cover. Inflation and the exchange	Noted. The cap is prescribed under the Prudential Standards to ensure appropriate supervision and reporting of this class of business. However, the rationale for having a separate class for funeral was also informed by conduct of business supervisory concerns. Similar caps are appropriate as funeral insurance is an inclusion product and, primarily the first

			rate put significant pressure on the buying power of the ZAR. The limit for policies categorised as assistance business was raised in recent years from R18 000 to R30 000 in recognition of the rising cost of funerals and the need for higher cover amounts, so it is counter intuitive to place a cap at this level. Clients will still seek the cover they require and they will achieve this buy purchasing multiple policies and that will mean they will carry the expense portion of the premium on multiple policies instead of on a single consolidated policy.	insurance policy that most consumers purchase / enter into, irrespective of the fact that the policy is underwritten by a microinsurer or another type of insurer. The additional protections afforded to this class of insurance business through these product standards are therefore necessary.
203.	Misrepresentation	Nick Flowers	In support of the above-mentioned comment, please see the Word document attached to my submission. (Legal opinion annexed to document)	Legal opinion noted. Please see the response to the comment in the body of the matrix.

Opinion on Materiality:

Submitted by Nick Flowers

What's Materiality Got to Do with It?

Introduction

On 2 March 2018 the Financial Services Board ("**FSB**") published for comment proposed amendments ("**Amendments**") to the Policyholder Protection Rules ("**PPRs**") under both the Long-term Insurance Act, 52 of 1998 ("**LT Act**") and Short-term Insurance Act, 53 of 1998 ("**ST Act**"). The Amendments aim to 'provide for certain conduct of business related requirements that will be repealed from the [LT Act] and the [ST Act] through Schedule 1 to the Insurance Act, 18 of 2017 ("**Insurance Act**")'.[7]

One of the key Amendments to be made, concerns misrepresentations and the instances when an Insurer may rely on a misrepresentation as a ground for repudiation. The current wording of the ST Act[8] at section 53 reads:

'(1)

(a) Notwithstanding anything to the contrary contained in a short-term policy, whether entered into before or after the commencement of this Act, but subject to subsection (2)—

i. the policy shall not be invalidated;

ii. the obligation of the short-term insurer thereunder shall not be excluded or limited; and

iii. the obligations of the policyholder shall not be increased, on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is such as to be likely to have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any renewal or variation thereof.

[7] See the FSB's 'statement On Proposed Amendments to the Policyholder Protection Rules Made under the Long-Term Insurance Act, 1998 And The Short-Term Insurance Act, 1998'.
[8] For the sake of brevity, this opinion will focus on misrepresentation in the context of the ST Act, but the viewpoint is equally applicable to the LT Act, since the wording and Amendments are identical.

(b) The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the short-term insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk.'

The wording under the Amendments under Rule 20 will read:

'Notwithstanding anything to the contrary contained in a policy, but subject to rule 20.2-

i. the policy must not be invalidated:

ii. the obligation of the insurer under the policy must not be excluded or limited; and

iii. the obligations of the policyholder must not be increased.

on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is likely to have materially affected the insurer's ability to assess the risk under the policy concerned at the time of the representation or non-disclosure.'

What should become immediately apparent upon first reading is the complete absence of subsection (b) ("**Subsection**") from that of the PPRs. The absence of this Subsection cannot be appreciated without first understanding the nature of misrepresentations and how this Subsection's insertion into the ST Act came about.

Nature of a Misrepresentation

A misrepresentation is where an insurer is supplied with information that is false or misleading; such conduct is delictual in nature.[9] Misrepresentations may either be positive or negative. A positive misrepresentation is where an insured provides an incorrect response to a question in a proposal form.[10] A negative misrepresentation occurs where an insured fails to disclose a material fact which is in his/her/its knowledge.

As discussed above, a misrepresentation constitutes a delict, it follows then that all the elements of a delict will need to be proven, namely: conduct, fault, wrongfulness, causation and harm. The court in *McCann v Goodall Group Operations (Pty) Ltd*[11] stated '*there is no difference in principle between a misstatement and a non-disclosure, inasmuch as either can create a misrepresentation but liability will follow only if the prerequisites have been complied with'*. However, South African courts have utilised different approaches as to determining wrongfulness in respect of positive or negative misrepresentations, particularly where materiality is concerned.

Historical Position on Wrongfulness and Materiality

A misrepresentation can only be actionable if it is wrongful.[12] In order for this element to be met the misrepresentation must relate to a material fact. [13] Initially, two separate tests existed for materiality. The first test was that of the 'reasonable insurer'; if facts influenced the minds of prudent and experienced underwriters assessing the risk, then the facts were material.[14] The other test was that of a 'reasonable insured': which considered whether the reasonable insured would regard the particular facts as relevant to the assessment of the risk.[15] Both tests clearly favour either the insured or the insurer. As a result of this favouring, there was a determination of materiality which failed to encompass circumstances affecting both sides.[16]

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[9] De Wet and Van Wyk *Kontraktereg* 47; Van der Merwe et al *Contract* par 4.2.3; *Kern Trust (Edms) Bpk v Hurter* 1981 2 All SA 286 (C).
[10] *Pereira v Marine & Trade Insurance Co Ltd* 1975 4 All SA 635 (A); *Rabinowitz v Ned-Equity Insurance Co Ltd* 1980 3 All SA 360 (W); *Pillay v SA National Life Assurance Co Ltd* 1991 1 SA 363 (D).
[11] 1995 3 All SA 276 (C).
[12] Nienaber and Reinecke *Life Insurance* par 23.9.
[13] *Malcher & Malcomess v Kingwilliamstown Fire & Marine Insurance & Trust Co* (1883) 3 EDC 271 279–289; *Fine v The General Accident*, *Fire & Life Assurance Corporation Ltd* 1915 AD 213 218–219; *Colonial Industries Ltd v Provincial Insurance Co Ltd* 1922 AD 33 40 42; *Whyte's Estate v Dominion Insurance Co of SA Ltd* 1945 TPD 382 403–406; *Roome v Southern Life Association of Africa* 1959 3 SA 638 (D) 640–642; *Pereira v Marine & Trade Insurance Co Ltd* 1975 4 All SA 635 (A); *Fransba Vervoer* (*Edms*) *Bpk v Incorporated General Insurances Ltd* 1976 4 SA 970 (W) 975–976; *Rabinowitz v Ned-Equity Insurance Co Ltd* 1980 3 All SA 360 (W); cf also *Alliance Assurance Co Ltd v Lewis* 1958 4 All SA 77 (SR); *Stumbles v New Zealand Insurance Co Ltd* 1963 1 All SA 15 (SR); *Kelly v Pickering* (*2*) 1980 4 All SA 19 (R); *Pickering v Standard General Insurance Co Ltd* 1980 4 All SA 699 (ZA); *Mutual & Federal Insurance Co Ltd v Oudtshoorn Municipality* 1985 1 All SA 324 (A); *Anderson Shipping* (*Pty*) *Ltd v Guardian National Insurance Co Ltd* 1987 2 All SA 307 (A).
[14] *Colonial Industries Ltd v Provincial Insurance Co Ltd* 1922 AD 33; *Fouche v The Corporation of the London Assurance* 1931 WLD 145 156; *Whyte's Estate v Dominion Insurance Co of SA Ltd* 1945 TPD 382 404; *Fransba Vervoer* (*Edms*) *Bpk v Incorporated General Insurances Ltd* 1976 4 SA 970 (W) 980.
[15] *Fine v The General Accident*, *Fire & Life Assurance Corporation Ltd* supra 220–221; *Fouche v The Corporation of the London Assurance* supra 159; *Roome v Southern Life Association of Africa* 1959 3 SA 638 (D) 641; *Fransba Vervoer* (*Edms*) *Bpk v Incorporated General Insurances Ltd* supra 976–977.
[16] *Lawsa* Vol 12 Part 1 para 226.

This position in respect of negative misrepresentations was altered by the case of *Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality*.[17] The facts of the matter are as follows. Oudtshoorn Municipality was sued following an airplane crash into power lines immediately outside the boundary of the Oudtshoorn aerodome. The Municipality had a valid public liability policy in place. The insurer wished to repudiate the claim on the basis that the insured had failed to disclose that the proximity of the power lines to the aerodrome constituted a hazard to night flying aircraft. In its judgment, the court rejected the criterion of the reasonable insured and reasonable insurer. Joubert JA said that

> "*there is a duty on both insured and insurer to disclose to each other prior to conclusion of the contract of insurance every fact relative and material to the risk or the assessment of the premium. This duty of disclosure relates to material facts of which the parties have actual knowledge or constructive knowledge prior to conclusion of the contract of insurance*."

The court then introduced the "reasonable man" test:[18] whether, from the point of view of the reasonable man or the average prudent person, the undisclosed information was reasonably relative to the assessment of the risk and the premium.[19] This test thus supported an objective assessment as to materiality.

However, the 'reasonable man' test in the context of positive misrepresentations was rejected in *Qilingile v SA Mutual Life Assurance Society Ltd*.[20] The court held that one had to look at the position of the particular insurer in determining whether a positive representation was material. The test was one that was thus subjective in nature. In justifying this approach Kriegler AJA pointed to the wording of s 63(3) of the (now repealed) Insurance Act, 27 of 1943 ("**Old Insurance Act**") which read:

> '*Notwithstanding anything to the contrary contained in any domestic policy or any document relating to such policy, any such policy issued before or after the commencement of this Act, shall not be invalidated and the obligation of an insurer thereunder shall not be excluded or limited and the obligations of the owner thereof shall not be increased, on account of any representation made to the insurer which is not true, whether or not such representation has been warranted to be true, unless the incorrectness of such representation is of such a nature as to be likely to have materially affected the assessment of the risk under the said policy at the time of issue or any reinstatement or renewal thereof*.'

[17] 1985 1 All SA 324 (A).
[18] Ibid at 435G.
[19] *Lawsa* Vol 12 Part 1 para 227.
[20] 1993 (1) SA 69 (AD).

The view of the court was that the wording of the Old Insurance Act was not wide enough to include non-disclosures. For this reason, the 'reasonable man' test adopted in *Oudtshoorn Municipality* did not apply. The court described this 'prudent insurer' test as follows:

> '*The enquiry as to the materiality of the misrepresentation is consequently not conducted in abstracto but is focused on the particular assessment. From that it follows that the evidence of the underwriter who attended to the assessment is not only relevant but may prove crucial. So, too, evidence that the insurer had a particular approach to risks of the kind in question would be relevant and could be cogent.*
>
> *Obviously general considerations affecting the assessment of the kind of risk in issue will bear on the probabilities and will be taken into account. But, and this serves to be emphasised, the enquiry is aimed at determining whether the specific assessment was probably materially affected by the specific misrepresentation in contention*.'

The court in *Theron v AA Life Assurance Association Ltd*[21] surmised this test as being a comparison of the different assessments in respect of the risk underwritten. '*The first is done on the basis of the facts as misrepresented by the insured. The second determines what the assessment would have been on the facts truly stated. If there is a significant disparity between the two, then the materiality requirement in s 63(3) is satisfied*.'[22]

Such interpretation of s 63(3) was criticised by Schutz JA in *Clifford v Commercial Union Insurance Co of SA Ltd.*[23] While the subjective test introduced by *Qilingele* was not rejected, the court was of the view that '*[the] interpretation does not give effect to the purpose or import of the subsection; nor does it differentiate clearly the concepts of materiality and inducement*.'[24]

The law around materiality was thus developing on two separate paths: an objective standard for negative misrepresentations and a subjective standard for positive misrepresentations. The clarity of this position was not rectified by the enactment of the LT Act and ST Act. Their respective sections read:

> *"the obligations of the policyholder shall not be increased, on account of any representation made to the insurer which is not true, whether or not the representation has been warranted to be true, unless that representation is such as to be likely to have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any renewal or variation thereof.*"

[21] 1995 (4) SA 361 (A).
[22] Ibid at 376H-I.
[23] 1998 JOL 2374 (A).
[24] Ibid at 156D.

This wording failed to address the deficiencies of the Old Insurance Act, namely: would its ambit cover non-disclosures?; What standard should be used for the test of materiality?; Who conducts the assessment of the risk?; and what does materiality relate to?[25]

The purpose of section 53 / 59 '*[was to] improve the lot of the insured, not to worsen it*'.[26] It evidently became apparent, that much like in 1969 following the *Jordan* case, legislative intervention would be needed.

The Legislature Intervenes

In a bid to ameliorate the ongoing issues surrounding materiality, the Insurance Amendment Act, 17 of 2003 was gazetted in July 2003. Sections 19 and 35 amended sections 59 and 53 respectively. The wording in its current form in both acts is as a result of these amendments.

Boruchowitz J in *Mahadeo v Dial Direct Insurance Limited*[27] succinctly summarised the effect of the amendments when he stated:[28]

> "*The effect of the most recent amendment is to bring the law with regard to positive representations into line with the law on non-disclosures. The statutory definition of materiality in section 53(b) is effectively identical to that adopted in the President Versekeringsmaatskappy case*[29] *in relation to the common law position. The test remains objective: The question whether the particular information ought to have been disclosed is judged not from the point of view of the insurer, or the insured, but from the point of view of the notional reasonable and prudent person. The subjective test propounded in the Qilingele case would appear to no longer apply.*"

Although highly verbose, this section is wide enough to include representations and non-disclosures, as well as ensuring that an objective test is applied when assessing the materiality of both.

The Concept of 'Treating Customers Fairly'

Materiality cannot be viewed as existing within a vacuum, and it must be understood within the context of the prevailing financial regulatory laws governing the insurance industry. The Financial Sector Regulation Act, 9 of 2017 ("**FSR Act**") was recently given effect to,[30] marking the commencement of the 'Twin Peaks' model of regulation within

[25] *Lawsa* Vol 12 Part 1 para 228.
[26] Supra note 17 at 158H.

[27] 2008 4 SA 80 (W).
[28] Ibid at para 17.
[29] Or read *Oudtshoorn Municipality*.
[30] See *Government Gazette* No. 41549, dated 29 March 2018.

South Africa. One of the peaks established - that of the Financial Sector Conduct Authority ("**FSCA**")[31] - concerns itself with market conduct regulation, and the practices with which insurers deal with their clients. One of the cornerstones of this peak is the concept that customers must be treated fairly ("**TCF Principle**").

This principle, which has its roots in Government's 2011 policy paper titled '*A safer financial sector to serve South Africa Better´* has often times clashed directly with materiality. This is evident in the 2013 case of *Jerrier v Outsurance Insurance Company Ltd*.[32] The facts of the case are that the insured's motor policy contained a clause requiring him had to report his claim or any incident that might lead to a claim to the insured, as soon as possible, but not later than 30 days, after any incident. The scope of the clause was extended to apply to any incidents which the insured did not want to claim, which may give rise to a claim in the future.[33] The insured was thus burdened with a duty of disclosure which extended 'beyond facts that are material in the pre-contractual situation'.[34]

The insured was involved in three accidents during his relationship with the insurer. The first was a minor accident due to a pothole which totalled R15 000. Not wanting to claim, the insured elected to self-fund this amount, but without notifying the insurer. He was then involved in a second accident, which by his own admission was his fault, which initially amounted to R20 000, but escalated to R200 000. The insured was then involved in a third accident and his claim was repudiated. The insurer based their repudiation on the fact that the insured did not disclose the prior two accidents.

The court viewed the earlier two accidents as being something:[35]

> "*[which] would cause a reasonable man to conclude that knowledge of their occurrence would indicate a change to the plaintiff's circumstances, at the very least from a claims history perspective, but also as a moral risk, that may (not necessarily would) influence whether the defendant would give the plaintiff cover, the conditions of cover or the premium they would charge*."

The court sided with the insurer in determining that the accidents should have been disclosed.

The result of the judgment was widespread panic amongst the public, with people believing that minor incidents such as scratches or dents would have to be disclosed, for fear of an insurer being entitled to reject future claims. National Treasury responded with a statement[36] which sought to alleviate these fears, by indicating that itself, the FSB and the South African Insurance Association ("**SAIA**") were considering the judgment's impact. National Treasury also again stressed the importance of the TCF Principle and that

[31] The FSB essentially becomes the FSCA.
[32] 2013 JDR 0562 (KZP)
[33] A reason for not wanting to claim may be the preservation of a 'no-claim' bonus.
[34] Van Niekerk "More on Insurance Misrepresentation, Materiality, Inducement and No-Claim Bonuses: Mahadeo v Dial Direct Insurance Ltd" 2008 SA Merc LJ 427 at 438.
[35] Supra note 27 at para 30.
[36] See http://www.treasury.gov.za/comm_media/press/2013/2013040401%20-%20Treasury%20calls%20on%20the%20Insurance%20sector%20to%20be%20fair%20to%20car%20owners.pdf.

insurers should 'ensure that customers understand any limitation on the cover they are purchasing'. Following a meeting between the three bodies, SAIA announced that its member companies 'would not reject motor car claims on the grounds that the insured did not report minor incidents'.

The *Jerrier* case was taken on appeal in 2015, where the original decision was set aside. The result was that insurers could not rely on the case when rejecting claims for non-disclosure of minor, even trivial, incidents. Chetty J at paragraph 36 expressed the concern that:

> "*it can be [difficult] for a prospective client seeking insurance to determine either at the commencement of a contract or at any time thereafter, what a reasonable person would have considered to be material for the purpose of ascertaining the risk to be assumed by the insurer*."

Jerrier highlights the fact that at one stage materiality was capable of triumphing over the TCF Principle. However, now under the guise of the 'Twin Peaks' model, materiality plays a role in ensuring that the TCF Principle is upheld and observed by insurers.

Analysis of the Proposed Amendments

The new wording in the PPRs, proposes to eliminate this subsection entirely. What is not yet apparent is just why the FSB wishes to pursue such a drastic measure. In the Tranche 2 comments matrix, no reason is given in track justifying the deletion of the subsection. The press statement accompanying the release of the Amendments is equally silent.

The only insight that can be gleaned regarding this Amendment is to be found in a presentation given by Lezanne Botha, on 4 April 2018, titled 'Tranche 2 Insurance Regulatory Reforms: The proposed amendments to Long-term Insurance Policyholder Protection Rules. The presentation aims to contextualise the Amendments in light of the commencement of the Twin Peaks model, and the regulatory shifts currently being experienced in South Africa's insurance industry. When discussing 'Rule 21: Misrepresentation', it indicates that section 59(1)(b)[37] is going to be repealed. This section evidently indicates what constitutes material misrepresentation. The comment (and to date the only clarity given) regarding this Amendment is merely: 'Therefore common law test will apply'. This still does not give any indication as to why the subsection is being deleted. Furthermore, it even appears to add greater uncertainty to the current position regarding materiality. This can best be illustrated by comparing the different wordings of insurance legislation throughout South Africa's history, and considering how they attempted to deal with materiality.

[37] And by extension section 53(1)(b) of the ST Act.

Old Insurance Act	ST Act (pre-2003)	ST Act (post-2003)	Amendments to the PPRS
Notwithstanding anything to the contrary contained in any domestic policy or any document relating to such policy, any such policy issued before or after the commencement of this Act, shall not be invalidated and the obligation of an insurer thereunder shall not be excluded or limited and the obligations of the owner thereof shall not be increased, on account of any representation made to the insurer which is not true, whether or not such representation has been warranted to be true, unless the incorrectness of such representation is of such a nature as to be likely to have materially affected the assessment of the risk under the said policy at the time of issue or any reinstatement or renewal thereof.	Notwithstanding anything to the contrary in a short-term policy contained, whether entered into before or after the commencement of this Act, but subject to subsection (2)- *(a)* the policy shall not be invalidated; *(b)* the obligation of the short-term insurer thereunder shall not be excluded or limited; and *(c)* the obligations of the policyholder shall not be increased, on account of any representation made to the insurer which is not true, whether or not the representation has been warranted to be true, unless that representation is such as to be likely to have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any renewal or variation thereof.	1) a) Notwithstanding anything to the contrary contained in a short-term policy, whether entered into before or after the commencement of this Act, but subject to subsection (2)— i) the policy shall not be invalidated; ii) the obligation of the short-term insurer thereunder shall not be excluded or limited; and iii) the obligations of the policyholder shall not be increased, on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is such as to be likely to have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any renewal or variation thereof. b) The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the short-term insurer so that the insurer could form its own view as to the effect of such information on the	Notwithstanding anything to the contrary contained in a policy, but subject to rule 20.2 – (i) the policy must not be invalidated; (ii) the obligation of the insurer under the policy must not be excluded or limited; and (iii) the obligations of the policyholder must not be increased, on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is likely to have materially affected the insurer's ability to assess the risk under the policy concerned at the time of the representation or non-disclosure.

		assessment of the relevant risk.	

Viewed side by side, it is easy to show how similar the different wording has been. At first glance, they may even appear to be identical. However, upon closer inspection, there are subtleties which underlie each section, and indicate the short-comings of legislation which preceded it. The Old Insurance Act was worded in such a way that it was not able to cover non-disclosures or promissory warranties.[38] This deficiency was carried over into both the ST Act and LT Act, with apparently no cognisance given to the courts' criticism of s63(3) of the Old Insurance Act. The amendment to these two acts by virtue of the Insurance Amendment Act, finally brought some much needed clarification. Not only was 'disclosure' expressly mentioned, but the question of the standard used to determine materiality was finally settled - an objective standard. This was achieved by s 53(1)(b) and 59(1)(b). The Amendments do not share this characteristic; in fact it can be argued that they have added to the confusion.

The wording of the Amendments reads in a very similar manner of the Old Insurance Act and ST and LT Acts, before there amendments. As cases decided under these acts show, the wording was not indicative of whether an objective or subjective standard should be used. This contentious issue is the precise reason why the Insurance Amendment Act was needed. In removing subsection (b) the FSB has effectively taken the law back to the position it was in pre-2003: that of conflicting tests. The justification by the FSB that the common law test will be used raises a further question: which test? As illustrated above two tests exist at common law, that of an objective one in *Oudtshoorn Municipality* and the subjective test of *Qilingele*. Neither of these tests have been authoritatively overturned, thus a scope exists for either to be argued in a given situation. The subjective test is clearly prejudicial to insured's attempting to claim under a policy, and it appears unlikely that this accords with the TCF Principle.

Furthermore, the Amendments present new wording which may give rise to issues in future. The phrase '*the insurer's ability to assess the risk under the policy concerned at the time of the representation or non-disclosure*'.[39] There are two elements to this phrase which appear problematic. First, it reads in such a way that materiality must be viewed from the position of the insurer. This is clearly subjective in nature and represents a significant obstacle for an insured to overcome in order to be successful in preventing the repudiation of their claim. Furthermore, the risk merely needs to be assessed, not even assessed properly. An insurer thus can succeed on potentially very flimsy grounds, with an allegation that their risk assessment was impacted. Additionally, whereas before the section applied to either of policy issuing, variation or renewal, the scope is widened to include whenever a representation or non-disclosure is made. Insureds

[38] Warranties are an entire topic on its own, and accordingly fall outside the scope of this opinion.
[39] Own underlining.

are going to be inundated with a burden that exists for the entire policy period, and coupled with the fact that the standard is a subjective assessment, it presents the perfect means by which insurers could repudiate claims.

The amended wording has removed the clarity regarding the timing of the representation or non-disclosure - especially as far as non-disclosure is concerned because an insured has a duty to inform an insurer of any material change to the risk. The reference to the time of the policy's issue, variation or renewal was important because it provides clear indication to an insured when the risk is assessed and disclosure is required. The proposed amended wording is contrary to the TCF Principle.

Conclusion

Materiality has existed turbulently in South African insurance law. Its position being in a relative state of flux: with courts undecided on whether or not an objective or subjective standard should be used. The position appeared to be settled with the passing of the Insurance Amendment Act, which expressly provided that an objective test be used. However, the Amendments to the PPRs published by the FSB appear to take the position back to one of uncertainty, with no clarification given as to why subsection (b) is being omitted. The wording of the Amendments appears to also shift the materiality assessment to being from the view of the insurer, a subjective position which highly disadvantages insureds. This clearly does not accord with the vision of the 'Twin Peaks' model, which focusses on inclusion and fairness. The amended wording has additionally removed the clarity regarding the timing of the representation or non-disclosure It is for these reasons above, submitted that the Amendments be changed so as to reverse the deletion of Rule 20.3 of the Short-term PPRs and Rule 21.2 of the Long-term PPRs. This Rule is vital to ensuring clarity of the law, as well as ensuring that policyholders are better protected.