FINANCIAL SECTOR CONDUCT AUTHORITY

NO. 997 **28 SEPTEMBER 2018**

LONG-TERM INSURANCE ACT, 1998: AMENDMENT OF POLICYHOLDER PROTECTION RULES PRESCRIBED UNDER SECTION 62

The Financial Sector Conduct Authority, hereby amend the Policyholder Protection Rules prescribed under section 62 of the Long-term Insurance Act, 1998 (Act No. 52 of 1998), as set out in the Schedule.

This Notice comes into operation on 1 October 2018.

CD da Silva
For the Transitional Management Committee
FINANCIAL SECTOR CONDUCT AUTHORITY

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SCHEDULE

1. Interpretation

In this Schedule, "the Rules" means the Policyholder Protection Rules (Long-term Insurance), 2017 promulgated under the Long-term Insurance Act, 1998 as published in Government Notice 1407 of 15 December 2017.

2. The Rules are hereby amended by the substitution of all references in the Rules to "Registrar" with "Authority".

3. The Rules are hereby amended by the substitution of all references in the Rules to "managing executive" with "senior manager".

4. Chapter 1 of the Rules is hereby amended by –

(a) the insertion in section 2.1 in Section 2 before the definition "advice" of the following definition:

"'**advertisement'** means any communication published through any medium and in any form, by itself or together with any other communication, which is intended to create interest by the public in the business, policies or related services of an insurer, or to persuade the public (or a part thereof) to transact in relation to a policy or related service of the insurer in any manner, but which does not purport to provide detailed information to or for a specific policyholder regarding a specific policy or related service;";

(b) the substitution in section 2.1 in Section 2 for the definition "advice" of the following definition:

"'**advice'** has the meaning assigned to it in the FAIS Act;";

(c) the substitution in section 2.1 in Section 2 for the definition "beneficiary" of the following definition:

"'**beneficiary'** in respect of a –

(a) registered insurer, means –

(i) a person nominated by the policyholder as the person in respect of whom the insurer should meet policy benefits; or

(ii) in the case of a fund member policy, a fund policy or a group scheme, a person nominated by the fund, member of the fund or member of the group scheme, or person otherwise determined in accordance with the rules of that fund or group scheme as the person in respect of whom the insurer should meet policy benefits;

(b) licensed insurer, has the meaning assigned to it in Schedule 2 of the Insurance Act; and for purposes of these rules includes in the case of a fund policy, a person nominated by the fund, or person otherwise determined in accordance

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with the rules of that fund as the person in respect of whom the insurer should meet policy benefits;";

(d) the insertion in section 2.1 in Section 2 after the definition "beneficiary" of the following definition:

"'**business day**' means any day excluding a Saturday, Sunday or public holiday;";

(e) the insertion in section 2.1 in Section 2 after the definition "FAIS General Code of Conduct" of the following definition:

"'**fund**' has the meaning assigned to it in Part 1 of the Regulations;";

(f) the insertion in section 2.1 in Section 2 after the definition "fund member policy" of the following definition:

"'**fund policy**' has the meaning assigned to it in Part 1 of the Regulations;";

(g) the substitution in section 2.1 in Section 2 for the definition "intermediary" of the following definition:

"'**intermediary**' means an independent intermediary or representative, respectively;";

(h) the substitution in section 2.1 in Section 2 for the definition "investment value" of the following definition:

"'**investment value**' in respect of a –

(a) registered insurer, means the value of a policy calculated as the accumulated basic premium and investment return stated in or ascertainable from the policy, less deductions specifically provided for in the policy;

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

(i) the substitution in section 2.1 in Section 2 for the definition "ombud" of the following definition:

"'**ombud**' has the meaning assigned to it in the –

(a) Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004) up until such time as such Act is repealed through Schedule 4 of the Financial Sector Regulation Act; and

(b) Financial Sector Regulation Act from the date on which such Act repeals the Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004) through Schedule 4 of such Act;";

(j) the substitution in section 2.1 in Section 2 for the definition "outsourcing" of the following definition:

"'**outsourcing**' means an outsourcing arrangement as defined in section 1 of the Financial Sector Regulation Act, and includes rendering services under a binder

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agreement, but excludes rendering services as intermediary, and "outsourced" has a corresponding meaning;";

(k) the insertion in section 2.1 in Section 2 after the definition "representative" of the following definition:

"'**repudiate**' in relation to a claim means any action by which an insurer rejects or refuses to pay a claim or any part of a claim, for any reason, and includes instances where a claimant lodges a claim –

(a) in respect of a loss event or risk not covered by a policy; and

(b) in respect of a loss event or risk covered by a policy, but the premium or premiums payable in respect of that policy are not paid;"; and

(l) the insertion in section 2.1 in Section 2 after the definition "risk policy" of the following definition:

"'**senior manager**' has the meaning assigned to it in the Insurance Act;".

5. Chapter 2 of the Rules is hereby amended by –

(a) the substitution in rule 1.6 in Rule 1 for paragraph (d) of the following paragraph:

"(d) rule 1.4(e) entitles the member to be provided with products that perform as either the member of the group scheme or the policyholder has been led to expect by the insurer or its representative, and services of the standard that either the member or the policyholder has been led to expect, in relation to the member's interest in the fund or group scheme; and".

6. Chapter 3 of the Rules is hereby amended by –

(a) the substitution in Rule 2 for rule 2.1 of the following rule:

"2.1 In this rule -

"financial instrument" has the meaning assigned to it in the Financial Sector Regulation Act.";

(b) the substitution in Rule 2 for rule 2.4 of the following rule:

"2.4 Rules 2.2 and 2.3 only apply to the development of any new product as of 1 January 2018 and any material change in design of an existing product.";

(c) the insertion after Rule 2 of the following rule:

"RULE 2A: MICROINSURANCE AND FUNERAL POLICY PRODUCT STANDARDS

2A.1 Definitions

In this rule –

"accident" has the meaning assigned to it in section 1 of the Insurance Act;

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"funeral policy" means a life insurance policy underwritten under the funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act, and includes any rider benefit that would constitute a policy written under the funeral class of insurance business referred to in Table 1 of Schedule 2 to the Insurance Act, had it not been a rider benefit;

"life insurance policy" has the meaning assigned to it in section 1 of the Insurance Act;

"microinsurance policy" means a life insurance policy underwritten by a microinsurer;

"microinsurer" has the meaning assigned to it in section 1 of the Insurance Act;

"rider benefit" has the meaning assigned to it in section 1 of the Insurance Act;

"underwritten on a group basis" has the meaning assigned to it in Schedule 2 of the Insurance Act.

2A.2 Application

2A.2.1 This rule, except where stated otherwise, applies to any microinsurance policy and any funeral policy and applies concurrently with, and in addition to, all other rules set out in the Rules.

2A.2.2 Policies entered into before this rule takes effect that meet the description of the funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act, must comply with this rule by 1 July 2021.

2A.2.3 This rule, except where stated otherwise applies to microinsurers and insurers licensed for the funeral class of insurance business referred to in Table 1 of Schedule 2 to the Insurance Act.

2A.2.4 If there is an inconsistency between any provision of this rule and any other rule in the Rules, the provision of this rule prevails.

2A.3 Use of terms and advertising

2A.3.1 An insurer, other than a microinsurer, or any person acting on behalf of that insurer may not use the term "microinsurance" or any derivative thereof in respect of a policy or in any advertisement in respect of a policy.

2A.4 Structure of policy benefits

2A.4.1 A microinsurance policy may not have a contract term of more than 12 months.

2A.4.2 The value of the policy benefits under a microinsurance policy or a funeral policy may not exceed the maximum amounts as prescribed by the Prudential Authority.

2A.4.3 A microinsurance policy must, upon expiry of its contract term, either be –

(a) automatically renewed; or

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(b) terminated in accordance with the requirements set out in these Rules.

2A.4.4 Despite the terms of an assistance policy entered into before 1 June 2009, the policyholder or member is entitled to demand that a policy benefit which is expressed otherwise than as a sum of money must be provided as a sum of money, in which case the sum of money must be equal in value to the policy benefit that would have been provided by the insurer or any person acting on behalf of the insurer had the policy benefit been provided otherwise than as a sum of money.

2A.4.5 Where an assistance policy, microinsurance policy or a funeral policy that provides for a policy benefit expressed otherwise than as a sum of money is entered into on or after 1 June 2009, that policy must-

(a) provide that the policyholder or member is entitled to demand that the policy benefit be provided as a sum of money in lieu of the benefit on the occurrence of the event insured against; and

(b) subject to rule 2A.4.6, state the amount of the policy benefit that is to be provided as a sum of money, which amount must be equal to the value of the policy benefit expressed otherwise than as a sum of money.

2A.4.6 Where due to the nature of the policy benefits the requirements in rule 2A.4.5(b) cannot reasonably be met, the policy must –

(a) state the reason why the amount of policy benefits that is to be provided as a sum of money cannot be stated upon entering into or varying of the policy; and

(b) confirm that the monetary value of the policy benefit concerned will be determined and communicated at claims stage and disclosed to the claimant to ensure that the policyholder is aware of how the monetary value was arrived at.

2A.4.7 When a policyholder or member chooses to receive policy benefits in money as set out in rules 2A.4.4 and 2A.4.5 above, an insurer or any person on behalf of an insurer, may not charge the policyholder or member any administration or similar fee in respect of that benefit.

2A.5 Variation and renewal of a microinsurance policy or a funeral policy

2A.5.1 The terms, conditions or provisions of a microinsurance policy or a funeral policy may not be changed or varied during the first 12 months after inception of the policy, unless –

(a) the insurer can demonstrate that –

(i) there are reasonable actuarial grounds to change or vary the terms, conditions or provisions of the policy; or

(ii) the variation will be to the benefit of the policyholder or member concerned; and

(b) the variation is done in accordance with rules 11.6.4 and 11.6.5.

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2A.5.2 Rule 2A.5.1 applies regardless of whether a microinsurance policy or a funeral policy has been renewed during the 12 month period referred to therein.

2A.5.3 Where a microinsurance policy or a funeral policy is underwritten on a group basis, the insurer may not selectively cancel or selectively decline to renew individual policies which form part of the group of people that are underwritten on a group basis.

2A.6 Waiting periods

2A.6.1 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 six months in respect of policy benefits payable on the happening of a death, disability or health event resulting from natural causes.

2A.6.2 A microinsurance policy or a funeral policy may not impose a waiting period in respect of policy benefits payable on the happening of a death, disability or health event resulting from an accident.

2A.6.3 A microinsurance policy underwritten under the credit life class of life insurance business as set out in Table 1 of Schedule 2 to the Insurance Act may not impose any waiting period other than the waiting periods allowed for in regulation 4 of the credit life insurance regulations made under the National Credit Act.

2A.6.4 A microinsurance policy or a funeral policy may not impose a waiting period when it is renewed.

2A.6.5 An insurer may not impose a waiting period under a microinsurance policy or a funeral policy if the policyholder or member confirms that –

(a) the policyholder or member, at least 31 days before entering into a new microinsurance policy or funeral policy with that insurer, had a previous policy with another insurer;

(b) the policy benefits under that previous policy provided cover in respect of similar risks relating to the same lives insured as those covered under the new microinsurance policy or funeral policy; and

(c) the policyholder or member had completed the waiting period in respect of that previous policy.

2A.6.6 An insurer underwriting the new microinsurance policy or funeral policy may impose a waiting period equal to the unexpired part of the waiting period under a previous microinsurance policy or funeral policy, if -

(a) the waiting period of the policyholder or member under the previous policy had not expired at the time that the policyholder or member enters into the new microinsurance policy or funeral policy; and

(b) the new microinsurance policy or funeral policy provides cover in respect of similar risks relating to predominantly the same lives

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insured as those covered under the previous microinsurance policy or funeral policy.

2A.6.7 An insurer must for purposes of determining a waiting period, before entering into a microinsurance policy or a funeral policy request the potential policyholder or potential member to confirm whether or not the potential policyholder or potential member had –

(a) a previous microinsurance policy or funeral policy; and

(b) completed a waiting period under that previous microinsurance policy or funeral policy.

2A.6.8 Rule 2A.6.7 does not apply to a microinsurance policy underwritten under the credit life class of life insurance business as set out in Table 1 of Schedule 2 to the Insurance Act.

2A.6.9 An insurer must, upon request by an insurer referred to in rule 2A.6.7, confirm whether or not the confirmation by the potential policyholder or potential member received in accordance with rule 2A.6.7 is correct.

2A.7 Exclusions

2A.7.1 A microinsurance policy underwritten under the funeral class of life insurance business as set out in Table 1 of Schedule 2 to the Insurance Act, or a funeral policy, may not impose any exclusion for a pre-existing health condition other than through a waiting period referred to in rule 2A.6.1.

2A.7.2 A microinsurance policy or a funeral policy may not impose any exclusion for suicide for a period that exceeds 12 months from the inception date of the policy.

2A.7.3 Limitation on exclusions for suicide as set out in rule 2A.7.2 applies regardless of whether a microinsurance policy or a funeral policy has been renewed during the 12 month period referred to in rule 2A.7.2.

2A.8 Claims

2A.8.1 Subject to rule 2A.8.2, an insurer must, within two business days after all required documents in respect of a claim under a microinsurance policy or a funeral policy have been received –

(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.

2A.8.2 If a claim is disputed as referred to in rule 2A.8.1(b)(iii), the insurer within 14 business days after expiry of the period referred to in rule 2A.8.1 –

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(a) may further investigate the claim;

(b) must make a decision whether or not the claim submitted is valid; and

(c) must pay or repudiate the claim.

2A.8.3 An insurer may not repudiate a claim under a microinsurance policy or a funeral policy on the basis that the policyholder did not disclose information, if the insurer did not specifically request the policyholder to disclose that information before the inception of the policy.

2A.9 Reinstatement

2A.9.1 If a microinsurance policy or a funeral policy has lapsed due to the non-payment of premium and the insurer reinstates such policy, the insurer –

(a) must do so on at least the same terms as the policy that had lapsed; and

(b) may not impose a waiting period under the reinstated policy.

2A.9.2 If an insurer enters into a new microinsurance policy or a funeral policy with the same policyholder or member within two months after a microinsurance policy or a funeral policy has lapsed due to the non-payment of premium, the insurer may not impose a waiting period under such new policy.

2A.9.3 Rule 2A.9.2 does not apply where the policyholder or member had not completed a waiting period imposed under the lapsed policy, in which case the insurer may impose a waiting period not exceeding the unexpired part of the waiting period under the lapsed policy.

2A.10 General

2A.10.1 A microinsurance policy or a funeral policy may not prescribe that a policy benefit payable as a sum of money is payable directly to a service provider.

2A.10.2 Despite rule 2A.10.1, a claimant may at claims stage direct an insurer to pay a policy benefit payable to the claimant directly to a service provider of the claimant's choice.

2A.10.3 When providing a service or other non-monetary benefit under a microinsurance policy or a funeral policy, an insurer or any person on behalf of an insurer may not charge the policyholder or member any administration or similar fee in respect of that service or similar benefit.

2A.11 Reporting of a new product

2A.11.1 An insurer must, at least 31 days prior to marketing or offering a new microinsurance or funeral product, notify the Authority of the intention to launch a new product and submit the following information to the Authority:

(a) a summary of the benefits, exclusions, terms and conditions forming part of the new product;

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(b) the proposed commission payable for rendering services as intermediary relating to the new product and the intended structure of the commission payable; and

(c) all material intended to be used in advertisements relating to the new product.

2A.11.2 For purposes of rule 2A.11.1 any material change to the design of an existing product or to the benefits, terms or conditions offered thereunder would constitute a new product.

2A.11.3 The Authority may at any time (within the 31 day period or at any time thereafter) by notice to an insurer –

(a) object to any of the benefits, terms and conditions, commission payable and advertisement of a microinsurance or funeral product, and

(b) instruct the insurer to –

(i) stop advertising, marketing or offering the microinsurance or funeral policies;

(ii) not renew the microinsurance or funeral policies;

(iii) terminate the microinsurance or funeral policies within 90 days of the date determined by the Authority; or

(iv) amend any of the benefits, terms and conditions and advertisements of any microinsurance policy or funeral policy or policies by a date determined by the Authority and in accordance with the requirements of the Authority.";

(d) the substitution in Rule 4 for rule 4.2 of the following rule:

"4.2 A policyholder may –

(a) in any case where no benefit has yet been paid or claimed or an event insured against has not yet occurred; and

(b) within a period of 31 days after the date of receipt of the information contemplated in rule 11.5, or a reasonable date on which it can be deemed that the policyholder received that information,

cancel a policy entered into with an insurer or any variation of such policy, excluding any policy or variation that has a duration of 31 days or less, by way of a cancellation notice to the insurer.";

(e) the substitution in Rule 7 for rule 7.1 of the following rule:

"7.1 A provision of a policy is void to the extent that it provides expressly or by implication –

(a) that in connection with any claim made under the policy, the policyholder or claimant may be obliged to undergo a polygraph, lie detector or truth verification test, or any other similar test or procedure

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which is furnished or made available by the insurer or any other person in terms of an arrangement with the insurer and which is conducted under the control of the insurer or such other person;

(b) for an inducement of any nature for a policyholder or claimant to voluntarily agree to undergo a test or procedure envisaged in paragraph (a);

(c) that where a policyholder or claimant under other circumstances than those contemplated in paragraph (b) voluntarily agrees to undergo a test or procedure envisaged in paragraph (a) of this rule, and the policyholder or claimant fails to pass such a test, the claim will be repudiated or the policy will become void merely as a result of such failure to pass the test or procedure;

(d) that in the event of any dispute arising under the policy, the dispute can only be resolved by means of arbitration;

(e) that an insurer may repudiate a claim because a premium was not paid on the due date, if payment was made during a period referred to in rule 15A.1, whether or not the payment was made prior to the event giving rise to the claim;

(f) that an insurer is exempted from liability for the actions, omissions or representations of a person acting on its behalf in relation to a policy;

(g) that the person who has entered into the policy declares or admits that a person who acted on behalf of the insurer in connection with an offer of that person to do so, or with the negotiations preceding the entering into it, was in fact appointed to act on behalf of the first-mentioned person;

(h) that the obligation of an insurer under a policy is dependent upon the discharging of an obligation of another person under a reinsurance policy; or

(i) that a person who has entered into a policy, or the life insured under a policy, waives a right to which such person is entitled, by or under the Act."; and

(f) the insertion after rule 7.2 in Rule 7 of the following rule:

"7.3 Validity of contracts

7.3.1 A policy is not void merely because a provision of a law, including a provision of the Act or the Insurance Act, has been contravened or not complied with in connection with that policy.

7.3.2 If a person has entered into a policy with an insurer who was, in terms of the Act or the Insurance Act, prohibited from entering or not authorised to enter into the policy, or with another person who is not an insurer but who has in terms of a policy undertaken an obligation as insurer, that person, by notice in writing to such insurer or other person, or the Authority by notice to such insurer or other person and on the official web site, may cancel the policy, whereupon that person shall be deemed to be in the same legal position in respect of such insurer or other person as if the

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policy had been cancelled by that person on account of a breach of contract by such insurer or other person.".

7. Chapter 4 of the Rules is hereby amended by –

(a) the deletion in rule 10.1 in Rule 10 of the definition "advertisement";

(b) the substitution in rule 10.1 in Rule 10 for the definition "group of companies" of the following definition:

"'**group of companies**' has the meaning assigned to it in the Insurance Act;";

(c) the insertion after subrule 10.4.12 in Rule 10 of the following subrule:

"10.4.13 An advertisement may not use the term "funeral" or any derivative thereof in relation to a policy, or suggest or create the impression that a policy is intended to cover funeral costs or any costs associated therewith unless the benefit under the policy is a lump sum, or specified or determinable equal or unequal sums of money payable at specified intervals to cover the cost associated with a funeral or the rendering of a service on the happening of a death event.";

(d) the substitution in Rule 10 for rule 10.14 of the following rule:

"10.14 Loyalty benefits or bonuses

10.14.1 An advertisement that references a loyalty benefit, no-claim bonus or rebate in premium must not create the impression that such benefit or bonus is free and must adequately –

(a) indicate if the loyalty benefit, no-claim bonus or rebate in premium is optional or not; and

(b) regardless of whether or not the loyalty benefit, no-claim bonus or rebate in premium is optional, express the cost of the benefit, bonus or rebate in premium including, where applicable, the impact that such cost has on the premium, unless the impact is negligible.

10.14.2 Rule 10.14.1 does not apply in respect of benefits a policyholder may receive from an insurer because that policyholder, together with all the policyholders of that insurer, is an owner or a member of the insurer or the direct holding company of that insurer.

10.14.3 For purposes of rule 10.14.1 –

(a) the impact is deemed to be negligible if the cost of the loyalty benefit, no-claim bonus or rebate in premium comprises less than 10% of the total premium payable under the policy;

(b) where the impact of a loyalty benefit, no-claim bonus or rebate in premium is not negligible and where the advertisement refers to the actual premium payable –

(i) the cost of the benefit, bonus or rebate must be shown as a percentage of that premium; and

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(ii) the insurer must be able to demonstrate that the premium and benefit cost used in the advertisement presents a true reflection of the cost impact for the average targeted policyholder; and

(c) where the impact of a loyalty benefit, no-claim bonus or rebate in premium is not negligible and where the advertisement does not refer to the actual premium payable, the average cost of the benefit, bonus or rebate as a percentage of premium must be provided.

10.14.4 Where an advertisement highlights a loyalty benefit, no-claim bonus or rebate in premium as a significant feature of a policy and makes reference to a projected value or rebate in premium that is payable on the expiry of a period in the future, it must also express the value of the projected benefit, bonus or rebate in present value terms, using reasonable assumptions about inflation.

10.14.5 An advertisement must clearly state whether the availability or extent of a loyalty benefit, no-claim bonus or rebate in premium is contingent on future actions of the policyholder or any factors not within the policyholder's control.

10.14.6 An advertisement may not create the impression that the bonus, benefit or rebate is guaranteed or more likely to materialise than the insurer reasonably expects for the average targeted policyholder.";

(e) the substitution in rule 11.1 in Rule 11 for the definition "policy loan" of the following definition:

"'**policy loan**' includes any loan granted by an insurer under a policy;";

(f) the substitution in rule 11.3 in Rule 11 for subrule 11.3.9 of the following subrule:

"11.3.9 An insurer must, wherever it is reasonably practicable for the insurer to communicate directly with a member in the normal course of business, provide the member with any information that an insurer is required to disclose to a policyholder in accordance with this rule that –

(a) could reasonably be expected to affect the rights or obligations of the member or the member's benefits under the fund or group scheme; and

(b) such member could reasonably require in order to make an informed decision in relation to the member's benefits.";

(g) the substitution in Rule 11 for rule 11.5 of the following rule:

"11.5 Disclosure after inception of policy

11.5.1 An insurer must at the earliest reasonable opportunity after inception of the policy, but no later than 31 days after such inception, provide the policyholder with all information referred to in rule 11.4 in writing, to the extent that any such information has not already been provided in writing by the insurer under rule 11.4, as well as the following information –

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(a) evidence of cover;

(b) the timing and manner in which the policy benefits will or may be made available to the policyholder or a beneficiary;

(c) comprehensive details of any restrictions on access to policy benefits and any penalties for early termination or withdrawal from or transfer of the policy, or other implications of such termination, withdrawal or transfer;

(d) comprehensive details of all of the following, where applicable, including the amount and frequency thereof, the recipient thereof, the purpose thereof and the manner of payment –

(i) any charges or fees to be levied against the policy or the premium including, where the policy has an investment component, the net investment amount ultimately invested for the benefit of the policyholder and the anticipated impact of such charges and fees on the policy benefits;

(ii) any commission or remuneration payable to any intermediary or binder holder in relation to the policy; and

(iii) any material tax consideration.

(e) comprehensive details of all exclusions or limitations, including prominent disclosure as contemplated in rule 10.15 of any significant exclusions or limitations;

(f) any obligation to monitor cover, and that the policyholder may need to review and update the cover periodically to ensure it remains adequate;

(g) any right to cancel, including the existence and duration of, and any conditions relating to, the right to cancel;

(h) the right to claim benefits, including conditions under which the policyholder can claim and the contact details for notifying the insurer of a claim;

(i) any requirement to make an election during the duration of the policy, including any default provisions that may apply if such election is not made, as contemplated in rule 5; and

(j) the representations made by or on behalf of the policyholder to the insurer which were regarded by that insurer as material to its assessment of the risks under the policy.

11.5.2 The information referred to in rule 11.5.1 must be provided to the policyholder in a format which is clearly distinguishable from the policy.

11.5.3 An insurer, in addition to the information referred to in rule 11.5.1 and 11.5.2, must provide a copy of the policy to the policyholder at the earliest

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reasonable opportunity after the commencement date of such policy, but not later than 31 days after such commencement.

11.5.4 Notwithstanding rule 11.5.3, the policyholder, member and the person who entered into the policy, is at any time entitled to be provided, upon request, with a copy of the policy.

11.5.5 Where any information referred to in rule 11.5.1 has previously been provided in a quotation or similar communication referred to in rule 11.4.1(a), the insurer must confirm whether and to what extent the information remains accurate and applicable in relation to the policy as issued.

11.5.6 In respect of fund policies, an insurer in addition to the information referred to in rule 11.5.1 –

(a) must issue and deliver a fund policy to either the principal officer of the fund, the trustees of the fund or any person managing the fund, at the earliest reasonable opportunity after the commencement date of such policy, but not later than 60 days after such commencement date;

(b) notwithstanding paragraph (a), may, with the approval of the Authority and subject to such conditions as the Authority may determine, postpone the issue, delivery or both of a fund policy. The insurer's application for approval must be submitted to the Authority in the form determined by the Authority.";

(h) the substitution in subrule 11.6.4 in rule 11.6 in Rule 11 for paragraph (a) of the following paragraph:

"(a) notification of any change to the premium and charges payable under a policy;"; and

(i) the substitution in subrule 11.6.5 in rule 11.6 in Rule 11 for paragraph (a) of the following paragraph:

"(a) where the change to the terms and conditions is effected at the specific request of the policyholder, be provided to the policyholder at the earliest reasonable opportunity but no later than 31 days after the change takes effect;".

8. Chapter 5 of the Rules is hereby amended by –

(a) the substitution in rule 12.1 in Rule 12 for the definition "intermediary agreement" of the following definition:

"'**intermediary agreement**' means an agreement entered into between an insurer and an intermediary setting out the terms under which the intermediary will render services as intermediary in respect of the policies of the insurer, and in respect of a representative, includes policies entered into with an insurer as contemplated in paragraphs (b), (c) and (d) of the definition of "representative" in Part 3A of the Regulations.".

9. Chapter 6 of the Rules is hereby amended by –

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(a) the substitution in rule 15.4 in Rule 15 for paragraph (b) of the following paragraph:

"(b) must be justified with reference to the extent to which the assumptions on which the premium was based have been met; and"; and

(b) the insertion after Rule 15 of the following rule:

"RULE 15A: PAYMENT OF PREMIUMS

Failure to pay premiums

15A.1 If a premium under a policy, other than a fund policy, has not been paid on its due date, the insurer must notify the policyholder of the non-payment within 15 days after the payment was due, and the policy and the cover must, notwithstanding anything therein to the contrary, in the case of a policy under which there are to be two or more premium payments at intervals of -

(a) one month or less, remain in force for a period of 15 days after that due date; or

(b) longer than one month, remain in force for a period of one month after that due date,

or for such longer period as may be determined by agreement between the parties.

15A.2 If the overdue premium in respect of a policy referred to in rule 15A.1 is not paid by the end of any such period, the policy must be dealt with in accordance with rule 15A.3 if applicable.

15A.3 The remaining value of a policy referred to in rule 15A.1 which, after the satisfaction of any claim of the insurer which is secured solely by the policy benefits to be provided under the policy, is greater than half of the aggregate amount of the premium payments due thereunder during the period of 12 months commencing on the due date of the unpaid premium, the insurer must -

(a) inform the policyholder of the amount of that remaining value and notify him or her that the policy will remain in force, in accordance with the documented procedure of the insurer, until –

(i) the policy no longer has any such remaining value, whereupon it will lapse;

(ii) the payment of premiums is resumed;

(iii) the provisions of the policy are amended, in accordance with the rules of the insurer, so that it becomes a policy which is fully paid-up; or

(iv) if the policyholder so requests, the policy is surrendered, in accordance with the rules of the insurer, and so much of the remaining value as then remains is, subject to section 54, paid to the policyholder; and

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(b) deal with the policy accordingly.

15A.4 An insurer must have documented procedures which to the satisfaction of its statutory actuary prescribe a sound basis on which, and the methods by which, a policy is to be valued and otherwise dealt with for the purposes of rule 15A.3.".

10. Chapter 7 of the Rules is hereby amended by –

(a) the substitution in rule 17.1 in Rule 17 for subrule 17.1.1 of the following subrule:

"17.1.1 For purposes of this rule, reference to a "policyholder" includes a member.";

(b) the deletion in rule 17.1 in Rule 17 of subrule 17.1.2;

(c) the insertion after rule 17.10 in Rule 17 of the following rule:

"17.11 Claims received during periods of grace

17.11.1 If a claimant submits a valid claim in respect of an event that occurred during the period referred to in rule 15A.1, the value of the claim may be reduced by the sum of the unpaid premium.";

(d) the substitution in paragraph (a) in the definition "variation of an individual risk policy" in rule 19.1 in Rule 19 for subparagraph (iv) of the following subparagraph:

"(iv) the application of the policy value as premiums payable in respect of the relevant policy referred to in rule 15A.3;";

(e) the substitution in subrule 20.2.1 in Rule 20.2 in Rule 20 for paragraph (a) of the following paragraph:

"(a) non-payment of a premium, subject to the insurer complying with the provisions of rule 15A; or;";

(f) the substitution in subrule 20.3.5 in Rule 20.3 in Rule 20 for the words preceding paragraph (a) of the following words:

"Where the insurer can demonstrate that due to the nature of the group scheme it is not reasonably practicable to communicate directly with the members of the group scheme in the normal course of business as contemplated in rule 20.3.4, the insurer must –";

(g) the substitution in rule 20.4 in Rule 20 for paragraph (b) of the following paragraph:

"(b) where it has any reason to believe that the contact details of the members of a group scheme are incomplete or there is a material risk that the required information may not reach members, it has taken reasonable steps to communicate with such members using other appropriate communication channels."; and

(h) the insertion after Rule 20 of the following rule:

"RULE 21: MISREPRESENTATION

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21.1 Notwithstanding anything to the contrary contained in a policy, but subject to rule 21.2 -

(a) the policy must not be invalidated;

(b) the obligation of the insurer under the policy must not be excluded or limited; and

(c) 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 a reasonable, prudent person would consider that representation or non-disclosure as being likely to have materially affected the insurer's ability to assess the risk under the policy concerned at the time of issue or time of any variation thereof.

21.2. 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 insurer so that the insurer could form its own view to the effect of such information on the assessment of the relevant risk.

21.3 If the age of a life insured under a policy has been incorrectly stated to the insurer, the policy benefits must, notwithstanding rules 21.1 and 21.2 and subject to rule 21.4, be those which would have been provided under that policy in return for the premium payable had the age been correctly stated.

21.4 If the nature of the policy is such as to render such arrangement as referred to in rule 21.3 inequitable, the Authority may direct the insurer to apply such different method of adjustment to the policy benefits of the policy as the Authority considers equitable in relation to the misstatement of age.".

11. Chapter 8 of the Rules is hereby amended by –

(a) the substitution in section 1.2 in Section 1 for paragraphs (a) and (b) of the following paragraphs:

"(a) for a period of 12 months from 1 January 2018:

(i) Rule 4, Part III: Basic Rules for Direct Marketers;

(ii) Rule 6, Part V: Rules on Cancellations of policies and Cooling-Off;

(iii) Rule 18 on Policy Loans and Cessions, Part VIII: Additional Insurer Duties; and

(b) for a period of 24 months from 1 January 2018:

(i) Rules 8 to 15, Part VII: Assistance Business Group Schemes."; and

(b) the substitution in Section 2 for section 2.2 of the following section:

"2.2 These rules will come into operation as follows –

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Chapter	Rule	Commencement
Chapter 1: Interpretation		1 January 2018
Chapter 2: Fair treatment of policyholders	Rule 1.1 to 1.4	1 January 2018
	Rule 1.5 to 1.9	1 January 2019
	Rule 1.10	1 January 2018
Chapter 3: Products	Rule 2	1 January 2018
	Rule 2A	1 October 2018
	Rule 3	1 January 2018
	Rule 4	1 January 2019
	Rule 5	1 January 2018
	Rule 6.1	1 January 2018
	Rule 6.2 to 6.4	1 July 2018
	Rule 6.5	1 January 2018
	Rule 7.1(a) to (e) and 7.2	1 January 2018
	Rule 7.1(f) to (i) and 7.3	1 October 2018
	Rule 8	1 January 2018
	Rule 9	1 January 2018
Chapter 4: Advertising and Disclosure	Rule 10	1 July 2018
	Rule 11 except for the following rules: 11.5.1(j), 11.5.2 and 11.5.4	1 January 2019
	Rule 11.5.1(j), 11.5.2 and 11.5.4	1 October 2018
Chapter 5: Intermediation and distribution	Rule 12.1 to 12.3 except for 12.2.1 and 12.2.2 in insofar as they relate to existing intermediary agreements	1 January 2018
	Rule 12.2.1 and 12.2.2 insofar as they relate to existing intermediary agreements	1 January 2019
	Rule 12.4	1 January 2019
Chapter 6: Product performance and acceptable service	Rule 13	1 January 2020
	Rule 14	1 July 2018
	Rule 15	1 July 2018
	Rule 15A	1 October 2018
	Rule 16	1 January 2019
Chapter 7: No unreasonable post-sale barriers	Rule 17, except insofar as it relates to group schemes	1 January 2019
	Rule 17, insofar as it relates to group schemes	1 July 2019
	Rule 18, except insofar as it relates to group schemes	1 January 2019
	Rule 18, insofar as it relates to group schemes	1 July 2019
	Rule 19	1 July 2018
	Rule 20	1 January 2020
	Rule 21	1 October 2018
Chapter 8:		1 January 2018

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Administration		

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12. The Arrangement of Rules is hereby amended by –

(a) the insertion after Rule 2 under Chapter 3 of the following rule:

"RULE 2A: MICROINSURANCE AND FUNERAL POLICY PRODUCT STANDARDS";

(b) the insertion after Rule 15 under Chapter 6 of the following rule:

"RULE 15A: PAYMENT OF PREMIUMS"; and

(c) the insertion after Rule 20 under Chapter 7 of the following rule:

"RULE 21: MISREPRESENTATION".

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