



Government Gazette Staatskoerant

REPUBLIC OF SOUTH AFRICA
REPUBLIEK VAN SUID AFRIKA

Vol. 630

15 December
Desember 2017

No. 41329

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ISSN 1682-5843



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GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

FINANCIAL SERVICES BOARD

NO. 1433

15 DECEMBER 2017

SHORT-TERM INSURANCE ACT, 1998 (ACT NO. 53 OF 1998)**REPLACEMENT OF THE POLICYHOLDER PROTECTION RULES**

I, Caroline Dey Da Silva, Deputy Registrar of Short-term Insurance, hereby, under the Short-term Insurance Act, 1998 (Act No. 53 of 1998), promulgate the replacement of the Policyholder Protection Rules ("PPRs") made under section 55 of the Short-term Insurance Act, 1998, as set out in the schedule.

The replacement of the PPRs is necessary to give effect to a number of conduct of business reforms.

This Notice comes into operation on 1 January 2018.



CD DA SILVA
DEPUTY REGISTRAR OF SHORT-TERM INSURANCE

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CHAPTER 1 INTERPRETATION

1. Application

1.1 These rules, except where the context indicates otherwise, do not apply to reinsurance policies.

1.2 These rules apply to all new and existing policies from the date on which a rule takes effect as set out in Chapter 8, except where otherwise indicated in a rule.

1.3 An insurer remains responsible for meeting the requirements set out in these rules, irrespective of –

- (a) reliance on a person to whom a function has been outsourced to facilitate compliance with a rule or a part thereof; or
- (b) reliance on a representative to facilitate compliance with a rule or a part thereof.

2. Definitions

2.1 In these rules “the Act” means the Short-term Insurance Act, 1998 (Act No. 53 of 1998), including the Regulations 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, and –

“**advice**” has the meaning assigned in the FAIS Act;

“**beneficiary**” means –

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

“**claim**” means, unless the context indicates otherwise, a demand for policy benefits by a person in relation to a policy, irrespective of whether or not the person’s demand is valid;

“**claimant**” means a person who makes a claim;

“**consumer credit insurance**” means credit insurance as defined in the National Credit Act;

“**credit life insurance**” has the meaning assigned to it in the National Credit Act;

“**excesses**” means amounts payable or borne by policyholders in the event of claims or losses under a policy;

“**exclusion**” means a loss or risk event not covered under a policy;

“existing policy” means a policy entered into before the date on which the relevant rule takes effect;

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

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

“group scheme” means a scheme or arrangement which provides for the entering into of one or more policies, in terms of which two or more persons without an insurable interest in each other, for the purposes of the scheme, are the lives insured;

“insurer” means a short-term insurer;

“intermediary” means an independent intermediary or a representative, respectively;

“juristic person” includes —

- (a) a company, close corporation or co-operative incorporated or registered in terms of legislation whether in the Republic or elsewhere;
- (b) a company, close corporation or co-operative incorporated or registered in terms of legislation whether in the Republic or elsewhere; or
- (c) a trust or trust fund;

“loyalty benefit” means any benefit (including a so-called cash- or premium-back bonus) that is directly or indirectly provided or made available to a policyholder by an insurer or an associate of the insurer, which benefit is wholly or partially contingent upon —

- (a) the policy or policies of that policyholder with that insurer remaining in place;
- (b) the policyholder increasing any policy benefit to be provided under a policy; or
- (c) the policyholder entering into any other policy or policy benefit or utilising any related services offered by that insurer or its associate;

“mandatory credit life insurance” means credit life insurance contemplated in section 106(1)(b) of the National Credit Act;

“member of a group scheme” means —

- (a) a person who participates in a group scheme to insure him or herself; or
- (b) a person who participates in a group scheme to insure the lives of one or more other persons in which the first-mentioned person has an insurable interest;

“National Credit Act” means the National Credit Act, 2005 (Act No. 34 of 2005);

“new policy” means a policy entered into on or after the date on which the relevant rule takes effect;

“no-claim bonus” means any benefit that is directly or indirectly provided or made available to a policyholder by an insurer in the event that the policyholder does not claim or does not make a certain claim under the policy within a specified period of time;

“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, 2017 (Act No. 9 of 2017); and
- (b) Financial Sector Regulation Act, 2017 (Act No. 9 of 2017) 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;

“optional credit life insurance” means credit life insurance contemplated in section 106(3) of the National Credit Act;

“outsourcing” means any arrangement of any form between an insurer and another person, whether that person is regulated or supervised under any law or not, in terms of which that party performs a function that is integral to the nature of the insurance business that an insurer provides, which would otherwise be performed by the insurer itself in conducting short-term insurance business, and includes rendering services under a binder agreement, but excludes rendering services as intermediary, and “outsourced” has a corresponding meaning;

“plain language” means communication that -

- (a) is clear and easy to understand;
- (b) avoids uncertainty or confusion; and
- (c) is adequate and appropriate in the circumstances,

taking into account the factually established or reasonably assumed level of knowledge of the person or average persons at whom the communication is targeted;

“policy” means a short-term policy where the policyholder is a –

- (a) natural person; or
- (b) a juristic person, whose asset value or annual turnover is less than the threshold value as determined by the Minister of the Department of Trade and Industry in terms of section 6(1) of the Consumer Protection Act, 2008 (Act No. 68 of 2008);

“potential member of a group scheme” means a person who –

- (a) has applied to or otherwise approached an insurer, an intermediary, or a group scheme to become a member of a group scheme;
- (b) has been solicited by an insurer, an intermediary, or a group scheme to become a member of a group scheme; or
- (c) has received advertising, as defined in rule 10, in relation to any group scheme;

“potential policyholder” means a person who –

- (a) has applied to or otherwise approached an insurer or an intermediary to become a policyholder;
- (b) has been solicited by an insurer or an intermediary to become a policyholder; or
- (c) has received advertising, as defined in rule 10, in relation to any policy or related service of an insurer;

“Regulations” means the Regulations made under the Short-term Insurance Act, 1998, promulgated by GN R.1493 of 27 November 1998 and amended from time to time;

“related service” means any service or benefit provided or made available by an insurer or any associate of that insurer, together with or in connection with any policy or policy benefit, and includes a loyalty benefit and a no-claim bonus;

“service provider” means any person (whether or not that person is the agent of the insurer) with whom an insurer has an arrangement relating to the marketing, distribution, administration or provision of policies or related services;

“variation of a policy” means any act that results in a change to –

- (a) the premium;
- (b) any term;
- (c) any condition;
- (d) any policy benefit;
- (e) any exclusion; or
- (f) the duration of a policy,

excluding any explicit pre-determined or determinable variation stated or provided for in the policy, and “variation of an existing policy” and “varying” has a corresponding meaning;

“waiting period” means a period during which a policyholder is not entitled to policy benefits;

“white labelling” refers to the marketing of or offering of a specific policy of an insurer under the brand of another person who is not the insurer in terms of an arrangement between the insurer and that other person; and

“writing” includes any communication by any appropriate electronic medium that is accurately and readily reducible to written or printed form; and “written” has a corresponding meaning.

2.2 Despite section 2.1, the meaning assigned to “enter into” in the Regulations shall not have such meaning for purposes of these Rules and the grammatical meaning of this term will apply.

CHAPTER 2 FAIR TREATMENT OF POLICYHOLDERS

RULE 1: REQUIREMENTS FOR THE FAIR TREATMENT OF POLICYHOLDERS

1.1 For purposes of this rule, “policyholder” includes a potential policyholder and “member of a group scheme” includes a potential member of a group scheme, where appropriate to the context.

1.2 An insurer, at all times, must act with due skill, care and diligence when dealing with policyholders.

1.3 An insurer must –

- (a) in any engagement with a policyholder, and in all communications and dealings with a policyholder, act honourably, professionally and with due regard to the fair treatment of the policyholder; and
- (b) at the start of any engagement initiated by the insurer clearly explain the purpose thereof.

1.4 An insurer must have appropriate policies and procedures in place to achieve the fair treatment of policyholders. The fair treatment of policyholders encompasses achieving at least the following outcomes:

- (a) policyholders can be confident that they are dealing with an insurer where the fair treatment of policyholders is central to the insurer’s culture;
- (b) products are designed to meet the needs of identified types, kinds or categories of policyholders and are targeted accordingly;
- (c) policyholders are given clear information and are kept appropriately informed before, during and after the time of entering into a policy;
- (d) where policyholders receive advice, the advice is suitable and takes account of their circumstances;
- (e) policyholders are provided with products that perform as insurers or their representatives have led them to expect, and the associated service is both of an acceptable standard and what they have been led to expect; and

- (f) policyholders do not face unreasonable post-sale barriers to change or replace a policy, submit a claim or make a complaint.

Group schemes

1.5 For purposes of rules 1.2 to 1.4, "policyholder" includes a member of a group scheme.

1.6 Despite rule 1.5, in circumstances where an insurer can demonstrate that due to the nature of the group scheme it is not reasonably practicable for the insurer to engage directly with the member of a group scheme in the normal course of business, rule 1.4 applies as follows:

- (a) rule 1.4(a) entitles the member of a group scheme to have confidence that the group scheme concerned is dealing with an insurer where the fair treatment of its members is central to the insurer's culture;
- (b) for purposes of achieving rule 1.4(c) the insurer must have arrangements in place with the group scheme policyholder concerned that facilitate and support the provision of the required information by the policyholder to the member of a group scheme;
- (c) in the case where advice is provided to the policyholder rather than the members of a group scheme, rule 1.4(d) requires that the advice should be suitable in relation to both the circumstances of the policyholder and the known or reasonably assumed circumstances of the members of the group scheme;
- (d) rule 1.4(e) entitles the member of a group scheme 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 of a group scheme or the policyholder has been led to expect, in relation to the member of a group scheme's interest in the group scheme; and
- (e) for purposes of achieving rule 1.4(f) the insurer must have arrangements in place with the policyholder concerned that facilitate and support the member of a group scheme's ability to make changes in relation to his or her interest in the group scheme (to the extent permitted in terms of the rules of the group scheme) or to submit claims or make complaints without unreasonable barriers.

1.7 All policies, procedures and arrangements required by rule 1.6 in relation to a group scheme must enable the insurer to monitor the extent to which fair treatment of members of a group scheme is being achieved. Where it becomes apparent to the insurer that fair treatment is compromised, including as a result of non-compliance by the policyholder (excluding a member) concerned with agreed policies, procedures and arrangements, the insurer must take reasonable steps to mitigate the risks to members or future members of a group scheme.

1.8 Despite rules 1.5 to 1.7 and any requirements in these rules specifically applicable to group schemes –

- (a) where any other provision of these rules prescribes a specific requirement in relation to members of a group scheme, that requirement must be complied with; and
- (b) if a member is also a policyholder of the group scheme policy or fund policy relating to the group scheme or fund of which it is a member, all the requirements relating to policyholders contained in these rules apply in respect of such a member.

Suitable advice

1.9 Where advice is provided by an intermediary other than the insurer's representative, rules 1.4(d) and 1.6(c) must be read to require the insurer to take reasonable steps to mitigate the risk of unsuitable advice. Such steps should take into account the nature of the business relationship between the insurer and the intermediary and any likelihood that such relationship may potentially influence the advice provided.

Review of policies and procedures

1.10 An insurer must regularly review its policies and procedures referred to in this rule and document any changes thereto.

CHAPTER 3 PRODUCTS

RULE 2: PRODUCT DESIGN

2.1 An insurer must in developing products –

- (a) make use of adequate information on the needs of identified types, kinds or categories of policyholders or members;
- (b) undertake a thorough assessment, by competent persons with the necessary skills, of the main characteristics of a new product, the distribution methods intended to be used in relation to the product and the disclosure documents related thereto in order to ensure that the product, distribution methods and disclosure documents –
 - (i) are consistent with the insurer's strategic objectives, business model and risk management approach and applicable rules and regulations;
 - (ii) target the types, kinds or categories of policyholders or members for whose needs the product is likely to be appropriate, while mitigating the risk of the product being used by types, kinds or categories of policyholders or members for whom it is likely to be inappropriate; and
 - (iii) take into account the fair treatment of customers; and
- (c) that are subject to white labelling arrangements, undertake due diligence assessments in respect of the governance, resources and operational capability of the persons with whom the insurer has such arrangements and ensure compliance with paragraph (b) above.

2.2 Before an insurer starts to market, offer or enter into specific policies in respect of a new product, a managing executive of the insurer must in writing approve the product and confirm that the product, distribution methods and disclosure documents meet the principles set out in rule 2.1(b).

2.3 This rule only applies to the development of any new product and any material change in design of an existing product.

RULE 3: CREDIT LIFE AND CONSUMER CREDIT INSURANCE

3.1 Mandatory credit life insurance

3.1.1 An insurer must not provide a mandatory credit life insurance policy to a policyholder, unless that policy and the costs associated with that policy comply with any relevant credit life insurance regulations made by the Minister of Trade and Industry under section 171 of the National Credit Act.

3.1.2 Rule 3.1.1 only applies to new policies.

3.2 Substitution of consumer credit insurance policy

3.2.1 An insurer must, where a policyholder or member of a group scheme informs that insurer, or the insurer otherwise should reasonably be aware, that the policyholder or member of a group scheme wishes to, or has, exercised the right under subsection 106(4)(a) of the National Credit Act to substitute any other consumer credit insurance with a policy issued by the insurer, assist the policyholder or member of a group scheme to, in relation to the substituted policy, to comply with –

- (a) any demands of a credit provider under section 106(6) of the National Credit Act; or
- (b) in respect of credit life insurance, with regulation 7 of the credit life insurance regulations made under the National Credit Act.

3.2.2 An insurer must, where an insurer is aware that a policyholder or member of a group scheme has substituted any other consumer credit insurance with a policy issued by that insurer, in writing and within a reasonable time of being requested to do so by the credit provider confirm to the credit provider that the policy is in force and that the credit provider is recorded as the beneficiary, cessionary or loss payee on the policy.

RULE 4: COOLING-OFF RIGHTS

4.1 For purposes of this rule a reference to the "variation" of a policy or a "varied" policy only includes a variation requested or initiated by the policyholder.

4.2 A policyholder may where a policy has a term longer than 31 days and no benefit has yet been paid or claimed or an event insured against under the policy has not yet occurred, within 14 days after the date of receipt of the policy contract following the entering into of a new policy or variation of an existing policy, or from a reasonable date on which it can be deemed that the policyholder received the policy contract, cancel the policy entered into with the insurer by way of a cancellation notice to the insurer.

4.3 All premiums or moneys paid by the policyholder to the insurer up to the date of receipt of the notice referred to in rule 4.2 or received at any date thereafter in respect of the cancelled or varied policy must be refunded to the policyholder, subject to the deduction of the cost of any risk cover actually enjoyed.

4.4 An insurer must comply with the request for cancellation received from a policyholder in accordance with rule 4.2 no later than 31 days after the insurer receives the cancellation notice.

4.5 An insurer must ensure that, where the policyholder is a group scheme in which member participation is voluntary, the policy places an obligation on that policyholder to afford every member thereof a right to end participation in the group scheme equal to the right afforded to a policyholder to cancel a policy in accordance with rules 4.2 and 4.3.

4.6 This rule only applies to new policies and variations of existing policies.

RULE 5: NEGATIVE OPTION SELECTION OF POLICY TERMS OR CONDITIONS

5.1 An insurer or any person acting on behalf of the insurer may not, where more than one option in respect of a policy term or condition (including, but not limited to, options relating to a premium increase, variation of benefits or exclusion) is available to the policyholder, potential policyholder, member of a group scheme or potential member of a group scheme on entering into, varying or renewing the policy or becoming a member of a group scheme, stipulate that a specific term or condition will apply except if such person explicitly elects a different term or condition.

5.2 Rule 5.1 does not apply –

- (a) to a specific term or condition that is required by legislation; or
- (b) where a specific term or condition is designed to address circumstances that arise during the duration of a policy that require a policyholder or member of a group scheme to make an election, provided the insurer can demonstrate that the specific term or condition is reasonably required to achieve fair treatment of the policyholder or member of a group scheme, and the policyholder or member fails to make the required election.

5.3 Any specific term or condition applied in terms of rule 5.2 must be clearly and prominently disclosed to the policyholder or member of a group scheme in accordance with rule 11.5.1(i) and may only be implemented after the insurer has taken reasonable steps to enable the policyholder or member of a group scheme to make the election concerned.

5.4 This rule only applies to new policies or variations or renewals of existing policies.

RULE 6: DETERMINING PREMIUMS AND EXCESSES

6.1 A premium payable under a policy and the manner in and the extent to which the risk of loss is borne by policyholders through the use of excesses must reasonably balance the interests of the insurer and the reasonable benefit expectations of a policyholder or members of a group scheme, and be based on assumptions that are realistic and that the insurer reasonably believes are likely to be met over the term of the policy.

6.2 An insurer may not charge a policyholder or member of a group scheme any fee or charge in addition to the premium payable under the policy.

6.3 The fee referred to in rule 6.2 does not include a fee or charge –

- (a) deducted from the policy benefits, where the deduction is explicitly provided for in the policy; or
- (b) that is permitted in terms of legislation.

6.4 Any fee referred to in rule 6.3 must be clearly and prominently disclosed to the policyholder or member of a group scheme in accordance with rule 10.15 and before the policy is entered into.

6.5 This rule only applies to new policies and changes to the premium or fee structure of existing policies.

RULE 7: VOID PROVISIONS

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 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 15, whether or not the payment was made prior to the event giving rise to the claim.

7.2 Rule 7.1(d) shall not be construed as rendering void a provision of a policy that the parties may, after a dispute under the policy has arisen, voluntarily agree to submit the dispute to arbitration or, in the absence of such a provision, as voiding any agreement between the parties to that effect.

RULE 8: WAIVER OF RIGHTS

No insurer or intermediary may request or induce in any manner a policyholder, potential policyholder, member of a group scheme or potential member of a group scheme or claimant or potential claimant to waive any right or benefit conferred on that person by or in terms of a provision of these rules, or recognise, accept or act on any such waiver, and any such waiver is null and void.

RULE 9: SIGNING OF BLANK OR UNCOMPLETED FORMS

No insurer or intermediary may in connection with any transaction relating to a policy require, permit or allow a policyholder, potential policyholder, member of a group scheme or potential member of a group scheme or claimant or potential claimant to sign any blank or partially completed form necessary for the purpose of the transaction, where another person will be required, permitted or allowed to fill in other required detail, or conclude any such transaction where any such signing and providing of detail have occurred.

CHAPTER 4 ADVERTISING AND DISCLOSURE

RULE 10: ADVERTISING

10.1 Definitions

In this rule –

“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 public interest 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;

“comparative” refers to a direct or indirect comparison between insurers or between the policies or related services of one or more insurers;

“endorsements” refer to public statements declaring the virtues of a policy or related service of an insurer or recommending the entering into of a policy or related service;

“group of companies” has the meaning assigned to it in the Companies Act, 2008 (Act No. 71 of 2008);

“publish” means to –

- (a) make generally known;
- (b) make public announcement of;
- (c) disseminate to the public; or
- (d) produce or release for distribution;

and “publication” has a corresponding meaning;

“**puffery**” means any value judgments or subjective assessments of quality based solely on the opinion of the evaluator and where there is no pre-established measure or standard; and

“**social media**” means websites, applications and other digital platforms that enable users to create and share content or participate in social networking and includes social and professional networks, forums, image and video-sharing platforms.

10.2 Application

10.2.1 For purposes of this rule, “policyholder” includes a potential policyholder, a member of a group scheme and a potential member of a group scheme.

10.2.2 The principles, requirements and standards contained in this rule apply regardless of the medium used to publish an advertisement.

10.2.3 This rule applies to any advertisement published on or after the date on which this rule takes effect, regardless of whether the advertisement was also previously published prior to this rule taking effect.

10.3 General principles

10.3.1 An insurer must have documented processes and procedures for the approval of advertisements by a managing executive or a person of appropriate seniority to whom the managing executive has delegated the approval.

10.3.2 An insurer must, prior to publishing an advertisement, take reasonable measures to ensure that the information provided in the advertisement is consistent with this rule.

10.3.3 Where feasible, measures must provide for an objective review of an advertisement other than by the person that prepared or designed them.

10.3.4 Where an advertisement is produced or published by another person the insurer must –

- (a) where the person producing or publishing the advertisement is the insurer’s representative or is otherwise acting on behalf of the insurer in relation to the advertisement, ensure that the advertisement is consistent with this rule and have appropriate processes in place to ensure such consistency; and
- (b) where the person producing or publishing the advertisement is not acting on behalf of the insurer in relation to the advertisement but the insurer is aware or ought reasonably to be aware of the production or publication, take reasonable steps to mitigate the risk of the advertisement not being consistent with this rule.

10.3.5 Where an insurer becomes aware that an advertisement that relates to its business, policies or related services, whether published by the insurer or any other person, is not consistent with this rule, the insurer must –

- (a) as soon as reasonably practicable correct or withdraw the advertisement; or

- (b) take reasonable steps to ensure that it is corrected or withdrawn; and
- (c) notify any persons who it knows to have relied on the advertisement.

10.4 Factually correct, balanced and not misleading

10.4.1 Advertisements must –

- (a) be factually correct, excluding aspects of an advertisement constituting puffery;
- (b) provide a balanced presentation of key information; and
- (c) not be misleading.

Factually correct

10.4.2 If statistics, performance data, achievements or awards are referenced in an advertisement the source and the date thereof must be disclosed.

10.4.3 An advertisement that refers to premiums must –

- (a) in the case where the premium will escalate automatically, indicate the escalation rate or basis; and
- (b) where the premium may change at a future date, indicate the period for which the premium is guaranteed.

Balanced

10.4.4 Descriptions in an advertisement must not exaggerate benefits or create expectations regarding policy performance or the performance of related services that the insurer does not reasonably expect to achieve.

10.4.5 Descriptions in an advertisement, in respect of a specific policy or related service, must include key limitations, exclusions, risks and charges, which must be clearly explained and must not be worded positively to imply a benefit.

10.4.6 Notwithstanding rule 10.4.5, but subject to all other requirements of this rule, where an insurer can demonstrate that, due to the nature of the medium used for the advertisement, it is not reasonably practicable for the information required in rule 10.4.5 to be fully included in the advertisement itself, the advertisement must indicate –

- (a) that additional information on key limitations, exclusions, risks and charges related to the policy or related service being advertised is available; and
- (b) where and how the additional information in paragraph (a) may be accessed.

10.4.7 The information referred to in rule 10.4.6 must be publicly available and readily accessible to the average policyholder targeted by the advertisement.

Not misleading

10.4.8 An advertisement, when examined as a whole, must not be constructed in such a way as to lead the average targeted policyholder to any false conclusions he or she might reasonably rely upon.

10.4.9 For the purposes of rule 10.4.8, an insurer must when constructing an advertisement consider the conclusions likely to be made by policyholders that are subject to the advertisement, and in doing so have regard to –

- (a) the literal meaning of the words;
- (b) impressions from nonverbal portions of the advertisement; and
- (c) materials and descriptions omitted from the advertisement.

10.4.10 An advertisement must not obscure information.

10.4.11 Each piece of information in an advertisement must be prominent enough in accordance with rule 10.15 and proximate enough to other information so as not to mislead the average targeted policyholder.

10.4.12 An advertisement must not be designed to exaggerate the need for urgency which could encourage the average targeted policyholder to make unduly hasty decisions.

10.5 Public interest

An advertisement must not disparage or make inaccurate, unfair or unsubstantiated criticisms about any financial product, financial service, product supplier or intermediary.

10.6 Identification of insurer

10.6.1 An advertisement relating to a policy must clearly and prominently in accordance with rule 10.15 identify the insurer.

10.6.2 An advertisement must not use the group or parent company name or the name of any other associate of an insurer to create the impression that any entity other than the insurer is financially liable under a policy.

10.6.3 An advertisement must not use the name of another person to mislead or deceive as to the true identity of the insurer or to create the impression that any person other than the insurer is financially liable under a policy.

10.6.4 An advertisement relating to a policy that is subject to a white labelling arrangement must clearly and prominently in accordance with rule 10.15 identify the insurer.

10.7 Appropriate language and medium

10.7.1 An advertisement must use plain language.

10.7.2 Terms must be defined or explained if the average targeted policyholder could not reasonably be expected to understand them.

10.7.3 An insurer must consider the appropriateness of the medium to be used to publish any advertisement in relation to the complexity of the policy features or other information being communicated.

10.8 Record keeping of advertisements

10.8.1 An insurer must keep adequate records of all advertisements.

10.8.2 All records referred to in rule 10.8.1 must be kept for a period of at least 5 years after publication.

10.9 Negative option marketing

An insurer or any person acting on its behalf may not offer to enter into a policy on the basis that the policy will automatically come into existence unless the policyholder explicitly declines the insurer's offer to enter into the policy.

10.10 Unwanted direct advertising

10.10.1 Where an insurer or any person acting on its behalf uses a telephone or mobile phone call, voice or text message or other electronic communication for an advertisement, it must allow the policyholder during that call or within a reasonable time after receiving the message, the opportunity to demand that the insurer or other person does not publish any further advertisements to the policyholder through any of these mediums.

10.10.2 An insurer or any person acting on its behalf may not charge a policyholder a fee or allow a service provider to charge a policyholder any fee for making a demand in terms of rule 10.10.1.

10.11 Comparative marketing

10.11.1 Where a survey or other product or service comparison informs a comparative advertisement, the survey or other product or service comparison –

- (a) must be undertaken by an independent person or, if it is not reasonably practicable that it is undertaken by an independent person, the advertisement must be so qualified;
- (b) must be conducted at regular intervals if relied on or referenced on an on-going basis;
- (c) must ensure that policies, products or related services being compared have the same or similar characteristics;
- (d) must take account of comparable features across the policy, product or related service offerings included in the sample to ensure that not only the price (e.g. the Rand value of premiums) is being compared, but also the benefits provided under the policies, products or related services concerned;
- (e) in particular, in the case of comparisons between policies, must ensure that price comparisons are based on policies with equivalent terms and conditions, including insured events, cover levels, exclusions, waiting periods, excesses and other key features to those of the insurer's policies used in the comparison; and
- (f) may not focus on the price of a policy, product or related service to the exclusion of the suitability of the policy, product or related service or its delivery on customer expectations.

10.11.2 The survey or other comparison source and date thereof must be referenced in the advertisement and the methodology applied must be publicly available and readily accessible to the public in an easily understandable format.

10.12 Puffery

Advertisements that include puffery must be consistent with the provisions relating to puffery in the Code of Advertising Practice issued by the Advertising Standards Authority of South Africa as amended from time to time.

10.13 Endorsements

10.13.1 Testimonials and third party endorsements used in an advertisement –

- (a) must be the genuine opinion and actual experience of the person making the testimonial or endorsement and be properly attributed to such person;
- (b) must be based upon actual statements made for testimonial or endorsement purposes; and
- (c) may use a pseudonym instead of the real name of the person making the testimonial or endorsement, provided this is stated in the advertisement concerned.

10.13.2 If the person making the testimonial or endorsement, or their employer or principal or any associate, has any financial interest or relationship to the insurer or any associate of the insurer or person acting on behalf of the insurer, or will or has been compensated for the endorsement by any person (other than through reimbursement of actual costs incurred by the person making the endorsement), this must be disclosed in the advertisement.

10.13.3 Any endorsement in an advertisement must clearly and prominently in accordance with rule 10.15 state that the endorsement does not constitute financial advice.

10.14 Loyalty benefits or bonuses

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

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

10.14.2 For purposes of rule 10.14.1 –

- (a) the impact is deemed to be negligible if the cost of the loyalty benefit or no-claim bonus comprises less than 10% of the total premium payable under the policy;
- (b) where the impact of a loyalty benefit or no-claim bonus is not negligible and where the advertisement refers to the actual premium payable –
 - (i) the cost of the benefit or bonus must be shown as a percentage of that premium; and

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

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

10.14.4 An advertisement must clearly state whether the availability or extent of a loyalty benefit or no-claims bonus is contingent on future actions of the policyholder or any factors not within the policyholder's control.

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

10.15 Prominence

10.15.1 In determining prominence, whenever information must be disclosed prominently as required by these rules, consideration must, as appropriate, be given to –

- (a) the target audience of the advertisement;
- (b) the likely information needs of the average targeted policyholder;
- (c) prominence in the context of the advertisement as a whole;
- (d) positioning of the text and audibility and speed of speech;
- (e) the duration of displays of key information;
- (f) background;
- (g) colour; and
- (h) font size.

10.15.2 A statement or information in an advertisement is not regarded as being prominent if, amongst other things, the statement or information is –

- (a) obscured through the close proximity of promotional illustrations and/or additional text;
- (b) difficult to read due to the use of small font sizes, unclear type styles or the duration for which it is displayed;
- (c) likely to be overlooked due to its position;

- (d) superimposed across a coloured or patterned background which lessens its visual impact; or
- (e) difficult to hear or understand due to the volume or speed at which speech is delivered.

10.15.3 Subject to rule 10.15.4, in an advertisement relating to a policy that is subject to a white labelling arrangement, the name of the insurer must be as frequently mentioned, as audible or as visible as that of the white label and, in respect of written media, must be at least the same font size as that of the white label.

10.15.4 Rule 10.15.3 does not apply to an advertisement relating to a policy that is subject to a white labelling arrangement where –

- (a) the white label arrangement is with another insurer or a bank that is part of the same group of companies that the insurer is part of;
- (b) the advertisement uses the brand of the other insurer or the bank; and
- (c) all requirements of rule 10.15.1 and 10.15.2 are complied with in relation to the identification of the insurer.

RULE 11: DISCLOSURE

11.1 Definitions

In this rule –

“direct marketing” means the marketing of a policy by or on behalf of an insurer by way of telephone, internet, digital application platform, media insert, direct or electronic mail in a manner which entails the completion or submission of an application, proposal, order, instruction or other contractual information required by the insurer in relation to the entering into of a policy or other transaction in relation to a policy or related services, but excludes the publication of an advertisement;

“significant exclusion or limitation” means an exclusion or limitation in a policy that may affect the decision of the average targeted policyholder to enter into the policy and includes –

- (a) any deferred payment periods;
- (b) any exclusion relating to certain diseases or medical conditions;
- (c) a waiting period;
- (d) any limit on the amount or amounts of cover;
- (e) any limit on the period for which benefits will be paid; and
- (f) any restrictions on eligibility to claim such as age, residence or employment.

11.2 Application

11.2.1 All requirements in this rule relating to information applicable to a policy apply equally to information applicable to a related service.

11.2.2 For purposes of this rule, "policyholder" includes a potential policyholder.

11.2.3 This rule applies to all communications from the date on which this rule takes effect, unless specifically excluded in relation to a specific requirement.

11.3 General disclosure requirements

Language and format

11.3.1 Any communication by an insurer to a policyholder in relation to a policy must –

- (a) be in plain language;
- (b) not be misleading;
- (c) be provided using an appropriate medium, taking into account the complexity of the information being provided;
- (d) where applicable, be in clear and readable print size, spacing and format; and
- (e) in respect of any amount, sum, premium, value, charge, fee, remuneration or monetary obligation mentioned or referred to therein, be stated in actual monetary terms, provided that where any such amount, sum, premium, value, charge, fee, remuneration or monetary obligation is not reasonably pre-determinable, its basis of calculation must be clearly and appropriately described.

Timing of the provision of information to policyholders

11.3.2 Subject to any specific provision in this rule relating to the timing of the provision of information, an insurer must take reasonable steps to ensure that a policyholder is given appropriate information about a policy in good time so that the policyholder can make an informed decision about the policy prior to inception and throughout the duration of the policy.

11.3.3 In determining what is "in good time", an insurer must consider the importance of the information to the policyholder's decision-making process and the point at which the information may be most useful.

Content of the provision of information to policyholders

11.3.4 Information provided must enable a policyholder to understand the features of the policy and help the policyholder understand whether it meets the policyholder's requirements. In determining the level of information to be disclosed the insurer must consider –

- (a) the factually established or reasonably assumed knowledge and experience of the policyholder or average targeted policyholder at whom the communication is targeted;

- (b) the policy terms and conditions, including its main benefits, exclusions, limitations, conditions and its duration;
- (c) the policy's overall complexity, including whether it is entered into together with other goods and services; and
- (d) whether the same information has been provided to the policyholder previously and, if so, when.

11.3.5 An insurer must take particular care to provide adequate information in respect of more complex or bundled features which are likely to be difficult for a policyholder to understand, particularly regarding the costs and risks involved, including defining or explaining terms that could not reasonably be expected to be understood.

Respective responsibilities of insurers and intermediaries

11.3.6 Where an insurer relies on or permits a representative to provide any information required by this rule to a policyholder or mandates an independent intermediary, binder holder or any other person to do so on its behalf, the insurer remains responsible to ensure that such information is provided in accordance with this rule.

11.3.7 Where the distribution model concerned is based on an intermediary agreement referred to in rule 12 between the insurer and an independent intermediary, the insurer -

- (a) must ensure that the intermediary agreement clarifies the respective responsibilities of the insurer and the intermediary in relation to the provision of information to policyholders, in a manner that will ensure that the requirements in rules 11.3.1 to 11.3.5, 11.4 and 11.5 are met;
- (b) must take reasonable steps to ensure that all applicable information required by this rule is in fact provided to the policyholder at the appropriate times; and
- (c) must take reasonable steps to mitigate risks to policyholders of the independent intermediary failing to meet its disclosure obligations in terms of the intermediary agreement or any applicable law.

Identification of the insurer

11.3.8 All information referred to in this rule must clearly and prominently identify the insurer in the same manner as contemplated in rules 10.6 and 10.15.1 to 10.15.3.

Group schemes

11.3.9 An insurer must, wherever it is reasonably practicable for the insurer to communicate directly with a member of a group scheme, provide the member of a group scheme 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 of a group scheme or his or her benefits under the group scheme; and
- (b) such member could reasonably require in order to make an informed decision in relation to his or her benefits.

11.3.10 Where due to the nature of the group scheme it is not reasonably practicable for the insurer to communicate directly with a member of the group scheme in the normal course of business, the insurer must ensure that policies and processes as contemplated in rules 1.6 and 1.7 are in place that –

- (a) identify information that must be disclosed to a member in accordance with rule 11.3.9; and
- (b) reasonably facilitate and support the provision of such information by the policyholder to the member of the group scheme.

11.3.11 The insurer must have policies and processes in place to monitor compliance with rule 11.3.10.

11.4 Disclosure before a policy is entered into

11.4.1 This rule 11.4 applies in the following circumstances –

- (a) where the insurer provides a policyholder or intermediary, before a policy is entered into, with a policy quotation or similar communication that purports to provide detailed information to or for the specific policyholder regarding a specific policy, and it may reasonably be expected that the policyholder will rely on the information to make a decision whether to enter into the policy or not, the quotation or communication must include the information set out in rule 11.4.2; and
- (b) where a policy is entered into as a result of direct marketing, the information set out in rule 11.4.2 must be provided by the insurer before the policy is entered into.

11.4.2 An insurer must provide a policyholder with the following information–

- (a) the name of the insurer and its contact details;
- (b) the type of policy and a reasonable and appropriate general explanation of the relevant policy;
- (c) the nature and extent of policy benefits, including, where applicable, when the insurance cover begins and ends and a description of the risk insured by the policy;
- (d) concise details of all of the following, where applicable –
 - (i) any charges or fees to be levied against the policy or the premium;
 - (ii) any commission or remuneration payable to any intermediary or binder holder in relation to the policy, and the recipient thereof; and
 - (iii) any excesses that may become payable by the policyholder, the circumstances under which it will be payable and the consequences of not paying;
- (e) in respect of premiums –

- (i) the premium that is payable under the policy;
 - (ii) the frequency at which the premium is payable;
 - (iii) details of any premium increases, including the frequency and basis thereof;
 - (iv) whether an increase will be linked to any commensurate increase in policy benefits and any options relating to premium increases that the policyholder may select;
 - (v) the implications of a failure to pay a premium at the frequency referred to in subparagraph (ii); and
 - (vi) in the case of policies where the premium (with or without contractual escalations) is not guaranteed for the full term of the policy, the period for which the premium is guaranteed, including the frequency at which or the circumstances in which a review will take place;
- (f) what cooling-off rights are offered and procedures for the exercise thereof;
 - (g) concise details of any significant exclusions or limitations, which information must be provided prominently as contemplated in rule 10.15;
 - (h) where a policy is entered into in connection with other goods or services (a bundled product), the premium payable in respect of the policy separately from any other prices for such other goods and services and whether entering into the policy or any policy benefit is a prerequisite for entering into or being eligible for any other goods or services;
 - (i) if the policy to be entered into is a consumer credit insurance policy the insurer must, where this information is known or should reasonably be known to the insurer, disclose to the policyholder whether the policy is a mandatory or optional credit life insurance policy and the difference between the two;
 - (j) the existence of any circumstance that could give rise to an actual or potential conflict of interest in dealing with the policyholder;
 - (k) any obligation to disclose material facts, including information to ensure that a policyholder knows what must be disclosed as well as the consequences of non-compliance with the obligations;
 - (l) where applicable, the right to request recordings of any telephonic disclosures; and
 - (m) the right to complain, including details on how and where to complain and the contact details of the insurer and contact details of the relevant ombud.

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 30 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 –

- (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 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;
 - (ii) any commission or remuneration payable to any intermediary or binder holder in relation to the policy; and
 - (iii) any excesses that may become payable by the policyholder and the circumstances under which it will be payable and the consequences of not paying;
- (d) comprehensive details of all exclusions or limitations, including prominent disclosure as contemplated in rule 10.15 of any significant exclusions or limitations;
- (e) any obligation to monitor cover, and that the policyholder may need to review and update the cover periodically to ensure it remains adequate;
- (f) any right to cancel, including the existence and duration of, and any conditions relating to, the right to cancel;
- (g) the right to claim benefits, including conditions under which the policyholder can claim and the contact details for notifying the insurer of a claim; and
- (h) 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.

11.5.2 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.

11.6 Ongoing disclosure

11.6.1 An insurer must in writing disclose to the policyholder information on any contractual changes during the duration of the policy and, on an ongoing basis, disclose to the policyholder relevant information depending on the type of policy.

Ongoing information on terms and conditions

11.6.2 Information that must be provided on an ongoing basis, and at least annually, includes any changes to information referred to in rules 11.4 and 11.5 to the extent that the policyholder can reasonably be expected to require such information in order to make an informed decision as to whether the policy continues to meet the policyholder's requirements.

Information on changes to terms and conditions

- 11.6.3 An insurer must provide the following to a policyholder in writing –
- (a) notification of any change to the premium payable under a policy;
 - (b) appropriate details of the reasons for any change to the premium payable under a policy;
 - (c) appropriate details of the reasons for any change to the provisions, terms or conditions of the policy, together with an explanation of the implications of that change;
 - (d) appropriate details of any change to or addition to the information referred to in rules 11.4 and 11.5 arising from any change referred to in paragraphs (a) to (c); and
 - (e) an explanation of the policyholder's rights and obligations regarding such changes, including what cooling-off rights are offered and procedures for the exercise thereof.
- 11.6.4 The details referred to in rule 11.6.3 must –
- (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;
 - (b) in any case other than as contemplated in paragraph (a), be provided to the policyholder at least 31 days before the change takes effect.

Information on renewal of policy

- 11.6.5 An insurer must, at least 31 days before the renewal date of a policy, where applicable, provide the following to a policyholder in writing –
- (a) the premium to be paid by the policyholder on renewal of the policy;
 - (b) the premium last paid by the policyholder under the policy to enable the policyholder to compare the premium to the premium referred to in paragraph (a);
 - (c) any change to the terms or conditions on renewal of the policy, together with an explanation of the implications of that change;
 - (d) any change to or addition to the information referred to in rules 11.4 and 11.5 arising from the renewal;
 - (e) the policyholder's rights and obligations regarding the renewal, including what cooling-off rights are offered and procedures for the exercise thereof; and
 - (f) a statement indicating that the policyholder should consider whether the level of cover to be offered on the renewal is appropriate for the policyholder's needs.

Information on non-payment of premium

11.6.6 An insurer must provide the policyholder with a written notification in the event that it did not receive the premium payable under a policy.

11.6.7 The notification referred to in rule 11.6.6 must be sent to the policyholder in good time, but no later than 15 days after the insurer became aware of the non-payment of the premium.

Information on the insurer

11.6.8 An insurer must, in addition to complying with any regulatory obligations, inform policyholders of –

- (a) any change in the name of the insurer, its legal form or the address of its head office and any other offices as appropriate;
- (b) any acquisition by another person resulting in organisational changes that may affect the policyholder; and
- (c) a transfer of insurance business from that insurer to another insurer where the transfer of business relates to such policyholders (including the policyholders' rights in this regard).

CHAPTER 5 INTERMEDIATION AND DISTRIBUTION

RULE 12: ARRANGEMENTS WITH INTERMEDIARIES AND OTHER PERSONS

12.1 Definitions

In this rule –

“FAIS product knowledge competency requirements” means the requirements relating to class of business training and product specific training prescribed under the FAIS Act; and

“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.

12.2 Intermediary agreements

12.2.1 An insurer may only enter into an intermediary agreement with an intermediary where –

- (a) in the case of an independent intermediary, that person has, been licensed as a financial services provider and authorised to render financial services in respect of the policies offered by the insurer in accordance with section 8 of the FAIS Act and the insurer has taken reasonable steps to satisfy itself that the independent intermediary and, where applicable, any persons rendering services as intermediary on the independent intermediary's behalf, meet the

FAIS product knowledge competency requirements in respect of the policies offered by the insurer; or

- (b) in the case of a representative of that insurer, that person has been duly appointed as a representative of the insurer in accordance with section 7(1)(b) of the FAIS Act and meets any requirements to be fit and proper prescribed under the FAIS Act in respect of that representative and the policies offered by the insurer including but not limited to the FAIS product knowledge competency requirements.

12.2.2 An intermediary agreement must be entered into directly between the insurer and the intermediary concerned and may not be entered into by a third party acting on behalf of either the insurer or the intermediary.

12.2.3 An insurer must, where an intermediary agreement has been entered into, furnish the intermediary with a written copy of the intermediary agreement setting out the terms and conditions thereof.

12.2.4 Despite any provision of an intermediary agreement or any provision in law to the contrary, when –

- (a) a licence referred to in rule 12.2.1(a) becomes inoperative by virtue of the licence being suspended or withdrawn in terms of section 9 of the FAIS Act or lapsing in terms of section 11 of the FAIS Act; or
- (b) the appointment of the representative referred to in rule 12.2.1(b) is terminated,

an intermediary agreement terminates.

12.3 Requests for information

12.3.1 An insurer must at the written request of an intermediary that is authorised in writing by a policyholder or a member of a group scheme, provide that intermediary or the policyholder or member of a group scheme with the information referred to in the authorisation, within a reasonable time after receipt of the request, irrespective of the fact that the intermediary does not have an intermediary agreement with that insurer.

12.3.2 Where the insurer provides the information referred to in rule 12.3.1 to the policyholder or member of a group scheme, the insurer must also provide the policyholder or member of a group scheme with a fair and objective explanation as to why the information was not provided to the intermediary.

12.3.3 An insurer must, at the written request of an intermediary with whom an intermediary agreement has been entered into, provide that intermediary, within a reasonable time after receipt of the request, with all information reasonably required by the intermediary to comply with any disclosure or other requirements binding on the intermediary by virtue of the FAIS Act or any other law.

12.4 Facilitation of fees payable by policyholder to an intermediary or any other person

12.4.1 An insurer may not facilitate the deduction or charging of any fee payable by a policyholder to an intermediary or any other person, unless the insurer has satisfied itself

that the amount and purpose of the fee have been explicitly agreed to by the policyholder in writing, and that it appears from such agreement that the fee -

- (a) relates to an actual service provided to a policyholder;
- (b) relates to a service other than rendering services as intermediary; and
- (c) does not result in the intermediary or other person being remunerated for any service that is also remunerated by the insurer.

CHAPTER 6 PRODUCT PERFORMANCE AND ACCEPTABLE SERVICE

RULE 13: DATA MANAGEMENT

13.1 In this rule any reference to “policyholder” includes a potential policyholder, a member of a group scheme and a potential member of a group scheme, except for rule 13.4, in which “policyholder” excludes a potential policyholder and potential member of a group scheme.

13.2 In this rule “processing” has the meaning assigned to it in section 1 of the Protection of Personal Information Act, 2013 (Act No. 4 of 2013) and includes processing of all policy-level and policyholder-level data including personal information.

13.3 An insurer must have an effective data management framework that includes appropriate strategies, policies, systems, processes and controls relating to the processing of any data which enables the insurer at all times to –

- (a) have access, as and when required, to data that is up-to-date, accurate, reliable, secure and complete;
- (b) properly identify, assess, measure and manage the conduct of business risks associated with its insurance business to ensure the ongoing monitoring and consistent delivery of fair outcomes to policyholders;
- (c) comply with all relevant legislation relating to confidentiality, privacy, security and retention of data;
- (d) comply with any regulatory reporting requirements;
- (e) assess its liability under each of its policies, including data pertaining to each risk that is covered by a policy and each outstanding claim in respect of a policy;
- (f) adequately categorise, record and report on complaints as required in terms of rule 18; and
- (g) have access to any other relevant data as prescribed by the Registrar.

13.4 An insurer must at a minimum, for the purposes of complying with rule 13.3, have access to the names, identity numbers and contact details of all its policyholders.

13.5 The contact details referred to in rule 13.4 must be as complete as possible, and where available include the mobile number and email address of the policyholder.

13.6 Where an insurer outsources the processing of any data, the insurer must be able to access such data at any time as and when required by the insurer.

13.7 An insurer must have sufficient organisational resources and the operational ability to ensure that its data management framework is effective, adequately implemented and complies with this rule.

13.8 An insurer must regularly review its data management framework and document any changes thereto.

RULE 14: ON-GOING REVIEW OF PRODUCT PERFORMANCE

14.1 An insurer must on an ongoing basis monitor a product, related distribution methods and disclosure documents after the launch of a product, taking into account any event that could materially affect the potential risk to targeted policyholders or members, in order to assess whether –

- (a) the product and its related disclosure documents remain consistent with the needs of targeted policyholders and continue to deliver fair outcomes for policyholders and members; and
- (b) the distribution method or methods remain appropriate.

14.2 An insurer must, where any shortcomings are identified through the assessment contemplated in rule 14.1 or in any other manner, implement appropriate remedial action to address such shortcomings.

RULE 15: PERIODS OF GRACE

15.1 Periods of grace

An insurer shall ensure that a policy contains a provision for a period of grace for the payment of premiums of not less than 15 days after the relevant due date: Provided that in the case of a monthly policy, such provision must apply with effect from the second month of the currency of the policy.

RULE 16: RECORD KEEPING

16.1 In this rule, any reference to “policyholder” includes a member of a group scheme.

16.2 This rule applies, in addition to any other record keeping requirements provided for in any other rule, to all communications related to a policy or a policyholder.

16.3 An insurer must have appropriate systems, processes and procedures in place to –

- (a) record all policy related communications with a policyholder;

- (b) store and retrieve transaction documentation (including the policy) and all other material documentation relating to the policy and the policyholder; and
 - (c) keep the policy and policyholder records and documentation safe from destruction.
- 16.4 Records referred to in rule 16.3 –
- (a) may be kept in an appropriate electronic or recorded format, which is accessible and readily reducible to written or printed form;
 - (b) must be kept for a period of at least five years after the policy came to end, or where the record does not relate to a particular policy, five years after the communication concerned; and
 - (c) must on request, timeously be made available to the Registrar, policyholder, former policyholder or, where the beneficiary is entitled to the information, to the beneficiary on request.

CHAPTER 7 NO UNREASONABLE POST-SALE BARRIERS

RULE 17: CLAIMS MANAGEMENT

17.1 Definitions

17.1.1 In this rule –

“**business day**” means any day excluding a Saturday, Sunday or public holiday; and

“**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.

17.1.2 For purposes of this rule, reference to a “policyholder” includes a member of a group scheme.

17.2 Establishment of claims management framework

17.2.1 An insurer must establish, maintain and operate an adequate and effective claims management framework to ensure the fair treatment of policyholders and claimants that –

- (a) is proportionate to the nature, scale and complexity of the insurer's business and risks;
- (b) is appropriate for the business model, policies, services, and policyholders and beneficiaries of the insurer;

- (c) enables claims to be assessed after taking reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of claimants;
- (d) does not impose unreasonable barriers to claimants; and
- (e) address and provide for, at least, the matters provided for in this rule.

17.2.2 An insurer must regularly review its claims management framework and document any changes thereto.

17.3 Requirements for claims management framework

17.3.1 The claims management framework must, at least, provide for –

- (a) relevant objectives, key principles and the proper allocation of responsibilities for dealing with claims across the business of the insurer;
- (b) appropriate performance standards and remuneration and reward strategies (internally and where any functions are outsourced) for claims management in general and specifically for claims assessment to –
 - (i) prevent conflicts of interest and the incentivisation of behaviour which could threaten the fair treatment of policyholders or claimants; and
 - (ii) ensure objectivity and impartiality;
- (c) documented procedures for the appropriate management of the claims process from the time the claim is received until it is finalised, including the expected timeframes for each of the stages and the circumstances under which any of the timeframes may be extended;
- (d) documented procedures setting out the circumstances in which interest will be payable in the event of late payment of claims, the process to be followed in such an instance and the rate of the interest payable;
- (e) documented procedures which clearly define the escalation and decision-making, monitoring and oversight and review processes within the claims management framework;
- (f) appropriate claims record keeping, monitoring and analysis of claims, and reporting (regular and ad hoc) to the executive management, the board of directors and any relevant committee of the board on –
 - (i) identified risks, trends and actions taken in response thereto; and
 - (ii) the effectiveness and outcomes of the claims management framework;
- (g) appropriate communication with claimants and their authorised representatives on the claims processes and procedures;
- (h) meeting requirements for reporting to the Registrar and public reporting in accordance with this rule; and

- (i) the establishment of a compliance programme for combating fraud and money laundering appropriate to the insurer's exposure and vulnerabilities, which programme must be consistent with the relevant risk management policies of the insurer.

17.4 Allocation of responsibilities

17.4.1 The board of directors of an insurer is responsible for effective claims management and must approve and oversee the effectiveness of the implementation of the insurer's claims management framework.

17.4.2 Any person that is responsible for making decisions or recommendations in respect of claims generally or a specific claim must –

- (a) be adequately trained;
- (b) be experienced in claims handling and be appropriately qualified;
- (c) not be subject to a conflict of interest; and
- (d) be adequately empowered to make impartial decisions or recommendations.

17.4.3 A claim received by an independent intermediary, binder holder or any other service provider that has been mandated by the insurer to manage claims on its behalf, or a claim received by a representative of the insurer, is deemed to have been received by the insurer itself.

17.4.4 The outsourcing of the claims management process or any part thereof to an intermediary, a binder holder or any other person, or any other involvement of an intermediary, binder holder or other person, in the claims management process does not in any way diminish the insurer's responsibilities in terms of this rule.

17.5 Claim escalation and review process

17.5.1 An insurer must establish and maintain an appropriate internal process in terms of which claims decisions can be escalated and/or reviewed and claims related disputes can be resolved.

17.5.2 Procedures within the claims escalation or review process should not be overly complicated, or impose unduly burdensome paperwork or other administrative requirements on claimants.

17.5.3 The escalation or review process should –

- (a) follow a balanced approach, bearing in mind the legitimate interests of all parties involved including the fair treatment of claimants;
- (b) provide for internal escalation of complex or unusual claims at the instance of the initial claim handler;
- (c) provide for claimants to escalate claims not resolved to their satisfaction; and

- (d) be allocated to an impartial, senior functionary within the insurer or appointed by the insurer for managing the claims escalation or review process of the insurer.

17.5.4 An insurer may structure its claims escalation and review process as a component of the complaints escalation and review process required by rule 18.6, provided such process complies with all relevant provisions of this rule insofar as it applies to claims-related complaints.

17.6 Decisions relating to claims and time limitation provisions for the institution of legal action

17.6.1 An insurer must accept, repudiate or dispute a claim or the quantum of a claim for a benefit under a policy within a reasonable period after receipt of a claim.

17.6.2 An insurer must within 10 days of taking any decision referred to in rule 17.6.1, notify the claimant in writing of its decision.

17.6.3 If the insurer repudiates or disputes a claim or the quantum of a claim, the notice referred to in rule 17.6.2 must, in plain language, inform the claimant –

- (a) of the reasons for the decision, in sufficient detail to enable the claimant to dispute such reasons if the claimant so chooses;
- (b) that the claimant may within a period of not less than 90 days after the date of receipt of the notice make representations to the relevant insurer in respect of the decision;
- (c) of details of the internal claim escalation and review process required by rule 17.5;
- (d) of the right to lodge a complaint to a relevant ombud and the relevant contact details and time limitation and other relevant legislative provisions relating to the lodging of such a complaint;
- (e) in the event that the relevant policy contains a time limitation provision for the institution of legal action, of that provision and the implications of that provision for the claimant; and
- (f) in the event that the relevant policy does not contain a time limitation provision for the institution of legal action, of the prescription period that will apply in terms of the Prescription Act, 1969 (Act No. 68 of 1969) and the implications of that Act for the claimant.

17.6.4 If a claim or quantum of a claim is repudiated or disputed as contemplated in rule 17.6.1 on behalf of an insurer by a person other than the insurer, such other person must provide the notice contemplated in rule 17.6.2 and include in that notice, in addition to the information referred to in rule 17.6.3, the name and contact details of the insurer and a statement that any recourse or enquiries must be directed directly to that insurer.

17.6.5 If the claimant makes representations to the relevant insurer in accordance with the internal claim escalation and review process referred to in rule 17.5 the insurer must within 45 days of receipt of the representation, in writing, notify the claimant of its decision to accept, repudiate or dispute the claim or the quantum of the claim.

17.6.6 If the insurer, despite the representations of the claimant, confirms the decision to repudiate or dispute the claim or the quantum of the claim, the notice referred to in rule 17.6.5 must –

- (a) inform the claimant of the reasons for the decision in sufficient detail to enable the claimant to dispute such reasons if the claimant so choose;
- (b) include the facts that informed the decision; and
- (c) include the information referred to in rules 17.6.3(c) to (f).

17.6.7 Any time limitation provision for the institution of legal action that may be provided for in a policy entered into before 1 January 2011 may not include the period referred to in rule 17.6.3(b) in the calculation of the time limitation period.

17.6.8 Any time limitation provision for the institution of legal action that may be provided for in a policy entered into on or after 1 January 2011 –

- (a) may not include the period referred to in rule 17.6.3(b) in the calculation of the time limitation period; and
- (b) must provide for a period of not less than 6 months after the expiry of the period referred to in rule 17.6.3(b) for the institution of legal action.

17.6.9 Despite the expiry of the period allowed for the institution of legal action in a time limitation clause provided for in a policy entered into before or after 1 January 2011, a claimant may request the court to condone non-compliance with the clause if the court is satisfied, among other things, that good cause exists for the failure to institute legal proceedings and that the clause is unfair to the claimant.

17.6.10 For the purposes of section 12(1) of the Prescription Act, 1969 (Act No. 68 of 1969) a debt is due after the expiry of the period referred to in rule 17.6.3(b).

17.7 Record keeping, monitoring and analysis

17.7.1 An insurer must ensure accurate, efficient and secure recording of all claims received, irrespective of whether the claims are valid or not.

17.7.2 The following must be recorded in respect of each claim received –

- (a) all relevant details of the claimant and the subject matter of the claim;
- (b) copies of all relevant evidence, correspondence and decisions; and
- (c) progress and status of the claim, including whether such progress is within or outside any set timelines.

17.7.3 An insurer must maintain the following claims related data on an ongoing basis –

- (a) number and quantum of claims received;
- (b) number and quantum of claims paid;
- (c) number and quantum of repudiated claims and reasons for the repudiation;

- (d) number of claims escalated by claimants to the internal claims escalation and review process and their outcome, which data must also be included in the records and reports required by rule 18 in relation to the category of complaints referred to in rule 18.5.1(h);
- (e) number of claims referred to an ombud and their outcome, which data must also be included in the records and reports required by rule 18.8.3(e); and
- (f) total number of claims outstanding.

17.7.4 Claims information recorded in accordance with this rule must be scrutinised and analysed by an insurer on an ongoing basis and utilised to manage conduct risks and effect improved outcomes and processes for its policyholders, and to prevent recurrences of poor outcomes and errors.

17.7.5 An insurer must establish and maintain appropriate processes for reporting of the information in rule 17.7.3 to its board of directors, executive management or relevant committees of the board.

17.8 Communications with claimants

17.8.1 An insurer must ensure that its claims processes and procedures are transparent, visible and accessible through channels that are appropriate to the insurer's policyholders and claimants.

17.8.2 All communications with a claimant must be in plain language.

17.8.3 An insurer must disclose to the claimant –

- (a) the type of information required from the claimant;
- (b) where, how and to whom a claim and related information must be submitted;
- (c) any time limits on submitting claims;
- (d) any excesses payable by the claimant;
- (e) details of any administrative fee payable in relation to management of the claim; and
- (f) any other relevant responsibilities of the claimant.

17.8.4 A claim is deemed to have been received on the day the insurer or its representative or an independent intermediary, binder holder or any other service provider that has been mandated by the insurer to manage claims on its behalf, receives notification thereof and an insurer or such independent intermediary, binder holder, service provider or representative must within a reasonable time after receipt of a claim acknowledge receipt thereof and inform a claimant of the process to be followed in processing the claim, including –

- (a) contact details of the person or department that will be processing the claim;
- (b) indicative timelines for finalising the claim; and

- (c) details of any outstanding requirements.

17.8.5 An insurer must only require from a claimant information or documentation which is essential to the assessment of the claim.

17.8.6 Claimants must be kept adequately informed of –

- (a) the progress of their claim;
- (b) causes of any delay in the finalisation of a claim and revised timelines; and
- (c) the insurer's decision in response to the claim.

17.8.7 An insurer must record a claim by no later than the first business day after the date that the initial claim is received and may not delay recording the claim until such time as all requirements relating to the claim have been received.

17.8.8 When an insurer makes a final payment or offer of settlement to a claimant, the insurer must explain to the claimant what the payment or settlement is for and the basis used for the payment or settlement.

17.8.9 Where the claimant is a member of a group scheme or a beneficiary, referred to in paragraph (b) of the definition of "beneficiary", the insurer must on receipt of the claim either –

- (a) obtain the contact details of the claimant to enable all communications required by this rule to take place directly with the claimant; or
- (b) obtain consent from the claimant that communications required by this rule may take place through the policyholder concerned.

17.9 Reporting of claims information

An insurer must have appropriate processes in place to ensure compliance with any prescribed requirements for reporting claims information to any relevant designated authority or to the public as may be required by the Registrar.

17.10 Excesses

17.10.1 Where any excess is payable by the policyholder, the excess –

- (a) must be clearly disclosed to the policyholder as required by rules 11.4.2(d)(iii) and 11.5.1(c)(iii);
- (b) must be disclosed to the claimant as required by rule 17.8.3;
- (c) must be fair and reasonable; and
- (d) may not constitute an unreasonable barrier to a claimant, taking into account the reasonably assumed circumstances and expectations of the average targeted policyholder and claimant in respect of the policy concerned.

17.11 Prohibited claims practices

17.11.1 An insurer may not –

- (a) dissuade a claimant from obtaining the services of an attorney or adjustor;
- (b) deny a claim without performing a reasonable investigation; or
- (c) deny a claim based solely on the outcome of a polygraph, lie detector, truth verification or similar test or procedure referred to in rule 7.1(a).

RULE 18: COMPLAINTS MANAGEMENT

18.1 Definitions

In this rule –

“complainant” means a person who submits a complaint and includes a –

- (a) policyholder or the policyholder's successor in title;
- (b) beneficiary or the beneficiary's successor in title;
- (c) person whose life is insured under a policy;
- (d) person that pays a premium in respect of a policy;
- (e) member of a group scheme; or
- (f) potential policyholder or potential member of a group scheme whose dissatisfaction relates to the relevant application, approach, solicitation or advertising or marketing material,

who has a direct interest in the agreement, policy or service to which the complaint relates, or a person acting on behalf of a person referred to in paragraphs (a) to (f);

“complaint” means an expression of dissatisfaction by a person to an insurer or, to the knowledge of the insurer, to the insurer's service provider relating to a policy or service provided or offered by that insurer which indicates or alleges, regardless of whether such an expression of dissatisfaction is submitted together with or in relation to a policyholder query, that -

- (a) the insurer or its service provider has contravened or failed to comply with an agreement, a law, a rule, or a code of conduct which is binding on the insurer or to which it subscribes;
- (b) the insurer or its service provider's maladministration or willful or negligent action or failure to act, has caused the person harm, prejudice, distress or substantial inconvenience; or
- (c) the insurer or its service provider has treated the person unfairly;

“compensation payment” means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of an insurer to a complainant to compensate the complainant for a proven or estimated financial loss incurred as a result of the insurer's contravention, non-compliance, action, failure to act, or

unfair treatment forming the basis of the complaint, where the insurer accepts liability for having caused the loss concerned, but excludes any –

- (a) goodwill payment;
- (b) payment contractually due to the complainant in terms of a policy; or
- (c) refund of an amount paid by or on behalf of the complainant to the insurer where such payment was not contractually due;

and includes any interest on late payment of any amount referred to in paragraphs (b) or (c);

“goodwill payment” means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of an insurer to a complainant as an expression of goodwill aimed at resolving a complaint, where the insurer does not accept liability for any financial loss to the complainant as a result of the matter complained about;

“policyholder query” means a request to the insurer or the insurer’s service provider by or on behalf of a policyholder, for information regarding the insurer’s policies, services or related processes, or to carry out a transaction or action in relation to any such policy or service;

“rejected” in relation to a complaint means that a complaint has not been upheld and the insurer regards the complaint as finalised after advising the complainant that it does not intend to take any further action to resolve the complaint and includes complaints regarded by the insurer as unjustified or invalid, or where the complainant does not accept or respond to the insurer’s proposals to resolve the complaint;

“reportable complaint” means any complaint other than a complaint that has been –

- (a) upheld immediately by the person who initially received the complaint;
- (b) upheld within the insurer’s ordinary processes for handling policyholder queries in relation to the type of policy or service complained about, provided that such process does not take more than five business days from the date the complaint is received; or
- (c) submitted to or brought to the attention of the insurer in such a manner that the insurer does not have a reasonable opportunity to record such details of the complaint as may be prescribed in relation to reportable complaints; and

“upheld” means that a complaint has been finalised wholly or partially in favour of the complainant and that –

- (a) the complainant has explicitly accepted that the matter is fully resolved; or
- (b) it is reasonable for the insurer to assume that the complainant has so accepted; and

- (c) all undertakings made by the insurer to resolve the complaint have been met or the complainant has explicitly indicated its satisfaction with any arrangements to ensure such undertakings will be met by the insurer within a time acceptable to the complainant.

18.2 Establishment of complaints management framework

18.2.1 An insurer must establish, maintain and operate an adequate and effective complaints management framework to ensure the fair treatment of complainants that –

- (a) is proportionate to the nature, scale and complexity of the insurer's business and risks;
- (b) is appropriate for the business model, policies, services, policyholders, and beneficiaries of the insurer;
- (c) enables complaints to be considered after taking reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of complainants;
- (d) does not impose unreasonable barriers to complainants; and
- (e) must address and provide for, at least, the matters provided for in this rule.

18.2.2 An insurer must regularly review its complaints management framework and document any changes thereto.

18.3 Requirements for complaints management framework

18.3.1 The complaints management framework must at least, provide for –

- (a) relevant objectives, key principles and the proper allocation of responsibilities for dealing with complaints across the business of the insurer;
- (b) appropriate performance standards and remuneration and reward strategies (internally and where any functions are outsourced) for complaints management to ensure objectivity and impartiality;
- (c) documented procedures for the appropriate management and categorisation of complaints, including expected timeframes and the circumstances under which any of the timeframes may be extended;
- (d) documented procedures which clearly define the escalation, decision-making, monitoring and oversight and review processes within the complaints management framework;
- (e) appropriate complaint record keeping, monitoring and analysis of complaints, and reporting (regular and ad hoc) to executive management, the board of directors and any relevant committee of the board on –
 - (i) identified risks, trends and actions taken in response thereto; and
 - (ii) the effectiveness and outcomes of the complaints management framework;

- (f) appropriate communication with complainants and their authorised representatives on the complaints and the complaints processes and procedures;
- (g) appropriate engagement between the insurer and a relevant ombud;
- (h) meeting requirements for reporting to the Registrar and public reporting in accordance with this rule;
- (i) a process for managing complaints relating to the insurer's service providers, insofar as such complaints relate to services provided in connection with the insurer's policies or related services, which process must -
 - (i) enable the insurer to reasonably satisfy itself that the service provider has adequate complaints management processes in place to ensure fair treatment of complainants;
 - (ii) provide for monitoring and analysis by the insurer of aggregated complaints data in relation to complaints received by the service provider and their outcomes;
 - (iii) include effective referral processes between the insurer and the service provider for handling and monitoring complaints that are submitted directly to either of them and require referral to the other for resolution; and
 - (iv) include processes to ensure that complainants are appropriately informed of the process being followed and the outcome of the complaint; and
- (j) regular monitoring of the complaints management framework generally.

18.4 Allocation of responsibilities

18.4.1 The board of directors of an insurer is responsible for effective complaints management and must approve and oversee the effectiveness of the implementation of the insurer's complaints management framework.

18.4.2 Any person that is responsible for making decisions or recommendations in respect of complaints generally or a specific complaint must –

- (a) be adequately trained;
- (b) have an appropriate mix of experience, knowledge and skills in complaints handling, fair treatment of customers, the subject matter of the complaints concerned and relevant legal and regulatory matters;
- (c) not be subject to a conflict of interest; and
- (d) be adequately empowered to make impartial decisions or recommendations.

18.5 Categorisation of complaints

18.5.1 An insurer must categorise reportable complaints in accordance with the following minimum categories –

- (a) complaints relating to the design of a policy or related service, including the premiums or other fees or charges related to that policy or service;
- (b) complaints relating to information provided to policyholders;
- (c) complaints relating to advice;
- (d) complaints relating to policy performance;
- (e) complaints relating to service to policyholders, including complaints relating to premium collection or lapsing of policies;
- (f) complaints relating to policy accessibility, changes or switches;
- (g) complaints relating to complaints handling;
- (h) complaints relating to insurance risk claims, including non-payment of claims; and
- (i) other complaints.

18.5.2 An insurer must, in addition to the categorisation set out in rule 18.5.1, consider additional categories relevant to its chosen business model, policies, services and policyholder base that will support the effectiveness of its complaint management framework in managing conduct risks and effecting improved outcomes and processes for its policyholders.

18.5.3 An insurer must categorise, record and report on reportable complaints by identifying the category contemplated in rules 18.5.1 and 18.5.2 to which a complaint most closely relates and group complaints accordingly.

18.6 Complaints escalation and review process

18.6.1 An insurer must establish and maintain an appropriate internal complaints escalation and review process.

18.6.2 Procedures within the complaints escalation and review process should not be overly complicated, or impose unduly burdensome paperwork or other administrative requirements on complainants.

18.6.3 The complaints escalation and review process should -

- (a) follow a balanced approach, bearing in mind the legitimate interests of all parties involved including the fair treatment of complainants;
- (b) provide for internal escalation of complex or unusual complaints at the instance of the initial complaint handler;
- (c) provide for complainants to escalate complaints not resolved to their satisfaction; and

- (d) be allocated to an impartial, senior functionary within the insurer or appointed by the insurer for managing the escalation or review process of the insurer.

18.7 Decisions relating to complaints

18.7.1 Where a complaint is upheld, any commitment by the insurer to make a compensation payment, goodwill payment or to take any other action must be carried out without undue delay and within any agreed timeframes.

18.7.2 Where a complaint is rejected, the complainant must be provided with clear and adequate reasons for the decision and must be informed of any applicable escalation or review processes, including how to use them and any relevant time limits.

18.8 Record keeping, monitoring and analysis of complaints

18.8.1 An insurer must ensure accurate, efficient and secure recording of complaints-related information.

18.8.2 The following must be recorded in respect of each reportable complaint –

- (a) all relevant details of the complainant and the subject matter of the complaint;
- (b) copies of all relevant evidence, correspondence and decisions;
- (c) the complaint categorisation as set out in rule 18.5; and
- (d) progress and status of the complaint, including whether such progress is within or outside any set timelines.

18.8.3 An insurer must maintain the following data in relation to reportable complaints categorised in accordance with rule 18.5 on an ongoing basis -

- (a) number of complaints received;
- (b) number of complaints upheld;
- (c) number of rejected complaints and reasons for the rejection;
- (d) number of complaints escalated by complainants to the internal complaints escalation process;
- (e) number of complaints referred to an ombud and their outcome;
- (f) number and amounts of compensation payments made;
- (g) number and amounts of goodwill payments made; and
- (h) total number of complaints outstanding.

18.8.4 Complaints information recorded in accordance with this rule must be scrutinised and analysed by an insurer on an ongoing basis and utilised to manage conduct risks and effect improved outcomes and processes for its policyholders, and to prevent recurrences of poor outcomes and errors.

18.8.5 An insurer must establish and maintain appropriate processes for reporting of the information in rule 18.8.4 to its board of directors, executive management or relevant committee of the board.

18.9 Communication with complainants

18.9.1 An insurer must ensure that its complaint processes and procedures are transparent, visible and accessible through channels that are appropriate to the insurer's policyholders and beneficiaries.

18.9.2 An insurer may not impose any charge for a complainant to make use of complaint processes and procedures.

18.9.3 All communications with a complainant must be in plain language.

18.9.4 An insurer must, wherever feasible, provide policyholders with a single point of contact for submitting complaints.

18.9.5 An insurer must disclose to a complainant –

- (a) the type of information required from a complainant;
- (b) where, how and to whom a complaint and related information must be submitted;
- (c) expected turnaround times in relation to complaints; and
- (d) any other relevant responsibilities of a complainant.

18.9.6 An insurer must within a reasonable time after receipt of a complaint acknowledge receipt thereof and promptly inform a complainant of the process to be followed in handling the complaint, including –

- (a) contact details of the person or department that will be handling the complaint;
- (b) indicative timelines for addressing the complaint;
- (c) details of the internal complaints escalation and review process if the complainant is not satisfied with the outcome of a complaint; and
- (d) details of escalation of complaints to the office of a relevant ombud where applicable.

18.9.7 Complainants must be kept adequately informed of –

- (a) the progress of their complaint;
- (b) causes of any delay in the finalisation of a complaint and revised timelines; and
- (c) the insurer's decision in response to the complaint.

18.10 Engagement with ombud

18.10.1 An insurer must –

- (a) have appropriate processes in place for engagement with any relevant ombud in relation to its complaints;
- (b) clearly and transparently communicate the availability and contact details of the relevant ombud services to complainants at all relevant stages of the insurance relationship, including at point of sale, in relevant periodic communications, and when a complaint is rejected or a claim is repudiated;
- (c) display and/or make available information regarding the availability and contact details of the relevant ombud services at the premises and/or on the web site of the insurer;
- (d) maintain specific records and carry out specific analysis of complaints referred to them by the ombud and the outcomes of such complaints; and
- (e) monitor determinations, publications and guidance issued by any relevant ombud with a view to identifying failings or risks in their own policies, services or practices.

18.10.2 An insurer must –

- (a) maintain open and honest communication and co-operation between itself and any ombud with whom it deals; and
- (b) endeavour to resolve a complaint before a final determination or ruling is made by an ombud, or through its internal escalation process, without impeding or unduly delaying a complainant's access to an ombud.

18.11 Reporting complaints information

An insurer must have appropriate processes in place to ensure compliance with any prescribed requirements for reporting complaints information to any relevant designated authority or to the public as may be required by the Registrar.

RULE 19: TERMINATION OF POLICIES**19.1 Definitions**

For purposes of this rule –

“material change” means any change in circumstances that results in a policyholder or beneficiary not being entitled to claim a policy benefit under a policy; and

“termination” or any derivative of the term, in relation to a policy, means that a policy comes to an end, for any reason, and includes –

- (a) the cancellation or lapsing of a policy; or

- (b) the non-renewal of a policy where the policy provides for the automatic renewal of that policy or if the policyholder has a legitimate expectation that the policy will be renewed.

19.2 Termination of policies by insurer

Individual policies

19.2.1 If an insurer intends to terminate a policy because of circumstances other than –

- (a) non-payment of a premium, subject to the insurer complying with the provisions of rule 15.1; or
- (b) a material change in the risk covered under the policy that, in terms of the policy, –
 - (i) results in the policy automatically coming to an end; or
 - (ii) provides the insurer with a right to end the policy; or
- (c) where immediate termination is required in law;

the insurer, despite any terms and conditions provided for in a policy, must give the policyholder at least 31 days' written notice of the intended termination.

19.2.2 In the event that the insurer terminates a policy in circumstances other than those set out in rule 19.2.1(a) – (c), the insurer will remain liable under the policy for the shorter of –

- (a) a period of 31 days after the date on which the insurer receives proof that the policyholder has been made aware of the intended termination of the policy; or
- (b) the period until the insurer receives proof that the policyholder has entered into another policy in respect of similar risks to those covered under the policy that the insurer intends to terminate.

19.2.3 In the event that the insurer is unable to obtain the proof referred to in rule 19.2.2 above, the insurer must be able to prove that –

- (a) a period of 31 days had passed since notification was sent to the last known address of the policyholder; and
- (b) it took all reasonable steps to –
 - (i) ensure the contact information of the policyholder is correct, and
 - (ii) to contact the policyholder.

Group schemes policies

19.2.4 If an insurer intends to terminate a group scheme policy, the insurer, despite any terms and conditions provided for in a policy, must –

- (a) give the policyholder and the Registrar at least 31 days' written notice of the intended termination; and

- (b) be able to demonstrate that it has taken reasonable steps to provide the members of the group scheme with notice of the intended termination.

19.2.5 Where the insurer can demonstrate that due to the nature of the group scheme it is not reasonably practicable to directly notify the members of the group scheme of the intended termination as contemplated in rule 19.2.4(b), the insurer must –

- (a) provide the policyholder with reasonable support in providing the notice of intended termination to the members of the group scheme; and
- (b) satisfy itself that the policyholder concerned has provided the notice of intended termination to the members of the group scheme.

19.2.6 An insurer referred to in rule 19.2.4 will remain liable under the policy for the shorter of –

- (a) a period of 31 days after the date on which the insurer has complied with rule 19.2.4 and 19.2.5; or
- (b) the period until the insurer receives proof that the policyholder has entered into another policy providing cover to the members of the group scheme in respect of similar risks as those covered under the policy that the insurer intends to terminate.

19.3 Termination and replacement of group scheme policy by policyholder

19.3.1 If a policyholder terminates or intends to terminate a group scheme policy, the insurer of the policy being terminated must notify the Registrar of the termination or intended termination as soon as reasonably possible after becoming aware of the termination or proposed termination.

19.3.2 An insurer must before entering into a group scheme policy determine whether the group scheme policy is intended to replace or substitute a group scheme policy.

19.3.3 It would, for purposes of rule 19.3.2, constitute prima facie evidence that it is the intention to substitute or replace a group scheme policy if –

- (a) the policyholder under the new group scheme policy to be entered into is the same person as the policyholder under the previous group scheme policy; and
- (b) the lives to be insured under the new group scheme policy are substantially the same as the lives insured under the previous group scheme policy.

19.3.4 If the group scheme policy is intended to substitute or replace a group scheme policy as contemplated in rule 19.3.2, the insurer must, at least 31 days before entering into the group scheme policy, take reasonable steps to provide the members with details of –

- (a) any material differences between the terms and conditions of the new group scheme policy and the group scheme policy being substituted or replaced, and
- (b) the reasons for the differences referred to in paragraph (a).

19.3.5 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 as contemplated in rule 19.3.4, the insurer must –

- (a) provide the policyholder with reasonable support in providing such information to the members; and
- (b) satisfy itself that the policyholder concerned has provided the information referred to in rule 19.3.4 to the members of the group scheme.

19.3.6 Any new waiting periods imposed by an insurer in respect of a group scheme policy which substitutes or replaces a previous group scheme policy will be void.

19.4 Communication with members of a group scheme

For purposes of rules 19.2.4(b) and 19.3.4 an insurer must be able to demonstrate that –

- (a) it has taken reasonable steps to communicate with the members using the contact details referred to in rules 13.4 and 13.5; and
- (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 made reasonable efforts to communicate with such members using other appropriate communication channels.

CHAPTER 8 ADMINISTRATION

1. Repeal and saving provision

1.1 The Policyholder Protection Rules published under Government Notice R.1128 in *Government Gazette* 26853 of 30 September 2004 and amended by Government Notice 1213 in *Government Gazette* 33881 of 17 December 2010 are hereby repealed.

1.2 Despite the repeal referred to in section 1.1, the following rules of the previous Policyholder Protection Rules referred to in section 1.1 continue to apply to all new and existing policies, products, services and arrangements as follows:

- (a) for a period of 12 months from the date of publication of these Policyholder Protection Rules in the *Gazette*, Rule 4, Part III: Basic Rules for Direct Marketers; and
- (b) for a period of 24 months from the date of publication of these Policyholder Protection Rules in the *Gazette*, Rule 7.3, Part V: Unilateral termination of policies.

2. Short title and commencement

2.1 These rules are called the Policyholder Protection Rules (Short-term Insurance), 2017.

2.2 These rules will come into operation as follows –

Chapter	Rule	Commencement
Chapter 1: Interpretation		Date of publication of this notice in the <i>Government Gazette</i>
Chapter 2: Fair treatment of policyholders	Rule 1.1 to 1.4	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 1.5 to 1.9	12 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 1.10	Date of publication of this notice in the <i>Government Gazette</i>
Chapter 3: Products	Rule 2	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 3	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 4	12 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 5	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 6.1	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 6.2 to 6.4	6 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 6.5	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 7	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 8	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 9	Date of publication of this notice in the <i>Government Gazette</i>
Chapter 4: Advertising and Disclosure	Rule 10	6 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 11	12 months after date of publication of this notice in the <i>Government Gazette</i>
Chapter 5:	Rule 12.1 to 12.3	Date of publication of this notice in the

Intermediation and distribution	except for 12.2.1 and 12.2.2 insofar as they relate to existing intermediary agreements	<i>Government Gazette</i>
	Rule 12.2.1 and 12.2.2 insofar as they relate to existing intermediary agreements	12 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 12.4	12 months after date of publication of this notice in the <i>Government Gazette</i>
Chapter 6: Product performance and acceptable service	Rule 13	24 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 14	6 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 15	Date of publication of this notice in the <i>Government Gazette</i>
	Rule 16	12 months after date of publication of this notice in the <i>Government Gazette</i>
Chapter 7: No unreasonable post-sale barriers	Rule 17, except insofar as it relates to group schemes	12 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 17, insofar as it relates to group schemes	18 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 18, except insofar as it relates to group schemes	12 months after date of publication of this notice in the <i>Government Gazette</i>
	Rule 18, insofar as it relates to	18 months after date of publication of this notice in the <i>Government Gazette</i>

	group schemes	
	Rule 19	24 months after date of publication of this notice in the <i>Government Gazette</i>
Chapter 8: Administration		Date of publication of this notice in the <i>Government Gazette</i>

Printed by and obtainable from the Government Printer, Bosman Street, Private Bag X85, Pretoria, 0001
Contact Centre Tel: 012-748 6200. eMail: info.egazette@gpw.gov.za
Publications: Tel: (012) 748 6053, 748 6061, 748 6065