JOINT FORUM:
RETIREMENT & SOCIAL SECURITY REFORM

GROUP RISK
Provision of Death and disability cover on income up to a defined limit

Please note this is a draft discussion document and is not a mandated position of the Joint Forum.

1. INTRODUCTION

Government is proposing the introduction of a social security arrangement applicable to the employed population which provides for mandatory contributions to a national retirement fund, together with provision of death and disability cover. It remains unclear whether unemployment insurance is or should be included and if so, should it remain as-is or be enhanced. It is envisaged that the reform will be achieved though the introduction of a multi- pillar system of benefits and contributions.

Basic Social assistance grants will continue being provided, funded from general government revenue.

The second of the suggested pillars is an all inclusive mandatory contribution of approximately 15% of income, applicable to all income earners earning above R12,000 per year, payable on income below the current Standard Income Tax on Employees (SITE) threshold of R60,000 per year. The agreed contribution rate is to include the cost of administration in addition to the benefits mentioned above.

This document is an examination of the options for the provision of the death and disability cover for this pillar, and details of the issues associated with the provision of such benefits, as identified by the corporate benefits industry in South Africa through its experience in providing such benefits to the private sector.

The National Social Security Fund Framework

According to the ILO (2000), social security is the protection which society provides for its members through a series of public measures:

- To compensate for the absence or substantial reduction from work resulting from various contingencies notably sickness, maternity, employment injury, unemployment, invalidity, old age and death of the breadwinner,
- To provide people with healthcare,
- To provide benefits for families with children.

Social protection includes not only public social security schemes but also private or non-statutory schemes with similar objectives, such as mutual societies and occupational pension schemes.

The proposed South African social security and retirement reforms include the introduction of a multi-pillar system, consisting of:

Social Assistance

Social assurance provides for the assurance of a basic standard of living and prevention of destitution in old age, or in circumstances of unemployment or incapacity. The government has already commenced with the reform of Social assistance programmes and has been successful in providing income grants to over 12.7 million beneficiaries. Current social assistance coverage provides income benefits to old age pensioners, war veterans, disability grants, foster care grants, care dependency grants and child support grants.

Social Insurance

Social insurance aims to encourage saving so as to provide for income replacement in the event of death or disability, and after retirement from the workplace, through long-term insurance arrangements. The national social security reform proposal suggests mandatory contributions for all income earners.

Strategic objectives of social insurance include

- Poverty prevention or elimination through a minimum level of income, income smoothing and insurance;
- Diversification of income sources and benefit provision to mitigate economic, investment and governance issues
- The achievement of reasonable income replacement;
- Adequate government underwriting and risk sharing;
- Fair sharing (subsidies) in public resources;
- Retirement income linked to working life earnings;
- Access to appropriate disability and survivor benefits;
- Income earners have a facility to make provision for healthcare before- and post-retirement.

Voluntary Insurance

Voluntary insurance allows for individuals to provide for private savings for Life cycle risks, such as death and disability, and insufficient income after retirement. This can take various forms, such as individual arrangement to grouped arrangements. The level of savings is normally determined by the individual, except for grouped arrangements such as an employer sponsored retirement fund.

Commenting on the Multi-pillar system

Pillar 0: Social Security Grant
Essentially fulfilling the aims and objectives of Social Assistance. This is funded from general revenue. Qualification to the grant is based on a means test however it is proposed to remove this test or increase the threshold substantially.

We propose that this grant (Pillar 0) continues and form a basic right of all citizens through the removal of the means test – by doing so we can avoid the disadvantages to the current means test as highlighted below.

- Administration is simplified if using SARS (no means test, applies to everyone, higher income earners can have it as a tax deduction on their annual returns);
- The is no burden on the citizen to prove need;
- It won't penalise those with limited means or discourage savings at the lower income levels.

Pillar 1: National Social Security Fund
Mandatory participation for all income earners in the National Social Security Fund providing basic retirement and risk benefits. Discussed at length in this document.

Pillar 2: Mandatory private provision
Additional mandatory participation in private pension funds to ensure adequate income replacement. Not discussed

Pillar 3: Voluntary private provision
Supplementary voluntary savings, tax-incentivised up to a cap. Not discussed.

4: Elderly support
Community and state non-cash support that enhances the well-being of the elderly. Not discussed.

Although numerous proposals and discussion papers have been presented it is still unclear as to where the government or private sector will play a role. What is likely is that the private sector will provide benefits in Pillar 3. The debate will focus on Pillar 1 and 2 as to whether a state pension fund can adequately provide for risk benefits or if there is a need for the private sector to offer survivor (death) and disability benefits.

We believe the private sector has a significant role to play in the provision of risk benefits regardless at what level of benefit is offered. The Australian social security system is an example of where the private sector and the state can work in partnership to offer affordable risk benefits to the working population.

2. OVERVIEW OF THE GROUP RISK MARKET

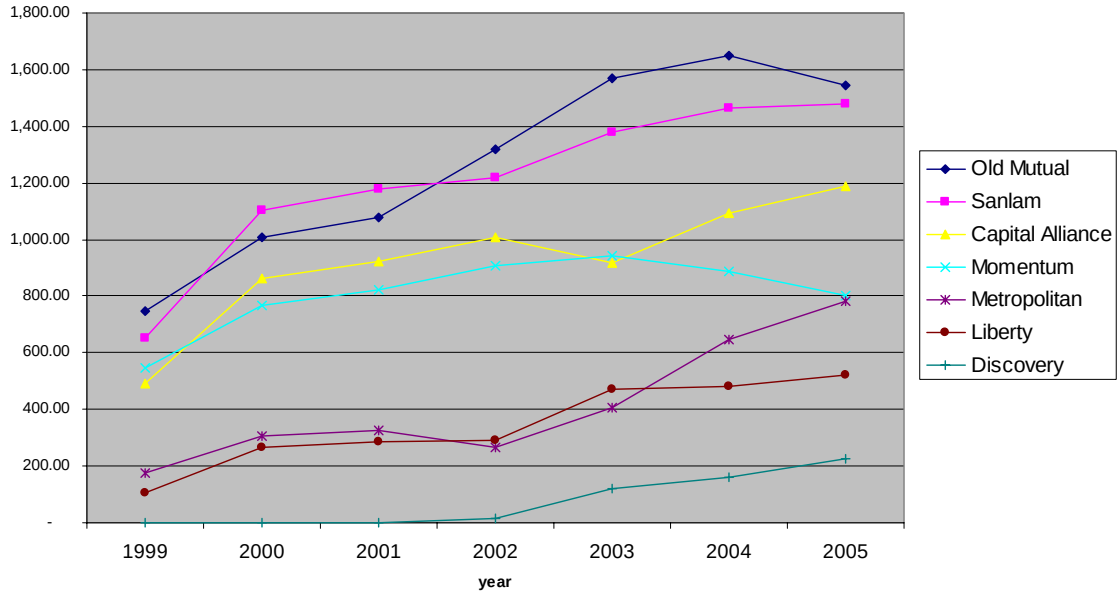
The South African life market has been static in the last few years. Whilst premiums increased by 2% on the 2004 figures and 5% on the 2005 figures, growth was mainly caused by salary inflation.

The group life market is heavily dominated by a small number of companies. While there are about 12 companies writing Group Life business, the top 10 companies have a market share of 100%.

Companies	2006	2005	2004	% Change 2005-2006	% Change 2004-2005
Old Mutual	1736	1425	1648	21%	-6%
SANLAM	1485	1477	1465	0.5%	1%
Capital Alliance	1147	1186	1092	-3%	9%
Momentum	1019	803	888	27%%	-10%
Metropolitan	900	784	647	15%	21%
Liberty	533	520	480	3%	8%
Discovery	216	226	161	-5%	40%
Sage		159	151		5%
Alexander Forbes	100	81	67	23%	21%
African Life	8	22	41	-63%	-47%
Medscheme	19				
Total	7163	6803	6640	5%	2%

Table of Group Business premiums for 2004, 2005 and 2006. (Source. Swiss re volume survey)

Premium growth by top 7 Group life insurance companies



As confirmed by the results of the Annual Survey of Retirement Benefits in South Africa 2007 conducted by Sanlam, the average occupational pension fund has an overall contribution rate of 15.17% of which 11.3% is allocated to retirement funding. The balance **(3.87%)** provides for average administration costs and average death cover of 3 times annual salary, and for average disability benefits of 75% of monthly salary (or a lump sum of 2.4 times salary). In addition, a further **2%** of salary (1% member and 1% employer) is payable to the National Unemployment Insurance Fund to provide for unemployment benefits.

3. RISK BENEFITS

To date, the discussion around risk benefits within the social security and retirement reform framework has been limited to broad statements about providing risk cover. The broad statements have covered principles rather than detail and otherwise have given a possible indication of how much of a total 15% contribution allocation might be allocated to risk benefits.

The principles include:

- ✓ Compulsory membership
- ✓ Access for all
- ✓ Affordable costs
- ✓ ***A preference for income rather than lump sum benefits***

Other broad benefit design issues to explore or to confirm include:

- ✓ Will there be no discrimination, and cross-subsidization embraced to the fullest extent, or will justifiable discrimination (e.g. by age) be tolerated?
- ✓ Extent of earnings for which cover is granted, and on which earnings contributions are based, i.e. full earnings or earnings capped to a certain amount
- ✓ Will there be an income cap, and if so, at what level will the cap be?
- ✓ Costs are effectively capped in terms of a fixed percentage of earnings; are benefits expressed in contribution terms or will benefits reduce if costs are exceeded?
- ✓ Whether retirement savings will serve as an off-set, e.g. will the death benefit be defined as a multiple of earnings (capped or uncapped) less retirement savings built up
- ✓ Weighting of scheme benefits to retirement savings or risk benefits, especially when many people are not surviving to retirement age, in terms of the relative sizes of the contribution to retirement savings, and the cost of risk benefits
- ✓ Degree of simplicity (e.g. a benefit defined in defined benefit terms with no variation by age, is far simpler than a benefit defined in defined contribution terms that might offer different cover levels for people in different age bands)
- ✓ Will there be male & female parity with respect to retirement age
- ✓ Appropriate level of expense loadings

- ✓ If funeral cover is offered, will it extend to spouses and children? (and will it cover multiple spouses and an indefinite number of children?)
- ✓ Extent of escalation on any income benefits, both before retirement and after

The following is a table of specific comments or suggested principles in respect of each of the above:

Benefit Design Issue	**Comment/Principle**
Compulsory membership	Support this principle. If income is used as the "identifier" of who qualifies and who not, then every effort must be made to include every person who qualifies, so as to limit the effect of any anti-selection. In individual life insurance, allowable discrimination is aimed at making sure people of similar risk profiles are pooled together through the rating process, but this does not really exist in group business. Within a group there is no differentiation between the premiums payable. Hence group business allows cross-subsidies to exist, e.g. between the ill and the healthy and between young and old.
Access for all	Supported by compulsory membership. There can be a plan to extend the Pillar 1 net to all South Africans, regardless of income band, over time.
Affordable costs	Initial pricing estimates give an indication of what level of benefits is affordable, as well as being sustainable.
Preference for income benefits	Support this principle for all but the funeral benefits and very low levels of income, assuming funeral benefits do form part of the final benefit design.
Cross subsidization	For the most, support the principle of no cross subsidization. There are areas where cross subsidization is reasonable and could be considered if it was deemed appropriate (by age and by gender in the following respects): ✓ Age: The benefit design could consider increased benefits (as a multiple of salary) for younger aged individuals – e.g. 4x salary for younger aged lives down to 1x salary for older aged lives. This is more equitable from a cost perspective and it acts as a proxy for the retirement savings off-set (see below) , but needs to be considered relative to the simplicity of having the same benefits for every individual regardless of age – e.g. 2x salary. ✓ Gender: There are currently different normal retirement ages for

	males and females. While this is fair in the current environment, there should be a plan to normalize this over time (e.g. female retirement age going up to age 65) and the benefit design should also allow flexibility for the normal retirement age to increase over time (e.g. from 65 to 66 to 67, etc as average age at death increases.) See also comment on income caps below.
Extent of earnings for which cover is granted	Is it basic salary? Is it cost to company? Is it all income? What is most practical from a premium collection perspective?
Income cap	From a risk benefit perspective, the higher the income cap, the less costly the risk benefits (since there is greater cross-subsidization). From an overall benefit design perspective – and in particular from a retirement savings perspective, an income cap at a lower level is more appropriate.
Benefits expressed in contribution terms or defined benefit terms	For ease of explanation and understanding, support the principle that benefits are expressed in defined benefit terms (e.g. 2x salary, as opposed to "the benefit that can be purchased with 2% of contribution). It is important however that the design explicitly allows for benefit levels to reduce if costs increase.
Retirement savings as an off-set	For simplicity, support the principle that survivor benefits (death mainly) do not off-set retirement savings benefits. The former can be added to the latter and payment in an income form can be made to the surviving beneficiaries.
Weighting between retirement and risk/survivor benefits	Since many South Africans do not reach retirement age currently, support the principle that risk/survivor benefits make up a more (rather than less) significant weighting in terms of the overall benefit design. This comment must be seen in a relative sense, though, since retirement savings will always be the greatest priority, so out of a 15% total contribution rate, it is appropriate for at least 10% to be allocated towards retirement savings. The weighting towards risk/survivor benefits would become a function of the allocation of the balance of the contribution, in the range: 3% - 5%. (One also needs to consider whether administration expenses – both for retirement savings and risk benefit administration – are a part of this 5% balance.)
Degree of simplicity	Support the principle that the benefit design be more simple than complex, so any of the considerations above to be gauged in this

	context.
Male and female parity of retirement age	Support the principle of moving towards the same retirement age over time
Automatic increases to retirement age	Support the principle of increases to retirement age over time, first to bring about parity in female and male retirement ages and then to increase the retirement age overall (though probably only needs to change by decades rather than years)
Disability benefits	Support the principle that these are also provided as an income rather than a lump sum, with escalations at an inflation-related level rather than no escalation (i.e. rather define the benefit as a lower percentage of salary with escalations, rather than a higher percentage of salary with no escalations)
Funeral benefits	Support the principle of providing these benefits, with benefits provided to more of the individual's family rather than less (in recognition of the cultural needs of most of the population, though affordability must be explored in the context of the overall benefit design)

National Treasury refer to a National Social Security Fund (NSSF) and suggest that up to 5% could be allocated to risk benefits (of the first Rx of annual salary, up to a cap – possibly R60,000 but it could be higher).

Social Development refer to a Government Sponsored Retirement Fund (GSRF) and suggest a provisional allocation of 3% to risk benefits (of annual earnings above R12,000 with no talk of a cap).

For the purposes of this discussion, exploring possible benefit structures in more detail, the following benefits are excluded from the scope:

- ✓ Post retirement medical aid benefits;
- ✓ UIF ***(although this possibly should be included at this stage at a higher level than current and phased down to the current level as the employment situation in SA improves);***
- ✓ Road Accident Fund.

4. RATING FACTORS & CROSS SUBSIDISATION

Rating Factors

Rating factors are factors that are taken into account to predict a scheme's future claims experience. These different factors constitute allowable forms of discrimination and help define why scheme A will pay x and why scheme B will pay y.

Risk factor	Risk level		Reason for the difference in risk
	Low	High	
Age	Young	Old	As people age the likelihood of becoming disabled or dying increases.
Gender	Female	Male	Females generally have a lower mortality rate than males especially at younger ages (20-30) where accidents are the most significant cause of death.
Region	Western Province	KZN	The HIV pandemic has spread at different rates in different regions in the RSA. Violence also increases the death risk in certain areas.
Industry	Financial	Mining	Industries can have higher mortality rates due to the danger involved in the job or due to the higher risk individuals that are employed.

Occupation	Professional	Heavy manual	Similar to industry heavy manual workers are more likely to be injured on duty and less likely to afford the best medical services. Certain occupations are more hazardous than others and are therefore a higher risk. Note that an executive (low risk) working in a mining industry (high risk) would probably have a similar risk factor to an executive in a financial institution.
Salary level	High	Low	Salary is a proxy for socio-economic class. Lower earners display a higher probability of death. As a person's salary determines the quality of the medical services that can be afforded. The spread of HIV has also been fastest in the lower income sector and lower earners are generally less aware of health issues.
HIV Management Programme	Yes	No	The presence and effectiveness of such a programme could bring about reduced rates, though if the programme has been in existence for a while, the positive impacts may already be evident in the experience.
State of health of the persons covered	Actively at work	Not	Are all members of the group actively at work, or are some of them disability claimants?

These factors will be used to set a technical rate, which is blended with an experience rate to provide the risk premium. The rate assessor will use judgement to make further adjustments and then load the risk rate for fees and profit.

Cross Subsidies

Cross subsidies form the heart of all insurance arrangements and essentially constitute allowable discrimination, though these cross subsidies must always be considered in light of any relevant legislation. People pool their experience together to rather pay the average claim cost than be exposed to the volatility of their own experience. As a result the premiums of people that survive cover the claims of those that die.

Decision-makers need to agree the level of cross subsidy between members that they are comfortable with. This section defines the most common types of cross subsidy, how to remove cross subsidies, and the balance between treating people equitably and pooling risk.

Types of cross subsidy

Cross subsidies arise when different risks are pooled together and charged an average premium. When this is the case the lower risk individual is paying too much (the average is higher than his or her risk) and the higher risk individual is paying too little (the average is lower than his or her risk). When different people are charged the same rate the higher risk individual is therefore subsidised by the lower risk individual.

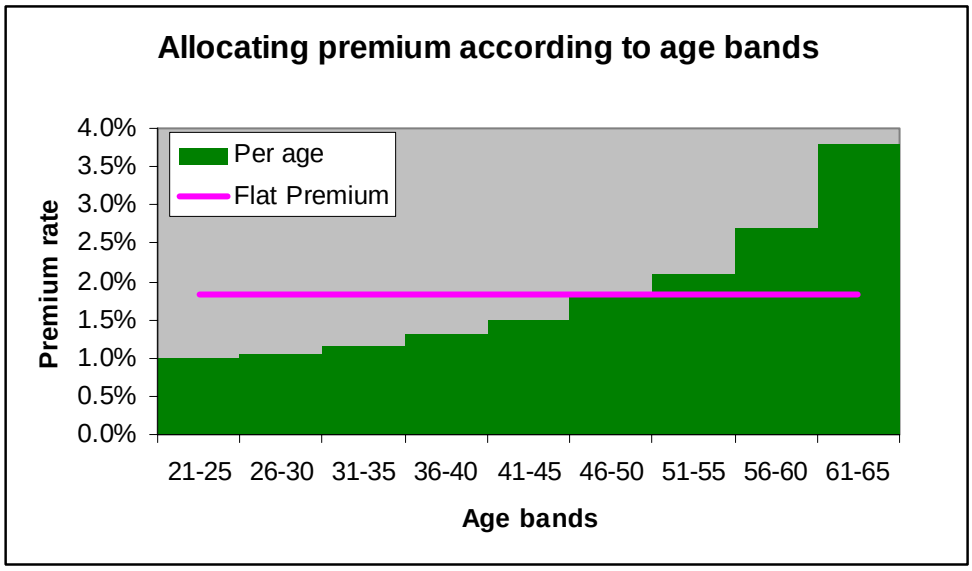
For example, assume that Males have a 2% chance of dying while females have 1%, if an insurer charges 1.5% the females are overpaying by 0.5% and the males underpaying by 0.5%, in total all the costs are covered but the females are subsidising the males.

Removing cross subsidies

Cross subsidies can be removed by splitting members into similar groups, where each member in the group has a similar level of risk to the others in that group, for example, to remove age cross subsidies, members could be grouped into 5-year age bands.

Once members are grouped each group is charged a premium that reflects the common risk of that group. The more groups used the more accurate the premium and the less pooling of risk across the wider pool of members.

The graph below plots two pricing scenarios: the pink line could be charged to all



members or the premiums could vary per age (according to the green area).

Equity vs. pooling of risk

Every person is unique and has a different risk level to his or her colleagues. When deciding whether to differentiate or how much to differentiate, decision-makers must balance the following factors:

- ✓ **Equity/fairness**: this means every person should be treated fairly and cross subsidies should be removed, the lower risk person should pay less for the same cover as a higher risk person.
- ✓ **Smoothing experience**: as mentioned before, insurance pools individuals together and charges everyone an average rate. This averaging means that people don't need to worry about their particular risks and the community shares the costs. This force therefore encourages people to be grouped together and more cross subsidies.
- ✓ **Political sensitivity**: in almost each case of risk classification there is the danger that it is viewed as unfair discrimination (e.g. is charging males more than females unfair discrimination, or is it unfair discrimination for females to be charged more than the risk they represent?). The trustees and employer need to be sensitive to the feelings of members when deciding how to group

people. This force promotes cross subsidies and pooling more members together.

- ✓ **Cost effectiveness/practicality**: Group assurance cover is usually considerably simpler than individual cover (e.g. everyone gets R100,000 cover rather than each person buying his or her own cover). This simplicity greatly reduces the administration effort, and therefore cost, of providing the cover. As a result this force encourages decision-makers only to differentiate between major risk groups where the effect is significant and justifies the increased admin cost.
- ✓ **Is cover compulsory or voluntary**? Where cover is compulsory all members are forced to have the cover and there can be pressure to simplify the offering and pool members rather than split them into groups as the political sensitivities mentioned above are magnified when the cover is compulsory. When the cover is voluntary members are electing whether to participate or even how much cover to buy and as a result the need to charge a fair and equitable price is increased.
- ✓ **Who pays for the cover?** This point is similar to the compulsory/voluntary point above. When the employer pays the premiums there may be more pressure to pool all employees and provide a standard level of cover to all. However, when the members pay for their own cover it makes more sense to remove cross subsidies and charge a fair and equitable price.

Risk pools in the context of a national fund

Overall, it is likely that cross-subsidization will not be accepted by people covered under existing risk benefit arrangements.

The discussion around risk pools will certainly be an emotional one for most employees currently enjoying risk benefits within a group arrangement. Even in industries and regions where AIDS experience is the worst, employers have been taking proactive measures to educate employees and limit the impact of AIDS on their workforce.

By extending risk benefit cover to a far wider group of lives, there is a reasonable prospect that the ratio of low income-earners in the national fund will exceed the ratio that exists in most existing retirement funds/employer groups. On this basis, you can expect many of the existing members of such arrangements to experience a national fund in a negative light, since their risk benefit cover levels in the national fund are likely to be lower than the level of risk benefits they are enjoying currently. This is

because the risk premium rate for the national fund is likely to be higher than the risk premium rate being charged for most of the existing arrangements, and hence the same rand amount of premium will buy less cover under the national fund.

Comparing a possible national fund set of benefits with the current average benefit levels being enjoyed by most funds (including funds with a significant number of low income earners) reveals the following:

	Possible National Fund	Current Average
Lump sum death benefit	2 x AS	3.5 x AS
Disability income benefit	75% with 6-month waiting period	75% with 6-month waiting period
Funeral benefit	R5,000	R7,500 (with about 50% offering R10,000 and 50% offering R5,000)

Our sense is that the “access to all” principle also implies the adoption of the “social” principle of high income-earners (low risk groups) cross-subsidizing low income-earners fully. Assuming this to be correct, then what the table above highlights is the need to communicate the rationale for the national fund very clearly and effectively, since the loss of benefits will be a very emotional issue for most individuals.

Even relatively low income-earners currently (R2,000 – R5,000 per month employees, many of whom form the nucleus of large union funds) will be cross-subsidizing the even lower income-earners (R1,000 – R2,000 per month employees), who have not enjoyed access to such cover before. These individuals will no doubt struggle to accept a reduction in benefits.

In the context of what this reform is aiming to achieve though, our sense is that this is a challenge that must be taken on. No doubt there will be many engagements with Labour and our hope is that Labour will recognize that it is simply the extension of cover to an even larger group of low-income earners than ever before that is contributing to this “reduced benefit” dynamic.

5. POSSIBLE RISK BENEFITS STRUCTURE & COSTS

Given the principles above, the following benefits are presented for consideration:

- ✓ Death
  - o Traditional life cover – lump sum (either fixed multiple of salary for all; or a multiple of salary that decreases with age; or an amount of salary that can be purchased with a fixed amount of contribution, with or without retirement savings offset)
  - o Spouses and/or children's pension on death of the member – income (% of salary)
  - o Funeral cover – lump sum (fixed amount, could extend to spouse, parents and/or children)
- ✓ Disability
  - o Traditional disability income benefit, with a waiting period – income (% of earnings)
  - o Lump sum disability benefit

A short-term, temporary disability benefit is sometimes offered to bridge the gap between an employer's sick leave benefits and the waiting period (often 6 months) under a traditional disability benefit. This is not proposed in a national context for cost reasons.

While there is a specific need for other cover (e.g. for critical illnesses such as cancer, heart attacks, strokes, etc.), these are excluded from the analysis on the basis that very few people enjoy such cover in group arrangements currently and the overall costs are also very likely to be in excess of what is affordable.

The following factors play a critical role in determining what overall level of benefits is affordable:

- ✓ Total contribution to risk benefits (is it 3% or 5%? are retirement saving administration costs funded out of this amount?)
- ✓ Level of the or existence of a cap (the higher the cap, the greater the cross-subsidization of low income earners by high income earners)

Assuming a cap of R60,000, for a possible benefit structure of the following, the overall cost ***(excluding fees)*** would be:

	R60,000 p.a. Cap
2xAS life cover (1 x AS life cover) A spouses annuity even at a low replacement ratio of 40% is expensive	2.60% of payroll (1.30% of payroll)
R10,000 funeral benefit member only Including parents (R5,000) and children (R2,500)	0.4% of payroll 1.00% of payroll
75% disability income with a 6-month waiting period, 5% escalation	1.07% of payroll
TOTAL (2xAS, member only funeral, disability) **TOTAL (1xAS, member only funeral, disability)** TOTAL (2xAS, family funeral, disability) TOTAL (1xAS, family funeral, disability)	4.07% **2.77%** 4.67% 3.37%

The structure highlighted in blue is within the cost parameters proposed by National Treasury and DSG

Note: *The pricing is highly sensitive to the average salary (however defined) in the working population group. The impact of a greater number of employees at the R1000 - R2000 per month average salary level is the main reason for the costs reflected above being different to that in the Sanlam survey (mentioned above in Section 2) Certainly, the contribution levels are* ***highly sensitive*** *to average salary. In addition, the Sanlam survey does not include a funeral benefit, which we have suggested as a possible benefit.*
Therefore, we could suggest the above benefits could be regarded as the likely ***minimum*** *benefit.*

General charges, margins and fees

Over and above the premium for the pure risk, most offices would load rates to

account for the following:

- Broker commission - up to 7.5% of the gross premium but scaled down substantially for larger schemes. **Not applicable here**
- Administration charges - typically of the order of 3% of the gross premium.
- Claims assessment management charges - usually from 5% for group life benefits, but ranges up to 12% of the risk premium for group disability income.
- Options - various options could be incorporated at loadings of 2.5% to 10% of the risk premium. **Not applicable here**

The above risk premium rates would, on average, need to have a 10% loading on the abovementioned percentages of payroll.

In addition, we propose that the death benefit be paid over period of time to the beneficiary. The appropriate period needs to be debated. For example, the period of payment may dependent on the size of the benefit with smaller benefits paid over a shorter time and/or consider aggregating and linking into the payment mechanism used to pay out the funded benefits. Funeral benefits are to be paid in full.

Source :

- Internal life offices pricing models, using data models derived from the SA Working Population statistics, Labour force statistics and AMPS data.
- ASSA (Actuarial Society of South Africa)

6. ADMINISTRATION

The administration of group risk benefits differs significantly from the administration of retirement funding arrangements. This summary focuses on the key group risk administrative processes. The administrative processes required from the perspective of a national scheme naturally will differ in many respects, but these will be self-evident from the summary below.

Product development
A team of actuarial resources is involved in the design and pricing of new products, and the maintenance of existing products. Reinsurers are available for support (e.g. if data is scanty).

Sales process
Currently most group business is sold via intermediaries (brokers). Some business is sold direct and some funds/employers elect to self-insure the risk benefits.

New business - tenders
Clients requiring risk cover request a tender from the insurer – either directly or through a broker. The insurer provides a quote, disclosing all the necessary terms and conditions required by FAIS. On the basis of these quotes, the client – often with the assistance of the broker – selects an insurer.

For large groups (say 1,000 members or more), an insurer will look at the actual experience of the group to determine the price/rate. For small groups (say under 200-500 lives), the insurer will apply a “technical” rate (i.e. a rate that is appropriate for that type of risk at large). For in-between-sized groups, the insurer will charge a combination of the technical and experience rates.

New business – contracts
If the tender was successful, the insurer will issue a contract formalizing the commitment to provide the benefits at the tendered rate.

Loading of scheme and member data
At this stage, the insurer will capture the scheme- and member-specific information in the relevant administrative database. It is important to ensure that the membership at take-on stage corresponds with the membership on which the original tender was

based. This information also makes it easier to check monthly premium payments as well as manage any claims that may be submitted during the coming year.

Medical underwriting
Most business still has maximum benefit limits, above which individuals need to go for underwriting (= "evidence of health"). This helps to prevent anti-selection from a high-earning senior executive and as such keeps the group cover affordable. Note that unhealthy lives will still be covered up to maximum "evidence of health" limit (also known as "free cover" limit – "free" in the context of "free from providing evidence of health"). Note also that unhealthy low-income earners are not a concern, since this does not impact on the overall rate too much.

Many insurers provide a facility where the basic underwriting assessment (e.g. drawing of blood for blood test) is done by a nurse who visits the individual at their place of work (or other convenient location).

Monthly billing and income management
Insurers issue a monthly invoice and employers/funds pay the invoice (either directly or via the fund administrator, respectively). The invoice is effective at the start of the month and is usually paid at the end of the month or in the early part of the next month (i.e. between 30-45 days after the invoice date). The insurers will check the payment to ensure that not too little or too much is paid.

Monthly updating of member data
It is not essential to obtain monthly member data, however if it can be obtained this will make premium and claims management more efficient. If a claim is submitted for a member of a group who was not in the group at the start of a year, it is normally quite simple to confirm that individual's membership and salary for claim payment purposes.

Commission payments
Where business is sourced through a broker, the insurer will pay commission in line with the approved commission scales.

Reassurance calculations and payments
An insurer may reinsure/reassure the risk with a reinsurer, either a percentage of their total book of business, or a percentage of a selective scheme(s), or only cover about a certain size (either for individual or bulk claims). Where this occurs,

administrative processes are required both to pay the premium due to the reinsurer, as well as recover any claim amount that might become due.

Lump sum claim assessments and payments

When a claim for a death, funeral or lump sum disability benefit occurs, the legitimacy of the claim needs to be assessed. If the claim is valid, it is "admitted" and paid (either to the Fund or the employer, depending on who owns the policy). Note that Fund trustees must still investigate a death claim to assess to whom the benefits should be paid, so while a risk insurer generally pays a death claim within 3 days, the beneficiaries may not receive the benefit until much later.

Disability claim assessments and payments

The process of investigating disability claims is probably the most time-consuming and specialized process of a risk insurer. There is often a waiting period that must elapse and then information is sourced from a variety of stakeholders (doctors, physiotherapists, psychologists, employers, etc.) to assess whether the condition does in fact fulfill the disability definition for which the cover is being provided.

For a bulk group of disability claims, it is quite possible to see ratios as follows:

- ✓ 30% of claims admitted
- ✓ 40% of claims deferred for more information/assessment
- ✓ 30% of claims declined

For claims that are admitted, a monthly payment process needs to be put in place which also takes account of what level of benefit increase should be applied every year.

Ongoing disability reassessments

Even where a disability claim is admitted, it is necessary to reassess the claim on an ongoing basis. There is often a change in the disability definition after an "initial" period (12 or 24 months) – i.e. a claim could be admitted in the initial period because the person is unable to perform their "own" occupation, but then the claim gets reassessed after the initial period in terms of whether the person can perform their "own or similar" occupation.

A lot of emphasis is also placed on enabling the claimant to return to work, which, if successful, would enable the claim payment to cease.

Annual review of individual scheme experience and scheme rates
Most business is only insured for 1 year, after which it is "rebroked" by the broker or the rate is "reviewed" by the insurer. The insurer will assess the claims experience against what is expected and also check any changes in the make-up of the underlying membership. (Note that changes in membership during the year could also result in an earlier review of the rates.)

Annual review of overall benefit experience and underlying technical rates
It is vital for an insurer to look at their overall experience every year or two to ensure that the underlying price they charge for risk cover is correct. The analysis might bring about changes in the underlying technical rate (for pricing purposes) or the reserves that are held for death and disability benefit purposes.

Support Role / Administration from Other Stakeholders (e.g. Brokers/Consultants, Fund Administrators, Employers, Trustees, Unions, Other Suppliers)
The processes above are also supported by a wider group of stakeholders, as suggested by the title of this section. Without going into the detail of how these different stakeholders contribute to each of these respective processes, it is useful to highlight the sorts of inputs that a group risk administration process enjoys from these other stakeholders:

- ✓ Advice on optimal benefit structures
- ✓ Data provision
- ✓ Notification to/interaction with members requiring underwriting
- ✓ Actual payment of contributions
- ✓ Provision of information to assist with disability claims assessment
- ✓ Process for deciding the reasonable allocation of death benefits
- ✓ General and specific communication with individual members

We now explore the two fundamental parts of the administration process, i.e. accurate collection of premiums for all eligible members and maintenance and reconciliation of premium records; and the accurate payment of eligible claims. Obviously there are many factors that need to be covered within these components.

Premium collection and record keeping

- **premium collection methodology**
  It is important that all eligible members pay all the premiums that are due by them, within an acceptable time frame.

In view of the fact that an effective UIF premium collection methodology already exists for all eligible members in this pillar, it would make sense to link the payment of risk premiums to UIF premium payment, thus UIF returns should be expanded to include risk premium payment.

Alternatively, another option would be to link it to the mechanism used to collect the retirement savings portion and from there, reallocate into the risk benefits. The merits of this needs to be debated and would largely depend on the approach taken to opting out.

- **Credit control.**
  Credit control methodology needs to be implemented to ensure that each employer, or each individual if self employed, submits the appropriate return and payment each month.
  Strict controls and penalties for non-compliance need to be implemented to ensure that employers do not withhold deducted amounts.
- **Member record keeping**
  - Premium receipt records need to be maintained at member level in order that a full history of premium payments is available for each member including amount and date paid. This will be required to facilitate accurate and correct claim payment.
  - Beneficiary details will also have to be maintained so that payment is made to the appropriate person in the event of death. It is suggested that each member is required to nominate a beneficiary, and this information together with the beneficiary's contact details accompanies monthly payments. Ongoing reminders will be required to request members to keep their nominations up to date.
- **Member communication**
  Some form of member communication will be required, to allow members to obtain confirmation that their premiums are being paid and to give them details of the recorded nominated beneficiary. This could be done through SMS, post, email, internet query, toll free call centres, enquiry at government facilities, or arrangements could be made with banks for the information to be available through ATM's.
- **Premium reconciliations**
  Methodology needs to be developed to ensure that all receipts are accounted for, and amounts received are balanced against the premium payment records that have been created at member level.

- **Backdated receipts**
  Scheme rules need to be developed to limit the risk of anti selection through the back dating of premium payment or backdating of increases in order to secure payment of a claim or an increased claim value.

Many of these functions can and/or will form part of the administration of the retirement fund component (which as currently noted in the industry has been problematic and plagued by governance and record keeping issues).
The benefits of keeping retirement and risk integrated is that is will:

- Make "Backdated receipts" and Salary manipulation more difficult
- Reduce risk of fraudulent risk claims
- Focus Member communication, regarding premium payment, on the total contribution picture, and
- Focus on linking the Beneficiary election for Risk to Retirement Funding.

The comment assume that the administration of the Retirement Savings will follow the current practices in the private sector.

Claim processing

The overriding requirements for claim processing are speed and fraud control. Members and their beneficiaries must be confident that claims will be settled promptly to eliminate undue hardship, but at the same time, fraudulent claims need to be identified before payment is effected.

The key to effective, efficient and risk-reduced claims processing is a critical reliance on having access to the Home Affairs database. IT is extremely critical that this access forms part of the NSSF administration procedures.

- **Processing of death claims**
  - **claim notification**

    The Administrators of the scheme would normally have to be notified of a claim in order to initiate the claim process. It is suggested that claim notification should be submitted by employers, and should ideally accompany the first monthly remittance for which premium payment is not being made. The notification process should not require the submission of any documentation other than an annotation on the monthly return that a claim

should be processed. Where an employer does not exist, a recorded toll free line should be made available for claim notification by beneficiaries or dependants.

Rules needs to be developed regarding allowable time lines for claim notification.

- **verification of death of member**
  Submission of death certificate or certified copies should not be a requirement. The claim administrators should have full enquiry access to the records of Department of Home Affairs to verify membership identity and death registration, and no claim should be admitted if not fully supported by Home Affairs' records (ID documents and death certificates).
- **verification of validity of claim**
  The deceased's contribution record should be checked to ensure that premiums have been paid consistently throughout the member's working life up till date of death, and that the amount of premium paid is consistent with declared earnings.
- **Standard fraud checks should be conducted**
  e.g., that the dates of issue of documents by the Department of Home Affairs (particularly where duplicate Identity documents have been issued, or Identity Documents for older adults have been issued for the first time) are reasonable, that no back dated entries have been made, that UIF premiums or SITE or PAYE payments are not being received after date of death.
- **Duplication of claims**
  Methodology to prevent duplicate or multiple payment of the same claim must be developed e.g.) Access to Home Affairs, use ID numbers.
- **Payment of benefits**
  Current pension fund legislation requires trustees of retirement funds from which death benefit may be payable to conduct full investigations into deceased's circumstances to ensure that death benefits are distributed to all dependants and eligible nominated beneficiaries. Where death benefits are payable through insurance policies, policies generally make provision for employers to give instructions regarding equitable distribution of benefits, taking due regard of any beneficiary nominations. This process is both time consuming and very costly.

  It is therefore suggested that members are allowed to nominate beneficiaries of their choice, preferably dependants.

  Payment would be made to the nominees over a certain period of time.

Methodology will have to be developed to ensure that payment reaches the intended nominee and is not fraudulently diverted, particularly if the nominee is not aware of their nomination.

Disability claim processing

It is envisaged that the benefit payable in the event of disability will be a monthly annuity to the disabled member rather than a lump sum.

- The definition of disability needs to be developed
- Disabled members will be required to prove disability thus methodology for proof of disability will have to be developed. It will be necessary to create guidelines for medical examiners for methodology to use to verify the identity of the person being examined to ensure that it is the same person as the claimant.
- proof of ongoing disability will be required
- a suggestion would be that employers are required to pay members during their period of disability for as long as they are in employment, with the employer being refunded by the fund.
- Controls will have to be put into place that payment of disability benefits ceases as soon as the death of the member is notified to the Department of Home Affairs

7. FRAUD

Given the large discrepancy between price and benefit, fraud is an important risk factor. The impact of fraud and the cost of fraud management may be the single largest cost component in the pricing of risk benefits.

Implementation of aggressive fraud management from the outset will be imperative in order to contain costs since any benefit in reduced premiums that the poorer members of society would expect to obtain by being cross subsidised by the wealthy will be completely negated by the cost of fraudulent claims and their containment.

It can be expected that fraud will occur at every level, by individuals and syndicates who have permeated into all areas of economic activity. Collusion between officials issuing documents, medical personnel providing medical information, funeral parlours, organised syndicates, claim administrators and individuals is rife

Fraudsters obtain details of the fraud prevention measures that are employed and then take steps to avoid detection.

Government needs to mine its data bases from all sources to cross reference all submissions for accuracy and fraud detection, including income tax returns, monthly PAYE and SITE returns, registers of deaths and births, emigration records, travel records and grants being paid.

In addition, claim data will have to be mined to find trends that could indicate fraudulent behaviour such as:

- excessive claims occurring from a specific area,
- excessive number of deaths being recorded by a single doctor or other authorised signatory,
- same person being nominated as beneficiary,
- same bank account being used for more than one claim.

Existing claims need to be checked against population registers to check that deceased members have not been revived, or that members receiving disability benefits have not died.

The corporate benefits industry in South Africa, through its experience in providing cover to the private sector has identified the following areas of fraudulent activity of particular concern:

Fraud associated with Death Claims

1. **Fraudulent Registration of Deaths using unclaimed bodies**

Deaths are registered in the name of insured lives, using unclaimed/ unidentified bodies at hospitals and morgues. Claims are submitted and settled, and the fraud is only discovered when the unsuspecting person who had been registered as deceased has reason to contact the Department of home affairs.

2. Registration of deaths using fraudulent documentation

A death certificate is issued by home affairs on receipt of a form BI 1663 (which is completed by the attending doctor or a form BI 1680 if no attending doctor is present).

This completion of these forms facilitates fraud in the following areas:

- The form is completed but there is no body. The form is completed quoting an insured life's details (i.e., the person signing the form commits the fraud).
- A legitimate form is duplicated and fictitious details are inserted.
- Fraudulent forms purporting to be completed by Traditional Authorities are submitted.

  Forms completed by traditional authorities are particular problems as
  - their stamps are easily duplicated
  - their signatures are easily forged
  - Secretaries who are authorised to issue documents on behalf of the authorities can be threatened or influenced to sign irregular documents.
  - There is no register of traditional healers against which their details can be verified

3. "Correction" of incorrectly issued death certificates

The notification of death forms (BI 1663 and BI1680) record details of the deceased and the person identifying the body. A death certificate is issued, then it is claimed that the form was completed incorrectly with the details of the deceased and the identifier having been twisted. A new death certificate is issued, leaving both in circulation. The fraud is committed by immediately applying for benefits on the first issued document before it is cancelled, and then applying on the second.

4. Registration of births with the aim of subsequently claiming benefits.

A birth is registered, but no child exists. The registered record lays dormant, contributions are made to the fund, and then a claim is submitted.

5. **Registration of deaths occurring outside the borders of South Africa, using fraudulent foreign documentation**.
Syndicates submit fraudulent foreign documentation which is almost impossible to verify, to register deaths in South Africa of insured lives.

6. Inflation of sum assured or salary
Sums assured or salaries, on which the sum assured is to be based, are inflated retrospectively in order to increase the claim value.

7. Back dated contracts
Lives are added to scheme records or a contract is created retrospectively, after a claim event occurs, in order to obtain payment of a claim for a person who had no intention of obtaining cover until after the claim event occurred.

8. Multiple submission of the same claim
Claims papers are submitted several times for the same claim in the hope that the administrator's processes and record keeping abilities are not adequate to identify that the same claim is already being, or has already been, processed.

9. **Internal fraud**
Internal claims administrators create fictitious claims. Alternatively, they alter legitimate claim information to increase the benefit payable, with the claimant being paid their legitimate amount and the balance diverted to the fraudster.

Fraud associated with Disability claims

1. fraudulent medical records are submitted to substantiate claims
2. other people are passed off as the claimant at medical examinations to prove disability
3. disability benefits continue being claimed by dependants for deceased members
4. Members exaggerate disability in order to claim.
5. sums assured or salaries are inflated in order to increase claim amount
6. members self mutilate in order to claim
7. If the level of disability cover is high relative to income before disability, the claimants have no incentive to return to work.

8. contracts are back dated in order to secure payment of a claim for a person who was not a member
9. repeated claims are made for the same disability

8. TAX ISSUES

Current practice:

Most group business is derived from pensions business, i.e. employer sponsored schemes that provide a pension on retirement plus some benefits should the member resign, become disabled or die before attaining the pension age. The typical tax treatment of such schemes is that contributions (or premiums) are deductible for tax purposes. Benefits are taxed as earned income, with special provisions for partial tax-free lump sum benefits or taxation of the balance of certain benefits at average (rather than marginal) tax rates. Investment income on such arrangements did not attract taxation, although in recent years it has been taxed at a preferential rate.

Group schemes also include "unapproved schemes", where the employee would pay premiums out of after-tax income. If the employer pays the premium, then the deemed premium is taxed as income in the employee's hands. The benefits payable under such schemes would typically be free of tax.

Group life schemes fall into the "approved" category (i.e. tax treatment as for pension funds) or the "unapproved" category. Lump sum disability contracts similarly fall into both categories. Disability income contracts are usually treated as separate but similar arrangements to pension funds.

Table 1. Tax treatment of Group Schemes

		Employer position	**Position of insured person**
Approved Policies			
Fund Owned	Premiums	Contributions to the pension/retirement fund are tax deductible as a business expense. The fund would then pay the premiums.	Contributions to the pension/retirement fund are accepted as a deduction from income for tax purposes.
	Benefits	Policy proceeds are received by the fund. The employer is not affected from a tax perspective.	The proceeds are received by the fund. The fund will pay out proceeds in one or both forms: 1. A pension, taxed as

			earned income. 2. A lump sum that is taxed as set out below. There is a tax free portion (broadly twice annual salary, subject to a minimum of R120,000). The balance is taxed at the employee's average tax rate.
Unapproved policies			
Employer owned	Premiums	Premiums are paid by the employer and allowed as a tax deduction (Business expense)	No impact. Premiums are paid by the employer.
	Benefits	The proceeds are taxable when received by the employer but the payout to the employee is tax-deductible. Because the two amounts are the same the payments of a benefit is tax neutral for the employer.	Benefits are typically paid in a lump sum and are taxed as follows: 1. The first R30, 000 is tax free. 2. The balance up to a total of the last three year's taxable income is taxed at average rates. 3. The balance is taxed at the employee's marginal rate.
Voluntary or employee owned	Premiums	The employer pays premiums that are allowed as a tax deduction (business expense) – net of any portion of the premium recovered from the employees.	The employees pay tax on the deemed value of any net contribution made by the employer. Premiums paid directly by the members of the scheme are not deductible for tax purposes.
	Benefits	Benefits are paid directly to the beneficiaries nominated	Benefits are paid to the beneficiaries free of income

		by the members – employer not involved.	tax (no tax payable).

Tax in terms of NSSF:

According to Treasury the envisaged resultant tax environment will allow for:

- Tax encouragement of mandatory contributions to the national security fund and private retirement funds;
  Limited tax-encouragement of a supplementary, voluntary component; and
- No special tax treatment above a certain ceiling.
- Minimum benefit (Pillar 1) – contributions pre-tax and benefits paid are tax free.
- Pillar 2 and 3 – contributions pre-tax and benefits taxed.
- Tax incentivisation required for mandatory savings and risk products
- Potential for cross-subsidies between income groups via wage subsidy or tax reform
- Contribution cap on taxation of benefits paid. Benefits paid on contributions less than X% are tax free.
- Incentivisation for those outside of the formal employment sector

Benefits paid in respect of Pillar 1 should be tax-free.

9. IMPLEMENTATION

The following points are guidelines to the implementation of risk benefits and are not set out in order of priority or are comprehensive in nature.

11.1 Risk management

Prior to any scheme offering insurance cover, a clear understanding of the risk to be covered is required.

11.2 Reduced need for master policies

Current practise requires that each group scheme be supplied with a master policy. The master policy outlines the terms and conditions of the contract. A universal group scheme would eliminate the need for multiple policy documents. Where voluntary schemes are created the need for a separate policy document will arise.

Standardisation of the policy terms and conditions will also reduce the need for lengthy and sometimes ambiguous policy wordings.

11.3 Collection of contributions

The collection of contributions should be done on one simple platform that is simple to administer and reduces the constraints on Human Resource departments. SARS could be proposed to collect contributions.

11.4 Payment of claims

Death benefit payments are generally a function of the administrator and requires little assessment. Receipt of a claim of application and death certificate is usually all that is required to authorise payment. Early claims could require additional assessment.

Disability claims require assessment skill and a thorough knowledge of the work function. The team of assessors should be employed to manage the payment of disability claims.

11.5 Fraud

The management of fraud will be key to the success of the provision of insurance benefits. Section 7 deals extensively with this subject.

11.6 Underwriting

As the size of the schemes increase the need for underwriting can be reduced. Where compulsory benefits are offered the need for underwriting will certainly be eliminated. It is only is cases of voluntary benefits where the concern for anti selection arises and therefore the increased need for underwriting.

Where medical underwriting is performed the scheme must ensure the data can be adequately stored and retrieved. Personnel handling the data must be adequately trained and be informed of the need for confidentiality.

11.8 Existing insurance industry

The South African insurance industry is an internationally respected industry. The industry has been at the forefront of insurance innovations. The government could make use of this expertise to create a seamless link to the provision of insurance benefits.

11.9 Regulation and supervision

A strong regulatory environment geared towards the protection of the consumer is essential.

11.12 Switching flexibility

A flexible system allowing consumers the freedom to switch providers should be encouraged.

11.13 Reporting principles

All providers of insurance benefits must adhere to prescribed reporting principles.

11.14 Catastrophe cover (capacity and cost)

Providers of insurance benefits must purchase adequate catastrophe cover. Providers must be required to produce evidence of the cover secured.

11.15 Expatriate cover

As South African expands into the Global economy it's citizens so too will follow the business opportunities. Companies will therefore require cover for it's members who are based in other countries. Social security must allow for the provision of cover for expatriates working abroad.

10. APPENDIX

Approved vs. Unapproved Benefits

Which benefits can a pension or provident fund provide?
The Pension Fund in the Pensions Funds Acts1956 regulates an association of persons established with the object of providing annuities or lump sums for members or former members of the fund upon their reaching retirement dates, or for the dependants of such members or former members in the event of their death.
A retirement fund may therefore only facilitate for the funding and payment of annuities and for payments of benefits on death of its members and former members. Any other benefits are provided directly through insurance polices.
Retirement funds may make application to the commissioner for Inland Revenue for approval as retirement funds. Contributions to Approved retirement funds are fully tax deductible and claim benefits are taxable; premiums for benefits provided by arrangements that are not approved (Unapproved arrangements) are not tax deductible, and lump sums paid are not taxable.

Pension and provident fund rules have been designed to provide benefits when a member leaves the fund (e.g. retirement, death or another termination of service).

This concept is currently being reviewed (in order to enforce preservation) but at present it still stands.

As a result, the fund can provide death benefits directly. However, there are two types of benefits that cannot be provided via a pension or provident fund:

- Benefits that insure the member but don't coincide with an exit from the fund (e.g. living assurance benefits that provide insurance cover for dread diseases) and
- Benefits that insure other people (e.g. a member's spouse or family).

These benefits need to be provided through a separate arrangement. In these instances the contract is usually with the employer or Union (or whatever entity defines the group being covered).

The table below splits products according to whether a pension or provident fund may provide them or not. Please note that the benefits in the first column may also

be provided separately. For example even though members' death benefit can be provided through a fund they could be provided separately.

Table A: Benefits that a fund may provide

May be provided	May not be provided
Death benefits (on member's life)	Disability income benefits – Permanent Health Insurance (PHI)
Retirement benefits	Total and Temporary Disability (TTD)
Accelerators of permissible benefits that are paid when the member leaves the fund (e.g. Lump Sum Disability Benefits)	Accelerators that don't require the member to exit (e.g. Living Assurance)
Member-only funeral cover	Spouses cover
	Family cover (i.e. Funeral cover for extended family)

"Approved" and "unapproved"

"Approved" means that a scheme is tax approved by the Commissioner for Inland Revenue. Some schemes are approved and others are not.

Table B: Effect of being approved or unapproved

	Approved	Unapproved
Premiums	Tax deductible	Form part of a member's taxable earnings (i.e. are taxed)
Benefits	Usually taxed	Lump sum benefits are tax free.

Any stand alone fund which was approved before 1.7.1986 retains its approval, but no new employers are allowed to join after 1.7.1986

Even though a fund may meet all requirements to be approved it may not request approval and therefore be unapproved.

Current Relevant Legislation

The following legislation is typically considered when structuring risk benefits:

- ✓ Labour Relations Act (LRA)
- ✓ Employment Equity Act (EE)
- ✓ Promotion of Equality & the Prevention of Unfair Discrimination Act
- ✓ Policyholder Protection Rules (PPR) - Long Term Insurance Act
- ✓ Financial Advisers and Intermediary Services bill (FAIS)

However, we are not sure of the application is retirement and social reform as proposed.

Summary of Typical Group Risk Products

The following summaries will give the reader a comprehensive sense of the products that can be purchased currently in the group risk market. (Those in bold are most likely to be considered from a reform perspective.)

Life Benefits

These products pay a benefit on the death of the insured:

- ✓ **Group Life Assurance (typically a multiple of salary)**
- ✓ DC Life Cover (cover levels decrease with increasing age)
- ✓ Credit Assurance
- ✓ Spouses' and Child's Pension Cover
- ✓ **Family Cover (funeral benefit)**
- ✓ **Extended Family Cover (funeral benefit)**
- ✓ Spouses' Life Cover
- ✓ Accident Death Cover

Accelerated Life Benefits

These products pay an advance of the life benefit (i.e. acceleration) on the diagnosis of a disabling condition of the insured. Some of these are also available on a stand-alone basis:

- ✓ **Lump Sum Disability** – lower cost alternative to disability income
- ✓ Critical Illness (cover for cancer, strokes, etc. – also known as "dread disease" cover)
- ✓ Dismemberment Insurance
- ✓ Spouses' Disability Cover
- ✓ Terminal Illness

Disability Benefits
These products pay a benefit (unrelated to any life benefit) on the temporary or permanent disablement of the insured:

- ✓ **Disability Income (PHI product)**
- ✓ Managed Disability
- ✓ Limited -term Disability
- ✓ Accident Disability Cover
- ✓ personal accident cover

Summary of Risk Benefit Structures within DB and DC Funds

Key differences between Defined Benefit (DB) and Defined Contribution (DC) Arrangements

DEFINED BENEFIT FUND	DEFINED CONTRIBUTION FUND
Treatment of Risk Benefits:	
The risk benefits are specified and the Employer/provider needs to meet the cost thereof. This could be a significant open-ended liability especially in an unchecked AIDS environment.	The risk benefits can continue to be provided on a defined benefit basis, although the benefits often need to be adjusted on a regular basis to compensate for the increasing costs due to AIDS.
The Risk benefits are generally defined in terms of need e.g. life cover, disability cover, spouse's benefits, family funeral benefits. They are sometimes criticised as being unfair to especially single members.	It is possible to eliminate all cross-subsidies, and provide members with a degree of choice about the level of their risk benefits relative to the contributions being paid on their behalf. this is true of DB funds too
Where risk benefits are provided in a Defined Benefit manner (e.g. 3x AS for group life cover), then it is increasingly common for a contribution cap to be introduced to limit the potential contribution liability. When the cap is reached, the most common action is to reduce the level of defined benefit being provided (e.g. from 3x AS down to say 2.5x AS).true of Dc funds too	Some funds have started to offer benefits in a Defined Contribution manner (e.g. the level of contribution is defined – say 2% of AS – and the benefit is whatever level of cover can be purchased for that level of contribution). This concept is commonly extended to different age groupings, both to allow more appropriately for need (younger lives typically need higher levels of life cover, when expressed as a multiple of AS) and also to eliminate age cross subsidies. this is true of DB funds too

Glossary of terms & acronyms

Accident Disability Benefit	Accident Disability Benefit will be paid when the member is totally and permanently disabled as a result of an accident.
Accident Death Benefit (ADB)	Accident Death Benefit provides an additional lump sum payment on the death of a member if his death is as a result of an accident.
Any Occupation DB	A type of disability definition for which a claimant must not be able to follow any occupation whatsoever, in order to receive the benefit.
Broker	An external adviser on insurance matters who acts between the Company and Insurer.
Brokerage	Brokerage is the fee given to the broker for his/her work performed. Also known as “commission”.
Contract	The document that sets out the terms, conditions and benefits of the scheme.
Conversion option (CO)	Conversion option allows an employee who belongs to the Plan the option to convert group cover to an Individual Life policy when withdrawing or retiring from the group, without needing to provide any evidence of health (except for an HIV test and a cotinine test if a non-smoker).
Covered	A person covered by a Group Assurance scheme is one who has fulfilled the eligibility requirements of the scheme.
Cover to continue (CTC)	Cover to continue makes provision for the continuation of GLA for the member in the event of ill-health early retirement or in respect of a disability claimant.
Critical Incidents	In the case of a specified dread disease, such as a heart attack or major organ transplant, the payment of life cover can be accelerated to meet the accelerated expenses e.g. medical costs.
Credibility Factor	Credibility factor is the level of credibility that is given to

	the experience i.e. the chances of past experience being repeated in the future.
Credit Assurance	Credit Assurance pays off the loan outstanding if the insured borrower dies (or becomes disabled).
Dismemberment	Dismemberment Insurance compensates the member for injury that results in the loss (or loss of use) of a limb, eyesight or hearing due to accidental causes.
Evidence of Health (EOH)	A medical Report or Questionnaire satisfying the underwriter's conditions for cover.
Evidence of Health limit	The cover or salary limit set by the underwriter up to which a member is not required to submit evidence of good health.
Experience Rate	Assuming no major changes in scheme membership and benefits have occurred, the experience from the past 5 years can be a good indicator of future experience. The experience rate is that which would have produced premiums (net of expenses) equal to claims. A method used to determine the GLA rate by means of claims experience rather than actual member's data.
Free limit	The cover or salary limit set by an insurer, up to which a member is not required to submit evidence of good health.
Group Life Assurance (GLA)	GLA provides life cover for a group of people.
Ill-health early retirement	Retirement on medical grounds before normal retirement date.
Loading	A percentage of the original cost (of the benefit) to allow for extra benefits or extra risk.
Lump Sum Disability (LSDB)	A disability benefit that compensates the member for lost earning capacity in the event of total and permanent disablement.
Medicals	A report or questionnaire in which a member's state of health is declared when applying for additional cover.

Own or similar occupation	A type of disability definition whereby a member will be eligible for the benefit if he is unable to follow his own or a similar occupation as result of disablement.
Policy	The contract issued by an insurer stating the terms and conditions governing the Group Assurance scheme.
Policy Fee	This is a nominal charge towards the administration and policy printing costs.
Pre-existing Conditions	Pre-existing conditions are medical conditions which exist at the time a member becomes covered for benefits and which could lead to disablement or death within a short period.
Premium	The cost to provide the Group Assurance benefits, and where applicable, the cost for the individual policy effected under the conversion option.
Rate per mille	Rate per R1 000 of cover.
Retention limit	The maximum amount of the assurance cover that the insurer is prepared to carry on any one individual life.
Salary Bill	The total monthly or annual salaries a Company pays to its employees.
Soundness	A term used to describe a scheme's financial stability in relation to the benefits it must provide.
Spouse's & Children's Pension Cover	Spouses' and Children's provides for the payment of a pension to the surviving spouse and/or orphans of the deceased, on death before retirement.
Spouse's Cover	This is a death benefit designed to cover the spouses of employees who are covered under the scheme.
Standard lives	A term applied to those members who, in the opinion of the underwriters, are in a state of health that does not constitute an abnormal risk.
Sub-standard lives	A term applied to those members who, in the opinion of the underwriters, are in a state of health that does constitute an abnormal risk.

Sum assured	The amount payable on death or disablement.
Technical Rate	Technical rate basis is a theoretical rate basis ignoring experience.
Total & Permanent	A type of disability definition where, in order to qualify for a benefit, a member must be totally disabled through accident or illness to the extent that he is incapable of earning an income from his own occupation, a similar occupation or another occupation for which he is reasonably suited by education, training or experience.
Underlying rate	The scale of premium rates used to determine the cost (premium) of a basic death benefit.
Unit rate	The average death benefit premium expressed as a rate per R1 000 death benefit.

11. ACKNOWLEDGEMENTS

The document was compiled by a sub-committee of the Group risk Managers Forum comprising John Kotze (Old Mutual), George Allen (Munich Re of Africa), Tjaart Esterhuyse (Metropolitan) and Tobé Hope (Hollard), and submitted to the LOA Retirement & Social Security Reform – Joint Forum.

The information in the document is taken form a number of internal sources which may have been supported by external studies, academic papers and hence those acknowledgments are noted where applicable.