FSCA

Financial Sector
Conduct Authority

FINANCIAL SECTOR REGULATION ACT, 2017

NOTICE REGARDING THE PUBLICATION OF DRAFT AMENDMENTS TO THE POLICYHOLDER PROTECTION RULES PRESCRIBED UNDER SECTION 55 OF THE SHORT-TERM INSURANCE ACT, 1998

The Financial Sector Conduct Authority (FSCA), in accordance with section 98(1)(a)(iv) of the Financial Sector Regulation Act, 2017 (Act No. 9 of 2017) (FSR Act), hereby invites submissions on the draft amendments to the Policyholder Protection Rules (Short-term Insurance), 2017 (STIA PPRs) to be made in terms of section 55(1) of the Short-term Insurance Act, 1998 (Act No. 53 of 1998), as per the Schedule below.

It is proposed that these amendments come into operation six (6) months after the publication of the final notice setting out the amendments in the *Gazette*.

The draft Notice, together with a tracked version of STIA PPRs showing the proposed amendments and a statement supporting the proposed amendments, are available on the FSCA's website at https://www.fsca.co.za.

Submissions on the draft Notice and supporting documents must be submitted in writing on or before **10 September 2021** to the FSCA at FSCA.RFDStandards@fsca.co.za. Commentators are requested to make use of the submission template published alongside the document available on the FSCA's website.

Unathi Kamlana
Commissioner
FINANCIAL SECTOR CONDUCT AUTHORITY

Date of publication: 30 July 2021

SCHEDULE

1. Interpretation

In this Schedule "the Rules" means the Policyholder Protection Rules (Short-term Insurance), 2017 promulgated under the Short-term Insurance Act, 1998 as published in Government Notice 1433 of 15 December 2017 and amended by:

GN 996 GG 41928 20180928.

2. Amendments to the Rules

(1) Chapter 1 of the Rules is hereby amended by –

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

"'beneficiary' has the meaning assigned to it in Schedule 2 of the Insurance Act;";

(b) the insertion in section 2.1 in Section 2 after the definition of "claimant" of the following definition:

"'commercial lines'" has the meaning assigned to it in the Insurance Act;";

(c) the substitution of the definition of "consumer credit insurance" in section 2.1 in Section 2 of the following definition:

"'consumer credit insurance' means one or more policies written under the Consumer Credit class of non-life insurance business as set out in Table 2 of Schedule 2 of the Insurance Act;".

(d) the deletion of the definition of "credit life insurance" in section 2.1 in Section 2;

(e) the substitution of the definition of "group scheme" in section 2.1 in Section 2 of the following definition:

"'group scheme' means a policy with a group as defined in Schedule 2 of the Insurance Act;";

(f) the deletion of the definition of "mandatory credit life insurance" in section 2.1 in Section 2;

(g) the deletion of the definition of "optional credit life insurance" in section 2.1 in Section 2;

(h) the substitution of the definition of "policy" in section 2.1 in Section 2 of the following definition:

"'policy' means a short-term policy;".

(i) the insertion in subsection 2.1 in Section 2 after the definition "potential policyholder" of the following definition:

"'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;".

(2) Chapter 2 of the Rules is hereby amended by –

(a) the substitution in rule 1.4 in Rule 1 of the following rule:

"An insurer must have appropriate policies**,** **[and]** procedures and systems 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 and objectives 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."

(3) Chapter 3 of the Rules is hereby amended by –

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

"RULE 2: PRODUCT DESIGN

2.1 **Product design principles**

2.1.1 An insurer must in developing products-

(a) make use of adequate information on the needs and objectives 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 policyholders and members;

(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;

(d) consider potential vulnerability of a product to fraud and money laundering based on its design.

2.1.2 The board of directors of an insurer is responsible for the appropriateness of all products that are introduced in the market.

2.1.3 An insurer must, when developing products, ensure that the product design –

(a) is based on realistic assumptions; and

(b) will not result in terms, conditions and product features that are overly complex.

2.1.4 Where a policy includes loyalty benefits-

(a) the structure of the loyalty benefits must be such that there is no undue cross-subsidies between those policyholders who receive loyalty bonuses and those policyholders who do not receive loyalty bonuses; and

(b) the product design must incorporate a payment structure upon termination of the policy due to the death of the policyholder that allows for the pay out of any accumulated value of the loyalty benefit to the policyholder or nominated beneficiary.

2.2 **Requirements of product design framework**

2.2.1 An insurer must establish, maintain and operate an adequate and effective product design framework to ensure the fair treatment of policyholders and that-

(a) is adequate and 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; and

(c) address and provide for, at least, the matters provided for in this rule.

2.2.2. The board of directors of an insurer must approve and oversee the effectiveness of the implementation of the insurer's product design framework.

2.2.3 An insurer must regularly review its product design framework and document any changes thereto.

2.2.4 The product design framework must, at least, provide for-

(a) relevant objectives and key principles for the development of new products and affecting any material change in design of existing products across the business of the insurer;

(b) appropriate performance standards and remuneration and reward strategies (internally and where any functions are outsourced) for product design;

(c) documented procedures for an appropriate product design process;

(d) documented procedures which clearly define the product approval processes within the product design framework; and

(e) the appropriate level of involvement of its compliance function prior to product approval.

2.2.5 Any person involved in the designing of insurance products must have the necessary experience, knowledge and skills to understand –

(a) the expected functioning of the insurance product; and

(b) the interests, objectives and characteristics of the kinds or categories of policyholders or members it is intended for.

2.2.6 An insurer must test all products appropriately before starting to market, offer or enter into specific policies in respect of a new product, and before affecting any material change in design of an existing product.

2.2.7 The product testing referred to in in Rule 2.2.6 must –

(a) assess whether the product will on an ongoing basis and over the lifetime of the product meet the identified needs, objectives

and characteristics of the kinds or categories of policyholders or members it is intended for; and

(b) be done in a qualitative and quantitative manner depending on the type and nature of the insurance product and the related risk of detriment to customers.

2.3 Product design approval

2.3.1 Before an insurer starts to market, offer or enter into specific policies in respect of a new product, or an existing product to which material changes have been made, a senior manager or a product approval committee must –

(a) in writing approve the product; and

(b) confirm that the product, distribution methods and disclosure documents meet the requirements set out in rule 2.2.

2.3.2 A product approval committee of an insurer referred to in rule 2.3.1 must –

(a) be established with the main purpose of approving the products of the insurer;

(b) be structured to ensure that it has the necessary authority, independence, resources, expertise and access to all relevant information to perform its functions; and

(c) consist of appropriate senior manager representation.

2.3.3 The product approval required in terms of this rule may not be delegated to another person, committee or forum by a senior manager or product approval committee.

2.4 This rule only applies to the development of any new product as of 1 January 2018 and any material change in design of an existing product."

(b) the deletion of rule 2A.4.1 in Rule 2A;

(c) the deletion of rule 2A.4.2 in Rule 2A;

(d) the substitution in rule 2A.6.1 in Rule 2A for the following:

2A.6.1 A microinsurance policy, underwritten under the accident and health class of non-life insurance business as set out in Table 2 of Schedule 2 to the Insurance Act, may not impose a waiting period exceeding the shorter of one quarter of the term of the policy or 6 months, in respect of which policy benefits are payable on the happening of a **[death, disability or]** health event resulting from natural causes.

(e) the substitution in paragraph (a) in rule 2A.6.5 in Rule 2A for the following:

"(a) the policyholder or member, **[at least]** within 31 days **[before]** preceding the date of entering into a new microinsurance policy with that insurer, had a previous policy with another insurer;"

(f) the insertion in rule 2A.11.1 in Rule 2A for the following:

"When providing a service or similar benefit as a policy benefit under a microinsurance policy, a microinsurer or any person on behalf of a microinsurer may not charge the policyholder, beneficiary or member any administration or similar fee in respect of that service or similar benefit."

(g) the substitution of the title of Rule 3 of the following title:

"RULE 3: [CREDIT LIFE AND] CONSUMER CREDIT INSURANCE"

(h) the deletion of rule 3.1 in Rule 3;

(i) the substitution in rule 3.2.1 in Rule 3 for the following:

"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 **[or, in the case of a registered insurer, and other credit life policy]** 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 any demands of a credit provider under section 106(6) of the National Credit Act."

(j) the insertion after rule 6.1 in in Rule 6 of the following rule:

"6.1A An insurer must when determining any excess payable under a personal lines policy where the aggregated excess amount exceeds the lower of R10 000 or 5% of the value of the insured risk -

(a) take into consideration the policyholder's ability to financially bear any costs or risks associated with the excess by conducting an affordability test; and

(b) disclose to the policyholder in writing the result of the affordability test referred to in (a) before the policy is entered into.";

(k) the insertion in rule 6.2 in Rule 6 for the following :

"An insurer may not, before or after the inception of a policy, charge a policyholder or member any fee or charge in addition to the premium payable under the policy."

(l) the insertion in after paragraph (e) in rule 7.1 in Rule 7 of the following paragraphs:

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

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

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

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

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

"**7.3 Validity of contracts**

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

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

7.3.3 For the purposes of the validity of a policy the payment of a premium under a policy to a person on behalf of the insurer shall be deemed to be payment to the insurer under that policy."

(4) Chapter 4 of the Rules is hereby amended by –

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

(b) the substitution in paragraph (f) of rule 10.11.1 in Rule 10 of the following:

"(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]** policyholder expectations."

(c) the insertion after rule 10.14.6 in Rule 10 of the following rule:

"10.14.7 An advertisement that references a loyalty benefit, no-claim bonus or rebate in premium –

(a) must be balanced in relation to the primary benefits provided under the policy;
(b) must not be used to induce a policyholder to enter into a policy; and
(c) must make clear that it is possible that a policy will not be suitable unless the policyholder maintains the policy until the point where the loyalty bonuses become payable."

(d) the substitution in rule 11.1 in Rule 11 for the definition of "significant exclusion or limitation" of the following definition:

"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 including excess structures;

(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.

(e) the deletion of paragraph (h) of rule 11.4.2 in Rule 11;

(f) the deletion of paragraph (i) of rule 11.4.2 in Rule 11;

(g) the insertion after rule 11.4.2 in in Rule of the following rules:

"11.4.3 In addition to the information in rule 11.4.2, an insurer must where a policy is entered into in connection with other goods or services (a bundled product) provide a policyholder with the following information:

(a) The premium payable in respect of the policy separately from any other prices for such other goods and services;

(b) whether entering into the policy or any policy benefit is a prerequisite for entering into or being eligible for any other goods or services;

(c) the impact on the premium should the policyholder decide to terminate any of the other goods or services in the bundled product;

(d) confirmation on whether the insurance or any aspects of the other goods or services are mandatory or optional; and

(e) where the other goods or services are optional and the policyholder elects to not purchase any such goods or services, details of any impact that not purchasing the goods or services may have on the policyholder or the policy.

11.4.4 An insurer must –

(a) where the aggregated excess on a personal lines policy could amount to 5% or more of the value of a claim; or

(b) the excess amount in rand value could exceed R10 000,

provide the policyholder with comprehensive information on the potential impact of the excess, including the maximum amount of excess that may be payable in case of a total loss, and examples of the potential impact thereof."

(h) the insertion after rule 11.6.2 in Rule 11 of the following rule:

"11.6.2A An insurer must at least on an annual basis and in addition to information referred to in rule 11.6.2, provide the following information to a policyholder in respect of loyalty benefits:

(a) The current value of the loyalty benefit and, where applicable, the amount of such value which is accessible to the policyholder;

(b) a summary containing adequate details of the change in value of the loyalty benefit that took place over the relevant period, including next vesting date; and

(c) details of any termination value of the loyalty benefit.";

(5) Chapter 5 of the Rules is hereby amended by –

(a) the insertion in Rule 12 of a subrule 12.1A:

"12.1A Distribution

12.2.1 An insurer must ensure that it -

(a) has dynamic and responsive processes and controls over its distribution channels that -
  (i) reduces the likelihood that unsuitable products will be issued to policyholders;
  (ii) effectively mitigates the risk of poor outcomes to policyholders;

(b) regularly reviews its distribution strategy and channels;

(c) makes improvements and adjustments to its distribution strategy and channels in response to –

  (i) deficiencies identified through a review referred to in paragraph (b) or any other means; and
  (ii) feedback and experience from policyholders.";

(6) Chapter 6 of the Rules is hereby amended by –

(a) substitution in rule 13.4 in Rule 13 of the following the following:

13.4 An insurer must at a minimum, for the purposes of complying with rule 13.3,

(a) in respect of personal lines business, have access to the names, identity numbers and contact details of all its policyholders; and

(b) in respect of commercial lines business, have access to the company registration number, the risk address, and contact details of the policyholder."

(b) the substitution of the title of Rule 14 of the following title:

"RULE 14: MONITORING AND [ONGOING] REVIEW OF PRODUCT PERFORMANCE"

(c) the substitution in rule 14.1 in Rule 14 of the following rule:

"14.1 An insurer must on an ongoing basis monitor and regularly review and analyse a product (including product performance), 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.

(d) the insertion after rule 14.2 in Rule 14 of the following rule:

"14.3 An insurer must have measures in place to ensure regular and ad hoc reporting to the executive management, the board of directors and any relevant committee of the board on -identified risks, trends in relation to product performance and actions taken in response thereto."

(e) the substitution in rule 15.1 of Rule 15 of the following:

15.1 An insurer **[shall]** must 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.

(7) Chapter 7 of the Rules is hereby amended by –

(a) the insertion after paragraph (c) in rule 17.3.1 in Rule 17 of the following paragraph:

"(cA) processes and procedures to ensure -

(i) reasonable time is allowed for policyholders to institute claims; and

(ii) appropriate and prominent disclosure of any time limitation provision for the institution of a claim;"

(b) the deletion in paragraph (h) in rule 17.3.1 in Rule 17 of the word "**[and]**";

(c) the insertion after paragraph (i) in rule 17.3.1 in Rule 17 of the following paragraphs:

"(j) claims management and practices that support the prevention of insurance fraud and which are aligned to the insurer's Insurance Fraud Risk Policy referred to in Attachment 1 of Prudential Standard GOI3 (Governance and Operational Standards for Insurers); and

(k) the establishment of a training programme on detection and prevention of insurance fraud for all persons responsible for the handling or making decisions or recommendations in respect of claims.";

(d) the insertion in paragraph (b) in rule 17.7.2 in Rule 17 of the following:

"(b) copies of all relevant evidence, communications, correspondence and decisions; and"

(e) the insertion after paragraph (a) in rule 17.7.3 in Rule 17 of the following paragraph:

"(aA) number and quantum of claims which have been fully assessed and the insurer has accepted the liability for the claim, but not yet paid;"

(f) the insertion in paragraph (b) in rule 17.7.3 in Rule 17 of the following:

"(b) number and quantum of claims paid (both fully and partially);"

(g) the insertion after paragraph (b) in rule 17.7.3 in Rule 17 of the following paragraph:

"(bA) number and quantum of claims withdrawn by policyholders and the reasons for the withdrawal;"

(h) the insertion after paragraph (c) in rule 17.8.3 in Rule 17 of the following paragraph:

"(cA) any potential consequences of submitting false and/or incomplete information;"

(i) the deletion in paragraph (b) in rule 17.10.1 in Rule 17 of the word **"[or]";**

(j) the insertion in paragraph (c) in rule 17.10.1 in Rule 17 of the following:

"(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) or information gathered from a tracking or fitness device; or"

(k) the insertion after paragraph (c) in rule 17.10.1 in Rule 17 of the following paragraph:

"(d) impose any charge for a claimant to make use of claims processes and procedures."

(l) the deletion in rule 18.1 of Rule 18 of the definition of "reportable complaint";

(m) the substitution in paragraph (b) of rule 18.4.2 in Rule 18 of the following:

"(b) have an appropriate mix of experience, knowledge and skills in complaints handling, fair treatment of **[customers]** complainants, the subject matter of the complaints concerned and relevant legal and regulatory matters;"

(n) the substitution in rule 18.5.1 in Rule 18 of the following:

"18.5.1 An insurer must categorise **[reportable]** complaints received 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."

(o) the substitution in rule 18.5.3 in Rule 18 of the following:

"18.5.3 An insurer must categorise, record and report on **[reportable]** complaints received 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."

(p) the substitution in rule 18.8.2 in Rule 18 of the following:

"18.8.2 The following must be recorded in respect of each **[reportable]** complaint received -

(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."

(q) the substitution in rule 18.8.3 in Rule 18 of the following:

"18.8.3 An insurer must maintain the following data in relation to **[reportable]** complaints received 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."

(r) the insertion after rule 19.4 of Rule 19 of the following rule:

"19.5 Termination of Loyalty benefits

19.5.1 Where a policy that includes a loyalty benefit terminates due to the death of a policyholder and the policy has not reached the agreed contractual date for payment of the loyalty benefit, the insurer must pay out any accumulated value of the loyalty benefit to the estate of the policyholder or the nominated beneficiary."

(s) the insertion of the following rule after Rule 19:

"RULE 20: MISREPRESENTATION

20.1 In this rule –

"accident and health policy" means a policy written under the "accident and health" class of non-life insurance business as set out in Table 2 of Schedule 2 of the Insurance Act;

20.2 Notwithstanding anything to the contrary contained in a policy, but subject to rule 20.3 –

(a) the policy must not be invalidated;

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

(c) the obligations of the policyholder must not be increased, on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is likely to have materially affected the insurer's ability to

assess the risk under the policy concerned at the time of the representation or non-disclosure.

20.3 The representation or non-disclosure referred to in rule 20.2 shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view to the effect of such information on the assessment of the relevant risk.

20.4 If the age of an insured under an accident and health policy has been incorrectly stated to the insurer, the policy benefits must, notwithstanding rule 20.2 and 20.3 subject to rule 20.5, be those which would have been provided under that policy in return for the premium payable had the age been correctly stated.

20.5 If the nature of an accident and health policy is such as to render the arrangement inequitable as referred to in rule 20.4, the Authority may direct the insurer to apply such different method of adjustment to the policy benefits of that accident and health policy as the Authority considers equitable in relation to the misstatement of age."

3. The Arrangement of Rules is hereby amended by –

(a) the substitution of the title of Rule 14 in Chapter 6 of the following title:

"RULE 14: MONITORING AND [ONGOING] REVIEW OF PRODUCT PERFORMANCE";

(b) the insertion after Rule 19 under Chapter 7 of the following rule:

"RULE 20: MISREPRESENTATION".

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