NOTICE

DEPUTY REGISTRAR OF SHORT-TERM INSURANCE

No. R. ……. **.. ……..…. 2016**

SHORT-TERM INSURANCE ACT, 1998: REPLACEMENT OF THE POLICYHOLDER PROTECTION RULES MADE UNDER SECTION 55

I, Jonathan Dixon, Deputy Registrar of Short-term Insurance, hereby publish for comment the proposed replacement of the Policyholder Protection Rules made under section 55 of the Short-term Insurance Act and published under GN R. 1128 of 30 September 2004, and amended from time to time, with the Policyholder Protection Rules as set out in the Schedule hereto.

The proposed replacement of the Policyholder Protection Rules is necessary to give effect to a number of conduct of business reforms undertaken and consulted on over the last few years.

The proposed Policyholder Protection Rules and a detailed supporting document that highlights and explains the purpose of each rule and sub-rule where necessary, are available on the Financial Services Board's website at http://www.fsb.co.za.

Comments on the proposed Policyholder Protection Rules may be submitted in writing on or before 22 February 2017 to the Financial Services Board, c/o Jo-Ann Ferreira at FSB.INSProposedPPRs@FSB.co.za.

(Signed)
J DIXON
DEPUTY REGISTRAR OF SHORT-TERM INSURANCE

SCHEDULE

POLICYHOLDER PROTECTION RULES (SHORT-TERM INSURANCE), 2016

Section 55, Short-term insurance Act, 1998

ARRANGEMENT OF CONTENTS

CHAPTER 1
INTERPRETATION

1. Application

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

1.2 These rules apply, subject to Chapter 8, to all new and existing policies from the date on which these rules take effect.

1.3 These rules apply to all policies regardless of the medium or method used to advertise, market or enter into policies or to communicate with policyholders in respect of policies.

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

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

(b) reliance on an intermediary to facilitate compliance with a rule or a part thereof.

2. Definitions

In these rules "the Act" means the Short-term Insurance Act, 1998 (Act No. 53 of 1998), including the regulations promulgated under section 70 of the Act, and any word or expression to which a meaning has been assigned in the Act bears, subject to context, that meaning unless otherwise defined –

"beneficiary" means the person stated in the insurance policy or a person nominated by the policyholder as the person in respect of whom the insurer should meet policy benefits;

"claim" means, unless the context indicates otherwise, a demand for policy benefits by a person to an insurer in relation to a policy, irrespective of whether or not the person's demand is valid;

"consumer credit insurance" means credit insurance as defined in the National Credit Act, 2005 (Act No. 34 of 2005), but excludes subsection (a) of such definition;

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

"exclusion" means a loss or risk event not covered under a policy;

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

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

"independent intermediary" has the meaning assigned to it in the Regulations;

"insurer" means a short-term insurer;

"intermediary" means a representative or an independent intermediary as defined in the Regulations, respectively;

"mandatory consumer credit insurance" means credit insurance contemplated in section 106(1)(b) of the National Credit Act;

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

"ombud" means an ombud as defined in the Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004);

"optional consumer credit insurance" means credit insurance contemplated in section 106(3) of the National Credit Act;

"outsourcing" means an outsourcing arrangement as defined in the Regulations;

"policy" means a short-term policy (excluding a reinsurance policy) where the policyholder is a –

(a) natural person; or

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

"policy contract" means the written document or combination of documents embodying the contract entered into between an insurer and a policyholder in respect of a policy;

"policyholder" subject to the context, includes a potential policyholder;

"potential policyholder" means a person who has applied to or otherwise approached an insurer or an independent intermediary in relation to becoming a policyholder of an insurer, or a person who has been solicited by an insurer or an independent intermediary to become a policyholder or has received advertising, brochures or similar communications in relation to the insurer's policies or services;

"product line" refers to policies that have the same or closely related contractual terms that are marketed, offered or entered into by an insurer;

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

"representative" has the meaning assigned to it in the Regulations;

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

"services as intermediary" has the meaning assigned to it in the Regulations;

"waiting period" means a period during which a policyholder is not entitled to claim a policy benefit; and

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

CHAPTER 2
FAIR TREATMENT OF POLICYHOLDERS

RULE 1: POLICIES AND PROCEDURES DEALING WITH THE FAIR TREATMENT OF POLICYHOLDERS

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

1.2 An insurer must –

(a) in any engagement with a policyholder, and in all communications and dealings with a policyholder, act honourably, professionally and with due regard to the convenience of the policyholder; and

(b) at the start of any engagement initiated by the insurer clearly explain the purpose thereof.

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

(a) policyholders are confident that they are dealing with an insurer where the fair treatment of policyholders is central to the insurer's culture;

(b) products are designed to meet the needs of identified customer groups 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 have led them to expect, and the associated service is both of an acceptable standard and what they have been led to expect;

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

1.4 An insurer must regularly review its policies and procedures referred to in sub-rule 1.3 and document any changes thereto.

CHAPTER 3
PRODUCTS

RULE 2: PRODUCT LINE DESIGN

2.1 An insurer must in developing product lines –

(a) make use of adequate information on the needs of identified customer groups; and

(b) undertake a thorough assessment, by competent persons with the necessary skills, of the main characteristics of a new product line, the distribution methods intended to be used in relation to the product line and the disclosure documents related thereto in order to ensure that the product line, distribution methods and disclosure documents –

(i) are consistent with the insurer's strategic objectives, business model and risk management approach and existing rules and regulations;

(ii) target the customer groups for whose needs the product line is likely to be appropriate, while limiting access by customer groups for whom the product line is likely to be inappropriate; and

(iii) take into account the fair treatment of customers;

(c) that are subject to white labelling arrangements, undertake due diligence assessments in respect of the governance, resources and operational capability of the persons with whom the insurer has such arrangements and ensure compliance with paragraph (b) above.

2.2 A new product line must, before an insurer starts to market, offer or enter into policies in respect of the product line, be signed off by a managing executive of the insurer.

2.3 The sign off of a new product line by a managing executive of the insurer referred to in rule 2.2 must be accompanied by a confirmation that the product line, distribution methods and disclosure documents meet the principles set out in rule 2.1(b).

RULE 3: CONSUMER CREDIT INSURANCE

3.1 Mandatory consumer credit insurance

An insurer must not provide a consumer credit insurance policy that constitutes or purports to constitute mandatory consumer credit insurance, unless that policy and the costs associated with that policy comply with any consumer credit insurance Regulations made by the Minister of Trade and Industry.

3.2 Substitution of insurance offered by a credit provider by policy of policyholder's own choice

3.2.1 An insurer must, where a policyholder informs that insurer or the insurer otherwise should reasonably be aware that the policyholder wishes to or has exercised the right under subsection 106(4)(a) of the National Credit Act to substitute any other consumer credit insurance with a policy issued by the insurer, assist the policyholder to comply with any demands of a credit provider under section 106(6) of the National Credit Act or any relevant consumer credit insurance Regulations

made by the Minister of Trade and Industry in terms of the National Credit Act in relation to the substituted policy.

3.2.2 An insurer must, where an insurer is or should reasonably be aware that a policyholder has substituted any other consumer credit insurance with a policy issued by that insurer, in writing and within 60 days of being requested to do so by the credit provider confirm to the credit provider that the policy is in force and that the credit provider is recorded as the beneficiary, cessionary or loss payee on the policy.

RULE 4: COOLING-OFF RIGHTS

4.1 A policyholder may where a policy has a term longer than 30 days and no benefit has yet been paid or claimed or an event insured against under the policy has not yet occurred, within 14 days after the date of the date of receipt of the policy contract, or from a reasonable date on which it can be deemed that the policyholder received the policy contract, cancel the policy entered into with the insurer by written notice to the insurer.

4.2 All premiums or moneys paid by the policyholder to the insurer up to the date of receipt of the notice referred to in rule 4.1 or received at any date thereafter in respect of the cancelled or varied policy shall be refunded to the policyholder.

RULE 5: NEGATIVE OPTION SELECTION OF POLICY TERMS OR CONDITIONS

An insurer or any person acting on behalf of the insurer may not, where more than one option in respect of a certain policy term or condition (including, but not limited to, premium increases, rate escalations, or variation of benefits) is available to the policyholder on entering into the policy, stipulate that a specific policy term or condition will apply unless the policyholder explicitly elects a different policy term or condition.

RULE 6: DETERMINING PREMIUMS

6.1 A premium payable under a policy must reasonably balance the interests of the insurer and the reasonable benefit expectations of policyholders, and be based on assumptions that are realistic and that the insurer reasonably believes are likely to be met over the term of the policy.

6.2 An insurer may not charge a policyholder any fee in addition to the premium payable under the policy.

RULE 7: VOID PROVISIONS

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

(a) that in connection with any claim made under the policy, the policyholder may be obliged to undergo a polygraph, lie detector or truth verification, or any other similar test or procedure which is furnished or made available by the insurer or any other person in terms of an arrangement with the insurer and which is conducted under the control of the insurer or such other person;

(b) for an inducement of any nature for a policyholder to voluntarily agree to undergo a test or procedure envisaged in paragraph (a) where the policyholder submits a claim under the policy;

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

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

(e) that an insurer may repudiate a claim because a premium was not paid on the due date, if payment was made during a period referred to in section 52(1) of the Act, whether or not the payment was made prior to the event giving rise to the claim.

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

RULE 8: WAIVER OF RIGHTS

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

RULE 9: SIGNING OF BLANK OR UNCOMPLETED FORMS

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

RULE 10: CONSENT REQUIRED TO INSURE A LIFE

An insurer may only insure a person’s life if it has obtained the written consent of that person to insure his or her life or, where applicable, the written consent of that person’s legal guardian.

CHAPTER 4
PROMOTION, MARKETING AND DISCLOSURE

RULE 11: ADVERTISING, BROCHURES OR SIMILAR COMMUNICATIONS

11.1 Definitions

In this rule –

“advertisement, brochure or similar communication” means any direct or indirect visual or oral communication transmitted by any medium, or any representation or reference written, inscribed, recorded, encoded upon or embedded within any medium, by any means of which a person seeks to create public interest in the business of an insurer or in policies, or to induce the public (or a part thereof) to purchase, increase, modify, reinstate, surrender, replace or retain a policy, including (but not limited to) printed and published material, audio material, audio visual material, and descriptive literature of an insurer issued, distributed or used in direct mail, newspapers, magazines, radio and television script, websites, mobile phone voice or text messages, or other electronic communications, billboards or similar displays, or social media, which does not purport to provide detailed information to a specific policyholder regarding a specific policy;

‘‘associate’’ has the meaning has the meaning assigned to it in the Regulations;

“comparative” refers to the direct or indirect comparison of a policy or insurer with one or more policies of another insurer or one or more other insurers;

“endorsements” refer to public statements declaring the virtues of a policy and/or recommending the entering into of a policy;

“loyalty benefit” means any benefit that is directly or indirectly provided or made available by an insurer or any associate of an insurer to a policyholder of that insurer, which benefit is linked to –

(a) the policy or policies of that policyholder with that insurer remaining in place;

(b) the policyholder increasing any policy benefit to be provided under a policy; or

(c) the policyholder entering into any other policy or policy benefit offered by that insurer;

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

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

“social media” means websites, applications and other digital platforms that enable users to create and share content or participate in social networking, and includes but is not limited to blogs, vlogs, microblogs, social and professional networks, forums and image and video-sharing platforms.

11.2 Application

The requirements and standards contained in this rule are medium neutral and apply to websites, mobile phone voice or text messages, or other electronic communications, billboards or similar displays, or social media as they would to any other medium.

11.3 General principles

11.3.1 An insurer must have documented processes and procedures for the signing off of advertisements, brochures or similar communications by a managing executive.

11.3.2 An insurer must, prior to publishing advertisements, brochures or similar communications, take reasonable measures to ensure that the information provided in the advertisements, brochures and similar communications is consistent with this rule.

11.3.3 Where feasible, measures must provide for an independent review of advertisements, brochures or similar communications other than by the person that prepared or designed them.

11.3.4 An insurer must at all times ensure that any advertisement, brochure or similar communication which relates to its business or policies that another person publishes on behalf of the insurer or of which the insurer is aware or ought to be aware of, is consistent with this rule.

11.3.5 An insurer must at all times ensure that any intermediary or other third party that distributes or promotes its policies on its behalf has appropriate processes in place to ensure that any advertisements, brochures or similar communications in respect of such policies are consistent with this rule.

11.4 Factually correct and not misleading

11.4.1 Advertisements, brochures or similar communications must be accurate.

11.4.2 If statistics, performance data, achievements or awards are referenced in advertisements, brochures or similar communications the source and the date thereof must be disclosed.

11.4.3 Advertisements, brochures or similar communications must provide a balanced presentation of key information.

11.4.4 Descriptions must not exaggerate benefits or create expectations regarding policy performance that the insurer does not reasonably expect to achieve.

11.4.5 Descriptions must clearly include key limitations, exclusions, risks and charges. Key limitations, exclusions, risks and charges must be clearly explained and must not be worded positively to imply a benefit.

11.4.6 Advertisements, brochures or similar communications must use plain and understandable language taking into account the needs and reasonably assumed level of knowledge of the customer groups at whom they are targeted. Terms must be defined or explained if the average policyholders or customer groups at whom the advertisements, brochures or similar communications are targeted could not reasonably be expected to understand them.

11.4.7 Any advertisements, brochures or similar communications, when examined as a whole, must not be constructed in such a way as to lead average policyholders at whom they are targeted to any false conclusions they might reasonably rely upon. In considering the conclusion likely to be made, regard must be had to the literal meaning of the words, impressions from nonverbal portions of the advertisement (e.g. pictures, charts, diagrams, actions or expressions of actors), and from

materials and descriptions omitted from the advertisement.

11.4.8 The physical presentation of advertisements, brochures or similar communications must not obscure information. Each piece of information must be prominent enough in accordance with rule 11.15 and proximate enough to other information so as not to mislead average policyholders at whom the advertisements, brochures or similar communications are targeted.

11.4.9 Advertisements, brochures or similar communications must not be designed to exaggerate the need for urgency which could encourage the average policyholder at whom they are targeted to make unduly hasty decisions.

11.4.10 Where advertisements, brochures or similar communications highlight a no-claims bonus or loyalty bonus as a significant feature of a policy, the projected no-claim bonus value or loyalty benefit value that is payable on the expiry of a period in the future must also express the value of the projected benefit in present value terms, utilising reasonable assumptions about inflation.

11.4.11 Advertisements, brochures or similar communications must indicate whether or not premiums for policies that provide risk benefits are fixed or not fixed. If premiums are fixed the term / period for which they are fixed must be disclosed. If premiums are not fixed, details of premium escalations must be disclosed.

11.5 Public interest

Advertisements, brochures or similar communications must not –

(a) disparage financial products, product suppliers or intermediaries; or

(b) make inaccurate, unfair or unsubstantiated criticisms of any other financial product, product supplier or intermediary.

11.6 Identification of insurer

11.6.1 Advertisements, brochures or similar communications relating to a policy must clearly and prominently in accordance with rule 11.15 identify the name of the insurer.

11.6.2 Advertisements, brochures or similar communications must not use the group or parent company name or the name of any other associate of an insurer to create the impression that any entity other than the insurer is financially liable under a policy.

11.6.3 No advertisements, brochures or similar communications must use the name of another person to mislead or deceive as to the true identity of the insurer or to create the impression that any person other than the insurer is financially liable under a policy.

11.6.4 Any advertisements, brochures or similar communications relating to a policy that is subject to a white labelling arrangement must clearly and prominently in accordance with rule 11.15 identify the insurer.

11.7 Media used for advertising

Where an insurer uses any media to publish an advertisement, brochure or similar

communication, the insurer must consider the appropriateness of such media as a medium for promoting complex features of policies.

11.8 Record keeping

11.8.1 An insurer must keep adequate records of all advertisements, brochures or similar communications.

11.8.2 All records referred to in rule 11.8.1 must be kept for a period of 3 years after the advertisement, brochure or similar communication was made available.

11.9 Negative option marketing and advertising

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

11.10 Unwanted direct marketing

11.10.1 An insurer or any person acting on its behalf must afford a policyholder to whom it markets a policy through a mobile phone voice or text message the right to demand during or within a reasonable time after the message that the insurer or person acting on its behalf desist from initiating any such further messages or any other communication.

11.10.2 An insurer or any person acting on its behalf may not charge a policyholder a fee or allow a mobile phone service provider to charge a policyholder any fee for making a demand in terms of 11.10.1.

11.11 Comparative marketing

11.11.1 Where a survey or other product or service comparison informs comparative advertisements, brochures or similar communications, the survey or other product or service comparison -

(a) must preferably be undertaken by an independent person or, if not undertaken by an independent person be so qualified in any advertisements, brochures or similar communications;

(b) must be conducted at regular intervals if relied on or referenced on an on-going basis;

(c) must ensure that policies, products or services being compared have the same or similar characteristics;

(d) must take account of comparable features across the policy, product or service offerings included in the sample to ensure that not only the price (e.g. the Rand value of premiums) is being compared, but also the benefits provided under the policies, products or services concerned;

(e) in particular, in the case of comparisons between policies, must ensure that price comparisons are based on policies with equivalent insured events, cover levels, exclusions, waiting periods, excesses and other key features to those of the insurer's policies used in the comparison; and

(f) may not focus on the price of a policy or product to the exclusion of the suitability of the policies or products or their delivery on customer expectations.

11.11.2 The survey or other comparison source and date thereof must be referenced in advertisements, brochures or similar communications and the methodology applied must be easily accessible to the public in an easily understandable format.

11.12 Puffery

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

11.13 Endorsements

11.13.1 Testimonials and third party endorsements used in advertisements, brochures or similar communications must represent the genuine opinion and actual experience of the person making the endorsement. The testimonials and third party endorsements must be based upon actual statements made for endorsement purposes and must be properly attributed to the subject(s) of the endorsement.

11.13.2 If the person making the endorsement, or their employer or principal, has any financial interest or relationship to the producer, or will or has been compensated for the endorsement, this must be disclosed in the advertisements, brochures or similar communications.

11.13.3 Any endorsement in advertisements, brochures or similar communications must clearly and prominently in accordance with rule 11.15 state that the endorsement does not constitute financial advice.

11.14 Loyalty benefits or bonuses

11.14.1 Advertisements, brochures or similar communications that reference a loyalty benefit (including so-called cash- or premium-back bonuses) or no-claim bonus must not create the impression that the benefit is free and must adequately –

(a) indicate if the benefit is optional or not; and

(b) express the cost of the benefit including, where applicable, the average impact that the no-claim cash- or premium back bonus feature has on the premium, unless the impact is negligible.

11.14.2 For purposes of rule 11.14.1 the impact is deemed to be negligible if the cost of providing for the no-claim cash- or premium back bonus comprises less than 5% of the total premium payable under the policy.

11.15 Prominence

11.15.1 In determining prominence, whenever information must be disclosed prominently as required by this rule 11 and rule 12, consideration must be given to, as appropriate, –

(i) the target audience of the advertisement, brochure or similar communication;

(ii) the likely information needs of the average recipient or target market;

(iii) prominence in the context of the advertisement, brochure or similar communication as a whole;

(iv) positioning of the text and audibility and speed of speech;

(v) the duration of displays of key information;

(vi) background;

(vii) colour; and

(viii) font size.

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

(a) obscured through the close proximity of promotional illustrations and/or additional text;

(b) diminished through the use of small font sizes and unclear type styles and the duration for which it is displayed;

(c) likely to be overlooked due to its position;

(d) superimposed across a coloured or patterned background which lessens its visual impact; and

(e) diminished by the speed at which speech is delivered.

11.15.3 In any advertisements, brochures or similar communications relating to a policy that is subject to a white labelling arrangement, the name of the insurer must be as frequently mentioned, as audible or as visible as that of the white label and, in respect of written media must be at least the same font size as that of the white label.

RULE 12: DISCLOSURE AND RECORD KEEPING

12.1 General disclosure requirements

Language and format

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

(a) be in plain and simple language, avoid uncertainty or confusion and not be misleading;

(b) be in clear and readable print size, spacing and format; and

(c) in respect of any amount, sum, value, charge, fee, remuneration or monetary obligation mentioned or referred to therein, be stated in actual monetary terms,

provided that where any such amount, sum, value, charge, fee, remuneration or monetary obligation is not reasonably pre-determinable, its basis of calculation must be clearly and appropriately described.

Timing of the provision of information to policyholders

12.1.2 An insurer must take reasonable steps to ensure that a policyholder is given appropriate information about a policy in good time so that the policyholder can make an informed decision about the policy prior to inception and throughout the duration of the policy.

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

Delivery of information to policyholders

12.1.4 Information should be provided in a way that is clear, fair and not misleading.

12.1.5 Information should be provided in writing.

12.1.6 Adequate information must be provided in respect of more complex or bundled policy features which are difficult for consumers to understand, particularly regarding the costs and risks involved.

Content of the provision of information to policyholders

12.1.7 Information provided must enable policyholders to understand the characteristics of the policy and help them understand whether and why it meets their requirements. In determining the level of information required to be disclosed the insurer must consider -

(a) the knowledge and experience of a typical policyholder for the policy in question;

(b) the policy terms and conditions, including its main benefits, exclusions, limitations, conditions and its duration;

(c) the policy's overall complexity, including whether the policy is bought in connection with other goods and services;

(d) whether the same information has been provided to the policyholder previously and, if so, when.

12.2 Disclosure at point of entering into a policy

Disclosure of policy features at point of entering into a policy

12.2.1 An insurer must provide a policyholder with the following information at the point of entering into a policy –

(a) the name of the insurer and its contact details;

(b) the type of policy on offer and a reasonable and appropriate general explanation of the relevant policy;

(c) the nature and extent of policy benefits, and when, how and in which manner the benefits will or may be made available to the policyholder or a beneficiary;

(d) any guaranteed minimum benefits or other guarantees, where relevant;

(e) when the insurance cover begins and ends;

(f) a description of the risk insured by the policy and of the excluded risks;

(g) any restrictions on or penalties for early termination or withdrawal from or transfer of the policy, or other implications of such termination, withdrawal or transfer;

(h) charges and fees to be levied against the policy including the amount and frequency thereof;

(i) commission, consideration, fees or charges payable by the policyholder directly or indirectly;

(j) nature and extent of monetary obligations assumed by the policyholder (including any anticipated or contractual escalations, increases or additions), manner of compliance therewith and consequences of non-compliance;

(k) in respect of premiums –

(i) the exact premium that is payable under the policy;

(ii) the frequency at which the premium is payable;

(iii) details of any options relating to premium increases that the policyholder may select;

(iv) details of any premium increases, and the frequency and basis thereof and if an increase will be linked to any commensurate increase in policy benefits; and

(v) the implications of a failure to pay a premium at the frequency referred to in (ii);

(l) what cooling-off rights are offered and procedures for the exercise thereof;

(m) any material risks associated with the policy;

(n) prominent and clear information on significant or unusual exclusions or limitations. A significant exclusion or limitation is one that would tend to affect the decision of consumers generally to enter into the policy. An unusual exclusion or limitation is one that is not normally found in comparable policies and includes matters such as –

(i) deferred payment periods;

(ii) exclusion of certain conditions, diseases or pre-existing medical conditions;

(iii) waiting periods;

(iv) excesses;

(v) limits on the amounts of cover;

(vi) limits on the period for which benefits will be paid; and

(vii) restrictions on eligibility to claim such as age, residence or employment.

(o) where a policy is bought in connection with other goods or services (a bundled product), premiums for each benefit (both main benefits and supplementary benefits) separately from any other prices and whether entering into the policy or any policy benefit is a prerequisite for entering into or being eligible for any other goods or services; and

(p) if the policy to be entered into is a consumer credit insurance policy as defined in rule 3, the insurer must disclose to the policyholder whether the entering into of the policy is mandatory or optional consumer credit insurance as defined in rule 3 and the difference between the two;

(q) the existence of any circumstance that could give rise to an actual or potential conflict of interest in dealing with the policyholder.

Disclosure of rights and obligations at point of entering into a policy

12.2.2 Before a policy is entered into, the insurer must inform a policyholder of any –

(a) obligation to disclose material facts, including information to ensure that a policyholder knows what must be disclosed;

(b) obligations to be complied with when a policy is concluded and during its lifetime, as well as the legal consequences of non-compliance with those obligations;

(c) obligation to monitor cover, including a statement, where relevant, that the policyholder may need to review and update the cover periodically to ensure it remains adequate;

(d) right to cancel, including the existence, duration and conditions relating to the right to cancel;

(e) right to claim benefits, including conditions under which the policyholder can claim and the contact details to notify a claim;

(f) right to complain, including the relevant contact details of the insurer and contact details of the relevant ombud.

12.3 Disclosure promptly after inception of policy

12.3.1 An insurer must provide a policyholder with evidence of cover (including policy inclusions and exclusions) promptly after inception of a policy.

12.4 Ongoing disclosure

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

Ongoing information on terms and conditions

12.4.2 Information that must be provided on an ongoing basis includes information referred to in sub-rules 12.2.1 and 12.2.2.

Information on changes to terms and conditions

12.4.3 An insurer must provide a policyholder with full details relating to –

(a) any change to the premium payable under a policy;

(b) any change to the provisions, terms or conditions in the policy, together with an explanation of the implications of that change; and

(c) the policyholder's rights and obligations regarding such changes.

12.4.4 The details referred to in rule 12.4.3 must be provided to the policyholder in writing at least 30 days before a change takes effect.

Information on renewal of policy

12.4.5 An insurer must, at least 30 days before the renewal date of a policy, where applicable, provide the following to the policyholder –

(a) the premium to be paid by the policyholder on renewal of the policy;

(b) the premium last paid by the policyholder under the policy to enable the policyholder to compare the premium to the premium referred to in (a);

(c) any change to the terms or conditions on renewal of the policy, together with an explanation of the implications of that change;

(d) the policyholder's rights and obligations regarding such the renewal; and

(e) a statement indicating that the policyholder should verify that the level of cover to be offered under the renewal is appropriate for their needs.

Information on the insurer

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

(a) any change in the name of the insurer, its legal form or the address of its head office and any other offices as appropriate;

(b) any acquisition by another person resulting in organisational changes that may affect the policyholder;

(c) a transfer of insurance business from that insurer to another insurer (including policyholders' rights in this regard).

12.5 Record keeping

12.5.1 An insurer must have appropriate systems, processes and procedures in place to -

(a) record all verbal and written communications with a policyholder;

(b) store and retrieve transaction documentation (including the policy contract) and all other documentation relating to the policyholder; and

(c) keep the policyholder records and documentation safe from destruction.

12.6.2 Records referred to in rule 12.6.1 –

(a) may be kept in an appropriate electronic or recorded format, which is accessible and readily reducible to written or printed form;

(b) must be kept for a period of at least five years after the policy came to end; and

(c) must timeously be made available to the Registrar, policyholder, former policyholder or beneficiary on request.

CHAPTER 5
INTERMEDIATION (DISTRIBUTION)

RULE 13: ARRANGEMENTS WITH INTERMEDIARIES

13.1 In this rule **"intermediary agreement"** means an agreement entered into between an insurer and an intermediary setting out the terms under which the intermediary will render services as intermediary in respect of the policies of the insurer.

13.2 Intermediary agreements

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

(a) in the case of an independent intermediary, that person has, where lawfully required, been licensed as a financial services provider and authorised to render financial services in respect of the policies offered by the insurer in accordance with section 8 of the FAIS Act and meets any competency requirements prescribed under the FAIS Act in respect of that intermediary and the policies offered by the insurer; or

(b) in the case of a representative of that insurer, that person has been duly appointed as a representative of the insurer in accordance with section 7(1)(b) of the FAIS Act and meets any competency requirements prescribed under the FAIS Act in respect of that representative and the policies offered by the insurer.

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

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

(a) a licence referred to in rule 13.2.1(a) becomes inoperative by virtue of the licence being suspended or withdrawn in terms of section 9 of the FAIS Act or lapsed in terms of section 11 of the FAIS Act; or

(b) the appointment referred to in rule 13.2.1(b) of the representative is terminated,

an intermediary agreement must terminate.

13.3 Requests for information

13.3.1 An insurer must at the request of an intermediary that is authorised by a policyholder of that insurer provide that intermediary or the policyholder with the information referred to in the authorisation, irrespective of the fact that the intermediary does not have an intermediary agreement with that insurer.

13.3.2 Where the insurer provides the information referred to in rule 13.3.1 to the policyholder, the insurer must also provide the policyholder with a fair and objective explanation as to why the information was not provided to the intermediary.

13.3.3 An insurer must, within a reasonable time after being requested to do so, provide any person with whom an intermediary agreement has been entered into, with all information reasonably required by such person to comply with any disclosure or other requirements binding on such person by virtue of the FAIS Act or any other law.

CHAPTER 6
PRODUCT PERFORMANCE AND ACCEPTABLE SERVICE

RULE 14: DATA MANAGEMENT

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

14.2 An insurer must have an appropriate data management framework that includes appropriate strategies, policies, systems, processes and controls relating to the processing of policy-level and policyholder-level data which enables the insurer to –

(a) have continuous access to data that is up-to-date, accurate, reliable, secure and complete and in respect of policyholder data should include at least the names, identity numbers and contact details of policyholders;

(b) properly identify, assess, measure and manage the conduct of business risks associated with its insurance business to ensure the ongoing monitoring and consistent delivery of fair outcomes for policyholders;

(c) comply with all relevant legislation relating to confidentiality, privacy, security and retention of data or information; and

(d) comply with any regulatory reporting requirements.

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

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

RULE 15: ON-GOING REVIEW OF PRODUCT LINE PERFORMANCE

15.1 An insurer must continually monitor a product line, 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, in order to assess whether the –

(a) the product line and its related disclosure documents remain consistent with the needs of targeted policyholders and continue to deliver fair outcomes for policyholders; and

(b) the distribution method or methods remain appropriate.

15.2 An insurer must, where any shortcomings are identified through the assessment contemplated in rule 15.1 or through any other manner, implement appropriate remedial action to address such shortcomings.

RULE 16: PERIODS OF GRACE

16.1 Periods of grace

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

CHAPTER 7
NO UNREASONABLE POST-SALE BARRIERS

RULE 17: CLAIMS MANAGEMENT

17.1 Definitions

In this rule –

"claimant" means a person who asserts a claim;

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

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

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

"turnaround time" means the total time taken between the submission of a claim and the decision to settle or repudiate the claim.

17.2 Establishment of claims management framework

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

(a) is proportionate to the nature, scale and complexity of the insurer's business and risks;

(b) is appropriate for the business model, policies, services, and policyholders and beneficiaries of the insurer;

(c) enables claims to be assessed after taking reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of claimants;

(d) does not impose unreasonable barriers to claimants; and

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

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

17.3 Requirements for claims management framework

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

(a) relevant objectives, key principles and the proper allocation of responsibilities for dealing with claims across the business of the insurer;

(b) appropriate performance standards and remuneration and reward strategies (internally and where any functions are outsourced) for claims management in general and specifically for claims assessment to -

(i) prevent conflicts of interest and the incentivisation of behaviour which could threaten the fair treatment of customers; and

(ii) ensure objectivity and impartiality;

(c) documented procedures for the appropriate management of the claims process from the time the claim is received until it is finalised, including the expected timeframes for each of the stages and the circumstances under which any of the timeframes may be extended;

(d) documented procedures which clearly define the escalation and decision-making, monitoring and oversight and review processes within the claims management framework;

(e) appropriate claims record keeping, monitoring and analysis of claims, and

reporting (regular and ad hoc) to the executive management, the board of directors and any relevant committee of the board on –

(i) identified risks, trends and actions taken in response thereto; and

(ii) the effectiveness and outcomes of the claims management framework;

(f) appropriate communication with claimants and their authorised representatives on the claims processes and procedures;

(g) meeting requirements for reporting to the Registrar and public reporting in accordance with this rule;

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

17.4 Allocation of responsibilities

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

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

(a) be adequately trained;

(b) be experienced in claims handling and be appropriately qualified;

(c) not be subject to a conflict of interest; and

(d) be adequately empowered to make impartial decisions or recommendations.

17.4.3 A claim submitted to an intermediary or a service provider acting on behalf of the insurer is deemed to have been submitted to the insurer itself. The involvement of an intermediary or a service provider in the claims handling process does not in any way diminish the insurer's responsibilities.

17.5 Claim escalation and review process

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

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

17.5.3 The escalation or review process should -

(a) follow a balanced approach, bearing in mind the legitimate interests of all parties involved including the fair treatment of claimants;

(b) provide for internal escalation of complex or unusual claims at the instance of

the initial claim handler;

(c) provide for claimants to escalate claims not resolved to their satisfaction; and

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

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

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

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

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

(a) of the reasons for the decision;

(b) that the claimant may within a period of not less than 90 days after the date of receipt of the notice make representations to the relevant insurer in respect of the decision;

(c) of the right to lodge a complaint to a relevant ombud and the relevant contact details and time limitation provisions under the Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004) and the relevant provisions of that Act relating to the lodging of such a complaint, in plain understandable language;

(d) in the event that the relevant policy contains a time limitation provision for the institution of legal action, of that provision and the implications of that provision for the claimant in an easily understandable manner; and

(e) in the event that the relevant policy does not contain a time limitation provision for the institution of legal action, of the prescription period that will apply in terms of the Prescription Act, 1969 (Act No. 68 of 1969) and the implications of that provision for the claimant in an easily understood manner.

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

17.6.5 If the claimant makes representations to the relevant insurer in accordance with rule 17.9.3(b) the insurer must within 45 days of receipt of the representation, in writing, notify the policyholder of its decision to accept, repudiate or dispute the claim or the quantum of the claim.

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

rule 17.6.5 must-

(a) inform the claimant of the reasons for the decision;

(b) include the facts that informed the decision; and

(c) include the information referred to in rule 17.6.3 (c) to (e).

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

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

(a) may not include the period referred to in rule 17.6.3(b) in the calculation of the time limitation period; and

(b) must provide for a period of not less than 6 months after the expiry of the period referred to in rule 17.6.3(b) for the institution of legal action.

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

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

17.7 Record keeping, monitoring and analysis

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

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

(a) all relevant details of the claimant and the subject matter of the claim;

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

(c) progress and status of the claim, including whether such progress is within or outside any set timelines.

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

(a) number and quantum of claims received;

(b) number and quantum of claims paid;

(c) number and quantum of repudiated claims and reasons for the repudiation;

(d) number of claims escalated by claimants to the internal claims escalation and review process and their outcome;

(e) number of claims referred to an ombud and their outcome; and

(f) total number of claims outstanding.

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

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

17.8 Communications with claimants

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

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

17.8.3 An insurer must ensure that a claimant is aware of –

(a) the type of information required from the claimant;

(b) where, how and to whom a claim and related information must be submitted;

(c) any time limits on submitting claims;

(d) expected turnaround times in relation to claims; and

(e) any other relevant responsibilities of the claimant.

17.8.4 A claim is deemed to have been received on the day the insurer receives notification thereof and an insurer must acknowledge receipt of a claim within a reasonable time after receipt thereof and promptly inform a claimant of the process to be followed in processing the claim, including –

(a) contact details of the person who will be processing the claim;

(b) indicative timelines for finalising the claim;

(c) details of the internal claims escalation and review process if the claimant is not satisfied with the outcome of a claim; and

(d) details of escalation of complaints to the office of a relevant ombud where applicable.

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

17.8.6 Claimants must be kept adequately informed of –

(a) the progress of their claim;

(b) causes of any delay in the finalisation of a claim and revised timelines; and

(c) the insurer's decision in response to the claim.

17.8.7 An insurer must record a claim on the date that the initial claim is received and may not delay recording the claim until such time as all documents relating to the claim has been received.

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

17.9 Reporting of claims information

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

17.10 Prohibited claims practices

17.10.1 An insurer may not –

(a) dissuade a claimant from obtaining the services of an attorney or adjustor;

(b) deny a claim without performing a reasonable investigation; or

(c) deny a claim based on the outcome of a polygraph, lie detector or truth verification.

RULE 18: COMPLAINTS MANAGEMENT

18.1 Definitions

In this rule –

"complainant" means a person who submits a complaint and includes a –

(a) policyholder or the policyholder's successor in title;

(b) beneficiary or the beneficiary's successor in title; or

(c) potential policyholder whose dissatisfaction relates to the relevant application, approach, solicitation or advertising or marketing material,

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

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

(a) the insurer or its service provider has contravened or failed to comply with an agreement, a law, a rule, or a code of conduct which is binding on the insurer or to which it subscribes;

(b) the insurer or its service provider's maladministration or wilful or negligent action or failure to act, has caused the person harm, prejudice, distress or substantial inconvenience; or

(c) the insurer or its service provider has treated the person unfairly;

"compensation payment" means a payment by an insurer to a complainant to compensate the complainant for a proven or estimated financial loss incurred as a result of the insurer's contravention, non-compliance, action, failure to act, or unfair treatment forming the basis of the complaint, where the insurer accepts liability for having caused the loss concerned, but excludes any –

(a) goodwill payment;

(b) payment contractually due to the complainant in terms of a policy; or

(c) refund of an amount paid by or on behalf of the complainant to the insurer where such payment was not contractually due;

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

"goodwill payment" means a payment by an insurer to a complainant as an expression of goodwill aimed at resolving a complaint, where the insurer does not accept liability for any financial loss to the complainant as a result of the matter complained about;

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

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

"reportable complaint" means any complaint other than a complaint that has been –

(a) upheld immediately by the person who initially received the complaint;

(b) upheld within the insurer's ordinary processes for handling policyholder queries in relation to the type of policy or service complained about, provided that such process does not take more than five business days to complete from the date the complaint is received; or

(c) submitted to or brought to the attention of the insurer in such a manner that the insurer does not have a reasonable opportunity to record such details of the complaint as may be prescribed in relation to reportable complaints;

"upheld" means that a complaint has been finalised in that –

(a) the complainant has explicitly accepted that the matter is fully resolved; or

(b) it is reasonable for the insurer to assume that the complainant has so accepted; and

(c) all undertakings made by the insurer to resolve the complaint have been met.

18.2 Establishment of complaints management framework

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

(a) is proportionate to the nature, scale and complexity of the insurer's business and risks;

(b) is appropriate for the business model, policies, services, policyholders, and beneficiaries of the insurer;

(c) enables complaints to be considered after taking reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of complainants;

(d) does not impose unreasonable barriers to complainants; and

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

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

18.3 Requirements for complaints management framework

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

(a) relevant objectives, key principles and the proper allocation of responsibilities for dealing with complaints across the business of the insurer;

(b) appropriate performance standards and remuneration and reward strategies (internally and where any functions are outsourced) for complaints management to ensure objectivity and impartiality;

(c) documented procedures for the appropriate management and categorisation of complaints, including expected timeframes and the circumstances under which any of the timeframes may be extended;

(d) documented procedures which clearly define the escalation, decision-making, monitoring and oversight and review processes within the complaints management framework;

(e) appropriate complaint record keeping, monitoring and analysis of complaints, and reporting (regular and ad hoc) to executive management, the board of directors and any relevant committee of the board on –

(i) identified risks, trends and actions taken in response thereto; and

(ii) the effectiveness and outcomes of the complaints management framework;

(f) appropriate communication with complainants and their authorised representatives on the complaints and the complaints processes and procedures;

(g) appropriate engagement between the insurer and a relevant ombud;

(h) meeting requirements for reporting to the Registrar and public reporting in accordance with this rule;

(i) a process for managing complaints relating to the insurer's service providers, which process must provide for -

(i) effective oversight by the insurer that the service provider has adequate complaints management processes in place to ensure fair treatment of complainants;

(ii) monitoring and analysis by the insurer of aggregated complaints data in relation to complaints received by the service provider and their outcomes;

(iii) effective referral processes between the insurer and the service provider for handling and monitoring complaints that are submitted directly to either of them and require referral to the other for resolution; and

(iv) processes to ensure that complainants are appropriately informed of the process being followed and the outcome of the complaint; and

(j) regular monitoring of the complaints management framework generally.

18.4 Allocation of responsibilities

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

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

(a) be adequately trained;

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

(c) not be subject to a conflict of interest; and

(d) be adequately empowered to make impartial decisions or recommendations.

18.5 Categorisation of complaints

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

(a) complaints relating to the design of a policy or 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;

(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;

(i) other complaints.

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

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

18.6 Complaints escalation and review process

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

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

18.6.3 The complaints escalation and review process should -

(a) follow a balanced approach, bearing in mind the legitimate interests of all parties involved including the fair treatment of complainants;

(b) provide for internal escalation of complex or unusual complaints at the instance of the initial complaint handler;

(c) provide for complainants to escalate complaints not resolved to their satisfaction; and

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

18.7 Decisions relating to complaints

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

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

18.8 Record keeping, monitoring and analysis of complaints

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

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

(a) all relevant details of the complainant and the subject matter of the complaint;

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

(c) the complaint categorisation;

(d) progress and status of the complaint, including whether such progress is within or outside any set timelines.

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

(a) number of complaints received;

(b) number of complaints upheld;

(c) number of rejected complaints and reasons for the rejection;

(d) number of complaints escalated by complainants to the internal complaints escalation process;

(e) number of complaints referred to an ombud and their outcome;

(f) number and amounts of compensation payments made;

(g) number and amounts of goodwill payments made; and

(h) total number of complaints outstanding.

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

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

18.9 Communication with complainants

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

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

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

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

18.9.5 An insurer must ensure that a policyholder is aware of –

(a) the type of information required from a complainant;

(b) where, how and to whom a complaint and related information must be submitted;

(c) expected turnaround times in relation to complaints; and

(d) any other relevant responsibilities of a complainant.

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

(a) contact details of the person who will be handling the complaint;

(b) indicative timelines for addressing the complaint;

(c) details of the internal complaints escalation and review process if the complainant is not satisfied with the outcome of a complaint; and

(d) details of escalation of complaints to the office of a relevant ombud where applicable.

18.9.7 Complainants must be kept adequately informed of –

(a) the progress of their complaint;

(b) causes of any delay in the finalisation of a complaint and revised timelines; and

(c) the insurer's decision in response to the complaint.

18.10 Complaints that are not reportable complaints

18.10.1 An insurer's complaints management framework must include appropriate

processes for handling of complaints that are not reportable complaints.

18.10.2 The processes referred to in 18.10.1 must -

(a) be aligned with the requirements of this rule (other than those requirements that are stated to apply to reportable complaints only);

(b) include reasonable steps to identify noteworthy trends in relation to the types, volumes or incidence of such non-reportable complaints; and

(c) consider such identified trends in managing conduct risks and effecting improved outcomes and processes for its policyholders**.**

18.11 Engagement with ombud

18.11.1 An insurer must -

(a) have appropriate processes in place for engagement with any relevant ombud in relation to its complaints;

(b) clearly and transparently communicate the availability and contact details of the relevant ombud services to complainants at all relevant stages of the insurance relationship, including at point of sale, in relevant periodic communications, on receipt of a complaint, and when a complaint is rejected or a claim is repudiated;

(c) display and / or make available information regarding the availability and contact details of the relevant ombud services at the premises and / or on the web site of the insurer;

(d) maintain specific records and carry out specific analysis of complaints referred to them by the ombud and the outcomes of such complaints; and

(e) monitor determinations, publications and guidance issued by any relevant ombud with a view to identifying failings or risks in their own policies, services or practices.

18.11.2 An insurer must –

(a) maintain open and honest communication and co-operation between itself and any ombud with whom it deals; and

(b) endeavour to resolve a complaint with the complainant before a final determination or ruling is made by an ombud, or through its internal escalation process, without impeding or unduly delaying a complainant’s access to an ombud.

18.12 Reporting complaints information

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

RULE 19: TERMINATION OF POLICIES

19.1 Definitions

For purposes of this rule –

"material change" means any change in circumstances that results in the policyholder not being entitled to claim a policy benefit under a policy;

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

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

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

19.2 Termination of policies by insurer

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

(a) non-payment of a premium, subject to the insurer complying with the provisions of rule 16.1; or

(b) a material change in the policyholder's risk profile which, in terms of the policy –

(i) results in the policy automatically coming to an end; or

(ii) provides the insurer with a right to end the policy,

the insurer, despite any terms and conditions provided for in a policy, must give the policyholder at least 30 days' written notice of the intended termination and will remain liable under the policy for the shorter of -

(aa) a period of 30 days after the date on which the insurer receives proof that the policyholder is made aware of the intended termination of the policy; or

(bb) the period until the insurer receives proof that the policyholder has entered into another policy in respect of similar risks as those covered under the policy that the insurer intends to terminate.

19.2.2 If, in accordance with the terms and conditions of a policy, an insurer terminates a policy or the policy automatically comes to an end because of a material change in the policyholder's risk profile the insurer must give the policyholder written notice of such termination.

CHAPTER 3
ADMINISTRATION

1. Penalties

An insurer or intermediary who contravenes or fails to comply with a provision of these rules shall be guilty of an offence and on conviction liable to a penalty or fine referred to in 64(1)(c) or 65(1)(c), as the case may be, of the Act.

2. Repeal and transitional provision

2.1 The Policyholder Protection Rules published under Government Notice R1128 in Government Gazette 26853 of 30 September 2004 and amended by Government Notice 1213 in Government Gazette 33881 of 17 December 2010 are hereby repealed.

2.2 Anything done under, in terms or by virtue of any provision of the previous rules is deemed, unless clearly inappropriate, to have been done under, in terms or by virtue of a corresponding provision of these rules.

3. Short title and commencement

3.1 These rules are called the Policyholder Protection Rules (Short-term Insurance), 2016, and come into operation on a date as determined and published by the Registrar.

3.2 The Registrar may set different dates for different provisions of the Policyholder Protection Rules (Short-term Insurance), 2016 to come into operation.