CHAPTER 7

POLICY SERVICING

Learning Outcomes

When you have completed this chapter you will be able to

- explain the reason why an efficient policy servicing department is a vital component of a life insurer's operations;
- list and explain the common duties that every life insurer's policy servicing department will have to deal with;
- explain the importance of the policy document and the procedures to be followed if this document should be lost or destroyed;
- list and describe the different components of a policy document;
- discuss the problems that may occur if the premium payments on a life insurance policy cease and the ways in which these are handled in different circumstances;
- describe the method used by the average insurer to grant a loan against a policy;
- explain the ASISA's Code of Practice on the Replacement of Policies.

A person who buys a life insurance policy generally hopes to have to wait a long time before he needs the money. Consider that the proceeds of a policy are normally only paid in the event of the death or disability of the life insured.

It is only with an endowment policy that the policyowner can look forward to a pre-determined date on which the policy will pay a large amount of money to him. However, even with an endowment policy, the policyowner will have to wait for at least five years before the policy can mature. It is only on earlier death or disability that a policy can pay a benefit before the expiry of the initial five year period. Part 4 of the Regulation to the Long Term Insurance Act is very clear on the fact that no life insurance company may sell a policy that has a term of less than 5 years, if there is a savings element, other than a retirement annuity.

It is very important that every life insurer has an efficient department that can maintain its policies and keep in contact with the policyowners. This department must also be competent in providing assistance to any policyowner, who may experience problems with his policy, or who may want to make changes to any of his policy's details.

In most life insurance companies this department is usually known as the **policy servicing department**.

While it is self evident that every life insurer will need to have some form of policy servicing department, it is important to appreciate that the way that the departments are structured and managed will differ from insurer to insurer. The market that an insurer concentrates in will dictate the services that its policy servicing department will need to provide, and will therefore affect the structure of the department. However, even though there are differences between the policy servicing departments of the different insurers, there are certain roles and functions that will need to be provided by the policy servicing department of every insurer.

These roles and functions entail:

- **conforming to any legal requirements**;
  Anything that is done by the policy servicing department will have to abide by the statutory laws and regulations of the Republic of South Africa. All insurers who operate in South Africa have to be registered as local insurers. Legislation that has the most relevance to life insurance includes:
  - the Long Term Insurance Act,
  - the Income Tax Act and
  - the Pensions Funds Act.

  The student must, however, appreciate that there are a number of pieces of legislation such as the Companies Act that must also be complied with.

- **acting in accordance with the conditions of the policy document**;
  Once a life insurer accepts a proposal form, the insurer will print a policy document with the details of the contract entered into, and send the document to the new policyowner as proof of the contract. The policy document will include all the terms and conditions of the contract, as well as a description of the benefits that have been included in the policy.

  Whenever a policyowner wants to alter the policy, or submit a claim against the policy, it is the responsibility of the policy servicing department to ensure that the change or claim is allowed in accordance with the terms and conditions contained in the policy document.

- **abiding by the company's practice**.
  Staff within the policy servicing department must be well versed with company practice in areas such as, the granting of loans against existing policies, and the interest to be charged thereon. This is to ensure that no mistakes are made when advising a policyowner.

Beneficiary changes

When you accept that the majority of payments made by a life insurer are death claims, you will begin to understand the importance of the nomination of a beneficiary to the policyowner. The deceased policyowner will have nominated a beneficiary to receive the proceeds as he can no longer do so. What you must, however, understand is that the policyowner is allowed to change the name of this beneficiary whenever he wants to do so.

There are a number of reasons why a policyowner may wish to change his nominated beneficiary. If one considers the high divorce rate, and the large number of policies that are nominated to a spouse may require a change to a child or parent. It is the responsibility of the policy servicing department to record the amendments of any beneficiary nominations.

If this is not done correctly, it is possible that the benefits from the policy may be paid to the wrong person when there is a claim. This could result in legal action being taken against the insurer. If it can be shown that the insurer was informed of the change, but did not react correctly, the possibility of having to pay the claim twice becomes a real danger.

General consensus in the past has been that any cession will cancel a beneficiary nomination. Should the policy cession at a later stage therefore be cancelled, the policy proceeds would be paid to the estate of the deceased if no new nomination of a beneficiary is made by the policyowner.

A policyowner, who receives back from the cessionary a previously ceded policy document, should appoint a new beneficiary. This must be done even if the beneficiary is the same as the one nominated prior to the cession. In following this action, there can be no doubt as to the intended recipient of the proceeds of the policy in the event of a death claim.

Policy alterations

If we accept the fact that a policyowner, who is 20 years old when he buys a life policy, could live to the age of 73, the policy will have been in force for 53 years before it becomes a claim. During this long period it is very likely that the policyowner's ideas about the policy and its intentions will change.

He might originally have bought a small policy that would have been enough to settle any debts he may have had if he had died. If the policyowner were, however, to get married after the policy commenced, he would soon realise that the amount of life cover included in the policy was inadequate.

With the universal type policies it is unnecessary for the policyowner to purchase a new policy if more life cover is required. The policyowner can simply ask the insurer to change his existing policy by adding more life cover. Any increase in cover will be subject to satisfactory evidence of health being provided to the underwriters of the insurer.

Once the underwriters have approved the amendment to the policy, their underwriting criteria may include the life insured having to undergo a medical examination, in which case the policy servicing department will have to issue an amendment to the policy document and send it to the policyowner.

Record maintenance

It is very important that the insurer keeps an accurate record of all the changes that are made to a policy.

One of the most important duties of the policy servicing department is the keeping of accurate records, and keeping these records up to date. Insurers maintain an accurate data-base of all their client details.

Policyowner queries

Any **call centre agent**, or clerk in a branch office, will be able to answer general queries that a policyowner has, by checking on the system.

Whenever a policyowner has a query about his policy that cannot be dealt with by the branch personnel the query will be sent to the policy servicing department. It is then the duty of a clerk in the policy services department to call for the file, check on the records and reply to the policyowner.

Premium collections and procedures

Most life insurers have a special premium accounts department that is responsible for the collection of premiums. This department will also keep an accurate record of the premiums that have been paid by the policyowner. Premiums can be collected by debit order, or stop order, and even cash. Cash payment is losing popularity in the industry, due to the risks and costs involved in handling cash, fraud and money laundering.

The policy servicing department, however, has the responsibility to ensure that the premium requested by the accounts department is correct and has not been changed as a result of a policy alteration or inflation escalation.

7.1 THE POLICY DOCUMENT

In contractual law there is a need for an offer and acceptance of the offer, in order for a contract to come into being. When a proposer fills in an application form for a life insurance policy he makes an offer to the life insurance company, asking them to accept him as a policyowner. The underwriters of the life insurer will check the information on the proposal form and, if the information provided is acceptable, will agree to enter into the contract on behalf of the insurer.

The policyowner will require proof that a contract has been entered into. The life insurer will therefore issue a policy document as proof of the contract and give the document to the policyowner.

The policy document is only evidence of the contract. The proposal form filled in by the proposer and any medical evidence asked for by the underwriter is also a part of the contract.

Should the policyowner lose the policy document, or if it is destroyed, the contract between the policyowner and the life insurer will not be jeopardised. The policyowner will be able to ask the policy servicing department to issue him with a replacement of the policy document.

According to the Long Term Insurance Act of 1998, it is no longer necessary that an insurer issue every policyowner with a policy document. A detailed summary, posted directly to the policyowner, may be printed instead. However, if a policyowner asks for a policy document, one must be printed and sent to him.

Most life insurers will charge a small fee, and follow a procedure similar to the one set out below when a new replacement policy document is asked for:

- the policyowner must sign a statement in front of a Commissioner of Oaths, called an affidavit, in which he states that the policy document has been lost or destroyed;
- the life insurer will place an advertisement in the Government Gazette, and a newspaper in the area where the policyowner lives, asking any person who might have the document to notify the insurer of this fact, and the reason why they are in possession of the document;
- should the policy document not have been found after a period of 6 weeks from the placement of the advertisements, the insurer will issue a replacement policy document.

Note

The replacement policy document will include a note that cancels the original document. This means that even if the original document is found and submitted to the insurer at a later stage it will be deemed to have no value and will be rejected by the insurer.

7.1.1 THE DETAILS OF THE POLICY DOCUMENT

The name and the business address of the life insurance company is reflected at the beginning of the policy document.

The information in the policy document will begin by reminding anyone that looks at the document that the proposal form and declaration signed by the proposer in the proposal form are the basis on which the insurer issued the policy, and that the insurer will continue to use this information as the basis of the contract.

The front page of the policy document is normally a schedule that provides all the details of the policyowner, life insured and benefits to be provided by the policy.

The date when the proposal form was signed, and the date of commencement of the cover in terms of the insurance policy, are also stated in the schedule. Other information normally included in the schedule will be:

- the life insured's date of birth;

- whether that age of the insured was admitted or not, for example, whether proof of age was provided with the proposal form, which can be a certified copy of an identity document;
- details of the premium due for the benefits to be provided;
- how often premiums must be paid, for example, monthly, quarterly, half-yearly, annually or once only;
- any premium escalation factor included to combat inflation;
- the sum insured;
- any sum insured escalation factor included to combat inflation, this escalation factor may be equal to but will never be greater than the premium escalation factor;
- the name of the nominated beneficiary, if any; and
- any special conditions that apply to the policy, such as an exclusion for hang-gliding.

The schedule

A typical schedule might look similar to the example shown below. Students must realise that every insurer will have its own schedule format and this might look a little different from the example provided here. Comparing the example here with the schedules of your own life insurance policies would be a good idea.

SCHEDULE

Policy number	ABC 2468
Date of proposal	10 February 2008
Date of commencement	1 March 2008
Policyowner	John Smith
Life insured	Mary Smith
Date of birth of life insured	25 April 1968
Age admitted	No
Nominated beneficiary	None

PREMIUM DETAILS

Initial premium	R100,00
Premium payment frequency	Monthly
Annual escalation of premium	10%

BENEFIT DETAILS

Universal life cover	R100 000
Capital disability	R100 000
Annual escalation of benefits	5%
Waiver of premium on the death of the premium payer – John Smith	

SPECIAL CONDITIONS

Any capital disability claim that results from lower back problems are excluded.

Operative clause

The operative clause of the policy is a promissory clause. It is a promise that the insurer undertakes to pay the benefits of the policy if the reason(s) why the policy was incepted, and issued by the insurer, happens while the policy is in force.

For example

The policy is a whole life policy with R100 000 life cover, that will pay when the life insured dies. The operative clause will be the insurer's promise to pay the benefit, so long as the policyowner pays the premiums.

Attestation

The insurer accepts a contract based on the proposal form submitted by the proposer. As proof of its acceptance of the proposal, and its entering into a contract, the insurer will print a policy document in which is stated what has been accepted. To ensure the validity of the contract, there will be printed in the policy document, the signature of a person who works for the insurer, and who has the authority to agree to the issuing of the policy. Often this is the signature of the Managing Director, Chief Executive Officer or Company Secretary.

The signature will be linked to the operative clause, which commits the insurer to pay the sum insured, when the reason for which the insurance was taken out for, occurs, such as the death or disability of the life insured.

General conditions

The rest of the policy document will explain to the policyowner what the conditions of the insurer's acceptance of the contract are. These are usually standard conditions, and are included in every policy document that the insurer prints for a policyowner.

An example of one of the conditions is that the insurer will want the policyowner to know that only 30 days of grace will be allowed for the late payment of a premium that is due. It will explain that if the premium is not paid within the days of grace then, subject only to certain conditions that are dealt with later, the policy will lapse.

Special conditions

The special conditions provide the policyowner with all the details regarding the specific benefits that he requested be included in his policy. The conditions under which a claim will be paid are explained, as well as any of the exclusions that will apply.

Any unique exclusions, such as claims due to back problems where the proposer has a history of back problems, will be indicated in the schedule.

Other unique exclusions that will be indicated on the schedule could be an exclusion for the loss of eye-sight, if the proposer indicated on the proposal form that he was already blind.

Take special note of the exclusions in a policy document. There are very few exclusions that apply with the basic life cover that is included in a policy, usually only suicide in the first two years that the policy is in force is excluded.

With any supplementary benefits that may be included to the basic life cover of the policy, most life insurers will have a number of exclusions.

These might include:

- driving while under the influence of alcohol;
- contravention of the law;
- flying other than as a fare-paying passenger on a recognised airline;
- self-inflicted injury, regardless of whether the insured was sane or insane at the time; and
- wilful exposure to danger unless this occurred in an attempt to save the life of another.

7.2 WHEN PREMIUMS STOP

There are a lot of reasons why a policyowner might decide to stop paying premiums on a policy that he owns. The accounts department will be the first to notice that the premiums are not being paid, when the debit or stop order is returned unpaid to them. The accounts department will then generate a double debit or stop order for the following month, in an attempt to bring premiums up to date.

Should the double deduction, however, also be returned unpaid the accounts department will issue no further debits or stop orders. As far as they are concerned, the premium payments have ceased, and they will now only react on a new written instruction from the client to deduct any further premiums.

The intention of the policyowner should be to carry on paying the premiums for as long as they are due, but it sometimes happens that circumstances change, and the payment of premiums stop. The policy servicing department can handle this in a number of different ways. It is important to understand the principles behind policy cash values, and the reasons why it takes a while for a policy to build up a cash value.

7.2.1 INITIAL EXPENSES

Most life insurance companies offer a policy called *a* **pure endowment** to their clients. This is a policy that has no life cover, or any benefits, other than an investment account. With one of these policies, the policyowner shares in the profits that the investment managers of the life insurer make, for all the policyowners that are allowed to share in these profits.

However, the main business of a life insurer is to sell policies that will give the policyowner protection against catastrophes, such as the life insured's death or permanent disability. To provide these benefits to the policyowner costs money.

The life insurer will use a part of the policyowner's premiums that he pays to buy these benefits. The life insurer also needs to make sure that:

- there is a policy services department that can maintain the status of the policy so that the policy will be claimable if a claim should occur;
- the proposer who submits a proposal is underwritten by the underwriting department to ensure that the risk being offered is one that the insurer is prepared to accept; and
- a policy document, explaining all the terms and conditions of the contract between the policyowner and life insurer, is printed and sent to the policyowner.

The life insurer will not only have staff in the policy servicing and accounts departments to look after existing policies. It will also have to have a number of other specially trained people in its New Business department, such as underwriters to process new applications for life insurance policies.

There will also have to be a Claims department, with specially trained people who will need to check to make sure that a claim is real and not fraudulent which unfortunately occurs fairly often with disability claims.

The biggest expense is, however, the expense of processing applications for new policies. This is because the following are only some of the costs that have to be paid:

- **the cost of underwriting the application**;

  This will include the salaries of the underwriters as well as the fees paid to any doctors and/or specialists who are asked to examine the applicant if the underwriters need more information to make a decision.

- **having sales offices all over the country**;

  Life insurance policies are sold by intermediaries. If these intermediaries work for the life insurer they will need to have offices, as well as back-up staff, like secretaries and receptionists. If the intermediaries that sell the policies are brokers the life insurer will need to have a staff of broker consultants who visit the brokers to make sure that the brokers will sell policies for the life insurer. The broker consultants, who are employees of the life insurer, will also need a back-up staff of secretaries and receptionists. Broker consultants also earn a basic salary, and/or commission, and are given company cars or a car allowance so that they can do their work.

- **the new business expenses at head office**;

  Once a proposal has been accepted, the information about the new policy must be captured into the system. It is, however, still necessary that all the original documentation that goes with a new application, like the proposal form and any medical examination reports that may have been asked for by the underwriters, is kept in a file at head office.

- **the printing and postage of the policy document**;

- **commissions**.

  Intermediaries who sell life insurance policies are usually not paid a salary by the life insurer or brokerage that they work for. They are paid a **commission** that is based on the amount of premium that a policyowner will pay on any new business that the life insurer accepts.

  No more commission is paid to an intermediary on a policy once it is more than two years old, unless the policy is changed and the premium increases. The intermediary will then be paid commission on the premium increase as if the increase were a new policy.

We have only looked at a few of the expenses that a life insurer has. Life insurers will therefore, charge these expenses to their policies and deduct them from the premiums that the policyowners pay.

There are basically two different methods used by life insurers to charge for their expenses. These are known as:

- up front recovery; and
- aggregated charging.

Up-front recovery

Where an insurer uses this method, the insurer keeps all the premiums paid by the policyowner until the costs it has incurred have been paid. Only once the insurer has been repaid, will the premiums be paid into the policy's investment account.

The premiums charged on a term insurance policy are worked out in such a way that the life insurer will only be fully repaid when the policy ends. This means that there will, in fact, never be any extra money to pay into an investment account. This is one of the reasons why term insurance policies do not build up any cash values.

Aggregated charging

Where an insurer uses this method, the insurer's actuary works out what the costs have been, and divides this cost by the number of years that the policy will run.

Note that where the policy is a whole life policy, the actuary will usually divide the cost by 30 years or the number of years from the life insured's current age until he turns 75, whichever is the shorter period. Once this amount has been determined the insurer will, on an annual basis, deduct the amount, plus a reasonable interest factor, from the premium that is paid by the policyowner.

The difference with this method, as opposed to the previous method, is that the policy will immediately start building funds within its investment account. As only a part of the premium is being used to recover expenses, the rest will be paid into the policy investment account.

There is one very important point: If the policyowner should stop paying his premiums at any time before the life insurer has recovered its costs, the insurer will claim the rest of its expenses out of the policy's investment account.

The policyowner must therefore not think that the amount of money in the policy's investment account after 5 years belongs to him. Should the policy still have to run for another 15 years before it matures, if the policy is a 20 year endowment, the insurer will not have recovered all its expenses.

If the policyowner decides that he wants to cancel the policy and so claims the money in the investment account, the life insurer will first need to recover the balance of its expenses. The money due to the policyowner will only be such amounts as remain in the investment account after the insurer has recouped the balance of its expenses.

7.2.2 CASH VALUES

A policyowner can ask the life insurer at any time what the cash value of his policy is. The life insurer's policy servicing or branch staff will be able to provide the policyowner with an immediate answer. The cash value will be the **current value of the investment account of the policy**. The cash values shown is the value of the investment account, and is not guaranteed. As has been mentioned earlier, there will be no cash value with a term insurance policy.

7.2.3 SURRENDER VALUES

It is important to understand the difference between the surrender value and the cash value of a policy. The cash value of a policy will be the current value of the investment account of the policy. The surrender value of a policy is that amount of money that a policyowner will receive out of the investment account **if he decides to cancel the policy.**

If we were to look at the two different ways that life insurers recover expenses we will get a better idea of the differences between the cash and surrender values of a policy.

Up-front recovery

Where an insurer uses this method, there is usually very little difference between the cash value and the surrender value of a policy. As the life insurer recovers all its expenses before an investment account will be started, the policyowner will be allowed to draw the value of the investment account if he decides to cancel the policy. The only reason why the surrender value may be slightly less than the cash value, is because the life insurer will have certain administrative expenses that have to be paid for when a policy is cancelled.

Aggregated charging

Where an insurer uses this method, there will usually be quite a large difference between the cash value and the surrender value of the policy, especially if the policy is still fairly new. Here the life insurer allows the investment account to start straight away, and only recovers **a part of its expenses every year**. There will, therefore, still be a large portion of the expenses outstanding, if the policyowner decides to cancel the policy early.

All of these expenses will be deducted from the investment account of the policy **before** any money that is left over will be paid to the policyowner. For this reason, there might be a big difference between the cash value and surrender value of a policy from a life insurer using this method to recover its expenses. Note that most life insurers use this method, as there is a clear advantage to the policyowner, who has the immediate accumulation in an investment account.

It is only with a policy that has been running for a long time that the cash and surrender values might be almost the same. This is because the life insurer will already have recovered most, if not all, of its expenses.

So when will a policy accumulate a surrender value?

A policy will only have a surrender value if the life insurer has recovered all its costs from the cash value, and there is still some money left over to pay to the policyowner. As was mentioned when we looked at the initial expenses that a life insurer has, one of these was the commission due to the intermediary.

The commission paid is based on the premium to be paid and the duration of the policy. The longer that the policy will run, the more commission that the intermediary will earn.

Because of this a policy will usually have a surrender value[8]:

If the term of the policy is	**Surrender value will accumulate after**
less than 10 years	1 year
between 10 and 20 years	2 years
more than 20 years	3 years

Remember that a term insurance policy will **never** have a surrender value.

[8] The more recent agreement between the insurers and the regulating authorities regarding improved values has affected the above principle to a certain extent.

Important Information

No matter how long the duration of a retirement annuity contract may have been, the policyowner will not be able to take the cash values that have built up out of the policy.

This would be a contravention of the Income Tax Act, where the definition of a retirement annuity fund includes the requirement that benefits may not be paid to a member before reaching age 55, unless the member is totally and permanently disabled.

He must wait, at least, until he is over 55 years of age and decides to retire from the retirement annuity fund. It is only if he is permanently disabled, or dies, that a retirement annuity fund can pay a benefit before the member of the fund is, or would have been, over the age of 55 years.

Here again, however, the full cash value will not usually be made available to the policyowner. Unless the fund value is less than R75 000, he will not be allowed to receive more than $^{1}/_{3}^{rd}$ of the proceeds in cash. The balance must be used to purchase a life annuity.

7.2.4 MINIMUM VALUES FOR LONG TERM POLICIES

Amendments to Part 5 of the Regulations to the Long Term Insurance Act (minimum values)

Following the various rulings made by the Pension Fund Adjudicator in 2005 and growing concern over the wide media coverage of the so-called unfair practices for investors in retirement annuity funds, and particularly those who, for personal reasons, had to make their investments paid up before the end of the planned term, the long term insurers and the National Treasury initiated a joint initiative to combat the public concern and agreed to an intent to offer minimum benefits for policies made paid up after 2002.

The Minister of Finance subsequently published an amendment to Part 5 of the Regulations to Long Term Insurance Act, which will regulate minimum benefits in terms of casual events in the future. Part V of the Regulations is that part of the Policyholder Protection Rules which deals with the cancellation of policies and the cooling off period.

In terms of the revised regulations, a casual event occurs when:

(a) the policy becomes fully paid-up;

(b) the basic premium is reduced, without the policy coming to an end or becoming fully paid-up;

(c) the remaining policy term or premium-paying term is reduced, without the policy coming to an end or becoming fully paid-up;

(d) the policy is surrendered in part other than for a Section 14 transfer or because the risk benefit under the policy has come to the end of its period;

(e) a fund member policy is surrendered in part in terms of a Section 14 transfer;

(f) a fund member policy is surrendered in full, other than in terms of a Section 14 transfer or the term coming to an end, or reaching its maturity date; or

(g) a fund member policy is surrendered in full in terms of a Section 14 transfer.

The minimum benefits and maximum charges allowed in terms of the amendment are as follows.

For a casual event occurring after 1 January 2001, the insurer may not charge a casual event charge which exceeds the maximum prescribed by the regulations.

For fund member policies:

- a maximum casual event charge of 30% when policy is made paid-up or surrendered, the term or premium term reduced, or the policy comes to an end for a reason other than it has reached maturity;
- a maximum casual event charge of 30% levied proportionately on the premium reduction factor if the premium is reduced without the term of policy coming to a close;
- a maximum casual event charge of 30% if the policy is surrendered in part.

For non-member policies:

The maximum charge for a casual event occurring after 1 January 2001 in terms of the regulation is:

(a) 30% if policy is made paid-up, or the term or the remaining premium-paying term, is reduced without the policy coming to end;

(b) 30% if the premium is reduced without the policy coming to an end or being made fully paid-up;

(c) 40% if the policy is surrendered in part;

(d) 40% if the policy is surrendered in full or comes to an end for a reason other than it has reached its maturity date.

Note that the Regulation requires retrospective adjustment, including interest, for policies where a charge has been levied since 2001, whether the policy has subsequently come to an end or not, but the maximum charges allowed are slightly higher than those contemplated for the future as set out above.

At the same time, Regulation 30 of the Pension Funds Act, which deals with compulsory inclusions in the rules of the fund, has been amended to ensure that, for funds under which the benefits are wholly or mainly provided via fund policies, the fund's liability to members in the event of a casual event, as defined in the revised Regulation V of the Long Term Insurance Act, is limited to the proceeds of the policies but also placing the onus on the fund's board of management to ensure that proper investigation of the charges under such policies is undertaken and that members are advised accordingly.

The requirements for pure investment policies issued after January 2009 are even more strict, with the maximum penalty being effectively restricted to 15%.

7.2.5 LAPSES

If a policy does not yet have a surrender value, it means that the life insurer has still not recovered all its expenses.

If a premium is therefore not paid during this early part of the contract, or during the days of grace allowed by the insurer, there will be no money to protect the benefits and the policy will be stopped by the insurer. In the life insurance industry we say that the policy has **lapsed**.

7.2.6 AUTOMATIC PREMIUM LOANS

Where a policy has been in force for long enough for there to be a surrender value, the insurer will use the surrender value to keep the benefits going for as long as possible.

This is known as an **Automatic Policy Loan** (APL) or a Non-Forfeiture Allocation (NFA). This will help the policyowner as he will be able to submit a claim even if the premiums are in arrears.

However, when the surrender value of the policy runs out, the policy will lapse and all benefits will be lost to the policyowner. Most life insurers have a clause in their general conditions that tells the policyowner that the insurer will use the surrender values for an automatic premium loan, if the premium payer stops paying the premiums.

If the policy is a retirement annuity contract there will be **no** automatic policy loan. The policy will automatically be made paid up if there is a cash value.

7.2.7 PAID UP POLICIES

With a paid up policy the surrender value that has built up in the policy can be used in a number of different ways:

- the surrender value can be used to pay for the benefits for as long as there is any money left;
- the policyowner can ask that the surrender value be used to pay for a smaller benefit that will continue for as long as the original policy would have done; or
- the policyowner can ask that all the life cover and other benefits with the policy are cancelled.

With this option, the surrender value of the policy will be treated as an **investment-only** policy with the insurer, which will pay out on the date that the original policy would have matured, or when the policyowner surrenders the policy. With this option, the policyowner will have the advantage that the investment will grow as part of the investments of the insurer.

7.2.8 REVIVAL CONDITIONS

If the premium payer starts paying the premiums again while the policy benefits are being paid for by an automatic policy loan, the insurer will usually allow the policy to carry on as if nothing had happened.

There will however be a loan against the policy's cash value that should be paid back. The premium payer can do this by paying an extra premium until the loan is repaid. Should the loan not be repaid, then the loan plus interest, will be claimed by the insurer when a claim is to be paid.

If the policy has lapsed, however, this will be a different matter. The policyowner will have to re-apply for the insurance cover. Any medical evidence that the underwriters might ask for will have to be given to them by the life insured.

The life insurer also has the right to refuse to renew the policy.

7.3 POLICY LOANS

There are many reasons as to why a policyowner may decide to stop paying the premiums on his policy. From time to time, most people go through tough periods where money is tight. Since insurance policies are meant to give on-going protection and benefits, the cancelling of a policy just to cover up a short term cash flow problem, is not a good idea. To help policyowners through tough times, insurers offer loans against the security of most policies.

Another choice that the policyowner has, is to approach the life insurance company with the request for a loan of a part of the surrender value. Insurers are usually happy to give the policyowner the loan if a policy has a surrender value, because it will mean that the policyowner will be able to afford to keep the policy going by paying the premiums. The value of the loan will be limited to a percentage of the surrender value of the policy.

Depending on the life insurer, the loan value will be between 80% and 95% of the surrender value of the policy.

A loan given by a life insurer is not taken directly out of the investment account of the policy that belongs to the policyowner. The life insurer will want the policy to be able to continue its growth and, in order to do so, the policy investment account needs to remain an integral part of the policy. The loan is, therefore, paid by the insurer with money retained in its reserve account. The surrender value of the policy is only used as a security for the life insurer so it will be able to get its money back.

Because of the way that the loan is structured by the insurer, there are some conditions that the policyowner will have to agree with:

- the life insurer must be given the policy document to keep as security for the loan. When the loan is paid back the policy document will be returned;

- interest will be charged on the loan at a rate set by the life insurer. The money belongs to the life insurer's shareholders and/or policyowners and so they will want to see some return on their investments. The loan will come out of the life insurer's corporate fund where shareholder and excess policyowner moneys called reserves, are invested; and

- the policyowner does not have to pay the loan back by having to pay higher premiums **but** this is one of his options. The loan can be repaid as a lump sum when the policyowner has the money.

The loan can also be paid back when a claim is made. The loan and any interest that has been added to its value will be subtracted from the value of any claim that is due when the policy matures or becomes a claim. The money that is then left over will be paid to the policyowner or beneficiary.

7.4 THE CODES OF CONDUCT OF THE ASSOCIATION FOR SAVINGS AND INVESTMENTS SA (ASISA)

The member offices of ASISA have, over the years, formulated codes of conduct on most aspects of their business as life insurers.

These codes, to which all member offices subscribe, are constantly updated to meet changing circumstances. Summaries of the codes are given below.

7.4.1 CODE ON THE LIFE REGISTER

It is critical for present and future policyowners that insurers remain financially healthy and that their products remain affordable. To achieve this, the insurance risks which insurers are asked to cover, and the insurance claims which they are asked to pay, must be properly assessed by them. Insurers must therefore have access to all information regarding these risks and claims. All this information cannot always be obtained directly from the persons to whom it relates and has to be obtained from some other sources, for example from other insurers.

ASISA assists with the exchange of such information between insurers. The Life Register is a data base through which insurers can share information about persons who propose for, or who are the lives insured under, policies and who have impairments[9] that are relevant to the risk or claim assessment.

The way in which this is done changes from time to time but at present it is done as follows:

- insurer A obtains information to assess a risk or a claim;
- where this information relates to an impairment, insurer A must give this information to ASISA, where confidentiality is strictly observed;
- if insurer B needs this information to assess a risk or claim, they may obtain the information from ASISA or insurer A.

[9] Impairments are any condition, or conditions, which result in a final extra mortality or extra morbidity of seventy-five percent or more (after debits and credits have been taken into account) regardless of the underwriting decision taken.

The person to whom the information held by ASISA relates may also obtain the information. There is a prescribed form available from ASISA on which this request must be submitted. ASISA will then arrange for the information to be disclosed to the person to whom the information relates, through his nominated medical attendant.

7.4.2 CODE ON DEMARCATION: MEDICAL SCHEMES AND HEALTH INSURANCE

The purpose of this document is for the:

- Council for Medical Schemes;
- Financial Services Board; and
- Association for Savings and Investments SA (ASISA)

to provide clarity to all stakeholders on the definition of the business of a medical scheme as defined in the Medical Schemes Act (MSA).

It is intended that this document applies to new business only. The Council for Medical Schemes is in a position to provide an exemption to any part of the Medical Schemes Act where an exceptional circumstance can be demonstrated.

It is important to distinguish health insurance business from other insurance business, most particularly, disability business. The LTIA defines disability in terms of the loss of a functional ability leading to impairment which is either permanent or temporary.

Travel insurance cover should also be excluded for this purpose as it is unlikely that such policies could undermine medical scheme business. Travel insurance policies include, *inter alia*, policies currently offered by travel agents and through credit cards. These policies offer coverage for a period of up to 180 days in respect of events occurring outside of the borders of South Africa during the period of cover.

The demarcation document of 7 September 2000 identified the key principles of:

- health insurance is voluntary cover purchased with after tax income to protect individuals against unforeseen health events:
    - that a key feature of the business of a medical scheme is the fact that it indemnifies individuals against medical expenses and so the benefits payable by a health policy must therefore be seen not to relate to the cost of treatment of the event or the condition;
    - health insurance may not be sold on a conditional basis to members of a medical scheme. No reference to a medical scheme can be made in the marketing or sale of health insurance products;
- insurance products should not pay benefits on the basis of **detailed** lists of conditions;
- a *limited number* of severity levels per condition will be allowable provided the stipulated benefits are not related to the payment of medical expenses;

- where a health insurance product groups different conditions as a percentage of a sum insured so that a single lump-sum payment, which is clearly not tailored to actual medical expenses, is made on any event, this will not be regarded as the business of a medical scheme;

- health event products should operate on the basis of a minimum sum insured.

ASISA strongly supports the statement that “where benefits offered by health insurance products are clearly linked to a contingency other than the payment of medical expenses, such as income replacement, then the business will not be regarded as the business of a medical scheme”.

The purpose is that any possible future disputes be handled swiftly and consistently.

Demarcation guideline

This guideline aims to distinguish between health insurance business written in terms of the Long Term Insurance Act, 1998 and the business of a medical scheme as defined in the Medical Schemes Act, 1998.

This guideline provides recommended practice in respect of all future new business and will be used by the ASISA in the assessment of complaints.

Principles

- A key feature of the business of a medical scheme is the fact that it indemnifies individuals against medical expenses incurred in respect of a relevant health service, as defined in the Medical Schemes Act.

- The Medical Schemes Act governs medical scheme business and health insurance business is governed by the Long and Short Term Insurance Acts.

- Health insurance is based on a health event which should only be triggered by the occurrence of a health event. The amount of the benefit payable on health insurance must not be retrospectively determined, but must be determinable at the occurrence of the event. The benefits payable by a health policy must therefore be seen not to relate to the cost of treatment of the event or the condition. The contingency covered should be something other than medical expenses.

- In any instance where the business involves the undertaking of a liability to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service, then that business constitutes medical scheme business.

- Health insurers may not offer cessions to medical service providers. Benefits must be paid to the policyholder and may not be paid by health insurers to medical service providers in return for medical services rendered to policyholders.

- Sales of health insurance may not be conditional on membership of a stipulated medical scheme. Sales and marketing material should also make it clear that a health insurance policy is not a substitute for medical scheme membership.

Guidelines

The intention of health insurance business is to provide cover for contingencies other than medical expenses, related to the occurrence of a health event.

This is the overriding principle of these guidelines:

- insurance products should not pay benefits on the basis of lists of services or procedures;
- up to 10 severity levels per product will be allowable provided the stipulated benefits are not related to the payment of medical expenses. Such severity levels may be defined as a percentage of sum insured;
- where benefits offered by health insurance products are clearly linked to a contingency other than the payment of medical expenses, such as income replacement, then the business will not be regarded as the business of a medical scheme; and
- where an insurance product pays benefits on a periodic basis for a contingency other than medical expenses, such as disability income benefits, it will be regarded as health insurance business, unless it can be shown that the benefits relate to the payment of medical expenses.

In addition to complying with the letter of the Insurance Acts, insurance products:

- must not be conditional upon membership of any particular medical scheme;
- must contain a mandatory standard warning to the effect that this is not a medical scheme and the cover is not equivalent to that of a medical scheme;
- sales and marketing material should make it clear that a health insurance policy is not a substitute for medical scheme membership;
- it is recommended that the word medical is not used in the name of the product; and
- health insurers may not offer cessions to medical service providers. Benefits must be paid to the policyholder and may not be paid by health insurers to medical service providers in return for medical services rendered to policyholders.

Health insurers may not make benefit payments to medical service providers through cessions or similar means.

7.4.3 CODE ON MEDICAL FEES, REPORT FORMS AND RELATED MATTERS

ASISA has established a set of fees which they recommend their members should charge for examinations for insurance purposes requested by member offices. These fees are not binding on member offices, who are free to negotiate lower fees, nor is the tariff binding on all registered medical practitioners.

ASISA's Medical and Underwriting Standing Committee has, however, drawn attention to the importance of life offices to keep to the fees so as to forestall any tendency that might otherwise arise for individual doctors to withdraw from the Tariff Agreement.

ASISA has also instituted certain protocols to ensure the confidentiality of medical information. These protocols have been implemented to ensure that medical reports, including reports obtained for underwriting and claims assessment purposes, do not become accessible to any person other than an authorised official at the life office concerned.

The basic rule is that medical reports have to be posted to the relevant life office and be addressed to an authorised official. Such envelopes must be clearly marked "Private and Confidential".

Medical reports may be handed to intermediaries and other authorised representatives of life offices, provided that the report is not accessible to the representative and is sealed in an envelope that complies with standards set by ASISA.

Branch offices may only have access to underwriting material if they maintain an independent underwriting department at the branch concerned, which is answerable to its head office underwriting department for its management on underwriting matters. Further, no intermediary or manager is allowed access to or extracts from the life register. Confidentiality of medical information is treated as a top priority and any breach is viewed in a very serious light.

7.4.4 CODE ON REPLACEMENT

The member offices of ASISA have agreed to this code for the protection of policyholders and the good name of the industry. It is the intention of the code to complement and support the Financial and Intermediary Services (FAIS) Act, so as to ensure that the interests of all parties are addressed in an equitable manner. By observing this code, members affirm that, as a general rule:

- it is contrary to the interests of a policyholder to terminate an existing insurance policy and then to effect a new insurance policy in its place;
- it is in the interests of a policyholder to vary an existing insurance policy in order to provide for changed requirements or circumstances; and
- that a replacement should not be effected without the benefit of proper disclosure and analysis of the consequences of replacing policies.

The Code does not limit the right of policyholders to terminate any insurance policy or to take out a new one, but it does try to ensure that the decision is made in a positive and informed way.

Member offices therefore undertake to ensure that:

- all intermediaries and direct selling staff are properly trained so as to understand the potential and real disadvantages of replacements and to give proper counselling where a replacement is proposed;
- they follow all such practices as will assist in preventing unwarranted replacements and to generally giving effect to this code;

- they make compliance with this code a term of their contractual relationship with intermediaries; and

- they make it a feature of their contractual relationship to deal with non-compliance with this code as breach of contract or misconduct and to deal with contraventions accordingly.

Note that while it was thought that the Code on Replacement would fall into disuse with the advent of the replacement controls in the Policyholder Protection Rules, this has proven not to be the case.

7.4.5 CODE ON THE S REFERENCE SYSTEM

This Code is applicable to all intermediaries, representatives or agents irrespective of any title such as broker, director, district manager or superintendent that they may assume and all participating corporate brokers and/or their employees directly engaged in canvassing and procuring new business and irrespective of whether they are paid by commission or by salary or both (intermediaries).

The **S Reference** system is essentially a system of self-regulation within the long term insurance industry to protect the public at large and the industry from persons who are not fit and proper to be engaged in the business of marketing the products of the industry, or in directly controlling or training those who are so engaged.

The participating members of ASISA, and this includes a large number of broking firms, will not:

- employ;

- accept new business from; or

- pay commission to

any intermediary with an S Reference, nor will they employ them in a position of control over intermediaries or their training.

The imposition of an S Reference is a very serious matter with serious consequences both for the industry and the intermediaries concerned.

The conduct which warrants a referral to ASISA's panel, which will investigate the charge and decide on the imposition of an S Reference or not, cannot be precisely defined and much will depend on the circumstances of each case. However, long experience suggests that certain conduct is at least prima facie evidence of conduct for which the S Reference would be an appropriate treatment.

This would include:

1. Evidence of misrepresentation (including contraventions of the Code on Benefit Illustrations) such as:
   (a) giving inflated quotations to procure business;
   (b) quoting incorrect details about products he is selling.

2. Evidence of dishonesty such as:
   (a) misappropriating any amount of money collected as premiums from the public;
   (b) forging the signature of a client on proposal forms, cheques, etc;
   (c) submission of fictitious business.

3. Dismissal due to personal behaviour which is detrimental to the long term insurance industry.

4. Dismissal arising from any criminal conviction on being found guilty of theft, fraud, forgery or uttering a forged instrument, perjury, an offence under the Prevention of Corruption Act, 1958; the Drugs and Drug Trafficking Act, 1992; or any offence involving dishonesty.

5. Proof of serious falsification of information to secure an agency or broker contract such as:
   (a) making serious false declarations when applying for a position;
   (b) failing to reveal a past criminal record.

6. Placing business for a former intermediary on whom an S reference has been imposed.

7. Replacement of policies as defined in the ASISA Code on Replacement where the intermediary was aware that a replacement was being effected, and where the replacement was clearly not in the interests of the client or was not disclosed in the proposal form.

   NB Where a full-time agent or an independent intermediary changes employers and thereafter embarks on a programme of replacing policies written with a former employer with policies written with a new employer, either office may institute S reference proceedings.

8. The obtaining (otherwise than directly from, and freely given to the intermediary by, the client) of medical or AIDS-risk life-style information relating to a client, or the disclosing of such information to a client or to any person other than an authorised employee of the insurer - except with the express written authority of the insurer.

   Examples (which do not limit the generality of the above):
   (a) to obtain such information by exerting pressure on medical practitioners, or their staff, or staff of a member office;
   (b) by intercepting such information at the rooms of medical practitioners, or the offices or staff of a member office;
   (c) by opening envelopes or otherwise accessing material not expressly stated to be for viewing by the intermediary;
   (d) by obtaining such information from the ASISA Life Register.

The basic question before the panel will always be whether the reported conduct warrants the imposition of an S Reference, which is operative for a period of 5 years.

Only if the panel is unanimously convinced that exceptional mitigating circumstances existed may it impose the S Reference for a shorter period, but not exceeding 24 months. The main consideration in reducing the term is the interest of the industry and not the personal circumstances or hardships of the intermediary.

There is no automatic right of appeal. On application by the intermediary, leave to appeal may be granted by the chairperson of the appeal board if he is convinced that there is a reasonable prospect of the appeal being successful.

The chairperson may refer the matter to one or more senior legal advisers of a disinterested office for a recommendation regarding the granting of leave to appeal. Unless an appeal before the Appeals board is successful a determination to impose an S Reference may not be suspended and it cannot be removed before its period has run its full course.

At the end of the period the “S” Reference is replaced by an “X” reference. An “X” reference indicates that the intermediary may, once again, be employed to market life insurance.

Note

In order to avoid duplication and towards aligning existing processes and procedures, no participant shall be entitled to lodge, process and proceed with an S reference recommendation in respect of any representative who has been debarred as contemplated in Section 14 of the Financial Advisory and Intermediary Services Act 37 of 2002.

7.4.6 CODE ON PUBLIC RELATIONS AND ON ADVERTISING AND PROMOTION

Member offices have agreed that any public statements made on behalf of the life insurance industry will only be made by ASISA or under the specific authority of ASISA. Where a member office makes a public statement, unless it has the specific authority of ASISA to do so, it must ensure, as far as practicable, that:

- persons hearing or reading the statement do not regard it as having been made on behalf of the life insurance industry; and
- it does not put the life insurance industry in an unfavourable light or otherwise harm the industry.

Member offices are also responsible for ensuring that their employees, including their field staff, do not make public statements without their permission and, where permission is given, that they comply with the previous two conditions.

Additional Information

This is in no way intended to discourage member offices or their officials from writing articles or making speeches on life insurance matters. On the contrary, the more information that is brought to the notice of the public, the better it will be for the industry. The aim is merely to provide that when member offices or their officials do make such statements, they ensure as far as practicable that:

- people are not misled into thinking that there is any greater authority for the statements made or opinions expressed than is in fact the case; and

- it be borne in mind that a statement or opinion which is perfectly harmless from the point of view of some offices may nevertheless damage other offices and be harmful to the industry as a whole.

While accepting the right of member offices to market their products in the spirit of the free enterprise system, members of ASISA believe that it is undesirable for member offices to make claims or engage in comparisons which are not properly substantiated or which could prove detrimental to the image of the industry as a whole.

The members of ASISA have agreed that all advertising must comply with a list of conditions contained in the code of conduct[10], which include the FAIS Code of Conduct requirements as well.

7.4.7 CODE ON POLICY QUOTATIONS

This Code was intended to ensure that policyholder expectations created as a result of illustrative policy benefits are reasonable and do not result in the industry's image being damaged.

The new guidelines contain the following key provisions:

The Code is intended to ensure that policyholder expectations of benefits and premium rates, created by quotations presented in the sales process, are reasonable (given the economic environment and policy charging structure) and do not damage the industry's image.

Specific objectives with the Code are to:

- regulate the use of projected values;
- demonstrate the consequences of early termination;
- show the effect of all expense charges on the overall investment return;
- show the expected impact of premium rate reviews after the expiry of the guaranteed term.

7.4.8 CODE ON THE CLAIMS REGISTER

To do proper claims assessment and to discourage fraud, insurers must be able to obtain all information relevant to those risks and claims. The Claims Register is a database through which insurers can share information about persons who are the lives insured under policies and who have made notifiable claims that are relevant to the assessment of future claims.

Notifiable claims are claims that meet the following criteria.

[10] Should you wish to examine the list, it can be accessed with the relevant code on ASISA's website

Early claims

- Individual or group scheme death claims:
  - on policies in force for less than 1 year (from date of entry, revival or ad hoc increase), irrespective of the insured amount; or
  - with a total death value (per policy) of R500 000 or more.

- Individual or group scheme disability or functional impairment claims:
  - on policies in force for less than 2 years (from date of entry, revival or ad hoc increase), irrespective of the insured amount.

- Individual medical policies:
  - in force for less than 3 years (from date of any of the following: entry, revival or ad hoc increase);
  - with a total benefit (per policy) of R50 000 and more; or
  - where hospitalisation exceeds a period of 10 days per claim.

Claims under special investigation
Claims that have not yet been finalised in light of the fact that these claims are the subject of special, such as forensic investigations.

Fraudulent claims
Where the insurer is satisfied beyond reasonable doubt that the claim or any aspect of the claim is fraudulent.

Repudiations
Death claims that have been repudiated.

Dread Disease benefit
All claims in respect of dread disease benefits.

Overseas claims
All claims that rise or are submitted from outside the national territory of the Republic of South Africa. This provision is not applicable to claims that are submitted or arise from Namibia, Lesotho or Botswana.

AIDS/HIV positive
All claims where evidence proves beyond reasonable doubt that the life insured was HIV positive or suffered from AIDS.

Permanent Health Insurance
Individual or group scheme disability claims where:

- the permanent health risk is greater than R20 000 per month, per policy, or

- the benefit has ceased for reasons other than death or the expiry of the benefit.

Beneficiary
For individual or group scheme death claims:

- where the beneficiary of any benefit in terms of the policy is not the spouse, child or close family relation of the proposer, life insured or policyholder;
- where the beneficiary is an intermediary.

7.4.9 CODE ON THE INTERMEDIARY REGISTER

The Intermediary Register is a database of current and historical information of appointments of all intermediaries active in the life insurance industry. This affords authorised users the opportunity to access relevant reference data before appointing an intermediary.

Again, with the control of intermediaries having being picked up by the FSB's FAIS Department, this register is no longer necessary.

7.4.10 CODE ON ASSISTANCE BUSINESS

The provision of a decent funeral for deceased family members is a universal social imperative. In South Africa assistance insurance provides, either individually or via membership of an affinity group, affordable cover for defraying funeral costs.

The Long Term Insurance Act recognises the particular circumstances of assistance business by leaving commission unregulated and by making specific provision for group schemes.

Where cover is provided on a group basis, sales and administration are typically outsourced to an administrator. The resulting separation of insurer and customer has given rise to a range of abuses whereby:

- marketing by third parties is largely unregulated and occasionally fraudulent;
- risk premiums may be subject to excessive mark-ups by administrators or their sales representatives;
- accounting for client premiums may be problematic; and
- claims may be declined through no fault of the client because of non-transmission of premiums to the administrator and/or insurer.

In order to minimise the scope for abuse all registered assistance insurers have agreed to follow the procedures included in this code of conduct which have been specifically designed to limit the abuses that were prevalent.

7.4.11 CODE ON GENETIC TESTING

The aim of the human genome project was to map the entire genetic code. This was an international research effort that took many years to complete.

The detailed genetic information that has become available through this project has substantial implications for both society and individuals. There is also an important implication for the insurance industry worldwide.

Various consumer groups have expressed concern about the implications of genetic testing and the availability of life and health insurance. Attention has been drawn to what they perceive as potential misuse of genetic information by insurance companies. This is given as a reason why companies should not have access to these results.

ASISA believes it is necessary that consideration of genetic testing issues should recognise the balance that is required between the legitimate interests of policyholders and insurance companies. It is important that there is an understanding of how voluntary insurance operates in order to maintain a balance between all these interests.

7.4.12 CODE ON UNCLAIMED BENEFITS

When a benefit becomes payable in terms of a policy, the policyholder or beneficiary has a contractual claim against the insurer which should not be treated differently to any other contractual claim. Nevertheless the members of ASISA recognised that it would be in their interest to inform policyholders or beneficiaries of unclaimed benefits under a policy in certain circumstances.

An investigation into the matter showed that members generally followed policies and procedures aimed at informing policyholders or beneficiaries of unclaimed benefits. However, the members of ASISA decided, in the interest of uniformity and fairness among insurers, to develop this code which is aimed at ensuring that reasonable steps are taken by members to inform the policyholders or beneficiaries of any unclaimed benefit.

7.4.13 CODE ON BENEFIT EXPECTATION MANAGEMENT

Introduction

- The value gap between what policyholders expect to get out and what they actually receive is mainly caused by what the policyholder was originally told or quoted when they were sold the policy. This is exacerbated by the insurers not managing the policyholder's benefit expectation well enough during the policy's lifetime.

- Better disclosure and transparency is required by legislation, the minimum termination values and the removal of projections from quotes and policy documents should go a long way to help close this perceived value gap.

Objective of guidelines

- To assist in managing policyholder's benefit expectations during the lifetime of a policy.

- To help close the value-for-money gap between reality and policyholders' expectations.

- To create better informed and satisfied policyholders thereby promoting the image of our industry and its products.

- To use it as an opportunity to educate consumers about the need for long term saving, thereby laying the foundation for diligent financial planning.

- To ensure that there is adequate disclosure governing reviewability of risk premiums in place so that it does not become an area of reputational risk for the industry.

Guiding principles

- Successful saving is a combination of:
  - amount saved;
  - length of saving;
  - allocation between different asset classes;
  - annual return achieved on selected funds;
  - the impact of costs on the investment;
  - tax.

- Savings products offered by life offices should be seen as long term investments.

- Inflation has a bearing on investment returns over the longer term.

- Following sound investment principles will greatly contribute to overall investment success, for example:
  - setting goals;
  - getting good advice;
  - staying committed;
  - not switching unnecessarily;
  - making regular contributions and increasing contributions with inflation over a long term;
  - that time in the market and not timing of the market is ultimately what counts as well as appropriate asset allocation depending on your personal circumstances.

- Policyholders need to know how much cover they enjoy, when their risk benefits will be paid, what the premiums are and for how long they are guaranteed and to whom the benefits will be paid.

Minimum communication requirements

- Current value of the policy e.g. where appropriate, the fund and/or cash values and the death and disability benefit payable.

- Whether there is a guarantee on the policy. If so, what is guaranteed e.g. on allocation amount not premiums and in the case of risk policies what the guaranteed premium paying term is and what happens when this guarantee expires.

  In addition to disclosure at time of sale, regular communication should be given to the policyholder informing them of the latest status of their policy and the likelihood of premiums needing to be increased.

Optional communication guidelines

- That policyholders should also always consult their policy documents for example, original quote, contract and policy information letter, their adviser or insurer's website where applicable for further information on matters covering, for example, past performance, fund composition and benchmarks, the risk profile of their chosen investment, costs and investment allocations, tax information, adviser fees and any exclusions or waiting periods that may apply to risk benefits.

- That saving and investment policies are essentially long term investments that need time to maximise their benefits from compound interest.

- A warning that policyholders should not make decisions based on short term investment performance or without considering their overall financial plan in a holistic way together with their adviser.

- Current nominated beneficiary or cessionary according to latest insurer records.

QUESTIONS ON CHAPTER 7

Mental revision questions

Work through these mental revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. Explain why the terms and conditions of the policy document need to be referred to when a request for an alteration or amendment to a policy is dealt with.

2. Does a cession cancel the nomination of a beneficiary?

3. Does the policy servicing department have to answer ALL queries that are directed at the insurer by a policyowner?

4. What is the relevance of a policy document?

5. Who is normally considered competent to attest to the validity of a policy contract?

6. What is the maximum scale of commission that an insurer can be expected to have to pay on a universal whole life policy?

7. At what stage can a policy be expected to have a surrender value?

Written questions

Attempt these questions after you have completed this chapter and its mental revision questions. Suggested answers to these questions are at the end of this book.

1. How has the introduction of universal policies simplified the process of altering a policy at the request of the policyowner?

2. Explain why it is difficult for an insurer to compete directly in the investment market against other investment players - even with pure endowment policies.