SUGGESTED ANSWERS

CHAPTER 1

1. Explain the role and functioning of ASISA.

ASISA represents the majority of South Africa's asset managers, collective investment scheme management companies, linked investment service providers, multi-managers and life insurance companies.

ASISA was formed in 2008 by members of the Association of Collective Investments (ACI), the Investment Management Association of SA (IMASA), the Linked Investment Service Providers Association (LIPSA) and the Life Office's Association (LOA). These associations have disbanded and all assets and activities have been transferred to ASISA.

The aims of this association are to:

- work towards greater level playing fields;
- create an environment enabling more holistic regulation;
- become more consumer focussed;
- collectively engage with government on policy issues.

2. Outline the aims of SASIMU.

The aims and objectives of SASIMU are:

(i) to be a representative body for the protecting and maintaining of ethical standards of persons engaged in the assessment of life, disability, health or miscellaneous long term risks;

(ii) to promote good fellowship amongst members of the society and other persons employed in the assessment of life, disability, health or miscellaneous long term risks;

(iii) to disseminate technical knowledge and inculcate sound insurance risk assessment practices;

(iv) to encourage the study of all matters relating to insurance and the assessment of risk and to recognise achievements and papers written by its members;

(v) to arrange recognised examinations, specifically dealing with the assessment of life, disability, health or miscellaneous long term risks with the aim of promoting the achievement of the status of a Fellow of the Institute of Life Underwriters;

(vi) to do such other lawful things as are incidental or conducive to the attainment of any or all of the above aims and objectives of the society.

3. What is the mission of the FPI?

The Financial Planning Institute will always be the leading independent representative body of professional financial planners in South Africa by ensuring that its members:

- are challenged by appropriate standards of competence through examination, continuing education and experience;
- are motivated to continually improve by being provided with a pathway to develop the necessary skills and knowledge;
- are supported with a framework within which they can establish themselves as a profession;
- are incentivised to maintain ethical standard through enforcing adherence to The Financial Planning Institute code of conduct and practice standards;
- are represented in such a way that their professional conduct is respected and appreciated;
- are recognised as having, through The Financial Planning Institute, an authoritative voice on all financial planning issues, thereby promoting the interests of consumers.

CHAPTER 2

1. Give five examples of insurable interest and briefly explain each one.

Any 5 of the following will suffice.

On the insured's own life
Insurable interest becomes irrelevant when the policy is on the insured's own life. Insurable interest is really only needed as proof of the good faith of the people involved in the contract. It is generally accepted that every person has an unlimited insurable interest in his own life.

On the life of a spouse
It is usually accepted that there is an unlimited insurable interest between spouses.

On the life of a fiancée
In practise it is usually accepted that an engaged couple have the same level of insurable interest in each others' lives as a couple who have already married.

On the life of a relative
In South African law both parents are under a legal duty to support their children and if they cannot support their children the duty passes to the grandparents.
A person who cannot support himself as a result of either a mental or physical disability, can claim support from a brother and/or sister if the parents are unable to provide it. A child must also support an infirm parent or grandparent. This legal duty creates an insurable interest. The insurable interest is based on and limited to the actual loss of maintenance that might occur if the person providing the support dies. To establish the amount of insurable interest the ages, state of health and wealth of both parties must be looked at.

Creditor on the life of a debtor
A creditor has an interest in the continued health of a person who owes him money. Insurance is allowed at least to the value of the debt plus some reasonable interest.

Partners
Partners create an insurable interest in each others lives when they sign an agreement to pay money to the estate of a partner that dies. The agreement, which must be binding, limits the insurable interest to the amount that must be paid to the estate on death.

Employers on their employees
An employer has an insurable interest on the life of an employee if it can be established that the earnings of the company rely on the employee's skill or services.

Employees on their employers
An employee who has a contract for a fixed number of years at an agreed salary has an insurable interest in the life of his employer equal to of the value of future salary.

2. Explain what is meant by the reasonable man test.

The proposer is expected to provide an insurer with all the relevant information required that a reasonable man would know to be material to the risk. It will be no excuse to state that facts were not disclosed because you thought that they were not important or material. If a reasonable man would have recognised the facts to be material, the proposer is expected to also have recognised this.

This does not mean that every proposer needs to be an underwriter. The emphasis is on what a reasonable man would consider to be necessary. Unfortunately there does not seem to be a clear definition of what is considered to be a reasonable man. Where this has been put to the test the opinion of a person with an average intelligence and some form of post-matriculation qualification was considered adequate. A knowledge of insurance, however, usually disqualifies the person as the opinion of a layman is what is wanted.

There is, however, some information that will always be considered to be material and so must, be disclosed.

- Insurance record of the proposer / insured.
- Character of the insured.
- Risk experience of proposer.
- Medical questions.

3. Give six of the restrictions applicable to any new policies that are now issued in accordance with Part 4 of the Regulations to the Long Term Insurance Act and briefly explain each one.

Any 6 of the following will suffice.

1. The minimum policy term must be 5 years. Where a policy "breaks" one of the rules explained here the minimum term to maturity must start again. Therefore, a change to the policy outside the rules will result in the policyowner having to wait 5 years for his full benefit to become available to him.

2. Life cover is not necessary. It is possible for an insurer to issue pure endowment policies. Where the policy is a company owned sinking fund policy it is not even necessary to nominate a token life insured.

3. It is possible to have more than one life insured on a policy. The policy can also provide for the payment of benefits only on the death of the last dying.

4. You can substitute a life insured on a contract and delete the original life insured completely.

5. Policyowners will only be allowed one partial surrender or loan against the policy during the first 5 years.

6. Increases in premiums are limited to a maximum of 20% per annum.

7. Payments of benefits (other than as a result of a claim) during a 5 year restriction period are limited to the greater of the surrender value, or a refund of contributions plus 5% interest.

8. Where a policy is to be fully surrendered during a restriction period the policyowner is only allowed to receive the total value of the policy if it does not exceed the value set out in point 7 by more than R2 500.

9. Benefits in terms of new policies can be paid during a restriction period if the claim is:
   (a) a death claim
   (b) payment due on the birth of a child to the life insured
   (c) a disability claim, or
   (d) a claim in terms of a health insurance policy.

10. The rules do not apply to any policy used to underwrite benefits available from:
    (a) a pension, provident or retirement annuity fund
    (b) a friendly society
    (c) a benefit fund
    provided that the benefits stay in the fund and are not ceded to a member. Benefits can be ceded to another fund similar to the one that the funds are currently in.

11. There is a definition of an annuity included in the legislation and, provided the definition is abided to, the rules also do not apply to an annuity. The definition means:
    (a) payments must be made at intervals not exceeding 12 months
    (b) at least one of the payments must be made in the 31 days before to the end of the restriction period
    (c) payments in one 12 month period may not differ from the payments in the 12 months immediately preceding by more than 20% unless as a result of fluctuations within a linked portfolio.

12. The Minister of Finance may amend, at any time, by regulations published in the Government Gazette:
    (a) the interest rate of 5%
    (b) the minimum period of 5 years
    (c) the escalation factor of 20%
    (d) the number of loans or surrenders permitted in the restriction period (currently one only).

4. Explain the duties of the trustees where the nominated beneficiary on the deceased's retirement annuity contract is not a dependant.

Any benefit payable by a retirement annuity fund in respect of a deceased member will not form part of the assets in his estate. The trustees are responsible for, as far as possible, acceding to the wishes of the deceased and paying the proceeds to whomsoever was nominated as a beneficiary. They are, however, restricted by the Pension Fund Act (Section 37C) and so must deal with the proceeds in the manner set out herein.

(a) If the fund within twelve months of the death of the member becomes aware of or traces a dependant or dependants of the member, the benefit shall be paid to such dependant, or in such proportions as may be deemed equitable by the person managing the business of the fund, to such dependants.

(b) If the fund does not become aware of or cannot trace any dependant of the member within twelve months of the death of the member, and the member has designated a nominee who is not a dependant to receive the benefit or a portion thereof, the benefit or portion thereof is to be paid to the nominee. The designation to the fund must have been in writing.

Here, if the debts of the estate of the deceased exceed his assets, the shortfall will be made up out of the proceeds of the pension fund (or retirement annuity) and only the balance will be paid out to the nominee. The payment to the estate will be in the form of a commuted lump sum.

(c) If a member has a dependant and has also nominated a beneficiary, who is not a dependant, the fund shall within twelve months of the death of the member pay the benefit to the dependant and the nominated beneficiary. It is the duty and responsibility of the person managing the fund to determine what proportions of the benefits will be paid to the relevant parties.

(d) If the fund does not become aware of or cannot trace any dependant of the member within twelve months of the death of the member and if there is no nominated beneficiary or the nominated beneficiary has predeceased the member the benefit will be paid into the deceased's estate. Should there be no inventory submitted for the estate, the estate being too small and the member dying intestate, the benefit will be paid into the Guardian's fund. Payment will be in the form of a commuted lump sum.

5. What conditions need to be met in order that an employee may claim the first R30 000 of a gratuity paid to him by an employer as a tax exempt amount?

In terms of Section 10(1)(x) of the Income Tax Act a lump sum amount not exceeding R30 000 is exempt from tax. Any other amounts previously excluded from tax as a result of this section (in the current or any previous year of assessment) will reduce the amount of the exemption now allowed. No exemption under this section will apply unless:

(a) the person receiving the amount has attained the age of fifty-five years; or

(b) the employee is relinquishing, terminating, losing, repudiating, cancelling, or varying his office or employment as a result of superannuation, ill health or other infirmity; or

(c) the employee is retrenched as a result of the employer ceasing his business or down-sizing.

CHAPTER 3

1. Explain how the fact that a person may have a heart-condition will result in him having to pay a higher life insurance premium than an average person.

Mortality tables have been built up by actuaries and statisticians over many years by collecting information on the number of people who have died at a certain age and in a certain year. This experience is used to work out how many people will probably die in any future year if the policyowners get to a particular age.

Naturally the figures that are worked out, based on the past, cannot be exactly accurate for what may happen in the future. But, the more information that is got together, the better the chances of the tables being right. This is called the concept of probabilities.

When looking at probabilities we accept that some events must happen - all living creatures will die at some time and the moon will be full next month. Events which must happen are given the probability of 1 (one). Other events will never happen - like "a pig learning to fly". Those events which will never happen are given the probability of 0 (zero). In between are events that may or may not happen. When probabilities are used to work out mortality tables the actuaries try to get enough information together so that they can reach a point where the tables will be as accurate as possible.

For example, you can call heads on the toss of a coin and although the probability is 1 out of 2 that heads will come up, you could toss the coin a few times and tails may appear each time. However, if the coin was tossed 1 000 times the probability of 1 out of 2 (i.e. 500 heads and 500 tails) would be close. This means that the probability is 0,5.

If we now move this to life insurance, the actuary will need to know what the probability of a man aged 30 living until he reaches age 31 is. Let us assume that the probability is set out in the mortality tables as 0,00028. This would mean that out of a group of 100 000 men that are 30 years old, 28 are expected to die before their 31st birthday. The actuary needs to know this information. If each one of the 100 000 men where to buy a policy for one year only that would have life insurance cover of R10 000 then the actuary will know that he will probably have to pay 28 claims. This will cost the insurer R280 000. The actuary would therefore have to charge a premium of R2,80 for the R10 000 life cover to each of the 100 000 men who buy a policy.

This is, of course a very simple example. There are a lot of other things that the actuary must also remember when he works out the premium that must be charges, for example, expenses, commission and interest on the premium which can be invested until the claims are put in.

What the actuary, however, needs to know are the probabilities available in order to calculate a life insurance premium. The probability of when death will happen is set out in the mortality tables that the life insurers use and forms the basis of the calculation of life premiums and are based on average people. This means people who are not overweight or underweight, or not to healthy or to sick. These people are called standard lives insured.

It is the duty of the underwriters who work for the insurer to work out whether an applicant for life insurance is a standard life insured who fits into the probabilities used for the mortality tables. The underwriters will ask for a medical examination or the completion of a non-medical declaration to find out whether a person is standard.

Where a person is not a standard life insured the underwriters will have to adjust the premiums that the proposer will be asked to pay. Should a proposer who is one of our group of 100 000 men have a heart-condition it could mean that he has a 50% higher chance of dying before he turns 31. The underwriter will have to add at least a 50% "loading" on the policy. This means that in our example this proposer would have to pay the following:

Normal premium	:	R2,80
Loading of 50%	:	R1,40
Total premium	:	R4,20

Naturally the proposer who is very healthy may have a better chance of living than the standard life insured used to draw up the mortality tables. Some life insurers are even prepared to consider a discount on the premium that the standard life insured person should pay for a person who is healthier than the average person.

2. Describe the factors that need to be taken into account when an actuary does a valuation and the reasons why it is necessary for a valuation to be done in the first place.

The official valuation that must be done at least once every three years is a ruling of the Insurance Act. It is seen as a test of an insurer's financial strength and protection of the interests of the policyowners. The results of the valuation (the valuation report) must be sent to the Registrar of Insurance. The Registrar can ask for a valuation at any time. Life offices usually carry out an internal valuation every year - usually at the end of their financial year.

When doing a valuation the following play a special role:

- *the rate of mortality* that the insurer has experienced in the past and what it estimates will be experienced in the future; and
- *the average rate of interest* (growth and earnings) it has earned in the past on its assets and what it estimates it will earn in the future; and
- *expenses* of running the business of the long term insurer - including commission and any other expenses involved in getting new business and servicing that business.

In simple terms a valuation puts a value on the assets and liabilities of an insurer. The assets are the policy reserves an insurer should be holding so that it can pay the future benefits (liabilities) it will have to pay when claims arise.

The main reason for carrying out a valuation is to make sure that the life insurer still has enough assets to pay its liabilities (i.e. whether it is solvent).

The second reason for carrying out a valuation is to work out the value of the surplus that a good investment strategy and watching the expenses has built up. There will be a surplus if the assets are a lot bigger than the liabilities.

Thirdly a valuation must be done if two or more insurers are planning to merge or if any part of an insurer's business is to be transferred to another insurer. Finally a valuation may be done to test the effect of new premiums and products.

Where there is a surplus at the time of a valuation it would be quite wrong to think that the surplus is a profit. In calculating the surplus, certain assumptions have to be made about the future. A true profit can only be worked out if the actuary can compare actual claims and expenses against actual premiums received and interest earned after the last of all the policies have been paid as a claim.

3. It has become common practice to alter a universal policy when more life insurance is required rather than contract for a new policy. Explain how the universal concept allows this trend to continue and expand.

Life insurers have always wanted to design a policy that is flexible enough to meet all the needs of the policyholder throughout his life. The development of computers have helped life insurers to design such a policy. This is because computers have the ability to do rapid calculations on a large scale. What has become generally known as the universal policy was developed.

To understand the universal concept we want you to use your imagination and imagine that a prospective policyholder who wants to buy a universal life policy has come into the offices of the insurer and opened a "bank account".

All premiums paid by the policyowner will in future be paid to this bank account. In the life insurance industry this bank account is commonly known as the policyowner's **investment account**.

On the proposal form the applicant will have asked for a certain level of life cover and, should he want to include them, some supplementary benefits. The underwriter of the insurer will assess the risk and decide the minimum premium needed to pay the expenses of the cover requested.

The following costs will be taken into account:

- *the cost of the life cover and supplementary benefits* required. This may either be at standard rates or with a loading - dependant on the underwriting decision, some insurers prefer to keep the supplementary benefits outside of the universal design and deduct the premium due before making the allocation to the investment account;

- *commission* to be paid to the intermediary;

- *up-front expenses* which the insurer will have to pay in the underwriting, assessment, acceptance and administration of the proposal;

- *the cost of issuing the policy document*;

- *general expense charges* that are allocated to every policy in order to pay for the general administration of the insurer.

The policyowner will be told what the minimum premium is that he will need to pay. The part of the universal concept that is so special and unique is in this very factor of a minimum premium. The policyowner may choose to pay any premium as long it is the same or more than the minimum premium. Remember that there is an **investment account** at the offices of the insurer that all the premiums are paid into. What usually happens is that all the expenses that are taken into account are taken out of this account as and when they happen.

With a universal policy the cost of the life cover and supplementary benefits needed by the life insured are calculated on a month-by-month basis, almost like a series of one month term insurances.

At the beginning of every month the computer will work out how much money the policy has in its investment account. Note that this money will also include any investment growth that there has been on the money that was in the account at the beginning of the previous month.

Let's look at an example of a client who has R100 000 life cover on his policy. At the beginning of a month during the term of the policy the investment account has R8 000 in it. In order to be able to pay a claim of R100 000 during the next month the life insurer only needs to add R92 000 of life insurance. This calculation is done every month to find the amount of cover that needs to be bought. The premium is then worked out using a mortality table and the life insured's age. The premium needed to purchase the life cover (and any supplementary benefits) is then drawn out of the investment account.

Because older people have a greater chance of getting sick and dying, the cost of life cover increases as a life insured grows older. Using the universal system the increase in the monthly cost of the life cover is reduced by the fact that the investment account grows and so the amount of life cover that must be bought decreases. It is even possible that, over time and depending on how quickly the investment account grows, the investment account could be equal to, or even bigger than the life cover needed. When this point is reached it will no longer be necessary to buy any life cover and the whole premium, less administration costs, would stay and grow in the investment account.

One of the other advantages of a universal life policy is that the insured can change the level of his life cover at any time because the amount of life cover that needs to be added to the policyowner is worked out monthly anyway. For example, if the insured were a young, unmarried man, his life cover need would probably be small, but would increase if he married and had a family. Then, when his children had grown up, his need would be for investment towards retirement. All these options can be a part of a universal life policy.

What one must, however, appreciate is that the underwriters will have to be supplied with evidence of continued good health that is satisfactory to them if any request for an increase in life cover is made. Should this not be a requirement the life insurers would face the danger that a seriously ill (or even dying) life insured could increase his life cover shortly before death. This would not be good for either the insurer or all the other policyowners.

4. A policyowner has just been informed that his universal policy has been reviewed and he needs to increase the premium on the policy by 12%. Explain to the policyowner how it is possible that this could occur.

One of the reasons why actuaries can calculate and offer a low rate of premiums for universal policies is based on the fact that the life insurer sells the policyowner a "new" monthly term insurance policy at the beginning of every month. This factor releases the insurer from having to provide a guarantee that the premium quoted at the beginning of the policy will remain the same for so long as the policy continues.

The actuary will only review the general mortality experience and not that of an individual life insured.

To ensure that the policyowner has some limited guarantee of a fixed premium for a period of time most universal policies have a guaranteed period after which a renewal date is included in the policy. Should the actuary want to charge a higher premium before a renewal date the extra premium required will be paid out of the reserve account of the insurer.

At the renewal date stated in the policy document the policyowner will be informed of the current status of his policy. A higher premium rate for the life cover may then be announced. Where it is found that costs have risen or the investment returns were below expectations, the policyowner may need to either reduce his life cover and/or supplementary benefits or increase the premium if there is not enough money in the investment account to meet the expected charges.

The insurer's actuary, being relieved from the need to build the cost of these guarantees into the premium can charge a lower premium knowing that the mortality charges may be changed at any time after the policy commences. The actuary of the insurer has the right to review the premium being charged at any stage.

Given the natural conservatism of actuaries in their calculation of costs this scenario is one that is considered to be highly unlikely. The policyowner must, however, accept that the possibility does exist and therefore must be taken into account.

CHAPTER 4

1. Describe how a retirement annuity policy works, making reference to the tax relief on contributions and the nature of the benefit payments.

In terms of the Income Tax Act the following conditions (amongst others) must be fulfilled to enable a person to obtain a retirement annuity and to enjoy the tax advantages thereof:

(a) the policy must not provide for any payment during his lifetime except by way of an annuity or partial commutation, unless the member is disabled;

(b) payment of the annuity must not start before the 55^{th} birthday;

(c) the annuity must be non-cedable but an annuity may be paid to a widow;

(d) limited commutation is allowed only up to $^1/_3$ of the annuity, apart from cases of relatively small amounts.

In the technical sense a retirement annuity works very much like an endowment policy - being for a specified term and being either without life cover, with life cover or with life and disability cover.

The policy is of advantage in that a fairly substantial annual sum paid by way of premium can be charged against income for tax relief in full. The maximum tax deductible contribution is defined as the greatest of

15% of non-pensionable income
or R3 500 per annum less pension contribution
or R1 750 per annum.

This allows a high rate tax payer to make pension provision at exceptionally low net cost, although the annuity purchased at retirement is regarded as income for tax purposes and not as purchased life annuity, which is given more favourable tax treatment.

The growth of the funds held by the insurance company under RA policies is not taxed. Furthermore, on death or at retirement a portion of the lump sum proceeds is tax free, the balance of the lump sum being taxed at the average rate, the higher of the average tax rate in the year of retirement or the previous year.

The disadvantages lie in the restriction placed upon these contacts.

- They may only partly be commuted for cash,
- they give limited capital sum cover at death and
- they may not be ceded.

Their use, therefore, is mainly restricted to the reason for their statutory existence, i.e. pension provision.

2. How much can Mr. and Mrs. Smith contribute to a retirement annuity fund and claim as a tax deduction?

Mr. and Mrs. Smith are totally separate taxpayers who will therefore each be able to claim their maximum deduction in his own right. We must first establish what Mr. Smith can deduct and then look at Mrs. Smith's position.

Mr. Smith

His deduction is limited to the greatest of:

(A) 15% of all income from non-retirement-funding employment after deducting all expenses incurred in earning this income;

OR

(B) an amount of R3 500 minus any contributions made by the taxpayer to a pension fund, that were allowed as a tax deduction;

OR

(C) the amount of R1 750.

Therefore

(A)	is 15% of R120 000	=	R18 000
OR			
(B)	R3 500 - R0	=	R3 500
OR			
(C)		=	R1 750

Mr. Smith will be able to contribute and claim R18 000 as a deduction to a retirement annuity.

Mrs. Smith

Her deduction is limited to the greatest of:

(A) 15% of all income from non-retirement-funding employment after deducting all expenses incurred in earning this income;

OR

(B) an amount of R3 500 minus any contributions made by the taxpayer to a pension fund, that were allowed as a tax deduction;

OR

(C) the amount of R1 750.

Therefore

(A)	is 15% of R80 000	=	R12 000
OR			
(B)	R3 500 - R0	=	R3 500
OR			
(C)		=	R1 750

Mrs. Smith will be able to contribute and claim R12 000 as a deduction to a retirement annuity.

3. Explain the reasons for the original development of equity linked annuities and the restrictions that have since been imposed on these annuities by the Receiver of Revenue.

The problems linked to inflation and the resultant decrease in the value of a fixed annuity over time, combined with the steady increase in the life expectancy of the average annuitant, led to the need for a solution that would assist those people who may not be fortunate enough to be members of a pre-funded defined benefit scheme.

The equity-linked life annuity has the capability to cater for persons who are retiring from a pension and/or retirement annuity fund without falling foul of the need to provide a life annuity.

The attraction of an equity-linked life annuity lies in its flexibility of payments and investment options as well as in the additional benefit that capital is not forfeited as with a conventional pension or annuity on the death of the pensioner or annuitant.

The performance of the equity-linked life annuity is directly tied to the performance of the underlying assets (often unit trusts) and is subject to the volatility of the market.

A large number of funds allow the retiree to move the capital amount available to purchase the annuity to a different investment medium, for example, an equity or unit trust linked portfolio, provided by an insurer - provided that the money will in fact be used to purchase an annuity and that the move is to the benefit of the member.

According to General Note GN 18/96 issued by the South African Revenue Service in August 1996 - “The annuity to be purchased must be compulsory, non-commutable, payable for and based on the lifetime of the retiring member and may not be transferred, assigned, reduced, hypothecated or attached by creditors”.

Once an individual has entered into an equity-linked life annuity he can select the level of income to be paid as a percentage of the capital invested.

Inland revenue was not happy with the degree of flexibility being offered as annuitants were able to either circumvent the requirement that the annuity be a life annuity or alternatively reduce their tax liabilities.

RF 1/96 set parameters to which all new flexible annuity arrangements had to comply with from 30 June 1996. All existing flexible annuity arrangements had to abide by the new parameters from the first anniversary date of the annuity immediately after 30 June 1996.

- Flexible annuity benefits paid to an annuitant are reviewed on an annual basis. On the anniversary date of inception, the revised fund value will be required to be determined in order to calculate the minimum and maximum annuity benefits payable.

- In the original circular, the income levels had to be based on a minimum of three (3) percent simple interest rate of return calculation and a maximum of twelve (12) percent simple interest rate of return calculation, and must at all times have produced a life annuity. This was adjusted in 2007 to 2,5% and 17,5% respectively to further prevent capital erosion.

- Flexible annuities provided on some other basis will not be recognised by Inland Revenue and funds providing such annuities will not be approved.

4. Give a brief explanation of permanent health insurance.

Most disability benefits only pay a benefit if the life insured is totally and permanently disabled. This is a problem for people who might be ill or disabled for a long time but who will probably recover. Short term insurance companies tried to help these people by selling them personal accident and sickness benefits. Unfortunately these benefits only paid for a short time. The short term insurance company could also cancel the policy if there were too many claims. Policyowners did not like these conditions.

Life insurance companies designed permanent health insurance to solve these problems. Permanent Health Insurance (PHI) pays a monthly income to a life insured who cannot work because of an illness or injury. Because it is a life insurance policy the insurer cannot cancel the policy unless the policyowner does not pay his premiums. The amount of the monthly benefit paid is linked to the policyholder's salary and must be restricted in order to discourage abuse. In order to discourage abuse the life insurance companies that are members of ASISA have agreed to place a limit on the benefits that will be paid. These limits mean that a person who claims an income benefit will be limited to a monthly amount equal to 75 of his monthly taxable earnings (immediately before the claim) with an overall maximum of R75 000.

Should the benefit be paid as a lump sum the lump sum payment may not be more than 90 times the insured's monthly taxable earnings (immediately before the claim). Monthly paid benefits can increase annually at the rate of the Consumer Price Index (CPI).

Because of the added expenses that the disabled person will have when the disability first occurs (for example, high hospital accounts, wheel-chairs) the ASISA members have agreed that in the first year after the disability or illness has started 100% of monthly benefits may be paid. (This also applies where it is thought that the additional expenditure is related to lifestyle adjustments or where it is thought that there may be an improved chance of better or earlier recovery as a result. However, the recommendation is then that the maximum level for subsequent payments should be further reduced.

Whether benefits are being paid or not the policy will stop on the policy anniversary before age 55, 60 or 65 next birthday of the life insured. The life insured will have to select the expiry age needed at the start of the policy.

Different people will also need different times that the benefits must start (for example, a self-employed will usually need an income as soon as possible BUT a person working for a big firm might still get paid his salary for up to one year after going off work). To cater for these different needs PHI policies have waiting periods before benefits start from between 7 days and 24 months.

Standard PHI benefits pay a level benefit to a disabled insured. Other options are available like a benefit that:

- increases annually with a fixed percentage or at the CPI rate;
- pays the premiums of the main policy to which the PHI benefit is linked.

The premiums paid for a PHI benefit can be deducted from the tax paid by the policyowner BUT the monthly income paid by a PHI benefit is taxed as ordinary income. If the life insured's disability is not total (i.e. he can work for a reduced salary) a percentage of the PHI benefit will still be paid. Because the chances of a person being temporarily disabled are a lot bigger than a person being totally and permanently disabled, the underwriting for a PHI benefit is very strict. Because of the strict underwriting and expensive premium, PHI is still only a small part of the life insurance policies in South Africa.

CHAPTER 5

1. Write an essay in which you describe the main taxation aspects that apply to healthcare plans in South Africa.

The current taxation approach to medical services in South Africa is somewhat disjointed with the use of a benefit fund for medical benefits having been prevalent where the fund was in fact not a medical aid registered in terms of the Medical Schemes Act.

Such a fund was described in paragraph "c" of the definition of a benefit fund in the preliminary part of the 1st Schedule of the Income tax Act as:

> *"any fund (other than a pension fund, provident fund or retirement annuity fund) which, in respect of the year of assessment in question, the Commissioner is satisfied is a permanent fund bona fide established for the purpose of providing sickness, accident or unemployment benefits for its members, or mainly for this purpose and also for the purpose of providing benefits for the dependants or nominees of deceased members."*

However, recent legislative changes have in fact stopped the registration of new schemes under paragraph "c" of the definition of benefit funds in the Income Tax Act.

Properly structured and registered medical schemes fell into the description of benefit funds in terms of section "b" and contributions to a medical aid or a medical scheme specifically set up and registered as a medical aid in accordance with the Medical Schemes Act, were (and still will be) tax deductible.

Where a benefit is paid under a medical aid scheme the proceeds are tax free. Where an employee is, however, required to contribute to the expenses of medical aid scheme membership and the employer simply pays the contributions to the medical aid scheme on behalf of the employee this is treated as taxable income in the hands of the individual.

This situation has led to the practise of employers paying the full medical aid contribution of employees. However, in the 1998 budget speech the Minister of Finance stated that only company medical aid contributions up to twice the member's contribution would be allowed without attracting tax.

However, in 2005, the National Treasury and the South Africa Revenue Service (SARS), in consultation with the Department of Health, undertook a review of the tax treatment of medical expenses and the tax treatment of medical scheme contributions and other medical expenses was changed with effect from 1 March 2006. Below is a summary of the new tax dispensation of contributions to medical schemes and other medical expenses.

1. Taxpayers 65 years and older and retired individuals

It is important to note that taxpayers older than 65 years continue to be able to deduct all medical scheme contributions and other medical expenses from their taxable income.

Also, individuals who took early retirement but still enjoy medical scheme coverage paid for by their former employers, will continue to enjoy this as a tax-free benefit.

2. Taxpayers 65 years or younger

Three types of medical expenses qualify for preferential tax treatment:

(a) Contributions to medical schemes

Members of a medical scheme can make contributions to the medical scheme themselves, their employers can make the contributions or contributions can be split between an employee and the employer. In terms of the new legislation, all (i.e. 100% of) contributions will qualify for preferential tax treatment, irrespective of who makes the contribution. This preferential tax treatment is, in the 2010/2011 tax year limited to a monetary amount of R670 for each of the first two beneficiaries and R410 for each additional beneficiary. (The old "$^2/_3$ rule" has fallen away.)These monetary caps are increased every year. (In 2011/2012 this has increased to R720 for each of the first two beneficiaries and R440 for each additional beneficiary.)

(b) Medical expenses paid by individuals (including medical scheme contribution paid by the individual)

Medical expenses paid for by the taxpayer in excess of 7,5 percent of his income, are tax-deductible. This threshold excludes medical scheme contributions which qualify as a tax deduction under a). Where taxpayer has a disability or has a dependant with a disability all medical expenses of the family unit will also be tax deductible.

(c) Employer provided medical treatment

Currently, no taxable benefit will arise for the employee where the employer provides medical treatment to employees at their place of work. Such medical treatment is normally covered under a company's occupational health initiative. However, should the medical treatment be provided to employees' families, employees would be liable to pay tax on the value of this benefit. Where the employer pays for medical treatment for the employee and/or his family and this treatment is provided at a place other than the employee's workplace, the employee will have to pay tax on the value of this benefit.

In terms of the new tax dispensation, all benefits derived from employer provided medical treatment (on- and off-site) will be tax-free in the hands of the employee, provided certain criteria are met. Only Prescribed Minimum Benefits may be provided tax-free at an off-site location. In cases where the off-site employer provided medical treatment constitutes the business of a medical scheme it must be granted exemption from complying with the requirements of a medical scheme by the Registrar of Medical Schemes in order to qualify for tax-free treatment. Where the off-site medical treatment does not constitute the business of a medical scheme it may be provided tax-free if it is only provided to employees (or their immediate dependants) who are not members of a medical scheme.

3. Who qualifies as a dependant

The Income Tax Act was amended to include a definition of dependant for purpose of medical scheme contributions. The new definition is in line with the definition of dependant in the Medical Schemes Act and recognises the fact that an individual may want to extent coverage to persons other than his immediate family. Medical scheme contributions made by the taxpayer to cover his parents or other persons in his care will qualify for preferential tax treatment.

However, in the case of out of pocket medical expenses only expenses incurred in respect of immediate family members i.e., spouses and children will qualify for preferential tax treatment. This more restrictive definition also applies to employer provided treatment and is aimed at limiting abuse and to favour wider medical scheme coverage.

Other

Growth on funds held by a medical aid scheme or a benefit fund other than a provident fund are not taxed.

The interest on a medical savings account is currently not taxed, although mention has been made of a possible change to this in the future.

The tax on growth in a pre-funding instrument using a provident fund is the same as for any provident fund - currently 0%.

2. Write an essay in which you discuss cross-subsidisation under medical schemes. In your answer you should outline what cross-subsidisation is, describe the more common fields of cross-subsidisation and comment on the pro's and con's of cross-subsidisation.

It should be accepted that any medical aid or medical insurance scheme must, by definition, allow a certain degree of cross-subsidisation from the healthy to the ill, otherwise individuals would simply take care of their medical costs through private savings accounts.

Under medical aid schemes it is normal for the younger members to subsidise the older members. Similarly, it is generally accepted that separate rates for males and females to reflect the different healthcare service usage by the sexes is not necessary. Smokers also do not pay more than non-smokers and little attempt is made to rate according to other habit or occupational classes. Cross-subsidisation also frequently occurs between those with large dependant families and single members.

However, increasingly funds are finding that the rate of growth of new members is not keeping pace, through a combination of the trend to lower population growth rates and through the younger, healthier members opting not to join a medical scheme, and this is placing a severe strain on the funding process which is made worse by the fact that people are tending to live longer than before and hence there are more older members.

There are four main components of the move to eliminate (or at least reduce) cross-subsidisation. They are:

- using underwriting to equate the premium and the risk more closely;
- adopting a structure which allows for class groupings - by age, sex, occupation;
- making use of medical savings accounts or similar devices to curtail the overall fund's share of some risks;
- allowing a drift of good lives into low-priced schemes and others into schemes priced according to risk profile.

Whilst these may well help to stop the young and healthy lives from opting out of health insurance schemes, they also have an adverse impact on the sickly (and the aged). New generation schemes are also making considerable inroads into the elimination of cross-subsidisation.

The rapid escalation of healthcare costs after normal retirement due to the increased usage as well as the medical cost inflation rate, has resulted in several attempts at creating funding mechanisms to cover these costs through contributions made during the working years. Whilst it could be said that this is only a small part of the greater retirement planning issue, it is also clear that the reality is that it needs specific attention.

One of the more innovative approaches being used is to link medical service usage during one's working years to contributions made to healthcare insurance plans, allowing individuals to build up a kind of credit account to be drawn on after retirement.

Other attempts include specific pre-retirement funding by means of set contributions, usually into a provident fund because of the long term security as well as the tax efficiency that these schemes offer. A major concern in these efforts is the direct link which often observed between pre- and post- retirement medical costs, meaning that it is those who have the higher costs during their working lives who are also likely to need more medical services in retirement.

3. Write an essay in which you describe the more common devices used in healthcare management to overcome the problem of escalating costs due to over-servicing.

Various devices have been tried to overcome the problem of escalating costs due to over-servicing. A number of innovative ideas have been tried and tested in overseas countries and the South African health care market is rapidly incorporating some of these methods in its efforts to curtail escalating costs as a result of over-servicing.

Co-payment schemes hold the patient responsible for a set percentage of each medical bill. Studies in the USA by the Rand Corporation have shown that this system is pretty effective in limiting costs while not having a serious impact on the quality of the healthcare through patients opting not to go for the appropriate attention.

Where Medical savings accounts have been introduced the individual contributes towards a fund from which medical expenses are paid but, as the fund is owned by the individual, there is a direct responsibility and motivation to limit the claims. Experience has shown that this approach has much the same success rate as the co-payment scheme, although practically it is only used in conjunction with some form of full insurance for the more major medical eventualities which the personal fund could not hope to pay.

By providing clinical guidelines and professional education the health care industry seeks to achieve the appropriate level of service through a combination of patient education and service provider guidelines which serve to create a more realistic level of understanding of the practical balance in the decision about treatment. It has been found to be more successful in situations where there is considerable variation in the quality of service providers.

Some schemes have implemented a system of utilisation reviews as a method of control in which a qualified third party checks the level of service being applied either:

(i) before the service is actually provided; or

(ii) as a form of case management during the overall treatment process; or

(iii) as a retrospective control, partly in the form of an audit of the bill.

With the capitation system the service provider is contracted to provide the service for a flat fee and is hence encouraged to find the most suitable balance between cost saving and effectiveness - the latter will include the potential for a prolonged period before recovery is complete which would normally add to the overall costs. The effect of the capitation system has been shown to be relatively successful and some schemes include some form of bonus or incentive scheme package to further control delivery decisions.

The use of service bundling is really a compromise between full “fee-for-service” and capitation in that it bundles a range of services to be provided at a fee. A complication which arises in practice is where referrals are made to providers outside of the agreement which result in added costs being incurred by the patient outside of the “prepaid” bundle.

In their extreme form, networks are MHO’s or PPO’s in that they work along the lines of a selection of various providers, restricting the member’s choice to boost volumes to the selected providers within the network in return for price advantages without sacrificing service levels. The capitation system of payment is sometimes used.

4. Write an essay in which you outline the underwriting process and issues in the healthcare market, including an explanation of what underwriting under this type of cover seeks to achieve.

The underwriting of health cover is made somewhat more complex by the fact that in most cases cover is being granted on the basis of a family unit (which may even include the immediate extended family of a member who are dependant on him, such as his grand parents) rather than an individual life.

Although the Medical Schemes Act does not allow schemes to exclude new members entirely, it is common practice to require information about the state of health of a new member.

Dependent on the information provided it is not uncommon for existing ailments to be excluded from a scheme's benefits. These exclusions are generally implemented even though rates are normally adjusted on an annual basis in order to fairly reflect the claims experience of the members.

In the same way as a group life scheme, medical aid administrators will view compulsory membership groups under relatively large schemes differently to individual - voluntary - applications. Medical aid administrators generally also offer a kind of "free cover" facility to compulsory membership groups, varying in approach according to the size of the group.

Where a new member is seeking cover for the first time schemes will often impose a three-month waiting period during which subscriptions are payable but benefits cannot be enjoyed. This is a way of limiting anti-selection by people who have already become aware of a medical condition before seeking cover. Transferring members who are seeking to move from one compulsory scheme to another compulsory scheme when changing jobs must be accepted immediately where they have been a member, or a dependant member, of another registered scheme for a continuous period of two years.

Another time when a form of underwriting is used by medical aids is where an existing member is seeking to upgrade the nature of the cover enjoyed from one with relatively low benefits to one with fuller cover. Usually this is only allowed on the anniversary of the scheme, while some schemes allow only one upgrade during the member's entire period of membership.

Medical insurance plans naturally use standard underwriting procedures, whereas new generation health insurers tend to use a kind of simplified underwriting approach.

It is common to place a nine month exclusion on pregnancy and maturity benefits and even a 12 month exclusion on special dentistry.

Underwriting seeks to achieve the following:

- a reduction in the variability of experience, thereby reducing the risk factor and allowing lower overall charges;
- a better alignment of the premium with the risk;
- a reduction (or elimination) of the anti-selection factor;
- protection of the risk pool of the members.

The main problems linked to underwriting by antagonists of this approach are that:

- they could lead to certain people not being able to obtain health insurance - the very people who need it most;

- even where cover is available, the process tends to group people of similar risk profile so that eventually the “good” risks all drift into a low-priced scheme and the remaining “bad” risks have no cross-subsidisation benefits and may not be able to afford the benefits.

5. Describe how a registered medical aid scheme differs from a so-called new-generation plan.

With a registered medical aid scheme the contributions paid in by members usually vary according to the size of the family covered and are adjusted over time to take into account the actual claims experience of the members.

The benefits paid follow a set basis of tariffs for each type of service as laid out by the Association of Medical Aids of South Africa (MASA), with some schemes paying benefits at the level of the MASA rates and others a percentage (for example, 80% or 150%) of the fees, or the full amount after deduction of a small excess or first payment by the member (for example, R10 of every prescription).

Often annual limits are imposed on various classes or types of medical service, such as R3 000 for normal dentistry for the family.

Another scale of benefits which is often used by the suppliers of medical treatment is the Representative Association of Medical Schemes (RAMS) scale, which is generally 150 to 200% of the MASA scale and often used by many of the private practitioners and hospitals, especially in the more affluent area. These suppliers are known as “contracted out” suppliers because they do not subscribe to the MASA tariffs.

It is common practise for schemes to offer members a choice of cover, varying from a low cover plan where relatively strict limits are imposed and MASA scales apply in return for a lower membership fee, to a fully comprehensive plan at a far higher level.

The new generation schemes on the other hand generally offer cover for the more serious medical costs on an insured basis. Low cost/high frequency costs such as general pharmacy expenses are either left to the member to pay on their own account or covered out of a type of savings account under which a regular monthly contribution from the member is invested in an accessible account.

New gen schemes also tend to apply more health management techniques and are quite likely to offer members some for of discount for gym membership, air travel tickets to encourage a better lifestyle.

It is probably true to say that the difference is becoming increasingly blurred as traditional scheme start to apply many of the concepts introduced by “new gen” schemes.

CHAPTER 6

1. Provide a brief history of the development of underwriting.

The word underwriter stems from the manner in which the first contracts for insurance were drawn up. Most experts agree that the first insurance contracts were property insurance covering sailing vessels and their contents. These contracts insured against several perils - such as fire and storms - which could cause the ship's owner to lose the ship or its contents. These contracts also stipulated the amount that the owner would receive from the insurer as compensation in the event of such a loss.

The first insurers were individuals who agreed to assume someone else's risk for a mutually agreed upon price. These individuals endorsed the contract under the signature of the party purchasing the insurance cover and became known as underwriters. Life insurance underwriting also originated in connection with maritime insurance, when insurance coverage was purchased to cover the lives of merchants and captains travelling on insured ships.

Later small groups of entrepreneurs formed insurance companies and the consensus of the members of the life company's board of directors replaced the individual underwriter's judgement, although there was still no body of quantitative mortality experience to guide the directors in their decisions.

In 1725, London Insurance took a significant step in the development of professional underwriting when it told its agents that they must ascertain that there is a good reason why the insurance is being purchased.

By the middle of the eighteenth century, the insurance companies were using mortality statistics to establish more reliable premiums. Actuaries who had expertise in the statistical methods used to formulate mortality rates, usually did the underwriting. Since actuaries did not have sufficient medical experience to assess the health of the applicants, many companies began to employ physicians to assess the health of the applicants.

The mortality tables used by early life insurers reflected the mortality of both insured and uninsured individuals. These early tables were not really suitable for evaluating insurance risks, since insureds and uninsured individuals experience different mortality rates. This difference is the result of the selection process performed by the insurance company.

With the advent of mortality tables based on the mortality of insured lives, companies realised that they were rejecting many people who could be insured if an extra premium were charged for certain impairments. As companies developed more experience at the practice of charging extra for certain impairments, the number of impaired individuals that could be insured with an extra premium charge increased.

This situation has continued to the present day with some modifications. Most applications are now evaluated by underwriters. Great progress is being made in understanding the nature, treatment, and effect on mortality of many diseases. The effect of this progress is that the medical assessment of substandard mortality risks is more accurate.

2. Why should the insurer's underwriting manual not be used as an absolute authority?

Although the underwriting manual has a significant place in the underwriting function, the manual should not be used as an absolute authority for several reasons:

- when the underwriter is faced with a combination of different impairments, he must have a sound medical knowledge in order to be able to determine whether the combination of risk factors greatly increases the risk - for example smoking and cancer - cigarettes are known to be carcinogenic. However with the combination of cancer and overweight - the obesity does not have a direct impact on the cancer;

- the task of keeping an underwriting manual up to date is formidable and time consuming, especially in light of the rapid pace of medical advances, and the information in such manuals is often dated and at best reflects the experience from risks accepted at least five years earlier;

- manuals generally reflect the anticipated extra mortality for ages 25 or 30 through to 55 or 60. Therefore, to assess a risk on either side of these age limits requires some modification of the manual's suggested ratings.

3. Define the functions of an experienced underwriter.

(a) An underwriter must have a well-founded store of knowledge on the technical, legal and medical basis of life insurance, must be thoroughly familiar with the objectives of underwriting and the company's administrative procedures. Since the underwriting scene is constantly changing, the underwriter must ensure that he is adequately informed regarding the new developments and tendencies within the field. Changes may occur in many different areas:

- *Medicine:* increasing importance of new kinds of medical treatment and advances in operative techniques, for example, hip replacement prostheses.

- *Epidemiology:* the diminishing importance of communicable diseases such as diphtheria and the increasing importance of new diseases such as AIDS.

- *Technological advances:* dangers of atomic energy, new technologies in racing or diving.

- *Travel problems:* the ever growing number of aviation and road traffic accidents.

- *Legislation:* changes in taxation laws may increase or decrease the demand for life insurance or make certain types of cover more attractive.

- *Economics:* during times of recession care should be taken in the underwriting of disability benefits. The insured population may be more tempted to claim on their benefits when they are feeling the economic squeeze.

- *Political situation:* the current crime wave that we are experiencing has a direct impact on claims experience for traumatic deaths and on disability claims for, amongst other things, post traumatic stress disorder. The underwriter must bear this in mind when underwriting certain occupations for example, policemen and taxi drivers who are very exposed to violence.

- *Marketing situation:* new types of policies and benefits may be developed and these may in turn involve new underwriting problems.

In order to keep abreast of such developments in these various fields, the underwriter must do a great deal of purposeful reading including insurance journals, suitable publications from the World Health Organisation and medical journals.

In order to ensure that information is not only acquired but that it also is available when needed, a simple but efficient system of collecting, summarising, classifying and indexing the relevant information should be developed. As the underwriter gains experience in assembling the current information relevant to the job, he will gradually learn to sift the important from the unimportant topics. Frequent discussions with the medical advisor, who usually welcomes the opportunity of an exchange of ideas with a competent underwriter and is well qualified to impart essential information or draw attention to new sources of information, and other professional colleagues will further broaden the underwriter's horizon and also enhance his prestige as a well informed expert. Such prestige is an indispensable asset for the underwriter who, as indicated previously, often is obliged to maintain his authority under pressure.

(b) Establishing and consistently enforcing reasonable and purposeful underwriting rules and adapting them periodically to changing circumstances is an important duty of the underwriter. This includes age limits, as well as amount limits for medical and non medical acceptance, rules setting out how applications must be completed, the choice of medical examiners, rules for obtaining PMA reports and rules for dealing with applications for reinstatement of lapsed policies. These rules are essential for effective administration.

While even the best rules will not in themselves prevent anti-selection - no administrative technique will ever achieve this - the knowledge that such rules exist and must be complied with is a constant reminder to the field force that the company means to exercise control over the quality of its new business.

(c) The design of application forms and other forms used in underwriting is closely linked to the need for good underwriting rules. The underwriter must develop the ability to draft forms and questionnaires that are simply worded, well arranged and sufficiently comprehensive to elicit the essential underwriting data from an honest applicant. The design of good forms is a skill which presupposes a thorough knowledge of the subject matter, good judgement, a sense of balance and some experience. Forms such as the medical examination form should only be designed in conjunction with the medical advisor. In certain cases it is essential that the company's legal advisor be consulted or that he draft certain sections of a form, for example declarations or warranties. Specimen forms found in books or journals can be used for reference but never copied because no specimen form designed by someone outside a company can fully meet that company's individual needs.

(d) Processing of application forms involves a large number of duties which the underwriter need not necessarily perform personally but with which he must be thoroughly familiar because some of the data being processed may also have underwriting significance. The underwriter must satisfy himself that the company's underwriting rules have been met. He will note the introducing agent and examining doctor, in cases where medical examinations were carried out. He will compare the relevant signatures, take note of the plan of insurance requested, the sum insured and also pay attention to the reasons for the cover and the insurable interest.

The medical factors will be carefully evaluated including occupation, sporting activities as well as amounts of existing cover. He should be able to determine whether the applicant is a first class risk or substandard, or even uninsurable. He should also be able to prepare all files that must be reviewed by his seniors or the medical advisor so that the senior underwriter can devote his time and knowledge to examining the problem aspects of the risk.

(e) The establishment and maintenance of close contact with company management, agency staff and the claims and actuarial departments.

4. Below are some of the medical terms that an underwriter will meet in his career. Provide the common meaning of each.

PREFIX		PART OF BODY		SUFFIX	
anti-	against	**aden**	gland	**-aemia**	blood
brachy-	short	**cardi(a)**	heart	**-asm**	condition
dys-	difficult	**cerebr(um)**	brain	**-cele**	tumour
endo-	within	**derma**	skin	**-ectomy**	removal
hydro-	water	**gast(e)r**	stomach	**-mania**	madness
melan-	black	**haem(a)**	blood	**-oma**	tumour
peri-	around	**os**	bone	**-philia**	affinity
tachy-	rapid	**pulmo**	lung	**-sepsis**	putrefaction
scler-	hard	**phleb(os)**	vein	**-troph**	stimulating
steno-	contracted	**vas**	blood vessel	**-uria**	urine

CHAPTER 7

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

Life insurers have always wanted to design a policy that is flexible enough to meet all the needs of the policyholder throughout his life. The development of computers has helped life insurers to design such a policy. This is because computers have the ability to do rapid calculations on a large scale. What has become generally known as the Universal policy was developed.

With a universal policy the cost of the life cover and supplementary benefits needed by the life insured are calculated on a month-by-month basis, almost like a series of one month term insurances.

At the beginning of every month the computer will work out how much money the policy has in its investment account and deduct this from the desired level of cover to establish the amount of risk cover that must be bought. Note that this money will also include any investment growth that there has been on the money that was in the account at the beginning of the previous month.

One of the major advantages of a universal life policy is that the insured can change the level of his life cover at any time because the amount of life cover that needs to be added to the policyowner is worked out monthly anyway. For example, if the insured were a young, unmarried man, his life cover need would probably be small, but would increase if he married and had a family. Then, when his children had grown up, his need would be for investment towards retirement. All these options can be a part of a universal life policy.

The underwriters will have to be supplied with evidence of continued good health that is satisfactory to them if any request for an increase in life cover is made. Should this not be a requirement the life insurers would face the danger that a seriously ill (or even dying) life insured could increase his life cover shortly before death. This would not be good for either the insurer or all the other policyowners.

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.

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; and

- 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, so that a policyowner is trying to "steal" money from the insurer - something that 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 doctor's 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 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 filed in such a way that it can be easily got if it is needed, for example, if there is a claim or if there is a change to the policy. All life insurers now use computers to speed up the processing of new business applications and the maintenance of existing policies.

It is, however, still necessary that all the information 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.

This file could be needed for a number of reasons where computer information will not be suitable.

One example is where a policyowner is unhappy about a decision made when a claim is handed in and decides to ask the Life Insurance Ombudsman or a court of law to investigate his complaint.

- *the printing of the policy document*;

  One must understand that the cost of printing the policy document with all the details mentioned is not cheap. Added to this will also be the expense of getting the policy document to the policyowner. These are therefore just further expenses that the life insurer will need to recover.

- *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 special expenses that a life insurer has. Most of these are expenses that other companies that provide only investments do not have. These are also expenses that a life insurer cannot afford not to charge for and so every life insurer will charge these expenses to its policies and take them out of the premiums that the policyowners pay.

CHAPTER 8

1. List and briefly explain what information the claims assessor must verify before the process of assessing the claim can be started.

One of the first procedures to be followed by the claims staff on receiving a claim against a policy is to verify all information relevant to the policy contract. This includes calling for the file and checking the information provided at the inception of the contract (i.e. on the proposal form) with the information now available with the claims documentation. This must not be considered as underwriting at claims stage. The aim and objective is merely to verify information and check that no non-disclosure of a material fact that could have affected the risk was withheld.

Insurable interest

Insurable interest can be defined as the legal right to insure and means that the proposer must have an actual, recognised relationship with the person to be insured, as a result of which he would suffer a financial loss if the event being insured against occurs.

It is the responsibility of the underwriter to check that insurable interest exists at the inception of the contract.

In the case of *Rixom vs Southern Life Association of Africa & Collins & Bain* the court decided that - "Insurable interest must be in existence at the beginning of the contract". As this decision was about a life insurance policy it is now accepted as applying to all life policies. In a life insurance contract one must prove insurable interest at commencement only. There is no need to prove insurable interest at claim stage.

Should it, however, appear to the claims clerk when a claim arises that insurable interest was accepted during the proposal stage based on false information, the claim must be very carefully assessed. If it is found that the false information provided would have had a material influence on the decision to accept the proposal, or not to accept the proposal, by the underwriter, the claims clerk should recommend to the claims committee that rejection of the claim be considered.

Personal particulars

Verification of personal particular is only necessary in those areas where incorrect information provided at inception would have had a bearing on the underwriting of the proposal. Information such as name, postal address and nominated beneficiary, whilst important, would probably not have led to the underwriter imposing a loading or rejecting the proposal. The personal particulars dealt with below could well have led to such a decision.

Age and gender

These must be checked if not already confirmed.

Smoking habits

There is a significant difference in rates for smokers and non-smokers. It is therefore essential to check that anti-selection did not take place. Unfortunately it is very difficult to obtain proof that the information provided during proposal was incorrect, and only in cases where irrefutable evidence can be found, is it possible that the values be adjusted.

Occupation
Only in cases where conclusive proof is found that incorrect information was provided intentionally in order to obtain better benefits / rates, must a recalculation be done or, in extreme cases, repudiation of the claim be recommended.

Part-time activities
Once again the claims clerk should check to see whether incorrect information was provided intentionally at the proposal stage in order to obtain better benefits / rates. Where this is the case it is likely that repudiation of the claim should be recommended.

Health aspects
Where a policy has been re-instated within the last 12 months it is imperative that all aspects of the insured's health be checked and verified. The reason for this is the possible non-disclosure of a deterioration of the health of the insured in the "declaration of continued good health" that was required at the time of reinstatement. It is also advisable that the insured's health be checked and verified if the period before maturity of the policy is greater than the periods indicated here:

- for death claims - 5 years;
- for disability claims - 10 years;
- for trauma claims - 10 years;
- for accident benefit claims - not required unless there is a suspicion that the insured may have suffered from some ailment that may have resulted in the accident (for example, epilepsy).

The reason for this is the fact that the claim has resulted in the insured falling outside the averages used by the actuaries in determining the premiums to be charged. As the norm is no longer applicable to the insured the reason for this should be established, where possible. This is not to say that the claim is invalid. The claims assessor does, however, owe it to the insurer and the other policyholders to investigate all situations that do not conform to expected standards.
The claims assessor should request a medical report from the insured's personal medical attendant (PMA) or any other doctor or institution that may possibly be in possession of information.
Where any claim results from unnatural causes, the medical report will not be necessary. (Remember to still check for false claims.) Should there be a suspicion that information has been concealed cases must be checked in the usual way.

AIDS exclusion clauses
With the decision by the member offices of ASISA to abandon the enforcement of HIV/AIDS exclusions on life and lump sum disability benefits, an HIV/AIDS check is only required for certain additional benefits, such as PHI cover.

2. Write an essay on the AIDS problem in South Africa and its implication on the life insurance industry.

Because mortality tables can only be based on past experience, by the time the data has been collected and the results published as mortality tables the experience to which it relates is often already years old. AIDS has become a very real scare in our modern society today and, as most people are now aware, at present there is no treatment or cure for AIDS. Once the full syndrome has developed, death will follow, usually within two years.

One of the most important questions, which is as yet unanswered, is what the chances are of a person who has become HIV positive developing AIDS and how quickly this will happen.

It is now almost certain that at least 50 percent will eventually get AIDS. Some scientists even say that all positive HIV persons will eventually develop AIDS.

Because of this it can be generally accepted that AIDS is going to have a major impact on the mortality tables of the life insurance industry in South Africa over the next decade or two.

Most - if not all - new proposers for life insurance are today asked to go for an HIV antibody test, except for some smaller policies. The underwriter will then know if the proposer is a risk to the insurer because he might die soon because of AIDS.

Most life insurance companies will, in fact, not give a person who is HIV positive life cover but there are many policies that were issued before AIDS became a problem. There is a niche player that is offering cover for those who are HIV positive at an appropriately loaded rate.

If one realises that the chances are that the number of HIV positive cases will double every 9 months or so then the real problem facing life insurers should become clear. The Department of Health has been testing women who attend ante-natal clinics in South Africa since 1990.
Should the growth trends of the epidemic continue the consequences will not only have an impact on mortality tables used by life insurers but will affect us all.

Particular problem areas relating to HIV/AIDS and the life insurance industry are:

- because of the so-called window period, a period of time during which a person may test negative for the HI virus but yet be already infected, even testing is not foolproof, especially bearing in mind the possibility of anti-selection on the part of a person who may have committed an indiscretion, such as unprotected sex with someone suspected of being HIV positive, and then immediately applies for life insurance;

- many medical practitioners are reluctant to give AIDS as the cause of death, generally the AIDS victim dies of some form of sickness such as TB and not from the AIDS itself, and so it is sometimes difficult to identify AIDS involvement when dealing with a claim;

- the delicate nature of the subject matter means that testing needs to be strictly controlled and ASISA has a set procedure for handling this, including pre- and post-test counselling and confidentiality requirements;

- testing is not cheap and the whole HIV/AIDS issue adds costs to the insurer's systems;
- the impact of HIV/AIDS on group life insurance schemes, where cover is not normally subject to underwriting, is causing group rates to rise dramatically;
- ASISA's ruling is likely to result in a general increase in the mortality and morbidity rates used by the life offices.

Of course it is also true that life insurers will also face indirect implications as a result of the pandemic, similar to those experienced by other businesses, such as skills shortages caused by the untimely death of a key staff member, added costs of training where skilled workers then die and have to be replaced, increased pressure on health service delivery, the possibility of increased taxation to cover government supported treatment for HIV positive people.

3. Under what circumstances would a life insurer consider a claim if the life insured dies before the policy comes into force?

Most companies work on the basis that the date of commencement of the cover on a new life insurance policy is the last occurring of:

- the inception date requested in the proposal by the proposer;
- the date on which the first premium is paid; or
- the date of notice of acceptance.

If the life insured dies before the date on which cover commences, the claim will usually be considered if:

- all documents were already in the life insurer's possession, for this purpose documentation in the hands of a marketer / broker will also be considered as being in the hands of the life insurer; and
- the risk would have been accepted based on the information in the proposal documentation; or
- the proposer / insured accepted the terms expressly or by implication, for example, by paying an extra amount for an increased premium or by giving permission for a loading before terms were known, if the risk was acceptable on terms other than ordinary rates; or
- a cash premium was submitted with the proposal and there was no request for the inception date to be later than the first of the following month; or
- death occurred during the month preceding the inception date; or
- premiums were to be paid by debit order or stop-order and the ability to pay can be established beyond reasonable doubt.

4. Explain the general policy applicable to claims where the cause of death is the suicide of the insured.

Most life insurers used to impose a suicide clause as a result of which a death claim as a result of suicide during the first 24 months of the contract will automatically be repudiated. However, the more recent trend has been towards the use of a 12 month period. Special consideration should be given to claims where it appears that the cause of death is suicide.

It is widely believed that it is a fundamental principle of insurance law that an insured cannot receive a benefit if, by his own deliberate act, he causes the event insured against. This is supported by the judgement of Lord Atkin and Lord MacMillan in the leading case of *Beresford vs Royal Insurance Co. Ltd (1938)*. These judges considered that the rule preventing payment was not that of public policy, but a fundamental implied term of the contract that "a man cannot by his own act cause the event on which the insurance money is payable".

The above principle does not apply if the life insured commits suicide whilst insane, as it can be said that he does not have the mental capacity to appreciate what he is doing. It can be argued that his estate would be able to recover the policy monies in such an instance.

If the policy contains a suicide clause then the position depends on the wording of the clause. Many offices include a clause such as:

> *"if the life insured shall commit suicide within twelve months from the date of the policy all benefits which otherwise have become payable shall be forfeited and belong to the insurer".*

Suicide would therefore not be covered if it occurred during the specified period. If suicide occurs after that period then the office would be liable for the claim even if the life insured was of sound mind at the time. This is because by having a suicide clause expressly excluding cover for a limited period, the office is impliedly insuring that risk after that time.

Most suicide clauses protect the interests of a third party, preserving the value of the policy for cedents. A typical proviso would be:

> *"this suicide condition shall not prejudice the interest in such monies of any third party who shall have bona fide acquired that interest for valuable consideration".*

If this is the case the life office itself is not a third party, as was shown in *Royal London Mutual Insurance Society vs Barrett (1928)*. There, a life policy was ceded to the life office along with leasehold property. The life insured committed suicide and the court held that the life office was not a third party, therefore, the policy was void and they could recover their debt against the leasehold property.

Where a life insurer can repudiate a claim on the grounds of suicide then not only can the legal personal representatives not claim but all those claiming a share in the estate as beneficiaries or creditors are equally barred.

This would also extend to the trustees of an own life policy effected on trust for others.

The burden of proving that suicide was the cause of death is on the life office. One problem is that the coroner's findings are not conclusive proof. The case of *Walsh vs Legal & General Insurance Society Ltd. (1935),* illustrates the difficulties which can arise. The life insured died when he fell from a train during the first year of a policy which excluded suicide within the first year. There were no other passengers in the compartment and examination of the carriage door showed no effect that might have allowed it to open of its own accord. In view of these circumstances the coroner's verdict was, "suicide while of unsound mind". Legal action was brought to claim the sum insured. It was held that the coroner's verdict was not conclusive proof of suicide and that as the life office could not positively prove it was suicide they were liable.

CHAPTER 9

1. The South African Government felt a need to involve themselves with the regulation of retirement funds. Discuss the advantages and disadvantages of this move from the point of view of:

1.1 the employee;
1.2 the employer;
1.3 the well-being of South Africa as a whole.

It may be said that any Government interference in something as private as the planning of the retirement of an individual is not a good thing as Government thinking will always need to concentrate on the broader picture. The retirement planning of an individual must be a unique exercise so that all the different implications and parameters of the individual's personal needs and preferences can be catered for.

On the other hand the regulation of retirement funds by the Government can cater for the broader picture if it concentrates on protecting the rights of and promoting the interests of, individuals and, if necessary, their employers and society as a whole.

Should we therefore look at Government's involvement from this perspective we should get a clearer picture as to whether the regulations imposed by Government pose advantages or disadvantages to the three categories of players mentioned in the question.

Controls can be defined as those imposed directly by Government through legislation (i.e. through the Pension Funds Act, its Regulations and the Income Tax Act) and by Government agencies through operational directives (i.e. PF Circulars from the office of the Registrar at the Financial Services Board and GN and RF Circulars from the offices of the South African Revenue Services).

1.1 From the point of view of the employee some of the regulations imposed have a definite advantage. A few examples are:

- the fact that the Income Tax Act requires the relinquishment of all control over the fund by the employer;
- the fact that the Income Tax Act demands that contributions, once paid, belong to the fund and are protected from the liquidation of the employer and the employee as well as against the abuse of the funds by the employer;
- the tax deductibility of contributions made to a pension or retirement annuity fund allowed by the Income Tax Act;
- the required appointments of valuators, auditors and administrators in accordance with the Pension Funds Act to ensure the safety and security of the fund;
- the need for administrators to be registered with the Registrar of Pension Funds so that a professional service will be offered;

- the compulsory details that funds have to provide to members on an annual basis in order to comply with PF 86;

- the fact that it detaches the retired employee from the employer in the sense that the financial well-being, or otherwise, of the employer will have no effect on his retirement income. Employees, once they have retired, attain a level of independence that they may never have had during their working lives. Most employers do, however, still provide some support to retired employees through the medium of pensioner clubs or annual pensioners' Christmas functions;

- the cost of providing retirement benefits is spread over a long period - it becomes part of the employee's monthly deductions. For the employee it is a form of structured or systematic saving that has long term benefits and provides peace of mind, knowing that the retirement years are being catered for;

- the additional benefits, such as surviving spouses and orphans benefits, often paid for by the employer and therefore at no cost to the employee, are usually only available with a retirement fund. Employees, being aware of these benefits that are linked to their retirement funds, will be appreciative of the concern expressed by the employer and will reflect this in their loyalty and dedication to the enterprise.

Some disadvantages that, however, also need to be considered are that:

- the Income Tax Act prohibits a member from taking more than one-third of the retirement benefit available from a pension fund as a lump sum (unless it is a very small amount);

- the RF 1/96 and GN 16 impose an effective limit on the size of an annuity that can be taken as a single lump sum without having to purchase an annuity with the two-thirds mentioned in the point above;

- the Income Tax Act imposes a limit on the size of the contributions that may be made to a pension or retirement annuity fund (unless the fund is a pension fund constituted by law);

- the Income Tax Act allows no deductions of contributions made by an employee to a provident fund;

- the Income Tax Act restricts the amount of tax free money that can be taken as a lump sum on retirement;

- the Income Tax Act taxes the money received from a pension or retirement annuity as income after retirement;

- the limitations on cash withdrawals before retirement age.

1.2 Some of the advantages for the employer are that:

- in the area of employer / employee relationships a great deal of goodwill is generated if an employee knows that he and his dependants are looked after. Without a retirement fund and the ancillary benefits that can be attached thereto the employee will need to make his own provisions, often at a cost that he cannot afford. The involvement of the employer must therefore be seen for what it is - a part of a social awareness and upliftment program for the employees and their dependants and not just as a way in which the employer can reduce the employees' wages;

- employers soon realise that the employees feel more secure and happier in their jobs - leading to a much more effective work-force. Working towards a defined retirement age allows an employee to plan for an enjoyable retirement;

- a retirement fund allows for a more orderly staff policy. The employer can now plan for succession and promotion, knowing that those reaching retirement age are adequately provided for. Younger employees also realise that they do not need to wait until they can "fill dead man shoes". Promotional prospects are real as the retirement of older employees will create opportunities for advancement;

- it makes for a more effective business operation. An employer is helped to release an employee who, as a result of a permanent illness or disability, needs to stop work before normal retirement age. Most retirement funds today include some form of permanent health or lump sum disability benefit. This is then used to assist the disabled employee to maintain a reasonable standard of living without having to rely on a monthly pay-check. The employer will therefore, with a clear conscience, be able to replace the employee with a person who does not have the health problems of the incumbent. The employer will know that all has been done that is possible to assist the disabled employee in maintaining an acceptable standard of living;

- a direct benefit to the employer is the fact that a good staff retirement fund is an attraction for a better calibre of applicant when recruiting for additional staff;

- funds are controlled and monitored by the Registrar of Pension Funds and so the employer cannot be accused of any unfair labour practices with regards to the retirement fund;

- the Income Tax Act allows the employer substantial tax deductibility of contributions that are paid on behalf of employees to a fund;

- the employer has no further obligations to an employee who retires, whether retirement is as a result of age or ill health;

- the cost of providing retirement benefits is spread over a long period - it becomes part of the employer's salary bill. For the employer this is a type of deferred pay and is more easily accommodated in the budgeting process.

It could be argued that some of the above no longer holds true in today's employment market.

The employer, however, also experiences some disadvantages that cannot be ignored, for example

- the Income Tax Act demands the relinquishment of all control over the fund by the employer;
- the Income Tax Act requires that contributions, once paid, belong to the fund and cannot be used by the employer if he should experience financial difficulties;
- it is generally accepted that the employer pays all administration costs and expenses incurred in the provision of ancillary benefits. Pressure from organised labour to provide substantial benefits can be very costly.

1.3 From the point of view of South Africa as a whole the advantages and disadvantages of the controls imposed by the Government are perhaps not all that clear as an advantage to some people may be perceived as a disadvantage to others.

Looking at the points therefore as a whole the following picture emerges:

- government control limits the abuse that may occur if unscrupulous individuals wanted to prey on the needs of people who wish to plan for their retirement. On the other hand people who may have a good plan to assist people will need to undergo a lengthy regulatory process to get the scheme into place;
- while government can monitor and control retirement funds for employees who belong to these funds there is no way that they can ensure that all employees belong to a fund, the employer may not have set up a fund;
- retirement funds do not cater for the unemployed. Some form of social grant system still needs to be in place. Social grants are paid out of tax income and therefore place an additional burden on the member of the retirement fund who is already paying tax and contributions to a retirement fund.

2. Explain why an employer should not ignore the feelings and opinions of organised labour when deciding to implement a retirement fund. What problems would you perceive in holding discussions with staff representatives?

South Africa is today a country where labour has become a major player in the decision making process. The National Economic, Development and Labour Council (NEDLAC) was created by government with the specific intention of providing a forum where business, labour and government negotiators could mediate on all matters relating to a better understanding between the key role players.

A typical example of the role played by NEDLAC was the lengthy negotiations entered into at the forum before the Labour Relations Act, 1995 was passed through parliament.

If one were to look at the labour unrest linked to the results of the deadlock within NEDLAC between business and labour over the terms and conditions of the Basic Conditions of Employment Bill during 1997, one can appreciate the power that labour has acquired since the initial creation of the labour union movement in the mid 1970's.

The predominance of COSATU (The Council of South African Trade Unions) in the dispute over the Basic Conditions of Employment Bill does not mean that they were (or are) the only labour representatives in the country.

An implication of the Labour Relations Act, 1995 was the creation of the need to establish workplace forums (Note, a workplace forum does not need any union representation) in any workplace in which an employer employs more than 100 employees.

The unilateral creation of a retirement benefits plan by an employer for his employees is unlikely to happen in today's business environment. The employer, having decided that the creation of a retirement benefits plan is in the best interests of both the business enterprise and its employees, will want to deal within a negotiation forum on the structure of the scheme. It is always better to discuss the proposed benefits with the eventual recipients to best ensure the acceptance of the scheme and to gain a measure of employee / member acceptance and satisfaction.

The first important decision that needs to be addressed is the composition of the employee representative group. The structure of the employee representative group will, to a large extent, be determined by the number of employees and their geographic positioning, for example, all staff concentrated in one establishment or divided into branches at all the major centres. Where there is already a large trade union representation it is also only natural that the trade union concerned would wish to be a part of the negotiation team.

With the introduction of Sections 7A to 7E of the Pension Funds Act, any new fund registered after 19 April 1997 must stipulate the composition of the management board with its rules and regulations. The initial defining of the management board and the arranging for an election of representatives may possibly be the best solution to the creation of an employee representative body. This body could then negotiate on the benefits to be included in the fund and form the member elected element of the management board.

There is no doubt that the employer and employees will need to have lengthy discussions on the number of representatives on the board. Where many distant branches are involved a resolution regarding representation on their behalf will also need to be resolved. It is also becoming a fairly common practice that trade union representation on the board is determined by the percentage of staff, within the organisation, that they represent. Should there be a 40% trade union membership amongst the employees and the number of member elected board members set at 5, the trade union would be permitted to appoint 2 of the 5 member elected representatives. Where a fund has been in existence for some time the number of pensioners on the scheme may be large enough for them to be entitled to vote their own representative(s) onto the management board.

The members of the fund are entitled to appoint at least 50% of the board members, in terms of Section 7A of the Pension Funds Act. The employer is entitled to appoint the balance of the board members.

The employer appointed board members must be given a clear mandate within which to negotiate on the position of the employer with regards the provision of benefits and should then enter into the negotiations that will result in the creation of the retirement fund. The employer's position will no doubt largely be dictated by the cost of any benefits that it will need to bear.

In a retirement fund where the employer has a minimal (or no) funding obligation it is even possible that the management board is made up entirely by member elected representatives, with possibly one or two employer appointed members purely to monitor proceedings. The structuring of the fund and all future decisions would be made entirely by the member representatives. This position is, however, unlikely as it tends to be the norm amongst current retirement fund structures that the employer bears the bulk of the costs of any administration expenses and pays for any ancillary benefits linked to the scheme.

3. A member who is earning a salary of R7 500 per month and has 22 years service is retiring at age 65. The defined benefit fund allows 2% for every year of service.

3.1 What would be his pension if he decided to take the maximum amount permitted as a lump sum?

3.2 Under what circumstances would you consider this to be sufficient retirement savings and why?

3.1 The formula is:

years of service × final salary × the 2% stipulated and so:

22 × 7 500 × 2% =

44% of R7 500 = R3 300

The maximum commuted amount would therefore be the equivalent of R1 100 (being $^{1}/_{3}^{rd}$ of R3 300) paid as a lump sum. This would be calculated using current interest rates and the life expectancy of the member.

His monthly pension would therefore be R2 200 per month.

3.2 A reduction of income to approximately $^{1}/_{3}^{rd}$ of what the member was earning at the time of retirement is not something that many people will be able to adapt to. In order to be able to survive on a reduce income of this level there are a number of factors that will have to be considered.

- Will the mortgage on his property have been paid of or will the lump sum be sufficient to do so?
- Will the member have a reliable car that will not need to be replaced? (We will have to assume that the member will be doing a limited amount of travelling now that he has retired.)

- Are the children of the member all self-sufficient and no longer living with the member?
- Does the member have additional investments that can be used if needed, for example, unit trusts, an equity portfolio, rented property.
- Does the member and/or his spouse have any retirement annuities that will mature in the future that can provide an additional income?
- Does the member have an additional or other source of income, for example, royalties or part time employment?
- Is the pension being received linked to inflation?

The answers to most or perhaps all of the questions above need to be "YES" if the income being provided by the retirement fund can expected to be adequate.

4. How does a preservation fund work? What are the advantages and disadvantages to an individual in transferring the withdrawal amount from a pension fund to a preservation fund as opposed to purchasing a lump sum retirement annuity with the amount?

Before the advent of preservation funds, a person had the following options available on withdrawal before retirement from a pension or provident fund:

- to remain a paid-up member of the employer's fund, if so permitted by the rules. This option did not appeal to an employee who wanted to sever all ties with his former employer;
- to take the withdrawal benefit in cash. Premature access to retirement benefits by a person may lead to the squandering thereof before retirement;
- to transfer the benefit directly to a retirement annuity fund with no tax consequences. A disadvantage of this option was that it precluded any access to the retirement funds before the age of 55.

The general response of the insurance industry to the shortcomings of the aforementioned options was the introduction of pension and provident preservation funds. These are pension and provident funds, respectively, to which members of existing pension or provident funds can transfer their accumulated benefits under certain circumstances. These funds are then available for the preservation and continued growth of the retirement benefits of employees who have withdrawn from their own pension or provident funds as a result of having resigned from their employment, having been retrenched or having been faced with the actual winding up of the pension or provident fund that they may have belonged to.

A person may transfer from a pension fund to a pension preservation fund or from a provident fund to a provident preservation fund. No provision exists, however, for a direct tax-free transfer from a pension fund to a provident preservation fund.

A disadvantage of a preservation fund is that the employer with whom the employee is terminating employment must become a participating employer in respect of the preservation fund in order for the employee to be eligible to transfer his benefits to the preservation fund. It is also a disadvantage to an employee that, although an employer may be a participating employer of more than one preservation fund, an employee who is a member of an existing pension or provident fund may only become a member of one preservation fund of which his former employer is a participating employer.

In essence the advantages that are enjoyed by a person who transfer from a pension or provident fund to an equivalent preservation fund are as follows:

- no tax liability on transfer;

- one withdrawal from the preservation fund is allowed - either partially or total - prior to retirement age. A member transferring his benefits from a pension or provident fund to an equivalent preservation fund must, however, understand clearly that the total value of benefits due must be transferred. As you are probably aware a member who elects to withdraw from a retirement fund and take the benefits as a cash amount will be able to receive a portion of any withdrawal benefit tax-free, but the total ceiling applies to all lump sum withdrawals. Members have taken advantage of this concession and instructed the funds from which they have withdrawn that a capital amount should be paid to them and the balance transferred to a preservation fund. The revenue authorities have indicated that this will be considered the “one” withdrawal from the preservation fund and that no further withdrawal will be allowed;

It is no longer necessary to preserve the person’s years of membership in the fund from which the benefits have been transferred as this has no impact on determining the tax-free amount of the lump-sum that may be taken from the preservation fun on death or retirement.

One interesting point is that a preservation fund (as well as a retirement annuity fund) can apply for exemption at the Registrar of Pension Funds for the appointment of a management board. Members therefore have no say in the running of the fund and must rely on the expertise of the insurer who provides the benefits, administration and investment strategy.

The nature of a preservation fund (i.e. only accepting lump sums) means that the administration costs of a preservation fund will be less than those of a retirement annuity fund. On the other hand the on-going income received by a retirement annuity fund means that the investment managers will be able to make full use of rand-cost averaging.

In the end the decision as to whether to use a retirement annuity fund or a preservation fund will rest with the individual who is withdrawing from a retirement fund.

5. List and describe the special grants payable under the Social Assistance Act.

Note that the basic pension would not normally be termed a grant.

(a) Old age grants
Payable to women who are 60 years of age and older, and to men who are 65 years of age and older, all of whom will be subject to the means test before their grants are approved.

(b) Grant-in-aid allowance
If the physical or mental condition of a person who is getting a social grant is so bad that he needs to be looked after all the time an additional amount per month may be paid. When this extra allowance is applied for a medical certificate must be sent with the application.

(c) War veterans
Anyone who was in any military, naval or air service during the wars that South Africans have fought in can apply for a war veteran grant when they reach the age of 60 years or older if they are unable to maintain themselves because of a mental or physical disability caused by the wars.

All people that apply will have to qualify with the means test. The war veteran's grant is slightly larger than the amount received as a normal social grant. War veterans applying for their grant must submit their discharge certificates.

(d) Disabled persons
The grants are paid to people who are 18 and older, who are disabled for six months and more who cannot support themselves because of the nature of their disability.

(e) Foster child
Persons who act as foster parents for children who have been taken away from their parents for their own safety or children who have been orphaned and need special care that cannot be provided by an orphanage (for example, new-born babies) can claim a special social grant for every child in their foster care. The appointment as a foster parent must be ratified in court and the foster parent will have to qualify for the grant in terms of the means test.

(f) Child support
A primary care giver who cares for a child or children (up to a maximum of six children) who are under the age of eighteen can apply for a special child-support grant.

CHAPTER 10

1. Mr. Big, the owner of a large company, wishes to retain the services of his key sales people. Explain to Mr. Big what a conforming policy is and what the tax advantages of such a policy are to both the company and the sales staff.

A conforming policy is one that conforms to certain rules set out in the Income Tax Act, which determine the type(s) of policy under which premiums paid by a business may be deducted from income for tax purposes.

The terms and conditions with which the policy must conform are set out below:

(a) the policy shall apply to one life insured only and no other life insured may be substituted;

(b) premiums must be payable at regular intervals (either annual, half-yearly, quarterly, monthly or weekly) and for the full death benefit period or until a claim occurs. Premiums may also not be increased unless the increase is in accordance with paragraph 11(5)(b) of the Sixth Schedule.

Even though the 6th Schedule has been withdrawn from the Act it is still used in effect in determining the nature of conforming policies.

(c) the policy must include a death benefit. The amount of life cover needed is determined by multiplying the "death benefit period" with the "premium factor".

To calculate the life cover needed use the formula:

80% × "P" × "N"

where:

"P" equals the net premium without the costs of any disability or accidental death benefits or any health or other loadings, and

"N" equals the term of the policy. Where the term exceeds 20 years or where the policy is a whole life contract we are permitted to assume that the term is 20 years.

(d) the terms and conditions set out in (a) to (c) must be incorporated into the policy document and while the policy is in force no changes can be made other than to make the policy paid-up to normal maturity. Should premiums not be paid in the early stages of the contract the insurer is permitted to terminate the contract.

Provided that-

(aa) no deduction will be allowed in respect of any premium paid while the policy was not the property of the employer;

(bb) no deduction will be allowed if:

(A) any person other than the taxpayer was entitled to a benefit under the policy during the year of assessment; or

(B) a loan was made to any person, using the policy as collateral, and the loan was still outstanding, unless the loan was made by the taxpayer in order to obtain funds needed because the employee is in ill health, infirmity, incapacity or has retired or left. A loan made by the insurer to the taxpayer will have to be included in his gross income (Section 1 paragraph (m) of the definition of gross income) but will not cancel his allowable deduction.

(dd) no deduction will be allowed unless:

(B) the policy is a term insurance policy; or

(C) the policy conforms to the regulations as set out in Regulation GN R2408 in the Government Gazette 8442 of 12 November 1982.

(ee) the deduction will be limited-

(B) in the case of a conforming policy, to an amount equal to 10% of the remuneration of the employee or director. Remuneration is defined in the Fourth Schedule and for the purpose of this deduction includes any advances that may have been paid to a director.

The maximum tax advantage will only arise if the policies are properly set up i.e. it is necessary to ensure the correct documentation surrounding the actual policies. The tax advantage to the company is that the premiums are tax deductible, so that, in effect, the policy costs less than it would otherwise. The proceeds, when paid out to the company, are taxable. However, should the proceeds be paid out by the company, say to the employee on retirement in terms of a prearranged undertaking, the amount paid is again deductible, thereby neutralising the effect of the tax from the company's point of view.

From the employee's side there is no tax implication while the premiums are being paid, although it could be deemed that the premiums paid are a form of "salary sacrifice" if the employee would have otherwise been given the equivalent as an increase which would be taxed at marginal rates. The proceeds at maturity enjoy two tax concessions - viz the first R30 000 is tax free under Section 10(1)(x) and the balance is taxed at the average rate of tax and not the marginal rate in terms of Section 7A(4A). Care should be taken in setting up the plans not to overdo the benefits. For example, a young employee may grow to be a big earner and his ultimate average rate of tax when the benefits are paid may then be so high that the advantage of tax deferral is wiped out.

Again there are certain requirements that must be met in order for the tax concessions to be granted, such as

(a) the taxpayer must be at least 55

(b) the termination of employment is as a result of normal retirement or ill health.

For the average tax rate concession it may also be allowed if termination of employment is as a result of the employer ceasing to trade or the employee being made redundant.

2. James Seller, a 24 year old sales "star" who works for Mr. Big, is not sure that a deferred compensation scheme is in his best interests. Explain the tax advantages, both before and after retirement, that Mr. Seller will enjoy if he partakes in the scheme.

In order to ensure that the employee is not taxed on the value of the premiums paid on the policy by the employer as if they were income accruing to him a number of rules have to be obeyed:

- the employee must not be entitled to any benefit under the policy other than those benefits as set out in the Service Agreement. These benefits must only be due to the employee as a result of the termination of his services;

- no salary sacrifice will be possible by the employee. Section 7(1) of the Income Tax Act incorporates into the income of a taxpayer any income which is due and payable to a taxpayer, notwithstanding the fact that such income has been invested or otherwise dealt with on his behalf. It will be argued that any salary sacrifice made by an employee to fund a deferred compensation scheme would be construed as an investment made on the employee's behalf.

Provided that these rules are complied with the position of the employee will be the same as it was prior to the institution of the scheme.

At retirement it must be understood that the employee will **not** be receiving the proceeds of an insurance policy. The money received by the employee from his employer at retirement is in the form of a gratuity which can be funded from any source. The gratuity is included in the gross income of the employee in terms of the definition of gross income included in Section 1, paragraph (d) of the Income Tax Act which includes -

> *"any amount received in respect of the relinquishment, termination, loss, repudiation, cancellation or variation of any office or employment."*

In terms of Section 10(1)(x) of the Income Tax Act an amount as does not exceed R30,000 is exempt from tax. This amount must be received as a lump sum. The receipt must be as a result of the reasons referred to in paragraph (d) of the definition of gross income in Section 1 of the Act. Any other amounts previously excluded from tax as a result of this section, in the current or any previous year of assessment, will reduce the amount of the exemption now allowed.

No exemption under this section will apply in respect of the amount received, or to be received in respect of the relinquishment, termination, loss, repudiation, cancellation or variation of office or employment, unless:

(i) the person receiving the amount has attained the age of fifty-five years; or

(ii) the employee is relinquishing, terminating, losing, repudiating, cancelling, or varying his office or employment as a result of superannuation, ill health or other infirmity; or

(iii) the termination of the employee's services are as a result of the employer ceasing to carry on business, or reducing the workforce, as a result of which the employee is retrenched. Where, however, the employer is a company and the employee is (or was at any time) a director and at some stage owned at least 5% of the share holding this particular point will not be applicable.

Let us further say that the taxable income of the taxpayer, after having received the exemption under Section 10(1)(x), still includes an amount received by way of a gratuity. The normal tax payable on that amount is then determined in accordance with the provisions of Section 5(10). This is the rating formula whereby the taxpayer pays tax at the average and not the marginal rate of tax. Once again there are conditions that will apply:

(a) the taxpayer must have attained age fifty-five, if male or age fifty, if female; or

(b) the termination of services is due to superannuation, ill health or some other infirmity; or

(c) the Commissioner is satisfied that-
  (i) the taxpayer's services have been terminated as a result of his employer ceasing to trade or the taxpayer having been made redundant, and
  (ii) the circumstances of the case warrant the concession.

Note: Once again any discrimination based on sex is not permitted in terms of the new Constitution of the Republic of South Africa. Point (a) above therefore needed to be changed to abide by this ruling. With effect from 1 March 2000 there will therefore be a common attained age of fifty-five years for both males and females.

The life cover attached to the policy would be a further benefit.

In this particular case it may be that the benefits are not too attractive to James. He is currently quite young and the main benefits may seem a long way away. He may also feel that he may not want to be tied to the company until the age of 55, so the benefits may not apply. As a "star salesman" he may also anticipate increasing his income over the years to the extent that his ultimate average rate of tax when the benefits are paid out may be higher than his marginal rate during the earlier years of his career, thereby wiping out much of the usual tax benefits.

3. Still not convinced, Mr. Seller asks that you explain a preferred compensation scheme to him. Mr. Big is also interested to know whether he will be better off with either a deferred or preferred compensation scheme. Prepare a report for:
3.1 Mr. Seller; and
3.2 Mr. Big.

(Note: you should use a proper report format.)

3.1 Mr. Seller receives a special increment from Mr. Big. This increase is only granted by Mr. Big because he expects Mr. Seller to remain in his service for a minimum period of (let us assume) 10 years. To ensure that this is in fact the case Mr. Big will require that Mr. Seller uses the special increase to purchase a life insurance policy. The policy must then be ceded to Mr. Big as security for Mr. Seller's undertaking to remain in service with Mr. Big.

The cession must be a security cession and not an outright cession. The importance of this is in the fact that ownership will not be transferred with a security cession and the policy will remain the property of Mr. Seller.

As Mr. Seller is a natural person the investment account of the policy will be placed in the individual policyholder's fund which is taxed at a lower rate than the company-owned policyholder's fund.

The policy, when taken out by Mr. Seller, must be taken out as a normal policy in accordance with the conditions contained in Section 59D of the Insurance Act. This will ensure that the proceeds will then be fully redeemable and tax-free at maturity.

Mr. Seller will not be able to claim any of the premiums as a tax deduction. It is necessary to first determine the tax due on the increment and then to ensure that balance is utilised for the premiums.

As Mr. Seller is the one taking out the policy and as the ownership will remain with him, he is able to take out any normal policy that may fit his needs. Any supplementary benefits available can also be added. Naturally no retirement annuity contract can be used for this scheme as a retirement annuity cannot be ceded.

As an ordinary life (with investment) policy is the most common policy type used, the policy will accumulate values. With the approval of Mr. Big, an approval that is often written into the agreement, it is possible for Mr. Seller to make periodic cash withdrawals from the policy. These withdrawals are, in a sense, additional bonuses paid to him by Mr. Big but with the added advantage that they are tax free.

3.2 Mr. Big pays Mr. Seller a special increment in lieu of the premium that he would have invested into a deferred compensation scheme. By making the increment non-retirement funding he will avoid the additional costs that are incurred with a normal increment, for example, the employer's contribution to the pension fund.

Mr. Big is permitted to claim salary expenses as a tax deduction in terms of Section 11(a), being expenses incurred in the production of income (the General Deduction). He will be able to claim the additional salary expense. His tax position is the same for a preferred compensation scheme as it would be for a deferred compensation scheme where premiums are deductible in terms of Section 11(w).

Mr. Big will not be the owner of the policy. The policy will, however, be ceded to him by means of a security cession (as per an agreement), and he will therefore, from the point of control have the same safeguards as would have been in place with a deferred compensation scheme.

4. Mr. Manufacturer knows that the new machinery that he has recently bought will need to be replaced in five years time. He has asked you for a solution in raising the required capital. Explain the option of a sinking fund, and how it works, to your client, giving an example.

The annual depreciation charge is matched with an annual payment into a pure endowment policy for a term of at least 5 years. The company takes out the policy on a non-conforming basis.

This means that the premiums will not be deductible in accordance with Section 11(w) of the Income Tax Act and therefore the proceeds will be tax free when received by the company at maturity.

In accordance with the conditions set out in Section 59D of the Insurance Act there is no longer a need for a policy to have a “life insured” if there is no life cover included in the policy. The company therefore owns the policy as an asset and no outside influences, like the death of the nominated life insured under an “old” policy, will affect the date of maturity.

For example, the company may be looking at replacing machinery which currently cost R500 000.

In 5 years' time it can be expected that the machinery, which is largely imported, may cost R1 050 170 (an average increase in price of 16% per annum compound).

Various advisors quote their maturity projections using different growth assumptions and companies wanting to use a conservative approach to their sinking fund would probably use a conservative projection to calculate the funding rate (or premium).

Allowing for policy expenses it may turn out that the company will need to take out a policy for, say, R15 000 per month.

CHAPTER 11

1. Who is liable for the payment of estate duty?

It is the responsibility of the executor of the estate to ensure that the estate duty is paid to the Commissioner of Inland Revenue who collects the duty on behalf of the state (Section 12). The estate is not, however, fully liable for that all the duty payable.

Where a beneficiary, in terms of the will of the deceased, receives a fiduciary, usufructuary or other like interest, (including an annuity not charged against property), the beneficiary is liable for the estate duty (Section 11(a)(i)). On all other property, the executor is liable to pay the estate duty out of the estate (Section 11(a)(ii)).

Where an insurance policy is payable directly to a beneficiary, the estate duty that is due on the proceeds of the policy will be payable by the beneficiary (Section 11(b)(i)). One must remember that, even though a beneficiary can receive the proceeds of an insurance policy directly from the insurer, the proceeds will, (under most circumstances), form part of the gross value of the estate of the deceased. Should the policy pay to the estate of the deceased, the executor is liable for the payment of the estate duty.

Where the estate of the deceased includes a commuted lump sum from a retirement annuity or pension fund, the beneficiary is liable for any estate duty on the amount received. Should the commuted value be paid into the estate, the executor will be liable for the duty. (As from January 2009, lump sum benefits from a retirement fund will not attract Estate Duty.)

The executor, whose responsibility it is to ensure that the estate duty is paid, is entitled to recover the duty payable from any beneficiary who becomes liable for the payment of the duty (Section 13(1)).

The Master will not file any liquidation and distribution account in his office or grant a discharge to any executor until he is satisfied the duty payable has, in fact, been paid or secured to the satisfaction of the Commissioner (for Inland Revenue) or that the Commissioner agrees to the discharge (Section 17).

Before delivering or transferring any property of the deceased to any heir or legatee the executor must satisfy the Commissioner that due provision has been made for the payment of any estate duty that may be payable (Section 18).

2. Set out the formalities required in the execution of a will.

There are certain formalities that must be abided by in order for a will to be considered the valid last Will and Testament of the deceased. The conditions that are explained herein are not only applicable to the will itself; any codicil or amendment to the will must also abide to these same conditions in order for them to be considered as a valid addition or amendment to the will of the deceased. It is always assumed (unless the contrary is proved) that any amendment made to a will, is brought about after the original will was executed.

(i) The will must be signed at the end by the testator. Should the testator be unable to sign he may appoint some other person who may sign on his behalf. This other person must, however, sign the will in the presence of the testator and can only do so when the testator is satisfied with the contents thereof.

(ii) The signing of the will by the testator (or his nominated representative) must be done in the presence of two or more competent witnesses who must all be present at the time of the signing of the will.

(iii) The witnesses must attest and sign the will in the presence of the testator and of each other. If the will has been signed by another person on behalf of the testator that person must also be present while the witnesses sign.

(iv) Where the will consists of more than one page, it is necessary that each page (and not only the last page) is also signed by the testator or his appointed representative.

NB: Whilst it is no longer required that the witnesses attest to and sign every page (other than the last page) there is still a school of thought that recommends that they do so.

(v) Where the testator is unable to sign he may appoint some other person who may sign on his behalf. Alternatively he may "sign" the will by making his mark thereon. Should the will have been signed in either of these manners, it is necessary that a Commissioner of Oaths certifies that he has satisfied himself as to the identity of the testator, and that the will so signed is the will of the testator. The Commissioner of Oaths will be required to sign every page of the will. Certification is only possible where the mark is made by the testator, or where the will is signed by the testator's appointed representative in the presence of the commissioner of oaths.

Should the testator die after the will is signed by an appointed representative, or where the testator has only made his mark, a Commissioner of Oaths may still certify the will as being a valid document, provided he can satisfy himself as to the identity of the testator, and that the will is, in fact, the last will and testament of the testator.

It may happen that a person dies before the formalities required for the signing of the will are completed. Provided that a court can then be convinced that the draft document placed before it was intended as the last will of the deceased, the court can instruct the Master to accept the document as the will of the deceased.

Where a Commissioner of Oaths is required to certify the validity of the signing of a will, the following wording may be used:

I, (full name) ..... of (full address) ....., in my capacity as commissioner of oaths certify that I have satisfied myself as to the identity of the testator (full name)..... and that the accompanying will is the will of the testator.

.....
Signature

Commissioner of oaths

.....
Capacity

....
Place Date

3. In order of prior claim - set out the method in which the estate of a person who has died intestate will be distributed.

(a) Where a person is survived by a spouse, but not by a descendant, the surviving spouse will inherit the entire intestate estate.

(b) Where a person is survived by a descendant, but not by a spouse, the descendant will inherit the entire intestate estate.

(c) Where a person is survived by a spouse and a descendant-
   (i) the spouse will inherit an amount equal to the greater of a child's share of the intestate estate or an amount which is fixed from time to time by the Minister of Justice in the Government Gazette. (At the time of going to print this amounted to R125 000);
   (ii) where the set down amount is greater than a child's share the descendant will inherit the residue (if any) of the intestate estate.

(d) Where a person is not survived by a spouse or a descendant, but is survived-
   (i) by both parents, the parents will inherit the intestate estate in equal shares;
   (ii) by one parent, the surviving parent will inherit one half of the intestate estate and the descendants of the deceased parent will share the other half of the estate. Should the deceased parent not have any descendants the surviving parent will inherit the entire estate.

(e) Should the deceased not be survived by either a spouse, a descendant or a parent the following will occur:
   (i) the intestate estate will be divided into two equal shares. One half will be shared by the descendants of the mother and the other half will be shared by the descendants of the father;
   (ii) where only one of the deceased's parents left other descendants, those brothers and sisters will share the entire intestate estate.

(f) Where the deceased is not survived by a spouse, descendants, parents or descendants of parents any blood relations who are related to the deceased to the nearest degree will inherit the intestate estate in equal shares.

It must be noted that, in terms of the Intestate Succession Act, illegitimacy will not effect the capacity of one blood relation to inherit from the intestate estate of another blood relation.

Where, however, a child is adopted, the adopted child is now deemed to be a descendant of his adoptive parent/s, and not of his natural parent/s. Therefore, an adopted child will have no claim against the intestate estate of a natural parent, unless the natural parent is also an adoptive parent, or was, at the time of adoption, married to the adoptive parent.

4. Explain the implications of the Maintenance of Surviving Spouses Act on the estate of a deceased spouse.

Where a marriage is dissolved by death, the surviving spouse has a claim against the estate of the deceased spouse for the provision of reasonable maintenance, until his death or remarriage, in so far as the surviving spouse is not able to provide therefore from his own means and earnings.

The claim for maintenance by a surviving spouse has the same order of preference as would a claim by a dependant child, and will be treated concurrently and, where necessary, the two claims may be reduced proportionally.

The executor may, if he deems it to be necessary, enter into an agreement with the surviving spouse, heirs and legatees whereby the executor creates a trust, or imposes an obligation on an heir or legatee, for the benefit of the claim of the surviving spouse.

In order to establish the reasonable maintenance needs of the surviving spouse, the following factors should be taken into account:

(a) The amount in the estate of the deceased available for distribution to heirs and legatees.

(b) The existing and expected means, earning capacity, financial needs and obligations of the survivor.

(c) The standard of living of the survivor during the marriage and his age at the death of the deceased.

A **legatee** is a person to whom the deceased has left a specific item or items, or a sum of money, as a specific mention in his will.

An **heir** is a person who has been mentioned in the will as one who is to share in the residue of the deceased's estate after the payment of all debts and legacies.