

KEY CHANGES TO THE POLICYHOLDER PROTECTION RULES EFFECTIVE FROM 1 JANUARY 2018

The FIA provided detailed input on the earlier drafts.

It should be noted that the main focus of the PPRs are on insurers and how they interact with their policyholders. However, intermediaries need to be aware of the rules.

The new requirements apply to new policies as well as existing policies, although some provisions allow for a transitional period.

Definitions

Mention is made of the term “associate of the insurer” but this term has not been specifically defined.

The rules include a clear definition of a beneficiary under a group scheme as is a definition of a member of a group scheme.

The definition of “outsourcing” specifically excludes services as an intermediary but includes binder services.

The definition of a policy as contemplated in these rules applies to a policy owned by a natural person or a juristic person where the asset value or annual turnover less than the threshold value under the Consumer Protection Act (currently R2 million).

Specific mention is made of “potential policyholder” and “potential member of a group scheme”. Potential policyholders are defined to include anyone who had applied to or approached an insurer or intermediary about becoming a policyholder, or has been solicited by an insurer or intermediary to become a policyholder or has received advertising in relation to a policy or service of an insurer, which is quite wide.

Services as an intermediary has not been defined here and will probably have to be addressed in future changes to the FAIS Act.

The definition of “service provider” includes agents of the insurer and also other intermediaries with whom an arrangement has been reached. We are not sure of the full implications of this other than the obligation on insurers to “oversee” intermediary behavior.

Fair treatment

Rule 1 sets out a range of requirements that will be deemed as “guidelines” for the fair treatment of policyholders. An interesting inclusion in these is the requirement that insurers ensure that advice given is “suitable and takes account of their circumstances”, which should prove quite difficult where an independent intermediary is involved and the insurer has no idea of the clients’ particular circumstances.

Some concessions are set out for communication with members of group schemes to make the requirements more practical.

Product design

Rule 2 talks about product design and the TCF requirement that insurers take appropriate steps to ensure that products are “fit for purpose” for the chosen target market.

Credit life and consumer credit insurance

Mandatory credit life policies are only allowed where they comply with the requirements of the National Credit Act, while there are also some guidelines on handling the substitution of these policies.

Cooling-off

Rule 4 entrenches the existing cooling-off rights but changes the period from 30 to 31 days. It would seem that true monthly short-term policies do not enjoy the cooling-off protection.

Determining premiums and excesses

Rule 6 is a new one and includes the requirement that insurers may not charge any kind of (policy) fee or charge over and above the premium.

Void provisions

Rule 7 retains the existing void provisions but expands on them, including banning the use of polygraphs to repudiate claims under both long-term and short-term policies.

Policyholder rights and incomplete forms

Rules 8 and 9 retain the requirements that policyholders cannot waive their rights and that blank or incomplete forms should not be signed. The waiver of rights specifically refers to those confirmed by the PPR, while there is a more general waiver restriction under the FAIS Code of Conduct.

Advertising and promotion

Rule 10 is quite long and sets out requirements for advertising and promotion, picking up much of the controls that were given for direct marketers in the existing PPRs. A 6-month phase-in period has been allowed.

Importantly, it allows for comparative advertising although certain requirements need to be followed, while it also puts some constraints on the promotion of loyalty benefits/bonuses.

Negative option marketing is forbidden (this is also detailed in Rule 5 where mention is made of the fact that it may be used in certain cases relating to a specific term or condition required by legislation).

Intermediaries should note that there is a requirement that advertisements must clearly identify the insurer involved. Care would have to be taken where an intermediary who deals with more than one insurer places an advertisement.

Where “white labelled” products are being advertised, the name of the insurer must feature just as prominently as the white labelling. (There is a “concession” on this where the white label arrangement is with an insurer or bank within the same group of companies, which is quite strange.)

Disclosure

Rule 11 deals with disclosures by insurers both before the policy is entered into and afterwards. To a certain extent this duplicates the disclosure requirements of intermediaries under FAIS but there are no real “surprises”.

The rule includes the previous requirements for policy loans and cessions in the long-term PPR.

Insurers must advise policyholders of non-payment of any premium not later than 15 days after having become aware of the non-payment.

Intermediary agreements

Rule 12 replaces the current requirements with few changes other than:

- 1) a requirement that insurers must release information to intermediaries when presented with an appropriate authorisation (broker appointment or letter of investigation); and
- 2) insurers may facilitate the collection of fees from clients for intermediaries provided that the fee –
 - (a) relates to an actual service provided to a policyholder;
 - (b) relates to a service other than rendering services as intermediary; and
 - (c) does not result in the intermediary or other person being remunerated for any service that is also remunerated by the insurer.

Intermediary agreements must be between the insurer and the intermediary directly and not through a third party.

Data management

Rule 13 imposes certain requirements on insurers to retain proper records of data, which makes sense. However, there may be some concern about the need to include the mobile number and e-mail address of clients (where possible), while obtaining the required data under some group schemes may present quite a challenge.

Importantly, where the insurer outsources any data responsibility (such as under a binder agreement) the insurer must be able to access the data at any time. A 24-month phase-in period has been allowed.

Product review

Under Rule 14 insurers must review the products regularly, including the distribution channel used.

Periods of grace (short term)

Rule 15 of the short-term rules sets out the grace period for payment of premiums, which remains unchanged from the existing requirement.

Premium reviews (long term)

Rule 15 of the long-term rules is a new one that addresses premium reviews. Insurers must comply with a range of requirements when undertaking a premium review in terms of the policy wording. Importantly, if such a review results in a premium increase, policyholders must be offered alternatives such as a reduction of benefits, a replacement policy or a fair cancellation.

Policyholder communication record keeping

According to Rule 16, insurers must set up appropriate systems to record all communication with policyholders.

Claims processing management

This is listed under the TCF requirement of “no unreasonable post-sale barriers and allows for a 12-month phase-in period has been allowed for (18 months for group schemes).

Under Rule 17 insurers must establish, maintain and operate a claims management process including proper records of all decisions as well as a claims escalation and review process. This is far more comprehensive than the rather brief requirements around the rejection of claims in the current rules.

Claims received by an independent intermediary are deemed to have been received by the insurer concerned.

Complaints management

Rule 18 deals with the management of complaints and largely addresses this issue as per the TCF guidelines. A 12-month phase-in period has been allowed for (18 months for group schemes).

Two important definitions to note are:

“complainant” means a person who submits a complaint and includes a –

- (a) policyholder or the policyholder’s successor in title;
- (b) beneficiary or the beneficiary’s successor in title;
- (c) person whose life is insured under a policy;

- (d) person that pays a premium in respect of a policy;
- (e) member of a group scheme; or
- (f) potential policyholder or potential member of a group scheme whose dissatisfaction relates to the relevant application, approach, solicitation or advertising or marketing material, who has a direct interest in the agreement, policy or service to which the complaint relates, or a person acting on behalf of a person referred to in (a) to (f);

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

- (a) the insurer or its service provider has contravened or failed to comply with an agreement, a law, a rule, or a code of conduct which is binding on the insurer or to which it subscribes;
- (b) the insurer or its service provider’s maladministration or willful or negligent action or failure to act, has caused the person harm, prejudice, distress or substantial inconvenience; or
- (c) the insurer or its service provider has treated the person unfairly.

(It should be noted that the definition is quite wide.)

Insurers must establish, maintain and operate a complaints management process including records of complaints and how they were dealt with as well as a complaints escalation process which leads up to an approach to an Ombuds’ office. Interestingly, the Rule does not specifically require insurers to keep intermediaries in the loop when dealing with a complaint.

Policy replacements

Rule 19 sets out the process that needs to be followed where a policy is being replaced. For long term policies, this is essentially the process that is currently followed, including the RPAR and adherence with Section 8(1)(d) of the FAIS General Code of Conduct. While earlier drafts suggested that commission would be “outlawed” on all replacements, the final version takes account of the submissions made on this and recognizes that in many cases replacements are in the interests of the policyholder and that intermediaries are sometimes obliged to recommend replacement as part of their duty towards their clients.

For short term policies Rule 19 formalises the process of cancellations (other than as a result of non-payment of premiums, automatic cancellation or termination required by law.

The following clauses should be noted:

19.2.2 In the event that the insurer terminates a policy in circumstances other than those set out in 19.2.1(a) – (c), the insurer will remain liable under the policy for the shorter of -

- (a) a period of 31 days after the date on which the insurer receives proof that the policyholder has been made aware of the intended termination of the policy; or
- (b) the period until the insurer receives proof that the policyholder has entered into another policy in respect of similar risks to those covered under the policy that the insurer intends to terminate.

19.2.3 In the event that the insurer is unable to obtain the proof referred to in rule 19.2.2 above, the insurer must be able to prove that –

- (a) a period of 31 days had passed since notification was sent to the last known address of the policyholder; and
- (b) it took all reasonable steps to –
 - (i) ensure the contact information of the policyholder is correct, and
 - (ii) to contact the policyholder.

The rule goes on to spell out the process to be followed under group scheme cancellation (either by the insurer or the policyholder). In both cases the Registrar must be notified prior to cancellation and care needs to be taken to ensure that the rights of the policyholder(s) are protected.

Rule 19 allows for a 24-month phase-in period.

Notes

The existing PPR included certain requirements specifically for direct marketers. The new rules capture much of this but now extend this to all forms of marketing. Similarly, the current long-term rules contain specific reference to fund policies and assistance business group schemes whereas the new rules tend to bring all requirements into line for all types of business.

The new rules do not specifically include the controls on debit orders as contained in the current short-term rules, which included giving policyholders 30 days of notice before cancelling an existing debit order as this has been covered in the general requirements for cancellations.

Although earlier drafts contained a requirement that the written consent of any person who is being insured needs to be obtained, this requirement has been “shelved” for now pending further investigation into what is thought to be cases of “abuse”. (The practical problems around this requirement, especially under certain group schemes and, for example, where a family funeral policy includes numerous relatives who may be difficult to contact, need to be considered.)

Similarly, a proposed clause containing penalties for contravention of the rules has been omitted in the final version, which means that contraventions will be subject to general enforcement action.

The reference to “due diligence requirements” contained in an earlier draft has been removed.

Although some attempt has been made to align various requirements with those under the FAIS Act, there are several areas of difference and one assumes that these will be addressed when the FAIS Act is replaced by the planned COFI Act, possibly during 2018.