(1 January 2020 – to date)

LONG-TERM INSURANCE ACT 52 OF 1998

(Gazette No. 19276, Notice No. 1190, dated 23 September 1998. Commencement date: 1 January 1999 [Proc. No. R127, Gazette No. 19596, dated 18 December 1998])

FINANCIAL SERVICES BOARD

REGULATIONS UNDER THE LONG-TERM INSURANCE ACT, 1998

Government Notice R1492 in Government Gazette 19495, dated 27 November 1998. Commencement date: 1 January 1999.

As amended by:

Government Notice R197 in Government Gazette 20934, dated 1 March 2000. Commencement date: 1 March 2000.

Government Notice R164 in Government Gazette 23105, dated 15 February 2002. Commencement date: 15 February 2002.

Government Notice R1208 and 1209 in Government Gazette 25370, dated 29 August 2003. Commencement date: 1 September 2003.

Government Notice R1218 in Government Gazette 29446, dated 1 December 2006. Commencement date: 1 December 2006.

Government Notice R186 in Government Gazette 29681, dated 1 March 2007. Commencement date: 1 March 2007.

Government Notice R952 in Government Gazette 31395, dated 5 September 2008. Commencement date: 1 January 2009.

Government Notice R1077 in Government Gazette 34877, dated 23 December 2011. Commencement date: 23 December 2011, unless otherwise indicated.

Government Notice R170 in Government Gazette 38507 dated 25 February 2015. Commencement date: 1 March 2015.

Government Notice 1582 in Government Gazette 40515 dated 23 December 2016. Commencement date: 1 April 2017.

Government Notice 1437 in Government Gazette 41334 dated 15 December 2017. Commencement date: 1 January 2018 – unless otherwise indicated

Government Notice 1437 in Government Gazette 41334 dated 15 December 2017. Commencement date of regulation 4(t): 1 July 2018

Government Notice 1015 in Government Gazette 41942 dated 28 September 2018. Commencement date: 28 September 2018 – unless otherwise indicated (Refer to GenN 652 dated 26 October 2018 for clarification of commencement dates)

Government Notice 1015 in Government Gazette 41942 dated 28 September 2018. Commencement of further regulations under 9.4: 1 January 2019 (Refer to regulation 9.4 and 9.5 as published in GN 1015, as well as GenN 652 dated 26 October 2018 for clarification of commencement dates)

Government Notice 1437 in Government Gazette 41334 dated 15 December 2017. Commencement date of regulation 7(w): 1 January 2020.

Publisher's Note:
The Regulations have been amended by GN 1015 of 2018 by the substitution of all references in the Regulations to "Registrar" with "Authority".

The Minister of Finance has under section 72 of the Long-term Insurance Act, 1998, made the regulations set out in the Schedule.

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1.1 Definitions

In these regulations "the Act" means the Long-term Insurance Act, 1998, and any word or expression to which a meaning has been assigned in the Act shall have the meaning so assigned to it, and unless a different meaning is assigned elsewhere in these regulations—

(Preamble substituted by regulation 2(a) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**Companies Act**" means the Companies Act, 2008 (Act No. 71 of 2008);

(Definition of "Companies Act" inserted by regulation 2(b) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"disability event" in respect of a -

(a) registered insurer, has the meaning assigned in section 1 of the Act; and

(b) licensed insurer, has the meaning assigned in section 1 of the Insurance Act;

(Definition of "disability event" inserted by regulation 3(a) of GN 1015 of 2018)

"**effective date**" .....

(Definition of "effective date" inserted by regulation 2(c) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Definition of "effective date" deleted by regulation 3(b) of GN 1015 of 2018)

"fund" in respect of a -

(a) registered insurer, has the meaning assigned to it in section 1 of the Act; and

(b) licensed insurer, has the meaning assigned to it in Schedule 2 of the Insurance Act;

(Definition of "fund" inserted by regulation 3(c) of GN 1015 of 2018)

"fund policy" in respect of a -

(a) registered insurer, has the meaning assigned to it in section 1 of the Act; and

(b) licensed insurer, means a policy underwritten under the fund risk or fund investment class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

(Definition of "fund policy" inserted by regulation 3(d) of GN 1015 of 2018)

"health event" in respect of a -

(a) registered insurer, has the meaning assigned to it in section 1 of the Act; and

(b) licensed insurer, has the meaning assigned to it in section 1 of the Insurance Act;

(Definition of "health event" inserted by regulation 3(e) of GN 1015 of 2018)

"Insurance Act" means the Insurance Act, 2017 (Act No. 18 of 2017);

(Definition of "Insurance Act" inserted by regulation 3(f) of GN 1015 of 2018)

"**insurer**" means a long-term insurer;

(Definition of "insurer" inserted by regulation 2(d) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**juristic person**" includes—

(a) a company, close corporation or co-operative incorporated or registered in terms of legislation whether in the Republic or elsewhere;

(b) an association, partnership, club or other body of persons of whatever description, corporate or unincorporated; or

(c) a trust or trust fund;

(Definition of "juristic person" inserted by regulation 2(e) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"Part" means the applicable Part of these regulations;

(Definition of "Part" amended by regulation 3(g) of GN 1015 of 2018)

"**policy**" means a long-term policy;

(Definition of "policy" inserted by regulation 2(f) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"Policyholder Protection Rules" means the Policyholder Protection Rules made under section 62 of the Act;

(Definition of "Policy Protection Rules" inserted by regulation 3(h) of GN 1015 of 2018)

"SAFEX" …….

(Definition of "SAFEX" deleted by regulation 2(g) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"Schedule" .....

(Definition of "Schedule" deleted by regulation 3(i) of GN 1015 of 2018)

"section" means the applicable section of the Act.

(Definition of "section" amended by regulation 3(j) of GN 1015 of 2018)

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(Part 2 deleted by regulation 4 of GN 1015 of 2018)

PART 3
REMUNERATION
(Section 49)

(Heading of Part 3 substituted by regulation 4(a) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

PART 3A

LIMITATION ON REMUNERATION FOR RENDERING SERVICES AS INTERMEDIARY - POLICIES OTHER THAN POLICIES TO WHICH PART 3B APPLIES

(Heading inserted by regulation 1.1 of Government Notice R952 of 2008)

(Heading of Part 3A substituted by regulation 4(b) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

3.1 Application of this Part 3A, and definitions

(Heading substituted by regulation 1.2(a) of Government Notice R952 of 2008)

This Part 3A applies to policies, components and benefit components other than those to which Part 3B applies, and unless the context indicates otherwise -

(Sentence following the heading substituted by regulation 1.2(a) of Government Notice R952 of 2008)

"administrative work" …….

(Definition of "administrative work" repealed by regulation 4(c) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017, with effect from 1 January 2019)

"annualised premium", in relation to a group scheme or fund policy, means 12/m of the total premiums payable under the group scheme or fund policy during a scheme year, excluding transfer values inwards and credits arising in the group scheme or fund policy to employers of fund members in consequence of the withdrawal of members;

"benefit component" means each separately identifiable kind of policy benefit undertaken to be provided under a particular kind of policy;

"component" means a part of a policy, if any, where that part provides a policy benefit for which an identifiable, separate premium is payable;

(Definition of "component" inserted by regulation 1.2(b) of Government Notice R952 of 2008)

"compulsory", in relation to an annuity, means that there is an obligation in terms of the rules of a fund to enter into a policy which provides the annuity;

"credit scheme" or purposes of Table 1 of Annexure 1 means a group scheme under which every life insured is indebted to or a surety of the policyholder whose insurable interest as policyholder arises solely from that indebtedness or suretyship;

(Definition of "credit scheme" substituted by regulation 5(a) of GN 1015 of 2018)

"fund member policy" in respect of a-

(a) registered insurer means an individual policy -

(i) of which a fund is the policyholder;

(ii) under which a specified member of the fund (or the surviving spouse, children, dependants or nominees of the member) is the life insured; and

(iii) which is entered into by the fund exclusively for the purpose of funding that fund's liability to the member (or the surviving spouse, children, dependants or nominees of the member) in terms of the rules of that fund;

(b) licensed insurer means a policy with an individual as defined in Schedule 2 of the Insurance Act underwritten under sub-classes (a) to (d) of the Risk class, or the Life Annuity, Individual Investment or Income Drawdown classes of life insurance business as set out in Schedule 2 of Table 1 of the Insurance Act and -

(i) of which a fund is the policyholder;

(ii) under which a specified member of the fund (or the surviving spouse, children, dependants or nominees of the member) is the life insured; and

(iii) which is entered into by the fund exclusively for the purpose of funding that fund's liability to the member (or the surviving spouse, children, dependants or nominees of the member) in terms of the rules of that fund;

(Definition of "fund member policy" substituted by regulation 5(b) of GN 1015 of 2018)

"**group of companies**" has the meaning defined in section 1 of the Companies Act;

(Definition of "group of companies" inserted by regulation 4(d) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"group scheme" in respect of a -

(a) registered insurer, means a scheme or arrangement which provides for the entering into of one or more policies, other than an individual policy, in terms of which two or more persons without an insurable interest in each other, for the purposes of the scheme, are the lives insured;

(b) a licensed insurer, means a policy with a group as defined in Schedule 2 of the Insurance Act;

(Definition of "group scheme" substituted by regulation 5(c) of GN 1015 of 2018)

"immediate annuity" means an annuity that is paid under a policy, where the first payment period begins within 12 months after the policy has been entered into;

(Definition of "immediate annuity" inserted by regulation 1.2(c) of Government Notice R952 of 2008)

"independent intermediary" means a person, other than a representative, rendering services as intermediary;

"individual policy" means -

(a) in respect of a registered insurer, a policy under which a particular person is the life insured, or two or more particular persons having an insurable interest in each other are the lives insured jointly;

(b) in respect of a licensed insurer, a policy with an individual as defined in Schedule 2 of the Insurance Act;

(Definition of "individual policy" substituted by regulation 5(d) of GN 1015 of 2018)

"investment policy" means a policy other than a policy which is an “excluded policy” as defined in Part 5A;

(Definition of “investment policy” substituted by regulation 1.2(d) of Government Notice R952 of 2008)

"m" means the number of months in a scheme year;

"multiple premium policy" means a policy under which the premium is payable in two or more amounts;

"policy" means a long-term policy other than a reinsurance policy;

"policy benefit” has the meaning assigned to it in the Act, but excludes a loan in respect of the policy, or a consideration payable upon the full or partial surrender of the policy;

(Definition of “policy benefit” inserted by regulation 1.2(e) of Government Notice R952 of 2008)

“**Policyholder Protection Rules**” .....

(Definition of “Policyholder Protection Rules” inserted by regulation 4(e) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Definition of "Policyholder Protection Rules" deleted by regulation 5(e) of GN 1015 of 2018)

"premium", in relation to a premium period, means the premium which is payable under a policy in respect of every separately identifiable benefit component of that policy;

(Definition of “premium” substituted by regulation 4(f) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"premium-paying term", in relation to a multiple premium policy, other than a group scheme or fund policy, means the whole period during which the several amounts of premium are payable, determined by reference to-

(a) the longer of-

(i) 10 years; or

(ii) the number of complete years in the period extending from the date of commencement of the first premium period of the policy to a date-

(aa) in the case of a fund member policy, 66 years; or

(bb) in any other case, 75 years, after the date of birth of the life insured under the policy; or

(b) if it is stated in or ascertainable from the written provisions of the policy at its commencement, and is a shorter period than that determined in accordance with paragraph (a), the shorter of-

(i) the particular limited period for which those several amounts of premium are expressed to be payable; or

(ii) the period during which those several amounts of premium must be paid before there shall or may-

(aa) be provided a policy benefit, otherwise than upon the death of, or upon the occurrence of a health event or a disability event in relation to a life insured under the policy; or

(bb) be paid, upon the surrender of the policy, consideration the amount of which is stated in or ascertainable from written provisions of the policy at its commencement;

"premium period", in relation to a policy other than a group scheme or a fund policy, means one of a succession of periods of time, each of 12 months' duration, the first of which commences on, and ends 12 months after, the date on which the policy is entered into or, if it is a later date, the date on which the obligation of the long-term insurer becomes operative;

"primary commission" means commission which is payable generally in respect of all policies in accordance with this Part other than secondary commission;

"rendering services as intermediary" means the performance by a person other than a long-term insurer or a policyholder, on behalf of a long-term insurer or a policyholder, of any act directed towards entering into, maintaining or servicing a policy or collecting, accounting for or paying premiums or providing administrative services in relation to a policy, and includes the performance of such an act in relation to a fund, a member of a fund and the agreement between the member and the fund;

“replacement investment event” means a causal event resulting in the levying of a causal event charge in excess of 15% of the investment value or materially equivalent value of a policy, where “causal

event", "causal event charge" and "investment value" have the meanings assigned to them in Part 5A and "materially equivalent value" means the value contemplated in sub-regulation 5.2(2)(b) of Part 5A;

(Definition of "replacement event" substituted by regulation 1.2(f) of Government Notice R952 of 2008)

(Definition of "replacement event" substituted for the definition of "replacement investment event" by regulation 4(g) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"replacement investment policy" means a multiple premium policy which is an investment policy, where the policyholder is or was either the policyholder or the life insured in respect of any other investment policy, and where a replacement event occurs in respect of that other investment policy within a period of 4 months before or after the replacement investment policy is entered into;

(Definition of "replacement policy" substituted for the definition of "replacement investment policy" by regulation 4(h) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**replacement risk policy**" means an individual risk policy as defined in the Policyholder Protection Rules that is entered into as a result of a replacement as contemplated in the Policyholder Protection Rules;

(Definition of "replacement risk policy" inserted by regulation 4(i) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"representative" means a person employed or mandated by a long-term insurer for the purpose of rendering services as intermediary only in relation to policies –

(a) entered into or to be entered into by that insurer;

(b) entered into or to be entered into by another insurer which is also part of the same group of companies that the insurer is part of;

(c) entered into or to be entered into on or after 1 January 2018 by another insurer which has a written agreement with that insurer in terms of which the person employed or mandated by that insurer may render services as intermediary in relation to –

(i) a class of policies of that other insurer which none of the insurers referred to in paragraphs (a) and (b) are registered to underwrite; or

(ii) a class or types of policies of that other insurer which the Authority has determined by notice on the official web site; or

(d) entered into prior to 1 January 2018 by another insurer which concluded a written agreement with that insurer prior to 1 January 2017 in terms of which the person employed or mandated by that insurer may render services as intermediary in relation to that other insurer's policies;

(Definition of "representative" substituted by regulation 4(j) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Definition of "representative" substituted by regulation 5(f) of GN 1015 of 2018)

“retirement annuity fund” means a retirement annuity fund as defined in the Income Tax Act, 1962;
(Definition of “retirement annuity fund” inserted by regulation 1.2(g) of Government Notice R952 of 2008)

"Scale A" means the scale of commission set out in Annexure 2 to this Part;

"secondary commission" means commission which is payable, in addition to primary commission, in respect of certain policies only, as provided in and subject to this Part;

"scheme year", in relation to a group scheme or a fund policy, means a period-

(a) commencing on the later of -

(i) the date that the fund policy or group scheme is entered into with the long-term insurer concerned, or any anniversary of that date; or

(ii) the date of the appointment of an independent intermediary for the purposes of rendering services as intermediary in relation to the group scheme or fund policy;

(b) and ending on the earlier of-

(i) the day preceding the commencement of the next scheme year;

(ii) the date of termination of the group scheme or fund policy with that long-term insurer; or

(iii) the date of termination of the appointment of the independent intermediary rendering services as intermediary in relation to that group scheme or fund policy;

"single premium policy" means a policy under which the premium is payable in one amount only;

"Table 1" means Table 1 of Annexure 1 to this Part that applies to registered insurers only;
(Definition of "Table 1" substituted for "Table" by regulation 5(g) of GN 1015 of 2018)

"Table 2" means Table 2 of Annexure 1 to this Part that applies to licensed insurers only;
(Definition of "Table 2" inserted by regulation 5(h) of GN 1015 of 2018)

"term cover" means a policy under which a long-term insurer undertakes to provide policy benefits only upon-

(a) the life of a life insured having ended;

(b) the life of a life insured having begun;

(c) a health event occurring; or

(d) a disability event occurring,

during a specified period only;

"this Part" means this Part 3A;

(Definition of "this Part" inserted by regulation 1.2(h) of Government Notice R952 of 2008)

"tied", in relation to a compulsory annuity, means that there is an obligation to enter into the policy concerned with a particular insurer and no other.

(Regulation 3.1 of Part 3 substituted by regulation GN 186 of 2007)

3.2 General limitations

(1) No consideration shall, directly or indirectly, be provided to, or accepted by or on behalf of, an independent intermediary for rendering services as intermediary, otherwise than by way of the payment of commission in monetary form.

(2) Subject to sub-regulation 3.4(1A), no commission shall be paid or accepted otherwise than in accordance with this Part generally, and specifically as specified in the Table.

(Regulation 3.2(2) substituted by regulation 1(a) of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

(3) Irrespective of how many persons render services as intermediary in relation to a policy, the total commission payable in respect of that policy shall not exceed the maximum commission payable in terms of regulation 3.4.

(4) No secondary commission shall be paid or accepted-

(a) in respect of a single premium policy;

(b) except in the case of a policy and benefit component of a kind specified in items 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of Table 1 or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa), 6(a)(i), 7, 8(a) and 8(b)(i)(aa) of Table 2;

(Regulation 3.2(4)(b) substituted by regulation 4(k) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Regulation 3.2(4)(b) substituted by regulation 5(i) of GN 1015 of 2018)

(c) if the policy concerned has terminated before the commencement of its second premium period.

(4A) No remuneration or consideration shall, directly or indirectly, be provided to, or accepted by or on behalf of, a representative for rendering services as intermediary, otherwise than in accordance with the principle of "Equivalence of Reward", in terms whereof the remuneration paid, whether in cash or in kind, must substantially be in accordance with this Part.

(Regulation 3.2(4A) inserted by regulation 4(l) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(5) The Authority may for purposes of subregulation (4A) by notice on the official web site determine that particular forms of remuneration or consideration, whether in cash or in kind, comply or do not comply with the principle of "Equivalence of Reward".

(Regulation 3.2 of Part 3 substituted by regulation GN 186 of 2007)

(Regulation 3.2(5) substituted by regulation 4(m) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

3.3 Time of payment of commission

(1) Primary commission shall not be paid or accepted before-

(a) the first premium period has commenced; or

(b) the premium in respect of which it is payable has been received by the long-term insurer concerned, except that, in the discretion of that insurer-

(i) in the case of a policy and benefit component of a kind specified in items 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of Table 1 or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa), 6(a)(i), 7, 8(a) and 8(b)(i)(aa) of Table 2, primary commission may be paid and accepted in one or more amounts after the policy has been entered into;

(Regulation 3.3(1)(b)(i) substituted by regulation 4(n) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Regulation 3.3(1)(b)(i) substituted by regulation 5(j) of GN 1015 of 2018)

(ii) in the case of a group scheme or fund policy, primary commission in respect of a particular scheme year may be paid and accepted in one or more amounts after the policy has been entered into; and

(iii) in any other case, primary commission in respect of a particular premium period may be paid in one or more payments and accepted after the commencement of that premium period.

(2) Secondary commission may be paid and accepted in one or more amounts after the second premium period has commenced, at the discretion of the long-term insurer.

(3) If the full amount of primary or secondary commission is paid in more than one amount aggregating to that full amount, the long-term insurer concerned may pay interest at 15 per cent per annum, or such other rate of interest as may be prescribed by the Authority from time to time, compounded annually from the earliest date on which the full amount could have been paid, on any outstanding amount, until the full amount has been paid.

(Regulation 3.3 of Part 3 substituted by regulation GN 186 of 2007)

3.4 Maximum commission payable

(1) No primary commission shall exceed, in respect of each kind of policy and benefit component specified in column 2 of Table 1 or Table 2, an amount arrived at by applying, in the case of-

(a) a single premium policy, other than a fund policy and a group scheme, the percentage specified in column 3 of Table 1 or Table 2 to the amount of the premium concerned;

(b) a multiple premium policy, other than a fund policy and a group scheme, the percentage specified in column 4 of Table 1 or Table 2 to the total amount of the premium payable during the premium-paying term, calculated as if the premium payable during the first premium period were payable at that level throughout the premium-paying term of the policy, which commission may be paid and accepted in one or more amounts at the discretion of the long-term insurer: Provided that such commission shall not exceed, in the case of a policy and benefit component specified in item 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of Table 1 or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa), 6(a)(i), 7, 8(a) and 8(b)(i)(aa) of Table 2, an amount equal to the percentage specified in column 5 of Table 1 or Table 2 of the premium payable during the first premium period of the policy; or

(c) a fund policy or a group scheme, an amount which shall not exceed 12/m of the aggregate commission on the annualised premium as provided for in Scale A.

(1A) Despite anything in this Part, no commission shall exceed, in respect of a contract identified in category 1 and 3 in the table under regulation 7.2(1) of the Regulations, the maximum commission specified in column two of the Scale below:

SCALE

Individual and group policy	
Column 1	**Column 2**
Monthly premium band	**Maximum Commission Level**
Above R1,200	5%
R601 to R1,200	10%
R300 to R600	15%

Individual and group policy	
Column 1	**Column 2**
Monthly premium band	**Maximum Commission Level**
Less than R300	20%

(2) No secondary commission shall exceed one -third of the amount of the primary commission paid in respect of the policy and benefit component concerned: Provided that if such commission is paid and accepted in more than one amount, the value thereof discounted at 15 per cent per annum, or such other rate of interest as may be prescribed by the Authority from time to time, compounded annually to the beginning of the second premium period of the policy, shall not exceed one third of the value of the primary commission excluding interest.

(Regulation 3.4 of Part 3 substituted by regulation GN 186 of 2007)

(Regulation 3.4 amended by regulation 1(b) of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

(Regulation 3.4 amended by regulation 4(o) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Regulation 3.4 substituted by regulation 5(k) of GN 1015 of 2018)

3.5 Adjustment and refund of commission

(1) If the provisions of a multiple premium policy are varied so that the total amount of the premium which was payable during the premium-paying term of the policy and which was used for the purpose of the calculation of commission in terms of regulation 3.4(1), is, for any reason-

(Words preceding regulation 3.5(1)(a) substituted by regulation 4(p) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(a) increased, the primary and secondary commission payable in relation to that increase shall be dealt with in terms of this Part as if-

(i) the total amount of the increase payable during the remainder of the premium-paying term were the only premium payable under the policy; and

(ii) the premium period in which that variation becomes operative were the first premium period of the policy; or

(b) reduced, with effect from a date before the end of the second premium period of the policy-

(i) the primary commission previously calculated in terms of regulation 3.4(1)(b) to be payable shall be recalculated in accordance with this Part in relation to the total amount of premium as so reduced and any amount of commission which has been paid, or would have been payable had the reduction not occurred, and which exceeds the amount payable in accordance with the recalculation, shall be determined by the insurer concerned; such part

of that amount as exceeds the percentage in column A of the Table in subregulation (2) shall be reversed and, if already paid, shall be refunded to the insurer by the person to whom it was paid;

(ii) the secondary commission previously calculated in terms of regulation 3.4(2) to be payable, shall be recalculated in accordance with this Part in relation to the total amount of primary commission as reduced in accordance with subparagraph (i) and any amount of commission which has been paid, or would have been payable had the reduction not occurred, and which exceeds the amount payable in accordance with the recalculation shall be determined by the insurer concerned; such part of that amount as exceeds the percentage in column B of the Table in subregulation (2) shall be reversed and, if already paid, shall be refunded to the insurer by the person to whom it was paid.

(2)

(a) If a premium or any part thereof is-

(i) for any reason refunded by the long-term insurer or, in the case of a multiple premium policy which is not-

(aa) a fund policy; or

(bb) a fund member policy other than a fund member policy which funds a retirement annuity fund, or

(cc) a policy in respect of which commission has been paid only after each premium in respect of which it is payable has been received by the long-term insurer concerned (including but not limited to a replacement investment policy),

(Regulation 3.5(2)(a)(i)(cc) substituted by regulation 4(q) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

for any reason not paid on its due date, including that the policy has been made paid-up or surrendered, but excluding termination upon a health event, a disability event or the death of a life insured, during the first two premium periods in the case of a policy referred to in items 1.1, 2.1.1, 2.2.1, 3.2.1 and 5.1.1 of Table 1 or items 1(a), 4(a)(i), 4(b)(i), 5(a)(i)(aa), 5(a)(ii)(aa), 5(c)(ii)(aa), 6(a)(i), 7, 8(a) and 8(b)(i)(aa) of Table 2 the commission payable in terms of this Part shall be recalculated by reference to the scale and shall not exceed the percentage of maximum commission in column A or B, respectively, and any amount of commission which has already been paid in excess of the commission as so recalculated, shall be reversed by the long-term insurer and refunded to it by the person to whom it was paid:

(Words following regulation 3.5(2)(a)(i)(cc) substituted by regulation 4(r) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Words following regulation 3.5(2)(a)(i)(cc) substituted by regulation 5(l) of GN 1015 of 2018)

Premiums received with an equivalent value to monthly premiums for-	Column A Maximum percentage of primary commission payable	Column B Maximum percentage of secondary commission payable
0-6 months	nil	not applicable
7 months	29,17	not applicable
8 months	33,33	not applicable
9 months	37,5	not applicable
10 months	41,67	not applicable
11 months	45,83	not applicable
12 months	50	not applicable
13 months	54,17	8,3
14 months	58,33	16,7
15 months	62,5	25
16 months	66,67	33,3
17 months	70,83	41,7
18 months	75	50
19 months	79,17	58,3
20 months	83,33	66,7
21 months	87,5	75
22 months	91,67	83,3
23 months	95,83	91,7
24 months	100	100

(ii) in the case of any policy not mentioned in subparagraph (i), for any reason refunded by the long-term insurer, or for any reason not paid on its due date, any commission paid by the long-term insurer shall be reversed and refunded to it by the person to whom it was paid;

(b) Subparagraphs (i) and (ii) of paragraph (a) shall-

(i) not apply to the extent that, and for so long as, payment of an unpaid premium is effected by means of the maintenance of the policy in force as contemplated in Rules 15A.2 and 15A.3 of the Policyholder Protection Rules;

(Regulation 3.5(2)(b)(i) of Part 3A substituted by regulation 5(m) of GN 1015 of 2018)

(ii) be deemed not to have been applicable if and to the extent that, any premium or part thereof which was unpaid is later paid to the long-term insurer, and in that event any reversed commission refunded to the long-term insurer may again be paid to the person by whom it was refunded.

(Regulation 3.5 of Part 3 substituted by regulation GN 186 of 2007)

3.6 Special provisions concerning fund and fund member policies

(1) No commission shall be paid or accepted in relation to so much of the premium payable under a fund policy as has already borne commission under a prior, substituted fund policy.

(2) The commission payable in respect of a fund policy or a fund member policy, as provided for in this Part shall be reduced by the value of any consideration provided by the fund concerned, or its members, for services rendered as intermediary in connection with the agreement whereby the fund assumed the obligation concerned to the member.

(Regulation 3.6 of Part 3 substituted by regulation GN 186 of 2007)

3.7 Commission when policy has different benefit components

(1) If, in respect of a policy which comprises more than one benefit component, it is not specified in or ascertainable from the written provisions of the policy what portion of the total premium payable is attributable to the different benefit components, the commission payable in terms of this Part shall not exceed that which would have been payable had the policy comprised, and had the total premium been attributable to, only that benefit component which most closely reflects the main purpose of the policy to the exclusion of other subordinate purposes of the policy.

(2) Despite sub-regulation (1), if, in respect of a policy which comprises more than one benefit component and one of the benefit components is a contract referred to in category 1 or 3 in the table under regulation 7.2(1) of the Regulations, it is not specified in or ascertainable from the written provisions of the policy what portion of the total premium payable is attributable to the different benefit components, the commission payable in respect of that policy shall not exceed the maximum commission allowable under the Scale in Regulation 3.4(1A).

(Regulation 3.7 of Part 3 substituted by regulation GN 186 of 2007)
(Regulation 3.7(2) of Part 3A substituted by regulation 5(n) of GN 1015 of 2018)
(Regulation 3.7 substituted by regulation 1(d) of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

3.8 Voidness of certain agreements

Any agreement, scheme or arrangement to provide consideration for the rendering of services as intermediary otherwise than in accordance with this Part shall be void.

(Regulation 3.8 of Part 3 substituted by regulation GN 186 of 2007)

3.9 Special provisions concerning replacement investment policies

(1) Commission may only be paid in respect of a replacement investment policy as a level percentage of the premiums received, and may only be paid once the premium in respect of which it is payable has been received by the long-term insurer concerned, whether or not -

(a) the replacement investment policy comprises more than one benefit component; or

(b) the portion of the total premium attributable to the different benefit components of the replacement investment policy is specified in or ascertainable from the written provisions of the policy.

(2)

(a) The total amount of commission paid on a replacement investment policy may not exceed the total of the primary and secondary commission that would have been payable in terms of this Part in respect of a policy other than a replacement investment policy; and

(b) in determining such total amount, the long-term insurer concerned may include interest at 15 per cent per annum, or such other rate of interest as may be prescribed by the Authority from time to time, compounded annually from the earliest date on which the full amount of primary or secondary commission could have been paid if the policy was not a replacement investment policy, until such full amount has been paid.

(3) In the event of commission on a replacement investment policy being paid or accepted otherwise than in accordance with subregulation (1) or (2), whether due to the fact that the long-term insurer was not aware at the time of payment that the policy in question was a replacement investment policy, or for any other reason, then any commission paid by the long-term insurer in excess of the commission payable in accordance with subregulation (2), or paid earlier than permitted in subregulation (1), shall upon identification of the excess or early payment, be reversed and refunded to the long-term insurer by the person to whom it was paid.

(Regulation 3.9 substituted by regulation 4(s) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Regulation 3.9 of Part 3 substituted by regulation GN 186 of 2007)

3.9A Special provisions concerning replacement risk policies

(1) Notwithstanding regulation 3.4, a long-term insurer must either –

(a) not pay any commission to any person in respect of a replacement risk policy unless and until the confirmation referred to in Rule 19 of the Policyholder Protection Rules, where required, has been provided; or

(b) where the long-term insurer does pay commission to a person in respect of a replacement risk policy, reverse such payment and ensure that the payment is refunded to the long-term insurer if

the confirmation referred to in Rule 19 of the Policyholder Protection Rules, where required, is not provided within the time specified in that Rule.

(2) In the event of commission on a replacement risk policy being paid or accepted otherwise than in accordance with subregulation (1), whether due to the fact that the long-term insurer was not aware at the time of payment that the policy in question was a replacement risk policy, or for any other reason, then any commission paid by the long-term insurer shall upon identification be reversed and refunded to the long-term insurer by the person to whom it was paid.

(Regulation 3.9A inserted by regulation 4(t) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017 with effect from 1 July 2018)

ANNEXURE 1

TABLE 1 – Registered insurers

(Heading of Table substituted by regulation 5(o)(i) of GN 1015 of 2018)

Item	*Kind of policy or benefit component*	*Maximum percentage*			*Notes*	
		Single premium policy	*Multiple premium policy*		*Up-front payment reg 3.3(1)(b)(i) applicable*	*Secondary commission: reg 3.2(4)(b) applicable*
			Basic percentage	*Limit per proviso to reg 3.4(1)(b)*		
	Column 2	*Column 3* %	*Column 4* %	*Column 5* %	*Column 6*	*Column 7*
1	**Individual policy, not elsewhere specified**					
1.1	not immediate annuity	3.0	3.25	85.0	yes*	yes*
1.2	immediate annuity					
1.2.1	not compulsory	1.5	not applicable	not applicable	no	no
1.2.2	compulsory, not tied	1.5	not applicable	not applicable	no	no
1.2.3	compulsory, tied	nil	not applicable	not applicable	no	no
2	**Fund member policy**					
2.1	funding a retirement annuity fund					
2.1.1	upon entry, not a transfer	2.5	3.0	75.0	yes*	yes*
2.1.2	upon entry, a transfer from a fund other than a retirement annuity fund to					
2.1.2.1	a fund chosen by the member	1.5	not applicable	not applicable	no	no

Item	*Kind of policy or benefit component*	*Maximum percentage*			*Notes*	
2.1.2.2	a fund not chosen by the member	nil	not applicable	not applicable	no	no
2.1.3	upon entry, a transfer from another retirement annuity fund	nil	not applicable	not applicable	no	no
2.2	not funding a retirement annuity fund					
2.2.1	upon entry, not a transfer	2.5	3.0	75.0	yes*	yes*
2.2.2	upon entry, a transfer from another fund	1.5	not applicable	not applicable	no	no
3	**Life policy**					
3.1	Other than term cover only					
3.1.1	incorporated in a group scheme					
3.1.1.1	which is a credit scheme	7.5	7.5	not applicable	no	no
3.1.1.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	no
3.2	Term cover only					
3.2.1	individual	7.5	3.25	85.0	yes	yes
3.2.2	incorporated in a group scheme					
3.2.2.1	which is a credit scheme	7.5	7.5	not applicable	no	no
3.2.2.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	no
4	**Fund policy**	Scale A	Scale A	not applicable	no	no
5	**Health policy and disability policy**					
5.1	other than term cover only					
5.1.1	individual	3.0	3.25	85.0	yes	yes

Item	*Kind of policy or benefit component*	*Maximum percentage*			*Notes*	
5.1.2	Incorporated in a group scheme					
5.1.2.1	which is a credit scheme	7.5	7.5	not applicable	no	no
5.1.2.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	no
5.2	term cover only					
5.2.1	individual	7.5	3.25	nil	no	no
5.2.2	incorporated in a group scheme					
5.2.2.1	which is a credit scheme	7.5	7.5	not applicable	no	no
5.2.2.2	which is not a credit scheme	Scale A	Scale A	not applicable	no	no
6	**Sinking fund policy**	3.0	3.0	nil	no	no
7	**Assistance policy**	-	-	-	no	no

Notes to Annexure 1:

- An asterisk (*) denotes “excluding a replacement investment policy”
- A dash (-) denotes that there is no limit.
- "nil" denotes that no commission may be paid.
- A policy, other than one that provides an immediate annuity, that is a fund member policy or a fund policy falls under item 2 or 4, as the case may be, irrespective whether it can fall also under another item. A policy that provides an immediate annuity that is a fund member policy or a fund policy attracts the commission referred to in item 1.2.
- Item 2.1.2.1 applies with effect from 1 March 2007.
- A health policy under item 5 refers to a health policy other than a contract identified as a health policy in category 1 and 3 in the table under regulation 7.2(1) of the Regulations.

(Last note to “Notes to Annexure 1” inserted by regulation 1(c) of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

(Table 1 substituted by regulation 4(u) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

Table 2 - Licensed insurers

In this Table -

"Credit Life" means a life insurance policy written under the Credit Life class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"credit provider policy" means a policy referred to in paragraph (a)(i) of the definition of "individual" as defined in Schedule 2 of the Insurance Act;

"death event" has the meaning assigned to such term in section 1 of the Insurance Act;

"employer policy" means a policy referred to in paragraph (a)(ii) of the definition of "individual" as defined in Schedule 2 of the Insurance Act;

"Fund" in item 3 means a fund policy;

"Fund Member" in item 4 means a fund member policy;

"Funeral" means a life insurance policy written under the Funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"Group Death" means a policy written under sub-class "e" of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"Group Disability" means a policy written under sub-class "g" or "h" of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"Group Health" means a policy written under sub-class "f" of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"Individual Death" means a policy written under sub-class "a" of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"Individual Disability" means a policy written under sub-class "c" or "d" of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"Individual Health" means a policy written under sub-class "b" of the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"Individual Investment" means a life insurance policy, excluding a fund member policy, written under the Individual Investment class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

"life event" has the meaning assigned to such term in section 1 of the Insurance Act;

"Microinsurance" means a life insurance policy written by a microinsurer as defined in section 1 of the Insurance Act; and

"Risk" means a life insurance policy written under the Risk class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act;

Item	*Class of insurance business*				*Maximum percentage*			*Notes*	
					Single premium policy	*Multiple premium policy*			
						Basic percentage	*Limit per proviso to reg 3.4(1)(b)*	*Up–front payment reg 3.3(1)(b)(i) applicable*	*Secondary commission reg 3.2(4)(b) applicable*
Item	**Column 2**				**Column 3**	**Column 4**	**Column 5**	**Column 6**	**Column 7**
					%	%	%		
1.	**Policy not elsewhere specified**	(a) not immediate annuity			3.0	3.25	85.0	yes*	yes*
		(b) immediate annuity	(i) not compulsory		1.5	not applicable	not applicable	no	No
			(ii) compulsory, not tied		1.5	not applicable	not applicable	no	No
			(iii) compulsory, tied		Nil	not applicable	not applicable	no	No
2.	**Individual Investment** unrelated to a life event which undertakes to provide one or more sums of money, on a fixed or determinable future date, as policy benefits				3.0	3.0	nil	no	No
3.	**Fund**				Scale A	Scale A	not applicable	no	no
4.	**Fund Member**	(a) funding a retirement annuity fund	(i) upon entry, not a transfer		2.5	3.0	75.0	yes*	yes*
			(ii) upon entry, a transfer from a fund other than a retirement annuity fund to	(aa) a fund chosen by the member	1.5	not applicable	not applicable	no	no
				(bb) a fund not chosen by the member	nil	not applicable	not applicable	no	no
			(iii) upon entry, a transfer from another retirement annuity fund		nil	not applicable	not applicable	no	no

		(b) not funding a retirement annuity fund	(i) upon entry, not a transfer		2.5	3.0	75.0	yes*	yes*
			(ii) upon entry, a transfer from another fund		1.5	not applicable	not applicable	no	no
5.	**Risk**	(a) Individual Death	(i) Term cover only	(aa) Other than an employer policy	7.5	3.25	85.0	yes	yes
				(bb) Employer policy	Scale A	Scale A	n/a	no	no
			(ii) Other than term cover only	(aa) Other than an employer policy	3.0	3.25	85.0	yes*	yes*
				(bb) Employer policy	Scale A	Scale A	n/a	no	no
		(b) Group Death			Scale A	Scale A	n/a	no	no
		(c) Individual Disability and Individual Health	(i) Term cover only	(aa) Other than employer policy	7.5	3.25	nil	no	no
				(bb) Employer policy	Scale A	Scale A	n/a	no	no
			(ii) Other than term cover only	(aa) Other than employer policy	3.0	3.25	85.0	yes	yes
				(bb) Employer policy	Scale A	Scale A	n/a	no	no
		(d) Group Disability and Group Health			Scale A	Scale A	n/a	no	no
6.	**Credit Life**	(a) Other than credit provider policy	(i) Death event		7.5	3.25	85.0	yes	yes
			(ii) Disability event, Health event or event of unemployment, or other insurable risk that is likely to impair a person's ability to earn an income or meet credit obligations		7.5	3.25	nil	no	no
		(b) Credit provider policy			7.5	7.5	n/a	no	no
7.	**Funeral**				-	-	-	yes	yes
8.	**Microinsurance**	(a) Risk and Funeral			-	-	-	yes	yes
		(b) Credit Life	(i) Other than credit provider policy	(aa) Death event	7.5	3.25	85.0	yes	yes
				(bb) Disability event, Health event or event of unemployment, or other insurable risk that is likely to impair a person's ability to earn an income or meet credit obligations	7.5	3.25	nil	no	no

			(ii) Credit provider policy	7.5	7.5	n/a	no	no

Notes to Table 2 of Annexure 1:

- An asterisk (*) denotes *"excluding a replacement policy"*.
- A dash (-) denotes that there is no limit.
- "nil" denotes that no commission may be paid.
- A policy, other than one that provides an immediate annuity, that is a fund policy or a fund member policy falls under item 3 or 4, as the case may be irrespective whether it can fall also under another item. A policy that provides an immediate annuity that is a fund policy or a fund member policy attracts the commission referred to in item 1(b).

(Table 2 added by regulation 5(o)(ii) of GN 1015 of 2018)

(Annexure 1 substituted by regulation 1.3 of Government Notice R952 of 2008)

ANNEXURE 2

SCALE A

1. Normal commission

MAXIMUM COMMISSION AS PERCENTAGE OF ANNUALISED PREMIUM UNDER A GROUP SCHEME OR FUND POLICY	ANNUALISED PREMIUM OF WHICH THE AMOUNT-	
	EXCEEDS	DOES NOT EXCEED
%	R	R
7,5%		200 000
5,0%	200 000	300 000
3,0%	300 000	600 000
2,0%	600 000	2 000 000
1,0%	2 000 000	UNLIMITED

(Paragraph 1 of Annexure 2 (Scale A) substituted by regulation 4(v) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

2. Special commission

In addition to the normal commission contemplated in paragraph 1, there may be paid, once only and only in respect of the period of 12 months following the date on which the group scheme or fund policy is established, a special commission equal to the lesser of-

(a) 7,5 per cent of the total premium payable during that period of 12 months; or

(b) R7 500.

(Paragraph 2(b) of Annexure 2 (Scale A) substituted by regulation 4(w) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Part 3 amended by Government Notice R197 of 2000)
(Part 3 amended by regulation 2(a) of Government Notice R164 of 2002)
(Part 3 amended by Government Notice R1208 and 1209 of 2003)
(Part 3 substituted by regulation 1 of Government Notice R186 of 2007)
(Part 3 effectively renumbered to Part 3A by Government Notice R952 of 2008)

PART 3B

LIMITATION ON REMUNERATION FOR RENDERING SERVICES AS INTERMEDIARY - INVESTMENT POLICIES THAT STARTED ON OR AFTER 1 JANUARY 2009

(Heading of Part 3B substituted by regulation 4(x) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

3.10 Application of this Part 3B, and definitions

(1) This Part 3B applies to –

(a) investment policies that started on or after 1 January 2009, but except only for purposes of regulation 3.15(4), does not apply to risk components of such investment policies; and

(b) any variable premium increase (as defined in Part 5A) in respect of a policy to which Part 5A applies.

(Regulation 3.10(1) substituted by regulation 4(y) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(2) In this Part 3B, unless defined differently in this Part 3B or unless the context indicates otherwise, any word or expression to which a meaning has been assigned in Part 3A or 5B has the meaning assigned to it in that Part, and –

"discount term", in relation to a multiple premium policy, means the period that begins on the premium commencement date and:

(a) in the case of a fund member policy, is a period of 25 years or, if it is shorter, the period for which the premium is to be paid specified in the policy, or determinable from its written provisions, as at the start of the policy; or

(b) in the case of a policy other than a fund member policy, is a period of 15 years or, if it is shorter, the period for which the premium is to be paid specified in the policy, or determinable from its written provisions, as at the start of the policy;

"fund member policy" has the meaning assigned to it in Part 5A;

"insurer" means a long-term insurer;

"investment policy" has the meaning assigned to it in Part 5B;

"member" has the meaning assigned to it in Part 5A;

"payment date", in relation to a premium, means the date on which that premium must be paid in terms of the policy;

"preservation fund" means a pension preservation fund or a provident preservation fund, which terms have the meanings assigned to it in section 1 of the Income Tax Act, 1962 (Act No. 58 of 1962);

"risk component" means a component that on its own constitutes an excluded policy;

"Table" means the table accompanying this Part; and

"this Part" means this Part 3B.

3.11 General prescriptions

(1) Remuneration for rendering services as intermediary may be paid by or on behalf of an insurer, and received by an independent intermediary -

(a) only in accordance with this Part;

(b) only after the policy has started; and

(c) only as commission in monetary form.

(2)

(a) No remuneration or consideration shall, directly or indirectly, be provided to, or accepted by or on behalf of, a representative for rendering services as intermediary, otherwise than in accordance with the principle of "Equivalence of Reward", in terms whereof the remuneration paid, whether in cash or in kind, must substantially be in accordance with this Part.

(b) The Authority may for purposes of paragraph (a) by notice on the official web site determine that particular forms of remuneration or consideration, whether in cash or in kind, comply or do not comply with the principle of "Equivalence of Reward.

(Regulation 3.11(2) substituted by regulation 4(z) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(3) The total commission per policy may not exceed the maximum prescribed by this Part, irrespective whether more than one independent intermediary or representative renders services in respect of that policy.

(4) If a policy has two or more components, each component must for the purposes of this Part, and where applicable, for the purposes of Part 3A, be dealt with as if it were a separate policy.

(5) If a policy (that does not have two or more components) or a component provides more than one type of policy benefit, and one or more of these benefits is a benefit other than a risk benefit, the maximum commission in respect of that policy or component must be determined in accordance with this Part.

(6) Any agreement, scheme or arrangement to offer, provide, accept, pay, or receive remuneration, otherwise than in accordance with this Part, is void.

3.12 Maximum commission

(1) The maximum commission that may be paid in respect of a multiple premium policy, is an amount equal to 5% of each premium.

(2)

(a) Subject to paragraph (b), the maximum commission that may be paid in respect of a single premium policy is an amount equal to 3% of the premium.

(b) The maximum commission that may be paid in respect of a single premium policy -

(i) of which the policy benefit is an immediate annuity, is an amount equal to 1.5% of the premium;

(ii) that is a fund member policy which funds a retirement annuity fund, upon a transfer from a fund other than a retirement annuity fund, is an amount equal to 1.5% of the premium;

(iii) that is a fund member policy which funds a retirement annuity fund, upon a transfer from a retirement annuity fund, is nil;

(iv) that is a fund member policy which funds a preservation fund, upon a transfer from a fund other than a preservation fund, is an amount equal to 1.5% of the premium;

(v) that is a fund member policy which funds a preservation fund, upon a transfer from a preservation fund, is nil;

(vi) that is a fund member policy, which does not fund a retirement annuity fund or a preservation fund, upon a transfer from another fund, is an amount equal to 1.5% of the premium.

3.13 Time of payment of commission

(1) Commission in respect of a premium may be paid only on or after the payment date of that premium.

(2) Despite subregulation (1), an insurer, at its discretion, may discount commission in respect of a multiple premium policy in terms of regulation 3.15, and pay the discounted commission at any time after the policy has started.

(3)

(a) An insurer, at its discretion, may pay commission in two or more instalments, provided that the sum of the instalments, before any increase in terms of paragraph (b), does not exceed the maximum commission referred to in regulation 3.12.

(b) Where commission is paid in two or more instalments, the insurer, at its discretion, may increase any instalment at an annual effective rate of not more than 6% from the date the commission becomes payable to the date on which that instalment is paid.

3.14 Premium increases and additional premiums

If the premium is increased in accordance with the terms of the policy as at the start of the policy or as amended from time to time, or if an additional premium is paid, the discounted and undiscounted commission in respect of the increased portion of the premium or in respect of the additional premium must, except for the purpose of subregulation 3.15(4), be dealt with as if -

(a) the increased portion of the premium, or the additional premium, were a premium payable or paid under a separate policy; and

(b) that separate policy starts on the first or only payment date of the increased portion of the premium or the additional premium.

3.15 Discounting of commission

(1) In the case of a multiple premium policy the insurer, at its discretion, may discount a portion of the commission in respect of every premium of which the payment date falls within the discount term: Provided that an insurer, at its discretion, may discount a portion of the commission in respect of every premium of which the payment date falls within a shorter period than the discount term, in which case that shorter period will be regarded as the discount term for purposes of that policy.

(2) The maximum portion of the commission that may be discounted in respect of each premium is an amount equal to 2,5% of that premium, and the portion of commission that is discounted must be the same proportion of every premium.

(3) The discounting must be done -

(a) once only and only at the start of the policy, and this may be done also at the payment of an additional premium and at the start of payment of an increased premium, as contemplated in regulation 3.14;

(b) from the payment date of each premium to the premium commencement date, at an annual effective rate of not less than 6%.

(4) Despite subregulation (2), but subject to regulation 3.12(1), if the commission discounted for the policy, or where the policy at its start has two or more components the aggregate commission discounted for all the components (including risk components), comes to less than four hundred Rand, the insurer, at its discretion, may discount a larger portion of the commission in respect of all the premiums, at a level higher than 2,5% of each premium, to allow for a discounted commission for the policy, or an aggregate discounted commission for all the components of the policy (including risk components), of not more than four hundred Rand.

(5) The discounting in terms of subregulation (4) may be done once only and only at the start of the policy, but not at the payment of an additional premium or at the start of an increased premium, as contemplated in regulation 3.14.

3.16 Redirecting of commission

(1) A policyholder (excluding a person to whom the policy has been ceded as security) or member may at any time during the life of an investment policy instruct the insurer in writing to stop paying further discounted and undiscounted commission to an independent intermediary or a representative, provided that as part of that instruction the policyholder or member also must instruct the insurer -

(a) to pay the further commission to another independent intermediary, nominated by the policyholder or member in that instruction, who has a contract with the insurer for rendering services as intermediary in respect of policies of the insurer of the type of policy in question; or

(b) to pay the applicable portion of the further commission, in accordance with the principle of equivalence of reward referred to in regulation 3.11(2), to another representative of the insurer nominated by the policyholder or member in that instruction, who is approved by the insurer to render services as intermediary in respect of the policy in question; or

(c) to pay the applicable portion of the further commission, in accordance with the principle of equivalence of reward referred to in regulation 3.11(2), to another representative of the insurer to be appointed by the insurer to render services as intermediary to the policyholder or member in respect of the policy in question.

(2) The insurer must, at no additional cost to the policyholder, comply with an instruction contemplated in subregulation (1).

3.17 Adjustment and refund of commission

(1) If, within 5 years after the premium commencement date, the premium is stopped or decreased - for any reason other than where the policy ends on account of a disability event, a health event, or the death of a life insured - the insurer must reverse a proportion of any discounted commission payable or paid on premiums received.

(2) The proportion of commission to be reversed based on premiums received as contemplated in terms of subregulation (1), must be calculated by applying the applicable adjustment percentage in column 2 of the Table to the ratio that the premium decrease bears to the premium in respect of which the discounted commission first was calculated.

(3) If a premium or a part of it, of which the payment date falls within 5 years after the premium commencement date, is not paid to the insurer or is paid back by the insurer - for any reason other than where the premium is stopped or decreased, or where the policy ends on account of a disability event, a health event, or the death of a life insured - the insurer must reverse any discounted commission payable or paid in respect of that premium or part of it.

(4) If a premium or a part of it, whether its payment date falls within or after 5 years after the premium commencement date, is not paid to the insurer or is paid back by the insurer, the insurer must reverse any undiscounted commission paid in respect of that premium or part of it.

(5)

(a) If discounted or undiscounted commission paid to an independent intermediary or a representative is reversed in terms of subregulation (1), (3) or (4), the independent intermediary or representative must pay it back to the insurer.

(b) If commission has been paid back to the insurer in terms of paragraph (a), and the premium in question or part of it is paid to the insurer thereafter, the insurer may again pay that commission to the independent intermediary or representative.

(6) Subregulations (1) to (5) do not apply to the extent that, and for as long as, the policy is maintained in terms of Rule 15A.3 of the Policyholder Protection Rules, but not made paid -up.

(Regulation 3.17(6) substituted by regulation 5(p) of GN 1015 of 2018)

3.18 Replacement investment policies

(1) Commission may not be discounted in respect of a replacement investment policy.

(2) In the event of commission in respect of a replacement investment policy having been paid otherwise than in accordance with this Part, whether because the insurer at the time of the payment was not aware

that the policy in question was a replacement investment policy, or for any other reason, then any commission paid by the insurer in excess of the maximum that may be paid in accordance with this Part, or paid earlier than permitted in this Part, must, upon identification of the payment, be reversed and paid back to the insurer by the person to whom it was paid.

(Regulation 3.18 substituted by regulation 4(aa) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

Table

Regulation 3.17(2)

Column 1 Premiums received with a value equivalent to monthly premiums for	**Column 2** Adjustment percentage
0 months	100
1 months	100
2 months	100
3 months	100
4 months	100
5 months	100
6 months	100
7 months	88,33
8 months	86,67
9 months	85
10 months	83,33
11 months	81,67
12 months	80
13 months	78,33
14 months	76,67
15 months	75
16 months	73,33
17 months	71,67
18 months	70
19 months	68,33
20 months	66,67
21 months	65
22 months	63,33
23 months	61,67
24 months	60
25 months	58,33
26 months	56,67
27 months	55

Column 1 Premiums received with a value equivalent to monthly premiums for	**Column 2** Adjustment percentage
31 months	48,33
32 months	46.67
33 months	45
34 months	43,33
35 months	41,67
36 months	40
37 months	38,33
38 months	36,67
39 months	35
40 months	33,33
41 months	31,67
42 months	30
43 months	28,33
44 months	26,67
45 months	25
46 months	23,33
47 months	21,67
48 months	20
49 months	18,33
50 months	16,67
51 months	15
52 months	13,33
53 months	11,67
54 months	10
55 months	8,33
56 months	6,67
57 months	5
58 months	3,33

28 months	53,33
29 months	51,67
30 months	50

59 months	1,67
60 months	0

(Part 3B inserted by regulation 1.4 of Government Notice R952 of 2008)

PART 3C
LIMITATION ON REMUNERATION FOR BINDER FUNCTIONS

3.19 Application of this Part 3C, and definitions

(1) This Part 3C applies to remuneration provided by an insurer or any person on its behalf to a person for a rendering binder function.

(2) In this Part 3C unless the context indicates otherwise, any word or expression to which a meaning has been assigned in Part 6 has the meaning assigned to it in that Part, and -

"**cell structure**" has the meaning assigned to it in section 1 of the Insurance Act.

(Definition of "cell structure" in regulation 3.19(2) of Part 3C substituted by regulation 5(q) of GN 1015 of 2018)

3.20 General principles for determining remuneration for binder functions

(1) When remuneration is provided by or on behalf of an insurer to any person for rendering a binder function-

(a) such remuneration must be reasonable and commensurate with the actual cost of performing the binder function, taking into account the nature of the function and the resources, skills and competencies reasonably required to perform it;

(b) the payment of such remuneration must not result in the person being remunerated more than once for performing a similar function on behalf of the insurer and/or policyholder;

(c) any actual or potential conflicts between the interests of policyholders and the interests of the person receiving the remuneration must be effectively mitigated; and

(d) the payment of such remuneration must not impede the delivery of fair outcomes to policyholders.

3.21 Remuneration that may be offered or provided to a binder holder

(1) An insurer may pay a binder holder a fee for services rendered under a binder agreement, if the fee is consistent with the principles referred to in regulation 3.20(1).

(2) Despite subregulation (1), an insurer must not without the prior approval of the Authority referred to in subregulation (3) pay a binder holder a fee for services rendered under a binder agreement that exceeds the value listed in the Table below, reflected as a percentage of the aggregate of the total premiums payable by policyholders in respect of the policies to which the binder function relates, if that binder holder is -

(a) a non-mandated intermediary that is authorised to render "advice" as defined in the FAIS Act in respect of policies;

(b) a non-mandated intermediary that is an associate of another non-mandated intermediary that is authorised to render "advice" as defined in the FAIS Act in respect of policies.

Table

BINDER FUNCTION		**MAXIMUM FEE PAYABLE**
Enter into, vary or renew a policy - section 49A(1)(a) ("function (a)")	Function (a) only	3.5%
Determine the wording of a policy - section 49A(1)(b) ("function (b)")	Function (a) and one or more of functions (b) - (d)	5%
Determine premiums under a policy - section 49A(1)(c) ("function (c)")		
Determine the value of policy benefits under a policy - section 49A(1)(d) ("function (d)")	One or more of functions (b) - (d) only	0%
Settle claims under a policy - section 49A(1)(e)		4%

(3) The Authority, subject to such conditions as the Authority may impose, may on application from an insurer grant approval to the insurer to pay a binder holder a fee in excess of the fees referred to in subregulation (2) if the Authority is satisfied that the fee is consistent with the principles referred to in regulation 3.20.

*(**Publisher's Note** on Commencement dates for regulations 3.21(2) and (3), as set out in regulation 8.3(d) of GN 1437 in GG 41334 dated 15 December 2017:*

"(d) insertion of subregulations (2) and (3) in regulation 3.21 in Part 3C takes effect-

(i) on the effective date for binder agreements entered into on or after the effective date;

(ii) for binder agreements entered into after 1 January 2017 but before the effective date, the earliest of-

(aa) 6 months after the effective date; or

(bb) the date on which any amendment to binder fees payable under such binder agreement is made;

(iii) for binder agreements entered into before 1 January 2017, the earliest of-

(aa) 12 months after the effective date; or

(bb) the date on which any amendment to binder fees payable under such binder agreement is made;")

(4) Any fee referred to under subregulation (1) payable to a non-mandated intermediary that may perform the service or function contemplated in section 49A(1)(e) of the Act under a binder agreement, may not

constitute or be based on a percentage of the difference between an amount claimed or the maximum value of policy benefits payable under a policy and the policy benefits actually provided to a policyholder in settlement of a claim.

(5) Any fee referred to under this regulation 3.21, payable to a non-mandated intermediary that is a binder holder, must be disclosed to a policyholder, which disclosure must be included in the disclosures contemplated under regulation 6.3(1)(g).

(Regulation 3.21(5) of Part 3C substituted by regulation 5(r) of GN 1015 of 2018)

3.22 Participation by a binder holder in profits attributable to the policies referred to in a binder agreement

(1) A non-mandated intermediary that is a binder holder, in respect of the services rendered under the binder agreement, may not directly or indirectly receive or be offered any share in the profits of the insurer attributable to the type or kind of policies referred to in the binder agreement.

(2) Subregulation (1) does not prohibit a non-mandated intermediary that is a binder holder and entered into a cell structure with an insurer from receiving dividends in respect of shares held in that insurer as part of that cell structure.

(3) An administrative FSP or underwriting manager, in respect of the services rendered under the binder agreement, may share in the profits of the insurer attributable to the type or kind of policies referred to in the binder agreement.

(Part 3C inserted by regulation 4(bb) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

PART 3D
NOTIFICATION OF CERTAIN ARRANGEMENTS WITH INDEPENDENT INTERMEDIARIES OR REPRESENTATIVES

3.23 Definitions

In this Part 3D –

"**binder function**" has the meaning assigned to it in Part 6; and

"**independent intermediary**", "**representative**" and "**rendering services as intermediary**" has the meaning assigned to such terms in Part 3A.

3.24 Notification of certain arrangements with independent intermediaries or representatives

An insurer must at least 30 days before entering into an arrangement to pay remuneration to an independent intermediary or representative for a service, function or activity which in the opinion of the insurer does not constitute rendering services as intermediary or a binder function notify the Authority in writing and in the format determined by the Authority of the arrangement to be entered into.

(Part 3D inserted by regulation 4(cc) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

PART 4
LIMITATION ON PROVISIONS OF CERTAIN POLICIES
(Section 54)

4.1 Definitions

In this Part-

"excess premium" means a premium which is received by, or which becomes due to, a long-term insurer during a premium period, and which -

(a) by itself exceeds;

(b) when aggregated with all premiums already received, and still to be received, during that premium period, exceeds; or

(c) is the first of increased recurrent premiums which, if it had been received by the long-term insurer at that increased rate during that premium period, would have caused the total value of the premiums received by the long-term insurer during that premium period to exceed,

by a rate of more than 20 per cent, the higher of the total value of the premiums received by the long-term insurer during any one of the two premium periods immediately preceding that premium period: Provided that if a premium is increased during the second premium period, the percentage increase shall be determined in relation to the first premium period only;

(Definition of "excess premium" substituted by regulation 5(a) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"extended restriction period" means a restriction period-

(a) which has not expired;

(b) which includes every earlier restriction period any part of which runs concurrently with it; and

(c) the commencement date of which, from time to time, is the commencement date of the earliest restriction period which runs concurrently with it;

"free surrender value" means the value of the consideration which the long-term insurer would provide if the policy is surrendered on the day preceding the date of commencement of an extended restriction period;

"fund member policy" has the meaning assigned to it in Part 3A;

(Definition of "fund member policy" substituted by regulation 5(b) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Definition of "fund member policy" substituted by regulation 6(a) of GN 1015 of 2018)

"linked benefit" means a policy benefit, the value of which is not guaranteed by the long-term insurer and is determined solely by reference to the value of particular assets or particular categories of assets which are specified in the policy and which are actually held by or on behalf of the long-term insurer specifically for the purpose of the policy;

"policy" means a long-term policy, whether entered into before or after the commencement of this Act, excluding -

(a) a reinsurance policy;

(b) a fund policy;

(c) a fund member policy, for as long as no right under the policy is transferred by the fund to a life insured under the policy, or is transferred to any person except another fund for the direct or indirect benefit of a life insured under the policy; or

(d) a living annuity as defined in section 1 of the Income Tax Act, 1962 (Act No. 58 of 1962);

(Definition of "policy" substituted by regulation 5(c) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"policy benefit" as the meaning assigned to it in the Act, but excludes a loan in respect of a policy or consideration upon the surrender of a policy;

(Definition of "policy benefit" substituted by regulation 6(b) of GN 1015 of 2018)

"premium" .....

(Definition of "premium" deleted by regulation 6(c) of GN 1015 of 2018)

"premium period" means one of a succession of periods, each of 12 months' duration, the first of which begins on, and ends 12 months after, the first day of the month in which the first premium, or any part thereof, is received by the long-term insurer or, if it is a later date, the first day of the month in which the undertaking of the long-term insurer to provide policy benefits under the policy, becomes operative;

"restricted amount" means an amount equal to-

(a) the aggregate of the free surrender value, and the total value of the premiums received by the long-term insurer during the extended restriction period concerned, plus interest on the free surrender value and each premium at the rate of 5 per cent per annum compounded annually; less

(b) the aggregate of all payments already made by the long-term insurer in respect of the policy, whether as a policy benefit (other than a policy benefit referred to in subregulation (2) of regulation 4.2) or upon the surrender of any part of the policy, during the extended restriction period concerned, plus interest on each payment at 5 per cent per annum compounded annually;

"restriction period" means a period of 5 years which commences, if the date concerned is 1 January 1994 or later-

(a) on the date when the first premium period begins; or

(b) during a premium period after the first such period, on the first day of the month in which an excess premium is received by the insurer.

4.1A Application of this Part

(1) This Part does not apply to a policy that is a tax free investment contemplated in section 12T of the Income Tax Act, 1962 (Act No. 58 of 1962).

(Regulation 4.1A inserted by regulation 2 of Government Notice R170 in Government Gazette 38507 dated 25 February 2015)

4.2 Limitations on policies

(1) Subject to subregulations (2), (3), (4) and (5), a long-term insurer, and any person who acts as intermediary between a long-term insurer and any person in respect of a policy or proposal for a policy, shall not undertake to provide, or provide-

(a) a policy benefit under a policy during an extended restriction period;

(b) upon the full or partial surrender of a policy during an extended restriction period-

(i) if the policy has previously been partially surrendered during the extended restriction period concerned, any further consideration; or

(ii) if the policy has not been previously partially surrendered during the extended restriction period concerned, any consideration the value of which exceeds the restricted amount less

the capital (excluding capitalised interest) of a loan already provided in respect of the policy during that extended restriction period: Provided that where the policy is fully surrendered and the full value of the consideration to be provided thereupon exceeds the amount thus determined by not more than R10 000 the full consideration may be provided;

(Regulation 4.2(1)(b) substituted by regulation 5(d) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Regulation 4.2(1)(b) substituted by regulation 6(d) of GN 1015 of 2018)

(c) a loan under or on security of a policy during an extended restriction period-

(i) if such a loan has previously been provided in respect of the policy during the extended restriction period concerned; or

(ii) if such a loan has not previously been provided in respect of the policy during the extended restriction period concerned, the amount of which exceeds the restricted amount; or

(d) directly or indirectly, by means of one or more policies, during an extended restriction period, any benefit (whether as policy benefits or loans in respect of policies or consideration upon the surrender of policies, or any combination thereof) which achieves substantially the result that is achieved by an annuity, but which is not, and is not expressly stipulated in the policy or policies to be, an annuity.

(2) Subregulation (1)(a) shall not apply to a policy benefit which is to be provided and is provided under the policy upon -

(a) the life of a life insured having ended;

(b) the life of a life insured having begun;

(c) a health event occurring;

(d) a disability event occurring;

(e) loss of income occurring.

(Regulation 4.2(2) substituted by regulation 5(e) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(3) Subparagraph (1)(a) shall not apply to a policy benefit which is an annuity-

(a) the payments of which are to be made, and are made, at intervals not exceeding 12 months;

(b) at least one of the payments of which is to be made and, except due to the prior death of the life insured, is made, within 31 days before the expiry of the extended restriction period concerned; and

(c) the total amount of the payments of which in any period of 12 months does not differ, by a rate of more than 20 per cent, from the total amount of the payments thereof in the immediately preceding period of 12 months, except in the case of an annuity-

(i) which constitutes a linked benefit, where the difference, during the period concerned, results solely from the determination of the value of the relevant assets;

(ii) payable in terms of a policy with two or more policyholders or lives insured and where the difference results solely from a reduction in the annuity payable during the period concerned consequent upon the death of one of those policyholders or lives insured; or

(iii) where the difference results solely from a reduction in the annuity payable during the period concerned consequent upon the surrender of a part of the policy.

(4) Subregulation (1) shall not apply in the event of-

(a) the death, placement under curatorship or sequestration of the estate of a policyholder who is a natural person; or

(b) the winding-up, liquidation, placement under curatorship or judicial management, by an order of Court, of a policyholder which is a juristic person.

(5) Subregulation (1)(c) and (d) shall not apply to a premium advance made under non-forfeiture provisions in a policy.

4.2A Maximum fees, penalties or any other charges on loans

(1) Where the terms of a loan on the security of a long-term policy provide for the charging of interest at a stated fixed rate, whether simple or compound interest, an insurer may only apply such interest to the capital amount of the loan and not to any other cost or loss in respect of the loan.

(2) Where the terms of a loan on security of a long-term policy do not provide for the charging of interest, an insurer may not impose any fees, penalties or other charges in respect of the loan in excess of an amount equal to the maximum causal event charge that the insurer would have been permitted to charge if the capital amount of the loan had been the amount surrendered in terms of a causal event referred to in paragraph (d) or (f) of the definition of causal event in Part 5A.

(Regulation 4.2A inserted by regulation 5(f) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

4.3 General exclusion

This Part shall not apply in respect of anything done, before or after the commencement of this Part, in relation to a policy entered into before the commencement of this Part if, from a date prior to 1 March 1993, the policy expressly provided, in writing, for it to be done.

PART 5
REQUIREMENTS AND LIMITATIONS REGARDING THE VALUES AND BENEFITS OF POLICIES
(Section 54)

PART 5A
POLICIES OTHER THAN POLICIES TO WHICH PART 5B APPLIES

(Heading inserted by regulation 2.1 of Government Notice R952 of 2008)

5.1 Application of this Part 5A, and definitions

(Heading substituted by regulation 2.2(a) of Government Notice R952 of 2008)

This Part 5A applies to policies other than policies to which Part 5B applies, and in this Part 5A, unless the context indicates otherwise -

(Sentence following the heading substituted by regulation 2.2(a) of Government Notice R952 of 2008)

"actuarial basis", in relation to a policy, means the underlying actuarial rules, specifications and formulae in terms of which the policy operates, which:

(a) in compliance with the Act, are approved by the statutory actuary of the insurer, in particular for the purposes of section 46 of the Act and Rules 15A.1 to 15A.4 of the Policyholder Protection Rules; and

(b) if and while the Insurance Act, 1943 applied to the policy, in compliance with that Act, were approved by the valuator of the insurer, in particular for the purposes of sections 34 and 62(2) of that Act;

(Definition of "actuarial basis" substituted by regulation 7(a) of GN 1015 of 2018)

"basic premium" means the premium, including a premium paid by virtue of a premium-waiver benefit, less charges (if any) deductible from the premium for rider-benefits;

"basic risk benefit" means a risk benefit for which the charge is determined periodically with reference to changes in factors pertaining to the risk, including but not limited to the age of the life insured, the amount of the risk cover, or the investment value of the policy, but excluding a rider-benefit;

"benefit" means a policy benefit, including a consideration payable upon the full or partial surrender of a policy, but excluding a loan in respect of a policy;

"causal event", in relation to a policy, means one of the following events:

(a) the policy becomes fully paid-up;

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

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

(d) the policy is surrendered in part, other than for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956, or a part of the policy comes to an end for another reason (other than because risk cover under the policy has come to an end);

(e) the policy, in the case of a fund member policy, is surrendered in part for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956;

(f) the policy is surrendered in full, other than for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956, or the policy comes to an end for another reason (other than because the policy has reached its maturity date); or

(g) the policy, in the case of a fund member policy, is surrendered in full for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956;

“causal event charge” means a charge, other than an administration charge contemplated in regulation 5.4A, occasioned by and pertaining to a causal event;

(Definition of “causal event charge” substituted by regulation 6(a) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"charge" means a charge stipulated in a policy or its actuarial basis, whether or not the actuarial basis has been expressly incorporated in the policy, which charge is deductible in respect of the policy in accordance with its terms or actuarial basis;

"come to an end" means that the final benefit under a policy has become payable, including in the case of a fund member policy for the purpose of a transfer from one fund to another in terms of section 14 of the Pension Funds Act, 1956, or that the policy has lapsed without a benefit becoming payable;

“**component**” has the meaning assigned in Part 3A;

(Definition of "component" inserted by regulation 6(b) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"dependant" has the meaning assigned in section 1 of the Pension Funds Act, 1956;

"effective date" means 1 December 2006;

"excluded policy" in respect of a -

(a) registered insurer means:

(i) a fund policy;

(ii) a reinsurance policy;

(iii) a policy that provides risk benefits only;

(iv) a whole-life policy that provides risk benefits and has an investment value or a materially equivalent value referred to in regulation 5.2(2)(b), and in respect of which policy, immediately before a causal event, the ratio of the aggregate of the sums insured of all basic risk benefits to the monthly basic premium (or the monthly equivalent where recurring premiums are not paid monthly) is greater than the threshold ratio in the table below:

Age next birthday of the life insured at the inception of the policy	**Threshold ratio**
Up to and including 30	480
31	468
32	456
33	444
34	432
35	420
36	408
37	396
38	384
39	372
40	360
41	348
42	336
43	324
44	312
45	300
46	288

47	276
48	264
49	252
50	240
51	228
52	216
53	204
54	192
55	180
56	168
57	156
58	144
59	132
60 and above	120

(v) and any other policy that provides primarily risk benefits;

(b) licensed insurer means a policy as defined in section 1 of the Insurance Act:

(i) written under one or more of the following classes of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act: Risk, Fund Risk, Credit Life, Funeral, Fund Investment and Reinsurance only;

(ii) that is a whole -life policy written under both the -

(aa) Risk, Credit Life or Funeral classes of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act; and

(bb) Life Annuity, Individual Investment or Income Drawdown classes of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act; and

that has an investment value or a materially equivalent value referred to in regulation 5.2(2)(b), and in respect of which policy, immediately before a causal event, the ratio of the aggregate of the sums insured of all basic risk benefits to the monthly basic premium (or the monthly equivalent where recurring premiums are not paid monthly) is greater than the threshold ratio in the table below:

Age next birthday of the life insured at the inception of the policy	**Threshold ratio**
Up to and including 30	480
31	468
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44	312
45	300
46	288
47	276
48	264
49	252
50	240
51	228
52	216
53	204
54	192
55	180
56	168
57	156
58	144
59	132
60 and above	120

(iii) and any other policy that provides primarily risk benefits;

(Definition of "excluded policy" substituted by regulation 7(b) of GN 1015 of 2018)

"fund member policy" in respect of a -

(a) registered insurer means a policy -

(i) of which a fund is or was the policyholder; and

(ii) which is or was entered into by the fund for the purpose of funding exclusively the fund's liability to a particular member (or to the surviving spouse, children, dependants or nominees of the member) in terms of the rules of the fund;

(b) licensed insurer means a policy written under the Life Annuity, Individual Investment or Income Drawdown classes of life insurance business as set out in Schedule 2 of Table 1 of the Insurance Act and -

(i) of which a fund is or was the policyholder; and

(ii) which is or was entered into by the fund for the purpose of funding exclusively the fund's liability to a particular member (or to the surviving spouse, children, dependants or nominees of the member) in terms of the rules of the fund;

(Definition of "fund member policy" substituted by regulation 7(c) of GN 1015 of 2018)

“growth rate" means, over a given period, the positive or negative investment return declared for a portfolio, which investment return is net of those portfolio charges that are deducted before the declaration of the investment return, and in the case where a bonus is declared is inclusive of vested and non-vested bonuses;

"insurer" …….

(Definition of “insurer” deleted by regulation 6(c) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"investment value" means the value of a policy:

(a) calculated using a method commonly referred to as a back-end loaded basis, by accumulating the basic premium less deductions at the growth rate that applies to the policy, which deductions comprise:

(i) benefits paid, excluding basic risk benefits and rider-benefits;

(ii) charges for basic risk benefits;

(iii) charges deducted when benefits are paid or the policy is altered;

(iv) charges stipulated as a fixed amount, which amount, over the full term of the policy, is designed to remain unchanged or is designed to be increased at a specified rate at regular intervals;

(v) charges stipulated as a percentage or proportion of premiums, which percentage or proportion is designed to remain unchanged over the full term of the policy; and

(vi) those portfolio charges that are deducted after the declaration of the growth rate, where, in the case of general portfolio charges deducted after the declaration of the growth rate, their

percentage or proportion of the value of the portfolio is designed to remain unchanged over the full term of the policy;

provided that in determining the growth rate to be applied for the purposes of this calculation, the percentage or proportion of the value of the portfolio for general portfolio charges that are deducted before the declaration of the growth rate, is designed to remain unchanged over the full term of the policy; and

(b) adjusted, where the growth rate that applies to the policy does not follow the fluctuation in the value of the portfolio on a daily basis, and where that is required by the terms or actuarial basis of the policy, by a market-adjustment factor to take into account the difference between the value of the policy so calculated and the value of the portfolio;

"member", in relation to a fund member policy, means the member of the fund in respect of whom the fund had or has taken out the policy;

"nominee", in relation to a member, means a nominee of the member contemplated in the rules of the fund;

"policy" means a long-term policy, whether entered into before or after the commencement of the Act;

"portfolio" means the one or more investment funds representing the underlying assets of a policy;

"portfolio charges" means charges deducted from a portfolio, being:

(a) "specific portfolio charges", namely charges for specific expenses, which expenses include but are not limited to taxes, statutory levies, investment expenses (including investment performance fees), and investment guarantees; and

(b) "general portfolio charges", namely management charges, capital charges and other stipulated general charges, which general portfolio charges are stipulated as a percentage or proportion of the value of the portfolio;

"rider-benefit" in respect of a –

(a) registered insurer, means a risk benefit for which the charge is a certain amount or a percentage of the premium or is otherwise fixed, which risk benefit excludes a basic risk benefit; and

(b) licensed insurer, has the meaning assigned to it in section 1 of the Insurance Act;

(Definition of "rider benefit" substituted by regulation 7(d) of GN 1015 of 2018)

"this Part" means this Part 5A;

(Definition of "this Part" substituted by regulation 2.2(b) of Government Notice R952 of 2008)

"**universal whole of life policy**" means a policy other than a fund member policy that is a whole-life policy that is not an excluded policy and -

(a) that provides risk benefits and has an investment value or a materially equivalent value referred to in regulation 5.2(2)(b); and

(b) in respect of which the underlying actuarial basis of the policy, whether or not the actuarial basis has been expressly incorporated in the policy, provides that, at inception of the policy, less than 40% of the total premium payable by the policyholder over the expected lifetime of the policy will be allocated towards the investment benefits;

(Definition of "universal whole of life policy" inserted by regulation 6(d) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"values" means all values of a policy including, but not limited to, its investment value, its remaining value and other values contemplated in Rule 15.11 of the Policyholder Protection Rules, and its maturity value;

(Definition of "values" amended by regulation 6(e), by the substitution for the full stop of a semi-colon, of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)
(Definition of "values" substituted by regulation 7(e) of GN 1015 of 2018)

"**variable premium increase**" means an increase in an existing recurring premium payable by a policyholder under a policy, which increase is not a regular contractual premium increase provided for and determinable in the policy at the start of that policy.

(Definition of "variable premium increase" inserted by regulation 6(f) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

5.2 Basis for determination of values and benefits of policies

(1) The values and benefits of a policy, and charges in respect of the policy, are determined, over the full term of the policy, in accordance with its terms and its underlying actuarial basis, whether or not the actuarial basis has been expressly incorporated in the policy.

(2) Notwithstanding anything to the contrary in the terms or actuarial basis of a policy which is not an excluded policy, and in respect of which a causal event has occurred on or after 1 January 2001, but subject to regulation 4.2:

(a) where the terms or actuarial basis of that policy make provision for the calculation of an investment value as described in the definition "investment value", regulations 5.3 to 5.6 apply to that policy; or

(b) where the terms or actuarial basis of that policy do not make provision for the calculation of an investment value as described in the definition "investment value", the values or benefits of that policy upon or immediately after the causal event must be, as certified by the insurer's statutory actuary, materially equivalent to such values or benefits as determined in accordance with regulations 5.3 to 5.6 for a policy contemplated in paragraph (a).

5.3 Fund member policies

(1) Where a causal event occurred in respect of a fund member policy on or after 1 January 2001, but before the effective date, and the insurer on account of that causal event deducted causal event charges which in total exceed the maximum prescribed in subregulation (2), the insurer must:

(a) if the policy has not come to an end before the effective date, within 6 months after the effective date credit the policy with the amount by which the total causal event charges deducted exceed the prescribed maximum ("the excess amount") plus interest on the excess amount calculated in accordance with regulation 5.5; or

(b) if the policy has come to an end before the effective date, and if the amount by which the total causal event charges deducted exceed the prescribed maximum ("the excess amount") is R150 or more, upon the written request of the member, or in the case of a deceased member upon the written request of the dependants or nominees of the member, which request in every case must be received by the insurer within three years after the effective date, within 6 months after having received the written request pay the excess amount plus interest on the excess amount calculated in accordance with regulation 5.6, less any tax that must be deducted, to the member or to the dependants or nominees of a deceased member.

(2) The maximum deductible charges for purposes of subregulation (1) are:

(a) where the causal event is one contemplated in paragraph (a), (c), (f) or (g) of the definition "causal event", 35% of the investment value immediately before the causal event;

(b) where the causal event is one contemplated in paragraph (b) of the definition "causal event", a percentage of the investment value immediately before the causal event equal to 35% multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;

(c) where the causal event is one contemplated in paragraph (d) or (e) of the definition "causal event", 35% of the amount by which the investment value immediately before the causal event has been reduced.

(3) Where a causal event occurs in respect of a fund member policy on or after the effective date but before 1 January 2018, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum prescribed in subregulation (4).

(Regulation 5.3(3) substituted by regulation 6(g) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(4) The maximum deductible charges for purposes of subregulation (3) are:

(a) where the causal event is one contemplated in paragraph (a), (c), (f) or (g) of the definition "causal event", 30% of the investment value immediately before the causal event;

(b) where the causal event is one contemplated in paragraph (b) of the definition "causal event", a percentage of the investment value immediately before the causal event equal to 30% multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;

(c) where the causal event is one contemplated in paragraph (d) or (e) of the definition "causal event", 30% of the amount by which the investment value immediately before the causal event has been reduced.

(5) Where a causal event occurs in respect of a fund member policy during a period referred to in column 1 of Table A below, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum percentage set out in the corresponding line in column 2 of Table A below.

Table A

Timing of causal event	Maximum if causal event is one contemplated in the following paragraph of the definition "causal event":		
	for purposes of paragraph (a), (c), (f) or (g), the maximum percentage below of the investment value immediately before the causal event:	for purposes of paragraph (b), the maximum percentage of the investment value immediately before the causal event equal to percentage below multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced:	for purpose of paragraph (d) or (e), the maximum percentage below of the amount by which the investment value immediately before the causal event has been reduced:
On or after 1 January 2018 but before 1 January 2019	20%	20%	20%
On or after 1 January 2019 but before 1 January 2020	18%	18%	18%

On or after 1 January 2020 but before 1 January 2021	16%	16%	16%
On or after 1 January 2021 but before 1 January 2022	14%	14%	14%
On or after 1 January 2022 but before 1 January 2023	12%	12%	12%
On or after 1 January 2023 but before 1 January 2024	11%	11%	11%
On or after 1 January 2024 but before 1 January 2025	10%	10%	10%
On or after 1 January 2025 but before 1 January 2026	9%	9%	9%
On or after 1 January 2026 but before 1 January 2027	8%	8%	8%
On or after 1 January 2027 but before 1 January 2028	7%	7%	7%
On or after 1 January 2028 but before 1 January 2029	6%	6%	6%
On or after 1 January 2029	5%	5%	5%

(Regulation 5.3(5) inserted by regulation 6(h) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

5.4 Policies other than fund member policies

(1)

(a) Where a causal event occurred in respect of a policy other than a fund member policy on or after 1 January 2001, but before the effective date, and the insurer on account of that casual event deducted causal event charges which in total exceed the maximum prescribed in subregulation (2), the insurer must, if the policy has not come to an end before the effective date, within 6 months after the effective date credit the policy with the amount by which the total causal event charges deducted exceed the prescribed maximum ("the excess amount") plus interest on the excess amount calculated in accordance with regulation 5.5.

(b) Despite paragraph (a), where a policy other than a fund member policy has come to an end before the effective date, no maximum is prescribed with regard to the deduction of causal event charges on account of a causal event.

(2) The maximum deductible charges for purposes of subregulation (1) are:

(a) where the causal event is one contemplated in paragraph (a) or (c) of the definition "causal event", 35% of the investment value immediately before the causal event;

(b) where the causal event is one contemplated in paragraph (b) of the definition "causal event", a percentage of the investment value immediately before the causal event equal to 35% multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;

(c) No maximum is prescribed with regard to the deduction of causal event charges on account of a causal event contemplated in paragraph (d) or (f) of the definition "causal event".

(3) Where a causal event occurs in respect of a policy other than a fund member policy on or after the effective date but before 1 January 2018, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum prescribed in subregulation (4).

(Regulation 5.4(3) substituted by regulation 6(i) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(4) The maximum deductible charges for purposes of subregulation (3) are:

(a) where the causal event is one contemplated in paragraph (a) or (c) of the definition "causal event", 30% of the investment value immediately before the causal event;

(b) where the causal event is one contemplated in paragraph (b) of the definition "causal event", a percentage of the investment value immediately before the causal event equal to 30% multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;

(c) where the causal event is one contemplated in paragraph (d) of the definition "causal event", 40% of the amount by which the investment value immediately before the causal event has been reduced;

(d) where the causal event is one contemplated in paragraph (f) of the definition "causal event", 40% of the investment value immediately before the causal event.

(5) Where a causal event occurs in respect of a policy other than a fund member policy, but that is not a universal whole of life policy, during a period referred to in column 1 of Table A below, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum percentage set out in the corresponding line in column 2 of Table A below.

Table A

Timing of causal event	Maximum in respect of a causal event contemplated in the following paragraph of the definition "causal event":		
	for purposes of paragraph (a), (c), (f), the maximum percentage below of the investment value immediately before the causal event:	for purposes of paragraph (b), the maximum percentage of the investment value immediately before the causal event equal to percentage below multiplied by the amount by which the basic	for purpose of paragraph (d), the maximum percentage below of the amount by which the investment value immediately before the causal event has been reduced:

		premium has been reduced divided by the basic premium before it was reduced:	
On or after 1 January 2018 but before 1 January 2019	20%	20%	20%
On or after 1 January 2019 but before 1 January 2020	18%	18%	18%
On or after 1 January 2020 but before 1 January 2021	16%	16%	16%
On or after 1 January 2021 but before 1 January 2022	14%	14%	14%
On or after 1 January 2022 but before 1 January 2023	12%	12%	12%
On or after 1 January 2023 but before 1 January 2024	11%	11%	11%
On or after 1 January 2024 but before 1 January 2025	10%	10%	10%
On or after 1 January 2025 but before 1 January 2026	9%	9%	9%
On or after 1 January 2026 but before 1 January 2027	8%	8%	8%
On or after 1 January 2027 but before 1 January 2028	7%	7%	7%
On or after 1 January 2028 but before 1 January 2029	6%	6%	6%
On or after 1 January 2029	5%	5%	5%

(Regulation 5.4(5) inserted by regulation 6(j) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(6) Where a causal event occurs in respect of a universal whole of life policy during a period referred to in column 1 of Table A below, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum percentage set out in the corresponding line in column 2 of Table A below.

Table A

Timing of causal event	Maximum in respect of a causal event contemplated in the following paragraph of the definition "causal event":		
	for purposes of paragraph (a), (c), (f), the maximum percentage below of the investment value immediately before the causal event:	for purposes of paragraph (b), the maximum percentage of the investment value immediately before the causal event equal to percentage below multiplied by the amount by which the basic premium has been reduced divided by the basic premium	for purpose of paragraph (d), the maximum percentage below of the amount by which the investment value immediately before the causal event has been reduced:

		before it was reduced:	
On or after 1 January 2018 but before 1 January 2019	20%	20%	20%
On or after 1 January 2019 but before 1 January 2020	19%	19%	19%
On or after 1 January 2020 but before 1 January 2021	18%	18%	18%
On or after 1 January 2021 but before 1 January 2022	17%	17%	17%
On or after 1 January 2022 but before 1 January 2023	16%	16%	16%
On or after 1 January 2023	15%	15%	15%

(Regulation 5.4(6) inserted by regulation 6(j) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

5.4A Deduction of administration charge

(1) The insurer may, in addition to causal event charges, deduct in respect of any causal event taking place after 31 December 2017, either during or after the charge term, an administration charge of not more than R500.

(2) Despite paragraph (a), the administration charge must, if necessary, be reduced proportionally so that the investment value immediately prior to the causal event, less the causal event charge and administration charge, is not smaller than 70% of the investment value immediately before the causal event.

(Regulation 5.4A inserted by regulation 6(k) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

5.5 Interest on the excess amount

The interest on the excess amount contemplated in regulations 5.3(1)(a) and 5.4(1)(a) is:

(a) calculated from and including the date the excess amount was deducted, to but excluding the date it is credited to the policy; and

(b) at an annual interest rate equal to the growth rate (net of those portfolio charges that are deducted after the declaration of the growth rate) over this period, which annual interest rate is subject to a maximum effective rate of 10% and a minimum effective rate of 0%.

5.6 The interest on the excess amount contemplated in regulation 5.3(1)(b) is:

(a) calculated from and including the date the causal event occurred, to but excluding the date the excess amount is paid to the member or to the dependants or nominees of a deceased member;

(b) for the period from the date the causal event occurred, to and including the date the policy came to an end, at an annual interest rate equal to the growth rate (net of those portfolio charges that are deducted after the declaration of the growth rate) over this period, which annual interest rate is subject to a maximum effective rate of 10% and a minimum effective rate of 0%; and

(c) for the period from and excluding the date the policy came to an end, to but excluding the date the excess amount is paid, at an annual effective rate of 5%.

5.7 …….

(Regulation 5.7 deleted by regulation 6(l) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

5.8 Amendments to actuarial basis and values

(1) An insurer must, before giving effect to an amendment made to the actuarial basis of a policy, where that amendment will have the effect of reducing the values or benefits of that policy, inform the Authority of the amendment. The insurer must also provide the reasons for the amendment.

(2) The Authority may, if he or she is of the opinion that an amendment contemplated in subregulation (1) was affected to directly or indirectly reduce the impact on the insurer of complying with this Part, direct the insurer to review that amendment.

(3) An insurer must keep a record of amendments contemplated in subregulation (1), which record must be made available to the Authority on request.

(Regulation 5.8 substituted by regulation 6(m) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

5.9 Variable premium increases in respect of policies to which this Part applies

Despite anything contained in this Part or the regulations, any variable premium increase on or after 1 January 2018 in respect of –

(a) a policy other than a universal whole of life policy to which this Part applies;

(b) the investment component of a universal whole of life policy;

is subject to Part 3B and Part 5B and must be regarded as constituting a separate policy for purposes of the application of those Parts.

(Regulation 5.9 substituted by regulation 6(n) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Part 5 substituted by regulation 1 of Government Notice R1218 of 2006)
(Part 5 effectually renumbered to Part 5A by Government Notice R952 of 2008)

PART 5B
INVESTMENT POLICIES THAT STARTED ON OR AFTER 1 JANUARY 2009

5.10 Application of this Part 5B, and definitions

This Part 5B applies to investment policies that started on or after 1 January 2009, and unless defined differently in this Part 5B or unless the context indicates otherwise, any word or expression to which a meaning has been assigned in Part 5A has the meaning assigned to it in that Part, and -

"causal event charge" means a charge, other than an administration charge contemplated in regulation 5.12(3), occasioned by and pertaining to a causal event;

"charge" means a charge stipulated in a policy, which charge is deductible in respect of that policy in accordance with its terms and its actuarial basis;

"charge percentage", in relation to an investment policy, means 15% reduced on a straight-line basis to 0% over the charge term;

"charge term" means the term during which the insurer may deduct a causal event charge, which term starts on the premium commencement date and is equal to:

(a) in the case of a single premium policy the shorter of -

(i) 5 years; or

(ii) the period until the date on which the policy will reach maturity;

(b) in the case of a multiple premium policy -

(i) 10 years, if the premium term is 20 years or longer;

(ii) half of the premium term, if the premium term is 10 years or longer but shorter than 20 years;

(iii) 5 years, if the premium term is 5 years or longer but shorter than 10 years; or

(iv) the premium term, if the premium term is shorter than 5 years;

"excluded policy" in respect of a -

(a) registered insurer means a policy contemplated in paragraphs (a)(i), (ii), (iii) and (iv) of the definition "excluded policy" in Part 5A;

(b) licensed insurer means a policy contemplated in paragraphs (b)(i) and (ii) of the definition "excluded policy" in Part 5A;

(Definition of "excluded policy" in Regulation 5.10 of Part 5B substituted by regulation 7(f) of GN 1015 of 2018)

"investment policy" means a single premium policy or a multiple premium policy, other than an excluded policy;

"payment date", in relation to a premium, means the date on which that premium must be paid in terms of the policy;

"premium commencement date" means the payment date of the only or first premium;

"premium term", in relation to a multiple premium policy, means the shorter of the following periods:

(a) the period for which the premiums are to be paid in terms of the policy - which period, as at the start of the policy, is specified in the policy or is determinable from its written provisions; or

(b) the period for which the premiums are to be paid before a policy benefit is to be provided - excluding where the policy benefit is to be provided on account of a disability event, a health event or the death of a life insured; or

(c) the period for which the premiums are to be paid before a consideration must or may be paid upon the full or partial surrender of the policy - if the amount of the consideration, as at the start of the policy, is specified in the policy or is determinable from its written provisions; or

(d) the longest of the following periods:

(i) 10 years; or

(ii) in the case of a fund member policy- the number of full years from the start of the policy to the 66th birthday of the life insured; or

(iii) the number of full years from the start of the policy to the 75th birthday of the life insured;

"start", in relation to a policy, means when the application for that policy is accepted by the insurer; and

"this Part" means this Part 5B.

5.11 Basis for determination of values and benefits of policies

(1) The values and benefits of an investment policy, and charges in respect of the policy, are determined, over the full term of the policy, in accordance with its terms, which terms must be in accordance with its actuarial basis.

(2) Notwithstanding anything to the contrary in the terms or actuarial basis of an investment policy, but subject to regulation 4.2, where a causal event has occurred in respect of that policy and that policy's terms or actuarial basis do not make provision for the calculation of an investment value as described in the definition of "investment value" in Part 5A, the values or benefits of that policy upon or immediately after the causal event must be, as certified by the insurer's statutory actuary, materially equivalent to such values or benefits as determined in accordance with regulation 5.12 for an investment policy of which the terms or actuarial basis do make provision for the calculation of an investment value as described in the definition "investment value".

5.12 Maximum charges that may be deducted

(1) Where a causal event occurs in respect of an investment policy, the insurer may not on account of that causal event deduct causal event charges which in total exceed the maximum prescribed in subregulation (2).

(2) The maximum deductible charges for purposes of subregulation (1) are:

(a) where the causal event is one contemplated in paragraph (a), (c), (f) or (g) of the definition "causal event", the charge percentage (15% or less) of the investment value immediately before the causal event;

(b) where the causal event is one contemplated in paragraph (b) of the definition "causal event", a percentage of the investment value immediately before the causal event equal to the charge percentage (15% or less) multiplied by the amount by which the basic premium has been reduced divided by the basic premium before it was reduced;

(c) where the causal event is one contemplated in paragraph (d) or (e) of the definition "causal event", the charge percentage (15% or less) of the amount by which the investment value immediately before the causal event has been reduced.

(3)

(a) The insurer may, in addition to causal event charges, deduct in respect of any causal event, either during or after the charge term, an administration charge of not more than R500.

(Regulation 5.12(3)(a) substituted by regulation 6(o) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(b) Despite paragraph (a), the administration charge must, if necessary, be reduced proportionally so that the investment value immediately prior to the causal event, less the causal event charge and administration charge, is not smaller than 70% of the investment value immediately before the causal event.

5.13 Disclosure

(1) An insurer must ensure that -

(a) when an investment policy is applied for, the prospective policyholder or member is within 30 days from the date of application provided in writing with the information referred to in subregulation (2);

(b) the summary to be provided to the policyholder or member in accordance with Rule 11.5 of the Policyholder Protection Rules contains the information referred to in subregulation (2); and
(Regulation 5.13(1)(b) of Part 5B substituted by regulation 7(g) of GN 1015 of 2018)

(c) the policyholder or member is at least annually provided with the information referred to in subregulation (2) in writing, by telefax or any appropriate electronic communication reducible to printed form.

(2) The information for purposes of subregulation (1) is -

(a) a summary of the content of the provisions of this Part to the extent that those provisions may be or may become applicable to the policy;

(b) an explanation of what constitutes a causal event in respect of the policy in question;

(c) a statement, expressed as a percentage and, where a Rand value amount is determinable, also as a Rand value amount, of the maximum causal event charges that may be deducted; and

(d) the administration charge that may be deducted when a causal event occurs.

(Part 5B inserted by regulation 2.3 of Government Notice R952 of 2008)

PART 5C
PRINCIPLES FOR CALCULATION OF CAUSAL EVENT CHARGES

5.14 Definitions

In this Part 5C any word or expression to which a meaning has been assigned in Part 5A and Part 5B, depending on the context in which this Part 5C is applied, has the meaning assigned to it in Part 5A and Part 5B, respectively.

5.15 General principles for the calculation of causal event charges

(1) For purposes of compliance with Parts 5A and 5B, an insurer must consider all causal event charges that arose after 1 January 2001.

(2) When calculating causal event charges in respect of policies referred to in Part 5A and Part 5B, an insurer must –

(a) take into account the cumulative effect on a policy's investment value of charges that have already been deducted in respect of previous causal events;

(b) on the occurrence of a second or subsequent causal event on a policy, determine the causal event charge for that second or subsequent event by taking into account the cumulative effect of that charge and all prior causal event charges on the policy's investment value;

(c) ensure that the cumulative effect of multiple causal event charges during the life of a policy does not result in the policy's investment value at any time being reduced by a greater portion than would have been the case if, at the time of the first causal event, the maximum causal event charge has been deducted.

(3) For purposes of subregulation (2)(b), the calculation of the cumulative causal event charges and the impact on the policy's investment value may take into account the time value of money, but any simplification applied in the calculation methodology may not result in a reduced policy investment value.

(4) For purposes of subregulation (2)(c), the maximum causal event charge means the lower of –

(a) the highest charge the insurer applies to any one causal event for the type of policy concerned according to the insurer's actuarial basis; and

(b) the highest causal event charge, at the time of the first causal event, provided for in Part 5A, Part 5B or for the type of policy concerned.

(5) In applying the principles in subregulation (2), an insurer must apply the same method of calculation to all policies of the same type.

(6) An insurer must, where the actuarial basis provides for a charge percentage that is less than the maximum prescribed charges, apply the lesser percentage in calculating causal event charges and in determining their cumulative effect.

(7) An insurer must, prior to adjusting the actuarial basis for policies to ensure that these bases are not inconsistent with the minimum principles contained in this Part, inform the Authority of the proposed amendment and the reasons therefore.

(Part 5C inserted by regulation 6(p) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

PART 6
BINDER AGREEMENTS

6.1 Definitions and interpretation

In this Part 6, unless the context indicates otherwise -

"administrative FSP" has the meaning assigned to it in the Codes of Conduct for administrative and discretionary FSPs published in Board Notice No. 79 of 8 August 2003, and amended from time to time, under the FAIS Act;

(Definition of "administrative FSP" substituted by regulation 7(a) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"associate" -

(a) has the meaning assigned to it in the General Code of Conduct; and

(b) in addition to paragraph (a), includes, in respect of a juristic person -

(i) another juristic person that has a significant owner or member of its governing body that is also a significant owner or member of the governing body of the first mentioned juristic person; and

(ii) another juristic person that has a person as a significant owner or member of its governing body who is an associate (within the meaning of paragraph (a)) of a significant owner or member of the governing body of the first mentioned juristic person;

(Definition of "associate" substituted by regulation 7(b) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"binder agreement" means an agreement contemplated in section 49A of the Act;

(Definition of "binder agreement" substituted by regulation 7(c) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**binder function**" means any of the functions contemplated in section 49A(1)(a) to (e) of the Act;
(Definition of "binder function" inserted by regulation 7(d) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"binder holder" means a person with whom an insurer has concluded a binder agreement;

"enter into" means any act that results in an insurer becoming liable to provide policy benefits under a policy where the person performing the act may do so without the insurer becoming aware of the act until after the act has been performed;

"**FAIS Act**" means the Financial Advisory and Intermediary Services Act, 2002 (Act No. 37 of 2002);
(Definition of "FAIS Act" inserted by regulation 7(e) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**funeral and assistance policies**" in respect of a –

(a) registered insurer, means one or more –

(i) life policies where the policy benefits relate only to services or costs associated with funerals; or

(ii) assistance policies;

(b) licensed insurer, means one or more policies underwritten -

(i) under the Funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act; or;

(ii) by a microinsurer as defined in section 1 of the Insurance Act;
(Definition of "funeral and assistance policies" inserted by regulation 7(f) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)
(Definition of "funeral and assistance policies" in Regulation 6.1 substituted by regulation 8(a) of GN 1015 of 2018)

"**General Code of Conduct**" means the General Code of Conduct for Authorised Financial Services Providers and Representatives as published in Board Notice No. 80 of 2003, and amended from time to time, under section 15 of the FAIS Act;
(Definition of "General Code of Conduct" inserted by regulation 7(g) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**governing body**" has the meaning assigned to it in section 1 of the Financial Sector Regulation Act, 2017 (Act No. 9 of 2017);

(Definition of "governing body" inserted by regulation 7(h) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Definition of "governing body" in Regulation 6.1 substituted by regulation 8(b) of GN 1015 of 2018)

"independent intermediary" has the meaning assigned to it in regulation 3.1;

"insurer" …….

(Definition of "insurer" deleted by regulation 7(i) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**integration**" means policy and policyholder data is in a format that is readily recognisable and capable of being meaningfully utilised immediately by the core insurance systems and applications of the insurer;

(Definition of "integration" inserted by regulation 7(j) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**inter-related**" has the meaning assigned to in section 1 of the Companies Act;

(Definition of "inter-related" inserted by regulation 7(k) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"mandated intermediary" means an independent intermediary that holds a written mandate from a potential policyholder or policyholder that authorises that intermediary, without having to obtain the prior approval of that potential policyholder or policyholder, to perform any act, including termination, in relation to a policy, that legally binds that potential policyholder or policyholder, other than an act directed only at changing the underlying investment portfolio of a policy;

"non-mandated intermediary" means a representative or an independent intermediary, other than a mandated intermediary or an underwriting manager;

"policy" means a long-term policy other than a reinsurance policy;

(Definition of "policy" substituted by regulation 7(l) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**qualifying stake**" means in respect of a person that –

(a) is a company, that another person, directly or indirectly, alone or together with a related or inter-related person -

(i) holds at least 15% of the issued shares of the first mentioned person;

(ii) has the ability to exercise or control the exercise of at least 15% of the voting rights attached to securities of the first mentioned person;

(iii) has the ability to dispose of or control the disposal of at least 15% of the first mentioned person's securities; or

(iv) holds rights in relation to the first mentioned person that, if exercised, would result in that other person, directly or indirectly, alone or together with a related or inter-related person -

(aa) holding at least 15% of the securities of the first mentioned person;

(bb) having the ability to exercise or control at least 15% of the voting rights attached to shares or other securities of the first mentioned person; or

(cc) having the ability to dispose of or direct the disposal of at least 15% of the first mentioned person's securities;

(b) is a close corporation, that another person, directly or indirectly, alone or together with a related or inter-related person, holds at least 15% of the members' interests or controls, or has the right to control, at least 15% of members' votes in the close corporation;

(c) is a trust, means that another person has, directly or indirectly, alone or together with a related or inter-related person -

(i) the ability to exercise or control the exercise of at least 15% of the votes of the trustees;

(ii) the power to appoint at least 15% of the trustees; or

(iii) the power to appoint or change any beneficiaries of the trust;

(Definition of "qualifying stake" inserted by regulation 7(m) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"**related**" has the meaning assigned to in section 1 of the Companies Act;

(Definition of "related" inserted by regulation 7(n) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"renew" means any act that results in the renewal or reinstatement of an insurer's liability to provide policy benefits under a policy where the person performing the act may do so without the insurer becoming aware of the act until after the act has been performed;

"representative" has the meaning assigned to it in regulation 3.1, but excludes any natural person;

(Definition of "representative" substituted by regulation 7(o) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"settle a claim" means any act that results in -

(a) the acceptance of partial or full liability under a claim for policy benefits or a part thereof;

(b) the determination of the liability of an insurer under a claim for policy benefits; or

(c) the rejection of or refusal to pay a claim for policy benefits or a part thereof;

where the person performing the act may do so without the insurer becoming aware of the act until after the act has been performed;

"**significant owner**" means a person that, directly or indirectly, alone or together with a related or inter-related person, has the ability to control or influence materially the business or strategy of another person. A person has the ability referred to in that subsection if –

(a) the person, directly or indirectly, alone or together with a related or inter-related person, has the power to appoint 15% of the members of the governing body of the other person;

(b) the consent of the person, alone or together with a related or inter-related person, is required for the appointment of 15% of the members of a governing body of the other person; or

(c) the person, directly or indirectly, alone or together with a related or inter-related person, holds a qualifying stake in the other person;

(Definition of "significant owner" inserted by regulation 7(p) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"this Part" means this Part 6;

"transformation in the insurance sector" has the meaning assigned to it in section 1 of the Insurance Act;

(Definition of "transformation in the insurance sector" in Regulation 6.1 inserted by regulation 8(c) of GN 1015 of 2018)

"underwriting manager" means a person that -

(a) performs one or more binder function; and

(b) if that person renders services as an intermediary as defined in Part 3A of the Regulations-

(i) does not perform any act directed towards entering into, maintaining or servicing a policy on behalf of an insurer, a potential policyholder or policyholder (including the performance of such an act in relation to a fund, a member of a fund and the agreement between the member and the fund); and

(ii) renders those services (other than the services referred to in paragraph (i) above) to or on behalf of an insurer only; and

(c) does not have any relationship with an insurer (including the secondment of that person's employees to an insurer or an associate of an insurer, the outsourcing of that person's infrastructure to an insurer or an associate of an insurer, or any similar arrangement) which may result in that person or its employees *de facto*, directly or indirectly, performing any act directed towards entering into, varying or renewing a policy on behalf of an insurer, a potential policyholder or policyholder; and

(Definition of "underwriting manager" substituted by regulation 7(q) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

"vary" means any act that results in the variation, termination, repudiation or denial of an insurer's liability to provide policy benefits under a policy where the person performing the act may do so without the insurer becoming aware of the act until after the act has been performed, and includes any act declaring a policy void.

6.2 Requirements, limitations and prohibitions relating to binder holders

(1) An insurer, subject to subregulations (1A) to (4) and regulation 6.5, may have a binder agreement with one or more of the following persons only -

(a) a non-mandated intermediary;

(b) an underwriting manager; or

(c) an administrative FSP.

(1A) An insurer may only enter into a binder agreement with a person referred to in subregulation (1) if the outsourcing of a binder function to that person –

(a) is intended to promote the delivery of fair outcomes to customers;

(b) would not result in a duplication of administrative efforts or costs for the insurer; and

(c) would not impede the insurer's ability to on an ongoing basis identify, assess, manage and report on the risks of poor customer outcomes potentially arising from the manner in which the insurer conducts its business.

(2) A non-mandated intermediary referred to under subregulation (1)(a) may not conduct any business with any mandated intermediary that is an associate of that non-mandated intermediary in relation to the same policy or policies of an insurer.

(3) An underwriting manager referred to under subregulation (1)(b) may not conduct any business with a mandated or non-mandated intermediary, or a representative of a mandated or non-mandated intermediary, or an administrative FSP that is an associate of that underwriting manager in relation to the same policy or policies of an insurer.

(4)

(a) An underwriting manager referred to under subregulation (1)(b) who is a binder holder of one insurer cannot also be a binder holder of other insurers in respect of the same class of policies defined in section 1 of the Act, unless all the relevant insurers have agreed thereto in writing.

(b) Paragraph (a) does not apply if an underwriting manager enters into a binder agreement with an insurer during a termination period referred to in regulation 6.3(1)(s) in respect of a binder agreement with another insurer and that underwriting manager may not perform any binder functions on behalf of that other insurer during that termination period.

(Regulation 6.2 substituted by regulation 7(r) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

6.2A Governance and oversight requirements

(1) An insurer must before entering into a binder agreement and at all times thereafter -

(a) have the necessary resources and ability to exercise effective oversight over the binder holder on an ongoing basis, particularly in respect of identifying, assessing, managing and reporting on the risks of poor customer outcomes arising from conducting insurance business through binder agreements;

(b) satisfy itself of the adequacy of the binder holder's -

(i) governance, risk management and internal control framework, including the binder holder's ability to comply with applicable laws and the binder agreement; and

(ii) fitness and propriety, including any specific technical expertise required to perform the function to which the binder agreement relate;

(c) have documented controls in place to ensure the validity, accuracy, completeness and security of any information provided by the binder holder; and

(d) have appropriate contingency plans in place to address any shortcomings it may identify that could lead to it not being satisfied as to the matters provided for in paragraph (b), including where the binder holder is unable to provide the insurer with the relevant data in the appropriate format.

(2) An insurer must before entering into a binder agreement and at all times thereafter be satisfied that the binder holder has the operational ability to ensure integration between the information technology system of the insurer and the information technology system of the binder holder, which enables the insurer to have access to up-to-date, accurate and complete data held by the binder holder as and when requested by the insurer and as required in terms of the binder agreement and any other regulatory requirements relating to data management, including the requirements in the Policyholder Protection Rules:*[sic]*

(Publisher's note – Regulation 6.2A(2) takes effect on 1 January 2020 – refer to regulation 8.3(e) of GN 1437 of 2017)

(3) An insurer must regularly review and, where appropriate, act upon the information received from the binder holder to assess the appropriateness and suitability of the functions being performed in terms of the binder arrangement in delivering fair outcomes to policyholders on an ongoing basis.

(Regulation 6.2A inserted by regulation 7(s) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

6.3 Requirements, limitations and prohibitions relating to binder agreements

(1) A binder agreement must, in addition to those matters provided for under section 49A(2) -

(a) specify if the binder holder is a non-mandated intermediary, an underwriting manager or an administrative FSP;

(b) specify the duration of the agreement;

(c) specify the level and standard of service that must be rendered to a policyholder, where relevant, and to the insurer;

(d) require that the binder holder at all times is fit and proper, and has appropriate governance, risk management, internal controls and information technology systems in place to render the services under the binder agreement;

(Regulation 6.3(1)(d) substituted by regulation 7(t) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(e) require that the binder holder comply with applicable laws;

(f) specify the Rand value of the remuneration or consideration contemplated under Part 3C payable by the insurer to the binder holder or, if the Rand value is not fixed or determinable on entering into the agreement, the basis on which the remuneration or consideration payable will be calculated, in respect of each binder function performed under the binder agreement;

(Regulation 6.3(1)(f) substituted by regulation 7(u) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(g) specify the disclosures that must be made and the information that must be provided to a policyholder, and the manner in which such disclosures or information must be made or provided when a binder holder -

(i) enters into, varies or renews a policy;

(ii) determines the wording of a policy;

(iii) determines premiums under a policy;

(iv) determines the value of policy benefits under a policy; or

(v) settles a claim under a policy;

(h) provide for the type and frequency of reporting by the binder holder on the services rendered under the binder agreement;

(i) provide for the manner in and the means by which an insurer will monitor the binder holder's performance under and compliance with the binder agreement;

(j) provide for periodic performance reviews of the binder holder and the regular review of the binder agreement;

(k) specify that the insurer has a right to access any data held by the binder holder as and when such data is requested by the insurer;

(Regulation 6.3(1)(k) substituted by regulation 7(v) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(l) address confidentiality, privacy and the security of information of the insurer and policyholders;

(m) address ownership of intellectual property;

(n) specify that the binder holder must take the necessary steps to allow the Authority access to its business and information in respect of the functions performed under the agreement;

(o) include indemnity and liability provisions;

(p) require the binder holder to provide the insurer with access to up-to-date, accurate and complete data (in accordance with regulation 6.2A(2)) to ensure that the insurer is able to comply with any regulatory requirements relating to data management, including any requirements provided for in the Policyholder Protection Rules, at the following intervals -

(i) daily, in respect of policies other than funeral and assistance policies;

(ii) monthly, in respect of funeral and assistance policies;

(Regulation 6.3(1)(p) substituted by regulation 7(w) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017, with effect from 1 January 2020)

(q) set out any warranties or guarantees to be furnished and insurance to be secured by the binder holder in respect of its ability to fulfil *[sic]* its contractual obligations;

(qA) provide for mechanisms and measures that will assist the insurer in meeting procurement, enterprise and supplier development targets relating to the transformation in the insurance sector;

(Regulation 6.3(1)(qA) (erroneously referred to as paragraph (q)) inserted by regulation 8(d) of GN 1015 of 2018 with effect from:

(i) the date referred to in regulation 9.2 [28 September 2018] for binder agreements entered into on or after the effective date;

(ii) 1 January 2019 for binder agreements entered into before the date referred to in regulation 9.2 [28 September 2018])

(r) provide for a dispute resolution process;

(s) provide for a termination period, irrespective of the circumstances under which the agreement is terminated (including the lapsing or non-renewal of the agreement), of at least 90 days, that will allow -

(i) the binder holder and insurer to comply with any legislative requirements relating to the policies referred to in the binder agreement; and

(ii) for the transfer or sharing of all electronic and paper-based records in respect of the policies referred to in the binder agreement, including the names and identity numbers of all policyholders, insured persons and beneficiaries; and

(t) provide for business contingency processes, including the continuity of service if the binder holder is placed under curatorship, business rescue, becomes insolvent, is liquidated or is for any reason unable to continue to render the services in accordance with the binder agreement.

(2) Sub-regulation (1)(t) does not prohibit a binder agreement from providing that an insurer may -

(a) limit or prevent a binder holder from performing certain or all binder functions during the termination period; or

(b) take reasonable measures to limit any risks it may be exposed to resulting from or associated with a binder agreement or its termination.

(3)

(a) A binder agreement may only provide for matters referred to in section 49A of the Act, this Part and matters incidental thereto, and may not regulate any other arrangement or relationship with the binder holder, irrespective of such other arrangement or relationship being dependent on the conclusion of a binder agreement or that the binder agreement is in addition to or consequential to such other arrangement or relationship.

(b) A binder agreement may not prohibit an insurer from communicating directly with its policyholders or any independent intermediary.

(4) A binder agreement concluded with a non-mandated intermediary, in addition to the matters provided for under sub-regulation (1), must limit the discretion of the binder holder in respect of -

(a) the maximum value of policy benefits that may be determined under each policy or the maximum value of any claim that may be settled by the binder holder under the policies to which the binder agreement relates;

(b) the morbidity and mortality risk factors, where appropriate, that must be considered by the binder holder when entering into, varying or renewing a policy or determining the value of policy benefits under a policy;

(c) other parameters in accordance with which the binder holder must render the services provided for in the binder agreement; and

(d) any guarantee of policy benefits that may be provided for under an investment policy as defined in Part 3A of the Regulation.

(5) A binder agreement concluded with a non-mandated intermediary may not authorise the binder holder to -

(a) refuse to renew a policy;

(b) reject or refuse to pay a claim for policy benefits or a part thereof;

(c) terminate, repudiate or deny an insurer's liability to provide policy benefits under a policy; or

(d) declare a policy void.

(6) An insurer must promptly take reasonable steps to rectify any non-adherence to a binder agreement.

(Regulation 6.3(6) inserted by regulation 7(x) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(7) An insurer must retain a copy of a binder agreement for a period of at least 5 years from the date on which a binder agreement is terminated.

(Regulation 6.3(7) inserted by regulation 7(x) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

6.4 …….

(Regulation 6.4 deleted by regulation 7(y) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

6.5 Exemption

(1) Despite regulation 6.2(2) or (3), the Authority may on application from an insurer referred to in regulation 6.2(2) or (3) or an insurer that is the holding company or associate of more than one person referred to in regulation 6.2(2) or (3) exempt, subject to such conditions as the Authority may impose, the insurer or such person from regulation 6.2(2) or (3), if the Authority is satisfied that-

(a) any actual or potential conflict of interest is effectively mitigated;

(b) the delivery of fair outcomes to policyholders will not be impeded; and

(c) the person has the operational and financial capability to perform the binder function or to conduct such business.

(Regulation 6.5 substituted by regulation 7(z) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

6.6 Reporting requirements

(1) An insurer must, at least 30 days before entering into a binder agreement, notify the Authority in writing and in the format determined by the Authority of the proposed binder agreement.

(2) An insurer must, at least 60 days before the expiry of the termination period referred to under regulation 6.3(1)(s), inform the Authority in writing and in the format required by the Authority-

(a) of the date on which the binder agreement will terminate;

(b) of the reasons for the termination of the binder agreement;

(c) how the policies to which the binder agreement relates will be dealt with;

(d) how any legislative requirements relating to the termination of the binder agreement or policies, if one or more policies to which the binder agreement relates will be terminated, will be complied with.

(Regulation 6.6 substituted by regulation 7(aa) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

6.7 …….

(Regulation 6.7 deleted by regulation 7(bb) of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Part 6 added by regulation 2 of Government Notice R1218 of 2006)
(Part 6 substituted by regulation 2 of Government Notice R186 of 2007)
(Part 6 amended by regulation 3 of Government Notice R952 of 2008)
(Part 6 substituted by regulation 1 of Government Notice R1077 of 2011 with effect from 1 January 2012)

PART 7
CONTRACTS IDENTIFIED AS HEALTH POLICIES UNDER SECTION 72(2A)(a) OF THE ACT

7.1 Definitions and interpretation

In this Part 7, unless the context indicates otherwise-

"**condition-specific waiting period**" means a period in which a policyholder is not entitled to claim policy benefits in respect of a specific condition for which medical advice, diagnosis, care or treatment was recommended or received within a period of 12 months preceding the day on which the policy was entered into;

"**general waiting period**" means a period in which a policyholder is not entitled to claim any, or may only claim certain, policy benefits;

"**hospitalisation**" means any admission for a procedure or administration of a therapeutic or diagnostic medical intervention wherein a person is expected to stay overnight in a facility;

"**insurer**" means a long-term insurer;

"**medical scheme**" has the meaning assigned under section 1 of the Medical Schemes Act;

"**member**" has the meaning assigned under section 1 of the Medical Schemes Act;

"**policy**" means a long-term policy;

"**product line**" in relation to a category and type of contract referred to in Regulation 7.2(1), means health policies that have the same or closely related contractual terms offered or entered into by an insurer;

"**relevant health service**" has the meaning assigned under section 1 of the Medical Schemes Act;

"**rider benefit**" means an additional insurance obligation under a long-term policy which obligation is ancillary to the primary insurance obligations assumed under that policy;

"**this Part**" means this Part 7;

"**underwritten on a group basis**" means where the risks relating to a policy forming part of a product line are rated based on the characteristics of a group of people (other than characteristics that relate to or may result in specific health conditions) together as opposed to that of the individual to whom the policy relates.

7.2 Categories and types of contracts identified as health policies

(1) The categories and types of contracts set out in the table below are identified as health policies. A contract will only be a health policy for purposes of this Part if it meets the contract description and requirements relating to policy benefits of a specific category and type of contract set out in the table below.

TABLE

Category	Contract Type	Contract description	Requirements relating to policy benefits
1	Non-medical expense cover as a result of hospitalisation	A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits on the happening of a health event that results in hospitalisation.	Policy benefits – (a) Are a fixed sum of money which does do*[sic]* not exceed R3 000.00 (three thousand Rand) per insured per day or a maximum lump sum amount of R20 000.00 (twenty thousand Rand) per annum irrespective of the number of days in hospital; (b) does not require hospitalisation for a period of longer than 3 days before they become payable; (c) once it becomes payable, are calculated from day 1 of hospitalisation; and (d) may not be paid or ceded to the provider of a relevant health service.
2	Frail Care	A contract – (a) in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event; and (b) the purpose of which is to cover the costs or expenses of assistance for activities of daily living.	
3	HIV, Aids, tuberculosis or malaria testing and treatment	A contract – (a) in terms of which a person, in return for a premium, undertakes to provide	Policy benefits are provided as a rider benefit.

Category	Contract Type	Contract description	Requirements relating to policy benefits
		policy benefits if a health event relating to HIV, Aids, tuberculosis or malaria occurs; and (b) the purpose of which is to cover the costs or expenses of testing and treatment of HIV, Aids, tuberculosis or malaria.	
4	Medical emergency evacuation or transport	A contract – (a) in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event; and (b) the purpose of which is to– (i) cover the costs of or provide emergency evacuation or transport to a medical treatment facility; or (ii) cover the cost of emergency medical treatment.	Policy benefits are provided as a rider benefit.

(2) All amounts referred to in sub-regulation (1) escalate annually, from the effective date of this Part, by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999)).

7.3 Limitations applicable to category 1 contracts

Prohibition of policy benefits that fully or partially indemnifies against medical expenses under category 1

(1) A contract referred to in category 1 in the table under regulation 7.2(1) may not provide policy benefits that are fully or partially related to indemnifying the policyholder against medical expenses incurred in respect of a relevant health service.

Underwritten on a group basis and non-discrimination

(2) A contract referred to in category 1 and 3 in the table under Regulation 7.2(1) must –

(a) be underwritten on a group basis; and

(b) not discriminate against a policyholder or potential policyholder on the basis of race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability, state of health or any similar grounds.

(3) An insurer may not refuse to enter into a contract referred to in category 1 with a potential policyholder unless where that potential policyholder has previously committed a fraudulent act related to insurance.

(4) Despite sub-regulation (2)(b), an insurer may in respect of contracts referred to in category 1 in the table under Regulation 7.2(1) require a policyholder that enters into a contract after a specific age to pay a higher premium than a policyholder that entered into the contract at a younger age, provided that the same higher premium is payable by all policyholders entering into a product line after a specific age.

Waiting periods

(5) Despite sub-regulation (2), a contract referred to in category 1 and 3 in the table under Regulation 7.2(1) may provide for a –

(a) general waiting period of up to 3 months; and

(b) condition-specific waiting period of up to 12 months.

(6) An insurer may not impose a condition-specific waiting period on a policyholder's health policy if that policyholder, for at least 90 days before entering into a health policy with the insurer, had a health policy with materially similar benefits and had completed the condition-specific waiting period in respect of that health policy;

(7) Where a waiting period of a policyholder under a previous health policy referred to in sub-regulation (6) had not expired at the time that that policyholder enters into a new health policy with materially similar benefits, the insurer may only impose a waiting period equalling the unexpired part of the waiting period in respect of that previous policy.

Variation of contracts

(8) For the purposes of this Part, the variation of a contract includes premium adjustments under a contract, unless agreed to at the commencement of the contract and such adjustments are not inconsistent with sub-regulation 7.3(2)(b).

(9) Despite sub-regulation (2), a contract referred to in category 1 and 3 in the table under Regulation 7.2(1) may be varied as a result of the health or claims experience of all policies forming part of a product line but may not be varied as a result of the health or claims experience of an individual policyholder.

Termination of contracts

(10) A contract referred to in category 1 in the table under Regulation 7.2(1) may be terminated by an insurer only if –

(a) the policyholder –

(i) fails to pay (within the time allowed in the contract and subject to any legislative requirements) the premium under the contract;

(ii) submitted fraudulent claims; or

(iii) committed any fraudulent act; or

(b) the insurer will no longer be offering a specific product line as part of its long-term insurance business and the insurer has given all of that product line policyholders 90-day notice before termination.

(11) For the purposes of this Part, termination of a contract includes the non-renewal of a contract by an insurer.

7.4 Contracts may not require medical scheme membership

A contract referred to in the table under Regulation 7.2(1) may not provide that the policyholder or insured person must be a member of a medical scheme.

7.5 Marketing and disclosures requirements

(1) Any marketing activity or marketing material in respect of a contract referred to in category 1 and 3 in the table under regulation 7.2(1) must –

(a) not identify that contract by the term "medical", "hospital" or any derivative thereof, except –

(i) where using the term "hospitalisation" to describe a contract, in which case the term must always be preceded by the words "non-medical expense cover as a result of"; or

(ii) where such terms are used in the contract itself to describe policy benefits;

(b) not in any manner create the perception that the contract –

(i) is a substitute for medical scheme membership; and

(ii) in the case of a contract referred to in category 1 in the table under regulation 7.2(1), indemnifies a policyholder against medical expenses incurred as a result of a relevant health service; and

(c) display the following statement in clear legible print in a prominent position:

"This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership."

7.6 Reporting requirements

(1) An insurer must, at least 1 month prior to marketing or offering a new product line, submit to the Authority and Registrar of Medical Schemes a summary of the benefits, terms and conditions and marketing material of the health policy or policies forming part of the product line.

(2) The Authority may at any time request information on the benefits, terms, conditions and marketing material of a contract that, in the opinion of the Authority or the Registrar of Medical Schemes, is or may be a contract referred to under regulation 7.2(1).

(3) The Registrar of Medical Schemes may at any time advise the Authority that the Registrar of Medical Schemes is of the opinion that the benefits, terms and conditions or marketing material relating to a contract under sub-regulation (1) or (2) is contrary to the objectives and purpose of the Medical Schemes Act and the principles referred to in sections 72(2A)(b)(i)(cc)(A) to (C) of the Act, and the reasons for this opinion.

(4) The Authority may at the Authority's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to under sub-regulation (3), by notice to an insurer, object to any of the benefits, terms and conditions and marketing material of a health policy under sub-regulation (1) and (2), and instruct the insurer to –

(a) stop marketing the health policy or policies;

(b) stop offering or renewing the health policy or policies to the public and within 90-days of the date determined by the Authority, terminate such health policy or policies; or

(c) by a date determined by the Authority, amend any of the benefits, terms and conditions and marketing material of a health policy or policies in accordance with the requirements of the Authority.

7.7 Transitional arrangements

(1) Contracts entered into before this Part took effect must comply with this Part as and when such contracts are varied or renewed subsequent to this Part becoming effective.

(Part 7 inserted by regulation 2 of Government Notice R1077 of 2011)
(Part 7 substituted by regulation 2 of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

PART 8

AUTHORISATION OF AND REQUIREMENTS FOR COLLECTION OF PREMIUMS BY INTERMEDIARIES (SECTION 47A)

8.1 Authorisation

(1) Any authorisation referred to in section 47A provided by an insurer to an independent intermediary to receive, hold or in any other manner deal with a premium payable under a policy of that insurer must be in writing.

(2) A written authorisation referred to in subregulation (1) must, amongst other things -

(a) specify the duration of the authorisation and the functions that may be performed under the authorisation;

(b) specify the level and standard of services that must be rendered in terms of the authorisation;

(c) specify the operational requirements that the independent intermediary must meet at all times to render services under the authorisation;

(d) specify the purposes for which premiums of the insurer received or held by the independent intermediary may and may not be utilised for by the independent intermediary;

(e) provide for appropriate requirements relating to the termination of the authorisation, including an adequate notice period, that take into account the interests of policyholders;

(f) provide for the type and frequency of reporting by the independent intermediary on the services rendered under the authorisation; and

(g) provide for the manner in and the means by which an insurer will monitor the independent intermediary's performance under and compliance with the authorisation.

(Commencement date of Regulation 8.1(2): 1 July 2019)

(3) An insurer may not, for purposes of subregulation (2)(d), authorise an independent intermediary to utilise premiums for a purpose that could potentially lead to a significant increase in risk to the insurer.

(Commencement date of Regulation 8.1(3): 1 July 2019)

(4) An independent intermediary may not delegate an authorisation that has been granted to it in accordance with section 47A.

(Commencement date of Regulation 8.1(4): 1 July 2019)

(5) An insurer must, before it authorises an independent intermediary under section 47A, and at all times thereafter, be satisfied that -

(a) the independent intermediary is fit and proper and has the necessary operational ability to satisfactorily perform the functions or activities contemplated in the authorisation;

(b) such authorisation will not materially increase risk to the insurer; and

(c) such authorisation will not compromise the fair treatment of or continuous and satisfactory service to policyholders.

(6) An insurer must on an ongoing basis take reasonable steps to monitor whether an independent intermediary authorised under section 47A receives, holds or in any other manner deals with premiums in accordance with the authorisation and in accordance with this Part.

(Commencement date of Regulation 8.1(6): 1 July 2019)

(7) An insurer must have appropriate contingency plans in place to address any shortcomings in the independent intermediary's performance of the authorised functions that it may identify through the monitoring contemplated in subregulation (6) or otherwise become aware of.

(Commencement date of Regulation 8.1(7): 1 July 2019)

8.2 Requirements relating to receiving premiums

(1) An independent intermediary who receives premiums must account for such premiums properly and promptly and open and maintain one or more separate bank account into which premiums are to be received.

(2) A separate bank account referred to in subregulation (1) may only contain monies collected from policyholders and may not contain any monies or funds of the independent intermediary.

(3) All premiums received by an independent intermediary -

(a) through electronic means must be received into a bank account referred to in subregulation (1); or

(b) in cash must be deposited into a bank account referred to in subregulation (1) within 1 business day after a premium is received.

(4) An independent intermediary must within a period of 15 days after the end of every month, pay to the insurer concerned the total amount of the premiums received during that month.

(5) Despite subregulation (4), an independent intermediary may, subject to the insurer's authorisation, prior to paying the total amount of the premiums received to the insurer reduce that amount by the value of -

(a) any refund of premiums due and payable by the insurer to any policyholder or prospective policyholder represented by such independent intermediary in respect of the policies that are subject to the authorisation granted by the insurer;

(b) any consideration payable to that independent intermediary by the insurer for rendering services as intermediary in respect of the policies concerned.

(6) If more than one independent intermediary is authorised by an insurer to receive or hold premiums in relation to the same policy, the period between the receipt thereof from the insured or any person on his or her behalf and payment to the insurer shall not exceed the period contemplated in subregulation (4).

(Commencement date of Regulation 8.2: 1 July 2019)

8.3 Returns

(1) An independent intermediary who has been authorised under section 47A must in respect of every month in respect of which the authority is in force, furnish the insurer concerned with returns -

(a) in the form required by that insurer;

(b) containing information relating to at least the premiums received, the commission payable to that intermediary and the amounts paid to the insurer in respect of the policies concerned; and

(c) within a period of 15 days after the end of the month concerned.

(Commencement date of Regulation 8.3: 1 July 2019)

8.4 Exemption

(1) The Authority may, on reasonable grounds, on application from an insurer or on the Authority's own initiative, subject to such conditions as the Authority may determine, exempt an insurer or independent intermediary from any requirement of this Part if the Authority is satisfied that -

(a) the granting of the exemption is necessary because practicalities impede the strict application of a specific provision of this Part or another Act of Parliament regulates an activity that is subject to this Part and that such regulation of the activity justifies the exemption from a specific requirement of this Part;

(b) the granting of the exemption will not materially increase risk to the insurer;

(c) the granting of the exemption will not be contrary to the public interest; and

(d) the granting of the exemption will not compromise the fair treatment of or continuous and satisfactory service to policyholders.

(Part 8 inserted by regulation 3 of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

(Part 8 substituted by regulation 8 of Government Notice 1437 in Government Gazette 41334 dated 15 December 2017)

(Part 8 substituted by regulation 9 of GN 1015 of 2018)

PART 9

TITLE AND COMMENCEMENT

9.1 These regulations are called the Regulations under the Long-term Insurance Act, 1998.

9.2 The amendments to the Regulations, subject to regulations 9.3 and 9.4, take effect on 1 July 2018.

9.3 Despite regulation 9.2, the -

(a) insertion of paragraph (q) in subregulation (1) in regulation 6.3 of Part 6 takes effect -

(i) on the date referred to in regulation 9.2 for binder agreements entered into on or after the effective date;

(ii) on 1 January 2019 for binder agreements entered into before the date referred to in regulation 9.2; and

(b) insertion of regulations 8.1(2), (3), (4) (6) and (7), 8.2 and 8.3 in Part 8 takes effect 12 months after the date referred to in regulation 9.2.

9.4 Despite regulation 9.2 the following amendments made to the Regulations through Government Notice 1437 as published in Government Gazette 41334 on 15 December 2017 take effect as follows -

(a) repeal of the definition of "administrative work" in regulation 3.1 in Part 3A takes effect 12 months after the effective date;

(b) insertion in Part 3A of regulation 3.9A takes effect 6 months after the effective date;

(c) the amendment of item 5.2.2.1 and repeal of items 5.2.2.1.1 and 5.2.2.1.2 in the Table in Annexure 1 in Part 3A takes effect 12 months after the effective date;

(d) insertion of subregulations (2) and (3) in regulation 3.21 in Part 3C takes effect -

(i) on the effective date for binder agreements entered into on or after the effective date;

(ii) for binder agreements entered into after 1 January 2017 but before the effective date, the earliest of -

(aa) 6 months after the effective date; or

(bb) the date on which any amendment to binder fees payable under such binder agreement is made;

(iii) for binder agreements entered into before 1 January 2017, the earliest of -

(aa) 12 months after the effective date; or

(bb) the date on which any amendment to binder fees payable under such binder agreement is made;

(e) insertion of subregulation (2) in regulation 6.2A in Part 6 takes effect 24 months after the effective date; and

(f) amendment to paragraph (p) in subregulation (1) in regulation 6.3 in Part 6 takes effect 24 months after the effective date.

9.5 For purposes of regulation 9.4 "effective date" means 1 January 2018.

(Part 9 inserted by regulation 10 of GN 1015 of 2018)

***(Editorial note:** The explanatory memorandum below was published in GNR 1077 of Government Gazette 34877 of 23 December 2011. It does not form part of the regulations as such, but has been added as it may be useful to those working in the field of binder agreements.)*

EXPLANATORY MEMORANDUM

1. PURPOSE

The purpose of this Explanatory Memorandum is to provide insight into the principles that informed the regulations and explain how these principles are reflected in the regulations.

2. BACKGROUND

The enhancement of the legislative framework relating to binder agreements commenced with the enactment of the Insurance Laws Amendment Act No. 27 of 2008.

The latter Act amended the existing provisions of the Short-term Insurance Act and introduced provisions in the Long-term Insurance Act relating to binder agreements. Before the enactment of the latter Act, binder agreements in the long-term insurance industry were not regulated.

The Long-term Insurance and Short-term Insurance Acts, as amended (the Insurance Laws), afford the Minister of Finance legislative authority to make regulations on a number of matters relating to binder agreements.

Subsequent to the enactment of the Insurance Laws Amendment Act, a Binder Task Team with representation from the National Treasury, the Financial Services Board and industry associations (ASISA, SAIA, FIA and SAUMA) was constituted. The mandate of the Binder Task Team was to draft binder regulations for consideration by the Minister of Finance. In addition, the Financial Services Board met separately with industry associations to discuss the potential impact of binder regulations on the long-term and short-term insurance industries.

The binder regulations are therefore the result of robust and inclusive consultation with interested and affected stakeholders.

3. SCOPE OF THE REGULATIONS

The regulations represent but one of a series of initiatives and projects of the National Government and the Financial Services Board.

The regulations therefore do not address the following aspects, which are the subject of separate processes, -

3.1 the issues relating to the definition of intermediary services and related remuneration in the insurance sector, which were raised in the call for contributions issued by the Financial Services Board on 11 November 2011;

3.2 the outsourcing of core insurer functions to third parties holistically, dealt with in draft Directive 159.A.i (LT & ST). The regulations only address a subset of outsourcing namely the outsourcing of binder functions;

3.3 ownership structures (including ownership structures in respect of cell arrangements)[1], in particular conflicts of interests that are inherent in these structures and arrangements as per Information Letter 2/2011 (LT & ST).

Binder functions are the collective term used for those functions that a binder holder performs as the agent of the insurer. The binder holder acts on behalf of the insurer, as if the binder holder were the insurer, when interacting with potential policyholders and policyholders. Binder functions differ from intermediary services in that binder functions comprise the actual act of entering into, varying or renewing a policy (in other words, the insurer will only be aware of the new policyholder liability after the fact), while intermediary services constitute any acts towards a person entering into, maintaining or servicing a policy.

4. RELEVANT ACTS AND THE REGULATIONS

4.1 **The Long-term Insurance Act:** The Long-term Insurance Act (the Act) contains the fundamental policy or underlying principles relating to binder agreements. It provides for the basic or minimum issues and powers necessary to regulate binder agreements and delegates legislative (law-making) and other authority to implement and enforce the Act to the Minister of Finance.

The regulations are the detailed regulation of matters provided for in the Act. They supplement the Act by prescribing detailed and technical rules

The regulations must be read with the Act.

The relevant extract from the Act (section 49A) is included at the end of this Schedule as Annexure 1.

4.2 **The Financial Advisory and Intermediary Services Act:** The regulations refer to the Financial Advisory and Intermediary Services Act (the FAIS Act). This is so as to, in as far as reasonably possible, ensure consistency in respect of terminology used and to avoid any interpretation difficulties that may arise in implementing the regulations.

[1] The regulations, however, do apply to any binder functions performed by, under or in terms of these ownership structures.

The regulations must be read with the FAIS Act.

5. BROAD PRINCIPLES THAT INFORMED THE REGULATIONS

The following broad principles informed the regulations:

5.1 **Accountability of the insurer**: The insurer is responsible for complying with the Act, irrespective of the fact that the insurer outsources some of its functions to a third party.

5.2 **Responsible outsourcing**: Where an insurer outsources "binder functions" to a third party, the insurer must ensure that the contractual arrangements, and the oversight and management of the contractual arrangements, facilitate (not impede) the insurer's compliance with the Act and the fair treatment of policyholders.

5.3 **Policyholder protection**: Policyholder interests and the fair treatment of policyholders may not be prejudiced by the outsourcing of "binder functions" by an insurer.

5.4 **Conflicts of interest**: Any potential conflicts of interest that may arise where a non-mandated intermediary is a binder holder must be avoided.

6. SUMMARY OF THE REGULATIONS

6.1 Who may be a binder holder?

[See regulation 6.2]

An underwriting manager, an administrative FSP or a non-mandated intermediary may be a binder holder.

Underwriting manager

[See regulations 6. 1 and 6. 2]

An underwriting manager is defined in the regulations as a person that -

- performs one or more of the binder functions referred to in section 49A; and
- may render services as an intermediary to or on behalf of an insurer, but when rendering such services does not perform any act directed towards entering into, maintaining or servicing a policy on behalf of an insurer, a potential policyholder or policyholder (i.e. solicit, market or sell a policy).

An underwriting manager may not do any business with a mandated or non-mandated intermediary, or a representative[2] of a mandated or non-mandated intermediary or an administrative FSP that is an associate[3] of that underwriting manager.

The person therefore acts as the agent of the insurer (i.e. as if that person is the insurer) and does not act on behalf of a policyholder, potential policyholder or an independent intermediary. The person also therefore does not solicit policies from, or market or sell policies to, the public or any segment of the public on behalf of an insurer.

An underwriting manager who is a binder holder in respect of certain classes of policies of an insurer cannot also be a binder holder of another insurer in respect of the same class of policies, unless the insurers have agreed thereto in writing. The insurers may when agreeing specify the types and kinds of policies within that same class of policies that are the subject of their agreement.

Administrative FSP

[See regulations 6.1 and 6.2]

An administrative FSP is defined in the regulations as having the meaning assigned to that term in the Codes of conduct for administrative and discretionary FSPs[4].

An administrative FSP (administrative FSP) acts as the agent of the insurer (i.e. as if the administrative FSP is the insurer), but may hold a written mandate from a policyholder that authorises that administrative FSP to change the underlying investment portfolio of a policy without having to obtain the prior approval of that policyholder. This does not mean, however, that the administrative FSP has the mandate to terminate the policy itself without the prior written approval of the policyholder.

Non-mandated intermediary

[See regulations 6.1 and 6.2]

In preparing the binder regulations, industry stakeholders indicated that it is essential, in the interest of administrative efficiency, than non-mandated intermediaries be permitted to perform certain binder functions. However, by allowing this it is also essential to manage any conflict or potential conflict of interest appropriately as non-mandated intermediaries simultaneously act or may act on behalf of an insurer and a policyholder.

A non-mandated intermediary is defined in the regulations as a representative or an independent intermediary, other than a mandated intermediary, underwriting manager or administrative FSP.

[2] A list of relevant definitions is included at the end of this Schedule as Annexure 2.
[3] A list of relevant definitions is included at the end of this Schedule as Annexure 2.
[4] Codes of conduct for administrative and discretionary FSPs published in Board Notice No. 79 of 8 August 2003, and amended from time to time, under section 15 of the Financial Advisory and Intermediary Services Act, 2002 (Act No. 37 of 2002)

A mandated intermediary is defined as an independent intermediary that holds a written mandate from a potential policyholder or policyholder that authorises that intermediary (without having to obtain the prior approval of that potential policyholder or policyholder) to terminate the policy of that policyholder or perform any act, in relation to a policy, that legally binds that potential policyholder or policyholder. This means that the mandated intermediary has a written mandate to move a policy or "book of business" to another insurer without having to secure the prior approval of the policyholder or all policyholders. It should be noted that very few, if any, independent intermediaries currently have such a written mandate to enter into, vary or renew a policy on behalf of a policyholder without the need for prior consultation with or approval of that policyholder.

This means that a non-mandated intermediary may be a binder holder, but is not permitted to move a policy or "book of business" to another insurer, unless the non-mandated intermediary has, in respect of each move, -

- expressly secured the prior written approval of each policyholder or complied with section 37 of the Long-term Insurance Act; and

- met the requirements relating to replacement products as set out in section 8 of the General Code of Conduct for Authorised Financial Services Providers and Representatives[5].

In order to limit potential conflicts of interest, a non-mandated intermediary that is a binder holder cannot simultaneously be a mandated intermediary, nor may it conduct any business with a mandated intermediary that is an associate of that non-mandated intermediary. However, certain exemptions are granted in this regard (see the discussion on exemptions immediately below). What constitutes an associate is defined in the regulations with reference to the definition of this term in the Code of Conduct for Authorised Financial Services Providers and Representatives.

As to the use of the term "writing", please note that the Electronic Communications and Transactions Act No. 25 of 2002, in section 12, provides that a requirement in law that a document or information must be in writing is met if the document or information is in the form of a data message and accessible in a manner usable for subsequent reference.

A non-mandated intermediary may be a binder holder for all types of business or just some, but this must be expressly specified in the binder agreement.

Exemptions

[See regulation 6. 5]

Certain exemptions from the general rules of who may be a binder holder as explained above are provided for in the regulations. The regulations allow the Registrar, on application from an insurer that

[5] The General Code of Conduct for Authorised Financial Services Providers and Representatives as published in Board Notice No. 80 of 2003, and amended from time to time, under section 15 of the Financial Advisory and Intermediary Services Act No. 37 of 2002

is the holding company or associate of more than one person referred to in regulation 6.2(2) or (3), to exempt that insurer and non-mandated intermediary or underwriting manager that is a subsidiary or associate of that insurer from regulation 6.2(2) or (3), if the Registrar is satisfied that no conflict of interest or potential conflict of interest exists.

6.2 What may be a binder holder do and not do on behalf of an insurer?

Definitions

[See regulation 6. 1]

The Act allows an insurer, in terms of a written agreement and in accordance with any requirements, limitations or prohibitions that may be prescribed by regulation, to allow another person to do any one or more of the following on behalf of that insurer:

- enter into, vary or renew a policy
- determine the wording of a policy
- determine premiums under a policy
- determine the value of policy benefits under a policy
- settle claims under a policy

The regulations define certain of these functions to ensure consistent interpretation. The regulations define the following terms "enter into", "renew", "vary" and "settle a claim".

General

[See regulations 6.3(1) and (2)]

The regulations require binder agreements to include matters in addition to those required by the Act.

The regulations further prohibit a binder agreement from regulating any other arrangement or relationship with the binder holder. The regulations also state that a binder agreement may not prohibit an insurer from communicating directly with its policyholders or independent intermediaries. These prohibitions on what may be included in a binder agreement are in addition to the prohibitions set out in the Act.

The Act states that a binder agreement may not authorise that other person to add an amount to any gross premium unless the regulations provides otherwise. After consideration of the issue, it was

concluded that it would not be appropriate to provide in the regulations for any additions to gross premiums or deductions from claims in respect of policies referred to in binder agreements, as all costs associated with the policy should be determined by the insurer and included in gross premiums. The regulations together with the Act therefore clearly stipulate what a binder holder may and may not do.

A binder holder may not further delegate binder functions. This does not however prohibit a binder holder from outsourcing certain functions that do not fall within the definition of binder functions, if this is allowed under the Act.

It is important to read the Act together with the regulations when drafting or entering into a binder agreement.

Limitations on binder agreements with a non-mandated intermediary

[See regulations 6.3(3) and (4)]

The regulations require a binder agreement concluded with a non-mandated intermediary to limit the discretion of the binder holder in respect of –

- the maximum value of policy benefits that may be determined under each policy or the maximum value of each claim that may be settled by the binder holder under the policies to which the binder agreement relates;

- the risk factors that must be considered by the binder holder when entering into, renewing or varying a policy or determining the value of policy benefits under a policy;

- other parameters in accordance with which the binder holder must render the services provided for in the binder agreement; and

- any guarantee of policy benefits that may be provided for under an investment policy as defined in Part 3A of the Regulation.

The regulations further prohibit a binder agreement concluded with a non-mandated intermediary from allowing that binder holder to refuse to renew a policy, reject or refuse to pay a claim for policy benefits or a part thereof, terminate, repudiate or deny an insurer's liability to provide policy benefits under a policy, or declare a policy void. This does not mean that the binder holder may not inform a policyholder that a claim cannot be dealt with until the documents and other information required under the policy have been received.

These additional requirements relating to binder agreements concluded with non-mandated intermediaries are necessary to prevent any potential conflicts of interest that may arise for non-mandated intermediaries when simultaneously acting on behalf of an insurer and a policyholder.

It should be noted that the prohibition on a non-mandated intermediary binder holder to reject claims for policy benefits or a part thereof, is not in conflict with Rule 16 of the Long-term Policyholder Protection Rules. The Rule must be read with the Act holistically, including any regulations issued under the Act. Rule 16 does not authorise any person other than the insurer to reject a claim. The Rules merely relate to, inter alia, what must be done where a person that may be authorised by an insurer under the Acts or Regulations, rejects a claim. This means that where an insurer may not authorise a person to reject claims on its behalf, Rule 16(2} cannot apply.

6.3 What must a binder agreement provide for?

[See regulations 6.3(1) to (5)]

As mentioned above, the regulations require binder agreements to include matters in addition to those required by the Act and prohibit matters in addition to those prohibited by the Act. Further, specific requirements are provided for binder agreements concluded with non-mandated intermediaries.

In this regard, it must be noted that regulation 6.3(1)(p) that requires a binder agreement to provide for the intervals at which the binder holder must update policyholder and policy information in the records of the insurer does not conflict with the Act that requires a binder holder to make available to the insurer, its statutory actuary and its auditors the policies to which the binder agreement relates and any information relating thereto upon request. The two requirements must be read together. The regulation provides for the regular updating of information and the Act provides for ad hoc information requests. Regulation 6.3(1)(p) and the Act do not impact on the constitutional rights of non-mandated intermediaries, underwriting managers and administrative FSPs to trade and to protect their commercially sensitive information. A policy constitutes a contract between the policyholder and the insurer under which the insurer has a responsibility to provide policy benefits. A non-mandated intermediary, underwriting manager or administrative FSP is not a party to that contract and, as a binder holder, acts on behalf of the insurer. A non-mandated intermediary or underwriting manager therefore has no right to withhold the information.

Further, it must be noted that regulation 6.3(1)(s) does not prohibit an insurer from stopping the binder holder from performing certain binder functions or taking steps to mitigate its risks pending the termination of the binder agreement. The minimum 90-day period is necessary to provide for the orderly winding-up of the binder agreement.

6.4 What consideration may a binder holder receive under a binder agreement?

General

[See regulation 6.4]

The regulations allow an insurer to pay a binder holder a fee for the services rendered under the binder agreement.

This fee must be reasonably commensurate with the actual costs incurred by the binder holder associated with rendering the services under the binder agreement, with allowance for a reasonable rate of return for the binder holder. This criterion is necessary to deter circumvention of the commission regulations and inappropriate incentives.

The regulation does not negate the payment of a market-related fee based on the value of assets under management, if the fee meets the criterion of being reasonably commensurate with the actual costs of the binder holder associated with rendering the services under the binder agreement.

The regulations do not affect any commission that may be payable to a non-mandated intermediary for rendering services as an intermediary in relation to the policies to which the binder agreement relates or an outsourcing fee payable for outsourced functions performed by the binder holder on behalf of the insurer, provided that –

- the commission regulations are complied with; and
- a person / intermediary may not be remunerated for the same or a similar service twice.

The Financial Services Board is currently developing proposals to clarify the interpretation of the definition of intermediary services for which regulated commission is payable versus outsourced insurer or policyholder services for which a fee may be payable.

Underwriting manager or administrative FSP

[See regulations 6.4(1) and (4)]

The regulations allow an underwriting manager or administrative FSP that is a binder holder to share in the profits of the insurer attributable to the type or kind of policies referred to in the binder agreement.

Non-mandated intermediary

[See regulations 6.4(1), (2), (3) and (5)]

The regulations prohibit any fee payable to a non-mandated intermediary that may settle claims or determine the value of policy benefits paid under a binder agreement, from constituting or being based on a percentage of the difference between an amount claimed or the maximum value of policy benefits payable under a policy and the policy benefits actually provided to a policyholder in settlement of a claim. This is necessary to prevent a non-mandated intermediary (that is supposed to act also in the interest of policyholders) from acting in the interest only of the insurer to the detriment of policyholders.

The fee payable to a non-mandated intermediary that is a binder holder must be disclosed to a policyholder.

The regulations further prohibit a non-mandated intermediary that is a binder holder from (directly or indirectly) receiving or being offered any share in the profits of the insurer in respect of, specifically, the services rendered under the binder agreement and the type or kind of policies referred to in the binder agreement. This prohibition is therefore not a general prohibition on profit sharing per se. It merely prohibits a non-mandated intermediary from being entitled to a percentage of the profits that the intermediary generates because of its performance of the binder functions provided for in the binder agreement. This is again necessary to prevent a non-mandated intermediary (that is supposed to act also in the interest of policyholders) from acting in the interest only of the insurer to the detriment of policyholders.

6.5 What must an insurer report to the Registrar when a binder agreement will terminate?

[See regulation 6. 6]

The regulations require an insurer, pending the termination of a binder agreement, to report the following to the Registrar -

- the date on which the binder agreement will terminate;
- the reasons for the termination of the binder agreement;
- how the policies to which the binder agreement relates will be dealt with;
- how any legislative requirements relating to the termination of the binder agreement or policies, if one or more policies to which the binder agreement relates will be terminated, will be complied with.

This is necessary to enable the Registrar to ensure that the termination and consequences of termination are managed in the best interest of the policyholders.

6.6. Must binder agreements entered into prior to the effective date of the regulations comply with the regulations?

[See regulation 6.7]

Binder agreements concluded before or on the date on which these regulations commence must be aligned with the regulations within one year of it coming into operation.

7. IMPLICATIONS FOR PARTICULAR PARTIES

The regulations will have particular implications for various parties often referred to in industry terms as "administrators". The term administrator is used broadly to refer to a variety of business models involving a range of administrative services, some of which may fall into the definition of binder functions or intermediary services.

As a binder agreement may only be entered into with a non-mandated intermediary, an underwriting manager or an administrative FSP, parties currently referred to as administrators, including assistance business group scheme administrators, wishing to perform binder functions must choose to do so as:

- a non-mandated intermediary, subject to the limitations on the binder function and policyholder mandate described above; or
- an underwriting manager; or
- an administrative FSP.

Administrators providing services that do not fall under either the definition of intermediary services or binder functions may continue to provide these administrative services to an insurer on an outsourced basis without having to be recognised as a non-mandated intermediary, underwriting manager or administrative FSP for the purposes of these regulations.

The Financial Services Board has published a draft Directive 159.A.i (LT & ST) in respect of the outsourcing of services and functions by insurers to ensure that adequate governance, internal controls and risk management are in place in respect of such outsourcing.

8. WHAT ARE THE CONSEQUENCES OF NOT COMPLYING WITH THE ACT AND THE REGULATIONS

Non-compliance with section 49A and the regulations issued under section 49A constitutes a criminal offence for insurers and binder holders (see sections 67(1)(b) and 66(1)(b), respectively, read with the definition of "this Act" in section 1)).

Further, the Registrar, under section 6A of the Financial Institutions (Protection of Funds) Act No. 28 of 2001, may refer any non-compliance with the Act or regulations issued thereunder to the enforcement committee established under section 1 0 of the Financial Services Board Act No. 97 of 1990.

ANNEXURE 1 TO SCHEDULE B

EXTRACT FROM THE LONG-TERM INSURANCE ACT: SECTION 49A

49A. Binder agreements

(1) A long-term insurer may, in terms of a written agreement only, and in accordance with any requirements, limitations or prohibitions that may be prescribed by regulation, allow another person to do any one or more of the following on behalf of that insurer:

(a) Enter into, vary or renew a long-term policy, other than a long-term reinsurance policy, on behalf of that insurer;

(b) determine the wording of a long-term policy;

(c) determine premiums under a long-term policy;

(d) determine the value of policy benefits under a long-term policy;

(e) settle claims under a long-term policy.

(2) A written agreement referred to in subsection (1) must-

(a) set out which of the activities referred to in subsection (1) that other person may perform and the particular kinds of long-term policies in respect of which those activities may be performed;

(b) set out the particular kinds of long-term policies which may be entered into, varied or renewed by that other person;

(c) state if that other person is authorised to determine the wording of the policies referred to in paragraph (a), and if authorised, the extent to which and the circumstances under which the wording may be determined;

(d) state if that other person is authorised to determine premiums in respect of the policies referred to in paragraph (a), and if authorised, the gross premiums or the basis for the calculation of gross premiums that may be determined, and the extent to which and the circumstances under which the premiums may be determined;

(e) state if that other person is authorised to determine the value of policy benefits, and if authorised, the maximum value of the policy benefits that may be determined under each kind of long-term policy referred to in paragraph (a), and the extent to which and the circumstances under which the benefits may be determined;

(f) state if that other person is authorised to settle claims under the policies referred to in paragraph (a), and if authorised, the extent to which and the circumstances under which the claims may be settled:

(g) state the basis on which that other person will be remunerated for services rendered in terms of paragraphs (b) to (f), which basis must be consistent with any requirements, limitations or prohibitions as may be prescribed by regulation;

(h) oblige that other person to –

(i) disclose to policyholders of policies referred to in paragraph (a) -

(aa) the name of the relevant long-term insurer, and the fact that that other person is acting in terms of an agreement contemplated in this section; and

(bb) any remuneration payable to that other person in terms of an agreement contemplated in this section;

(ii) include the name of the long-term insurer underwriting the long-term policy in any advertisement, brochure or similar communication which relates to the long-term policy referred to in paragraph {a);

(iii) keep and maintain proper books of account and other records in respect of the policies referred to in paragraph (a) and allow the long-term insurer, its statutory actuary and its auditors full and unfettered access to those books of account and records; and

(iv) make available to the long-term insurer, its statutory actuary and its auditors the policies referred to in paragraph (a) and any information relating thereto, including the names, identity numbers and contact details of policyholders, insured persons and beneficiaries, upon request;

(i) prohibit that other person to delegate, assign or subcontract any of the functions referred to in paragraphs (b) to (f) to another person; and

(j) state the circumstances under which the agreement will lapse or may be terminated, and the necessary steps that must be taken to ensure the effective and efficient termination of the. agreement taking into account the interests of policyholders.

(3) A written agreement referred to in subsection (1), subject to any requirements, limitations or prohibitions as may be prescribed by regulation-

(a) may not authorise that other person to add an amount to any gross premium referred to in subsection (2)(d);

(b) may not authorise that other person to deduct any amount from any claims referred to in subsection (2)(f); or

(c) may provide or prohibit that person to directly or indirectly participate in the profits attributable to the policies referred to in subsection 2(a).

(4) A person "that entered into an agreement contemplated in subsection (1) with a long-term insurer may-

(a) render the services contemplated in subsection (1)(a) to (e) in respect of any kind of long-term policy issued by that long-term insurer identified in the agreement only in accordance with any requirements, limitations or prohibitions as may be prescribed by regulation; and

(b) not render any of the services contemplated in subsection (1)(a) to (e) in respect of any kind of long-term policy issued by that long-term insurer not identified in the agreement.

(5) Despite any term to the contrary contained in an agreement contemplated in subsection (1) the longterm insurer that entered into the agreement remains-

(a) responsible for compliance with this Act;

(b) liable for any claims relating to policies included in the agreement, including any claims that may arise because of the failure of that other person to comply with the agreement; and

(c) the owner of any information and documentation relating to the policies contemplated in the agreement. which must, upon termination of the agreement, be returned to the long-term insurer.

(6) Any party to a written agreement referred to in subsection (1) must make a copy of that agreement available to the Registrar on request.

ANNEXURE 2 TO SCHEDULE B

RELEVANT DEFINITIONS

LONG-TERM INSURANCE ACT NO. 52 OF 1998: REGULATION 3.1 OF THE REGULATIONS ISSUED UNDER SECTION 72 OF THE LONG-TERM INSURANCE ACT

"independent intermediary" means a person, other than a representative, rendering services as intermediary;

"rendering services as intermediary" means the performance by a person other than a long-term insurer or a policyholder, on behalf of a long-term insurer or a policyholder, of any act directed towards entering into, maintaining or servicing a policy or collecting, accounting for or paying premiums or providing administrative services in relation to a policy, and includes the performance of such an act in relation to a fund, a member of a fund and the agreement between the member and the fund;

"representative" means a person-

(a) employed or engaged by a long-term insurer for the purpose of rendering services as intermediary only in relation to policies entered into or to be entered into by-

(i) that insurer;

(ii) another insurer which is a subsidiary or holding company of that insurer; or

(ii) another insurer which has entered into a written agreement with that insurer in terms of which persons employed or engaged by that insurer may render services as intermediary in relation to the other insurer's policies;

(b) on conditions of employment or engagement complying with the principle of "Equivalence of Reward", in terms whereof the remuneration paid by an insurer, whether in cash or in kind, shall substantially be in accordance with this Part, as determined by the Registrar, but excludes such a person in respect of whom the Registrar has made a determination under regulation 3.2(5);

Financial Advisory and Intermediary Services Act No. 37 of 2002

Codes of conduct for administrative and discretionary FSPs published in Board Notice No. 79 of 8 August 2003

"administrative FSP" means a FSP, other than a discretionary FSP –

(a) that renders intermediary services in respect of financial products referred to in paragraphs (a), (b), (c) (excluding any short-term insurance contract or policy referred to therein), {d) and (e), read with paragraphs (h), (i) and (j) of the definition of "financial product" in section 1 (1) of the Act, on the instructions of a client or another FSP and through the method of bulking; and

{b) acting for that purpose specifically in accordance with the provisions of this Code, read with the Act, the General Code (where applicable), and any other applicable law;

"discretionary FSP" means a FSP –

(a) that renders intermediary services of a discretionary nature as regards the choice of a particular financial product referred to in the definition of "administrative FSP" in this subsection, but without implementing any bulking; and

(b) acting for that purpose specifically in accordance with the provisions of the Code set out in Chapter II of this Schedule, read with the Act, the General Code (where applicable) and any other applicable law;

Section 1 of the Financial Advisory and Intermediary Services Act

"financial product" means, subject to subsection (2) –

(a) securities and instruments, including –

(i) shares in a company other than a "share block company" as defined in the Share Blocks Control Act, 1980 (Act No. 59 of 1980);

(ii) debentures and securitised debt;

(iii) any money-market instrument;

(iv) any warrant, certificate, and other instrument acknowledging, conferring or creating rights to subscribe to, acquire, dispose of, or convert securities and instruments referred to in subparagraphs (i), (ii) and (iii);

(v) any "securities" as defined in section 1 of the Securities Services Act, 2002;

(b) a participatory interest in one or more collective investment schemes;

(c) a long-term or a short-term insurance contract or policy, referred to in the Long-term Insurance Act, 1998 (Act No. 52 of 1998), and the Short-term Insurance Act, 1998 (Act No. 53 of 1998), respectively;

(d) a benefit provided by-

(i) a pension fund organisation as defined in section 1(1) of the Pension Funds Act, 1956 (Act No. 24 of 1956), to the members of the organisation by virtue of membership; or

(ii) a friendly society referred to in the Friendly Societies Act, 1956 (Act No. 25 of 1956), to the members of the society by virtue of membership;

(e) a foreign currency denominated investment instrument, including a foreign currency deposit;

(f) a deposit as defined in section 1(1) of the Banks Act, 1990 (Act No. 94 of 1990);

(g) a health service benefit provided by a medical scheme as defined in section 1 (1) of the Medical Schemes Act, 1998 (Act No. 131 of 1998);

(h) any other product similar in nature to any financial product referred to in paragraphs (a) to (g), inclusive, declared by the registrar, after consultation with the Advisory Committee, by notice in the Gazette to be a financial product for the purposes of this Act;

(i) any combined product containing one or more of the financial products referred to in paragraphs (a) to {h), inclusive; .

(j) any financial product issued by any foreign product supplier and marketed in the Republic and which in nature and character is essentially similar or corresponding to a financial product referred to in paragraphs (a) to (i), inclusive;

General Code of Conduct for Authorised Financial Services Providers and Representatives as published in Board Notice No. 80 of 2003

"associate" –

(a) in relation to a natural person, means –

(i) a person who is recognised in law or the tenets of religion as the spouse, life partner or civil union partner of that person;

(ii) a child of that person, including a stepchild, adopted child and a child born out of wedlock;

(iii) a parent or stepparent of that person;

(iv) a person who is recognised in law or appointed by a Court as the person legally responsible for managing the affairs of or meeting the daily care needs of the first mentioned person;

(v) a person who is the spouse, life partner or civil union partner of a person referred to in subparagraphs (ii) to (iv);

(vi) a person who is in a commercial partnership with that person;

(b) in relation to a juristic person –

(i) which is a company, means any subsidiary or holding company of that company, any other subsidiary of that holding company and any other company of which that holding company is a subsidiary;

(ii) which is a close corporation registered under the Close Corporations Act, 1984 (Act No. 69 of 1984), means any member thereof as defined in section 1 of that Act;

(iii) which is not a company or a close corporation as referred to in subparagraphs (i) or (ii), means another juristic person which would have been a subsidiary or holding company of the firstmentioned juristic person –

(aa) had such first-mentioned juristic person been a company; or

(bb) in the case where that other juristic person, too, is not a company, had both the firstmentioned juristic person and that other juristic person been a company;

(iv) means any person in accordance with whose directions or instructions the board of directors of or, in the case where such juristic person is not a company, the governing body of such juristic person is accustomed to act;

(c) in relation to any person –

(i) means any juristic person of which the board of directors or, in the case where such juristic person is not a company, of which the governing body is accustomed to act in accordance with the directions or instructions of the person first-mentioned in this paragraph;

(ii) includes any trust controlled or administered by that person.