

(1 January 2020 – to date)

SHORT-TERM INSURANCE ACT 53 OF 1998

(Gazette No. 19277, Notice No. 1191, dated 23 September 1998. Commencement date: 1 January 1999)

FINANCIAL SERVICES BOARD

REGULATIONS UNDER THE SHORT-TERM INSURANCE ACT, 1998

Government Notice R1493 in Government Gazette 19495 of 27 November 1998. Commencement date: 1 January 1999.

As amended by:

Government Notice R462 in Government Gazette 30988 of 25 April 2008. Commencement date: 25 April 2008.

Government Notice R1076 in Government Gazette 34877 of 23 December 2011. Commencement date: 23 December 2011.

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

Government Notice 1439 in Government Gazette 41334 dated 15 December. Commencement date: 1 January 2018 – unless otherwise indicated

Government Notice 1018 in Government Gazette 41946 dated 28 September 2018. Commencement date: 28 September 2018 – unless otherwise indicated, also see General Notice 652 (Clarification of commencement date) in Government Gazette 41996 dated 26 October 2019.

Government Notice 1439 in Government Gazette 41334 dated 15 December. Commencement date of regulation 6(w): 1 January 2020

Publisher's Note:

The Regulations have been amended by regulation 2 of GN 1018 of 2018 by the substitution of all references in the Regulations to "Registrar" with "Authority".

The Minister of Finance has under section 70 of the Short-term Insurance Act, 1998, made the regulations set out in the Schedule.

SCHEDULE

Prepared by:

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**PART 1
INTERPRETATION**

1.1 Definitions

In these regulations “the Act” means the Short-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 1439 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 1439 in Government Gazette 41334 dated 15 December 2017)

“**effective date**”

(Definition of “effective date” inserted by regulation 2(c) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Definition of “effective date” deleted by regulation 3(a) of GN 1018 of 2018)

“**independent intermediary**” means a person, other than a representative, who renders services as intermediary;

(Definition of “independent intermediary” inserted by regulation 2(d) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Definition of “independent intermediary” substituted by regulation 3(b) of GN 1018 of 2018)

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

(Definition of “Insurance Act” inserted by regulation 3(c) of GN 1018 of 2018)

“insurer” means a short-term insurer;

(Definition of “insurer” inserted by regulation 2(e) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

“long-term policy” means a long-term policy as defined in the Long-term Insurance Act, 1998;

(Definition of “long-term policy” amended by regulation 3(d) of GN 1018 of 2018)

“microinsurer” has the meaning assigned to it in section 1 of the Insurance Act;

(Definition of “microinsurer” inserted by regulation 3(e) of GN 1018 of 2018)

“Part” means the applicable Part of these regulations;

(Definition of “Part” amended by regulation 3(f) of GN 1018 of 2018)

“policy” means a short-term policy;

(Definition of “policy” inserted by regulation 2(f) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

“Policyholder Protection Rules” means the Policyholder Protection Rules made under section 55 of the Act;

(Definition of “Policyholder Protection Rules” inserted by regulation 2(g) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

“representative” means a natural person employed –

(a) by or working for an insurer and receiving or entitled to receive remuneration; and

(b) for the purpose of rendering services as intermediary in relation to the policies entered into or to be entered into by the insurer only;

(Definition of “representative” inserted by regulation 2(h) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Definition of “representative” substituted by regulation 3(g) of GN 1018 of 2018)

“SAFEX”

(Definition of “SAFEX” deleted by regulation 2(j) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

“Schedule”

(Definition of “Schedule” deleted by regulation 3(h) of GN 1018 of 2018)

“**section**” means the applicable section of the Act.

(Definition of “section” amended by regulation 3(i) of GN 1018 of 2018)

“**services as intermediary**” means any act performed by a person –

(a) the result of which is that another person will or does or offers to enter into, vary or renew a policy;
or

(b) with a view to –

(i) maintaining, servicing or otherwise dealing with;

(ii) collecting or accounting for premium payable under; or

(iii) receiving, submitting or processing claims under,

a policy.

*(Definition of “services as intermediary” inserted by regulation 2(i) of Government Notice 1439 in
Government Gazette 41334 dated 15 December 2017)*

(Definition of “services as intermediary” substituted by regulation 3(j) of GN 1018 of 2018)

PART 2

CALCULATION OF ADDITIONAL AMOUNTS OF ASSETS (SECTION 29(1))

2.1

2.2

*(Part 2 deleted by regulation 3 of Government Notice 1439 in Government Gazette 41334 dated 15
December 2017)*

PART 3

LIMITATION ON ASSETS

(SECTION 30)

3.1

3.2

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(Part 3 amended by regulation 4 of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Part 3 deleted by regulation 4 of GN 1018 of 2018)

PART 4

AUTHORISATION OF AND REQUIREMENTS FOR COLLECTION OF PREMIUMS BY INTERMEDIARIES (SECTION 45)

4.1 Authorisation

- (1) Any authorisation referred to in section 45 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.
- (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 4.1(2): 1 July 2019)

(Commencement date of regulation 4.1(3): 1 July 2019)

- (4) An independent intermediary may not delegate an authorisation that has been granted to it in accordance with section 45.

(Commencement date of regulation 4.1(4): 1 July 2019)

- (5) An insurer must, before it authorises an independent intermediary under section 45, 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 45 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 4.1(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 4.1(7): 1 July 2019)

4.2 Requirements relating to receiving premiums

- (1) The payment of a premium to an independent intermediary authorised under section 45 to receive a premium is deemed to be a payment to the insurer under the policy concerned.

- (2) 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.

(Commencement date of regulation 4.2(2): 1 July 2019)

- (3) A separate bank account referred to in subregulation (2) may only contain monies collected from policyholders and may not contain any monies or funds of the independent intermediary.

(Commencement date of regulation 4.2(3): 1 July 2019)

- (4) All premiums received by an independent intermediary -

- (a) through electronic means must be received into a bank account referred to in subregulation (2);
or
- (b) in cash must be deposited into a bank account referred to in subregulation (2) within 1 business day after a premium is received.

(Commencement date of regulation 4.2(4): 1 July 2019)

- (5) When an independent intermediary receives a premium in cash, that independent intermediary must as soon as reasonably practicable after receiving the premium give to the payer a written receipt for the premium received containing the name, address and telephone number of the recipient, the policy number and the name of the insurer on whose behalf the premium is received.
- (6) 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.
- (7) Despite subregulation (6), 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.
- (8) If more than one independent intermediary is authorised by an insurer to receive 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 (6).

4.3 Returns

- (1) An independent intermediary who has been authorised under section 45 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.

4.4 Exemption

Prepared by:

- (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 the granting of the exemption –
- (a) 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) will not materially increase risk to the insurer;
 - (c) will not be contrary to the public interest; and
 - (d) will not compromise the fair treatment of or continuous and satisfactory service to policyholders.

(Part 4 amended by GN R462 of 2008)

(Part 4 substituted by regulation 5 of GN 1018 of 2018)

PART 5
REMUNERATION
(SECTION 48)

(Heading of Part 5 substituted by regulation 5(a) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

PART 5A
LIMITATION ON REMUNERATION FOR SERVICES AS INTERMEDIARY

(Heading of Part 5A inserted by regulation 5(b) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

5.1 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 commission in monetary form.

(Regulation 5.1(1) substituted by regulation 5(c) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

- (2) No commission shall be paid or accepted otherwise than subject to this Part.
- (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 amount payable in terms of regulation 5.3.

5.2 Time and payment of commission

Commission shall not be paid or accepted before the date on which the premium in respect of which it is payable has been paid to the insurer.

(Regulation 5.2 in Part 5A substituted by regulation 6(a) of GN 1018 of 2018)

5.3 Maximum commission payable

- (1) Subject to subregulation (2), no commission shall exceed, in respect of -
 - (a) a motor policy and a policy underwritten under the "Motor" class of non-life insurance business as set out in Table 2 of Schedule 2 of the Insurance Act, 12,5 per cent of the premium payable under the policy;
 - (b) a contract identified in category 1, 2 and 3 in the table under regulation 7.2(1) of the Regulations, the maximum commission specified in column two of the Scale below (in relation to the monthly premium band specified in column 1); and
 - (c) any other policy, 20 per cent of the premium payable under the policy.
- (2) Despite subregulation (1), -
 - (a) paragraph (a) of subregulation (1) does not apply to a policy underwritten by a microinsurer under the "Motor" class of non-life insurance business as set out in Table 2 of Schedule 2 of the Insurance Act in respect of which the aggregate value of the policy benefits is R120,000 or less;
 - (b) paragraph (c) of subregulation (1) does not apply to a policy underwritten by a microinsurer.

(Regulation 5.3 substituted by regulation 1(a) of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

(Regulation 5.3 in Part 5A substituted by regulation 6(b) of GN 1018 of 2018)

5.4 Reversal of commission

If a premium or any part thereof is for any reason refunded by an insurer, the commission payable in terms of this Part in respect of that premium, or the part of that premium, which is so refunded, shall be refunded, to the insurer by the person to whom it was paid.

(Regulation 5.4 in Part 5A substituted by regulation 6(c) of GN 1018 of 2018)

5.5 Commission when policy comprises combination of policies

- (1) If a policy is a contract comprising a combination of any two or more of the short-term policies defined in section 1, the maximum commission payable shall be determined by aggregating the maximum payable in terms of this Part in respect of each of the separate kinds of policies comprising the combination by reference to the premium payable for each such policy, and if the premium attributable to each component is not specified in or ascertainable from the policy, the maximum shall not exceed that which would have been payable had the policy been the kind of policy to which the lowest maximum rate of commission applies.
- (2) Despite sub-regulation (1), if a policy is a contract comprising a combination of any two or more of the short-term policies defined in section 1 and one of the policies is a contract referred to in category 1, 2 or 3 in the table under regulation 7.2(1), the maximum commission payable shall be determined by aggregating the maximum payable in terms of this Part in respect of each of the separate kinds of policies comprising the combination by reference to the premium payable for each such policy, and if the premium attributable to each component is not specified in or ascertainable from the policy, the maximum commission payable for the whole of the policy shall not exceed the maximum commission allowable under Scale in Regulation 5.3(1).

(Regulation 5.5 substituted by regulation 1(b) of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

(Regulation 5.5 in Part 5A substituted by regulation 6(d) of GN 1018 of 2018)

PART 5B

LIMITATION ON REMUNERATION FOR BINDER FUNCTIONS

5.6 Application of this Part 5B, and definitions

- (1) This Part 5B applies to remuneration provided by an insurer or any person on its behalf to a person for rendering a binder function.
- (2) In this Part 5B, 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 5.6(2) in Part 5B substituted by regulation 6(e) of GN 1018 of 2018)

5.7 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.

5.8 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 5.7(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 48A(1)(a) ("function (a)")	Function (a) only	3.5%
Determine the wording of a policy – section 48A(1)(b) ("function (b)")	Function (a) and one or more of functions (b) - (d)	5%
Determine premiums under a policy – section 48A(1)(c) ("function (c)")		
Determine the value of policy benefits under a policy – section 48A(1)(d) ("function (d)")	One or more of functions (b) - (d) only	0%

BINDER FUNCTION	MAXIMUM FEE PAYABLE
Settle claims under a policy – section 48A(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 5.7(1).

(Publisher's Note on Commencement dates for regulations 5.8(2) and (3), as set out in regulation 8.3(a) of GN 1439 in GG 41334 dated 15 December 2017:

“(a) insertion of subregulations (2) and (3) in regulation 5.8 in Part 5B 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 48A(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 5.8, 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 6.2(1)(g).

5.9 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 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 5B inserted by regulation 5(d) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

PART 5C
NOTIFICATION OF CERTAIN ARRANGEMENTS WITH INDEPENDENT INTERMEDIARIES OR REPRESENTATIVES

5.10 Definitions

In this Part 5C “binder function” has the meaning assigned to it in Part 6.

(Regulation 5.10 in Part 5C substituted by regulation 6(f) of GN 1018 of 2018)

5.11 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 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 5C inserted by regulation 5(e) of Government Notice 1439 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 -

"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 6(a) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

“binder agreement” means an agreement contemplated in section 48A of the Act;

(Definition of “binder agreement” substituted by regulation 6(b) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

“binder function” means any of the functions contemplated in section 48A(1)(a) to (e) of the Act;

(Definition of “binder function” inserted by regulation 6(c) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

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

“commercial lines business” means short-term insurance business other than in respect of personal lines business;

(Definition of “commercial lines business” substituted by regulation 6(d) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Definition of “commercial lines business” substituted by regulation 7(a) of GN 1018 of 2018)

“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 6(e) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

“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 6(f) of Government Notice 1439 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 6(g) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Definition of “governing body” substituted by regulation 7(b) of GN 1018 of 2018)

“insurer” means a short-term insurer but excludes SASRIA as defined in section 1 and referred to in the Conversion of SASRIA Act, 1998 (Act 134 of 1998);

(Definition of "insurer" substituted by regulation 6(h) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Definition of "insurer" substituted by regulation 7(c) of GN 1018 of 2018)

"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 6(i) of Government Notice 1439 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 6(j) of Government Notice 1439 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 6(k) of Government Notice 1439 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;

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

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

(Definition of "policy" substituted by regulation 6(l) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Definition of "policy" substituted by regulation 7(d) of GN 1018 of 2018)

"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 6(m) of Government Notice 1439 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 6(n) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

"renew" means any act that results in the renewal 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 in Part 1, but excludes an employee of an insurer;
(Definition of "representative" substituted by regulation 6(o) of Government Notice 1439 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 6(p) of Government Notice 1439 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" inserted by regulation 7(e) of GN 1018 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 1 of the Regulations –
 - (i) does not perform any act the result of which is that another person will or does or offers to enter into vary or renew a policy on behalf of an insurer, a potential policyholder or policyholder; 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, potential policyholder or policyholder; and

(Definition of "underwriting manager" substituted by regulation 6(q) of Government Notice 1439 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; or
 - (b) an underwriting manager.
- (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 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 6(r) of Government Notice 1439 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;

(Publisher's note – Regulation 6.2A(2) takes effect 24 months after the effective date (1 January 2020) – refer to regulation 8.3(b) of GN 1439 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 6(s) of Government Notice 1439 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 48A(2) -
- (a) specify if the binder holder is a non-mandated intermediary or an underwriting manager;
 - (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 6(t) of Government Notice 1439 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 5B 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 6(u) of Government Notice 1439 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 6(v) of Government Notice 1439 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)) on a daily basis 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;

(Regulation 6.3(1)(p) substituted by regulation 6(w) of Government Notice 1439 in Government Gazette 41334 dated 15 December. Commencement date of regulation 6(w): 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 fulfill *[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 "(q)") inserted by regulation 7(f) of GN 1018 of 2018 with effect from:

- (i) *the date referred to in regulation 8.2 [28 September 2018] for binder agreements entered into on or after the date referred to in regulation 8.2;*
- (ii) *1 January 2019 for binder agreements entered into before the date referred to in regulation 8.2 [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 48A 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 risk factors 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; and
 - (c) other parameters in accordance with which the binder holder must render the services provided for in the binder agreement.
- (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 6(x) of Government Notice 1439 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 6(x) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

6.4

(Regulation 6.4 deleted by regulation 6(y) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

6.5 Exemption

- (1) Despite regulation 6.2(1), –

- (a) an insurer may conclude a hold-covered binder agreement with a mandated intermediary or a non-mandated intermediary, if –

- (i) that agreement provides for the entering into policies on an interim and limited-in-time basis only; and
- (ii) the legal liability of the insurer under such policies lapses after a maximum period of 96 hours in respect of personal lines business and 30 days in respect of commercial lines business, unless the insurer, in respect of each policy, confirms its legal liability under that policy in writing prior to the expiry of such period; and
- (iii) no fee for the services rendered under the hold-covered binder agreement is payable to the mandated intermediary or non-mandated intermediary by the insurer.

- (2) 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.

- (3)

- (a) Regulation 6.3(1)(f) does not apply to a hold-covered binder agreement concluded under sub-regulation (1)(a).

- (b) For purposes of a hold-covered binder agreement, the timeframes referred to under regulations 6.3(1)(p) and (s) are 96 hours in respect of personal lines business and 30 days in respect of commercial lines business.

(Regulation 6.5 substituted by regulation 6(z) of Government Notice 1439 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 required 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 6(aa) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

6.7

(Regulation 6.7 deleted by regulation 6(bb) of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Part 6 substituted by regulation 1 of Government Notice R1076 of 2011)

PART 7 CONTRACTS IDENTIFIED AS ACCIDENT AND HEALTH POLICIES UNDER SECTION 70(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 under a policy in respect of a 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 medical procedure or administration of a therapeutic or diagnostic medical intervention wherein a person is expected to stay overnight in a facility;

"insurer" means a short-term insurer or a Lloyd's underwriter;

"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 short-term policy;

"product line" in relation to a category and type of contract referred to in Regulation 7.2(1), means accident and 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;

"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 accident and health policies

- (1) The categories and types of contracts set out in the table below are identified as accident and health policies. A contract will only be an accident and 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	Medical expense shortfall	<p>A contract –</p> <p>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits if a health event contemplated in the contract as a risk event occurs; and</p> <p>(b) the purpose of which is to cover the difference or a part of the difference between the total costs or expenses of a relevant health service and the amount a person's medical scheme paid towards such costs.</p>	<p>Policy benefits –</p> <p>(a) are one or more sums of money; and</p> <p>(b) in aggregate, do not exceed R150 000,00 (one hundred and fifty thousand Rand) per insured person per annum.</p>
2	Non-medical expense cover as a result of hospitalisation	<p>A contract-</p> <p>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits if a health event contemplated in the contract as a risk event resulting in hospitalisation occurs; and</p> <p>(b) the purpose of which is to cover non-medical expenses associated with hospitalisation.</p>	<p>Policy benefits-</p> <p>(a) are a fixed some[sic] sum of money per insured per day not exceeding R3 000,00 (three thousand Rand) or a maximum lump sum amount of R20 000.00 (twenty thousand Rand) per annum irrespective of the number of days in hospital;</p> <p>(b) does not require hospitalisation for a period of longer than 3 days before they become payable;</p> <p>(c) once it becomes payable, are calculated from day 1 of hospitalisation; and</p>

Category	Contract Type	Contract description	Requirements relating to policy benefits
			(d) may not be paid or ceded to the provider of a health service.
3	HIV, Aids, tuberculosis and malaria testing and treatment	<p>A contract –</p> <p>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits if a health event relating to HIV, Aids, tuberculosis or malaria (contemplated in the contract as a risk event) occurs; and</p> <p>(b) the purpose of which is to cover expenses for testing and treatment of HIV, Aids, tuberculosis or malaria.</p>	
4	International travel insurance	<p>A contract –</p> <p>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits if a health event contemplated in the contract as a risk occurs; and</p> <p>(b) the purpose of which is to cover costs associated with a relevant health service while travelling in a country in which the insured persons are not ordinarily resident.</p>	
5	Medical emergency	A contract –	

Category	Contract Type	Contract description	Requirements relating to policy benefits
	evacuation or transport	<p>(a) in terms of which a person, in return for a premium, undertakes to provide policy benefits if a health event contemplated in the contract as a risk event occurs; and</p> <p>(b) the purpose of which is to-</p> <p>(i) cover the costs of or provide emergency evacuation or transport to a medical treatment facility; or</p> <p>(ii) cover the cost of emergency medical treatment.</p>	

- (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, 2 and 3 contracts

Prohibition of policy benefits that fully or partially indemnifies against medical expenses under category 2

- (1) A contract referred to in category 2 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, 2 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, 2 and 3 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, 2 and 3 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, 2 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 accident and health policy if that policyholder, for at least 90 days before entering into that accident and health policy with the insurer, had an accident and health policy with materially similar benefits and had completed the condition-specific waiting period in respect of that accident and health policy;
- (7) Where the condition-specific waiting period of a policyholder under a previous accident and health policy referred to in sub-regulation (6) had not expired at the time that that policyholder enters into a new accident and health policy with materially similar benefits, the insurer may only impose a waiting period for a 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.
- (9) Despite sub-regulation (2), a contract referred to in category 1, 2 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, 2 and 3 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 short-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 Requirements applicable to all contracts referred to in the Table under regulation 7.2(1)

Contracts may not require medical scheme membership

- (1) A contract referred to in categories 2 to 5 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.

Information to be included in contract

- (2) A contract referred to in the table under Regulation 7.2(1) must in clear and easily understood language –
- (a) state the premiums payable and the policy benefits to be provided under the policy;
 - (b) state the events in respect of which the policy benefits are to be provided and the circumstances (if any) in which those benefits are not to be provided; and
 - (c) identify those representations made by or on behalf of the policyholder to the insurer which were regarded by that insurer –

- (i) in respect of a contract referred to in category 1 to 3 in the table under Regulation 7.2(1), as having any relation or bearing to exclusions that apply under a condition-specific waiting period and reasons for differentiating premiums based on age; or
- (ii) in respect of a contract referred to in category 4 or 5 in the table under Regulation 7.2(1), as being material to its assessment of the risks under the policy.

7.5 Marketing and disclosures requirements

- (1) Any marketing activity or marketing material in respect of a contract referred to in category 1, 2 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 "medical" to describe a contract referred to in category 1 in the table under regulation 7.2(1), in which case the term must always be succeeded by the words "expense shortfall";
 - (ii) where using the term "hospitalisation" to describe a contract referred to in category 2 in the table under regulation 7.2(1), in which case the term must always be preceded by the words "non-medical expense cover as a result of"; or
 - (iii) 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 2 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 accident and 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 70(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 an accident and health policy under sub-regulation (1) and (2), and instruct the insurer to –
 - (a) stop marketing the accident and health policy or policies;
 - (b) stop offering or renewing the accident and health policy or policies to the public and within 90-days of the date determined by the Authority, terminate such accident and 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 an accident and 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 by 1 January 2018.

(Part 7 inserted by regulation 2 of Government Notice R1076 of 2011)

(Part 7 substituted by regulation 2 of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

PART 8

TITLE AND COMMENCEMENT

- 8.1** These regulations are called the Regulations under the Short-term Insurance Act, 1998.

- 8.2** The amendments to the Regulations, subject to subregulation 8.3 and 8.4, take effect on 28 September 2018.

(Effective date of regulation 8.2 amended by General Notice 652 (Clarification of commencement date) in Government Gazette 41996 dated 26 October 2019)

8.3 Despite regulation 8.2, the –

(a) insertion of –

(i) regulation 4.1(2), (3), (4), (6) and (7); and

(ii) regulation 4.2(2), (3) and (4);

in Part 4 takes effect 12 months after the date referred to in regulation 8.2; and

(b) insertion of paragraph (q) [*sic*] in subregulation (1) in regulation 6.3 of Part 6 takes effect -

(i) on the date referred to in regulation 8.2 for binder agreements entered into on or after the date referred to in regulation 8.2;

(ii) on 1 January 2019 for binder agreements entered into before the date referred to in regulation 8.2.

8.4 Despite regulation 8.2, the following amendments made to the Regulations through Government Notice 1439 as published in *Government Gazette* 41334 on 15 December 2017 take effect as follows -

(a) insertion of subregulations (2) and (3) in regulation 5.8 in Part 5B 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;

- (b) insertion of subregulation (2) in regulation 6.2A in Part 6 takes effect 24 months after the effective date; and
- (c) amendment to paragraph (p) in subregulation (1) in regulation 6.3 in Part 6 takes effect 24 months after the effective date.

8.5 For purposes of regulation 8.4 "effective date" means 1 January 2018.

(Part 8 inserted by regulation 3 of Government Notice 1582 in Government Gazette 40515 dated 23 December 2016)

(Part 8 substituted by regulation 7 of Government Notice 1439 in Government Gazette 41334 dated 15 December 2017)

(Part 8 substituted by regulation 8 of GN 1018 of 2018)