FINANCIAL SECTOR CONDUCT AUTHORITY

NO. 996 **28 SEPTEMBER 2018**

SHORT-TERM INSURANCE ACT, 1998: AMENDMENT OF POLICYHOLDER PROTECTION RULES PRESCRIBED UNDER SECTION 55

The Financial Sector Conduct Authority, hereby amend the Policyholder Protection Rules prescribed under section 55 of the Short-term Insurance Act, 1998 (Act No. 53 of 1998), as set out in the schedule.

This Notice comes into operation on 1 October 2018.

CD da Silva
For the Transitional Management Committee
FINANCIAL SECTOR CONDUCT AUTHORITY

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SCHEDULE

1. Interpretation

In this Schedule, "the Rules" means the Policyholder Protection Rules (Short-term Insurance), 2017 promulgated under the Short-term Insurance Act, 1998 as published in Government Notice 1433 of 15 December 2017.

2. The Rules are hereby amended by the substitution of all references in the Rules to "Registrar" with "Authority".

3. The Rules are hereby amended by the substitution of all references in the Rules to "managing executive" with "senior manager".

4. Chapter 1 of the Rules is hereby amended by –

(a) the insertion in section 2.1 in Section 2 before the definition "advice" of the following definition:

"'**advertisement**' means any communication published through any medium and in any form, by itself or together with any other communication, which is intended to create interest by the public in the business, policies or related services of an insurer, or to persuade the public (or a part thereof) to transact in relation to a policy or related service of the insurer in any manner, but which does not purport to provide detailed information to or for a specific policyholder regarding a specific policy or related service;";

(b) the substitution in section 2.1 in Section 2 for the definition "advice" of the following definition:

"'**advice**' has the meaning assigned to it in the FAIS Act;";

(c) the substitution in section 2.1 in Section 2 for the definition "beneficiary" of the following definition:

"'**beneficiary**' in respect of a –

(a) registered insurer, means –

(i) a person nominated by the policyholder as the person in respect of whom the insurer should meet policy benefits; or

(ii) in the case of a group scheme, a person nominated by the group scheme or member of the group scheme or person otherwise determined in accordance with the rules of that group scheme as the person in respect of whom the insurer should meet policy benefits;

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

(d) the insertion in section 2.1 in Section 2 after the definition "beneficiary" of the following definition:

"'**business day**' means any day excluding a Saturday, Sunday or public holiday;";

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(e) the substitution in section 2.1 in Section 2 for the definition "consumer credit insurance" of the following definition:

"'**consumer credit insurance**' in respect of a –

(a) registered insurer, means credit insurance as defined in the National Credit Act;

(b) licensed insurer, means one or more policies written under the Consumer Credit class of non-life insurance business as set out in Table 2 of Schedule 2 of the Insurance Act;";

(f) the substitution in section 2.1 in Section 2 for the definition "credit life insurance" of the following definition:

"'**credit life insurance**' in respect of a registered insurer, has the meaning assigned to it in the National Credit Act;";

(g) the substitution in section 2.1 in Section 2 for the definition "group scheme" of the following definition:

"'**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, 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;";

(h) the deletion in section 2.1 in Section 2 of the definition "juristic person";

(i) the substitution in section 2.1 in Section 2 for the definition "mandatory credit life insurance" of the following definition:

"'**mandatory credit life insurance**' in respect of a registered insurer, means credit life insurance contemplated in section 106(1)(b) of the National Credit Act;";

(j) the substitution in section 2.1 in Section 2 for the definition "ombud" of the following definition:

"'**ombud**' has the meaning assigned to it in the –

(a) Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004) up until such time as such Act is repealed through Schedule 4 of the Financial Sector Regulation Act; and

(b) Financial Sector Regulation Act from the date on which such Act repeals the Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004) through Schedule 4 of such Act;";

(k) the substitution in section 2.1 in Section 2 for the definition "optional credit life insurance" of the following definition:

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"'**optional credit life insurance**' in respect of a registered insurer, means credit life insurance contemplated in section 106(3) of the National Credit Act;";

(l) the substitution in section 2.1 in Section 2 for the definition "outsourcing" of the following definition:

"'**outsourcing**' means an outsourcing arrangement as defined in section 1 of the Financial Sector Regulation Act, and includes rendering services under a binder agreement, but excludes rendering services as intermediary, and "outsourced" has a corresponding meaning;";

(m) the insertion in section 2.1 in Section 2 after the definition "related service" of the following definition:

"'**repudiate**' in relation to a claim means any action by which an insurer rejects or refuses to pay a claim or any part of a claim, for any reason, and includes instances where a claimant lodges a claim –

(a) in respect of a loss event or risk not covered by a policy; and

(b) in respect of a loss event or risk covered by a policy, but the premium or premiums payable in respect of that policy are not paid;"; and

(n) the insertion in section 2.1 in Section 2 after the definition "repudiate" of the following definition:

"'**senior manager**' has the meaning assigned to it in the Insurance Act;".

5. Chapter 2 of the Rules is hereby amended by –

(a) the substitution in rule 1.6 in Rule 1 for paragraph (d) of the following paragraph:

"(d) rule 1.4(e) entitles the member of a group scheme to be provided with products that perform as either the member of the group scheme or the policyholder has been led to expect by the insurer or its representative, and services of the standard that either the member of a group scheme or the policyholder has been led to expect, in relation to the member of a group scheme's interest in the group scheme; and"; and

(b) the substitution in rule 1.6 in Rule 1 for paragraph (e) of the following paragraph:

"(e) for purposes of achieving rule 1.4(f) the insurer must have arrangements in place with the policyholder concerned that facilitate and support the member of a group scheme's ability to make changes in relation to the member's interest in the group scheme (to the extent permitted in terms of the rules of the group scheme) or to submit claims or make complaints without unreasonable barriers.".

6. Chapter 3 of the Rules is hereby amended by –

(a) the substitution in Rule 2 for rule 2.3 of the following rule:

"2.3 This rule only applies to the development of any new product as of 1 January 2018 and any material change in design of an existing product.";

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(b) the insertion after Rule 2 of the following rule:

"RULE 2A: MICROINSURANCE PRODUCT STANDARDS

2A.1 Definitions

In this rule –

"accident" has the meaning assigned to it in section 1 of the Insurance Act;

"microinsurance policy" means a non-life insurance policy entered into by a microinsurer;

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

"non-life insurance policy" has the meaning assigned to it in section 1 of the Insurance Act;

"underwritten on a group basis" has the meaning assigned to it in Schedule 2 of the Insurance Act.

2A.2 Application

2A.2.1 This rule applies to any microinsurance policy and applies concurrently with, and in addition to, all other rules set out in these Policyholder Protection Rules.

2A.2.2 If there is an inconsistency between any provision of this rule and any other rule in these Policyholder Protection Rules, the provision of this rule prevails.

2A.3 Use of the term "microinsurance"

2A.3.1 An insurer, other than a microinsurer, or any person acting on behalf of that insurer may not use the term "microinsurance" or any derivative thereof in respect of a policy or in any advertisement in respect of a policy.

2A.4 Structure of policy benefits

2A.4.1 A microinsurance policy may not have a contract term of more than 12 months.

2A.4.2 The value of the policy benefits under a microinsurance policy may not exceed the maximum amounts as prescribed by the Prudential Authority.

2A.4.3 A microinsurance policy must, upon expiry of its contract term, either be –

(a) automatically renewed; or

(b) terminated in accordance with the requirements set out in these rules.

2A.4.4 A microinsurance policy may not provide that any of the policy benefits thereunder is subject to the principle of average.

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2A.5 Variation and renewal of a microinsurance policy

2A.5.1 The terms, conditions or provisions of a microinsurance policy may not be changed or varied during the first 12 months after inception of the policy, unless –

(a) the microinsurer can demonstrate that –

(i) there are reasonable actuarial grounds to change or vary the terms, conditions or provisions of the microinsurance policy; or

(ii) the variation will be to the benefit of the policyholder or member of a group scheme concerned; and

(b) the variation is done in accordance with rules 11.6.3 and 11.6.4.

2A.5.2 Rule 2A.5.1 applies regardless of whether a microinsurance policy has been renewed during the 12 month period referred to therein.

2A.5.3 Where a microinsurance policy is underwritten on a group basis, the microinsurer may not selectively cancel or selectively decline to renew individual policies which form part of the group of people that are underwritten on a group basis.

2A.6 Waiting periods

2A.6.1 A microinsurance policy, underwritten under the accident and health class of non-life insurance business as set out in Table 2 of Schedule 2 to the Insurance Act, may not impose a waiting period exceeding the shorter of one quarter of the term of the policy or 6 months, in respect of which policy benefits are payable on the happening of a death, disability or health event resulting from natural causes.

2A.6.2 A microinsurance policy may not impose a waiting period in respect of policy benefits payable on the happening of a death, disability or health event resulting from an accident.

2A.6.3 A microinsurance policy may not impose a waiting period when it is renewed.

2A.6.4 A microinsurer may not impose a waiting period under a microinsurance policy if the policyholder or member of a group scheme confirms that –

(a) the policyholder or member of a group scheme, at least 31 days before entering into a new microinsurance policy with that microinsurer, had a previous microinsurance policy or non-life insurance policy with another insurer;

(b) the policy benefits under that previous policy provided cover in respect of similar risks as those covered under the new microinsurance policy; and

(c) the policyholder or member of a group scheme had completed the waiting period in respect of that previous policy.

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2A.6.5 An insurer underwriting the new microinsurance policy may impose a waiting period equal to the unexpired part of the waiting period under a previous microinsurance policy, if -

(a) the waiting period of the policyholder or member under the previous policy had not expired at the time that the policyholder or member enters into the new microinsurance policy; and

(b) the new microinsurance policy provides cover in respect of similar risks as those covered under the previous microinsurance policy.

2A.6.6 A microinsurer must for purposes of determining a waiting period, before entering into a microinsurance policy request the potential policyholder or potential member of a group scheme to confirm whether or not the potential policyholder or potential member had –

(a) a previous microinsurance policy; and

(b) completed a waiting period under that previous microinsurance policy.

2A.6.7 Rule 2A.6.6 does not apply to a microinsurance policy underwritten under the consumer credit class of non-life insurance business as set out in Table 2 of Schedule 2 to the Insurance Act.

2A.6.8 A microinsurer must, upon request by a microinsurer referred to in rule 2A.6.6 confirm whether or not the confirmation by the potential policyholder or potential member of a group scheme received in accordance with rule 2A.6.6 is correct.

2A.7 Exclusions

2A.7.1 A microinsurance policy in respect of which the aggregate value of the policy benefits is R120 000 or less may not impose any exclusions or conditions limiting the liability of the microinsurer, other than exclusions or conditions relating to –

(a) unlawful conduct, provided that such exclusions may only be applied or relied on if there is a direct link between the cause of the loss and the unlawful conduct;

(b) special risks referred to in the Conversion of the SASRIA Act, 1998 (Act No. 134 of 1998);

(c) the condition of any asset insured at inception of the policy, other than exclusions relating to the wear and tear of the asset;

(d) the maintenance and usage of the insured asset under a policy that insures against unforeseen mechanical or electrical component failure;

(e) consequential loss; or

(f) any combination of (a) to (e).

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2A.7.2 A microinsurance policy in respect of which the aggregate value of the policy benefits exceeds R120 000 may impose exclusions or conditions, in addition to those set out in rule 2A.7.1(a) to (f), limiting the liability of the microinsurer if the microinsurer is able to demonstrate that such exclusions or conditions will -

(a) not unreasonably erode the value of the benefits under the policy, taking into account the nature of the policy benefits;

(b) continue to render the policy being suitable for targeted policyholders; and

(c) not compromise the consistent delivery of fair outcomes to the policyholders or members.

2A.8 Excesses

2A.8.1 A microinsurance policy may only provide one standard excess per risk event covered under a particular class of non-life insurance business referred to in Table 2 of Schedule 2 of the Insurance Act.

2A.8.2 If an excess is payable under a microinsurance policy, such excess must be disclosed to a policyholder or member of a group scheme, or a potential policyholder or potential member of a group scheme in accordance with rules 11.4.1, 11.5.1 and 17.10.

2A.8.3 Where any excess is payable under a microinsurance policy in respect of which the aggregate value of the policy benefits is R120 000 or less, the excess may not exceed the lower of –

(a) 10% of the value of the policy benefits, payable for the risk event as set out in the policy; or

(b) R 1 000.

2A.8.4 Any excess payable under a microinsurance policy in respect of which the aggregate value of the policy benefits exceeds R120 000, may not exceed 10% of the value of the policy benefits, payable for the risk event as set out in the policy.

2A.8.5 The amounts referred to in this rule escalates annually, from the effective date of this rule, 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).

2A.9 Claims

2A.9.1 Subject to rule 2A.9.2, a microinsurer must, within 2 business days after all required documents in respect of a claim under a microinsurance policy have been received –

(a) assess and make a decision whether or not the claim submitted is valid, and

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(b) (i) authorise payment of the claim;

(ii) repudiate the claim; or

(iii) dispute the claim and notify the claimant of the dispute.

2A.9.2 If a claim is disputed as referred to in rule 2A.9.1(b)(iii), the microinsurer, within 14 business days after expiry of the period referred to in rule 2A.9.1 –

(a) may further investigate the claim;

(b) must make a decision whether or not the claim submitted is valid; and

(c) must pay or repudiate the claim.

2A.9.3 A microinsurer may not repudiate a claim under a microinsurance policy on the basis that the policyholder did not disclose information, if the microinsurer did not specifically request the policyholder to disclose that information before the inception of the policy.

2A.10 Reinstatement

2A.10.1 If a microinsurance policy has lapsed due to the non-payment of premium and the microinsurer reinstates such policy, the microinsurer –

(a) must do so on at least the same terms as the policy that had lapsed; and

(b) may not impose a waiting period under the reinstated policy.

2A.10.2 If a microinsurer enters into a new microinsurance policy with the same policyholder or member of a group scheme within 2 months after a microinsurance policy has lapsed due to the non-payment of premium, the microinsurer may not impose a waiting period under such new policy.

2A.10.3 Rule 2A.10.2 does not apply where the policyholder or member of a group scheme had not completed a waiting period imposed under the lapsed policy, in which case the microinsurer may impose a waiting period not exceeding the unexpired part of the waiting period under the lapsed policy.

2A.11 General

2A.11.1 When providing a service or similar benefit as a policy benefit under a microinsurance policy, a microinsurer or any person on behalf of a microinsurer may not charge the policyholder or member of a group scheme any administration or similar fee in respect of that service or similar benefit.

2A.12 Reporting of a new product

2A.12.1 A microinsurer must, at least 31 days prior to marketing or offering a new microinsurance product, notify the Authority of the intention to launch a new product and submit the following information to the Authority:

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(a) a summary of the benefits, exclusions, terms and conditions forming part of the new product;

(b) the proposed commission payable for rendering services as intermediary relating to the new product and the intended structure of the commission payable; and

(c) all material intended to be used in advertisements relating to the new product.

2A.12.2 For purposes of rule 2A.12.1 any material change to the design of an existing product or to the benefits, terms or conditions offered thereunder would constitute a new product.

2A.12.3 The Authority may at any time (within the 31 day period or any time thereafter) by notice to a microinsurer –

(a) object to any of the benefits, terms and conditions, commission payable and advertisement of a microinsurance product, and

(b) instruct the microinsurer to –

(i) stop advertising, marketing or offering the microinsurance policies;

(ii) not renew the microinsurance policies;

(iii) terminate the microinsurance policies within 90 days of the date determined by the Authority; or

(iv) amend any of the benefits, terms and conditions and advertisements of any microinsurance policy or policies by a date determined by the Authority and in accordance with the requirements of the Authority.";

(c) the substitution in Rule 3 for subrule 3.1.1 of the following subrule:

3.1.1 A registered insurer must not provide a mandatory credit life insurance policy to a policyholder, unless that policy and the costs associated with that policy comply with any relevant credit life insurance regulations made by the Minister of Trade and Industry under section 171 of the National Credit Act.";

(d) the substitution in Rule 3 for subrule 3.2.1 of the following subrule:

"3.2.1 An insurer must, where a policyholder or member of a group scheme informs that insurer, or the insurer otherwise should reasonably be aware, that the policyholder or member of a group scheme wishes to, or has, exercised the right under subsection 106(4)(a) of the National Credit Act to substitute any other consumer credit insurance or, in the case of a registered insurer, and other credit life policy with a policy issued by the insurer, assist the policyholder or member of a group scheme to, in relation to the substituted policy, to comply –

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(a) with any demands of a credit provider under section 106(6) of the National Credit Act; or

(b) in respect of a registered insurer providing credit life insurance, with regulation 7 of the credit life insurance regulations made under the National Credit Act.".

7. Chapter 4 of the Rules is hereby amended by –

(a) the deletion in rule 10.1 in Rule 10 of the definition "advertisement";

(b) the substitution in rule 10.1 in Rule 10 for the definition "group of companies" of the following definition:

"'**group of companies**' has the meaning assigned to it in the Insurance Act;";

(c) the substitution in Rule 10 for rule 10.14 of the following rule:

"10.14 Loyalty benefits or bonuses

10.14.1 An advertisement that references a loyalty benefit, no-claim bonus or rebate in premium must not create the impression that such benefit or bonus is free and must adequately –

(a) indicate if the loyalty benefit, no-claim bonus or rebate in premium is optional or not; and

(b) regardless of whether or not the loyalty benefit, no-claim bonus or rebate in premium is optional, express the cost of the benefit, bonus or rebate in premium including, where applicable, the impact that such cost has on the premium, unless the impact is negligible.

10.14.2 For purposes of rule 10.14.1 –

(a) the impact is deemed to be negligible if the cost of the loyalty benefit, no-claim bonus or rebate in premium comprises less than 10% of the total premium payable under the policy;

(b) where the impact of a loyalty benefit, no-claim bonus or rebate in premium is not negligible and where the advertisement refers to the actual premium payable –

(i) the cost of the benefit, bonus or rebate must be shown as a percentage of that premium; and

(ii) the insurer must be able to demonstrate that the premium and benefit cost used in the advertisement presents a true reflection of the cost impact for the average targeted policyholder; and

(c) where the impact of a loyalty benefit, no-claim bonus or rebate in premium is not negligible and where the advertisement does not refer to the actual premium payable, the average cost of the benefit, bonus or rebate as a percentage of premium must be provided.

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10.14.3 Where an advertisement highlights a loyalty benefit, no-claim bonus or rebate in premium as a significant feature of a policy and makes reference to a projected value or rebate that is payable on the expiry of a period in the future, it must also express the value of the projected benefit, bonus or rebate in premium in present value terms, using reasonable assumptions about inflation.

10.14.4 An advertisement must clearly state whether the availability or extent of a loyalty benefit, no-claim bonus or rebate in premium is contingent on future actions of the policyholder or any factors not within the policyholder's control.

10.14.5 An advertisement may not create the impression that the bonus, benefit or rebate is guaranteed or more likely to materialise than the insurer reasonably expects for the average targeted policyholder.";

(d) the substitution in rule 11.3 in Rule 11 for subrule 11.3.9 of the following subrule:

"11.3.9 An insurer must, wherever it is reasonably practicable for the insurer to communicate directly with a member of a group scheme in the normal course of business, provide the member of a group scheme with any information that an insurer is required to disclose to a policyholder in accordance with this rule that –

(a) could reasonably be expected to affect the rights or obligations of the member of a group scheme or the member's benefits under the group scheme; and

(b) such member could reasonably require in order to make an informed decision in relation to the member's benefits."; and

(e) the substitution in Rule 11 for rule 11.5 of the following rule:

"11.5 Disclosure after inception of policy

11.5.1 An insurer must at the earliest reasonable opportunity after inception of the policy, but no later than 31 days after such inception, provide the policyholder with all information referred to in rule 11.4 in writing, to the extent that any such information has not already been provided in writing by the insurer under rule 11.4, as well as the following information –

(a) evidence of cover;

(b) the timing and manner in which the policy benefits will or may be made available to the policyholder or a beneficiary;

(c) comprehensive details of all of the following, where applicable, including the amount and frequency thereof, the recipient thereof, the purpose thereof and the manner of payment –

(i) any charges or fees to be levied against the policy or the premium;

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(ii) any commission or remuneration payable to any intermediary or binder holder in relation to the policy; and

(iii) any excesses that may become payable by the policyholder and the circumstances under which it will be payable and the consequences of not paying;

(d) comprehensive details of all exclusions or limitations, including prominent disclosure as contemplated in rule 10.15 of any significant exclusions or limitations;

(e) any obligation to monitor cover, and that the policyholder may need to review and update the cover periodically to ensure it remains adequate;

(f) any right to cancel, including the existence and duration of, and any conditions relating to, the right to cancel;

(g) the right to claim benefits, including conditions under which the policyholder can claim and the contact details for notifying the insurer of a claim;

(h) any requirement to make an election during the duration of the policy, including any default provisions that may apply if such election is not made, as contemplated in rule 5; and

(i) the representations made by or on behalf of the policyholder to the insurer which were regarded by that insurer as material to its assessment of the risks under the policy.

11.5.2 The information referred to in rule 11.5.1 must be provided to the policyholder in a format which is clearly distinguishable from the policy.

11.5.3 An insurer, in addition to the information referred to in rule 11.5.1 and 11.5.2, must provide a copy of the policy to the policyholder at the earliest reasonable opportunity after the commencement date of such policy, but not later than 31 days after such commencement.

11.5.4 Notwithstanding rule 11.5.3, the policyholder, member of a group scheme and the person who entered into the policy, is at any time entitled to be provided, upon request, with a copy of the policy.

11.5.5 Where any information referred to in rule 11.5.1 has previously been provided in a quotation or similar communication referred to in rule 11.4.1(a), the insurer must confirm whether and to what extent the information remains accurate and applicable in relation to the policy as issued.".

8. Chapter 6 of the Rules is hereby amended by –

(a) the substitution in Rule 15 for rule 15.1 of the following rule:

"15.1 An insurer shall ensure that a policy contains a provision for a period of grace for the payment of premiums of not less than 15 days after the relevant due date: Provided that in the case of a monthly policy, such

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provision must apply with effect from the second month of the currency of the policy.".

9. Chapter 7 of the Rules is hereby amended by –

(a) the substitution in rule 17.1 in Rule 17 for subrule 17.1.1 of the following subrule:

"17.1.1 For purposes of this rule, reference to a "policyholder" includes a member of a group scheme.";

(b) the deletion in rule 17.1 in Rule 17 of subrule 17.1.2;

(c) the insertion after rule 17.11 in Rule 17 of the following rule:

"17.12 Claims received during periods of grace

17.12.1 If a claimant submits a valid claim in respect of an event that occurred during the period referred to in rule 15, the value of the claim may be reduced by the sum of the unpaid premium.";

(d) the substitution in subrule 19.3.5 in rule 19.3 in Rule 19 for the words preceding paragraph (a) of the following words:

"Where the insurer can demonstrate that due to the nature of the group scheme it is not reasonably practicable to communicate directly with the members of the group scheme in the normal course of business as contemplated in rule 19.3.4, the insurer must –"; and

(e) the substitution in rule 19.4 in Rule 19 for paragraph (b) of the following paragraph:

"(b) where it has any reason to believe that the contact details of the members of a group scheme are incomplete or there is a material risk that the required information may not reach members, it has taken reasonable steps to communicate with such members using other appropriate communication channels.".

10. Chapter 8 of the Rules is hereby amended by –

(a) the substitution in section 1.2 in Section 1 for paragraphs (a) and (b) of the following paragraphs:

"(a) for a period of 12 months from 1 January 2018, Rule 4, Part III: Basic Rules for Direct Marketers; and

(b) for a period of 24 months from 1 January 2018, Rule 7.3, Part V: Unilateral termination of policies."; and

(b) the substitution in Section 2 for section 2.2 of the following section:

"2.2 These rules will come into operation as follows –

Chapter	Rule	Commencement
Chapter 1: Interpretation		1 January 2018
Chapter 2: Fair treatment of	Rule 1.1 to 1.4	1 January 2018

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policyholders		
	Rule 1.5 to 1.9	1 January 2019
	Rule 1.10	1 January 2018
Chapter 3: Products	Rule 2	1 January 2018
	Rule 2A	1 October 2018
	Rule 3	1 January 2018
	Rule 4	1 January 2019
	Rule 5	1 January 2018
	Rule 6.1	1 January 2018
	Rule 6.2 to 6.4	1 July 2018
	Rule 6.5	1 January 2018
	Rule 7	1 January 2018
	Rule 8	1 January 2018
	Rule 9	1 January 2018
Chapter 4: Advertising and Disclosure	Rule 10	1 July 2018
	Rule 11 except for 11.5.1(j), 11.5.2 to 11.5.4	1 January 2019
	Rule 11.5.1(j) and 11.5.2	1 July 2019
	Rule 11.5.3 and 11.5.4	1 October 2018
Chapter 5: Intermediation and distribution	Rule 12.1 to 12.3 except for 12.2.1 and 12.2.2 insofar as they relate to existing intermediary agreements	1 January 2018
	Rule 12.2.1 and 12.2.2 insofar as they relate to existing intermediary agreements	1 January 2019
	Rule 12.4	1 January 2019
Chapter 6: Product performance and acceptable service	Rule 13	1 January 2020
	Rule 14	1 July 2018
	Rule 15	1 January 2018
	Rule 16	1 January 2019
Chapter 7: No unreasonable post-sale barriers	Rule 17, except insofar as it relates to group schemes	1 January 2019
	Rule 17, insofar as it relates to group schemes	1 July 2019
	Rule 18, except insofar as it relates to group schemes	1 January 2019
	Rule 18, insofar as it relates to group schemes	1 July 2019
	Rule 19	1 January 2020

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Chapter 8: Administration		1 January 2018

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11. The Arrangement of Rules is hereby amended by –

(a) the insertion after Rule 2 under Chapter 3 of the following rule:

"RULE 2A: MICROINSURANCE PRODUCT STANDARDS".

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