BOARD NOTICE 30 OF 2018

FINANCIAL SERVICES BOARD

LONG-TERM INSURANCE ACT, 1998 (ACT NO. 52 OF 1998) AND SHORT-TERM INSURANCE ACT, 1998 (ACT NO. 53 OF 1998)

PROPOSED AMENDMENTS TO THE POLICYHOLDER PROTECTION RULES

I, Caroline Dey Da Silva, Deputy Registrar of Long-term Insurance and Short-term Insurance, hereby, under the Long-term Insurance Act, 1998 (Act No. 52 of 1998) and Short-term Insurance Act, 1998 (Act No. 53 of 1998) ("the Acts"), give notice of the release, for public comment, of proposed amendments to the Policyholder Protection Rules ("PPRs") made under section 62 of the Long-term Insurance Act, 1998 and section 55 of the Short-term Insurance Act, 1998.

The proposed amendments to the PPRs, together with a statement explaining the amendments and tracked changes versions of the existing PPRs highlighting the proposed amendments are available on the Financial Services Board's website at https://www.fsb.co.za.

Comments on the proposed PPRs may be submitted in writing on or before 13 April 2018 to the Financial Services Board, c/o Jo-Ann Ferreira at FSB.INSProposedPPRs@FSB.co.za.

CD DA SILVA
DEPUTY REGISTRAR OF LONG-TERM INSURANCE AND SHORT-TERM INSURANCE

FINANCIAL SERVICES BOARD

STATEMENT ON PROPOSED AMENDMENTS TO THE POLICYHOLDER PROTECTION RULES MADE UNDER THE LONG-TERM INSURANCE ACT, 1998 AND THE SHORT-TERM INSURANCE ACT, 1998

1. INTRODUCTION

This statement is published in relation to the proposed amendments to the Policyholder Protection Rules ("PPRs") made under the Long-term Insurance Act, 1998 ("LTIA") and the Short-term Insurance, 1998 ("STIA") ("proposed amendments"), respectively published for public comment by the Registrar Long-term insurance and Short-Term insurance on 2 March 2018.

The statement provides an overview of and the rationale for the proposed amendments to the PPRs. It also explains the need for, and the intended operation and expected impact of the proposed amendments to the PPRs.

The proposed amendments to the PPRs as published for public comment are available on the Financial Services Board's website at https://www.fsb.co.za. Tracked changes versions of the existing PPRs highlighting the proposed amendments are also available on the Financial Services Board's website.

2. THE SCOPE OF THE PROPOSED AMENDMENTS TO THE PPRs

The proposed amendments to the PPRs are necessary to –

- align the PPRs with the Insurance Act, 2017 (Act No.18 of 2017) ("Insurance Act");
- provide for certain conduct of business related requirements that will be repealed from the LTIA and the STIA through Schedule 1 to the Insurance Act, once the latter Act commences, as these conduct requirements are better placed in subordinate legislation; and
- provide for microinsurance product standards by giving effect to the National Treasury's Microinsurance Policy Document ("Policy Document") released in July 2011, which is available on the National Treasury's website https://www.treasury.gov.za.

3. THE PROPOSED AMENDMENTS

3.1 Alignment with the Insurance Act

The Insurance Act was enacted on 18 January 2017. The Insurance Act provides the prudential legislative framework for insurers. The commencement date of the Insurance Act is still to be determined by the Minister of Finance, but it is envisaged that this date will be 1 July 2018.

Schedule 1 to the Insurance Act repeals all prudential requirements currently provided for in the LTIA and the STIA. The remaining sections in the LTIA and the STIA will remain in force in order to provide for an interim conduct of business legislative framework for insurers, pending phase two of the 'Twin Peaks' process and the implementation of the envisaged Conduct of Financial Institutions Act.

The Insurance Act introduces, amongst other things, new authorisation classes of insurance business. These authorisation classes are significantly more granular than the current "classes" or types of policies provided for under the LTIA and the STIA.

The Insurance Act also defines various concepts in a manner that differs from how such concepts are currently defined in the LTIA and the STIA. To ensure alignment between the LTIA, the STIA and the Insurance Act, Schedule 1 to the Insurance Act amended the LTIA and the STIA by differentiating between registered insurers and licensed insurers and defining the respective "classes" of insurance business in the context of both of these insurers. Put differently, the existing terminology in the LTIA and STIA will apply to registered insurers, and the Insurance Act terminology will apply to licensed insurers. This same approach as adopted in the LTIA and STIA has been perpetuated in the PPRs. For this reason, some of the definitions in the PPRs have been be amended.

It is envisaged that the alignment of terminology between the LTIA and the STIA and the Insurance Act, as provided for in the proposed amendments, will not have a significant regulatory impact. The intention is for existing requirements to be perpetuated into the new regulatory framework under the Insurance Act. The proposed amendments will not create any new regulatory obligations on insurers. Instead it will ensure that licensed insurers, which are subject to the Insurance Act, are able to interpret the PPRs under the LTIA and the STIA with reference to Insurance Act terminology. This will in turn support consistency across the insurance regulatory framework and ensure a smooth transition for regulated insurers under the current regulatory framework to licensed insurers under the Insurance Act at the time of the conversion of their registrations.

3.2 Conduct of business related sections repealed from the LTIA and STIA, and provided for in the PPRs

The Insurance Act also amends the LTIA and the STIA by repealing some of the existing conduct of business provisions in these Acts. The repealed conduct of business requirements are incorporated into the proposed amendments to the PPRs as these requirements are better placed in subordinate legislation. The Table below sets out the provisions that will be repealed from the LTIA and the STIA and the proposed rule in the PPRs that will incorporate these requirements in the PPRs:

LTIA		
Section	**Heading**	**Rule in the proposed amendments to the PPRs**
48	Summary, inspection and copy of policy	Rule 11: Disclosure
52	Failure to pay premiums	Rule 15A: Payment of Premiums
53	Option for payment of policy benefits in money	Rule 2: Product Design
56	Voidness of certain provisions of agreements	Rule 7: Void provisions
59	Misrepresentation and failure to disclose material information	Rule 21: Misrepresentation and non-disclosure
60	Validity of contracts	Rule 7: Void provisions
STIA		
Section	**Heading**	**Rule in the proposed amendments to the PPRs**
47	Copy of policy and inspection of policy records	Rule 11: Disclosure
51	Voidness of certain provisions of agreements	Rule 7: Void provisions
53	Misrepresentation and failure to disclose material information	Rule 20 : Misrepresentation and non-disclosure

54	Validity of contracts	Rule 7: Void provisions

Given that these proposed amendments emanate from existing requirements set out in the LTIA and the STIA, it is envisaged that the proposed amendments will not have a significant regulatory impact. The proposed amendments will ensure that the requirements that prescribe the conduct of business requirements for insurers in their interaction with policyholders and underpin fair outcomes for policyholder are all appropriately provided for in the PPRs. This will ensure legal certainty in the interpretation of the legislative framework.

3.3 The introduction of the microinsurance and funeral policy product standards

The microinsurance regulatory framework proposed in the National Treasury ("NT") Policy Document aims to create a dedicated microinsurance license that will promote financial inclusion, encourage entrance of new providers into the market and enhance consumer protection through appropriate prudential and business conduct regulation.

The NT Policy Document makes provision for the introduction of a proportionate and appropriate regulatory and supervisory framework for microinsurers. This framework includes prudential requirements suited to the risk profile of microinsurers and the development of product standards to ensure that products are designed in an appropriate manner to support an improved understanding of these products by policyholders. These product standards will be given effect as follows:

- the conduct of business requirements for microinsurance products will be incorporated into the PPRs, and
- the prudential requirements for microinsurance products will be set out in Prudential Standards to be made by the Prudential Authority under the Insurance Act[1].

The NT Policy Document makes a number of proposals on the microinsurance product standards and all of these proposals were considered in drafting the proposed microinsurance product standards in the PPRs. However cognisant of the fact that the NT Policy Document was published in 2011 and the insurance landscape has changed over the past 7 years, some of the proposals were adapted in consultation with NT to more appropriately provide for the current insurance landscape.

3.3.1 Application of the product standards

In terms of the NT Policy Document, product standards should only apply to microinsurance policies offered by microinsurers conducting microinsurance business. According to the definition of "microinsurance business" in the Insurance Act, a microinsurer can only conduct business in the following classes of life and non-life insurance business as referred to in Schedule 2 of the Insurance Act, subject to the insurance obligations (policy benefits) under such policies not exceeding the prescribed amounts:

CLASSES OF LIFE INSURANCE BUSINESS
Risk
Credit Life
Funeral

[1] The draft Prudential Standards to be published shortly for public comment will provide that a microinsurer may not, without the approval of the Prudential Authority, issue a life insurance policy or a non-life insurance policy that provides for a loyalty benefit, no-claim bonus or rebate in premiums. For purposes of this standard, "loyalty benefit" and "no-claim bonus" have the meaning assigned in the Policyholder Protection Rules made under the Long-Term Insurance Act, 1998 and the Short-term Insurance Act, 1998, respectively.

Reinsurance (in as far as it relates to the above life classes of insurance business)
CLASSES OF NON-LIFE INSURANCE BUSINESS
Motor
Property
Agriculture
Legal expense
Consumer credit
Accident and health
Liability (in as far as it relates to the above non-life classes of insurance business)
Reinsurance (in as far as it relates to the above non-life classes of insurance business)

It is envisaged that the policy benefits under a microinsurance policy will be capped by the Prudential Authority at R60 000 for life insurance and R120 000 for non-life insurance in Prudential Standards to be made under the Insurance Act.

The NT Policy Document also proposes that life and non-life policies designed for low income earners, with similar features as microinsurance policies and are offered by traditional insurers[2] will not be subject to the product standards.

However, consideration was given to the fact that funeral policies are generally not complex and in many instances funeral cover is also taken up by low income earners. It is envisaged that the maximum benefit for funeral policies offered by both microinsurers and traditional insurers will be capped by the Prudential Authority at R 60 000 in Prudential Standards to be made under the Insurance Act.

The FSB with the support of the NT therefore proposes that the product standards should apply to all funeral policies regardless of whether they are underwritten by a microinsurer or by a traditional insurer. This will ensure a level playing field between microinsurers and traditional insurers in respect of funeral policies. Subjecting all funeral policies to the same products standards will ensure that policyholders are afforded the same protections.

3.3.2 The use of the word "microinsurance" and "funeral policy"

In terms of the proposed amendments, only microinsurers will be allowed to use the word "microinsurance" or any derivative thereof in respect of a policy or in any advertisement in respect of a policy. This is meant to avoid confusion in the market by clearly distinguishing between microinsurers and traditional insurers, as well as their product offering.

The product standards further prohibit the use of the term "funeral policy[3] or any suggestion to create the impression that policy benefits are intended to cover the costs associated with a funeral or a funeral service, other than for a funeral policy. This prohibition is meant to avoid regulatory arbitrage whereby insurers advertise life risk policies as funeral policies in order to circumvent compliance with the product standards that apply to funeral policies.

3.3.3 Structure of the policy benefits

The proposed product standards include requirements relating to the structure of the policy benefits.

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[2] These are insurers other than microinsurers.

[3] A funeral policy" means a life insurance policy entered into by an insurer underwritten under the Funeral class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act

In the PPRs made under LTIA, it is proposed that microinsurance policies and funeral policies only provide risk benefits with no surrender value or investment elements. This is to ensure that these policies are uncomplicated and easily understandable.

In terms of the PPRs made under STIA, a microinsurance policy may not make any of its policy benefits subject to the principle of average.

In line with the proposal in the NT Policy Document, it is proposed that microinsurance policies (and funeral policies underwritten by traditional insurers) should have a contract term of up to, but not exceeding, 12 months. To facilitate uninterrupted cover, the proposed amendments also propose that microinsurance policies and funeral policies should be automatically renewable at the end of the contract term. Upon the expiry of the contact term the policy must either be automatically renewed (subject to insurer meeting the prescribed disclosure requirements on renewal set out in Rule 11 of the PPRs) or terminated in accordance with the requirements in the PPRs on termination.

3.3.4 Variation and renewals of microinsurance policies

In terms of the proposed amendments, variation of the terms and conditions of microinsurance policies is prohibited unless under exceptional circumstances where the insurer can demonstrate that reasonable actuarial grounds exists to justify the variation or change, and that the variation will benefit the policyholder or member concerned. In addition to these requirements, all the requirements prescribed regarding disclosures when varying a policy as set out in the rule on disclosures will equally apply to such microinsurance policies.

Where microinsurance policies are underwritten on a group basis it is proposed that insurers should not be able to selectively cancel (i.e. to refuse to renew) individual policies within the group. Should the insurer no longer find the level of risk acceptable, it must decline to renew the policies for the whole group or increase the premiums for the whole group.

3.3.5 Waiting periods

The product standards relating to waiting periods are intended to discourage adverse selection by policyholders while at the same time ensuring the protection of policyholders against insurers imposing unreasonable waiting periods. The product standards propose that the waiting period for microinsurance policy and funeral policy be restricted to a quarter of the contract term for death or disability due to natural causes. Given that the risk of adverse selection falls away in the case of accidental death or disability, it is proposed that no waiting period be allowed for policies covering these risks. Given the nature of credit life insurance policies, it is also proposed that no waiting period be allowed for these policies.

The imposition of a waiting period could adversely affect policyholders, should they move between insurers. The proposed product standards acknowledge this potential adverse impact. Therefore no waiting period may be imposed when a policyholder cancels a policy with one insurer in favour of a policy providing similar cover with another insurer.

3.3.6 Exclusions

The requirements and limitations relating to exclusions in the proposed product standards differ between life and non-life microinsurance policies. To ensure consistency and fair treatment of consumers across product offerings, the proposed amendments to PPRs made under LTIA, propose that no exclusions should be allowed for pre-existing health conditions for funeral polices and credit life insurance policies. The proposal in the NT Policy Document was that no exclusions should be allowed for pre-existing health condition, however considering the adverse impact such a limitation may have on the cost of underwriting such policies it is proposed that this prohibition only apply to funeral and credit life classes of microinsurance policies.

It is also proposed that exclusions for suicide will be allowed for a period not exceeding 12 months from inception of the policy regardless of whether a microinsurance policy or a funeral policy has been renewed during the 12 month period.

The proposed amendments to the PPRs made under the STIA, it is proposed that a microinsurance policy may not impose any exclusion other than the exclusions allowed for in the description of short-term insurance personal lines in the FAIS Board Notice 194 of 2017: Determination of Fit and proper requirements for FSPs. Exclusions that will be allowed for non-life microinsurance products include:

- exclusions relating to unlawful conduct;
- special risks referred to in the Conversion of the SASRIA Act, No. 134 of 1998;
- exclusions relating to the condition of any asset insured at inception of the policy, other than exclusions relating to the wear and tear of the asset;
- exclusions relating to the maintenance and usage of the insured asset under a policy that insures against unforeseen mechanical or electrical component failure; and
- exclusions relating to consequential loss.

This alignment is also intended to facilitate the intermediation dispensation as referred to in the NT policy document.

3.3.7 Excesses

The product standards on excesses will only apply to non-life microinsurance policies. It is proposed that a non-life microinsurance policy may only impose one standard excess per risk event covered. This is intended to ensure uncomplicated excesses that are easily understandable. It is further proposed that no excess may exceed 10% of the value of the policy benefits payable for the risk event, or R 1000, whichever is the lower amount.

3.3.8 Claims

With regard to claims, the proposed amendments propose that all valid microinsurance policies and funeral policies claims should be paid within a period of 48 hours after the insurer received all the requisite documentation. This is common practice in the current funeral insurance market and short-term insurance personal lines market and therefore this product standard is reasonable.

The product standards on claims also provides for an adapted version of the so-called "non-contestable rule" which is applied in some other jurisdictions. It is proposed that a claim should not be repudiated under a microinsurance policy on the basis that the policyholder or member of a group scheme did not disclose information, if the microinsurer did not specifically request the policyholder or member of a group scheme to disclose that information before the inception of the policy.

3.3.9 Reinstatement

To ensure that policyholders are not unduly disadvantaged when their microinsurance policies or funeral policies lapse as a result of non-payment of premium, the product standards propose that where an insurer reinstates a policy after it lapsed due to non-payment it must be reinstated on at least the same terms as the policy that had lapsed. Such reinstated policies may not impose a waiting period on policy benefits.

It is however not mandatory that an insurer must reinstate a policy when it has lapsed due to non-payment. The insurer and policyholder may choose to rather enter into a new policy instead

of reinstating the lapsed policy. If such a new policy is entered into within 6 months of the previous policy lapsing the insurer may not impose a waiting period.

3.3.10 General standards

It is proposed that a microinsurance policy may not provide that a policy benefit payable as a sum of money is payable directly to a service provider. This means that a policy may not prescribe that benefits are payable to a service provider. This does not preclude a policyholder to at claim stage request that the insurer pay the benefit over to the service provider of the policyholder's choice. Further, the charging of any administration or similar fee when providing a service as a policy benefit under a microinsurance policy will be prohibited. This is aligned to the general rule in the PPRs on determining premium.

3.3.11 Reporting of new product

To facilitate effective supervision of compliance with the microinsurance product standards, insurers are required to submit all proposed new microinsurance policies and funeral policies to the FSB / FSCA at least 31 days before launching the policies.

4. ENVISAGED EFFECTIVE DATE

It is expected that the proposed amendments to the PPRs will come into operation on 1 July 2018 to coincide with the expected commencement date of the Insurance Act and Prudential Standards to be made under that Act.

GOVERNMENT NOTICE

FINANCIAL SERVICES BOARD

NO. .... **.. .... 2018**

LONG-TERM INSURANCE ACT, 1998: PROPOSED AMENDMENT OF POLICYHOLDER PROTECTION RULES MADE UNDER SECTION 62

I, Caroline Dey Da Silva, Deputy Registrar of Long-term Insurance, hereby, under the Long-term Insurance Act, 1998 (Act No. 52 of 1998), hereby amend the Policyholder Protection Rules ("PPRs") made under section 62 of the Short-term Insurance Act, 1998, as set out in the schedule.

CD DA SILVA
DEPUTY REGISTRAR OF LONG-TERM INSURANCE

SCHEDULE

1. **Interpretation**

In this Schedule "the Rules" means the Policyholder Protection Rules (Long-term Insurance), 2017 promulgated under the Long-term Insurance Act, 1998 as published in Government Notice 1407 of 15 December 2017.

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

3. The Rules are hereby amended by the substitution of all references in these Policyholder Protection 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 public interest 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 fund member policy, a fund policy or a group scheme, a person nominated by the fund, member of the fund or member of the group scheme, or otherwise determined in accordance with the rules of that fund or 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; and for purposes of these Policyholder Protection Rules includes in the case of a fund policy, a person nominated by the fund, or otherwise determined in accordance with the rules of that fund as the person in respect of whom the insurer should meet policy benefits;";

(d) the insertion in section 2.1 in Section 2 after the definition "FAIS General Code of Conduct" of the following definition:

"'**fund**' has the meaning assigned to it in Part 1 of the Regulations;";

(e) the insertion in section 2.1 in Section 2 after the definition "fund member policy" of the following definition:

"'**fund policy**' has the meaning assigned to it in Part 1 of the Regulations;";

(f) the substitution in section 2.1 in Section 2 for the definition "investment value" of the following definition:

"'**investment value**' in respect of a –

(a) registered insurer, means the value of a policy calculated as the accumulated basic premium and investment return stated in or ascertainable from the policy, less deductions specifically provided for in the policy;

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

(g) 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;";

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

"'**outsourcing**' has the meaning assigned to it in 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;";

(i) the insertion in section 2.1 in Section 2 after the definition "representative" 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

(j) the insertion in section 2.1 in Section 2 after the definition "risk policy" 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 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 or the policyholder has been led to expect, in relation to the member's interest in the fund or group scheme; and".

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

(a) the substitution in Rule 2 for rule 2.1 of the following rule:

"2.1 In this rule -

"financial instrument" has the meaning assigned to it in the Financial Sector Regulation Act.";

(b) the insertion above rule 2.2 in Rule 2 of the following heading:

"General requirements";

(c) the substitution in Rule 2 for rule 2.4 of the following rule:

"2.4 Rules 2.2 and 2.3 only apply to the development of any new product as of 1 January 2018 and any material change in design of an existing product.";

(d) the insertion after rule 2.4 in Rule 2 of the following rules:

"Option for payment of policy benefits in money

2.5 Despite the terms of a policy entered into before 1 June 2009, the policyholder or member is entitled to demand that a policy benefit which is expressed otherwise than as a sum of money must be provided as a sum of money, in which case the sum of money must be equal in value to the policy benefit that would have been provided by the insurer or any person acting on behalf of the insurer had the policy benefit been provided otherwise than as a sum of money.

2.6 Where a policy that provides for a policy benefit expressed otherwise than as a sum of money is entered into on or after 1 June 2009, that policy must -

(a) provide that the policyholder or member is entitled to demand that the policy benefit be provided as a sum of money in lieu of the benefit on the occurrence of the event insured against; and

(b) state the amount of the policy benefit that is to be provided as a sum of money, which amount must be equal to the value of the policy benefit expressed otherwise than as a sum of money.

2.7 When a policyholder or member chooses to receive policy benefits in money as set out in rules 2.5 and 2.6 above, an insurer or any person on behalf of an insurer, may not charge the policyholder or member any administration or similar fee in respect of that benefit.";

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

"RULE 2A: MICROINSURANCE AND FUNERAL POLICY PRODUCT STANDARDS

2A.1 Definitions

In this rule –

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

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

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

"microinsurance policy" means a life insurance policy underwritten by a microinsurer;

"microinsurer" 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 any funeral policy and applies concurrently with, and in addition to, all other rules set out in these Policyholder Protection Rules.

2A.2.2 This rule applies to microinsurers and insurers licensed for the funeral class of insurance business referred to in Table 1 of Schedule 2 to the Insurance Act.

2A.2.3 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 terms and advertising

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.3.2 An advertisement may not use the term "funeral policy" in relation to any policy, or suggest or create the impression that a policy or policy benefits thereunder can be used to cover –

(a) the cost associated with a funeral;

(b) the rendering of a funeral service on the happening of a death event; or

(c) any cost associated therewith,

unless that policy is a funeral policy.

2A.4 Structure of policy benefits

2A.4.1 A microinsurance policy or a funeral policy may only provide risk policy benefits and may not have a surrender or investment value.

2A.4.2 A microinsurance policy or a funeral policy may not have a contract term of more than 12 months.

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

(a) automatically renewed, subject to the insurer meeting the disclosure requirements relating to the renewal of policies as set out in rule 11.6.6; or

(b) terminated in accordance with the requirements set out in rule 20.

2A.4.4 Policy benefits payable as a sum of money provided for under a microinsurance policy or a funeral policy must be defined on a sum assured basis.

2A.5 Variation and renewal of a microinsurance policy or a funeral policy

2A.5.1 The terms, conditions or provisions of a microinsurance policy or a funeral policy may not be changed or varied during the first 12 months after inception of the policy, unless the insurer can demonstrate that --

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

(b) the variation will be to the benefit of the policyholder or member concerned; and

(c) the variation is done in accordance with rules 11.6.4 and 11.6.5.

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

2A.5.3 Where a microinsurance policy or a funeral policy is underwritten on a group basis, the insurer 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 or a funeral policy may not impose a waiting period exceeding one quarter of the term of the policy, in respect of policy benefits payable on the happening of a death, disability or health event resulting from natural causes.

2A.6.2 A microinsurance policy or a funeral 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 Notwithstanding rules 2A.6.1 and 2A.6.2, a microinsurance policy underwritten under the credit life class of life insurance business as set out in Table 1 of Schedule 2 to the Insurance Act may not impose any waiting period.

2A.6.4 A microinsurance policy or a funeral policy may not impose a waiting period when it is renewed.

2A.6.5 An insurer may not impose a waiting period under a microinsurance policy or a funeral policy if –

(a) the policyholder or member, at least 31 days before entering into a new microinsurance policy or funeral policy with that insurer, had a previous policy with another insurer;

(b) the policy benefits under that previous policy were materially similar to benefits under the new microinsurance policy or funeral policy; and

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

2A.6.6 Where a waiting period of a policyholder or member under a previous policy had not expired at the time that the policyholder or member enters into a new microinsurance policy or funeral policy with policy benefits that are materially similar to the previous microinsurance policy or funeral policy, the insurer underwriting the new microinsurance policy or funeral policy may impose a waiting period equal to the unexpired part of the waiting period under the previous microinsurance policy or funeral policy.

2A.6.7 An insurer must, before entering into a microinsurance policy or a funeral policy request the potential policyholder or potential member to confirm whether or not it had –

(a) a previous microinsurance policy or funeral policy; and

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

2A.6.8 Rule 2A.6.7 does not apply to a microinsurance policy underwritten under the credit life class of life insurance business as set out in Table 1 of Schedule 2 to the Insurance Act.

2A.6.9 An insurer must, upon request by an insurer referred to in rule 2A.6.7, confirm whether or not the confirmation by the potential policyholder or potential member received in accordance with rule 2A.6.7 is correct.

2A.7 Exclusions

2A.7.1 A microinsurance policy underwritten under the credit life class of life insurance business as set out in Table 1 of Schedule 2 to the Insurance Act, or a funeral policy, may not impose any exclusion for a pre-existing health condition.

2A.7.2 A microinsurance policy or a funeral policy may not impose any exclusion for suicide for a period that exceeds 12 months from the inception date of the policy.

2A.7.3 Limitation on exclusions for suicide as set out in rule 2A.7.2 applies regardless of whether a microinsurance policy or a funeral policy has been renewed during the 12 month period referred to in rule 2A.7.2.

2A.8 Claims

2A.8.1 Subject to rule 2A.8.2, an insurer must, within 48 hours after all required documents in respect of a claim under a microinsurance policy or a funeral policy have been submitted –

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

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

(ii) repudiate the claim; or

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

2A.8.2 If a claim is disputed as referred to in rule 2A.8.1(b)(iii), the insurer within 14 days after expiry of the period referred to in rule 2A.8.1 –

(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.8.3 An insurer may not repudiate a claim under a microinsurance policy or a funeral policy on the basis that the policyholder or member did not disclose information, if the insurer did not specifically request the policyholder or member to disclose that information before the inception of the policy.

2A.9 Reinstatement

2A.9.1 If a microinsurance policy or a funeral policy has lapsed due to the non-payment of premium and the insurer reinstates such policy, the insurer –

(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.9.2 If an insurer enters into a new microinsurance policy or a funeral policy with the same policyholder or member within 6 months after a microinsurance policy or a funeral policy has lapsed due to the non-payment of premium, the insurer may not impose a waiting period under such new policy.

2A.9.3 Rule 2A.9.2 does not apply where the policyholder or member had not completed a waiting period imposed under the lapsed policy, in which case the insurer may impose a waiting period not exceeding the unexpired part of the waiting period under the lapsed policy.

2A.10 General

2A.10.1 A microinsurance policy or a funeral policy may not provide that a policy benefit payable as a sum of money is payable directly to a service provider.

2A.10.2 When providing a service or other non-monetary benefit under a microinsurance policy or a funeral policy, an insurer or any person on behalf of an insurer may not charge the policyholder or member any administration or similar fee in respect of that service or similar benefit.

2A.11 Reporting of a new product

2A.11.1 An insurer must, at least 31 days prior to marketing or offering a new microinsurance or funeral product, notify the Authority of the intention to launch a new product and submit the following information to the Authority:

(a) a summary of the benefits, 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.11.2 The Authority may at any time (within the 31 day period or at any time thereafter) by notice to an insurer –

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

(b) instruct the insurer to –

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

(ii) not renew the microinsurance or funeral policies;

(iii) terminate the microinsurance or funeral 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 funeral policy or policies by a date determined by the Authority and in accordance with the requirements of the Authority.";

(f) the substitution in Rule 4 for rule 4.2 of the following rule:

"4.2 A policyholder may –

(a) in any case where no benefit has yet been paid or claimed or an event insured against has not yet occurred; and

(b) within a period of 31 days after the date of receipt of the information contemplated in rule 11.5, or a reasonable date on which it can be deemed that the policyholder received that information,

cancel a policy entered into with an insurer or any variation of such policy, excluding any policy or variation that has a duration of 31 days or less, by way of a cancellation notice to the insurer.";

(g) the substitution in Rule 7 for rule 7.1 of the following rule:

"7.1 A provision of a policy is void to the extent that it provides expressly or by implication –

(a) that in connection with any claim made under the policy, the policyholder or claimant may be obliged to undergo a polygraph, lie detector or truth verification test, or any other similar test or procedure which is furnished or made available by the insurer or any other person in terms of an arrangement with the insurer and which is conducted under the control of the insurer or such other person;

(b) for an inducement of any nature for a policyholder or claimant to voluntarily agree to undergo a test or procedure envisaged in paragraph (a);

(c) that where a policyholder or claimant under other circumstances than those contemplated in paragraph (b) voluntarily agrees to undergo a test or procedure envisaged in paragraph (a) of this rule, and the policyholder or claimant fails to pass such a test, the claim will be repudiated or the policy will become void merely as a result of such failure to pass the test or procedure;

(d) that in the event of any dispute arising under the policy, the dispute can only be resolved by means of arbitration;

(e) that an insurer may repudiate a claim because a premium was not paid on the due date, if payment was made during a period referred to in rule 15A.1, whether or not the payment was made prior to the event giving rise to the claim;

(f) that an insurer is exempted from liability for the actions, omissions or representations of a person acting on its behalf in relation to a policy;

(g) that the person who has entered into the policy declares or admits that a person who acted on behalf of the insurer in connection with an offer of that person to do so, or with the negotiations preceding the entering into it, was in fact appointed to act on behalf of the first-mentioned person;

(h) that the obligation of an insurer under a policy is dependent upon the discharging of an obligation of another person under a reinsurance policy; or

(i) that a person who has entered into a policy, or the life insured under a policy, waives a right to which such person is entitled, by or under the Act."; and

(h) the insertion after rule 7.2 in Rule 7 of the following rule:

"7.3 Validity of contracts

7.3.1 A policy is not void merely because a provision of a law, including a provision of the Act or the Insurance Act, has been contravened or not complied with in connection with that policy.

7.3.2 If a person has entered into a policy with an insurer who was, in terms of the Act or the Insurance Act, prohibited from entering or not authorised to enter into the policy, or with another person who is not an insurer but who has in terms of a policy undertaken an obligation as insurer, that person, by notice in writing to such insurer or other person, or the Authority by notice to such insurer or other person and on the official web site, may cancel the policy, whereupon that person shall be deemed to be in the same legal position in respect of such insurer or other person as if the policy had been cancelled by that person on account of a breach of contract by such insurer or other person.".

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 Rule 10.14.1 does not apply in respect of benefits a policyholder may receive from an insurer because that policyholder, together with all the policyholders of that insurer, is an owner or a member of the insurer or the direct holding company of that insurer.

10.14.3 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.

10.14.4 Where an advertisement highlights a loyalty benefit, no-claims 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 present value terms, using reasonable assumptions about inflation.

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

10.14.6 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 11.1 in Rule 11 for the definition "policy loan" of the following definition:

"'**policy loan**' includes any loan granted by an insurer under a policy;";

(e) 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 in the normal course of business, provide the member 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 or the member's benefits under the fund or group scheme; and

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

(f) 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 any restrictions on access to policy benefits and any penalties for early termination or withdrawal from or transfer of the policy, or other implications of such termination, withdrawal or transfer;

(d) 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 including, where the policy has an investment component, the net investment amount ultimately invested for the benefit of the policyholder and the anticipated impact of such charges and fees on the policy benefits;

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

(iii) any material tax consideration.

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

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

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

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

(i) 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

(j) those of 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 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 issue and deliver 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 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.

11.5.6 In respect of fund policies, an insurer in addition to the information referred to in rule 11.5.1 –

(a) must issue and deliver a fund policy to either the principal officer of the fund, the trustees of the fund or any person managing the fund, at the earliest reasonable opportunity after the commencement date of such policy, but not later than 31 days after such commencement date;

(b) notwithstanding paragraph (a), may, with the approval of the Authority and subject to such conditions as the Authority may determine, postpone the issue, delivery or both of a fund policy. The insurer's application for approval must be submitted to the Authority in the form determined by the Authority."; and

(g) the substitution in rule 11.6 in Rule 11 for subrule 11.6.5 for paragraph (a) of the following paragraph:

"(a) where the change to the terms and conditions is effected at the specific request of the policyholder, be provided to the policyholder at the earliest

reasonable opportunity but no later than 60 days after the change takes effect;".

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

(a) the substitution in rule 15.4 in Rule 15 for paragraph (b) of the following paragraph:

"(b) must be justified with reference to the extent to which the assumptions on which the premium was based have been met; and"

(b) the insertion after Rule 15 of the following rule:

"RULE 15A: PAYMENT OF PREMIUMS

Failure to pay premiums

15A.1 If a premium under a policy, other than a fund policy, has not been paid on its due date, the insurer must notify the policyholder of the non-payment within 15 days after the payment was due, and the policy must, notwithstanding anything therein to the contrary, in the case of a policy under which there are to be two or more premium payments at intervals of -

(a) one month or less, remain in force for a period of 15 days after that due date; or

(b) longer than one month, remain in force for a period of one month after that due date,

or for such longer period as may be determined by agreement between the parties.

15A.2 If the overdue premium in respect of a policy referred to in rule 15A.1 is not paid by the end of any such period, the policy must be dealt with in accordance with Rule 15A.3.

15A.3 The remaining value of a policy referred to in rule 15A.1 which, after the satisfaction of any claim of the insurer which is secured solely by the policy benefits to be provided under the policy, is greater than half of the aggregate amount of the premium payments due thereunder during the period of 12 months commencing on the due date of the unpaid premium, the long-term insurer must -

(a) inform the policyholder of the amount of that remaining value and notify him or her that the policy will remain in force, in accordance with the documented procedure of the insurer, until –

(i) the policy no longer has any such remaining value, whereupon it will lapse;

(ii) the payment of premiums is resumed;

(iii) the provisions of the policy are amended, in accordance with the rules of the insurer, so that it becomes a policy which is fully paid-up; or

(iv) if the policyholder so requests, the policy is surrendered, in accordance with the rules of the long-term insurer, and so much of the remaining value as then remains is, subject to section 54, paid to the policyholder; and

(b) deal with the policy accordingly.

15A.4 An insurer will have documented procedures which to the satisfaction of its statutory actuary prescribe a sound basis on which, and the methods by which, a policy is to be valued and otherwise dealt with for the purposes of rule 15A.3.";

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

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

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

(b) the deletion in subrule 17.1.1 in rule 17.1 in Rule 17 of the definition "repudiate";

(c) the insertion after rule 17.10 in rule 17 of the following rule:

"17.11 Claims received during periods of grace

17.11.1 If a claimant submits a valid claim during the period referred to in rule 15A.1, the value of the claim may be reduced by the sum of the unpaid premium.";

(d) the substitution in paragraph (a) in the definition "variation of an individual risk policy" in rule 19.1 in Rule 19 for subparagraph (iv) of the following subparagraph:

"(iv) the application of the policy value as premiums payable in respect of the relevant policy referred to in Rule 15A.3;";

(e) the substitution in subrule 20.2.1 in rule 20.2 in Rule 20 for paragraph (a) of the following paragraph:

"(a) non-payment of a premium, subject to the insurer complying with the provisions of Rules 15A; or;";

(f) the substitution in subrule 20.3.5 in rule 20.3 in Rule 20 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 20.3.4, the insurer must –";

(g) the substitution in rule 20.4 in Rule 20 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."; and

(h) the insertion after Rule 20 of the following rule:

"RULE 21: MISREPRESENTATION

21.1 Notwithstanding anything to the contrary contained in a policy, but subject to rule 21.2 -

(a) the policy must not be invalidated;

(b) the obligation of the insurer under the policy must not be excluded or limited; and

(c) the obligations of the policyholder must not be increased,

on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless a reasonable, prudent person would consider that representation or non-disclosure as being likely to have materially affected the insurer's ability to assess the risk under the policy concerned at the time of the representation or non-disclosure.

21.2 If the age of a life insured under a policy has been incorrectly stated to the insurer, the policy benefits must, notwithstanding rule 21.1 and subject to rule 21.3, be those which would have been provided under that policy in return for the premium payable had the age been correctly stated.

21.3 If the nature of the policy is such as to render such arrangement as referred to in rule 21.2 inequitable, the Authority may direct the insurer to apply such different method of adjustment to the policy benefits of the policy as the Authority considers equitable in relation to the misstatement of age.".

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 15 December 2017:

(i) Rule 4, Part III: Basic Rules for Direct Marketers;

(ii) Rule 6, Part V: Rules on Cancellations of policies and Cooling-Off;

(iii) Rule 18 on Policy Loans and Cessions, Part VIII: Additional Insurer Duties; and

(b) for a period of 24 months from 15 December 2017:

(i) Rules 8 to 15, Part VII: Assistance Business Group Schemes."; 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		15 December 2017
Chapter 2: Fair treatment of policyholders	Rule 1.1 to 1.4	15 December 2017
	Rule 1.5 to 1.9	15 December 2018
	Rule 1.10	15 December 2017
Chapter 3: Products	Rule 2	15 December 2017
	Rule 2A	1 July 2018
	Rule 3	15 December 2017
	Rule 4	15 December 2018
	Rule 5	15 December 2017
	Rule 6.1	15 December 2017
	Rule 6.2 to 6.4	15 June 2018
	Rule 6.5	15 December 2017
	Rule 7.1 (a) to (e) and 7.2	15 December 2017
	Rule 7.1 (f) to (i) and 7.3	1 July 2018
	Rule 8	15 December 2017
	Rule 9	15 December 2017
Chapter 4: Advertising and Disclosure	Rule 10	15 June 2018
	Rule 11 except for the following rules: 11.5.1(j), 11.5.2 to 11.5.4	15 December 2018
	Rule 11.5.1(j), 11.5.2 to 11.5.4	1 July 2018
Chapter 5: Intermediation and distribution	Rule 12.1 to 12.3 except for 12.2.1 and 12.2.2 in insofar as they relate to existing intermediary agreements	15 December 2017
	Rule 12.2.1 and 12.2.2 insofar as they relate to existing intermediary agreements	15 December 2018
	Rule 12.4	15 December 2018
Chapter 6: Product performance and acceptable service	Rule 13	15 December 2019
	Rule 14	15 June 2018
	Rule 15.1 to 15.8	15 June 2018
	Rule 15.9 to 15.12	1 July 2018
	Rule 16	15 December 2018
Chapter 7: No unreasonable post-sale barriers	Rule 17, except insofar as it relates to group schemes	15 December 2018
	Rule 17, insofar as it relates to group schemes	15 June 2019
	Rule 18, except insofar as it relates to group schemes	15 December 2018
	Rule 18, insofar as it relates to group schemes	15 June 2019
	Rule 19	15 June 2018
	Rule 20	15 December 2019
	Rule 21	1 July 2018
Chapter 8:		15 December 2017

Administration		

11. The amendment of the Arrangement of Rules –

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

"RULE 2A: MICROINSURANCE AND FUNERAL POLICY PRODUCT STANDARDS";

(b) by the insertion after Rule 15 under Chapter 6 of the following rule:

"RULE 15A: PAYMENT OF PREMIUMS"; and

(c) by the insertion after Rule 20 under Chapter 7 of the following rule:

"RULE 21: MISREPRESENTATION".