**MARKING MEMO: LONG TERM INSURANCE ADVICE**

**FORMATIVE ASSESSMENT ACTIVITIES**

**SECTION 1: 100 MARKS**

1. **Define Insurance in your own words with reference to the purpose of long-term insurance and give any two examples of events covered by long term insurance. (6 Marks)**

***Insurance*** *is a contract between the insurer and the insured wherein against receipt of certain amount, called premium, the insurer agrees to make good any financial loss that may be suffered by the insured, due to the operation of an insured peril on the subject matter of insurance.*

*The purpose of long-term insurance is to****provide economic protection****against the losses that****may be incurred****due to insured****chance and unfortunate events****such as:*

* *Death*
* *Disability*
* *Medical expenses*
* *Incapacitating illness or medical condition, like cancer, stroke or paralysis.*

## List and describe four types of long-term insurance. (8 Marks)

* ***LIFE insurance*** *is an insurance that is directly linked to an insured person’s life or wellbeing. This type of insurance is usually paid over a long period of time and includes life insurance, disability insurance and income protection insurance. This insurance will pay out an agreed amount after a defined event has taken place, such as in the event of an accident that results in disability, unemployment or death of the insured person.*
* ***TERM INSURANCE*** *Long term insurance that runs for a known period of time, and either expires or pays out a maturity amount.*
* ***DISABILITY INSURANCE*** *is insurance that covers the insured in the event of him/her being occupationally incapacitated or impaired. It replaces one’s income and can also pay for physical disablement even if one is able to go to work.*
* ***DREAD DISEASE INSURANCE*** *–The insured pays monthly premiums to the insurance company and in the event of being diagnosed with a covered ailment or medical condition, the insurer releases an agreed amount in compensation.*

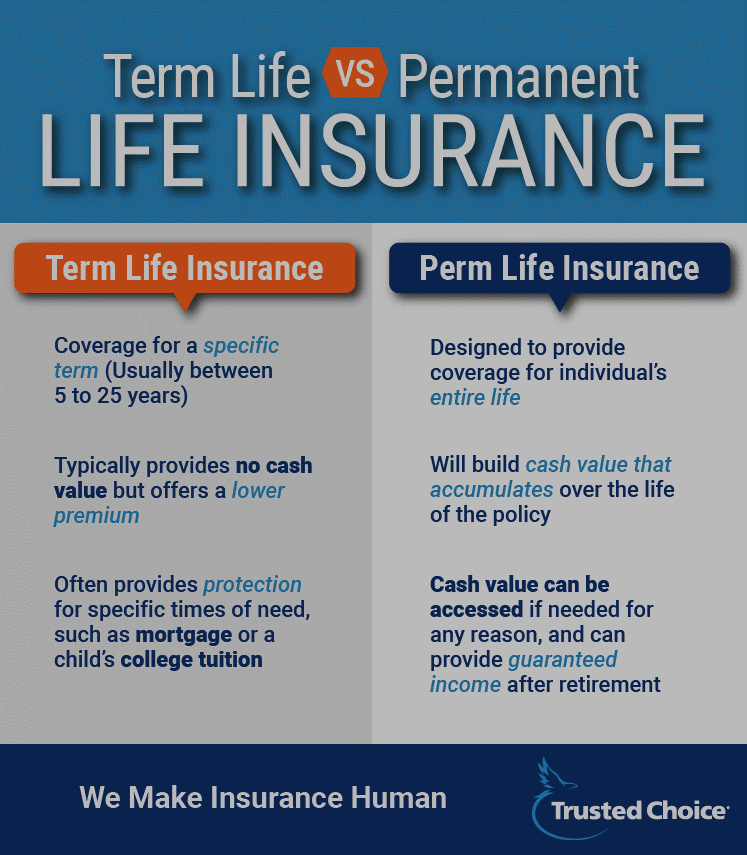
## Discuss the purpose of term insurance and describe any 5 features of term insurance. (7 Marks)

*A term life insurance policy covers you for a set, predetermined length of time. It is a good type of coverage to have if you feel you only need insurance coverage for a short or limited period of time. These policies typically can be purchased for ten, fifteen, and twenty years so they are excellent policies to have during major time frames of your life, like paying off your home mortgage. These policies tend to be very affordable, but they do not have any type of cash or investment value once you have paid the policy off. Basically, the coverage will cease to exist at the end of the term. If during the term of the policy something happens and the Insured passes away, the policy will pay out to their estate*

#### **Features of term life insurance**

* *Term life insurance guarantees payment of a stated death benefit to the insured's beneficiaries during a specified term.*
* *Pays benefits only if you die while the term of the policy is in effect*
* *Term life premiums are based on a person’s age, health, and life expectancy, which is set by the insurer.*
* *Easiest and most affordable life insurance to buy*
* *Purchased for a specific time period, such as 5, 10, 15, or 30 years, known as a “term”*
* *Becomes more expensive as you age, especially after age 50*
* *The term must be renewed if you want coverage to be extended beyond the term length*
* *If the insured dies within the specified policy term, the insurer pays the face value of the policy.*
* *Can be used as temporary additional coverage with a permanent life insurance policy*
* *Can be converted to whole life insurance*

1. **Make use of a table to compare the differences between term life and whole life insurance . (4 Marks)**



1. **Give a real-life example of why one should enter into a Term Life Insurance policy. (3 Marks)**

*Answers may vary so marks are awarded based on the Assessor’s discretion*

1. **Outline the options that may become available when a term life insurance policy has expired. (6 Marks)**

* ***Renewal:****Add a new term to your policy that will give you the same benefit amount. Problem here is that it will take into account your new age and your rates will be much higher. But, say you developed some serious illness, you may not be approved for a whole new policy, so you may just want to take what you can get.*
* ***Convert to a permanent policy:****This is perhaps the easiest option. Here you would roll your policy over into a nice, permanent policy with the same benefit that will last as long as you do. Again, premiums would go up, but you can usually assume that at this point, your kids have grown, your house may be paid for, and the costs fit your budget much better.*
* ***Terminate:****Maybe you’ve already prearranged your funeral and you’ve got things all sorted out for after your passing. In that case, you may find yourself not needing the policy anymore. Or you can terminate your policy and purchase a new type of insurance or a new benefit limit that fits your needs.*

1. **Give a brief description of** **Conventional Life Products in your own words. (3 Marks)**

*Conventional Plans are traditional life insurance plans. They usually invest in low risk return options and offer guaranteed maturity proceeds along with declared bonuses. The term traditional insurance usually means the products designed by the combination of term insurance and pure endowment insurance, that is: term insurance itself, endowment insurance, fix term, pure endowment with premium refund, whole life, and annuities. Their characteristics are fixed technical interest rate, and that all major parameters of different points of the insurance term can be well foreseen.*

1. **Outline any four features of Conventional Life Products. (4 Marks)**

* *These plans do not allow you to choose investment avenues. Your funds are invested as per the strategy and discretion of the company.*
* *Your premiums are invested in a common 'with profits' fund and therefore you cannot track your individual portfolio.*
* *At the time of maturity, you get the sum assured plus bonuses, if applicable in the plan.*
* *Conventional plans do not allow you to withdraw part of your fund. Instead, some policies offer you the facility to take a loan against your investment.*
* *Switching options are generally not available since the investment decision is taken by the insurance company.*
* *These plans do not specify the charges involved.*
* *The single premium top up facility is not available.*

1. **What is the purpose of Conventional Life Products with reference to its pricing? (5 Marks)**

*While the main purpose of conventional life insurance policies is to provide death cover, some policies include an investment element which may pay bonuses (profits) to the investor. A person who invests in such a life insurance policy is seen as deriving income from a profit-making transaction.*

*Conventional policies are comparatively more affordable as they may not have many benefits inherent. In an insurance company, the rate of premium insurance plays an important role, whereas it is based on the concept of pooling or sharing of loss. The sharing of loss, in turn, involves the accumulation of a fund from amounts paid by insured to provide benefits for the unfortunate few who suffer loss, where to establish the amount to be charged by the insurer to the insured must start with some idea as to*

*likelihood of loss for the group. The likelihood of losses in life insurance is shown by specially constructed namely mortality table. Mortality table represented a record of mortality observed in the past and is arranged so as to show the probabilities*

*of death and survival at each age separately. It shows hypothetical group individuals beginning with a certain age and traces the history of the entire group year by year until all have died.*

*The basic principle of insurance pricing is if insurers are to sell coverage willingly, they must receive premiums that:*

* *is sufficient to fund their expected claim and administrative expenses.*
* *are providing an expected profit to compensate for the charge of obtaining the capital necessary to support the sale of coverage.*
* *In addition, the premium level that is just sufficient to fund the insurer’s expected costs and provide insurance company owners with a fair return on their invested capital is known as the fair premiums.*
* *Further, confirms that insurance premiums must be adequate, which means that for a group of contracts, the money collected from policyholders, plus the interest earned from the investment of these amounts, shall be sufficient to pay all promised amounts and cover the insurance company expenses; insurance premiums must be equitable, that risk must consider each person insured.*
* *insurance premiums should not be excessive compared to the sums insured.*

*The rate of premium for life insurance policy is generally based on two underlying concepts namely mortality and interest. However, there may be a third variable; the expense factor which is the amount the company adds to the cost of the policy to cover operating costs of selling insurance, investing the premiums, and paying claims. Mortality in life insurance is based on the sharing of the risk of death by a large group of people. The amount at risk must be known to predict the cost to each member of the group.*

*Mortality tables are used to give the company a basic estimate of how much money it will need to pay for death claims each year. By using a mortality table, the insurer can be to determine the average life expectancy for each age group. Later, the rate of Interest is the second factor used in calculating premium that is interest rate earnings.*

*Companies invest your premiums in bonds, stocks, mortgages, real estate, etc., and assume they will earn a certain rate of interest on these invested funds.*

*In addition, third consideration is the expenses of operating the company. The company estimates such expenses as salaries, agents’ compensation, rent, legal fees, postage, etc. The amount charged to cover each policy’s share of the expenses of operation is called the expense loading. This is a cost area that can vary from company to company based on its operations and efficiency.*

1. **Describe any 2 features of Universal Life Products with reference to the purposes of the cash savings account. (5 Marks)**

*•****Savings Return****- A whole life policy has a fixed, guaranteed rate of return. A universal policy has its rate or return set either by the market or (in some cases) your investment choices.*

*•****Death Benefit****- A whole life policy has a fixed death benefit. With a universal policy you can adjust the death benefit as needed.*

*•****Premium Flexibility****- A whole life policy has a fixed premium. With a universal policy you can adjust the premium by adjusting the death benefit or accessing the savings account.*

*The most common uses for the cash value savings account in a universal life insurance policy are:*

*•****Premium adjustment****- You can draw down on the cash in your account to substitute for some or all of the premiums on your life insurance policy. Structured correctly, some people use this to eventually stop paying premiums altogether.*

*•****Surrender value****- You can surrender your life insurance policy. At this point, you no longer have coverage but your insurance company will return the value of your savings account. This is particularly useful for older insureds who may have less use for the policy benefits than the cash. (For example, an elderly couple might have more use for $150,000 up front than the payment when one spouse dies.)*

*•****Account loans****- You can take a loan from your cash value account. This loan typically comes with an interest rate, and if you don't return it, it can either reduce the amount of your death benefits or (depending on your policy) might jeopardize coverage.*

*•****Partial withdrawal****- Depending on the terms of your policy you might be able to withdraw some of your cash value account. Doing so will reduce the death benefits your policy provides.*

1. **Compare the advantages and disadvantages of Universal Life Insurance. (4 Marks)**

|  |  |
| --- | --- |
| ***Pros*** | ***Cons*** |
| * *Designed to offer more flexibility than whole life* | * *Doesn’t have the guaranteed level premium that’s available with whole life* |
| * *Cash value grows at a variable interest rate, which could yield higher returns* | * *Variable rates also mean that the interest on the cash value could be low* |
| 1. *More opportunity to increase the policy’s cash value* | * *A policy usually needs to have a positive cash value to remain active* |

1. **Conduct research on recent developments in product innovations in the life insurance business in South Africa. (6 Marks)**

*There is common perception that life insurance policyholders have suffered at the hands of insurers over the past decade. Although this argument holds sway in the investment space the opposite is true for pure protection policies. Compared to a decade ago life insurance policyholders pay between 30% and 40% less premium while benefiting from more comprehensive cover and a range of product innovation. The industry also more than doubled claims pay-outs. Discovery may have championed the move from Universal policies as they did not seem to offer much immediate benefits to the insured, and the breakthrough point, when the investment account intersected with the cover, was too far into the future, practically one had to live to well over 120 years to enjoy the benefit!!*

*Like many industries, insurance is benefiting from the technological boom and the ‘consumer first’ type attitude. Insurances such as Discovery and IndieFin from Sanlam are changing the industry as we know it, by making it easier for clients to buy their products and also to manage – if a consumer wants to skip a payment or change their plan, it is simple.*

*Cover seems to not be enough for insurers to make sure that clients stick around, being reason why many insurers have created products that redefine the value of insurance. A good number of products are rewarding investment that clients receive whilst they are insured. The insurance can generate future wealth for the consumer. Insurance companies can no longer just focus on making a profit, they have to offer products that are quality and reward consumers in more ways than just cover.*

*Being able to sign up for insurance packages online, is a big draw which makes digital-first insurers more popular with millennials. It streamlines the process and makes the underwriting process go faster. Allowing prospective customers to have access to the industry’s website, to the chat, to social media and emails 24/7 keeps the company’s availability open so that the client can research and sign up in their own time.*

*Answers may vary; therefore, Assessor’s discretion can be used.*

1. **Discuss the avenues available for a client to contribute towards their Retirement Annuities. (6 Marks)**

***Recurring Premium Annuity;*** *premiums or contributions are made largely through a regular payment arrangement. A debit order arrangement can be effected with a known amount collected from a client’s bank account on a specific date every month for the effective period. Government employees find it easier to arrange stop orders where their employer facilitates deduction of the contribution before remuneration is paid into the customer’s bank account.*

***Single Premium Annuity:*** *A single payment is made by the contributor, either as a once off payment and no other payments are made, or one payment per 12-month period.*

***Ad-hoc Premium Annuity:***  *Ad hoc refers to situational or impromptu or momentary payments, with little prior arrangements nor an ongoing payment arrangement.*

1. **Briefly describe the any two available options at retirement with regards to retirement annuities. (4 Marks)**

***Annuitize Income Stream***

*Annuitization involves exchanging a lump sum of cash for a pension-style income stream. You can annuitize your contract at maturity. Your monthly income payments are based on the value of your annuity at maturity. Many insurance providers allow you to choose between several different payment options.*

*For the highest monthly payment, you can choose a****limited term pay-out, which may involve receiving income for five or 10 years.****Your payments are smaller if you choose to convert your annuity into a lifetime income stream. Payments are smaller still on a jointly owned annuity because the payments continue until the last owner dies.*

***Renewing Your Annuity Contract***

***Annuity withdrawals are fully taxable****. You can delay the annuitization process and the resulting taxes by renewing your annuity. Insurance providers typically provide you with a number of different renewal options. The renewal interest rate and term may differ from your original contract since annuity rates are sensitive to interest rate fluctuations.*

*You can also roll your matured annuity into a different type of deferred annuity, such as a variable or a fixed annuity. Both products offer returns based on market indexes or mutual funds rather than a flat interest rate. Such products prove popular when interest rates are low.*

***Exchanging for Another Annuity***

*If you do not like the annuity offerings available from your current provider, you can move your funds to another insurance firm. During this process, you do not have direct access to the funds. You sign a purchase contract for a new annuity and your current provider disburses the matured contract proceeds to the new provider.*

*So-called "rate shoppers" routinely move funds from one company to another in search of the highest yield.*

***Redeeming in Lump Sums***

*At maturity, you can redeem your fixed annuity, in which case you receive a fully taxable lump sum. If you are not yet 59 1/2 years of age****,*** *you****also pay a 10 percent penalty on the interest and any portion of the principal****that has not previously been taxed. You might opt to cash in the contract and pay the taxes if you need access to the lump sum and do not want to tie it up in another contract or convert it into an income stream.*

*Once you withdraw the cash, you can deposit it into an interest-bearing bank account, buy stocks, bonds or a variety of other instruments. You could also use the cash to pay down debt or just deposit it into your checking account.*

1. **Explain what you understand by the term supplementary benefits and give examples of supplementary benefits under life insurance. (5 marks)**

*It may of paramount importance for the insured to understand the additional benefits they can add onto their policy. Supplementary insurance is insurance coverage that is purchased in addition to an insurance policy to provide additional benefits or coverage. Beyond this base benefit, individuals can elect to purchase supplementary insurance to cover services not included in the package. Supplementary benefits are the auxiliary or complimentary, value added products that one opts to attach onto policy for a number of reasons.*

*Benefits include the following:*

* *Accidental death benefits*
* *Funeral benefits*
* *Dread disease insurance*
* *Disability and Income protection insurance*
* *Debility cover*

*Insured choses benefit as they see fit, and as per their life/financial situation. Insurers make benefits accessible normally at an additional premium.*

1. **Compare the differences between Supplementary benefits, standalone benefits and Accelerated Benefits. (6 Marks)**

*Free Standing Benefits: Free standing cover means that cover stand independently from other covers and that a claim won't have any impact on your death sum insured. For Example, if you have R2million Death Cover and R1million Disability cover and you claim on your Disability cover, the R2mlionil Death Cover remains untouched. Free Standing cover is usually underwritten separately and may attract a separate premium on a policy.*

*Supplementary Benefit: Some additional benefits are purely supplementary. A claim on the benefit accesses the death benefit and reduced the death benefit.*

*Accelerated Benefits: Accelerated benefits refers to a clause in certain life insurance policies that enable the policyholder to receive the benefits before death. ... Insurers offer anywhere from 25 to 100 percent of the death benefit as an early payment. 'Accelerated benefits' refers to a clause in certain life insurance policies that enable the policyholder to receive the benefits before death. Accelerated benefits are normally reserved for those that suffer from a terminal illness, have a long term high-cost illness, require permanent nursing home confinement or have a medically incapacitating condition. Some insurance companies differ on how much cash can be pulled out and how close to death the insured has to be in order to receive these benefits. Accelerated benefits are also referred to as living benefits.*

***BREAKING DOWN Accelerated Benefits***

*Choosing an insurance policy with accelerated benefits allows the policyholder to pay for their daily living in an effort to make it as comfortable as possible while also allowing the holder to look after his or her family once they pass away. This type of benefit was originally started in the late 1980s in an attempt to alleviate the financial pressures of those that were diagnosed with AIDS.*

*Some policies might make an accelerated benefit available even if it's not mentioned in the contract. You qualify for accelerated benefits if you contract a terminal illness and are expected to die within two years. You also qualify if you've been diagnosed with an illness that will reduce your expected lifespan, if you need organ transplant because of illness or if you are in hospice long-term care. Accelerated benefits are also a possibility if you need assistance with everyday activities like bathing or using the toilet.*

*The cost of a living benefit can vary according to insurance company and policy. If the coverage is already included, the cost will be included in the policy. If not, then you will have to pay a fee or a percentage of the death benefit.*

**LONG TERM INSURANCE ACT**

**1: 30 MARKS**

1. Describe the main purpose of the Long-Term Insurance Act (3 Marks)

*An Act is a piece of legislation that gets promulgated as a result of the approval of a Bill by the National Legislature (Parliament). Most Bills are prepared by government departments under the direction of their Ministers or Deputy Ministers as a result of issues arising in various parts of the economy of industries. (For example, matters relating to finance, consumer protection, health, housing, public transport and many others). As a result of the existence of the Long-term insurance industry, there was need to present a bill in parliament in order to professionalise the industry through the implementation of the relevant legislation to regulate the registration and activities of long-term insurers.*

1. **List any 5 Acts that govern Insurance and give a brief explanation of why there is more than one Act in the insurance industry (8 Marks)**

*The main pieces of legislation that govern insurance are;*

* *The Insurance Act 18 of 2017*
* *The Long-Term Insurance Act 52 of 1998*
* *The Short-Term Insurance Act 53 of 1998*
* *The Pension Funds Act 24 of 1956*
* *The Friendly Societies Act 25 of 1956 and*
* *The Medical Schemes Act 131 of 1998.*
* *Collective Investment Schemes Control Act 45 of 2002*
* *The Financial Advisory and Intermediary Services Act 37 of 2002*
* *The Financial Sector Regulation Act 9 of 2017*
* *The Financial Intelligence Centre Act 38 of 2001*
* *The Promotion of Access to Information Act 4 of 2013*
* *Income Tax Act 58 of 1962*

*The purpose of the above-mentioned acts that follow an institutional approach is to regulate the registration and operations of the insurers as well as the development of various different insurance products. Therefore, there is need for different acts that are specifically aligned to particular institutions due to the difference in the nature, complexity and specific conditions that are imposed on the insurance products.*

1. **Describe the difference between a functional and institutional approach with reference to the relevant Acts. (3 Marks)**

*The Financial Advisory and Intermediary Services Act 37 of 2002 that governs insurance as well follows a Functional approach and not an Institutional approach meaning it regulates all the Institutions that perform a function of rendering financial services regardless of the subsector that the institution falls under. On the other hand, Acts such as (The Long-Term Insurance Act 52 of 1998, The Short-Term Insurance Act 53 of 1998, etc) that follow an Institutional approach regulate specific institutions depending on the types of financial products that they deal with.*

1. **What is the difference between the Short Term and Long-Term Insurance Acts? (2 Marks)**

*The Short-Term Insurance Act regulates the registration and activities of short-term insurance companies, and The Long-Term Insurance Act regulates the registration and activities of long-term insurance companies with regards to how they conduct, manage, market and maintain their business. The activities of these insurers are separated between the fact that short term insurers provide indemnity and long-term insurers provide compensation to their clients.*

1. **Explain in detail with the aid of examples the differences between indemnity and non-indemnity with reference to short term and long-term insurance respectively. (6 Marks)**

*Indemnity means security, protection and compensation given against damage, loss or injury; therefore indemnity only applies to short term insurance in which the subject matter of insurance has a monetary value but in case of life insurance, the principle of indemnity does not apply because the value of human life cannot be measured in terms of money, the two concepts are explain below in detail.*

***Indemnity***

*One of the most important principle of short-term insurance is that the insured should not profit from a loss or damage but should be returned (as near as possible) to the same financial position that existed before the loss or damage occurred. In other words, the insured cannot recover more than his or her actual loss from the insurer. This principle is referred to as the indemnity principle.*

***Non-Indemnity (Compensation)***

*Compensation is also a way of reimbursing the insured for the losses that he might sustain. However, unlike indemnity, compensation need not bear any relationship to the actual loss suffered by the insured. Here the intentions are not to put the insured in exactly the same financial position he was in before the loss, but simply to make good for the loss suffered and reduce any financial burden that comes as a result of the particular loss.*

*For example, a person can insure himself against disability for R250 000 and this amount does not need to be equal to the actual loss suffered as a result of the injury. The reason for this being that no one can ever be able to put a value on anyone’s life.*

1. Define risk as it is applied to the long term insurance products (3 Marks)

*Risk in insurance could be described as an uncertainty – this would mean that the event may occur or may not occur no one knows for example in short term insurance, the fire might burn a house, or they may never be a fire at all, similarly in long term insurance, one may become disabled or never become disabled in their entire life. However, in long term insurance, death is the only event that is certain to occur.*

1. **Give a brief explanation on how a long-term risk is assessed. (5 Marks)**

*Risk assessment, also called underwriting, is the methodology used by insurers for evaluating and assessing the risks associated with an insurance policy. The same helps in making a decision on whether the insurer should accept or reject carrying the risk of the client and should the insurer accept the client application then there will be a calculation of the correct premium for an insured.*

*A long-term risk is assessed based on some unknown future outcome. The unknowns can be grouped broadly into two categories;*

* *Demographic unknowns relate to the risks of living or dying, becoming disabled or sick, etc.*
* *Economic unknowns relate to interest and inflation rates, investment returns and other economic factors.*

*The following are some of the factors that are taken into consideration during the risk assessment process in long term insurance, also known as underwriting factors;*

*Age*

*Gender*

*Occupation*

*Education*

*Avocations*

*Number of dependants*

*Health Status*

*Pre-existing conditions*

*Family Medical History*

*Marital Status*

**2: 50 MARKS**

1. **Define the concept of Long Term as it is used in the Long Term Insurance Act (2 Marks)**

*Long term insurance business is the business that covers life-changing events in life, such as death, retirement, illness, and disability.*

*The purpose of long-term insurance is to provide you with an income in the long term (retirement), or a lump sum of money in the event that you become permanently disabled, sick or pass away. Long term insurance policies include life insurance, funeral insurance, retirement annuities, disability, dread disease, and endowment policies. Below are the main concepts in the provision of Long-Term Insurance products;*

1. **Explain the following concepts of long-term insurance and give examples for each concept. (6 Marks)**
2. ***Insurable Interest***

*Insurable interest exists when an insured person derives a financial or other kind of benefit from the continuous existence, without repairment or damage, of the insured object (or in the case of a person, their continued survival). A person has an insurable interest in something when loss of or damage to that thing or a person would cause the person to suffer a financial or other kind of loss (e.g. emotional loss). Normally, insurable interest is established by ownership, possession, or direct relationship. For example, people have insurable interests in their own relatives, business partners, property, employers and employees, but not in their neighbours’ children, property and almost certainly not those of strangers unless there is proof of custodianship. Insurable interest must exist for an insurance contract to be legally binding therefore if there is no insurable interest then the insurance contract is null and void.*

1. ***Compensation***

*Compensation (Non-indemnity) is a concept in which long term insurance tends to cover things with no real replacement value. The amount of compensation received cannot be directly correlated with the loss.  For example, life insurance is non-indemnity insurance because you cannot place a value or a cost of replacement on a person’s life. Instead the benefits of the long-term insurance policy only reduce the financial burden that has been brought about by the loss*

1. **Identify and describe the different classes of long-term insurance policies. (12 Marks)**

*The different policy classes in the Act, can be outlined as follows:*

***Life Policy-****means a contract in terms of which a person, in return for a premium, undertakes to-*

1. *provide policy benefits upon, and exclusively as a result of, a life event; or*
2. *pay an annuity for a period*
3. *and includes a reinsurance policy in respect of such a contract.*

***For an example; Whole Life policy, Endowment policy, Universal Life Policy and Term Life Policy***

***Assistance Policy-*** *means a life policy in respect of which the aggregate of-*

1. *the value of the policy benefits, other than an annuity, to be provided (not taking into account any bonuses to be determined in the discretion of the long-term insurer); and*
2. *the amount of the premium in return for which an annuity is to be provided,*
3. *does not exceed R10 000, or another maximum amount prescribed by the Minister; and includes a reinsurance policy in respect of such a policy.*

***For an example; Funeral Policy***

***Disability Policy-****means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a disability event; and includes a reinsurance policy in respect of such a contract.*

***For an Example; Occupational disability, Physical Impairment***

***Health Policy-*** *means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event, but excluding any contract-*

1. *of which the contemplated policy benefits-*

*(i) are something other than a stated sum of money;*

* 1. *are to be provided upon a person having incurred, and to defray expenditure in respect of any health service obtained as a result of the health event concerned; and*

*(iii) are to be provided to any provider of a health service in return for the provision of such service; or*

*(b) (i) of which the policyholder is a medical scheme registered under the Medical Schemes Act, 1976 (Act No.72 of 1967);*

* + 1. *which relates to a particular member of the scheme or to the beneficiaries of such member; and*
    2. *which is entered into by the scheme to fund in whole or in part its liability so such member or beneficiaries in terms of its rules;*

*and includes a reinsurance policy in respect of such a contract.*

***For an Example; Dread Disease policy, Medical Aid, Medical Insurance***

***Fund Policy-*** *means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits for the purpose of funding in whole or in part the liability of a fund to provide benefits to its members in terms of its rules, other than such a contract relating exclusively to a particular member of the fund or to the surviving spouse, children, dependants or nominees of a particular member of the fund; and includes a reinsurance policy in respect of such a contract.*

***For an Example; Pension Funds, Provident Fund, Retirement Annuity***

***Sinking Fund Policy-*** *means a contract, other than a life policy, in terms of which a person, in return for a premium, undertakes to provide one or more sums of money, on a fixed or determinable future date, as policy benefits; and includes a reinsurance policy in respect of such a contract.*

***For an Example; Savings or Investment with no life assured or risk cover***

1. **List and describe the parties to a Long-Term insurance contract and give a detailed explanation of their relationship, rights and obligations. (12 Marks)**

***Long Term Insurer;***

*Means a person registered or deemed to be registered as a long-term insurer under this Act who accepts the risk of the insured and has an obligation to compensate the insured in the event of a loss*

***Policyholder;***

*Means the person entitled to be provided with the policy benefits under a long-term policy and this the owner of the policy.*

***Life Insured;***

*Means the person or unborn to whose life, or to the functional ability or health of whose mind or body, a long-term policy relates. This is the party whose life is covered by the insurer (the insurer carries the risk on his/her life). The insured life and the policyholder could be the same person.*

*It is common to nominate a second life or even a third life insured in order to ensure that the plan will continue in the event of the first life insured dying.*

***Contribution payer***

*This is the party who agrees to pay a contribution for a specific term or until such time it is no longer required.*

*The life insured and the contribution payer can be the same person.*

***Beneficiary***

*This is the party who has been nominated by the policyholder to receive the proceeds in the event of the life insured’s death.*

***Cessionary***

*This refers to the person normally the third party that receives the rights of the policy through a process called a cession either temporarily or permanently.*

1. **Discuss the limits on cover imposed on the lives of children and the reasons for such limits. (5 Marks)**

***Limitation on policy benefits in event of death of unborn or of certain minors.****-(1) A long-term insurer shall not undertake to provide, or provide, policy benefits in terms of a life policy or assistance policy, in the event of the death of an unborn, or of a minor before that minor attains the age of 14 years, the value of which, on its own or when added to the value of policy benefits which to its knowledge are to be provided in that event by a long-term insurer or a short-term insurer or a friendly society in terms of any policy, exceeds, in the event of the death-*

*(a) of that unborn, or of that minor before he or she attains the age of six years, R10 000; or*

*(b) of that minor after he or she attains the age of six years but before he or she attains the age of 14 years, R30 000,*

*or such other amount prescribed by the Minister: Provided that this section shall not apply to or prohibit the allocation of profit in respect of such policies on the lives of minors, which allocation does not exceed the profits allocated to other such policies on the lives of persons who are not minors.*

*The reason for these limits is to limit cases of fraudulent claims and if the amounts of cover for children’s life policies are higher, then children will be vulnerable when their parents or legal guardians face financial hardships.*

1. **Discuss the purpose of a life insurance contract (3 Marks)**

*A life insurance is a contract between an insurer and a policyholder in which the insurer guarantees payment of a death benefit to named beneficiaries upon the death of the insured. The insurance company promises a death benefit in consideration of the payment of premium by the insured. In some cases, the life policy may have an investment component which may pay to the insured should he/she survive until the maturity date of the investment component.*

1. **Outline the characteristics of a life insurance contract that makes it different from all other contracts with reference to the age and contractual capacity of the insured. (6 Marks)**

* *The purpose of this life insurance contract is to provide financial protection to surviving dependents after the death of an insured therefore its solely meant to provide a death benefit.*
* *Life Insurance contract is a non-indemnity contract meaning its benefits do not replace the actual loss suffered but it is meant to reduce the financial burden to the dependents as a result of a loss of the life assured.*
* *Life insurance contracts are continuous in such a way that if the policy has an investment component then non-payment of premiums for a specific period may not necessarily lead to termination of the contract.*
* *Life contracts run for the rest of the insured’s life with the exception of a Term life policy which is taken out for a specific period of time.*
* *Life contracts except term life policies can provide a loan to the insured.*
* *Life Insurance policies can be used as collateral security when taking out loans such as a mortgage loan*
* *There used to be a difference in the legal capacity in terms of the age at which one would access a life insurance product but it is now the same as all other contracts. Life insurance contracts used to be accessed only at the age of 21 but now one can take out a life insurance policy at the age of 18 just like any other contracts.*

### Explain how the proceeds of a life insurance contract are protected in case of the insolvency of the policyholder with reference to the Long-Term Insurance Act. (4 Marks)

*Section 63 of The Long-Term Insurance Act stipulates the following with regards to the Protection of policy benefits under certain long-term policies;*

*The policy benefits provided or to be provided to a person under one or more assistance, life, disability or health policies in which that person or the spouse of that person is the life insured and which has or have been in force for at least three years (or the assets acquired exclusively with those policy benefits) shall, other than for a debt secured by the policy—*

*1)(a) during his or her lifetime, not be liable to be attached or subjected to execution*

*under a judgment of a court or form part of his or her insolvent estate; or*

*b) upon his or her death, if he or she is survived by a spouse, child, stepchild or parent,*

*not be available for the purpose of the payment of his or her debts.*

*2) The protection contemplated in subsection (1) above shall apply to policy benefits and assets acquired solely with the policy benefits, for a period of five years from the date on which the policy benefits were provided.*

*3) Policy benefits are only protected as provided in—*

*a) subsection (1)(b), if they devolve upon the spouse, child, stepchild or parent of the*

*person referred to in subsection (1) in the event of that person's death; and*

*b) subsection (1)(a) and (b), if the person claiming such protection is able to prove on a*

*balance of probabilities that the protection is afforded to him or her under this*

*section.*

*(4) Policy benefits are protected as provided for in subsection (1)(a) and (b), unless it can be*

*shown that the policy in question was taken out with the intention to defraud creditors.*

**3: 20 MARKS**

**Group Activity**

1. In groups of 2 or more, research the powers of the FSCA Commissioner and his/her deputies. (8 Marks)

*The person appointed as Commissioner of the Financial Sector Conduct Authority appointed in terms of section 61(1) of the Financial Regulation Act 2017 and has the powers and duties provided for by or under this Act or any other law.*

***Learners must research and explain in detail who the Commissioner is and the powers vested in him/her***

1. **Explain with the aid of examples the concept of the non-disclosure of material factors that may influence the assessment of long-term risk. (4 Marks)**

*Non-disclosure means failure to divulge a relevant fact when applying for an insurance policy. This is a violation of the principle of good faith which should be observed in insurance negotiations. A claim might not be awarded if the insurer has proof of an insured's non-disclosure.*

*It is important that a person answers the questions in an insurance application honestly. If they don't, they are guilty of misrepresentation and the consequence might be the following: the contract can either be voided or their claim may be denied. Their other obligation is to voluntarily offer information which is relevant to the policy that they wish to buy. That is disclosure.*

*According to the Section 59 (2) of The Long Term Insurance Act, the representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk.*

*For an example, an applicant who wants to get a life insurance policy, it is of paramount importance to give out information about any relevant pre-existing conditions, smoking and drinking or any dangerous avocations that the applicant engages in.*

*Disclosure requirement is an ongoing aspect as long as the policy is still in force, failure to update the insurer of any changes in the health or any life circumstances of the insured constitute non-disclosure which may lead to repudiation of a claim. Below is a case study involving a case of non-disclosure of a change in the health status of the insured;*

# Read the article below and give your opinion on the issue of non-disclosure. (5 Marks)

|  |
| --- |
| Life insurer rejects R2.4m policy payout for blood sugar non-disclosure |
| https://image.iol.co.za/image/1/process/620x349?source=https://inm-baobab-prod-eu-west-1.s3.amazonaws.com/public/inm/media/image/106421252.JPG&operation=CROP&offset=0x411&resize=1488x835 |
| How the Independent on Saturday reported Nathan Ganas’ murder last March.  Durban - Shallcross resident Nathan Ganas, 42, was killed in a hail of bullets trying to protect his wife, Denise, during a hijacking in the driveway of their Shallcross home last March - and she is now fighting to get a R2.4 million life insurance payout which has been declined by the insurer on the grounds Nathan had high blood sugar levels.  The couple’s 10-year-old daughter, Carmen, now 12, was also injured when bullets ripped through the front of the house during the attack.  The insurer, Momentum, said the claim had been declined because of non-disclosure by Nathan regarding being diagnosed with raised blood sugar levels which may have occurred before he completed his application for the policy in 2014.  Momentum have also asked Denise to repay R50000, which was an instant cash benefit from the policy and which the family used to pay for Nathan’s funeral.  Denise said she was shocked by the rejection: “The post mortem report states that he (Nathan) had died of gunshot wounds and not diabetes.” |

***Learners must project their line of thinking about the issue of non-disclosure mentioned in the article and marks shall be awarded at the Assessor’s discretion***

1. **What are the consequences if an unregistered organisation conducts insurance business? (3 Marks)**

*1) No person shall carry on any kind of long-term insurance business, unless that person—*

*a) is registered or deemed to be registered as a long-term insurer, and is authorised to*

*carry on the kind of long-term insurance business concerned, under this Act; and*

*A person, other than a long-term insurer, who contravenes or fails to comply with a provision of* ***section 7(1)(a)*** *, 8(3) ; 20(5)(b) or 26(1) or (2), shall be guilty of an offence and liable on conviction to a* ***fine not exceeding R10 million or to imprisonment for a period not exceeding 10 years, or to both such fine and such imprisonment***

**4: 15 MARKS**

1. With reference to Endowment Policies, give an overview of the accessibility to funds in the first five years of a contract in terms of frequency and values. (2 Marks)

*According to the Long Term Insurance Act, funds of a long term insurance policy cannot be accessed within the first five years starting from when the first premium is paid or from the first of any month during which a premium is received such that the premium for that policy year will exceed the higher of the premiums received in the previous two policy years by more than 20%.*

*However, access of funds can only be acceptable if any of the following events occur;*

1. *The life assured dies.*
2. *A health event (e.g. insured diagnosed with a dread disease).*
3. *A disability event (e.g. insured becoming physically impaired).*
4. *A single policy loan within the restriction period subject to policy conditions*
5. *The benefit is an annuity that meets certain criteria subject to policy conditions*
6. *A single surrender or part-surrender within the restriction period subject to policy conditions*
7. **Describe any two minimum terms of a valid contract that should be present with reference to the requirements of the Act. (4 Marks)**

*An insurance contract is a legally binding agreement between the insurer and the insured on particular guidelines These guidelines must be met by both parties; the insurer and insured. The insurer is essentially guaranteeing that they will pay, in the case of need, for set amount of money promised by the insured. These guidelines assure that every party is safe and protected if the insurance is used. Each contract is unique to its insurance; however, there are elements that are standard.*

* ***Offer****- This is where the insurer will offer a specific service, such as paying to the beneficiaries in case of death of the life assured.*
* ***Acceptance or Agreement****- The agreement is the section where the insured agrees to the offer by paying a certain amount to secure the service.*
* ***Competent Parties and Components****- This is the list of events that will be covered, and what will not be covered.*
* ***Consideration*** *All the lawful requirements needed to be met by both parties will be here, making them responsible for what they promise. The Insurer will pay the benefits of the policy should an insured event occurs and the insured will pay premiums on regular intervals to the insurer.*
* ***Legal Relationship****(Formalities)- This follows the consideration section because it is a section mostly used for signatures and guidelines for the requirements by every party agreeing to the contract, and then the consequences if a party does not hold up their end of the bargain. Additionally, this is the section where you have to agree that you are a responsible party that can enter into a legally binding contract, which usually focuses on age and sometimes credit concerns.*
* ***Legal Capacity:*** *An insurer cannot enter into a contract with a minor unless there is a representation of a legal guardian*
* ***Other Essential obligations as per the Long-Term Insurance Act:*** *The insurer must adhere to the maximum benefits for the life cover of children as per the limits stipulated in the Long-Term Insurance Act. The Insurer must also adhere to the restrictions of increasing policy premiums by 20%. Also, the period of insurance must be stated in the terms of the contract.*

*If a premium has not been paid on its due date, the insurer shall notify the policyholder of the non-payment, and the policy shall remain in force for a prescribed grace period (maximum of one month), or for such longer period as may be agreed between the parties*

*An insurer may not cancel an insurance contract on any wrong statements made by a policyholder if such statements do not materially affect the risk under the contract. Benefits may, however, be adjusted to the correct age, where the age was wrongly given.*

1. State the consequence of increasing a policy premium by more than 20% with reference to the Long-Term Insurance Act. (3 Marks)

*The amount of insurance premiums charged by the insurance companies is determined by statistics and mathematical calculations done by the underwriting department of the insurance company.*

*The level of insurance premium charged to a customer depends on statistical data that exists about life history, age and health. During the current economic conditions, inflation tends to erode the value of money such that insurers will be under pressures of trying to make sure that their clients will get sufficient cover claims stage.*

*By so doing insurers normally apply annual increases of premiums to compensate that percentage loss of value of money as a result of inflation. Insurers also increase the premiums because of the changes in the underwriting factors for each individual in which the insured health and general life circumstance changes for the worst living him/her being high risk to the insurer. Existence of anti-selection and fraudulent claims also lead to increase in premiums.*

*However, according to the Long-Term Insurance Act, insurers must not increase the premiums by more than 20% within the first 5 years from the date of inception as it will be against the Section 54 of the Act. Failure to adhere to this regulation may lead to the insurer liable for a penalty stipulated in the Act.*

*It is therefore not possible to increase a premium by more than 20% if a policy is within 5 years of its maturity date, as the restricted period of 5 years, which will be imposed on the increase in premium, will take the policy beyond its maturity date.*

1. **Discuss in detail the impact of the four funds approach to a long-term policy with reference to Income Tax Legislation (6 Marks)**

*South Africa taxes long term insurance business in accordance with the four funds approach. In terms of the four funds approach, all long-term insurance business written by a long-term insurer must be separated into three policyholder funds and a corporate fund. These are as follows:*

* *The Individual Policyholder Fund (IPF) for policies owned by individuals.*
* *The Company Policyholder Fund (CPF) for policies owned by corporate entities.*
* *The Untaxed Policyholder Fund (UPF) for policies owned by untaxed entities and annuity contracts. It consists of policies owned by retirement funds and other tax-exempt entities and annuity contracts currently paying annuities.*
* *Corporate Fund. It consists of all the assets held by the insurer and all the liabilities owed by the insurer not falling in the above-mentioned policyholder funds. With regard to the three policyholders’ funds ((i.e. IPF, CPF and UPF), the insurer is required to allocate assets, income, expenditure and liabilities relating to each fund and the taxable income of each fund is determined separately in accordance with the applicable taxation principles.*

*With regard to the policyholder funds, the insurer acts as a “trustee” to collect tax from the pool of policyholders and to pay it to SARS “on behalf” of the policyholders. With regard to the corporate fund, the intention of the legislature is to tax the insurer (corporate fund) in respect of “profits earned” from running the insurance business.*

*The liabilities of each policyholder fund are required to be actuarially valued at the end of each year of assessment and to the extent that assets in a policyholder fund exceed the liabilities the surplus must be transferred to the corporate fund where it is taxed at the corporate income tax rate. The surpluses transferred represent part of the profit earned by the “shareholder” fund of the long-term insurer.*

*So, an endowment is taxed within the fund over the 5-year term, this means that the Investment company pays the tax over to SARS and not the owner of the endowment. For the Investment company to establish how much tax needs to be paid over to SARS they need to categorize the investment into 4 categories as explained below.*

**The four fund is defined can be illustrated follows:**

*UPF - Untaxed Policyholder Funds (Taxed at 0%)*

*This is Institutes that is non-tax paying such as Charities, Churches and Local Authorities.*

*CPF - Company Policyholder Funds (Taxed at 28%)*

*This is Companies or Closed Corporations or Trusts where the beneficiaries are non-individuals*

*IPF - Individual Policyholder Funds (Taxed at 30%)*

*This is Individuals such as yourself or Trust where the beneficiaries is individuals.*

*CF - Corporate Fund (Taxed at 28%)*

*This is for instance if the Investment company holds an endowment in their own name.*

**DISABILITY INSURANCE**

**SECTION 3:**

**60 MARKS**

* + 1. **Describe the concept of disability insurance in your own words. (4 Marks)**

*Disability insurance is a type of insurance that will provide income in the event a worker is unable to perform their work and earn money due to a disability. There are many types of organizations that provide different types of disability insurance. Each organization and disability insurance type have specific rules as to what constitutes a disability and how a person might qualify to receive the disability benefit. Short term disability insurance policies offer a worker a portion of their salary if they are unable to work for a short period- typically three to six months. Long term disability insurance offers a worker a portion of their salary if they are unable to work for a longer period- typically a period of over six months. Both short term and long-term disability policies have a period that a person must be disabled for before that individual is able to start receiving disability benefits. That period of time is called an elimination period. If a person becomes disabled, they must wait until the elimination period is over before they start receiving benefits.*

*Disability insurance replaces a portion of employee income when they can't work because of an illness or disability. For the most part, disability insurance will not replace* *all of someone's income. Instead, disabi3 RSlity insurance provides wage replacement benefits that cover, on average, up to 60% of employee earnings.*

*Disability insurance provides you with financial compensation if you are disabled by an accident or illness and unable to work. It covers more than just serious illnesses and helps you financially in case of physical impairment.*

*Disability insurance covers everything from total to partial disability to disability so severe that the insurance company presumes that you won’t recover from it.*

***BREAKING DOWN Disability Insurance***

*Disability insurance comes in many forms and can be obtained through a wide range of providers for a wide range of prices. The price of a disability insurance policy will be dependent upon the length of the elimination period, the benefit period (how long a person is able to receive the disability benefit), and how strict the definition of disability is under the policy. Each policy can have its own definition of what qualifies as "disabled," so it is important to understand these rules before buying a policy. The two most common definitions are "own occupation," where a person is considered disabled if they are no longer able to perform the occupation, they had prior to becoming disabled, and "any occupation," where a person is considered disabled if they are unable to perform any job at all. Obviously, the "any occupation" definition is stricter. All else equal, the policy with the stricter definition of disability will be the cheaper policy because there is less of a chance of an insurer having to pay benefits under a stricter policy.*

* + 1. **What Is the purpose of Disability Insurance? (3 Marks)**

*Disability insurance covers everything from total to partial disability to disability so severe that the insurance company presumes that you won’t recover from it.*

*Disability insurance is like insurance for your pay cheque. If you become disabled and can no longer work at your job, your disability insurance company will pay you benefits that roughly match up to your take-home pay.*

*Disability insurance may cover everything from total disability to rehabilitation and even the short period after you recover from your disability. Some policies also offer partial disability coverage and coverage for disabilities so severe that the disability insurance company presumes you won’t ever recover.*

*While virtually every type of illness or accidental injury is covered by disability insurance, some non-illness or injury conditions could be covered as well, such as pregnancy and childbirth. And when something is excluded from coverage, such as certain pre-existing conditions or dangerous situations, your policy will make it as clear as possible so there’s no mystery or confusion.*

* + 1. **Discuss the differences between Occupational Disability and Physical impairment. (6 Marks)**

*Occupational disability benefits are provided when the member becomes disabled as a direct result of injuries or diseases arising out of and in the course of state employment. Occupational disability benefits and reemployment of disabled employees.*

|  |
| --- |
| *Capital Disability*  *Capital Disability pays you a lump sum if you are unable to do your day to day job. This is available as an accelerated and non-accelerated option (Capital Disability Plus). The difference between Capital Disability and Capital Disability Plus is that Capital Disability is taken as part of your Life Cover, and claiming on this reduces the Life Cover sum assured. Whereas the Capital Disability Plus is taken in addition to your Life Cover, claiming on this benefit does not affect the Life Cover sum assured.* |
| *Income Disability* |
| *Income Disability pays you a monthly income if you are unable to perform your occupational duties. This benefit is paid if you are permanently or temporarily disabled. This is only available as a non-accelerated benefit, which means it can only be taken in addition to your Life Cover, and claiming on this benefit does not reduce your Life Cover sum assured.* |
| *There are two types of occupational disability which you need to discuss with your representative:* |
| 1. *Own occupation disability (OOD), which is cover for your own current job – the benefit is payable if you cannot do your specific job. For example, if you are a surgeon and suffer from an injury, then this benefit will be paid even if you have the experience and training to become a lecturer.* |
| 1. *Own or reasonable occupation disability (OD), which is cover for your own or similar job – the benefit will only be paid if you are unable to perform your job or any reasonable job. So, using the example above, if the surgeon has the experience and training to be a lecturer, but is unable to perform this role because of the disability, then the claim will be paid.* |

***PHYSICAL IMPAIRMENT***

*Impairment cover protects you against the long-term financial impact of permanent illnesses or injuries such as paraplegia, blindness and dementia.*

*The claim approval criteria are stricter than those of critical illness benefits, which generally pay out on diagnosis of an illness, whether the condition is permanent or not. Impairment benefits require the illness to cause a permanent impairment. An ‘impairment’ can be described as an injury or illness that results in a physical or functional disorder and the individuals existing job is not relevant.*

*Let’s say you are a computer programmer, and that you lost the use of your legs due to a spinal injury in a car accident.  Although this would mean you are physically disabled as you cannot walk or use your legs, it would not actually prevent you from doing your job, which is being in front of a computer and not requiring physical agility. So, an own occupation disability benefit would not cover you in this instance as you are still able to perform your job as a computer programmer.*

*This is where impairment benefits come in.  Impairment benefits provide cover in the event that you suffer a permanent impairment, but that impairment does not have to have any bearing on your ability to continue working. In other words, impairment cover is not linked to your occupation and ability to earn an income. The impairment claim event is assessed against a list of conditions listed in the policy when you take it out – for example musculoskeletal/spinal injury – and would pay out according to your policy limits.*

*If you are not able to function independently, impairment cover helps you to do the following:*

* *Make lifestyle adjustments, such as modifying your house or car.*
* *Provide for additional ongoing expenses, such as the cost of a private nurse or a frail care facility.*
  + 1. **Outline the exclusions one may find under disability insurance policies. (4 Marks)**

*Before you even apply for disability insurance coverage, you should know that certain conditions will make it difficult or impossible for your application to be approved. Among them are serious illnesses, like cancer or a history of heart attacks.*

*People over the age of 65 are also unable to get disability insurance or may find it prohibitively expensive.*

*If you do get approved despite having a pre-existing condition, that condition may be listed as an****exclusion****in your policy. That means your disability insurance doesn’t cover it; if you become disabled due to the condition, you won’t be eligible to receive benefits.*

*Other types of situations that aren’t covered don’t involve your health. Disability caused by any of the following situations is generally not covered:*

* *Fighting in a war.*
* *Committing a crime, participating in a riot, or during incarceration.*
* *Self-inflicted and intentional injury.*
  + 1. **Briefly describe the ways in which a disability product pays out. (4 Marks)**

*Disability benefits can be structured as lump sum payments to settle liabilities and the balance can be invested to provide an income or can be purchased as a monthly income disability benefit which will provide a monthly income in the event of disablement. A monthly income disability benefit will pay until one of the following:*

* *You recover from your disability.*
* *You die.*
* *You reach the benefit cease age.*
* *The benefit can be paid out as a disability replacement income whereby you will receive a monthly income.*
* *This amount is usually 75% of your earnings at the time of disablement, which is less income than you were earning.*
* *Lump sum disability benefits are normally paid as a once off lump sum amount in the event of total and permanent disablement and these amounts would need to be invested to provide a sustainable long-term income.*
* *Dread disease cover usually pays out a lump sum.*
* *You can only receive the benefit if you are deemed to be disabled in terms of the definition of disability specified in your policy or Company Disability Scheme.*
* *Generally, there is a waiting period of six months before your benefit will be paid out. This period will vary depending on your policy or Company Disability Scheme.*
* *Ensure that you have emergency funds set aside to provide you with an income during the waiting period.*

*Disability income benefits are typically related to an insured’s monthly earnings when they take out a policy, but may also escalate annually, and pay out until a selected retirement age. Income benefits were traditionally paid until an insured’s expected retirement age, typically 60 or 65*

*Disability cover is provided in the form of a once-off lump-sum benefit or an ongoing income benefit.*

*Lump-sum benefits are specified when one takes out a policy and may grow on an annual basis at an escalation rate selected by the insured. Disability income benefits are typically related to one’s monthly earnings when they take out a policy, but may also escalate annually, and pay out until a selected retirement age.*

*Income benefits were traditionally paid until an expected retirement age, typically 60 or 65. People are evidently living longer and having to work until they are older, many insurers now offer income benefits that are paid until the age of 70.*

*A problem an insured may encounter when claiming on a lump-sum benefit policy is that these benefits are typically only paid out when one is permanently disabled, whereas income benefits can provide for both temporary and permanent disability.*

*Proving that your disability is permanent may take time.*

*If disability is one from which one may recover, the processing of a claim may be delayed while the assurer waits to see if medical treatment will bring about an improvement in the impairment, ability to do a job or to do daily activities.*

*Policies that pay income benefits often offer both temporary cover and permanent cover*

* + 1. **Explain the limits imposed by the ASISA rules with regards to disability pay-outs. (4 Marks)**  
       *The industry works on 75% of a client’s income to determine this allowance. To allow for both lump sum and income benefits, all benefits should be expressed in terms of a monthly benefit. The monthly benefit can then be compared to the monthly earnings of the client to check for any over-insurance. The principle followed when aggregating different benefits, is to consider the degree to which the benefit definitions overlap.*

*The client should disclose all disability cover at new business stage as this would allow over-insurance to be detected upfront and the extent of the over-insurance to be assessed. The broker would, of course, also be able to establish this when conducting a thorough needs analysis. In the event that the application is still submitted, the correct response would be to reduce cover at the new business stage rather than to reduce benefits at claim stage, since there is no refund of premiums in the event of benefits or part thereof being declined as a result of over-insurance.*

* + 1. **Discuss in detail the income generation for the disabled and the risks associated with one’s occupation. (6 Marks)**

*The underwriting or approval process for a disability insurance policy is typically much more in-depth. Your policy terms are not only affected by your health, but your premiums are drastically altered by your occupation. In addition, the amount of coverage for which you can apply is directly determined by your income.*

*Specific to disability insurance underwriting, the underwriter will review:*

*(1) your health history*

*(2) your insurance application history*

*(3) your occupation*

*(4) your income*

*(5) your prescription drug history*

*(6) your “fun” activities*

*(7) and really, anything else he or she deems material to a decision*

*The risk, of course, with disability insurance underwriting, is the risk of disability.*

***Your Occupation***

*Correct occupational classification for disability insurance is critical in determining the proper premium rate or even eligibility for insurance. Occupation, unless extremely hazardous, is rarely a concern for life insurance underwriting.*

*This might be obvious. Your occupation matters in disability insurance underwriting. An accountant has a less risky job than a construction labourer, right?*

*Nearly all life insurers have a classification system for occupations. At one end of the spectrum are the lowest risk and most stable occupations, which have the lowest premium rates. At the other end are the occupations that are usually associated with heavy physical exertion, hazardous working environments and have the highest risk of injuries or illnesses, for example 1 to 5 (or 6) with 5/6 being the best, or by In other words, the higher the number, the lower the disability risk of your occupation. Moreover, the lower the disability risk, the lower the premium, all things being equal.*

*That means if you are a skilled tradesman, you should still enrol in a policy, even if you have to pay a higher premium compared that of an accountant. Why? A disability can strike anytime. While occupational disabilities happen – and they happen all the time – they are not the number one disability. As mentioned earlier, illnesses cause a majority of disabilities.*

*During the underwriting process, the disability insurance carrier takes a look at your employment and income to help it decide how much coverage they can offer you. ... In underwriting, the disability insurance company assesses the risk you pose that you'll become disabled and it'll have to pay benefits.*

*The application for disability insurance is the legal basis of the contract and has been designed to elicit pertinent information needed to determine whether a policy can be issued. Therefore, it is important that the applicant understands his/her obligation to answer medical and other questions accurately and completely. All relevant information should be included in the application. Medical underwriting helps determine conditions present, pre-existing and their implication to the risk and the underwriting decisions.*

***Risk associated with Occupation***

*One’s occupation can be classified as risky as it can increase the possibility of a disability. As indicated, jobs have functions which may include office administration, on the road travel, and manual labour. Underwriters may need to gauge the risk level associated with one’s job function. Manual labour and high levels of on the road travel usually pose high risks, and may attract premium loadings, while desk-based office functions are considered desirable risks*

* + 1. **Conduct research on the recent developments/innovations in the industry with regards to disability cover. (6 Marks).**

**Industry Developments: Traditional vs Innovation**

*Disability, like other insurance products have taken long to evolve and move with the times. Changes in technology, legislation and consumer attitudes have however made it possible for some improvements in the sector. The rise of lifestyle-related disabilities suggests that there should be a far greater focus on prevention. With the exception of HIV/AIDS, the top 4 claim causes are lifestyle related. There is grown emphasis on wellness and rewards for healthy living. Health in the workplaces is also quite topical.*

*Technological advancements have also made it possible to improve on services around disability insurance. Online products and introduction of mobile application have enhanced the flexibility on insurance products.*

***Provision for disablement for different types of Retirement funds.***

*The purpose of your pension fund is to provide you with retirement benefits so that you can retire at an appropriate age. Funds also provide death benefits to ensure that your dependants are taken care of if you die before retirement. Although the Pension Funds Act makes no mention of disability benefits, many funds provide these benefits so that should you become unable to work, you will have an income on which to live. It is important to know how these benefits are provided, who decides that you are disabled and what your employer's role is in deciding if you should get disability benefits.*

*Disability usually comes as a welcome rider on a Pension or Provident fund, as it, in addition to ensuring a disabled employee’s income is replaced or receives compensation, assist in rehabilitation of an employee. This ensures once rehabilitated, the employee resumes their functions in productivity.*

*A disability benefit may take the form of a lump sum (which is norm-ally a multiple of your pensionable salary) or it may be in the form of an annuity*

*Sometimes you may also qualify for a temporary disability income benefit. But because the Income Tax Act does not allow pension funds to provide temporary benefits, this will usually be secured by a separate assurance policy outside your fund.*

*Answers may vary and Assessor’s discretion will be used.*

* + 1. **Explain the effect of a change in occupation and avocation risks on disability cover and the importance of disclosure. (6 Marks)**

*Occupation defined: an activity or task with which one occupies oneself; usually specifically the productive activity, service, trade, or craft for which one is regularly paid; a job. The risk associated with occupation have been discussed above. An insured’s occupation may increase the probability of a disability, and therefore considered high risk. Occupations scheduled as high risk are likely to also be classified as undesirable risks, to be approached with caution. Such jobs attract higher premiums and may have strict underwriting requirements compared to the less risky occupations.*

*Avocation defined: An avocation is an activity that someone engages in as a hobby outside their main occupation. ... Many times, a person's regular vocation may lead to an avocation.*

*Avocations are hobbies or pursuits which may pose a higher than normal risk in terms of life, disability and critical illness cover, and as such affect the underwriting assessment.*

*In underwriting an application for life insurance, avocations significantly affect the rate or premium. This is because a sky diver, for example, is at greater personal risk than a non-skydiver, and is accordingly charged a much higher premium for life cover.*

*Clients often comment that their particular avocation is safer than driving a car in South Africa. This, of course, may be true, but remember that driving a car is already included in the rates provided whereas avocations are not.*

*Exclusions*

*The client can opt for an exclusion, especially in instances where there is no regular participation and the client cannot justify the additional expense.*

*In addition, not all insurers automatically exclude avocations. Some policies, for example, offers cover for once-off participation in an event. As such, a person who does a resort diving course while on holiday or a once-off bungee jump would be covered without the client having to be concerned as to whether or not he or she has cover.*

*Full disclosure*

*However, avocations which could be deemed dangerous should be declared at inception of the policy. If clients take up such an avocation after inception of the policy, they are obliged to let the insurer know.*

*As a general rule for avocations, provide the insurer with as many details as possible in order to ensure a fair assessment. Below are some examples of avocations and the type of information needed to determine the correct loading.*

*Mount climbing*

*Factors to be considered for clients who are ardent mountain climbers include:*

* *when climbing alone the risk increases, either technically or in the event of an accident;*
* *climbing without ropes is dangerous for more obvious reasons;*
* *height of mountains – Climbing Mount Everest is not the same as climbing Table Mountain, brings an additional risk of altitude-related disorders such as pulmonary hypertension, hypoventilation and heart failure.*

*Scuba diving*

*Normal recreational diving up to 40 metres would not be loaded provided it’s within the client’s qualifications. However, cave diving, potholing and the like can carry an additional loading or, if preferred, an exclusion.*

*Aviation  
To ensure a fair rate and appropriate cover, aviation rates should be individually calculated according to the client’s personal experience by an actuary who is also an experienced commercial pilot. Considerations to take into account should include the type of aviation licence, type of aircraft, how much experience the pilot has and the number of hours he or she is expected to be in the air over the next 12 months – even down to the type of airstrips and quality of airports used.*

*Other avocations include the following:*

* *Car Racing in its various forms*
* *Bungee Jumping*
* *Motorboat racing*
* *Para-sailing*
* *Cave Explorations*
* *Sky diving*
* *White water Rafting*

*An underwriter should ensure that a client has made full disclosure regarding the nature and frequency of these avocations, and the underwriter should have the necessary expertise to rate the client fairly and on an individual basis.*

*Certain events or situations can make the cover ineffective or invalid, and result in non-payment by the insurance company. Exclusions are the conditions that allow the insurer to not pay a claim.*

*That being said, there are a number of “custom” exclusions. These include pre-existing conditions such as a previous mental/nervous disorder or a spinal injury, or participating in hazardous activities.  Depending on the severity of the health condition, the exclusion may be temporary or permanent.  In some instances, the disability insurer may allow for a reconsideration of the exclusion after a period of time.*

*A change in occupation or job functions may signal a significant change in occupation class and lifestyle. A former police Sergeant who now works in an Insurance office may have substantially reduced the risk of disability and may qualify for an upgrade ratings-wise. The former Sergeant’s exposure to certain risks significantly reduces for instance interactions with criminals, travelling, firearms.*

*It is always the insured’s duty to make such information available to the insurer to enable the later to make necessary adjustments.*

* + 1. **List any four exclusions with regards to disability cover. (4 Marks)**

*There are several general or inherent exclusions in every disability insurance policy. Disability Benefits may not be paid for claims for injury or illness resulting from:*

* *Acts of war,*
* *committing a crime,*
* *self-inflicted injury*
* *Riots, strikes and Civil commotion*
* *Or Operating machinery or a motor vehicle while intoxicated.*
  + 1. **Explain briefly the importance of disability as part of a client’s holistic financial planning. (5 Marks)**

*Disability insurance, as indicated covers the financial implications of an injury or illness that either takes a person’s income earning capability or Musculoskeletal disorders that affect physical or psychological well-being.*

*Besides providing a much-needed cash injection, Disability insurance also provides a source of income to people who are unable to work due to an accident or illness. Remember that your earning power is one of your greatest financial assets.*

*People often take for granted just how dependent they are on a steady income. Even if one is not living pay cheque to pay cheque, it wouldn’t take long for anyone’s finances to dry up in the absence of a salary. Because of lifestyle inflation, most people just don’t have the luxury of avoiding bills and other expenses for more than a week or two – and in many cases not even that long.*

*So, what happens if you’re suddenly rendered unable to work?*

*It is difficult to imagine a situation where you can’t physically work, when you’re young and healthy. That’s why so many people eventually find themselves in a situation where their income vanishes with nothing to replace it. That can lead to a downward spiral of debt, desperation and depression.*

*That’s the situation disability insurance can help you avoid. Here’s a rundown of what*

*Remember, disability coverage usually only replaces 75 percent of your income, so you shouldn’t rely on it completely. It can also be one of the most expensive insurance policies, depending on the level of coverage, your age, and income and whether or not you have the option to buy it through your employer. Short-term coverage is always more affordable than long-term, because it only needs to provide coverage for a small window of time.*

*Costs generally go up the older you get, as you’re more likely to get hurt and rendered unable to work. In that case, it might be better to increase your emergency fund and keep saving aggressively for retirement.*

* + 1. **Obtain a disability policy from any Insurance Company of your choice and describe the cover, exclusions as well as any important terms and conditions. (8 Marks). Please attach your findings as evidence.**

*Assessor’s discretion will be used*

**FRAUD IN THE LONG-TERM INSURANCE INDUSTRY**

**SECTION 4: 50 MARKS**

* 1. **Explain the concept of fraud with the aid of examples. (6 Marks)**

*Fraud is the crime of gaining money or financial benefits by a trick or by lying*

*“The unlawful and intentional making of a misrepresentation which causes actual prejudice, or which is potentially prejudicial to another.”*

*The wrongful or criminal deception intended to result in financial or personal gain.*

*Insurance Fraud generally refers to the wrongful or criminal deception of an insurance company for the purpose of wrongfully receiving compensation or benefits. Insurance fraud may entail a person filing a false insurance claim altogether, or exaggerating their damages, injuries or other losses in order to receive benefits. It is easy to fail to consider that insurance fraud can also apply to an insurance company knowingly denying benefits that are, in fact, due, or committing other forms of deception at the expense of stakeholders, mainly clients.*

*Insurance fraud occurs when a person or entity makes false insurance claims in order to obtain compensation or benefits to which they are not entitled. Insurance fraud is committed in many forms, but regardless of the type, it is considered a serious crime in all jurisdictions.*

*Insurance fraud may entail a person filing a false insurance claim altogether, or exaggerating their damages, injuries or other losses in order to receive benefits. Many people fail to consider that insurance fraud can also apply to an insurance company knowingly denying benefits that are, in fact, due.*

*Assessor to use discretion on the examples given by the learners.*

* 1. **Describe the four elements of fraud. (4 Marks)**

***Unlawfulness*** *– the action must be seen to be wrong in the eyes of society*

***Misrepresentation*** *– a false statement made by one person to another – the misrepresentation may take the form of words; words & conduct; or just conduct – a misrepresentation may also be a failure to disclose certain information in circumstances where there is a duty to do so.*

***Intent –*** *the person making the misrepresentation must have intended, or foreseen that the victim would be deceived.*

***Prejudice*** *– the victim would have suffered prejudice by reason of altering his position to his detriment after 6 6 relying upon the misrepresentation. Potential prejudice is also sufficient if it is reasonably possible that the victim, relying on the misrepresentation, would have suffered harm.*

* 1. **List and explain any four Indicators of fraud in long term insurance. (8 Marks)**

*When it comes to fraud, it’s important to keep your guard up, to watch for common (and not-so-common) signs of fraud, and to have tools at your disposal that can help you further investigate any concerns. Generally, the following could be the common indicators of fraud:*

* *Repeat offenders*
* *Familiarity with claims processes*
* *Evidence of falsified documentation, or inconsistent descriptions*
* *Unverifiable documents*
* *Incomplete information*
* *Blatant misrepresentations*
* *Situational Clues*
* *Amendments soon after effecting cover: changing beneficiaries, addresses etc*
* *Claims soon after contestable periods, increased benefits etc*

*Situational Clues*

*Good investigators know to look for certain fraud indicators in a claimant’s recent and ongoing situational clues. If a claimant recently declared bankruptcy or filed a substantial financial loss, for example, it could give the person a motive for insurance fraud. Another red-flag situation is if the claimant recently purchased a new insurance policy. Claims managers know to look for this as an immediate sign of fraud and will likely put an investigator on the case right away.*

*Familiarity with the claims processes*

*Although it’s not unusual for a person to be familiar with the accident claims process, especially those in repeat accidents, he or she shouldn’t be too familiar. If a claimant is overly knowledgeable about the insurance process, lingo, terminology, and standard procedures, it’s a sign that he or she has done this too many times before or has researched what to say.*

*Evidence of falsified documentation*

*If a claimant waits an abnormally long time after an accident to see a doctor for injuries, it’s a sign that he or she didn’t sustain the injury in the crash. Often, a fraudster might use an old car accident to receive a settlement check for a new injury. Other signs of this type of fraud are medical documentation or lost wage forms that appear falsified.*

***Evidence to substantiate fraud***

*Insurance companies have become adept at spotting a scam from a mile away, but the average Joe can’t. This is how they catch the fraudsters.*

*For as long as insurance has been around – there have been insurance scams. People often make false claims, which ultimately cost firms a ton of money and send our premiums sky-high. It’s little wonder why some people opt for the low road. Health insurance in this country covers less than your hospital gown does. Insurance fraud, however, is a lot more difficult to pull off than you might think. For these scams to work, you may have to swindle investigators, detectives, doctors and even your friends and family. You have to live your lies. We’ve all heard about that one person who ‘slipped’ and fell in Pick n Pay and went on to collect a huge settlement. Or the motorists who suddenly slam on the brakes, hoping that somebody will rear-end them so that they can fake an injury. These are pretty ‘old school’ ideas – these days the fraud has gotten a little more sophisticated. These scams are a big problem in South Africa. Insurance companies actually have advanced forensic specialist security branches to tell the mischief-makers from the good, honest folks out there.*

*The first thing investigators do is perform a basic cross-check. They look for patterns in payments. If you’re receiving a lot of pay-outs, let’s say, to the same address or bank account – that sets off the warning bells. Likewise, if you’ve submitted many claims in your lifetime or received payments under different names. These are also a big indicator of possible fraud. Investigators use a list of ‘suspicious loss indicators’ to determine whether or not a claim could be bogus. Such as when a claimant appears too cool and composed after submitting a claim, or when receipts are handwritten. Some people may be too impatient and pushy after submitting a claim. People are often foolhardy enough to increase their insurance cover just before submitting a claim. Or crashing their car into a tree two days after losing their job. If anything seems suspicious, investigators will then do an in-depth study of your life. They’ll look at your criminal records and credit record. They might even shadow you to see if you display any absurd behaviour. These investigators know when an insured is in hiding instead of a genuine disappearance. They can determine if your injuries match the reported incident and will conduct full financial reviews on you. Claimants who are behind on any payments are flagged as possible scam artists. They may even turn to social media. Supposedly suffering from terrible back pain after a fender-bender!! That video of you table-dancing down at the beach last week says otherwise.*

*A form of insurance fraud on the rise involves physicians, clinics or chiropractors submitting an inflated bill to the insurance company. They may be charging for goods never used, treatment of non-existent injuries or procedures that were never performed. You may be suffering from genuine back pain after an accident, and sometimes these people will try to get you to participate in the fraud. Even if you refuse and it isn’t your fault, when the scam is eventually uncovered, you may be dragged into it. These instances eventually result in nearly unaffordable medical aid premiums for everybody else.*

*Hospital plans have for the longest of times posed a problem in South Africa. TV ads promise large amounts of cash for every day we spend in hospital – resulting in many people flooding already-strained hospitals instead of trying to stay healthy. Hospital insurance does not cover your hospital bill or the cost of any operations. They pay cash per day, regardless of what medical procedures you’ve had. Therefore, these plans encourage collusion between doctors and patients to extend hospital stays and cash in, which could be up to R5 000 a day!*

* 1. **Conduct research on the fraud trends in South Africa and write a report making use of a graphical representation of your findings. (9 Marks)**
* ***KZN is the most dishonest in terms of fraudulent insurance claims***
* [*INSURANCE*](https://www.iol.co.za/personal-finance/insurance)*/ 18 DECEMBER 2018,*
* *South African life insurers foiled a total of 5 026 irregular claims to a value of R1.13 billion in 2017.*
* *South African life insurers foiled a total of 5 026 irregular claims to a value of R1.13 billion in 2017.*
* *The Association for Savings and Investment South Africa (ASISA) this week released the 2017 consolidated statistics of fraudulent and dishonest claims, which show that while the total number of thwarted fraudulent and dishonest claims across different types of long-term insurance products was much lower in 2017 than in 2016 when 13 488 claims (mostly funeral claims) proved to be irregular, the value was almost the same. In 2016 fraudulent and dishonest claims worth R1.03 billion were detected.*
* *Donovan Herman, convenor of the ASISA Claims Standing Committee, points out that life insurers are under constant pressure to adapt their detection methods as fraud attempts become more sophisticated due to fast evolving technology.*
* *He says while life insurers are frequently accused of trying to find ways of getting out of paying claims, the numbers tell a different story. While claims worth R1.13 billion were found to be irregular and therefore not paid in 2017, South African life insurers made benefit payments of R469 billion to policyholders and beneficiaries in the same year.  Of this amount, more than R60 billion was paid to individuals who had experienced either death or disability in their family circle – an increase of almost R5 billion from 2016.*
* *“The reality is that as the custodians of a significant portion of South Africa’s savings pool, life insurers are obliged to protect the integrity of this savings pool and the interests of honest policyholders by preventing fraud and dishonesty.*
* *“If we left fraud and dishonesty to spiral out of control, honest policyholders would end up footing the bill through higher premiums driven by untenable claims rates.”*
* *Below follows a summary of irregular claims detected for different types of long-term insurance cover.*
* ***Death claims***
* *A total of 2 111 death claims worth R564.2 million was declined in 2017 due to fraud and dishonesty compared to 444 death claims worth R275.2 million in 2016.*
* *In the majority of death claims (1 784) rejected in 2017, insurers detected that fraudulent documentation had been submitted. A further 316 claims were declined due to misrepresentation and/or material non-disclosure.*
* *Misrepresentation occurs when a policyholder deliberately provides misleading information to a life insurer, while material non-disclosure refers to the failure of policyholders to disclose important information about a medical condition or lifestyle.*
* *Since the person applying for insurance knows more about the risk to be insured than the insurer, the law compels applicants to honestly disclose all information likely to influence the judgment of the insurer when determining appropriate policy terms and premiums. Information generally regarded as material include medical history, state of health, family history, and life style. Only when all the facts are disclosed honestly by the applicant is the insurer able to set premiums that are appropriate for a certain level of risk, thereby ensuring that every person pays a fair premium without subsidising someone less healthy.*
* ***Funeral claims***
* *A total of 1 025 funeral claims worth R34.9 million was rejected in 2017, mainly due to misrepresentation and material non-disclosure, as well as fraud. In 2016, there were 11 302 irregular funeral claims worth R168.3 million.*
* *Herman says funeral policies are designed to pay out quickly and without hassle when an insured family member die. They also do not require blood tests and medical examinations. “This can tempt people to take out funeral cover on people that do not exist or to buy funeral cover only once they have developed a serious illness and are expecting to die as a result.”*
* *Life insurers have reported a number of cases where funeral cover was taken out on the lives of people under the pretence that they were family members of the policyholder, when in fact they were either colleagues, fellow church members or even fictional people.*
* ***Disability claims***
* *Misrepresentation and material non-disclosure by policyholders was by far the biggest reason for disability claims worth R516.5 million being declined in 2017. Out of the 775 claims not paid, 757 were rejected due to misrepresentation or material non-disclosure. In 2016, some 621 claims worth R578.8 million were rejected.*
* *Herman says over the past two years the life industry noticed a significant increase in legitimate claims against individual disability policies. “Since disability claims tend to increase when the economy is under strain, we are not surprised that dishonest claims also increased significantly.”*
* *He says policyholders are often tempted to not disclose existing health conditions with the aim of securing lower premiums. “This is very short sighted since the life insurer is likely to uncover deliberate attempts to hide material information, which will lead to claims being declined.”*
* ***Hospital cash plans***
* *Strict measures introduced by life insurers a couple of years ago to curb the abuse of hospital cash plans continued to pay off as fraudulent and dishonest claims against hospital cash plans showed a further decline in 2017. A total of 989 claims worth R6.1 million was declined compared to 2016 when 1 047 claims worth R8.5 million were rejected.*
* *Herman says hospital cash plans are easy to understand products designed to help consumers cope with unexpected expenses as a result of being admitted to hospital. Unfortunately, he adds, the simplicity of these products leaves them wide open to abuse.*
* *This forced life insurers to implement tough measures to ensure the financial viability of these products.*
* ***Retrenchment benefit claims***
* *Dishonest and fraudulent retrenchment claims increased from 74 in 2016 to 126 in 2017. Life insurers declined 113 claims due to misrepresentation and non-disclosure and 13 dues to fraud.*
* *The total value of these claims amounted to R3.6 million in 2017, compared to R2 million in 2016.*
* ***Most dishonest provinces***
* *Herman reports that 31% of all fraudulent and dishonest claims were detected in KZN, followed by the Eastern Cape with 22.3% and Gauteng with 20.5%.*
* *The Western Cape was responsible for 6.7% of claims declined and the Free State for 5.1%. Other provinces were responsible for 5% or less.*
* *Supplied by Association for Savings and Investment South Africa (ASISA)*

*Assessor’s discretion will be used*

* 1. **List the Legislation governing fraud in the long term insurance industry. (3 marks)**

*FICA, LTIA, FAIS*

*Legislation governing fraud includes the Income Tax Act, Financial Intelligence Centre Act, Financial Advisory and Intermediary Services Act, Prevention of Organise Crime Act, Health Professionals` Act, Long term Insurance Act, Pharmacy Act, Law of contract.*

*Fraud incidents can be treated as strict criminal acts and perpetrators may need to be prosecuted by the state. Insurers usually need to recover the benefits paid out.*

*Persons implicated in fraud may find themselves “S” referenced and may not be able to get themselves an insurance policy in the South African Insurance industry.*

* 1. **Explain the consequences of committing fraud with reference to the impact of fraud in the industry. (6 Marks)**

*But for every large-scale insurance criminal taking out a myriad of policies, there are at least ten smaller crooks trying to be opportunistic when misfortune strikes.*

*Loosely speaking, there are two different types of insurance fraud: those who take out policies disingenuously with the intention of stealing and those with existing policies who either pretend they are ill and hospitalised when they are well, or who over-inflate the values in their claims when someone is legitimately disabled or ill.*

*Although it may be tempting to ‘cheat the man’ by trying to weasel some extra money out of insurers, it’s simply not worth it. Many fraudulent claims result in legal action against the claimant, who can be prosecuted even after a claim has already been paid out. With the Insurance Crime Bureau working hard on centralising crime detection and prevention in insurance, this likely means your chances of getting another insurance policy in SA could be over – for the rest of your life.*

*Impact of Fraud on Industry*

*It is a common misconception that a rise in insurance fraud costs just the industry. In fact, it is often the honest that must pay, ironically, and not always in ways immediately visible.*

*This cost of fraud is thus borne by both the insurance industry, and the public, as the costs of providing insurance is increased. Simply put, fraud detection is expensive and insurers’ fees must increase as the cost of doing business increases, just like in any other field. So monthly payments are likely to get higher the higher the level of fraud is.*

*Another significant cost to the average policyholder is time. Ultimately, the amount of bandwidth each insurer will have to spend investigating each fraudulent case will ironically mean delaying pay-outs of legitimate claims that come through to them, costing honest people time and peace of mind.*

*Generally speaking, fraud if not prevented or detected has far reaching effects for the country and the economy alike.*

*South Africa gets regarded as a heaven for criminals as they seem to “get away with it”. The reputation of the country worldwide is easily tarnished by such perceptions. Genuine business dealers may face unnecessary scrutiny on international business forums. The perceptions created in the past nine years are believed to have eroded the economic gains and confidence and may take much longer than 15 years to realise. The general population may begin to loosely believe that crime pays, which further worsens the fraud situation. The economy misses out on opportunities as business selects against corrupt economies, and basically shun to be associated with an unfaithful industry.*

* 1. **Outline the fraud investigation process and explain the importance of confidentiality. (6 Marks)**

*Primary source is the concerned insured. Analysis of the information collected from the client is vital to confirm intent and the initiation of the deception process. It also provides evidence of illegality.*

*Insurers, like other financial institutions can apply to have access to information in the public domain. Generally, lifestyle audits can include perpetrators’ statuses on twitter and Facebook etc. Institutions may need to match lifestyle to a person’s income levels, that requires “following the money”*

***Industry-related information that insurers share among themselves.****Long-term insurers share statistics, which alert them to trends. Short-term insurers, through a database established by the South African Insurance Association and administered by data agency TransUnion, have access to your claims over the past seven years (see “The Insurance Data System”, below).*

***Presenting the case***

*Following the gathering of evidence, an insurer would need to present their case so as to initiate criminal investigations or civil claims to recover benefits paid. Outcomes of claims assessments, tip offs, or reports by staff or other customers may have necessitated the investigation. Information gathered forms part of the case. Elements of proof need to be arranged and presented in some order, usually chronologically. It is important to prove the existence of the elements of fraud as guided by the laws.*

***Importance of confidentiality***

*When a suspect is under investigation confidentiality is expected of all that are involved. A suspect may not be notified of an impending or ongoing investigation. Perpetrators are known to attempt to manipulate or tamper with the evidence to their advantage, or make certain crucial elements disappear. If a fraud case implicates persons within an organisation, they may unfortunately need to be suspended from contact with work and processes to enable some independence in the information gathering process.*

* 1. **Briefly discuss the control mechanisms that can be used to combat fraud in the long term insurance industry. ( 8 Marks)**

*Possible recommendations*

*Insurance fraud costs companies billions of Rands per year across the globe, making it imperative that insurers take a proactive stance against fraud. Insurance companies should establish a technology framework, tap into advanced automation and analytics, and take steps to prevent it.  
By many measures, fraud is deeply prevalent in the insurance industry. The Association for Savings and Investments South Africa ASISA estimates that the total cost of insurance fraud in the Long-term insurance sector is more than R1.5 billion per year, which translates to increased premiums of R400 to R700 per year for the average family. In 2018, insurers uncovered more than 5026 fraudulent claims, valued at R1.13 billion.  
At the same time, cost pressures and an exodus of people with claims skills have forced insurers to increase their automation of claims handling. As automation increases, sensitivity to fraud by the claim’s handler decreases. Professional fraudsters are continually on the lookout for insurers without, or with less effective, fraud prevention barriers.*

***SIX STEPS*** *To avoid expensive litigation and other costly measures, it is essential that insurance companies move forcefully against fraud. This begins by adopting a proactive stance toward fraud detection. Companies should not wait for fraud to occur and deal with it after the fact; instead, they should take actions and implement processes that identify potential fraud early and provide the ability to move quickly when fraud is detected.  
Moving from reactive to proactive fraud detection takes six steps:****1. IMPLEMENT A FOUNDATIONAL FRAMEWORK*** *A foundational framework should reflect a fraud-detection strategy that addresses such questions as: How can companies check all claims for fraud but ensure fast claim processing? How can companies identify fraud before a claim is paid? How can companies improve fraud investigation efficiency? How can companies keep track of changing fraud behaviours? How can companies reduce false positive signals? And finally: What is the best approach to automate the fraud-detection process and predict the likelihood of fraud? Implementing a foundational framework enables management to make better decisions about priorities, resource deployment and investments.  
A foundational framework can range from an “out-of-the-box” solution that automates the institutional knowledge of your claims professionals and enables workflow management to full social networking analysis of the parties involved in a claim. From there, insurers can add a multitude of scoring engines, third-party data captures, criminal history lookups and many other tools. An important aspect of fraud detection is having a culture in claims staff, and other staff that emphasizes the importance of recognizing, identifying and investigating suspicious claims. Empower staff to be involved, and then the tools deployed will function much more effectively.****2. KNOW THE RELATIVE LEVEL OF FRAUD POTENTIAL*** *Knowing the relative level of fraud potential for every type of claim allows the best, and quickest, action to be taken to maximize special investigative unit (SIU) efficiency and savings. With limited resources to devote to fraud, it is important to make sure that investigations can be focused on the items that have the greatest potential for cost avoidance and successful identifications. For example, a theft claim involving the suspicious disappearance of expensive jewellery has a higher potential for being fraudulent than a stolen smartphone or laptop.*

***3. USE DATA ANALYTICS TO DETECT FRAUD*** *Fraud comes in all shapes and sizes. In general, insurance fraud can be divided into two categories: criminal fraud, which is perpetrated by professionals habitually trying to milk the system; and cultural fraud, which is a genuine claimant being opportunistic or exaggerating a claim.  
Data analytics can be applied to detect fraud. By analysing past fraud, insurers can use predictive modelling to produce what is called a “Suspicion Score,” a value for the propensity of fraud. The process works like this: Adjusters simply enter data, and claims are automatically given a Suspicion Score to indicate the likelihood that fraud has occurred. The technology behind this involves utilizing data-mining tools and applying quantitative analysis.  
Even with automation and data analytics, the weakest link in fighting fraud can be a company’s own employees. The importance of checks and balances cannot be stressed enough.*

***4. CONTINUALLY REVIEW AND RESCORE CLAIMS*** *Success in combating insurance fraud comes from persistence and good timing. Above all, apply an arsenal of tools — including data analytics and predictive modelling — early and often. Claims should be continuously monitored for fraud potential. As an insurance company, it is imperative to target the right claims, at the right time, with the right tools. Luckily, predictive modelling and advanced analytics are coming into play as essential tools for fighting insurance fraud. These tools can be automated, preventing the need for hands-on manual analysis.  
By continuously reviewing and rescoring claims using Suspicion Scores, insurers can detect patterns that reveal fraud. Some claims score high immediately at first notice of loss, prompting your SIU to get involved immediately. For others, high scores do not show up until after the claim has been collected.  
Monitoring Suspicion Scores has been shown to be more accurate and more effective than traditional fraud-detection methods. But again, the key is to not rely solely on technology to do all of the heavy lifting — human analysts are required to initiate action after the suspected fraud has been flagged, and your people must follow through with appropriate measures. This is where training employees to identify fraud becomes an important piece of the overall fraud-detection puzzle.****5. ADOPT A LAYERED APPROACH*** *In the world of IT, a “layered approach” refers to using a variety of tools and technologies to tackle a challenge. In detecting insurance fraud, this means throwing the kitchen sink at the criminals, but doing it in an organized, well-considered fashion.  
Fraud is a complex, multifaceted problem, and no single method can detect all fraud. Each fraud-detection method needs to be crafted to address a specific area. Different rules and indicators are needed for different types of policies and claims. Plus, fraudsters usually hide in multiple databases, so fraud-detection methods must search them all. Because of the complexity of fighting fraud, it is advisable to bring in outside expertise to help formulate a framework and implement the technology, tools and methods needed to deal effectively with fraud.  
The modern insurance organization has a number of technology tools at its disposal to detect fraud. For example, videos, photos and even livestreaming can be used to document evidence at an accident, a disappearance or crime scene. It’s difficult for the average person to fake a video, especially when the device’s location access is turned on. A virtual gold mine lies within unstructured data, and it is imperative to collect, organize, index and mine the data to detect fraud. Always remember: “You can’t claim what you can’t prove”.*

***6. REVISE BASED ON MARKET CONDITIONS*** *Criminals are ever resourceful, so it is imperative to always be ready to quickly adapt to changes in the ways fraud is undertaken, as well as changes in the industry. For example, professional criminals are sophisticated enough to become familiar with the analytical approaches that insurance companies use to detect fraud, and to change their tactics when committing fraud. As fighting fraud becomes more proactive, insurers must spot new fraud trends early and take steps to stay.  
  
Your everyday policyholders may also try to be more creative with their insurance claims when the economy is in a down cycle. The current economic downturn has resulted in high levels of unemployment, and general standards of lives taking a nose dive. Keeping your staff aware of the type of market conditions the policyholders are facing so the staff can be on the lookout for new and inventive fraud attempts that may be unknown to the software in place. South Africa is seeing an increase in “fake deaths” claims.****BE READY*** *Companies can use a combination of technology, tools and approaches to combat fraud. Through it all, industry leaders must never forget that their focus should not only be on the technology tools they use in detecting and fighting fraud, but also on the human beings in their own offices. Emphasizing fraud training and awareness, implementing checks and balances, and being generally ready to adapt quickly to changing market conditions, could prove immensely valuable in the fight against fraud.*

***Risk if not implemented***

*Slow economic growth and unemployment have resulted in an increase in fraudulent insurance claims, estimated to cost the industry billions of Rands. It is often the honest who must pay, ironically, and not always in ways immediately visible. This cost of fraud is thus borne by both the insurance industry and the public, as the costs of providing insurance is increased. Simply put, fraud detection is expensive and insurers’ fees must increase as the cost of doing business increases, just like in any other field. So monthly payments are likely to get higher the higher the level of fraud is.*

**ROLE PLAYERS IN THE INDUSTRY**

**SECTION 5:**

1. **Briefly explain the role of actuaries in a Long-term insurance organisation with reference to the development of models and the analyses of trends in mortality, morbidity and financial investments. (12 Marks)**

*Actuaries play a crucial role in the operation and profitability of any insurance business. They help the firm with their expertise in calculation of premiums of various insurance policies, rating methods and reserves, etc*

*Actuaries analyse the financial costs of risk and uncertainty. They use mathematics, statistics, and financial theory to assess the risk that an event will occur and help businesses and clients develop policies that minimize the cost of that risk. Actuaries' work is essential to the insurance industry.*

*All actuaries in one shape or another are there to ensure that a company is run in a financially sound manner and to make sure the insurance company has the right amount and kind of financial support, understand and help control risk, stay on the right side of regulation and treat customers fairly.*

*So, Actuaries are involved in the following broad areas:*

* *Product development*
* *Product pricing*
* *Product management*
* *Valuation*
* *Risk management*
* *Investment*

*The actuary uses risk analysis to help design and price insurance policies. An insurance actuary examines statistics about claims frequency and the severity of the claim to advise insurance companies how they can best achieve the desired balance between growth and profit.*

***Mortality Trends***

*Within a national population there is a considerable degree of mortality heterogeneity. Persons accepted for life insurance tend to have mortality that is lower than that of the national population over much of the age span because they are generally better educated, more affluent, and subject to medical scrutiny by the insurer. Purchasers of life annuities have even lower mortality as no one expecting to live only a relatively short time would purchase a life annuity. Because of these and other differences between the mortalities of the various subpopulations, many different types of life tables are regularly prepared, covering, for example, non-smoker insured lives, smoker insured lives, super-select insured lives, annuitants, members of pension funds, actively employed persons, age retirees, and persons who have retired because of ill health. Large insurance companies often can prepare their own life tables on the basis of their own experience, and those tables reflect their own standards of underwriting. Only a small proportion of life tables are ever published.*

*Standard tables based on confidential data collected from groups of insurers are prepared and reviewed regularly by the various actuarial professional bodies.*

*Finding a suitable life table for use in a developing market is a problem faced by many actuaries and requires considerable judgment. Actuaries usually have to rely on insurance tables prepared for similar products in another market that is believed to have similar characteristics. If national life tables are available, they may be used as collateral information. The collection of local insurance mortality data is a high priority.*

***Morbidity Trends***

*As with mortality, the actuarial professional bodies coordinate the collection and analysis of morbidity data and the preparation of standard tables of incidence and recovery.*

*Almost since the dawn of life insurance, insurance companies and their actuarial advisers have sought genetic information from those applying for life insurance by asking details about survivorship and cause of death of family members. With the recent rapid developments in genetics considerably more information about the likely survivorship and morbidity of an individual can be provided by a genetic test. A person who has taken a test may be aware that he or she is more likely to die younger or be subject to increased ill health. Serious ethical questions ensue. Should insurers be permitted to demand genetic tests? If not, should an individual who has taken a genetic test be required to reveal the results to the insurer under the basic insurance principle of utmost good faith (uberrima fides)? If such information is available only to the proposer, there is a serious risk of selection against the insurer, to the detriment of the company and others insured with it.*

*Even in situations where no genetic test has been undertaken, an insured life may take one and, after learning that he or she does not have deleterious genes, discontinue the insurance, leaving the insurer with a higher-than-average proportion of policyholders with genes associated with increased morbidity and premature death.*

***Financial Investments***

*Investment factors are clearly a primary risk-and-return driver for life insurance companies. When thinking about where they take their risk and how they're exposed to wild swings in income, investment-related issues top the list. Investment actuaries typically focus on strategy development and evaluation and investment risk management. We do not tend to focus on relative value and trading decisions. We do not look at which bonds to buy or sell this week, how to execute particular derivative trades and so on. It's more of a strategic level analysis.*

*The nuts and bolts of this could be to model the existing portfolio, which involves reconciling all the items to the balance sheet, validating market values and yield and doing cash-flow projections. Assets these days are much more complicated if very detailed, structured finance transactions that may have many embedded options and conversions, as well as assumptions for non-fixed income assets are taken into account.*

1. **Name and describe the categories of statistics gathered by actuaries and the respective sources. (8 Marks)**

* [***Statistics South Africa***](http://www.statssa.gov.za/)*-General overview of the demographic and economic information and any other necessary data required for the development of models used in the development of insurance products.*
* [***Department of Health Statistics***](http://www.health-e.org.za/statistics/)*-shows the morbidity trends which help actuaries to create probability models that are used to create risk brackets for premium calculation purposes.*
* [***Department of Education Statistics***](http://www.education.gov.za/EMIS/StatisticalPublications/tabid/462/Default.aspx)*-Shows the literacy levels which influence issues of mortality and morbidity.*
* ***Police reports****-Crime statistics and other death statistics contribute to the calculation of life expectancy which also help actuaries in coming up with the mortality trends.*
* ***Immigration statistics and reports****-This shows the number of foreign nationals living South Africa and the number of South African national living abroad.*
* ***Other Insurers and Financial Institutions****-Reports from other insurers show a clear picture of loss/claims trends which help the actuaries in developing the probability model for risks and loss.*

1. ***Discuss the purpose of actuarial reports in relation to determining the reserves required to ensure the financial soundness of an insurance organisation (5 Marks)***

*The purpose of an actuarial report is to show an organization's loss experience using probability theory and other methods of statistical analysis. It can be used to determine an insured's projected losses, a self-insured's liability accruals, the adequacy of the insurer's statutory loss reserves, or a life insurer's unearned premium (technical) reserves as well as an estimate of the value of a claims or group of claims not yet paid. Insurers will also set****reserves****for their entire books of business to estimate their future liabilities realistic allocations to reserves, based on expected future trends and taking account of all the company’s existing liabilities, and additional risk capital, based on the company’s business risks, the current business plan and the asset allocation applying.*

*It is clear that the actuarial report will help the insurer to have a clear picture of whether the organisations will be financially viable or not in the near future, a typical actuarial report can have the following important information for the insurer;*

*The appointed actuary will produce reports annually, for submission to the insurance company management, a report on the company’s current status and possible developments from the actuarial perspective.*

1. **Research and present a typical actuarial report for a long-term insurance company of your choice (15 Marks)**

*The following guidelines can be used by the Assessor but discretion can be used on the details of the learners ‘presentation*

1. **Introduction**

*The report is to cover the insurance company’s entire business. Where the report deals with the specialist areas of other responsible persons, the appointed actuary is to gather expert information from those persons and integrate their analyses into the report. It is assumed that the financial requirements of a secured business are made up of the following two components:*

* *realistic allocations to reserves, based on expected future trends and taking account of all the company’s existing liabilities, and*
* *additional risk capital, based on the company’s business risks, the current business plan and the asset allocation applying.*

1. ***Legal basis***

*The legal bases for the actuarial report are derived from the fundamentals of the Insurance Act and other applicable legislation.*

1. ***Evaluation of obligations accepted***

*In the report, the actuary gives his/her opinion on the obligations arising out of insurance contracts. This opinion requires distinctions to be made based on the type of obligations accepted and the actuarial assumptions applied.*

*The report should assess the underwriting results of the lines of business, thereby allowing statements to be made about:*

*o profitability and sources of profits (costs, risk, interest)*

*o claims experience*

*o cost trends*

*o technical provisions, in particular principles for valuation*

*o portfolio development*

*o profit sharing*

*o risk capital required for ALM (Asset Liability Management) risks, underwriting risks and other risks*

*o acceptability of long-term rate guarantees*

*o taking account of embedded options in the contract structure*

*o developments constituting a threat to solvency and measures taken to control them*

*Evaluating the obligations accepted also involves making statements about pricing policy and underwriting policy. In particular, attention must be drawn to sub-portfolios with different risk assessments.*

1. ***Evaluation of reserves***

*The report highlights the essential points of the reserving policy for the various obligations accepted and contains a detailed presentation of the reserves from a statutory and economic point of view.*

*In particular, it provides clarity about the debit amount of the tied assets, about the strengthening of reserves additionally carried out, and about the reserves over and above those that are considered operationally necessary.*

*Reserves are considered to be operationally necessary, taking account of the current economic and demographic parameters and including the promised profit sharing.*

1. ***Evaluation of solvency***

*Here, a distinction is made between the minimum solvency (statutory) on the one hand and, on the other, the target capital and the risk-bearing capital (market-oriented).*

*In his/her report, the appointed actuary will comment on the company’s results from the extent to which the solvency requirements are met, from both the current perspective as well as regarding future developments.*

1. ***Other points in the report***

* *Pricing policy for new products and underwriting policy*
* *Profit-sharing policy: Principles for bonus plans, liabilities and freedom of action, development of the surplus fund*
* *Assessment of the margins in the actuarial assumptions*
* *Reinsurance arrangements made. These also include existing financial reinsurances and assessment of the effects of any financing treaties.*

1. ***Assumptions and stress tests***

*The assumptions made with regard to economic and demographic parameters and the*

*methods used must be clearly recorded. Any changes in hypotheses and methods compared to earlier reports must be explained and their effects on the results indicated.*

*Suitable methods must be used to check the extent to which developments differing from the assumptions made affect the company’s solvency. Suitable measures include asset liability management (ALM) models, stress tests and dynamic solvency analyses.*

*Particular attention should be paid to the risks of a mismatch between investments and liabilities (asset liability management).*

*Besides the specifically material findings, the report should also contain statements about the quality and extent of the underlying data sets.*

1. ***Recommendations***

*In their reports, actuaries are required to draw attention to any risks that in their view constitute a threat to solvency, be they underwriting risks, market risks, credit risks, operational risks or strategic risks. They must point out possible measures that the company could use to counter unfavourable developments and make known their recommendations.*

**SECTION**

1. **Briefly discuss the role of underwriters in a Long-term insurance organisation (2 Marks)**

*During the process of applying for life cover you need to be assessed by an underwriter. This involves being asked a number of questions – some of them quite personal – for example about your age, occupation, hobbies and medical history.*

*Therefore, Underwriting is the process of risk assessment in order for the insurer to make a decision of accepting or rejecting the application by the proposer and also to come with an accurate premium should the insurer accept the application of the proposer. This risk assessment process is done by a professional called an Underwriter.*

*Life insurance underwriters decide if the amount of cover you've requested is justified by your individual risk. In the process the underwriter also ensures that, as a client, you're charged the correct life insurance premium in accordance with your risk profile. This means that you don't end up paying more than you should in order to cover the cost of someone's else life risk within the group of people we're insuring. Essentially, it's a way of making things fairer for everyone.*

*Underwriters evaluate the client risk versus the pricing and product model that has been developed by actuaries based on coverage for standard and average group risks.*

*It is the role of the underwriters to utilise the actuarial rates and make a decision whether there is need to deviate or not depending on a particular risk at hand.*

*Life insurance underwriters determine the risk category that each client falls into and apply any terms and conditions thereof.*

1. **Name and describe the underwriting information gathered by underwriters and indicate how it is used to determine underwriting profit /loss ratios. (6 Marks)**

*To ensure that clients are charged the correct premiums for their life insurance policies, an underwriting assessment is conducted for each client based on the following:*

1. ***Medical disclosure****: This takes into account the health status information that the client gives to the insurer. Underwriters then determine whether you need any medical examinations or tests to evaluate your risk of death, illness or disability.*
2. ***Occupation****: The occupation details are needed to determine the risks in the client’s work environment that could increase the probability of your death, disability or illness.*
3. ***Avocational activities or hobbies****: The underwriter will look not only at what the client does at work, but also at what the client does their spare time that could increase the risk of a claim against your life insurance or disability policy. Some examples of avocations or hobbies that could pose an additional risk are bungee jumping, sky diving and scuba diving.*
4. ***Financial information****: Here the underwriters gather and assess the client’s financial information so that the application is consistent with the likely financial loss you could suffer. This process helps you to avoid being overcharged for life insurance cover, and also makes it easier to claim.*
5. ***Age****: The older the client is the higher the probability of a loss in terms of long-term insurance therefore an older client will pay higher premiums as opposed to a younger client.*
6. ***Gender****: Women are believed to live longer than men according to statistics. This is because men tend to take risks meaning they tend to be more careless than women and women live longer due to biological aspects such as having menstrual cycle which helps them to have a natural detox of any toxins in their blood system on a monthly basis.*
7. ***Personal Habits****: Underwriters make use of information such as whether the client smokes and drinks alcohol.*

*The information gathered by the underwriters will assist the insurer to manage the risk of covering high risk clients on standard premiums which may lead to underwriting losses. Therefore, it is important to gather all the necessary information so that an accurate premium is calculated which will help achieve an underwriting profit. However, even if the correct underwriting has been done, the insurer still needs to have more clients in the pool in order to fully achieve underwriting profit.*

1. **Define anti-selection and give two examples thereof and explain how it impacts on life insurance business. (4 Marks)**

*Anti-selection refers to a sociological phenomenon in which those persons with the most dangerous lifestyles or careers are the most likely to buy life insurance policies and by so doing put insurers at a disadvantage. Anti-selection may also occur if those persons conceal or falsify relevant information when they apply for the insurance policy. This has the potential of economic hardship for life insurance companies because those most likely to receive a death benefit are the ones buying policies. This reduces profit potential.*

1. **Briefly discuss ways in which underwriters protect an organisation against anti-selection. (3 Marks)**

*Life insurance companies attempt to counteract anti-selection by imposing strict terms and conditions, limiting coverage and/or loading premiums. If the risk is too great some insurers could decline to provide cover to the applicant.*

*The decline rates for most insurers are generally low as companies realise that there is a real need for all types of insurance. It is very important for an applicant to understand the meaning of an exclusion clause as these policy wordings cannot be changed once the policy has been issued.”*

**3**

1. **Outline the role of the claims assessor in a Long-term insurance organisation in terms of assessing the validity of claims. (3 Marks)**

*Claims Assessors, investigate*[*insurance claims*](https://en.wikipedia.org/wiki/Insurance_claim)*by interviewing the claimant and witnesses, consulting police and hospital records, and inspecting property damage to determine the extent of the long term insurer’s liability.*

*Their main role is to investigate the claims, negotiate settlements, and authorize payments to claimants. They must determine whether the customer’ s insurance policy covers the loss and how much of the loss should be paid to the claimant.*

*The claims assessor will in essence focus on the claim situation (what happened, where, when, how) and will determine whether it fits within the scope of cover and may also offer risk management advice post the claim.*

1. **Give a detailed indication of claims information gathered by assessors. (5 Marks)**

**Information gathered by claims assessors.**

*Insurance is based on trust. Policyholders who intentionally make fraudulent or inflated claims abuse that trust, which makes claiming just a little more difficult for honest policyholders.*

*It is in the interests of policyholders’ that fraudulent claims are not paid out, because that would push up premiums.*

*Insurers therefore need to gather information about you and verify that information, both when you apply for cover and when you claim. They have the following avenues open to them for doing that:*

***Information provided by the client.***

*The primary source of information is what the client tells the insurer, both on the application form (or during the telephone discussion in the case of a call-centre application) when a client takes out cover and, on the claim, -form questionnaire when a claim is submitted.*

*The questions on the claim form may encompass issues that go beyond the claim itself. The answers to these questions are compared with what is on record from when the client took out the policy and the facts should match.*

***Information in the public domain.***

*The client would probably be surprised by how much information about the client is in the public domain. Deeds Office records of property ownership, details of directors of companies and police records are some sources. But there’s also what’s out there on the internet, which insurers may use to corroborate the information the client have provided. As an extreme example, if, soon after a policyholder submits a disability claim, the insurer comes across a Facebook picture of the policyholder skiing in the Alps, it is certain to investigate further.*

*It is important to note that although the insurer may not have direct access to your social media accounts, and although you may restrict your posts to a private circle of friends, you have little control over your posts. Your friends may forward a post to their friends, and, before you know it, it is available for all to see.*

***Private information accessed with your consent.***

*Medical and banking records are confidential and may be accessed only with the client’s consent. The terms and conditions of your policy may include a clause stating that the insurer has the right to ask for access to these records. In the case of medical and bank records, you do not sign away your right of consent when you take  out the policy, she says, but you may be asked to provide consent at claims stage. If you don’t, it may raise suspicions, and if the insurer has a strong enough case, it could obtain a court order to access your records.*

*Your credit history, which is also private information, is usually required upfront, when you take out a policy. Insurers will typically require you to disclose any adverse entries on your credit record before agreeing to cover you. The insurer will use your credit information and your claims history, among other factors, to assess your risk, which will determine your premium.*

***Industry-related information that insurers share among themselves.***

*Long-term insurers share statistics, which alert them to trends which may assist in conducting investigations before a long-term insurance claim is paid out.*

***Clients’ premiums not up to date***

*A policy is a legal contract – you pay a monthly premium in exchange for insurance cover. Stop (or forget) to pay, and that contract no longer exists, because you have not kept your side of the bargain.*

*One of two situations typically occur:*

* *You fail to pay the regular monthly premium for one or two months, in which case your cover is suspended, and your claim may be declined.*
* *You fail to pay for several months; in which case the contract could be terminated and there is no possibility of claiming.*

***Underwriting Information***

*Claims Assessors also gather information from the underwriters so that their decision to authorise a claim will be consistent with the standards, terms and conditions of the policy set during the* *underwriting stage.*

1. **Give an indication of how to determine underwriting profit. (3 Marks)**

*Claims assessors are there to make sure that the information mentioned above is accurate in order for the insurer to pay legitimate claims otherwise the underwriting profit will be compromised severely.*

*Underwriting profit is the net of premiums an insurer receives, minus losses paid out in the form of claims and administrative expenses over a given period. It does not include the gains made from invested premiums.*

*The role of an insurance firm is to provide financial coverage against risks to willing clients. In return, the clients pay a fee termed as premiums. For example, an insurance company offering auto insurance relies on the premiums paid to compensate any losses claimed. Since not every client makes a claim, the insurance firm can pool together the earned premiums to cover significant losses. The surplus is invested in income-generating projects for the firm.*

*Underwriting losses arise when the claims exceed the earned premiums or due to major disasters, such as earthquakes and floods, that led to extraordinary and numerous claims. Expenses, on the other hand, arise due to mandatory needs, such as administration expenses, rental expenses, among others. Therefore, underwriting profit is realized after taking into consideration the cash inflow from premiums and outflow on paying out claims and other expenses. Underwriting profit is often used as a measure of the success of an insurance firm.*

1. **What is the importance of technical, underwriting, and legal knowledge in assessing a claim? (4 Marks)**

*The life insurance company should be contacted as soon as possible following the death, disablement or diagnosis of an illness of the insured to begin the claims process. The claims assessor will request paperwork to process the claim. However, the claims assessor needs to possess complex knowledge which is more than just checking the paperwork. For the claims process to run smoothly, the claims assessor needs to be well versed with the following technical, underwriting and legal knowledge;*

* *The risk that was accepted during the underwriting stage*
* *Exclusions applied to the particular policy in question*
* *The premiums that the client was paying and if they are up to date or not*
* *Material disclosures required and available as per the insurance policy*
* *The nominated beneficiaries of the policy in case of death*
* *Existence of pre-existing conditions at the date of inception*

*The importance of having the above-mentioned knowledge minimises or prevents cases of disputes and complaints from clients if the Claims Assessor rejects a claim because of conditions that were accepted during the underwriting stage.*

*It also helps the Insurer from losing out on fraudulent claims and paying out claims that are not supposed to be paid because of non-adherence by the insured to the agreed terms and conditions.*

*Having this knowledge also creates a degree of certainty that the benefits of the policy are being paid to the right beneficiary.*

*A Claims Assessor must have the legal knowledge in order to be able to follow the correct procedures in cases where there are complications at the claims stage, e.g. if the nominated beneficiary is also deceased. Below are some of the pieces of legislation that the Claims Assessor needs to be familiar with in case of death;*

* *The Matrimonial Property Act 88 of 1984*
* *Intestate Succession Act 81 of 1987*
* *Wills Act 7 of 1953*

*Claims Assessors must also work in the best interests of clients because it is by law an obligation of the Insurer to pay a legitimate claim whenever it arises therefore it is vital for a claims assessor to be familiar with the applicable legislation in order to execute his/her duties fairly to the policyholders ‘satisfaction. This enables the insurer to remain compliant with the applicable legislation and ultimately safe guarding the operating licence. Below are the main pieces of legislation to long term insurers;*

* *The Financial Advisory and Intermediary Services Act 37 of 2002*
* *Long Term Insurance Act 52 of 1998*
* *Policy holder protection rules*

**SECTION 4**

1. **Define reinsurance. (2 Marks)**

*Reinsurance is "insurance for insurance companies”, in other words a “second level of insurance." It is an arrangement in which a company, the reinsurer, agrees to indemnify an insurance company, the ceding company, against all or a portion of the primary insurance risks underwritten by the ceding company under one or more insurance contracts.*

1. **Outline the role of the reinsurer with the aid of examples. (6 Marks)**

*a) Limiting Liability*

*By providing a mechanism through which insurers limit their loss exposure to levels commensurate with their net assets, reinsurance enables insurance companies to offer coverage limits considerably higher than they could otherwise provide. This function of reinsurance is crucial because it allows all companies, large and small, to offer coverage limits to meet their policyholders' needs. In this manner, reinsurance provides an avenue for small-to medium size companies to compete with industry giants.*

*b) Stabilisation:*

*Insurance companies having a more diversified portfolio of risks will tend to have more stable financial results. Using reinsurance will allow insurance companies to participate in a diversity of risks using the same working capital by ceding part of the risk and keeping a smaller portion of each risk. This reduction in the concentration on risk will diminish the volatility of the annual results.*

*c) Catastrophe Protection: Reinsurance provides protection against catastrophic loss in much the same way it helps stabilize an insurer's loss experience. Insurers use reinsurance to protect against catastrophes in two ways.*

*d) Increased Capacity:*

*Capacity measures the Rand amount of risk an insurer can prudently assume based on its surplus and the nature of the business written. When an insurance company issues a policy, the expenses associated with issuing that policy, are charged immediately against the company's income, resulting in a decrease in surplus. Meanwhile, the premium collected must be set aside in an unearned premium reserve to be recognized as income over a period of time. This accounting procedure allows for strong solvency regulation; however, it ultimately leads to decreased capacity. As an insurance company sells more policies, it must pay more expenses from its surplus. Therefore, the company's ability to write additional business is reduced.*

*Rapidly expanding companies are particularly susceptible to the timing problem between expenses that must be debited immediately, and income that must be credited over time. By reinsuring a portion of its insurance policies, an insurance company reduces the problem of decreased surplus. Through reinsurance, the company shares a portion of its underwriting expenses with its reinsurer and reduces the drain on surplus.*

*If the reinsurer has satisfied certain regulatory requirements intended to assure the security of the reinsurance arrangement, a ceding insurer can expand its own capacity by supplementing it with reinsurance payments it is owed on its paid claims. This is known as credit for reinsurance, and allows the ceding insurer to expand its capacity.*

*The ceding company can also reduce liabilities and loss reserves attributable by ceding that business to a reinsurer.*

*A reinsurer often will give the ceding company a ceding commission as reimbursement for expenses, such as agent commissions, taxes and overhead, associated with acquiring the business being reinsured. When added directly to the ceding company's surplus, the ceding commission further increases its capacity.*

*e) Provision of Expertise*

*In addition, reinsurers often provide insurers with a variety of other services. Some reinsurers provide guidance to insurers in underwriting, claims reserving and handling, investments and even general management. These services are particularly important to smaller companies or companies interested in entering new lines of insurance.*

*f) Surplus relief*

*The use of reinsurance allows insurance companies to partially transfer risks off their balance sheet. While the ultimate responsibility to the policy holders still remains with the insurance company, most jurisdictions recognize reinsurance as a risk managing tool that allows a reduction of statutory surplus requirements.*

1. **Explain the difference between treaty and facultative reinsurance. (4 Marks)**

***Treaty Reinsurance***

*In treaty reinsurance, the ceding company is contractually bound to cede and the reinsurer is bound to assume a specified portion of a type or category of risks insured by the ceding company.*

*Treaty reinsurers do not separately evaluate each of the individual risks assumed under their treaties and, consequently, after a review of the ceding company's underwriting practices, are dependent on the original risk underwriting decisions made by the ceding primary policy writers.*

*Such dependence subjects’ reinsurers to the possibility that the ceding companies have not adequately evaluated the risks to be reinsured and, therefore, the premiums ceded in connection may not adequately compensate the reinsurer for the risk assumed.*

*The reinsurer's evaluation of the ceding company's risk management and underwriting practices as well as claims settlement practices and procedures, therefore, will usually impact the pricing of the treaty.*

***Facultative Reinsurance***

*In facultative reinsurance, the ceding company cedes and the reinsurer assumes all or part of the risk assumed by a particular specified insurance policy.*

*Facultative reinsurance is negotiated separately for each insurance contract that is reinsured. Facultative reinsurance normally is purchased by ceding companies for individual risks not covered by their reinsurance treaties, for amounts in excess of the monetary limits of their reinsurance treaties and for unusual risks.*

*Underwriting expenses and, in particular, personnel costs, are higher on facultative business because each risk is individually underwritten and administered.*

***Facultative Reinsurance Characteristics***

* *Facultative Reinsurance is the oldest and purist form of reinsurance*
* *It is the offer by one Reinsurer to another to accept part of an individual risk*
* *The Reinsurer has the right to accept, decline or offer alternative terms*
* *The nature of Facultative Reinsurance leaves it susceptible to commercial pressure as it is both time consuming and expensive*
* *When considering an offer, the Reinsurer should have, or should obtain, knowledge of the Reinsured before considering making an acceptance.*

1. **Compare any two advantages and disadvantages of both treaty and facultative reinsurance. (8 Marks)**

***Advantages of Treaty Reinsurance***

* *The Treaty-method provides obligatory and automatic nature of reinsurance acceptances. The reinsurer cannot decline to accept any cession coming within its scope.*
* *The risk commences simultaneously with that of the ceding insurer. Under the facultative method, the reinsurance cover operates only from the time the reinsurer accepts the risk.*
* *The treaty method involves much less clerical work and costs as compared to the costs involves in the facultative reinsurance.*
* *The rights and obligations of each party are clearly defined in the treaty agreement, whereas in facultative, it has not been so easy.*
* *The treaty-method ensures a constant and regular flow of business.*

***Disadvantages of Treaty Reinsurance***

*Disadvantages are very little and some of the minor ones are;*

* *For big liability insurances or for protection against losses of catastrophe nature, other methods like Excess of Loss or Stop Loss arrangements are better suited.*
* *Re-insurers cannot usually apply underwriting judgment for each and every individual case, even though they might have entries into ceding company’s account at periodical intervals.*
* *This method is not suitable for new insurance companies.*

***Advantages of Using Facultative Reinsurance***

* *Facilitates reinsurance of risks where no treaty protection available*
* *Facilitates a reduction in exposure on risks where a higher degree of hazard than normal exists*
* *Facilitates capacity where the volume of business does not justify treaty arrangements – example - where new lines of business are written*
* *Facilitates specialist technical assistance from another office because when you phone the reinsurer, they might give you more insight into the risk being underwritten.*
* *Facilitates Fronting of risks (this is when the insurance company is ceding 100% of the risk to the reinsurer because it cannot insure the risk in its own account. The risk could be too hazardous.*
* *Where the insurer has either accepted the entire risk in error and is unable to withdraw his share.*

***Disadvantages of Using Facultative Reinsurance***

* *It is administratively expensive as explained earlier*
* *It is time Consuming because you have to place the risks individually*
* *There no obligation from Reinsurers to accept. No automatic acceptance*
* *Commissions may be lower than under treaties because it is too administratively involving.*
* *The error factor is inherent in hasty facultative placements*
* *Cover cannot be confirmed until placement is affected and confirmed.*

1. **Conduct research on 3 different reinsurers and compare the services that they offer by indicating the reinsurer that offers the most beneficial benefits to a specific insurance organisation. (15 Marks) (Attach any supporting evidence of your research).**

*The sections above mentioned the role of reinsurance and the types of reinsurance available. Reinsurance companies are an integral part of the insurance industry as they aid for risk sharing amongst insurers and examples of those reinsurance companies are Munich Re, Swiss Re, Hannover Re etc.*

**MODULE 3 THE ISSUE OF ABNORMAL RISK**

**SECTION 1: 40 MARKS**

1. **Define abnormal risk in your own words. (2 Marks)**

*An abnormal risk refers to a probability or threat of damage, injury, liability, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through pre-emptive action. This type of risk has a higher probability of bringing a claim that is higher than average.*

*The Assessor to use his/her discretion as answers may vary*

1. **Briefly explain the concept of non-disclosure in insurance and give an example of such. (4 Marks)**

*Non-disclosure refers to the situation where a customer fails to reveal a relevant or material fact when applying for or renewing an insurance contract and even at any point in time as long as the insurance policy is still in force*

***For an example***

*Clients who fail to disclose the existence of a pre-existing condition at the application stage of a life insurance policy may end up paying less premiums yet they were supposed to pay higher premiums or they will be accepted for cover yet the insurer would have declined covering the risk because the magnitude of the risk would have been too high for the insurer to bear.*

1. **Discuss the effect of non-disclosure on the risk to be accepted by the insurer. (4 Marks)**

*If a customer fails to disclose all the material facts to the insurer, then this places the insurer at a disadvantage because the underwriters will place the insured into a wrong risk bracket.*

*The argument which the insurer makes is that if the relevant information had been disclosed the insurer would not have accepted the risk because it would create a higher probability of a claim by the insured. As a result, the insurer is entitled to cancel the policy back to inception. This means that the insurer is entitled to deny any claims made under the policy. However, in some instances the insurer may refund all the premiums that the client had paid.*

*An insurance policy can be cancelled on the basis of material non-disclosure only if the undisclosed medical condition or diagnosis would have stopped the insurer from granting the policy in the first place.*

*In other cases of non-disclosure, the insurance firm must reconstruct the policy taking into account the increased risk profile and higher premium in order to determine what to pay in the insurance claim,*

1. **What is the relationship between non-disclosure and the cause of a claim? (2 Marks)**

*If there is material non-disclosure, the insurer is entitled to deny any claims made under the policy because the aspect of non-disclosure would have increased the likelihood of the claim which is a loss to the insurer. However, in some instances the insurer may refund all the premiums that the client had paid.*

*In other cases of non-disclosure, the insurance firm must reconstruct the policy taking into account the increased risk profile and higher premium in order to determine what to pay in the insurance claim.*

1. **State the benefits that could be excluded as a result of non-disclosure. (4 Marks)**

*Non-disclosure with respect to the client can lead to an unfortunate occurrence of any of the aspects below;*

* *The policy can be cancelled immediately by the insurer*
* *The claim can be repudiated by the insurer*
* *The insurer can impose new strict conditions and limits as a result of the client’s lack of good faith.*
* *It can be difficult to be accepted for insurance cover in the future after having a record of non-disclosure.*

1. **Choose one case study from Annexures 1-3 and summarise the case and include your opinion about the outcome of the non-disclosure case. (6 Marks)**

*Assessor to use his/her discretion on the accurate summary and relevant opinions to the case study.*

1. **Explain the difference between policy wording and a policy schedule. (4 Marks)**

*A policy wording is the terms and conditions and definitions of insurance coverage as they are written down in the insurance policy. It is meant to reiterate the discussion during the sales stage and the record of advice so that the insured can understand the rights and obligations as stated in the insurance contract.*

*A policy schedule is the part of the insurance contract that identifies the policyholder and details the persons covered, the amount of coverage, the exclusions and the premium. It essentially shows what the insured is covered for and what is not covered.*

1. **Analyse the Clientele Life policy wording on Annexure 4 and identify the actions to be taken in a case of non-disclosure. (2 Marks)**

*Assessor to use discretion on the answers provided.*

1. **Identify the types of evidence required in cases of non-disclosure from the attached case studies on Annexures 5, 6 & 7. (4 Marks)**

*The duty of disclosure exists until the time the contract of insurance is concluded. Even if at the time of completing a proposal and some material facts exist but before the contract of insurance is concluded, those facts must also be disclosed. A new duty to disclose arises at the time of renewal, or variation of the policy, because in law a new contract is concluded on each such occasion. Therefore, failure to adhere to the above will constitute a case of non-disclosure through the evidence of record of advice during the proposal stage.*

*Assessor to use discretion on the answers provided*.

1. **Discuss the possible materiality for non-disclosure with reference to medical ailments, consultations, outcomes and diagnoses. (5 Marks)**

*The onus is on the insurer to prove that the material non-disclosure caused the insurer to contract as it did, although the non-disclosure need not be the sole cause of that contracting. It is sufficient to prove that the non-disclosure was one of the operative causes which induced the insurer to contract as it did.*

*This means that the element of non-disclosure has to be material for the insurer to cancel the policy or to repudiate a claim.*

*With reference to the medical ailments, consultations and diagnosis, it is the duty of the underwriter to request any additional information that can prove the existence of any chronic illness which can change the level of risk of the client. This is because a client can give out information in the form of self-reported ailments with no record of actual diagnosis and should there be an underlying pre-existing condition then the non-disclosure will not be material if there was no request by the underwriter for medical report and it will be proven beyond reasonable doubt that the client was only aware of the self-reported ailment but not of the underlying pre-existing condition.*

1. **With an aid of an example, explain the concept of a reasonable person. (3 Marks)**

*The degree of caution and prudence used by a reasonable person when doing an activity that could foreseeably harm others is called the “standard of care. Therefore, the reasonable man concept is used to determine the materiality of non-disclosure by the insurer in any case where the insured failed to disclose certain information in the event of a claim.*

***Example***

*A long-term insurance client answered the questions on the proposal form and was given an opportunity to disclose all the medical conditions that he had prior to taking out the policy but he only mentioned an incident of chest pains without stating that the doctor told him that he had a heart murmur. Using a reasonable man concept, this shows that the client was negligent and intentionally withheld material information because the question stated that the client must disclose all the conditions, therefore any reasonable man would have acted differently in this case.*

**SECTION 2: 20 MARKS**

1. **What are self-reported ailments and list any 5 common self-reported ailments in long term insurance underwriting. (7 Marks)**

*Self-reported ailments are based on the premise that the insured is knowledgeable enough to report on certain ailments without any record from the medical practitioners of the existence of a chronic illness that can influence the level of risk that the insurer is willing to accept. Below is a list of some of the common self-reported ailments;*

* *Influenza like sicknesses*
* *Repeated chest and back pains*
* *Headaches*
* *Shortness of breath*
* *Existence of lumps and boils*
* *Fainting regularly*
* *Heart murmur*

1. **Explain how self-reported ailments could result in fraudulent claims. (2 Marks)**

*Clients usually mention some of these ailments during the underwriting stage but there could be more to it meaning that there may be pre-existing conditions that the client may be aware of which could lead to a claim within a short period after the inception date.*

1. **What are the implications of self-reported ailments at underwriting with reference to potential fraud? (5 Marks)**

*The use of self-reported chronic conditions by long term insurance companies seem to underestimate the prevalence of many chronic conditions amongst the clients which results in biased and inaccurate probability of multimorbidity and mortality trends at underwriting stage.*

*This is because the insurer will just send a proposal form or questionnaire to the applicant and the client is given the opportunity to state some ailments that that have suffered from* *before and this is where they will just state some ailments like having lumps or chest pains. Normally some clients will have just used over the counter medication without any recorded diagnosis or treatment, therefore there will be a high probability of the existence of a pre-existing condition meaning the client could pose an abnormal risk to the insurer.*

*The use of self-reported ailments will lead to costly discrepancies during the underwriting stage in which the clients will have an opportunity to lodge fraudulent claims for losses that were caused by pre-existing conditions. If the insurer had realised of the pre-existing conditions at the underwriting stage, then the client may not have been admitted for cover or strict term and conditions would have been imposed.*

1. **Discuss the difficulties relating to the measurement of self-reported ailments in assessing a claim with reference to valid evidence and the amount of payment. (6 Marks)**

*As mentioned above that self-reported ailments are based on the premise that the insured is knowledgeable enough to report on certain ailments without any record from the medical practitioners of the existence of a chronic illness.*

*This poses a great complication in terms of assessing claims because as long as the underwriter did not request a doctor’s report after the insured mentioned about the self-reported ailment then if there was any underlying chronic illness, the insurer cannot repudiate the claim on grounds of non-disclosure of a pre-existing condition.*

*If there is no evidence of the insured knowing about the underlying pre-existing condition then there will not be valid evidence of non-disclosure should the pre-existing condition being known at claims stage.*

*Therefore, the insurer will be obliged to settle the claim even though there was a pre-existing condition but the client was only aware of a particular symptom and in this case, which was a self-reported ailment.*

**SECTION 3: 25 MARKS**

1. **Differentiate between the concepts of intentional and unintentional fraud and give examples of each. (6 Marks)**

***Intentional Fraud vs Unintentional Fraud***

*The accusation of intentional fraud in long term insurance and healthcare services implies that a person intentionally and willingly tried to gain a financial benefit by making false claims to receive money or compensation to which they are not legitimately entitled.*

*One of the most common types of fraud is trying to inflate claims to state or private health insurance schemes. These claims may be entirely false, where no treatment was offered to the insured person. More commonly though, fraudulent claims charge for services that were not provided or charge for a more expensive service than the one provided.*

*Another common type of intentional fraud in long term insurance is that of clients paying doctors to write a fake disability diagnosis in order to cash out on the disability insurance policy.*

*Unintentional fraud refers to a situation where a party does something without the knowledge of the fact that the particular action stands to put them at an advantage over the other party in the insurance contract.*

*Most incidents of unintentional fraud arise from paperwork mistakes or from ignorance of what is legal or illegal. Internal procedures, such as cross-checking forms or using external auditors such as a*[*claims clearinghouse*](https://checkpointehr.com/claim-scrubbing/)*, can detect problems before claims are submitted.*

*Basically, intentional fraud happens when the perpetrator is very much aware of the deceit and is willingly doing so in order to have a financial advantage over the other party or parties involved in the insurance contract. Unintentional fraud arises from mistakes and errors done normally on the administration aspect of the contract, but which leaves one party or other parties benefiting financially in the process.*

1. **List and explain any 2 possible signs of intent to commit fraud in the long term industry (4 Marks)**

*There are several signs of the intention to commit fraud by any party in the insurance industry and some of them are listed below;*

* *Repeat offenders-This refers to a perpetrator that creates a pattern around the same way of deceiving the other party or parties to the contract which shows that the party intended to commit fraud on different occasions.*
* *Internal records-This type of indicator is usually generated when a life assured is entered into the new business system of an insurer and all previous reports surface from the company’s internal record keeping system showing the client’s previous cases of fraudulent claims.*
* *Forging of client’s signature-In this indicator of fraud, the sign of intent to commit fraud is of the forged signature which can be done by the intermediary or even by another family member at claims stage with aim of benefiting from the insurance benefits yet they are not the nominated beneficiaries.*
* *Misrepresenting policy information such as insurable interest-This normally happens when the intermediary is also involved in the process of pushing the policy through the system where the principle of insurable interest is compromised. One good example is the case where an adult child who is well financially self-sufficient would be the premium payer and the beneficiary on a life insurance policy on his/her elderly mother with the intention to make a financial gain on her death.*

1. **Explain the concept of quality of proof with the aid of an example and indicate the level of evidence required to have a watertight case. (4 Marks)**

*The quality of proof is how reliable such evidence should be considered. Important rules that govern admissibility concern hearsay, authentication, relevance, privilege, witnesses, opinions, expert testimony, identification and rules of physical evidence.*

*Exceptional quality of proof can lead to successful prosecution in terms of fraud cases. This is because the prosecutor must show the perpetrator’s intent to commit the fraudulent activity beyond reasonable doubt. Another type of evidence that may be useful to strengthen the case against the offender is to gather proof of similar additional crimes committed by the same offender.*

*The better the quality of proof will create a higher probability of a successful prosecution otherwise if the quality of proof is poor then the perpetrator can easily be acquitted in the court of law after committing a fraudulent activity which will affect honest policy holders in the insurance industry because if insurers continue to lose a lot of money from fraud then they will increase premiums.*

1. **Briefly describe the techniques that may be used in making a decision to prosecute and to follow civil proceedings. (5 Marks)**

*Cases of fraud can result in either criminal prosecution or civil proceedings in order to protect different interests. In criminal cases, there will be prosecution to protect the interests of the public as well as private interests because the perpetrator who have acted against public policy. In this case the state will institute the proceedings.*

*On the other hand, civil proceedings are normally between the parties that have a conflict without the State instituting any proceedings. In this case it can be between the Insurer and the insured or beneficiary who may be the perpetrator who has committed fraud against the Insurer.*

*In terms of the criminal proceedings, the aim is to punish the perpetrator using the law and this can result to a fine or imprisonment of the perpetrator but with regards to the civil proceedings, the objective is to recoup the losses that one party (plaintiff) would have suffered as a result of the fraudulent activity committed by the other party (defendant).*

*The decision to prosecute or not mainly depends on the size of the loss to the organisation as well as the time and effort needed during the prosecuting process if it is justifiable with the amount of loss brought about by the fraudulent activity. A lack of sufficient evidence would also be another reason why the aggrieved parties may not prosecute.*

*The decision to pursue civil proceedings can be taken if it was an unintentional fraud and if is clear that offender can afford to pay back the amount lost through the fraudulent activity otherwise if the offender cannot afford to pay back then the aggrieved party may as well lay criminal charges.*

1. **State the resources required to prove and prosecute. (4 Marks)**

*For perfect prosecution to be executed efficiently, there has to be financial resources to pay/hire the professional investigators and warrants to access relevant private and public documents that are considered necessary to contribute to the investigation.*

*During the investigations, the investigator will talk and listen to certain people and examine relevant aspects to the case.*

*There is also need for technological resources such as fraud detection systems, video, audio recording systems and authenticating systems like password, biometrics and access cards. Over and above all these important resources, having a huge financial muscle can also assist to hire the best legal advice that can lead to a successful prosecution.*

1. **State any 4 financial consequences of a decision to prosecute. (2 Marks)**

* *Legal Costs*
* *Time lost when attending court cases*
* *Loss of productivity while holding disciplinary hearings leading to reduced profitability.*
* *Hiring and firing costs*
* *Reputation damage of the organisation for constantly appearing in the media because of fraud cases which will lead to loss of market share*

**SECTION 4: 20 MARKS**

1. **Define an intermediary in your own words. (3 Marks)**

*An intermediary is a broker or agent who introduce the insurer to the consumers in insurance transactions. Insurance intermediaries are contracted with multiple insurance companies so they can focus on matching their client's needs with the most suitable insurance products.*

1. **What is the importance of accurate and relevant questioning in establishing risk within the context of insurance? (3 Marks)**

*It is vital for the intermediary to ask the necessary questions in order to establish the needs of the client and render appropriate advice by recommending the financial products to match those client’s specific needs.*

1. **Explain the roles of an intermediary in insurance business with reference to applying good questioning techniques in executing their roles. (5 Marks)**

*One of the functions of some insurance intermediaries is to help clients manage their risks, improving their risk profiles and reducing the likelihood that an insured event will occur.*

*Insurance intermediaries render financial services for or on behalf of insurers to clients in the form of advice and/or intermediary services.*

*Intermediaries use their expertise to recommend products that best suit the clients’ needs and to help manage the risks that the client is exposed to.*

*All the above-mentioned roles of intermediaries can only be executed efficiently if the intermediary gathers all the required information from the client through accurate questioning techniques.*

1. **Discuss the consequences for the client in cases of non-disclosure by the intermediary with reference to the intermediary’s role in explaining a policy. (5 Marks)**

*The intermediary should take reasonable steps to ensure that the proposed policy is suitable for the client’s needs and by definition, a policy which is voidable for non-disclosure is not suitable. Clients must be able to make informed decisions and choices and must therefore receive all the relevant information. A provider must, where it is enabled to provide clients with financial services in respect of a choice of product suppliers, exercise judgment objectively in the interest of the client concerned.*

*This means that, if the intermediary fails to disclose all the material facts to the client during the sales stage then the client will lose trust in the intermediary and may not be able to choose a product that best suits his/her financial needs.*

*The client can end up signing up for a financial product that costs more but the product will not be the best product because lack of adequate information to the client from the intermediary will hinder the client from making an informed decision.*

1. **State the consequences for the intermediary in instances where he/she is found guilty of non-disclosure. (4 Marks)**

*It is an intermediary’s obligation to adhere to the above-mentioned responsibilities when dealing with clients with regards to disclosing material facts to clients. Failure to for the intermediary to disclose the necessary information to clients will lead to the following consequences.*

*The intermediary can;*

* *be debarred*
* *the licence can be withdrawn or suspended*
* *have too many complaints from clients whose needs won’t be satisfied*
* *pay a fine of a maximum of R10 million or imprisonment of not more than 10 years or both*
* *lose reputation and consequently lose market share leading to reduction in profitability*