**105026: Occupational Certificate:**

**Financial Advisor**

**Module 5**

**Long-term Insurance Advice**

**SAQA ID: 105022**

**NQF Level 5**

**150 credits**

**LEARNER GUIDE**

Contents

[LEARNING UNIT 1: PRODUCTS OF THE LONG-TERM INSURANCE INDUSTRY 6](#_Toc43462964)

[INTRODUCTION 7](#_Toc43462965)

[1.1 The purpose of long-term insurance 7](#_Toc43462966)

[1.2 The types of long-term insurance 8](#_Toc43462967)

[1.3 Term insurance 10](#_Toc43462968)

[1.4 Conventional life insurance products 16](#_Toc43462969)

[1.5 Universal life products 19](#_Toc43462970)

[1.6 Recent developments in product innovations 25](#_Toc43462971)

[1.7 Retirement annuities 25](#_Toc43462972)

[1.8 Investment linked products 33](#_Toc43462973)

[1.9 Supplementary benefits 36](#_Toc43462974)

[LEARNING UNIT 2: THE LONG-TERM INSURANCE ACT 52 OF 1998 39](#_Toc43462975)

[2.1 Regulation of insurance business 40](#_Toc43462976)

[2.2 The Acts that govern Insurance and an explanation of why there is more than one Act 40](#_Toc43462977)

[2.3 The Short Term and Long-Term Acts 41](#_Toc43462978)

[2.4 The Long-term Insurance Act 45](#_Toc43462979)

[2.5 The different classes of policies 48](#_Toc43462981)

[2.6 The parties to a Long-Term insurance contract 50](#_Toc43462982)

[2.7 Insuring the lives of children 51](#_Toc43462983)

[2.8 Life contracts and all other contracts 52](#_Toc43462984)

[2.9 The life insurance contract and insolvency 53](#_Toc43462985)

[2.10 The four funds approach 56](#_Toc43462986)

[LEARNING UNIT 3: DISABILITY INSURANCE 59](#_Toc43462987)

[3.1 Concept of disability insurance 63](#_Toc43462988)

[3.2 The purpose of disability insurance 65](#_Toc43462989)

[3.3 Physical impairment 71](#_Toc43462990)

[3.4 Free-standing disability vs linked disability cover 77](#_Toc43462991)

[3.5 Income generation for the disabled 77](#_Toc43462992)

[3.6 Industry developments: traditional vs innovation 79](#_Toc43462993)

[3.7 Occupation and avocation risks and cover 80](#_Toc43462994)

[3.8 Holistic financial planning 84](#_Toc43462995)

[LEARNING UNIT 4: FRAUD IN THE LONG-TERM INSURANCE INDUSTRY 86](#_Toc43462996)

[4.1 Concept of fraud 87](#_Toc43462997)

[4.2 Forms of fraud 88](#_Toc43462998)

[4.3 Indicators of fraud 95](#_Toc43462999)

[4.4 Legal aspects 97](#_Toc43463000)

[4.5 Investigating fraud 99](#_Toc43463001)

[4.6 Fraud trends 100](#_Toc43463002)

[4.7 Control mechanisms 103](#_Toc43463003)

[LEARNING UNIT 5: ROLE PLAYERS IN THE LONG-TERM INSURANCE ENVIRONMENT 108](#_Toc43463004)

[5.1 The role of actuaries in Long-term insurance 109](#_Toc43463005)

[5.2 Underwriters and their role 115](#_Toc43463006)

[5.3 Claims assessors and their role 117](#_Toc43463007)

[5.4 Reinsurers and their functions 121](#_Toc43463008)

[5.5 How long-term products are developed 127](#_Toc43463009)

[LEARNING UNIT 6: PRODUCTS OF THE ISSUE OF ABNORMAL RISK 135](#_Toc43463010)

[6.1 The issue of non-disclosure and abnormal risk 136](#_Toc43463011)

[6.2 Self-reported ailments 139](#_Toc43463012)

[6.3 Analysis of long-term application for cover 140](#_Toc43463013)

[6.4 Role of intermediary 144](#_Toc43463014)

**1. HOW TO USE THIS GUIDE**

This guide belongs to you. It is designed to serve as a guide for the duration of your training programme and as a resource for after the time. It contains readings, activities, and application aids that will assist you in developing the knowledge and skills stipulated in the specific outcomes and assessment criteria. Follow along in the guide as the facilitator takes you through the material, and feel free to make notes and diagrams that will help you to clarify or retain information. Jot down things that work well or ideas that come from the group. Also, note any points you would like to explore further. Participate actively in the skills practice activities, as they will give you an opportunity to gain insights from other people’s experiences and to practice the skills. Do not forget to share your own experiences so that others can learn from you too.

**2. ICONS**



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**3. HOW YOU WILL LEARN**

The programme methodology includes facilitator presentations, readings, individual activities, group discussions, and skill application exercises.

**4. OVERVIEW OF THE MODULE**

This Module is at NQF level 05 and successful completion of the module will earn you credits towards Occupational Certificate: Financial Investment Advisor.

The time you will spend on this module will be a combination of classroom training, self-study and workplace learning. It involves learning, practising, completing activities of a formative nature, doing self-evaluation and putting into practice, in your workplace, what you have learnt.

The approach of classroom contact session-based training is that an adult learning situation is created (through stimulation) by the facilitator to get as much participation as possible from the course participants.

This module will introduce the learner to some of the most important principles of Long-term Insurance and how these impact on the insurance advisor. The module will also take the learner through some of the important processes and procedures in underwriting long term insurance products that take into consideration applicable principles and legislation.

# LEARNING UNIT 1: PRODUCTS OF THE LONG-TERM INSURANCE INDUSTRY



**Learning Outcomes**

By the end of this learning unit and having completed all the formative assessment activities, you should be able to:

* Explain the concept of Term insurance making use of examples (long term insurance).
* Define and explain conventional insurance and compare a conventional policy with new generation policy.
* Describe universal life product and identify supplementary benefits linked to Universal life products.
* Explain Retirement Annuities and list and discuss the type of retirement annuities in the market
* Explain with examples the concept of an investment linked product
* Describe supplementary benefits and discuss with examples

## INTRODUCTION

In one form or another, we all need insurance. Whether it is motor, medical, liability, disability or life, insurance serves as an excellent risk-management and wealth preservation tool. Having the right kind of insurance is a critical component of any good financial plan. While most of us own insurance, many of us do not understand what it is or how it works. In this section, we will review the basics of insurance and how it works, then take you through the main types of insurance out there.

Insurance is a way of reducing potential financial loss or hardship. It can help cover the cost of unexpected events such as disability, illness or property damage. Insurance can also provide loved ones with a financial payment upon one’s death.



**Insurance** is a contract between the insurer and the insured wherein against receipt of certain amounts, called premiums, the insurer agrees to make good any financial loss that may be suffered by the insured, due to the occurrence of an insured event .

**Insurance** is a form of risk management in which the insured transfers the cost or financial implications of a fortuitous unfortunate event to another entity in exchange for monetary consideration called a premium.

## 1.1 The purpose of long-term insurance

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

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

Insurance is important because of the uncertainty of what might happen in the future. Some of the questions that can be asked are:

* What happens to your family or dependants when you die? You could organise your financial affairs, service your debts and have them continue their current standard of living without you.
* If you were to be seriously injured, could you pay for your hospital costs, ongoing treatment, time off work, and pay the living costs for you and your family until you are fully recovered, if you are fully recovered?
* If you are injured and are unable to continue working, are you able to service your debtors and maintain any standard of living?
* If you were ill and needed immediate treatment at a hospital, could you afford costly expenses related to that treatment?

These factors are very helpful, especially while choosing the kind of insurance package that best serves a client.

The purpose of long-term insurance is ultimately to provide a client and their dependants with an income in the long term (retirement), or a lump sum of money in the event that the client becomes permanently disabled, succumbs to ill health or passes away.

## 1.2 The types of long-term insurance

In the insurance industry, there are various types of insurance. There are different insurance policies on the market to protect individuals or companies against the financial implications of various risks. Organisations can take out employers’ liability cover to protect themselves against legal liability of death, injury or disease an employee may sustain while employed. Individuals may take out health insurance to ensure their costs will be covered when there is a medical emergency.

Insurance is generally sold as long-term insurance, short-term insurance, and in some parts, it can be statutory insurance, or voluntary.

* **LIFE INSURANCE** is an insurance that is directly linked to an insured person’s life or wellbeing. This type of insurance is usually paid as a lump sum and can also be paid over a long period of time and includes life insurance, dread disease/critical illness insurance and disability 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, and either expires or pays out an amount at maturity.
* **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** –Commonly known in the South African market as Severe Illness 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.

There are numerous long-term insurance companies in the South African market that provide a vast array of insurance products and solutions.



*It is important to note that the sum assured does not necessarily relate to the actual loss. Long-term insurance refers to a range of insurance products that provide either:*

* *An income in the long term (usually upon retirement) an endowment policy or;*
* *A lump sum of money paid out should insured become permanently disabled or pass away. These products include life insurance, disability insurance and funeral insurance.*

In long-term insurance, the client pays a monthly premium over time until death or up until the policy matures at a specified date.

## 1.3 Term insurance

 A term life insurance policy covers a client for a set, predetermined length of time. It is a good type of coverage to have if client feel they 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 a person’s life, like paying off a home mortgage. These policies tend to be very affordable but they do not have any type of cash or investment value once client has 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, or to a financial institution directly in case of a mortgage.

In a term insurance contract, the insurer undertakes the liability – against the premium payment of the contractor (policyholder) – of paying a sum specified in advance (sum insured) to the person specified in advance (beneficiary) if the person specified dies (insured) during a certain period of time (insurance term). If the insured lives at the end of the insurance term, or outlives the specified term, the insurance policy may be terminated without benefit payment.

* ***Term life insurance:****It is like yogurt. It is really good for you, but it always comes with a firm expiration date. Here, you get life insurance for a set period or "term" (commonly 10, 20 or 30 years) that you decide. Your premiums maybe fixed for the entire length of your term. And it may be considerably less r whole life cover. (*[*https://www.trustedchoice.com/term-life-insurance/*](https://www.trustedchoice.com/term-life-insurance/)*)*
* Term life insurance, also known as pure life insurance, is life insurance that guarantees payment of a stated death benefit during a specified term. Once the term expires, the policyholder can either renew it for another term, convert the policy to whole life coverage if the terms and conditions offer the option, or allow the policy to terminate.

**Features of term life insurance**

* Term life insurance may guarantee payment of a stated death benefit to the insured's beneficiaries during a specified term.
* Pays benefits only if client dies during the term of the policy and whilst the term of the policy is in effect
* Term life premiums are based on a person’s age, health, and life expectancy, which is determined by the insurer.
* May be considered easy and affordable life insurance to buy, initially.
* Purchased for a specific time period, such as 5, 10, 15, or 30 years, known as a “term”
* Becomes more expensive with age, especially after age 50
* The term may be renewed if client wants coverage to be extended beyond the term length, if the terms and conditions permit
* If the insured dies within the specified policy term, the insurer pays the insured of the policy.
* Can be used as temporary additional coverage with a whole life insurance policy
* Can be converted to whole life insurance

**Purpose and pricing:**

Based on this it seems that the functioning of the insurance means that the money collected by the risk community will go to only a few, to those (or persons connected to those) who die during the insurance term. Because of this it is possible to receive relatively high levels of benefits with low levels of contributions When using a term insurance, the most important thing to consider is that a death in a family – if it is the death of a wage-earner – can cause great financial difficulties, or it may even lead to total bankruptcy. The more the welfare of the family is depended on the wage-earner, the greater the bankruptcy.

* +  A 30-year-old woman raises two children on her own, and at the same time is building a house. She thinks that if everything goes well, the building operations will be finished in 5 years. If, on the other hand something happened to her, a term insurance sum would save her children from bankruptcy. This way she takes out a 5-year term insurance policy.

In light of the above we highlight a few concrete situations when it is useful to take out a term insurance:

Term insurance may be deemed “cheaper” insurance in the sense that the benefit received can be high compared to the premium paid. When product is affordable, it becomes accessible to young householders, who are currently trying to build the bases of their living (building a house, starting a business, etc). They don’t have much money that could be saved up but are afraid that their family could be deprived of a promising possibility of financial stability due to In relation to the above example we can also mention using term insurance as a credit life or loan insurance. If one takes out a car loan, a home loan, store credit, or becomes indebted to anyone, then a term insurance policy, commonly in the form of Credit Life Cover is an effective solution to cater for the event of death, disablement or retrenchment whilst the loan/debt is outstanding.

**Why Should One Buy Term Life Insurance?**

Life insurance in its various forma can play a very vital role in a person’s life and financial wellbeing. The type one buys is based on needs and means. Term insurance is used for a variety of reasons. Short, medium term and long-term financial plans can be handled using Term policies.

Education Policies, that pay a lumpsum at a known maturity date are popular among customers for reducing the burden of paying hefty fees for children’s education.

Just like in this scenario:

Thabo is a married father of 6 children. They live in a new-ish home and he is the family’s sole breadwinner. If he were to suddenly pass away, his wife would have an immense financial burden on her hands.

For Thabo, a term life policy for 20 or 30 years would get the kids out of school and to the point where hopefully the home is paid off.

Credit Life insurance helps pay off debt in the event of inability to pay due to death, disablement, disease or even retrenchment. Term policies can be used as a savings or investment facility for a financial engagement planned for the future. One may plan to receive a lumpsum from an endowment policy at retirement, when they need to purchase an asset. A lumpsum pay-out can be used as deposit for a house loan, a car or even to finance a holiday.

**How Much Does Term Life Insurance Cost?**

The cost depends on a number of factors. These factors include the following: How old a client is ? And what the state of his/her health is? Age and health are two of the strongest factors that go into the costing of premiums. Insurance companies have actuaries and actuarial models that help with the determination of premiums.

When one applies for a policy, underwriters analyse the presented risk profile, to determine the level of risk, and decide on whether to accept the risk or not, and what premium to charge, and the terms and conditions applicable.

**What Does Term Life Insurance Cover?**

A policyholder will select the amount of life insurance they want, then a client passed on, their beneficiary receives the full pay-out in the manner in which they choose normally a lump sum.

From there, they can do whatever they want with the money. It is usually a good call to choose a trusted person to be a beneficiary. Most often, the money can be used for things like funeral expenses, medical bills, or setting up a trust for any young children.

**What Happens When My Term Life Insurance Ends?**

Term policy may end when the maturity date arrives, at which point a payment may be made. A Credit life policy’s term is usually determined by the underlying credit agreement, and covers the outstanding debt. The cover then ends with the credit agreement end date, or at times when the debt is paid up. It follows then that the amount at cover decreases over the term with loan repayments. Where the term policy is an endowment, the insurer in some markets may warn the client in advance that the policy is about to expire and, where the terms allow, offer options, like:

* **Renewal:**Add a new term to the policy that will give the same benefit amount. A problem here may be that it will take into account client’s new age and rates may be much higher. But, say client developed some serious illness, he/she may not be approved for a whole new policy, so he/she may just want to take what they can get.
* **Convert to a whole life policy:**This is perhaps the easiest option, if allowed by the terms and conditions of the policy. Here one would roll the policy over into a nice, whole life policy with the same benefit that will last as long as they live. Again, premiums could go up due to age, and other underwriting factors.
* **Terminate:**Maybe one has already prearranged their funeral and have got things all sorted out for after they pass. In that case, client may find themself not needing the policy anymore. Client can also terminate the policy and purchase a new type of insurance or a new benefit limit that fits their needs.

**Supplementary benefits and additional products**

Supplementary benefits are additional complementary benefits one can add onto a policy for various reasons. The product may exhibit gaps that a client wishes covered, supplementary benefits can help. The benefits can also be used to tailor-make a product to suit a client’s requirements.

Supplementary benefits include the following:

* Disability benefits
* Dread disease benefits,
* Funeral cover
* Accidental death benefit
* Premium waiver.

## 1.4 Conventional life insurance products



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.

A traditional whole life policy is a type of life insurance contract that provides for insurance coverage of the policy holder for his/her entire life. Unlike term life insurance, which covers the policy holder until a specified age limit, or a fixed term, a traditional whole life policy never runs out.

**Features:**

* These plans do not allow the client to choose investment avenues. Funds are invested as per the strategy and discretion of the company.
* Premiums are invested in a common 'with profits' fund and therefore one cannot track individual portfolio.
* At the occurrence of an insured event, the client receives the sum assured plus bonuses, if applicable in the plan.
* Conventional plans do not allow withdrawal part of the fund. Instead, some policies offer the facility to take a loan against a client’s investment.

**Purpose and pricing**

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 demonstrated by life expectancy tables. Life expectancy is a statistical measure of the average time someone is expected to live, based on the year of their birth, current age and other demographic factors including their sex. It is used to assess and set a number of important policies that impact on everyday life, for example, setting the State Pension age and targeting health policy initiatives.

To calculate life expectancy, one uses a life table. This shows, for each age, what the probability is that a person will die before his or her next birthday. A life table, also known as a mortality table, or actuarial table, shows the rate of deaths occurring in a defined population during a selected time interval, or survival rates from birth to death.

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 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 premiums in a number of prescribed assets including bonds, shares and property and assume they will earn a certain rate of interest on these invested funds.

In addition, a 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 can vary from company to company based on its operations and efficiency.

**Supplementary benefits and additional products**

Additional benefits would include the following:

* Disability and dread disease cover
* Funeral cover
* Premium holiday and waiver
* Retrenchment benefit
* Accidental death benefit.

Refer to section 6 of this Learning Unit for more details on Supplementary benefits.

## 1.5 Universal life products



The Hippo website gives the following description: “Universal Life Insurance offers a policy that pays out a lump sum when the policyholder passes away. The difference with this policy is that you gain interest on the sum of the money that is placed in an investment account. At a point within your lifetime, the amount of money in the investment account can match the amount you are insured for, meaning you will no longer have to make monthly payments.”

A universal life policy is a specific type of cover where the total premium payment has two components: the risk premium and a payment towards an investment or savings part of the policy.

The first one covers the cost of death benefits and administrative fees and it usually the minimum sum required, while the latter constitutes any payment above the risk premium to keep the policy in place – also known as the cash value.

**Benefits of Universal Life Insurance:**

You can change, remove, or add cover and benefits at any time.

You can stop payment when you reach a certain age.

There is potential to grow your money far more than if it was put straight into a bank.

While this is a more expensive policy as there is more risk involved due to the investment you make, you won’t know if it is for you until you do your research. Compare what different providers can offer you and their quotes online, to find the best deal on Life Insurance that will suit your needs.

**Problems with Universal Life Policies**Universal life policies – Are the chickens coming home to roost?

by Paul Kruger on 14 September 2020  
Posted in Compliance and Legislation

The office of the Long-term Ombud has raised an extremely concerning trend in the August edition of its quarterly newsletter, OMBUZZ. An investigation identified at least 68 complaints received since 2018 from policyholders, often nearing or in retirement, having to face steep premium increases (or a drastic drop in their cover amount) as a result of premium reviews to their universal life policies. It cites four examples which clearly outlines the seriousness of the problem.

Background

Universal life policies are policies which were popular in South Africa from the mid 1980’s to early 2000’s, where the product design is characterised by both risk and savings elements in a policy.

Essentially, these policies comprised two elements: a life risk and endowment combination where actuarial calculations attempted to balance the rising cost of life cover with growth in the endowment during the chosen guarantee period. The Ombud notes: “The extent to which this materialises depends on the actual investment returns achieved relative to the assumptions made at inception.”

“For a given premium, the policyholder could elect the level of risk cover ranging from minimum risk cover, where virtually the entire premium is applied to the savings element, to maximum risk cover, where the risk component is as large as possible, with a very small savings component.”

“Policyholders could choose a guaranteed cover term, which guaranteed the cover for the selected term at the set premium (level or increasing). The guaranteed cover term is the period the policy can sustain the cost of providing the level of cover. The longer the guaranteed cover term, the higher the premium is set when the policy is purchased, so the guaranteed cover term was mostly shorter than the term of the policy, e.g. 10 or 15 years.”

“To mitigate the possible loss of cover after the guaranteed cover term, universal life policies commonly made provision for policy reviews, in terms of which the insurer would monitor the performance of the policies, and advise the policyholder should it appear that the investment account balance and future premiums would be insufficient to maintain the cover beyond the guaranteed cover term. However, the review clauses differ from insurer to insurer and are often vague as to what constitutes the review, when the review will be performed and what steps would follow. It appears that insurers did not necessarily institute policy reviews for a very long time, some state they did but decided to take no action, and in some cases subsidised the cost of cover for a while before implementing premium increases.”

“From the time these policies were sold, the inflation rate has declined considerably over the years, leading to lower investment returns than assumed. In addition, there were prolonged adverse economic conditions, especially after 2008, which compounded the problem of poor investment returns. The lower the investment account balance, the greater the amount at risk and the amount of the cover charge. This is further exacerbated by the increase in the cover charge with ageing, and the snowballing effect leads to a rapid depletion of the investment account. Insurers were jolted into action and policyholders were taken by surprise, especially by the level of increased premium required, leading many to question the insurer’s right to increase premiums and the timeliness of the review. Needless to say, the maximum cover policies require the steepest increases.”

“Universal life policies essentially transferred the investment risk, and in some instances the mortality risk, to the policyholder. Whether policyholders, or even the financial advisors selling the products, understood this risk, or contemplated the possibility of the premium being insufficient to maintain the life cover, is questionable.”

“Complainants are of the view that insurers prejudiced them by not informing them earlier that premiums were not sufficient to cover the cost of the cover. These complainants argue that this deprived them of the opportunity at an earlier stage to consider whether to carry on with the policy or to terminate it. Regular reviews would also have prepared them for gradual, reasonable increases rather than the drastic increases now required.”

The Ombud notes that it only focused on the issue of premium reviews. Other issues giving rise to complaints includes low or no maturity values as at the date of maturity, despite regular premium payments.

**In closing**

“The problem with Universal life policies is not unique to South Africa. It is also not a problem that this office is able to easily resolve by granting relief to individual complainants. These are issues which have a wider impact, and they involve the actuarial viability of policies. We have thus raised awareness of the issues with the Financial Sector Conduct Authority (“FSCA”) and National Treasury and to question whether an approach at industry level is required.”

With a **universal life insurance** policy, the **insured** is protected with a guaranteed amount of death benefit proceeds. In addition, funds that are in the policy's savings component are invested to provide the policyholder with cash value build up. Over time, this cash can grow on a tax-deferred basis.

Universality also means that the insurer is able to satisfy all insurance needs of an insured within one policy.

Universality necessarily means also that compared to conventional insurance it has much more features in common with non-insurance financial instruments, so the boundary line between life insurance and other financial areas is starting to fade, not in the least thanks to unit linked insurance.

A universal life insurance policy is basically a whole life policy with an investment option. For every premium payment made above the monthly premium cost of the insurance an additional cash amount is credited to the client’s account. Interest is earned on that cash amount each month or per investment period. This type of policy offers client the possibility of rapid growth on their investment.

Here is a brief explanation of the most important supplementary benefits available: It is important to note that supplementary benefits are dependent on conditions of the policy.

**Waiver of Premium**

This benefit can be considered a disability benefit as it applies only in the event of client becoming totally disabled before the age of 60 or 65. Following on from an initial waiting period, where applicable, the client may not be required to pay any further policy premiums in this instance. The full insurance coverage and benefits may be unaffected and the rider will continue to operate for the duration of disability.

Generally, this is a valuable yet can be an affordable addition.

**Disability Income**

Limited to a percentage of the death benefit, this benefit provides a monthly income should client become totally or temporarily disabled during the period of coverage. An initial waiting period may need to expire before payment commences, depending on policy terms and conditions.

**Accidental Death Benefit**

This extension can provide an additional amount of coverage should client’s death occur as a result of an accident. In some cases, this benefit can be as much as three times that of the standard policy amount provided for accidental death.

There are however exclusions to this benefit; accidental death must occur prior to the age of 65 and death by sickness will not be covered. There will also be other exclusions, all dependent on policy conditions.

**Consumer price index linked benefit**

In order to assist in offsetting client’s increased insurance needs that may occur as a result of inflation, client can add the cost-of-living benefit to the policy. With this benefit in place client can purchase more insurance annually, the value of which is based on the inflation.

Typically, the premium for the additional annual coverage is calculated using low rates and generally clients may not need to provide evidence of health or insurability.

**Joint Life Cover**

Joint Life Insurance allows client and their partner to be covered by a single policy with the same terms and conditions. It will be paid out when one partner passes away. The surviving partner will then not be insured. This option may be cheaper than other life covers due to its one payout.

The popular supplementary benefits for the South African market include Accidental Death or Disability covers, Funeral cover, Retrenchment Benefits, Severe Illness cover.

## 1.6 Recent developments in product innovations

There is common perception that life insurance policyholders have suffered at the hands of insurers over the past decade. 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 Insurance 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 Insurance 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 come with incentives and rewards 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.

## 1.7 Retirement annuities

A retirement annuity (RA) is a retirement fund in terms of the Pension Funds Act. It is a tax effective investment vehicle designed for individual investors (as opposed to employees who contribute to a workplace retirement fund).

A deferred annuity wherein consideration is paid in instalments until reaching a pre-selected retirement age.  
(www.businessdictionary.com)

A retirement annuity is ideal for people who

* are self-employed;
* don’t have access to a work-place pension or provident fund through their employer;
* want to supplement their pension or provident fund savings
* earn significant amounts of non-*pensionable income* (e.g. interest and rental income).

 *Pensionable income* is the income used by an employer to calculate contributions to the company pension or provident fund. This will likely include the full basic salary but may exclude discretionary payments such as bonuses/incentives. It may also exclude any non-work-related income, such as interest or rental income.

**Tax benefits**: Since 1 March 2016, RAs qualify for the same tax incentives as pension and provident funds. One may deduct contributions to a RA fund up to 27.5% of taxable income or gross remuneration (whichever is the higher) for tax. The 27.5% limit applies to the aggregate of contributions to all funds (pension, provident and RA). The overall tax-deductible limit is R350,000 per annum. Contributions over the annual rand limits may be rolled over to future years but will be subject to the limits applicable in those years.

One can join as many RAs as they wish, but the tax relief is determined in aggregate, not in respect of each individual fund. An employer may contribute to a RA fund on behalf of an employee. They can deduct unlimited contributions, but those contributions will be taxed as a fringe benefit in the employee’s hands.

**Access:** One can only retire from an RA from age 55 onwards (the one exception is early retirement due to ill-health). A client can however withdraw before age 55, either on emigration, if you have gone through the formal financial emigration process with SARB and SARS, or if the paid-up RA value is less than R15,000. Withdrawals are subject to withdrawal lump sum tax (see table below).

You can also make your RA ‘paid-up’. This means you no longer pay monthly contributions; however, you will stay invested until you retire (from age 55 onward).

At retirement, you may take up to one third as a cash lump sum (subject to retirement lump sum tax (see table below); at least two-thirds must go towards a compulsory annuity. Compulsory annuitisation applies to fund balances above R247,500. If you own multiple RAs in one RA fund, then the annuitisation requirement considers the aggregate value of your RAs. If you have multiple RAs in different RA funds, then the annuitisation requirement is applied to each RA individually.

There is no maximum age at which you need to stop contributing to an RA, or at which you need to access your RA.

On *death*, your benefit will be allocated by the Fund Trustees according to the rules set out in the Pension Funds Act. The Trustees must ensure that all your financial dependents are considered. You can assist them by listing all such dependents in your beneficiary nomination form.   If you do not leave any financial dependents, the Trustees will allocate the benefit according to your beneficiary nomination form. If you do not have any financial dependents and you fail to complete this form, the money will fall into your estate and will be distributed according to your will or intestate if you have no will. Any lump sum payment on your death will be taxed as a retirement benefit as though it had been received by you prior to your passing.

**Fig 1: Retirement and withdrawal lump sum tax tables**

**2022 tax year (1 March 2021 – 28 February 2022) –**No changes from last year

|  |  |
| --- | --- |
| **Taxable income (R)** | **​Rate of tax (R)** |
| 1 – 500 000​ | ​0% of taxable income​ |
| ​500 001 – 700 000​ | ​18% of taxable income above 500 000 |
| 700 001 – 1 050 000​ | ​​36 000 + 27% of taxable income above 700 000 |
| ​1 050 001 and above | ​130 500 + 36% of taxable income above 1 050 000 |

*Source: SARS*

**Transfers**: Client can transfer their RA tax free from one RA provider to another but one cannot transfer their RA to another type of retirement fund. The *cost or penalty* for transferring or making a RA paid-up depends on service provider.

**Types of RAs**: There are two broad types or forms of RAs. The traditional policy-based RA is underwritten by the big life assurance companies whereas the “new generation” unit-trust based RA is offered by the asset management industry.

*Policy-based RAs* are inflexible. a client enters into a long-term contract and incurs obligations for decades into the future, specifying how much one must save and for how long. Breaking these terms accelerates the recovery of upfront costs (mainly commissions) loaded against the policy. These then appear as the notorious variation or early termination charges everyone complains about. They are capped at a maximum of 30% of client’s RA (if the policy was bought before 2006) or 15% (if the policy was bought after 2006).

Traditional RAs are usually sold through a broker. Even if client opts to deal directly with a financial services provider, they may be “allocated” a financial adviser. The financial advisor’s commission depends on the terms agreed to. The higher a client’s contribution, escalation rate, the fund fees and the investment term, the bigger the financial advisor’s commission. The recovery of this cost can reduce client’s investment return by between 0,5% and 0,75% pa. This may not seem like a lot, but over a 30-year savings period, it may cut the final pay-out by up to 15%!

Client can avoid these issues with a *new generation RA*. Client are not locked in; they can cancel or lower their contributions at any time. Or sometimes the client can take an indefinite contribution holiday. As fees are recovered on an as-and-when basis only, there is no charge for unrecovered costs.

**Costs** are an important consideration with any investment. Traditional RAs have a reputation for being very expensive, costing as much as 3% pa, after taking into account investment management, platform, broker and administration fees.

A client usually has contribution payment options when saving for their retirement through a Retirement Annuity:

**Recurring Premium Annuity;** premiums or contributions are made largely through a regular payment arrangement. A debit order arrangement can be effected with a certain amount collected from a client’s bank account on a specific date every month for the effective period.

**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 occasional payments, with little prior arrangements nor an ongoing payment arrangement.

**What is the tax benefit of a recurring, single and ad hoc RA premium?**

Retirement annuity contributions are tax deductible up to a maximum of 27.5% of a client’s remuneration or non-pensionable taxable income, whichever is higher, and no more than R350 000. If one contributes more, you may claim excess amounts in future tax years. but after reaching these limits, a client’s contributions are rolled forward to and automatically deducted in future years. Also, the limit applies to all retirement savings combined (including retirement annuities, pension funds and provident funds). So if one contributed the maximum of R350,000 in total, and R150,000 went to a pension fund at work, only R200,000 of RA contributions would be deductible.

**Available options at retirement**

**a) A fixed annuity**

A fixed annuity is an interest-bearing life insurance product. An annuity typically has a term length of at least four years, during which it grows on a tax-deferred basis. Annuities are designed to provide you with an eventual income stream. You have several other options to choose from when your fixed annuity matures, including redeeming it, renewing it and annuitizing it.

The client will pay income tax if they redeem their annuity, but will be able to defer income tax payments if they renew or annuitize their annuity.

**b) A living annuity**

Living annuities are governed by the Long-Term Insurance Act but, unlike life annuities, are actually investments linked to unit trusts, cash investments or share portfolios held in the name of the annuitant. Because it is not an insurance policy, the living annuity does not insure the annuitant against investment risk nor against longevity. There is no age limit for purchasing a living annuity, although the earliest you will be permitted to retire from a retirement fund is age 55, meaning that a living annuity structure is available from this point onwards.

Once the funds have been set up in the living annuity structure, the annuitant is obliged to draw a regular income on a monthly, quarterly, or annual basis, and the onus of ensuring that they don’t run out of capital rests with them. Being an investment, it is important to bear in mind that a living annuity offers no guarantee on your capital which is linked to investment performance and, as such, selecting an appropriate investment strategy is key to sustainable cashflow in retirement.

**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 an annuity contract**

**Annuity withdrawals are fully taxable**. One can delay the annuitization process and the resulting taxes by renewing an 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.

***Case Study***

*My uncle took early retirement at 55 years old. His employer said he had two options:*

1. *He gets one third of his pension money and then gets a monthly income; or*
2. *He can cash out his pension*

*He wanted to go with option two, so he went to Old Mutual to find out if he can get a preservation account with them. He was told it is possible, he can diversify his funds with them.*

*Then he went to a bank to find out what products are available if he wants to invest his pension money with them. He was told that he can only access one third of the pension fund and the rest must be used to buy an annuity. He cannot cash it out.*

*He is confused as to which information is correct: can he access more than one third of his pension fund and invest it in different portfolios, or can he only access one third of the pension fund money and then the rest must be used to buy a retirement annuity?*

*Understandably, this can sometimes be confusing and frustrating. So, let’s clear this up for your uncle:*

*From the age of 55 years your uncle can ‘retire’ from his pension fund. On his retirement he has the following options:*

* *He can transfer the entire pension fund to a preservation fund, no matter what the value of the fund is – tax free. Once it is in this preservation fund, he can select multiple investment portfolios that match his risk profile to continue to grow his money until he needs access to it. The purpose of the preservation fund is to preserve the money so that it can be cashed in at a later date. In other words, if your uncle does not need access to any of the funds now, this is the ideal place to park it. He cannot make any further contributions to the preservation fund*
* *He can cash in his entire pension fund, provided the balance of the fund is below R247 500. This will be subject to income tax, which is explained below.*
* *If his pension fund is over R 247 500, he can withdraw up to a third of the fund in cash and the balance of the funds (two-thirds) must be used to purchase a compulsory annuity. The compulsory annuity will then pay him an annuity (or pension) each month (can be paid quarterly and/or annually as well). This payment is also subject to income tax, which is explained below.*

*Whether your uncle draws a third in cash or is able to withdraw the full amount, such a lump sum withdrawal will be subject to income tax. SARS also provides for a portion of the lump sum withdrawals to be exempt from tax. The rates below will apply, if your uncle has not previously withdrawn or retired from any other retirement fund. If he has, then this will affect the tax on his current retirement from his present pension fund.*

* *The 4th option is to leave his funds in his ex-employer’s default fund. Expand on this option in the appropriate module, not this module*

The pension or annuity that he would receive from the compulsory annuity I mentioned before is deemed to be normal income and will be added to any other income he may be receiving and be subject to normal income tax.

If your uncle chooses to place all or part of his pension fund into a compulsory annuity, there are many different types of options, benefits and underlying investments to choose from. This can get a little complicated and understandably this is a big decision. It is important that he meet with a financial planning professional to ensure that he understands the choices available and how this will impact on his own personal circumstances for the sake of his financial security.

Historically, RAs contained lock-in provisions so that members could not access any benefits before reaching the age of 55.  
Even then, they could access only a retirement benefit as contemplated in the act (in other words, a third of the benefit). The other two-thirds had to be used to purchase an income. In addition, members could not belong to an RA after the age of 70.  
In 2008 some of the rules changed and a few small exceptions were introduced. For example, the upper age limit of 70 was removed, enabling members to keep on contributing to the fund past their 70th birthday.

Nowadays, the entire benefit amount in the RA (not only a third) can be withdrawn as a lump sum if the benefitis less thanR15 000 as of 1 July 2021.

Moreover, should a member emigrate, the entire benefit can be taken as a lump sum subject to exchange control. Or, should the benefit in the fund not exceed R75 000, the entire amount can be taken as a lump sum.

In case of divorce, the court can also make an order in terms of which the non-member spouse may be allowed to access a portion of the benefit, subject to certain tax rules.

In the event of a member becoming totally incapacitated due to sickness, accident, injury or infirmity of mind, the trustees may decide to allow the member to take early ill-health retirement. In this case, the member retires in the normal way and becomes a pensioner.

These, however, are the exceptions to the rules.   
In most instances it is not possible to withdraw funds from your RA before you turn 55. If you run into financial difficulties before then, you can stop making contributions and the benefit will stay in the fund and grow until you retire from it.   
Even though you are not contributing, you will still only be allowed to access the money at or after the age of 55.

When you turn of 55, you will in most instances only be allowed to withdraw a third in cash, and you should consider the tax implications before doing so.

RAs are a tax-friendly investment, and for that reason strict rules in terms of the Pension Fund Act govern RA funds.

## 1.8 Historical product - investment linked products (ILP)

Investment Linked Insurance was introduced in the United Kingdom in the 50s at first was nothing else but the combination of a traditional term insurance and a few investment funds. The client regularly paid a premium to the insurer, which had two components of fixed size that the client could also see, namely the premium of the term insurance and the premium part filling the investment funds;

* Death benefit in case of death
* Maturity benefit at the end of the term.

**Investment-linked insurance policies (ILPs) have both a life insurance and an investment component. Y**our premiums are used to pay for units in one or more sub-funds of your choice. Some of the units purchased are then sold to pay for insurance and other charges, while the rest remain invested.

ILPs provide insurance protection in the event of death or if included, total and permanent disability (TPD). Depending on the policy, the death or TPD benefit may comprise the higher of the sum assured or the value of the units in the sub-fund at that point in time or some combination of the two.

The value of these units depends on their price, which in turn depends on the sub-fund’s performance. This is why ILPs usually do not have any guaranteed cash values.

 Investment-linked insurance policies (ILPs) have both a life insurance and an investment component. Find out how ILPs work and what you should know if you are considering whether to buy one.

**Key takeaways**

* ILPs combine life insurance coverage and investment.
* Investment returns are based on the sub-fund’s performance, so you need to select one that meets your investment objectives and risk profile.
* You bear the full investment risk, there are no guaranteed returns.
* Insurance charges are paid for by the investment portion of the ILP. Such charges rise with age and there is a risk that your units may not be enough to pay for them.

Currently, there are no ILPs in South Africa.

## 1.9 Supplementary benefits

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 complementary, 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

The Insured chooses benefits as he/she sees fit, and as per their life/financial situation. Insurers make benefits accessible normally at an additional premium.

There are different forms of supplementary/additional benefits at an insured’s disposal.

Free Standing Benefits: Free standing or standalone cover means that cover stands independently from other covers and that a claim will not have any impact on your death sum insured. For example, if you have R2 million Death Cover and R1million Disability cover and you claim on your Disability cover, the R2 million 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, meaning they are strictly added onto an existing policy. A claim on the benefit may reduce the death benefit .



Accelerated Benefits: Accelerated benefits refers to a clause in certain life insurance policies that enables 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 policyholder 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 is 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 have been diagnosed with an illness that will reduce your expected lifespan, if you need an 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 CPI linked 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 one will have to pay a fee or a percentage of the death benefit.

# LEARNING UNIT 2: THE LONG-TERM INSURANCE ACT 52 OF 1998



**Learning Outcomes**

By the end of this learning unit and having completed all the formative assessment activities, you should be able to:

* Explain the Acts governing insurance, and the rationale for more than one Act
* Discuss the terminology and concepts of the Long-Term Insurance Act 52 of 1998
* Explain the requirements of the Long-Term Insurance Act 52 of 1998 including the Registrar and non-disclosure
* Describe the application of the Long-Term Insurance Act 52 of 1998
* Define basic investment and economic principles.

## 2.1 Regulation of insurance business

An Act is a piece of legislation that gets promulgated as a result of the approval of a Bill by the National Legislature (Parliament).

Parliament, as the national legislature, considers draft pieces of legislation in order to exercise its power to make laws. A draft piece of legislation (called a Bill) must formally be submitted to Parliament before it can be considered a law. 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 or specific industries. (For an example, matters relating to finance, consumer protection, health, housing, public transport and many others).

The [preparation of a Bill](http://www.justice.gov.za/legislation/bills/bills.htm)involves a number of steps, for example the investigation and evaluation of the legislative proposals (which can either be proposed amendments to [existing legislation](http://www.justice.gov.za/legislation/acts/Statutes%20administered%20by%20DOJCD%20%5B30%20Mar%202007%5D%20list.pdf) or proposed [new legislation](http://www.justice.gov.za/legislation/acts/acts_full.html)) and consultation with interested parties.

Thereafter the relevant government department will submit a Cabinet memorandum and draft Bill (containing the legislative proposals that are supported) to the Minister in order to obtain Cabinet approval for the introduction of the Bill in Parliament and ultimately an Act will be promulgated after the Bill is approved in Parliament.

## 2.2 The Acts that govern Insurance and an explanation of why there is more than one Act

The main pieces of legislation that govern insurance and please note they follow an Institutional approach are as follows;

* 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 following are other pieces of legislation that regulate the Financial Services Industry as a whole, which is the Insurance, Banking and Investment Sub sectors;

* 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 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 and the Short-Term Insurance Act 53 of 1998, follows an Institutional approach which regulates specific institutions depending on the types of financial products that they deal with.

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 different insurance products. Therefore, there is a 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.

The above-mentioned Acts ensure that insurers remain solvent and are able to execute their duties to the public, and also to ensure that the insured public is protected.

## 2.3 The Short Term and Long-Term Acts

The Short-Term Insurance Act 53 of 1998 regulates the registration and activities of short-term insurance companies and The Long-Term Insurance Act 52 of 1998 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.

It must be noted that the concept of short-term insurance is discussed in this module to differentiate it from long-term insurance.

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

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. t In case of long-term 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 explained below in detail.

**Indemnity**

One of the most important principles 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. There are, however, certain exceptions to this rule, such as personal accident and life insurance policies where the policy amount is paid on occurrence of accident or death and the question of profit does not arise. Some marine insurance policies also constitute an exception because the settlement of a total loss is based on a sum agreed upon at the time the insurance policy was written.

Indemnity insurance includes insurances such as:

* Fire and natural perils
* Motor vehicle
* Burglary
* Public liability
* Marine insurance, etc.

**Forms of Indemnity**

Indemnity can be provided in the form of:

* **Reinstatement:** The damaged or lost item can also be restored e.g. a building
* **Repair:** Repair is a commonly used when indemnifying motor accidents
* **Cash-in-lieu:** The insured can be indemnified by the payment of cash, which should not be more than what the insured stands to lose financially.
* **Replacement:** Indemnity can be in a form of replacement with an equivalent item rather than in a form of cash

It is important to note that the concept of indemnity is largely applied to short term insurance, and is only discussed hereon to distinguish it from long term insurance.

**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.

Compensation can be done through:

* Disability insurance
* Dread Disease insurance
* Life insurance
* Personal accident insurance
* Health insurance.

**Risk Concept**

Risk in insurance could be described as an uncertainty – this would mean that the event may or may not occur. For example in short term insurance, the fire might burn a house or there may never be a fire at all., Similarly in long term insurance, one may become disabled or never become disabled in one’s entire life. However, in long term insurance, death is the only event that is certain to occur.

The risk covered under long term insurance solely depends on the different policy classes that a particular long-term insurer is registered and authorised to market under the Long-Term Insurance Act. Below are the policy classes as laid down in the Long-Term Insurance Act;

* Life policy - A life policy is an insurance policy for risk cover in which the insurer undertakes to provide benefits on the occurrence of a life event to pay a designated beneficiary a sum of money (the benefit) in exchange for a premium, upon the death of an insured person (often the policy holder)
* Assistance Policy - A policy in respect of which the value of policy benefits does not exceed R30 000, however in practice, cover amounts up to R50 000 are now acceptable for these types of policies
* Disability Policy - This refers to a policy in which the insurer undertakes to provide benefits in return of a premium upon the occurrence of a disability event.
* Health Policy - This refers to a policy in which the insurer undertakes to provide benefits in return of a premium upon the occurrence of a health event.
* Fund Policy - . A policy where an insurer, 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 term of its rules. E.g. Pension Funds
* Sinking Fund - a policy, excluding a life policy, which provides one or more sums of money at a fixed or determinable future date. A sinking fund was introduced to allow business entities to invest via a long-term insurance policy.

**Risk assessment in long term insurance**

Risk assessment, also called underwriting, is the methodology used by insurers for evaluating and assessing the risks associated with an insured life. Underwriting assists insurers in determining whether the insurer should accept or reject carrying the risk of the client. Should the insurer accept the client application then what follows is the calculation of the appropriate 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. It is also known as underwriting factors;

* Age
* Gender
* Occupation
* Education
* Avocations
* Number of dependants
* Health Status
* Pre-existing conditions
* Family Medical History
* Marital Status.

## 2.4 The Long-term Insurance Act

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

**Requirements of the Act**

**2.4.1 The concept of non-disclosure.**

Non-disclosure means the 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 do not, they might be found to be guilty of misrepresentation and the consequence could be the following: the contract can either be declared void or their claim may be denied. Their other obligation is to voluntarily offer information which is relevant to the policy that they wish to enter into. That is disclosure.

The disclosure obligation is an ongoing aspect as long as the policy is still in force., The failure to update the insurer of any changes in the health or any life circumstances of the insured may constitute non-disclosure and which ultimately may lead to the 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.

|  |
| --- |
| **Life insurer rejects R2.4m policy pay-out 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 pay-out which has been declined by the insurer on the grounds that 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.” |

**2.4.3 Registration required in order to carry on long-term insurance business**

Below is an extract from the Long-Term Insurance Act Section 7 Sub Section (1)(a);

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**

**2.4.4 Accessibility to funds**

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%. This does not, however apply to a pure life policy or a disability or illness policy.

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 (applicable to endowments)
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.

## 2.5 The different classes of policies

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.

**Example: Whole Life policy, Endowment 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 R30 000, or another maximum amount prescribed by the Minister; and includes a reinsurance policy in respect of such a policy.

**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.

**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.

**Example; Dread Disease policy, , 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.

**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.

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

**Common terms**

Below are the main concepts in the provision of Long-Term Insurance products.

**a) Insurable Interest**

Insurable interest refers to an insured’s interest or concern in the non-occurrence of the event insured against. In life insurance, insurable interest means that someone would experience financial hardship upon the death of the insured person. This is a basic requirement for a life insurance contract: The person who is purchasing the policy needs to have an insurable interest in the insured person.

**Example:**

If a man’s family is financially dependent on him, they have an insurable interest in the man’s life. This means that they would suffer a financial loss and not be able to meet all their expenses if the man passed away. Without the man’s income, family could not afford some or all of their housing, food, and education costs. Because there is an insurable interest, a policy holder can insure his/her life on a life insurance policy and name his/her spouse or child as beneficiary. If the insured, who is also the policyholder pass away, their beneficiary can use the insurance pay-out to pay expenses like food, school fees and a home loan.

**b) 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 one cannot place a value or a cost of replacement on a person’s life. Instead, the benefits of the long-term insurance policy only reduces the financial burden that has been brought about by the loss.

## 2.6 The parties to a Long-Term insurance contract

**a) Long Term Insurer**

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

**b) Policyholder**

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

**c) 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.

**d) Premium 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.

**e) 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.

**f) Cessionary**

This refers to the person, normally a third party, that receives the rights to the policy through a process called a cession. This can either be temporarily or permanently as indicated below;

There are two types of cessions:

* **Absolute cession:**

This occurs when the policyholder also referred to as the cedent, cedes or transfers all his/her rights to the policy to a third party (the cessionary). The cedent cannot take back his/her rights back in the future.

* **Collateral or security cession:**

This occurs when the policyholder cedes the policy to a third party, normally a financial institution, as security for a debt such as a mortgage loan. The policyholder does not cede all the rights to the policy to this cessionary. The cessionary may only keep the policy as security until the debt has been settled. If the debt is not settled prior to death of the cedent, the financial institution may only be entitled to a portion of the policy equal to the outstanding balance. The policy, provided it still has value, must revert to the original owner. The same applies in the event of death of the cedent prior to settling the debt.

## 2.7 Insuring the lives of children

The Long-Term Insurance Act stipulates the provision of benefits in the event of a child’s death including the unborn insured “life” and “assistance” policy benefits as described below;

**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, R20 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, R50 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.

(2) Subsection (1) shall not apply in relation to a policy in terms of which, in the event of the death of the unborn, or of the minor before he or she attains the age of 14 years, the value of the policy benefits does not exceed an amount equal to the aggregate of all the premiums paid in terms of that policy, plus interest on each premium at a rate prescribed by the Minister, compounded annually.

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 may become vulnerable if their parents or legal guardians face financial hardships.

## 2.8 Life contracts and all other contracts

**2.8.1 Life Insurance Contract definition**

According to the Long-Term Insurance Act, a life policy contract is defined 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.

In essence, a life insurance is a contract between an insurer and a policyholder in which the insurer guarantees payment of a death benefit to the 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.

**2.8.2 Characteristics of a life insurance contract**

* The purpose of this life insurance contract is to provide financial protection to surviving dependents after the death of an insured. Therefore it is solely meant to provide a death benefit.
* A 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 upon 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 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.

## 2.9 The life insurance contract and insolvency

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.

**2.9.1 The minimum terms of a contract**

An insurance contract is a legally binding agreement between the insurer and the insured in terms of 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 a claim, for a determinable amount of money promised to the policyholder or beneficiaries of the insured as the case may be. These guidelines ensure that every party is safe and protected if the insurance is entered into. Each contract is unique ; however, there are certain 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 the premiums at 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 business relationship 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 one has to agree that client is 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. 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, or misrepresentation regarding smoking status.

**2.9.2 Increasing policy premiums**

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 policyholder 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 pressure to ensure that their clients will get sufficient cover at the 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 circumstances changes for the worst living him/her being high risk to the insurer. Existence of anti-selection (a situation where people only seek cover at the point they really need it) and fraudulent claims also lead to increase in premiums.

## 2.10 The five funds approach

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 regards to the policyholder funds, the insurer acts as a “trustee” to collect taxes 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 and not the policyholder pays the tax over to SARS . 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 funds**

UPF - Untaxed Policyholder Funds (Taxed at 0%)

This applies to entities 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 not natural persons.

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.

However, there was an amendment to the Section 29A of the Income Tax Act from using the Four Funds approach to now using the Five Funds approach from 1 January 2016.

The taxable income derived by any insurer in respect of any year of assessment must be determined in accordance with the Act, but subject to sections 29A and 29B. Every insurer is required to establish five separate funds and to maintain such funds. These funds form the foundation for the operation of section 29A of the Income Tax Act as a whole.

The taxable income derived by an insurer in respect of the;

* untaxed policyholder fund,
* the individual policyholder fund,
* the company policyholder fund,
* the corporate fund and
* the risk policy fund must be determined separately in accordance with the Act as if each such fund had been a separate taxpayer.

The risk policy fund was introduced as one of the five funds because of concerns that the taxation of insurers under the previous four funds did not distinguish between investment and risk business. In practice, a risk policy will pay out a specified cash amount on the happening of an event regardless of the amount of investment income earned during the term of the policy. This could result in a loss in respect of a specific policy.



***Facts***

A disability policy is issued for R500 000 in year 1.

The policyholder becomes disabled in year 4.

During the duration of the policy, the policyholder paid premiums of R36 000.

The policyholder received a cash payment of R500 000 when he became disabled.

***Results***

Ignoring other expenses such as sales commission and the cost of administering the policy, the disability policy will result in a loss of R464 000 for the insurer.

Profits or losses arising in respect of risk business should therefore not form part of the tax calculation of a policyholder fund since it is not part of the investment business that should be taxed on the trustee basis. It should be taxed in the corporate fund.

Section 29A of the Income Tax Act was thus amended to provide that risk policies be taxed in the risk policy fund with effect from 1 January 2016.

# LEARNING UNIT 3: DISABILITY INSURANCE



**Learning Outcomes**

By the end of this learning unit and having completed all the formative assessment activities, you should be able to:

* Explain the concepts of occupational disability and physical impairment
* Explain the income generation concept and risks associated with selected occupations
* Describe Occupation and Avocation risks and the effects of job function changes
* Conduct a needs analysis to determine sources of income and cover needs of a client.

Disability Insurance Glossary.

This glossary can be used as a reference for commonly used disability insurance terms.

|  |  |
| --- | --- |
| **Active, full-time employee:** | An individual must work for the employer on a regular basis in the usual course of the employer’s business to be considered an active, full-time employee and thus be eligible for coverage. Usually, a minimum number of hours of regular work are specified. |
| **Benefit percentage:** | The percentage of the insured’s pre-disability income, up to an overall maximum benefit amount, that will be the amount payable to the insured upon disability. |
| **Benefit Period** | : The longest period of time for which benefits are payable for continuous disability. |
| **Definition of total disability:** | Arguably the most important provision in the disability contract. The definition of total disability is used to determine an employee’s eligibility for benefits. |
| **Own occupation** | A definition of disability which states that as long as the insured is unable to perform the duties of his or her regular occupation(s) at the time of disability, the insured will be considered eligible to receive the full benefit under the policy. |
| **Any occupation:** | An insured will be considered disabled only if he or she is unable to work in any occupation for which he or she is qualified by education, training or experience. |
| **Disability** | An individual’s physical or mental inability to perform the major duties of his or her occupation because of sickness or injury. |
| **Waiting period:** | The period of time between the date the disability commences and the beginning of the benefit payment period. It is the period during which an employee must be disabled before payment of benefits begins. |
| **Exclusions:** | Certain conditions and causes that are not covered by the policy. These are listed in the policy. For example, a plan will typically exclude coverage for disabilities resulting from war, participation in a riot, commission of a felony or a self-inflicted injury. |
| **Limitations:** | Specific provisions included in the group disability policy that limit coverage in certain situations. For example, often only limited benefits are payable for disabilities caused by mental illness and pre-existing conditions. |
| **Maximum benefit period (benefit duration)** | The maximum length of time for which benefits are payable under the plan as long as the employee remains continuously disabled. |
| **Maximum monthly benefit:** | The highest rand amount a disabled employee can receive on a monthly basis under the long-term disability policy. |
| **Minimum monthly benefit:** | The minimum amount paid as a monthly benefit after deductions for other income benefits (see below). |
| **Aggregation of benefits** | While disabled, an insured may be eligible for benefits from other sources. Benefits payable under the group long-term disability plan may be offset by other sources of disability income (Social Security, workers’ compensation or other disability benefits). |
| **Partial or residual disability:** | An insured’s physical inability to perform some, but not all, of the duties of his or her regular occupation due to sickness or injury. |
| **Pre-disability earnings:** | The amount of an employee’s wages or salary that was in effect and covered by the plan on the day before the disability began. |
| **Pre-existing condition limitations** | : Most plans exclude or reduce disability benefits for any illness or injury for which an employee received medical treatment or consultation within a specified time period before becoming covered under the plan. |
| **Sickness** | : A sickness or disease, which is first diagnosed and treated while the policy is in force. |
| **Total disability:** | The physical or mental inability to perform the major duties of one’s occupation because of sickness or injury. |
| **Waiting period (for plan enrolment eligibility)** | A specified number of continuous days of service as an active, full-time employee that an employee must satisfy in order to become eligible for coverage under the group disability policy. |
| **Waiver of premium** | A provision that [allows](https://www.collinsdictionary.com/dictionary/english/allow) the [insured](https://www.collinsdictionary.com/dictionary/english/insure) not to pay premiums during a period of disability that has [lasted](https://www.collinsdictionary.com/dictionary/english/last) for a particular length of time. |

## 3.1 Concept of disability insurance

One of the important assets a person has is their income, or at least your ability to work and earn the income. If you are involved in an accident or suffer from a long illness, you may lose your ability to earn income. With no source of income, you and your dependents become financially crippled, and may become dependent on others for your wellbeing.

Disability can happen anytime, to anyone and is not discriminatory. There is no telling how long such incapacitation will last.

Insurance that covers the financial implications of such unfortunate and unforeseen scenarios is useful. Life could surely be tough without an income, what more with no income and being disabled!



(Collen Daniel; www.iol.co.za)

Disability insurance is a type of insurance that will provide an income in the event that an employee 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 waiting 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 an employee’s income when they cannot work because of an illness or disability. For the most part, disability insurance will not replace all of someone's income. Instead, disability insurance provides wage replacement benefits that cover, on average, up to 75% of an employee’s earnings.

Disability insurance covers everything from total to partial disability to disability so severe that the insurance company presumes that you will not 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 waiting 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 – measured against qualifications, experience etc. Obviously, the "any occupation" definition is stricter. All else equal, the policy with the strictest 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.

## 3.2 The purpose of disability insurance

Disability insurance is like insurance for your pay cheque. If you become disabled and can no longer do 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.

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 is no mystery or confusion.

**Coverage for total disability**

When you think of disability insurance, you are probably thinking of coverage for total disability. Total disability coverage means you’ve become injured or ill and [lose your ability to earn income](https://www.policygenius.com/disability-insurance/learn/do-i-need-disability-insurance/). Your disability insurance will pay you benefits each month until you recover or [your coverage expires](https://www.policygenius.com/disability-insurance/how-long-do-long-term-disability-insurance-benefits-last/), which should help pay the bills and maintain your standard of living.

Make sure you are getting enough coverage. Your monthly benefit amount should be about 75% of your pre-tax income, or roughly equal your take-home pay. You may be able to purchase more coverage as needed [or add a rider](https://www.policygenius.com/disability-insurance/what-disability-riders-do-you-need/) to cover increases in the cost of living.

Total disability means being unable to continue working at your job, but make sure your policy’s definition of disability is [**own-occupation**](https://www.policygenius.com/disability-insurance/own-occupation-disability-insurance/). An own-occupation policy means you only have to be so disabled that you cannot work for the job you had at the time of your disability.

The alternative, an **any-occupation policy**, means you have to be so disabled that you are unable to do any job, which could make it difficult for some people with serious medical conditions to qualify.

**How disability insurance can help one’s recovery**

The insurer may cover the **costs of an insured’s rehabilitation** to help them recover from the disability. Such expenses include training and care expenses as well as for modifications to home, vehicle, or workplace. The sooner an insured can go back to work and start earning an income again, the sooner they no longer need to rely on disability insurance benefits.

Other insurers offer **retraining benefits**, which may pay for the cost of going back to school to brush up on your training if you’ve been disabled for a long time. Retraining benefits cover expenses like tuition, books, and equipment, and can be used for vocational and business school. It must be noted however that in South Africa, lump sums or a monthly income is paid and the insured must apply these funds to whatever he/she wants to. Providers are not paid directly

Disability insurance may also provide cover after the insured has recovered from a disability. Like partial disability coverage, a small amount of **recovery benefits** may be paid for a period of time if your disability causes one to lose a percentage of their income.

**Disability insurance coverage for pregnancy**

Your insurer should cover complications resulting from pregnancy and childbirth. Sometimes, this could mean conditions that don’t show up until weeks or even months after you give birth.

However, you may not be able to receive coverage for a normal pregnancy, even if you miss work during your pregnancy or for maternity leave. Others that do offer coverage for normal pregnancy require that you have an elimination period and benefits period of 90 days or longer.

**Disability insurance coverage for mental illness**

Certain types of pre-existing conditions may be excluded from coverage. Some insurers include mental illness among these exclusions, including anxiety, depression, and other types of nervous disorders.

Some insurers also offer coverage for disabilities caused by alcohol and drug abuse, but coverage may be limited. If you abused these substances prior to taking out the policy, they may be excluded from coverage.

If your mental illness is not excluded, or if it developed after taking out the policy, you may be able to receive disability benefits if it causes you to lose your ability to earn an income. However, ask your disability insurer how long you can receive benefits. Some insurers only cover mental illness for a set period of time that may be much less than your benefits period, after which disability benefits will stop.

**What’s not covered by disability insurance?**



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.

|  |
| --- |
| There are two types of occupational disability which you, as the financial advisor need to discuss with a client: |
| 1. Own occupation disability (OOD), which is cover for customer’s own current job – the benefit is payable if one cannot do a specific job. For example, a surgeon suffers 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  own or similar job – the benefit will only be paid if the insured is unable to perform his/her job or any other reasonable job. So, using the example above, if the surgeon has the experience and training to become a lecturer, but is unable to perform his usual job as a surgeon, then he will be expected to take up the position as a lecturer resulting in his claim not being paid.   **CASE STUDY: HOW INCOME PROTECTION HELPED GARETH**  Posted July 22, 2015 www.1life.co.za/blog  Gareth Griffiths was training for the Argus Cycle Tour, preparing to face the challenges of the gruelling race. He didn’t anticipate that a freak accident would leave him facing challenges of an entirely different nature.  One Saturday morning, on the home stretch of his training route on Chapman’s Peak, he lost control of his bicycle on a corner and collided with a granite rock face at the side of the road. He managed to break the fall with his arm, but ripped all the ligaments and some tendons in his shoulder in what would later be described as an “inferior compound dislocation” by the emergency room doctor.  He was found by a passer-by who called the emergency services. Later, at the hospital, he learnt that he would have to have an operation to repair his shoulder. A day later, the doctors discovered that he’d broken the wrist on his other arm as well. After four days in hospital he was allowed to go home, but this was really only the beginning of his recovery.  With one arm immobilised in a cast and the other in a sling, Gareth couldn’t do a thing for himself for the first few weeks after the accident – he couldn’t eat or shower, and he certainly couldn’t type on a computer or drive a car to meet with his clients.  As a freelance media consultant and photographer, this meant that he wasn’t able to earn an income while both his arms were incapacitated. Gareth has two daughters, and his wife’s income couldn’t cover the family’s expenses.  Fortunately, Gareth had weighed up the impact that an accident like this could have on his earnings, and he had taken out income protection cover. This meant that in the first weeks after his accident, his income was replaced entirely by the insurance pay-out. In the subsequent four months it took for him to be able to resume full-time work, the insurance was paid out on a sliding scale, taking into account how much he could earn for himself.  Gareth says that the experience taught him a number of valuable lessons. He remains convinced that it is vital for people who earn an income and have a family that relies on them to have a decent medical aid and an income protection policy in place. Although this accident didn’t leave him permanently disabled, he believes it’s also important to have life insurance, dread disease cover and disability cover.  But for a self-employed individual, coming back to work isn’t simply about sitting down at a desk and waiting for the income to roll in. Gareth found that in the four months that he’d been unable to work, he had lost a few of his major clients. In fact, it took about ten months for the true financial impact of the accident to become apparent. “Our resources were drained and we nearly ended up in trouble,” he recalls.  This highlights the point that even with good medical cover and life and disability insurance in place, it is vital for people to have decent savings, so that in a financial crisis there are resources that can support them.  Since his recovery, Gareth has restructured his client base so that he’s not as reliant on a single source of income. “The lesson for me was not to put all my eggs into one basket. So, I’ve been trying to do lots of small things to bring in income as a result of the accident.”  Gareth was extremely lucky. His shoulder and wrist were badly hurt, but he made a full recovery. As for his finances, they have recovered because of luck of a different kind – the kind you make yourself. Because Gareth had taken the financial steps to safeguard his health, his income and his family, he was able to walk away from the accident without any permanent financial scars to show for it. |

## 3.3 Physical impairment

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

The claims 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.

**Disability pay-outs**

Disability and dread disease cover provide for the replacement of income as well as for additional expected medical costs as a result of becoming disabled or contracting a dread disease or critical illness. Unlike death cover, disability and dread disease cover is aimed at providing benefits to keep a standard of living during a client’s lifetime.

* 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.
* Benefits can only be received if client is deemed to be disabled in terms of the definition of disability specified in the policy or Group Life Benefits.
* Generally, there is a waiting period of 3 - 12 months before benefit will be paid out. This period will vary depending on the policy or Group Disability Scheme.
* Client should ensure that he has emergency funds set aside to provide 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.

Income benefits were traditionally paid until an expected retirement age, typically 60 or 65. As 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 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 insurer 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 whole life cover.

Temporary cover only pays out for a temporary period. This makes it affordable. Once the claims start to pay, they only pay for a certain period such as six, 12 or 24 months.

Temporary cover is vital for self-employed people who don’t enjoy the benefit of paid sick leave, and who can suffer loss of earnings as a result of disability.

Temporary cover benefits may be paid for a disability from which one will recover or for a disability which is later confirmed as permanent.

If disability is not permanent – for example, if the insured is a tour guide and had a knee replacement and could not drive for six weeks – he/she would not be able to claim on a policy that offers cover only for permanent disability since it is likely he will have a full recovery after the surgery.

Disability benefits are typically also subject to waiting periods – during which benefits are not paid. The longer the waiting period, the cheaper the premium, up to 24 months.

The Association for Savings and Investment South Africa (ASISA) which represents the collective interests of the country’s asset managers, collective investment scheme management companies, linked investment service providers, multi-managers and life insurance companies, cautions that when choosing the waiting period on a policy, the insured must consider how long they can be off work without losing an income. Many salaried employees have at least 30 days sick leave and will only experience a loss of income after being disabled and unable to work for more than a month.

**Note:** A copy of ASISA guidelines have been included as part of the training materials

If one is entitled to sick leave, they could select a one-month waiting period on a policy which means it will only start paying in the event of being off work for more than a month.

Lump-sum disability policies have a six-month waiting period to establish whether the disability is permanent. Insured needs to follow all reasonable medical advice and undergo reasonable treatment until the maximum medical improvement is achieved.

**Aggregation of benefits: in case of over-insurance**

The principle of aggregation may be applied in case of over insurance. Over-insurance occurs when a client is insured in excess of their determinable income requirements. The objective of this purpose is to ensure that disability insurance compensates the individual only for the inability to work.(, due to ill health or disability), and does not incentivise the insured to stay at home rather than go back to work.

Aggregation effectively combines all a client’s disability benefits as well as post-disability income to ensure that he does not receive more than 75 to 100 percent of their pre-disability earnings while disabled. The rationale is to limit the incentive for opportunistic clients to claim. This is done to provide an incentive for clients to go for rehabilitation, recover and return to work, since they earn more by being at work.

A client should not be placed in a better position, or be enriched, through a disability claim so it would be financially more attractive for him or her to stay at home rather than go back to work. The benefit may cause anti-selective behaviour as an individual with a higher-than-average likelihood of claiming could potentially buy as much cover as possible in order to profit from likely future claims. Excessive benefits could in themselves create an incentive to claim.

Creating a ceiling  
A ceiling is therefore placed on the total amount payable for disablement regardless of the number of policies purchased. This is based on the principle that people should at all times be incentivised to go back to work where possible. It is important to note that the policy covers the ability to work and not the ability to find work.

The Association for Savings and Investment SA’s (ASISA) Code of Good Practice for Disability Insurance (Chapter 3) illustrates the factors that can be used to determine the amount of disability cover a client is allowed in terms of their age.

Establishing over-insurance  
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 financial planner 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.

**Aggregation**

At claim stage, other sources of disability cover would be determined and if the client failed to disclose this information regarding the additional cover when taking out the policy, the proceeds from the claim may be reduced and the insurance companies involved in the disability claim could share the reduction of benefits amounts amongst themselves.

Aggregations take into account all forms of disability cover, including disability income benefits (PHI), occupational disability, impairment and group life benefits.

When calculating the disability cover allowed, details such as how many income earning years to retirement age should be factored in. The particular needs for business assurance, personal cover and cover in respect of debt are considered in setting the maximum allowance.

The methods used to determine the maximum allowance do not replace the necessity of a thorough individual needs analysis that includes all income as well as the impact of disability on that income. It also factors in all disability cover, including group cover that is in force. Only then can the need for further cover be ascertained.

The Association for Savings & Investment SA (ASISA) outlines the various types of aggregation:

* Aggregation with disability benefits provided by a number of insurers: insurers will reduce their payments proportionately to ensure the sum of all payments does not exceed the agreed percentage of pre-disability earnings to be replaced.
* Aggregation with lump-sum disability benefits: some insurers may aggregate your income benefits with your lump-sum benefits. This is done by converting your lump sum to a monthly amount depending on your age at disability and expected duration to retirement and adding this to your disability income benefit to ensure income does not exceed the agreed percentage of your pre-disability monthly earnings.
* Aggregation with group risk benefits: if you are a salaried employee, you probably belong to a group scheme which provides between 60 and 75 percent of pre-disability earnings on a disability event. If you buy additional income benefits, you need to understand the impact. Aggregation will usually result in reduced benefits being paid. However, it is important to know whether your employer’s group risk scheme allows for a continuation of cover should you leave your employer. If not, there may be good reason to have additional cover in your own capacity, even if there is some element of over-insurance.
* Aggregation with post-disability earnings: sometimes disability does not lead to a full loss of income; you may continue to earn a partial income if partially disabled. You also need to understand how post-disability income will be treated by your insurer.
* No aggregation: sickness benefits are usually not aggregated against post-disability earnings or disability benefits from other insurers.

## 3.4 Free-standing disability vs linked disability cover

Disability insurance can be purchased as a separate policy with its own underwriting, terms and conditions and a premium arrangement, or it can be an auxiliary benefit complement to a life policy.

Free standing cover or standalone benefits means that the disability cover stands independently from other benefits and that any disability claim won't have any impact on the death sum insured. For example, if you have R2 million Death Cover and R1 million Disability cover and you submit a claim against your Disability cover, the R2 million Death Cover remains untouched. Free Standing disability cover is underwritten separately, and may attract a separate premium on a policy.

Linked disability is a pure supplementary benefit on a life policy and is, sometimes referred to as an accelerated benefit. When they are accelerated, it means that if you submit a claim for the R1 million Disability cover, your Death cover is reduced to just R1 million. Because of this you will pay a reduced premium for accelerated benefits which makes it more affordable.

## 3.5 Income generation for the disabled

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 impacted 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:

* your health history
* your insurance application history
* your occupation
* your income
* your prescription drug history
* your “fun” activities
* 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 these usually have the highest risk of injuries or illnesses., for example, using a risk ranking of 1 to 6, with 1 being adverse risk and 6 the good or desirable risk;1 to 5 (or 6) with 5/6 being the best, a ranking of 5 attracts a lower premium compared to a ranking of 1 or 2. Moreover, the lower the disability risk, the lower the premium, all things being equal.

That means a skilled tradesman should still enter or consider a policy, even if they have to pay a higher premium compared to that of an accountant. Why? A disability can strike anytime. While occupational disabilities happen – and they happen often – they are not the number one disability. As mentioned earlier, illnesses cause a significant number 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 that you'll become disabled and the probability that it will have to meet these disability claims.

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 and under what terms and conditions it can be so 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 medical conditions- present and pre-existing and its implications to the risk and the underwriting decisions.

**Risk associated with Occupation**

One’s occupation can be classified as a risk factor 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 higher risks, and may attract premium loadings, while desk-based office functions are considered less risky.

## 3.6 Industry developments: traditional vs innovation



Disability, like other insurance products have taken some time to evolve. . 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, like cancer, heart attack and diabetes. Trauma also contributes significantly to disability statistics and claims. There is growing 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 the introduction of mobile applications have enhanced the flexibility of 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. This is possible where the Pension or Provident Fund is linked to group life benefits which may be approved and unapproved.

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, assists in the rehabilitation of an employee. This ensures that once rehabilitated, the employee is able to resume their job functions .

A disability benefit may take the form of a lump sum (which is normally 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.

## 3.7 Occupation and avocation risks and cover

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 risks associated with occupations has been discussed above. An insured’s occupation may increase the probability of a disability, and in this case would be considered high risk. Occupations scheduled as high risk are likely to also be classified as undesirable risks and, to be approached with caution by insurers. Such jobs attract higher premiums and may have stricter 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. Somtimes 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 affects 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 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, it is important to 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 pricing of premiums.

Mountain 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., The former 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 likely be loaded provided it’s within the client’s qualifications. However, cave diving, potholing and the like can carry an additional loading or even an exclusion.

Aviation  
To ensure a fair rate and appropriate cover, aviation rates should be individually calculated by an actuary according to the client, who is an experienced commercial pilot, personal experience . 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 includes 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.

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.

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.



Ryan R. lost both of his parents last year to a tragic car accident.  Obviously, he was distraught. To deal with this monumental loss, his doctor prescribed him anxiety medication. He filled his prescription and took the medication for several months.

After the pain of losing his parents subsided, he no longer needed to take the medication.  Two years later, Ryan applies for a disability insurance policy.

More than likely, Ryan is going to have a mental/nervous exclusion applied to his policy.  Because his anxiety was brought on by acute circumstances, he might be able to get the exclusion lifted after a few years.  Of course, this assumes that he doesn’t miss any work due to his previous condition, has no other anxiety issues, and is no longer on any medication.

A disability insurance policy may also include certain limitations. These are similar to exclusions except that instead of completely limiting coverage to certain conditions only, the policy may limit benefits in certain circumstances. Like exclusions, some insurance company limitations are general, while others may be added to a specific policy based on the applicant’s underwriting.

One of the more common limitations are disabilities that are caused by mental illness or anxiety. Many policies that pay disability benefits for 10 years or to age 65 may limit the benefit period for mental illness to 12 months or two years.

The underwriter may also consider some of the underwriting conditions risky enough to limit coverage. For example, the company may limit benefits period to 10 years because of a pre-existing health condition, even if the client applied for benefits to age 65. Some policies may also limit the client’s ability to purchase additional coverage in later years without going through the underwriting process.

The presence of exclusions and limitations is an important reason why one needs to get disability insurance quotes from multiple insurance companies, and not just compare price and features.

It has been noted that it is the Job function, the actual duties engaged by the insured and not just the job title that are important in the determination of occupation classes, and therefore risk bands. Those who have split duties, such as business owners and managers, are more difficult to classify. It is important to establish all of the duties and the percentage of time spent at each to properly classify the occupation class.

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 is significantly reduced. These may include less or no interactions with criminals, travelling and, firearms.

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

## 3.8 Holistic financial planning

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. Income, or the capacity to earn income is one of a client’s greatest 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 a person can’t physically work, when they are 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 avoid.

Disability coverage usually only replaces 75 percent of income, clients may not rely on it completely. It can also be one of the most expensive insurance policies, depending on the level of coverage, age, and income and whether or not there is the option to buy it through an 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 a client gets, as likelihood to get hurt and rendered unable to work increases. In that case, it might be better to increase emergency funds and to keep saving aggressively for retirement.

Traditionally employed clients may be offered disability insurance either for free or at a greatly reduced price. Some employers include a certain amount of disability coverage in their benefits package.

However, people who do not have access to disability insurance through work often have to pay expensive premiums for coverage from the life insurance companies.

**Other options**

If you cannot afford disability insurance, there are other ways you can protect yourself and your family if you become unable to work.

The easiest and most common way is to save for an emergency fund with at least three months’ worth of expenses. If you have children, a mortgage, or are the sole provider, you should save a year’s worth just to be safe.

Not sure how much your regular expenses are each month? Go through your bank and credit card statements and calculate how much you spend on the essentials. Include rent, groceries, childcare, insurance, gas, utilities, internet and pets. Don’t include discretionary costs such as house cleaners, concerts or restaurants. You can live without those if you lose your job and need to cut back.

Then, add up how much you have in liquid savings. This includes your savings account or any cash you have stashed in the house. Divide that amount by how much your necessary expenses cost each month to determine how many months’ worth of expenses you have.

If you don’t have a solid emergency fund, focus all your efforts to building one up. You never know when you might lose the ability to work; it’s better to be prepared now.

# LEARNING UNIT 4: FRAUD IN THE LONG-TERM INSURANCE INDUSTRY



**Learning Outcomes**

By the end of this learning unit and having completed all the formative assessment activities, you should be able to:

* Explain with authentic examples the concept of fraud in the Long-term insurance industry.
* Identify the legislation governing fraud as applied in Long Term insurance
* Describe a long-term insurer’s internal policy relating to fraud
* Identify and discuss fraud trends in the industry
* Identify and discuss possible control measures that could be used to manage fraud.

## 4.1 Concept of fraud



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.

*The well-known South African criminal law jurist, C R Snyman, explains fraud as “…the unlawful and intentional making of a misrepresentation which causes actual prejudice or which is potentially prejudicial to another.”*

Insurance Fraud generally refers to the wrongful or criminal deception visited upon 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. But 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.

Therefore, Fraud comprises the following elements:

* **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 i.e. non-disclosure.
* **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 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.

## 4.2 Forms of fraud

**Faked own death**

Faking of one’s own death maybe more difficult than it seems. An example involved a Joe Doe who faked his own death in a canoeing accident, leaving his wife to collect the insurance money. He lived next door to her for six years before being found out. The two were sentenced to six years in prison.

**When things are going poorly at work, get retrenchment cover, quick.**

Companies don't usually go under (fail) without any warning. Often employees can see the future, and try to prepare for it. But the more people there are who can be vigilante and can alert the insurance industry or authorities, the less likely they are to get cover.

The insurance industry has grown pretty good at spotting a sudden spate of applications for retrenchment insurance from a particular employer. When that happens, such application is likely to be declined.

**Die suddenly and unexpectedly – suspiciously soon after taking out a life insurance policy.**

People who die soon after taking out life insurance sets off alarm bells. There was a case recently of a 44-year-old who died within a month of the policy commencement, seemingly of natural causes. The insurance company later found that its supposedly healthy policyholder had a history of chronic renal issues as well as hypertension.

It is possible for something like that to go undiscovered, and claims are paid if there isn't any evidence of non-disclosure.

**Get the insurance first, and only then the test.**

Some people get life insurance – and only then do they get tested for HIV.

The signs are there, the symptoms are there, then before they get tested people get insurance.

If it can't be proven that the person knew they had it the insurance will pay.

**Listen carefully at church, and don't let a death go to waste.**

Attempts at fraud in funeral-cover claims – which in 2016 made up more than 80% of all attempted life insurance scams – almost always revolve around what the industry terms misrepresentation of insurable interest. In other words, people taking out policies on people who aren't family members, and sometimes little more than acquaintances.

Quite often, acquaintances from church. It is a proven fact that, in times of really bad health, people tend to turn to their congregation or religious leaders for consolation.

The knowledge of the probable impending death of another can seem like an opportunity for some and one where work colleagues and fellow church members in particular, tend to try to exploit.

**Areas of industry where Fraud is prevalent + parties involved**

**Media Release**

**Association for Savings and Investment South Africa (ASISA)**

**9 December 2020**

**Life insurers report a marked reduction in irregular claims for 2019**

South African life insurers detected 2 837 fraudulent and dishonest claims to the value of R537.1 million last year.

The 2019 fraudulent and dishonest claims statistics, released this week by the Association for Savings and Investment South Africa (ASISA), show a marked reduction in both the number of irregular claims detected as well as in the value of these claims.

According to Megan Govender, convenor of the ASISA Forensics Standing Committee, the number of claims identified as either fraudulent or dishonest in 2019 dropped by 20% from the 3 708 detected in 2018. He adds that the value of the irregular claims in 2019 was less than half the R1.13 billion recorded in 2018.

Govender describes the drop in fraudulent and dishonest claims as good news for both consumers as well as for the life industry.

He says when consumers take out a long-term insurance policy, they do so to protect themselves and their families against the financial risk of a life event like death or disability. It is the duty of the life insurer to assess the risk of such a life event happening based on the information received from the person applying for cover as well as the prevailing claims rates. “Insurers are expected to put a fair price on this risk protection in the form a premium. If we do nothing to counter fraudulent and dishonest claims, honest policyholders will ultimately end up footing the bill through higher premiums driven by untenable claims rates.”

Govender points out that while life insurers are frequently accused of trying to avoid paying claims, the numbers tell a different story. In 2019, life insurers paid 99% of claims made against fully underwritten individual life policies alone, to a value of R16.7 billion. He adds that in the first half of this year, life insurers also paid claims and benefit payments of R230 billion to policyholders and their beneficiaries.

According to Govender, the highest incidence of fraud and dishonesty for 2019 took place in the funeral insurance space. “Funeral insurance policies do not require blood tests and medical examinations and are designed to pay out quickly and without hassle when an insured family member dies. This makes it tempting for criminals and dishonest individuals to try and access pay outs via dishonest or criminal means.”

**Funeral claims**

Life insurers detected fraud, dishonesty or criminal intent in 1 783 funeral claims worth R54.2 million last year. Govender points out that while there was a marginal reduction in the number of cases detected the value of the claims dropped by more than two thirds from R176.4 million in 2018 to R54.2 million in 2019.

2 www.asisa.org.za 2019 2018 Cases Value Cases Value Funeral Claims 1 783 R54.2 million 1 915 R176.4 million Misrepresentation/ Material NonDisclosure 666 R25.6 million 625 R25 million Fraudulent Documentation 1 095 R27.8 million 1 127 R147.5 million Syndicate Involvement 20 R0.8 million 156 R3.5 million Beneficiary Involvement in death 1 R0.02 million 7 R0.4 million Adviser/Broker Involvement 1 R0.02 million 0 0

**Death claims**

Life insurers reported a significant drop in both the number of irregular death claims as well as the value of the claims submitted last year. In 2019, 346 cases worth R271.4 million were detected, compared to 698 cases to a value of R417.3 million in 2018.

Govender says while the significant reduction in fraudulent death claims is good news for the life industry, the increase from 195 to 276 in misrepresentation and material nondisclosure cases is concerning. Misrepresentation and non-disclosure refer to policyholders not disclosing or misrepresenting material information to a life insurer about a medical or lifestyle condition to secure lower premiums or to obtain cover without exclusions.

Govender says misrepresenting material information or not disclosing important information such as any lifestyle or health related detail that could materially affect the terms of the policy, is incredibly short-sighted and likely to have devastating financial consequences for those financially dependent on a policyholder.

Govender points out that policy applicants are compelled by law to honestly disclose all information likely to influence the judgment of the insurer when determining appropriate policy terms and premiums. “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.”

3 www.asisa.org.za 2019 2018 Cases Value Cases Value Death Claims 346 R271.4 million 698 R417.3 million Misrepresentation/ Material NonDisclosure 276 R175.5 million 195 R237.8 million Fraudulent Documentation 62 R93.3 million 481 R171.7 million Syndicate Involvement 7 R0.1 million 7 R3.6 million Beneficiary Involvement in death 1 R2.5 million 0 0 Adviser/Broker Involvement 0 0 15 R4.2 million

**Disability claims**

Misrepresentation and material non-disclosure with the aim to mislead insurers was once again the number one reason for disability claims being declined in 2019. Out of the 447 irregular claims detected, 437 were rejected due to misrepresentation or material nondisclosure. Govender comments that the value of these claims had, however, more than halved in 2019 when compared to 2018.

2019 2018 Cases Value Cases Value Disability Claims 447 R208.7 million 530 R463.9 million Misrepresentation/ Material NonDisclosure 437 R219.6 million 463 R433.5 million Fraudulent Documentation 10 R10.2 million 16 R30.4 million Syndicate Involvement 0 0 0 0 Adviser/Broker Involvement 0 0 0 0

**Hospital cash plans**

Dishonest claims against hospital cash plans dropped significantly in 2019, both in numbers and in value. Govender attributes the decline to increased vigilance by life insurers in 4 www.asisa.org.za recent years, after fraud and dishonest claims threatened to spiral out of control. While in 2010 some 649 dishonest claims against hospital cash plans worth R12.6 million were foiled, only 192 cases worth R1.3 million were uncovered in 2019.

Govender 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. He adds that unfortunately, as is the case with funeral insurance products, the simplicity of these products often leaves them wide open to abuse. This forced life insurers to apply heightened vigilance when processing claims to ensure the financial viability of these products.

2019 2018 Cases Value Cases Value Hospital Cash Plan Claims 192 R1.3 million 519 R3.2 million Misrepresentation/ Material NonDisclosure 191 R1.3 million 517 R3.1 million Fraudulent Documentation 0 0 0 0 Syndicate Involvement 1 R0.02 million 2 R0.1 million Adviser/Broker Involvement 0 0 0 0

**Retrenchment benefit claims**

Dishonest and fraudulent retrenchment claims recorded a slight increase from 46 in 2018 to 69 in 2019. Life insurers declined 61 claims due to misrepresentation and non-disclosure and eight due to fraudulent documentation.

2019 2018 Cases Value Cases Value Retrenchment Claims 69 R1.5 million 46 R1.4 million Misrepresentation/ Material NonDisclosure 61 R1.2 million 39 R1.2 million Fraudulent Documentation 8 R0.3 million 7 R0.2 million Syndicate Involvement 0 0 0 0 Adviser/Broker Involvement 0 0 0 0 5 [www.asisa.org.za](http://www.asisa.org.za)

**Fraudulent and dishonest claims across the provinces**

Govender reports that 33% of all fraudulent and dishonest claims were detected in KwaZulu-Natal, followed by the Eastern Cape with 18% and Gauteng with 13%.

PROVINCE SUB-TOTAL PERCENTAGE KZN 948 33% Eastern Cape 506 18% Gauteng 382 13% Western Cape 225 8% Northern Cape 159 6% North West 110 4% Free State 102 4% Mpumalanga 84 3% Limpopo 77 3% Unallocated 244 8% TOTAL 2 837 100%

Ends

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**Issued on behalf of**:

Megan Govender

Convenor of the Forensics Standing Committee

The Association for Savings and Investment South Africa (ASISA)

*ASISA represents the majority of South Africa’s asset managers, collective investment scheme management companies, linked investment service providers, multi-managers, and life insurance companies*.

*www.asisa.org.za Media Release Association for Savings and Investment South Africa (ASISA) 11 December 2018*

**Life insurers report a spike in fraudulent death claims for 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2017 | | 2016 | |
| **Cases** | **Rand Value** | **Cases** | **Rand Value** |
| **Death** | **2 111** | **564.2 million** | **444** | **275.2 million** |
| Misrepresentation/  Material Non-Disclosure | 316 | 253.3 million | 335 | 228.4 million |
| Fraudulent Documentation | 1784 | 307.8 million | 44 | 34.7 million |
| Syndicate Involvement | 7 |  | 15 | 3.7million |
| Beneficiary Involvement in death | 1 | 821 645 | 19 | 8.1 million |
| Adviser/Broker Involvement | 3 | 2 million | 31 | 213 696 |

**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 dies. 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2017 | | 2016 | |
| Cases | **Rand Value** | Cases | **Rand Value** |
| **Funeral Claims** | **1 025** | **34.9 million** | **11 302** | **168.3 million** |
| Misrepresentation/  Material Non-Disclosure | 755 | 23.7 million | 10 885 | 145.2 million |
| Fraudulent Documentation | 232 | 5 million | 344 | 20.8 million |
| Syndicate Involvement | 28 | 494 526 | 71 | 2.3 million |
| Beneficiary Involvement in death | 10 | 5.7 million | 2 | 55 000 |
| Adviser/Broker Involvement | 0 | 0 | 0 | 0 |
|  |  |  |  |  |

**Disability claims**

Misrepresentation and material non-disclosure by policyholders were 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.”

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2017 | | 2016 | |
| Cases | **Rand Value** | Cases | **Rand Value** |
| **Disability Claims** | **775** | **516.5 million** | **621** | **578.8 million** |
| Misrepresentation/  Material Non-Disclosure | 757 | 23.7 million | 617 | 577.6 million |
| Fraudulent Documentation | 17 | 4 million | 4 | 1.1 million |
| Syndicate Involvement | 1 | 267 645 | 0 | 0 |
| Adviser/Broker Involvement | 0 | 0 | 0 | 0 |

**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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2017 | | 2016 | |
| Cases | **Rand Value** | Cases | **Rand Value** |
| **Hospital Cash Plan Claims** | **989** | **6.1 million** | **1 047** | **8.5 million** |
| Misrepresentation/  Material Non-Disclosure | 971 | 5.8 million | 982 | 7.9 million |
| Fraudulent Documentation | 8 | 95 063 | 65 | 592 540 |
| Syndicate Involvement | 10 | 231 985 | 0 | 0 |
| Adviser/Broker Involvement | 0 | 0 | 0 | 0 |
|  |  |  |  |  |

**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 due to fraud. The total value of these claims amounted to R3.6 million in 2017, compared to R2 million in 2016.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2017 | | 2016 | |
| Cases | **Rand Value** | Cases | **Rand Value** |
| **Retrenchment Claims** | **126** | **3.6 million** | **74** | **2 million** |
| Misrepresentation/  Material Non-Disclosure | 113 | 2.7 million | 45 | 791 384 |
| Fraudulent Documentation | 13 | 902 513 | 29 | 1.2 million |
| Syndicate Involvement | 0 | 0 | 0 | 0 |
| Adviser/Broker Involvement | 0 | 0 | 0 | 0 |

**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.

**End**

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## 4.3 Indicators of fraud

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. It is important to note that the mere suspicion or presence of these indicators does not necessarily confirm fraud; a proper investigation with evidence is required to confirm the presence of fraud. 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 claim for a substantial financial loss, for example, it could give the person a motive for insurance fraud. Another red-flag situation is if the claimant purchased a new insurance policy and shortly thereafter submitted a claim . 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 could be 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 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. 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.  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 motorist who suddenly slams 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. This is 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.

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 insurance premiums for everybody else.

Hospital plans have for the longest of times posed a problem in the South African insurance sector. TV ads promise large amounts of cash for every day spent 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.

## 4.4 Legal aspects

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

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.

Insurers may view fraud as a criminal offence, or a civil case, in which the injured party seeks to recover lost value from the perpetrator. Both routes may require imply legal action being taken.

**Consequences of committing fraud**

Generally, there are two different types of insurance fraud that could occur: 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 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 the perpetrator’s 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 insurance industry; it lso costs the economy as a whole. 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 time an 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 becomes known as haven 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 general population may begin to believe that crime pays, which further worsens the fraud situation. The economy misses out on opportunities as other countries and businesses would not want to engage in business deals with corrupt economies

## 4.5 Investigating fraud



Social media is the primary source of information in the investigation of the concerned insured. 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).

The central data bases, enable insurers to record and access information that may be necessary in handling cases of fraud. It is also possible to use other platforms like credit bureaus and information from claims assessors’ and other investigations to gather evidence.

**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. The 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.

**Importance of confidentiality**

When a suspect is under investigation confidentiality is expected from all parties 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 their employment to enable some independence in the information gathering process.

## 4.6 Fraud trends

**KZN is the most dishonest in terms of fraudulent insurance claims**

[*INSURANCE*](https://www.iol.co.za/personal-finance/insurance)*/ 18 DECEMBER 2018,*

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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 dies. 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 were 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 due 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)*

## 4.7 Control mechanisms

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

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 involves 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 speedy and prompt 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 analyses 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 the first detection 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, 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 deal with them.

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 living declines. South Africa is witnessing an increase in “fake deaths” claims.

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 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.

# LEARNING UNIT 5: ROLE PLAYERS IN THE LONG-TERM INSURANCE ENVIRONMENT



**Learning Outcomes**

By the end of this learning unit and having completed all the formative activities, you should be able to:

* Explain the role of actuaries in Long Term insurance, and the use of actuarial reports
* Explain the role of Underwriters in Long term Insurance, and how they protect organisations against anti-selection
* Explain the role of the Claims assessor in Long Term Insurance, and the importance of technical underwriting and legal knowledge
* The functions and roles of reinsurance are explained with examples
* Explain the roles and functions of the actuary, the legal department, the underwriter and the claims assessor in product development.

## 5.1 The role of actuaries in Long-term insurance

Actuaries are professionals who apply mathematics to financial problems. They evaluate the financial implications of contingent events, in other words, events that are not certain to occur. They are often involved in managing the risks that can arise from undesirable contingent events. Actuaries evaluate the likelihood of future events. They also design ways to reduce the financial impact of undesirable events that do occur. To do their work, actuaries must have a high level of technical knowledge. For example, they need to understand the nature of insurance, the risks inherent in different types of assets, the ways in which statistical models can be used, and the legal and regulatory constraints that apply to the business. They must also have good business sense, problem solving skills, and the ability to communicate effectively with others. Their work often affects many stakeholders, so they must be able to balance different interests and observe high ethical standards in doing so.

An actuary is a professional with expertise in the fields of economics, statistics and mathematics, who helps in risk assessment and estimation of premiums, for an insurance business. An actuary also develops the rating tables per each risk bracket and the base premiums which will be used by underwriters to match the applicant’s profile to the appropriate risk bracket.

Insurers require advanced statistical and analytical skills for the evaluation of risks and returns associated with each proposal. Insurance companies employ these experts from the field of economics, statistics, mathematics, risk assessment and management.   
Actuaries play a crucial role in the operation and profitability of any insurance business. They help the firm with their expertise in the 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.

**5.1.1 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.

**5.1.2 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.

Human rights advocates, , insurers, actuaries, insurance regulators and legislators are continuing to grapple these issues,

**5.1.3 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 volatility in income, investment-related issues top the list. Investment actuaries typically focus on strategy development and evaluation and investment risk management.

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.

**5.1.4 Statistics gathered by actuaries.**

Actuaries make use of historical data to develop mathematical models when they come up with premium rates for insurers. Below are the main sources of information used by actuaries;

* [**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 nationals 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 models for risks and loss.

**5.1.5 The purpose of actuarial reports**

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 claim or group of claims not yet paid. Insurers set **reserves** for their entire books of business to estimate their future liabilities. Realistic allocations to reserves, based on expected future trends and taking into account all the company’s existing liabilities, and additional risk capital, based on the company’s business risks are important.

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:

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 into account all of 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:

* profitability and sources of profits (costs, risk, interest)
* claims experience
* cost trends
* technical provisions, in particular principles for valuation
* portfolio development
* profit sharing
* risk capital required for risks, underwriting risks and other risks
* acceptability of long-term rate guarantees
* taking account of embedded options in the contract structure
* 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 into account the current economic and demographic parameters and including profit sharing.

1. **Evaluation of solvency**

Here, a distinction is made between the minimum solvency (statutory) requirements 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, 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.

## 5.2 Underwriters and their role

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 else’s life risk within the group of people being insured. 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 applies any terms and conditions thereof.

**5.2.1 Underwriting information gathered by underwriters.**

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 in 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 one could suffer. This process helps to ensure that there is parity between cover applied for and the actual loss envisaged and helps client 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 live longer than men according to statistics.
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.

**5.2.2 Underwriters and anti-selection**

Anti-selection

This 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.

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.

## 5.3 Claims assessors and their role

Claims Assessors investigate insurance claims 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.

**5.3.1 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 request access to these records. In the case of medical and bank records, you do not sign away your right of consent when you takeout the policy, 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.**

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.

**5.3.2 Determination of Underwriting Profit**

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 lead to extraordinary and numerous claims. Expenses, on the other hand, arise due to operationaleeds, 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.

**5.3.3 Technical, underwriting**

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 safeguard the insurer’s operating licence. Below are the main pieces of legislation applicable 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

## 5.4 Reinsurers and their functions

Reinsurance is "insurance for insurance companies”, in other words a “second layer 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.

**5.4.1 The role of the reinsurer**

There are several reasons for an insurance company to use reinsurance. We will discuss the most important ones.

**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 as 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 (ceding insurer), most jurisdictions recognize reinsurance as a risk managing tool that allows a reduction of statutory surplus requirements.

**5.4.2 Treaty vs Facultative Reinsurance**

The two basic types of reinsurance arrangements are **treaty and facultative reinsurance.**

**a) 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.

Insurance company A would approach Munich Re towards end of 2018 to negotiate Life Insurance Treaty. (Note that treaties are negotiated annually hence they normally run for a year and then renewed thereafter). Munich Re will then evaluate their underwriting and claims process before accepting or declining the Treaty arrangement proposed.

In the case that Munich Re accepts to reinsure Insurance A business, it would mean that for the coming year all risks (policies) underwritten by the insurer will be shared with Munich Re.

Munich Re assumes that Insurance Company A will maintain or improve the underwriting and claims standards.

**Advantages of Treaty Reinsurance**

* The Treaty-method provides obligatory and automatic nature of reinsurance acceptances. The reinsurer cannot decline to accept any cession falling 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 administration and costs as compared to the costs involved in facultative reinsurance.
* The treaty-method ensures a constant and regular flow of business.

**Disadvantages of Treaty Reinsurance**

Disadvantages are very few and some of the minor disadvantages are:

* For big liability insurances or for protection against losses of a catastrophic nature, other methods like Excess of Loss (type of reinsurance where the ceding company is compensated for losses that exceed a specified limit) or Stop Loss (reinsurance under which the reinsurer pays the cedant's losses in any year over a particular percentage of the earned premium) arrangements are better suited.
* Re-insurers cannot usually apply underwriting judgment for each and every individual policies, even though they might have records from the ceding company’s accounts

**b) 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 is normally 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 insurer to another (the reinsurer) 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.

**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 engaging with the reinsurer, they might give the insurer 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 its share.

**Disadvantages of Using Facultative Reinsurance**

* It is administratively expensive as explained earlier
* It is time consuming because the risks are placed individually
* There no obligation from Reinsurers to accept the risk. There is no automatic acceptance
* Commissions may be lower than under treaties because it is too administratively intensive.
* The error factor is amplified in hasty facultative placements
* Cover cannot be confirmed until placement is effected and confirmed.

**5.4.3 Comparison of Facultative and Treaty Reinsurance**

|  |  |
| --- | --- |
| **Facultative** | **Treaty** |
| 1. Each risk is evaluated individually by both the insurer and the reinsurer which makes it potentially costly. 2. The reinsurer is not obliged to accept the ceded risk hence it creates uncertainty. | 1. Risk is accepted per class e.g. as Fire Risks or Motor Risk hence there is no individual risk scrutiny by the reinsurer. 2. The reinsurer is obliged to accept the risk. 3. It is less costly than facultative reinsurance because it’s considered to be bulk business and there is certainty that the reinsurer will get the business from the primary insurer for the next year. 4. One contract encompasses all subject risks hence it becomes cheaper to administer. |

## 5.5 How long-term products are developed

There are many ways to increase revenue within an insurance company. Productdevelopment is the organizational function that involves expanding operations to include forming a new company, writing new lines of business, adding geographical areas, or creating new paths to deliver the current products.

**a) The role of actuaries in the development stage**

**Pricing and product design**

A key actuarial role is to determine the profitability of all products issued by the insurance company. This includes determination of premium rates, development of actuarial models to measure profitability, conducting experience reviews, setting key pricing assumptions such as mortality, and working closely with the product development department. Pricing actuaries will also interact with other areas of the company, which include underwriting, contract development, policy administration, and distribution.

**Design**

Insurers seek to design products that will meet market needs. The risks insured under their products must be ones that are capable of being managed. For example, individuals might be willing to buy a product that would insure them against the risk of unemployment, but if the insurance covered situations where an individual quit voluntarily, it is unlikely that the risk could be managed by the insurer. Of course, products must also be designed in a way that they can be priced appropriately, from the perspectives of both the insurer and its policyholders. Actuaries often play important roles in the product design process. They assist in identifying market needs, for example, through the analysis of sales patterns, competitors’ products, and social and demographic trends. They work with others, such as marketing, underwriting, and investment experts, on product design teams. Their work can involve assessing the feasibility of product design features suggested by others, as well as proposing alternatives for consideration. Actuaries are also involved in designing compensation schemes for the intermediaries that will sell the products. The compensation schemes must be attractive to the intermediaries, affordable, and provide incentives to promote the sale of high-quality business.

**Pricing**

If an insurer is to be successful in the long term, its products must be priced adequately to produce profits. At the same time, prices must be competitive with those offered by other insurers and, for some types of products, non-insurance alternatives. Prices must be reasonable from the policyholders’ perspective, being equitable among various classes of policyholders and bearing a reasonable relationship to the benefits provided by the policy.

There are many factors that must be considered when calculating premium rates that can be expected to produce profits. The costs of the benefits provided by the product design must be estimated, including not only basic claims costs but also the potential costs of any guarantees and options provided to policyholders. Expenses must be accounted for, including commissions, underwriting costs, other policy administration costs, and overhead costs. The prices must reflect the rates of return that the insurer expects to earn on the investment of premiums, as well as expectations about the willingness of the policyholders to continue paying premiums and maintain their policies.. To the underlying cost factors mentioned above must be added the need to produce a reasonable profit margin. In many jurisdictions, insurers are required to maintain capital at levels that are related to the risks inherent in the policies they have underwritten. Even in the absence of such requirements, sound business practice dictates that insurers have adequate capital to support the risks they have assumed.

Accordingly, the profit margins should be sufficient to provide a return on capital that is acceptable to the insurer’s shareholders. Further complicating matters, in some jurisdictions there are regulatory constraints on the pricing of insurance products. Actuaries are often heavily involved in the pricing process, particularly for long term life insurance products. They develop assumptions for the various cost factors, taking into account the design of the product, the insurer’s past experience with similar products, the experience of other insurers, and expectations of future demographic and economic conditions.

Actuaries use models to project future cash flows from the product, solving for the premium rates that will produce the desired profit margins. However, rarely does the actuary’s job end there. The calculated premium rates might be uncompetitive, at least for some potential policyholders, or outside of the constraints set by regulation. In such cases, the actuary may need to adjust the premium rates, for example, lowering them at some ages and raising them at others, or modify features of the product design. The actuary also needs to test the sensitivity of the profit margin to variations in the cost factors. If profitability is too sensitive to certain factors, the product design may need to be changed or an additional premium charged for the risk involved.

**Valuation and financial reporting**

Actuaries are responsible for determining the liabilities associated with any policies issued by the insurer, also known as reserves. This function requires the actuary to set appropriate assumptions for valuation, develop and maintain valuation models, and ensure appropriate controls are in place. Because insurance contract liabilities are a prominent item in the company’s financial statements, actuaries are heavily involved in the financial reporting function. They can also play roles in surplus management, required capital reporting, risk management, and asset-liability management.

**What is Actuarial Risk?**

Actuarial risks are the risks that the assumptions that actuaries implement into a model to price a specific insurance policy may turn out wrong or somewhat inaccurate. Possible assumptions include the frequency of losses, severity of losses and the correlation of losses between contracts. Actuarial risk is also known as "insurance risk."

**Breaking down Actuarial Risk**

The level of actuarial risk is directly proportional to the reliability of assumptions implemented in pricing models used by insurance companies to set premiums.

Life, in general, carries many risks. For example, a homeowner faces a large potential for variation associated with the possibility of economic loss caused by a house fire. A driver faces a potential economic loss if his car is damaged. A larger possible economic risk exists with respect to potential damages a driver might have to pay if he injures a third party in a car accident for which he is responsible. A major part of an actuary's job is to predict the frequency and severity of these risks as they relate to the financial liability for risks taken on by an insurer in an insurance contract.

Actuaries use various types of prediction models to estimate risk levels. These prediction models are based on assumptions, and ensuring those assumptions in a model actually reflect real life is vital for the pricing of all types of insurance.

Flaws in a model's assumptions could lead to premium mispricing. In the worst-case scenario, an actuary may underestimate the frequency of an event. The unaccounted incidents will cause an increase in the frequency of pay-outs, which could bankrupt an insurer.

**Actuarial Risk and Life Tables**

One of the most common risk assessment models – and thus actuarial risk – are life expectancy tables, which are used to price life insurance policies. Life expectancy tables seek to predict the probability that a person will die before his or her next birthday. There are two primary types of life tables used in modern actuarial science – period life tables and cohort life tables.

A period life table represents mortality rates during a specific time period of a certain population. A cohort life table, often referred to as a generation life table, represents the overall mortality rates of a certain population's entire lifetime. For a cohort life table, a population must have been born during the same specific time interval. A cohort life table is more frequently used because it is able to make a prediction of any expected changes in mortality rates of a population in the future. This type of table also analyses patterns in mortality rates that can be observed over time. Both of these types of life tables are created based on an actual population from the present, as well as an educated prediction of the experience of a population in the near future. However, as the weight given to "educated predictions" in a life table increases, the more actuarial risk will be involved with writing insurance policies based on those predictions.

Life tables may also be based on historical records. Historical records often undercount infants and understate infant mortality . The reliability and completeness of those historical records also affect the actuarial risk of such calculations.

**b) The role of the legal department in Product Development**

The Legal area provides valuable opinions on current or upcoming laws in order to ensure that the business of the insurer and its operating model align with the regulations. Its advice is strongly useful since regulations can be evaluated and interpreted very differently within different contexts

The Legal Department regularly assists insurers in the process of drafting policy forms and endorsements, ranging from the preparation of a single endorsement to the creation of policy documents—or even an entire line of product offerings—from scratch. Attorneys identify and monitor trends affecting insurers' underlying exposures, advising insurers concerning the underwriting of specific risks or entire classes of business.  The department assists in the preparation of marketing materials, furnishing real-world claim scenarios drawn from case law to serve as illustrative examples of risks faced by potential policyholders.

It is a crucial responsibility of the legal department to ensure that the wording of insurance policies conform to the laws of the land, and protects the company from unwarranted claims and liabilities. If the legal department is not directly involved in drawing up the legal documents, they advise personnel engaged in drawing up of legal documents, such as insurance contracts.

**c) The Role of Underwriters**

The underwriter plays an integral role in the implementation of just about any business initiative that gets a green light from management.

Most would agree that an underwriter’s perspective is certainly useful when it comes to launching a new insurance product. Here are a few ideas on how that perspective can benefit the company’s product development process.

Most underwriters have their ear to the ground when it comes to broker and client sentiment. Central to the underwriting role is attention to those things that brings in more opportunities to write core products. Obviously, aggressive pricing – often called acquisition pricing – of those core products is one way to bring in more business. But it’s probably not a viable long-term solution to this fundamental business challenge. More likely, broadening the appeal of your company’s products will have a more lasting effect. While efforts toward this broader product appeal can take many forms and involve multiple disciplines, an underwriter’s contribution can be most useful in developing new products and expanding existing ones.

**The underwriter’s contributions**  
**Risk mitigation.** Underwriters participate in the plan design process and formulate guidelines for selecting and pricing coverage for prospective clients. Underwriters act as gatekeepers to ensure adequately priced and fairly selected exposures are entering the company’s books.  
**Know thy self.**It makes sense to develop offerings that fit well within the insurer’s portfolio of products and that complement rather than compete with the in-force block of business. Underwriters can validate whether a product strategy is consistent with the insurer’s identity and mix of business.   
**Voluntary gap products are all the rage now.**There are so many options that it is vital to maintain a focus on serving the bottom line. The underwriting department can determine whether it has the bench strength to handle voluntary products, which requires evaluating low-frequency claim products that are subject to adverse selection, such as critical illness. Maybe the insurer is more suited to a higher-frequency claim product with minimal adverse selection concerns and less underwriting rigor, such as voluntary accident cover.

**Improving overall portfolio persistency will relieve new business production pressures.** What better way to deepen existing relationships as well as broaden the client base than with multiple product lines? We know multiple product bundles make all the business “stickier” and harder to move. An underwriter’s perspective on what to bundle or when to upsell is key to keeping the competition at bay.

**Market intelligence.**The underwriter plays a consultative role in helping sales understand how and why certain product features help or hinder risk mitigation and may influence the final product design. Ultimately the goal is to build a product to sell more business, but writing the right business is equally, if not more, important.

**Knowing the competition’s contracts (including variable benefit options) and understanding your company’s risk appetite are vital.** Consider whether benefit amounts, waiting periods, expected by the market are in accordance with that risk appetite. Building flexibility into the offerings is essential. Pressure to meet or beat the competition may compound adverse selection trends. This area is certainly in an underwriter’s ‘wheel house’ and their input is essential.

**Distribution**. One size does not fit all. A great group life producer doesn’t always make for a great voluntary products salesperson. Underwriters often know who among their producers fills the bill and who doesn’t. Perhaps an existing distribution channel expressed a need for the product. Maybe a currently employed third-party administrator has an enrolment’s function. Enrollers can be worthy producers, too. The bottom line here is that you need qualified producers who are already well-versed in the product’s value proposition and who are able to hit the ground running. Educating and coaching new producers consumes time and resources. Regardless of how quickly you can develop and file your contracts, the experience level of your distribution network will impact your speed to market and product launch timeline.

**Product administration**. Underwriters may not run these systems, but they can be quite familiar with where the warts are. Legacy administration systems often lack the capability to administer the new product from online enrolment straight through to claims. Smooth processing means happy customers and happy management. Modifications will likely have to be made on the fly, so factor that timeline into the process.

**Education**. Consumer education is essential to the success of new products.. Underwriters are in a unique position, situated between the products and the sellers, and they can share their knowledge of and belief in the product with the distributors. Underwriter enthusiasm breeds producer enthusiasm, and knowledgeable and enthusiastic producers should lead to greater group participation percentages. Even so, as important as underwriting involvement is, professional enrollers or dedicated on-boarding teams will typically take the lead in consumer education and enhance the buying experience by assisting those consumers in making educated (needs-based) purchase decisions. The effectiveness of enrolment efforts is the single most important determining factor in the success of these products.  
It takes a team effort to bring new coverage options to the consumer market. The successful execution of such an initiative should generate a number of benefits for your company, and the underwriters’ insights and active involvement can help optimize results.

**d) Role of claims assessors**

Claims assessors work in different types of insurance including property, life and health where they evaluate, investigate and determine the validity of insurance claims. They would be involved in the following:

* Assess a variety of medical, legal and financial information, perform research, conduct inspections, collaborate with other insurance professionals, such as claims examiners and appraisers, and consult with attorneys, physicians and other experts.
* Provide a proactive approach to claims management through quality conversations. Utilise specialists around the business to assess and implement claim strategies.
* Assessors review insurance policies,
* Claims assessors negotiate claims settlements with the insured, authorise payments and defend contested settlements.
* A loss adjuster is a claims specialist appointed and paid by an insurance company to investigate a complex or contentious claim on their behalf. They are responsible for establishing the cause of a loss and to determine whether it is covered by your insurance policy.

The claims assessor understands the cover options, the risk and risk management aspects. 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 what the cost is.

It is mainly due to the fact that they deal with the policy at claims stage that it is vital that they are included in the process of developing products. They work with the underwriters in determining covers and covered events, and require legal support in establishing liability, communicating with customers about claims issues, policy matters and ongoing underwriting developments on existing policies.

Claims assessors usually keep an eye on the industry’s behaviours and establish trends and recommendations which can be used to make both underwriting and legal policy decisions with regards to products marketed by an insurance company.

It makes sense to involve all concerned parties in the process of developing new products, or improving on existing products.

# LEARNING UNIT 6: PRODUCTS OF THE ISSUE OF ABNORMAL RISK



**Learning Outcomes**

By the end of this learning unit and having completed all the formative assessment activities, you should be able to:

* Explain the concept of non-disclosure and its effects on risk making use of examples.
* Identify and explain common self-reported risks and the difficulty they pose when analysing claims
* Analyse a long-term application for cover
* Explain the role of the intermediary and the importance of accurate questioning.

## 6.1 The issue of non-disclosure and abnormal risk

Insurers have a standard risk that is acceptable with normal underwriting. A lot of risk profiles however, deviate from this standard, and these deviations usually increase the likelihood of a claim. An abnormal risk refers to a situation where the probability or threat of death, injury, liability, loss, or any other negative occurrence is unusually high. The elevation of risk may be caused by external or internal vulnerabilities, and may be avoided through pre-emptive action. This type of risk has a higher probability of bringing a claim that may at times be higher than average.

**1.1 Non-disclosure.**

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

***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 than what they were supposed to pay or they will be accepted for cover under circumstances where the insurer would have declined the cover because the magnitude of the risk would have been too high for the insurer to bear.

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 have created 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 condition or diagnosis would have prevented the insurer from issuing the policy in the first place.

In other cases of non-disclosure, the insurer may reconstruct the policy taking into account the increased risk profile and higher premium in order to determine the level of liability on their part (or the level of prejudiced it suffered as as result of the non disclosure) and decide on the extent of claim settlement.

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***This can be further shown by the attached case studies on Annexures 1, 2 & 3***.

**1.3 In case of non-disclosure**A policy wording is the terms and conditions and definitions of insurance coverage as they arewritten 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. It is important to note that any ambiguity in an insurer's proposal form or policy wording will be construed against the insurer.

***Discuss the attached Clientele Life Policy wording with your facilitator as attached on Annexure 4.***

**1.4 Evidence required.**

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.

***Please read the 3 case studies on the Annexures 5, 6 & 7 attached.***

**1.5 Possible materiality for non-disclosure**

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 reports 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.

**1.6 The concept of a reasonable person**

A reasonable person or reasonable man is a hypothetical person of legal fiction further refined through case law.

In South African law, before a person can be judged according to the standard of the reasonable person, the person must first be held accountable. If a person cannot be held accountable, then the standard does not apply at all.

In King v Arbour Town (Pty) Ltd and another it was held that to be successful with a personal injury claim, one have to prove (establish) that another party’s negligence resulted in (caused) significant personal harm or injury. Negligence can be defined as the failure to take reasonable care to avoid causing injury or loss to another person.

The reasonable person test is used to compare the person’s act or omission to the conduct expected of the reasonable person acting under the same or similar circumstances. In the event that the person’s conduct does not meet the standard expected of the reasonable person, the conduct could be considered negligent.

The classic test for negligence was formulated in *Kruger v Coetzee* 1966 (2) SA 428 (A) where the Court stated that liability for negligence arises if a reasonable person in the position of the defendant would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss and would take reasonable steps to guard against such occurrence and the defendant failed to take such steps.



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.

## 6.2 Analysis of long-term application for cover

**6.2.1 Intentional and 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. 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 actual 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, 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 gain 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.

**6.2.2 Possible signs of intent to commit fraud**

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 the aim of benefiting from the insurance benefits yet they are not the nominated beneficiaries.

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.

**Financial consequences of a decision to prosecute.**

* 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.

## 6.4 Role of intermediary

**6.4.1 Accuracy in establishing risk**

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

Therefore, 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.

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.

**6.4.2 Non-Disclosure and the client.**

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, and any other stages, 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 of a lack of adequate information .This might hinder the client from making an informed decision.

**6.4.3 Non-Disclosure and the intermediary**

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

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