CHAPTER 7

REGULATION OF THE SHORT TERM MARKET

Learning Outcomes

When you have completed this chapter you should be able to:

- list the various duties of the short term insurer under the Short Term Insurance Act (1998);
- describe the various statements and accounts that must be submitted;
- describe what must be contained in the statement of liabilities;
- explain why the correct claims estimate is important;
- explain the importance of premium collection with regard to the company assets;
- explain the importance of the solvency margin and how it is calculated;
- detail the solvency requirements in terms of the Act;
- outline the workings of Value Added Tax with regard to premium and claims, including recoveries and third party claims;
- list examples of statutes governing compulsory forms of insurance;
- list the reasons for compulsory insurance; and
- explain some of the differences between state insurance and commercial insurance.

In this chapter we are going to briefly look at the regulation of the short term insurance industry by the government. Much of it is similar to long term insurance, but there are some differences.

7.1 SHORT TERM INSURANCE BUSINESS

Short term insurance is described by the Act as the business of providing or undertaking to provide policy benefits under any of the following short term policies:

an engineering policy relating to the possession, use or ownership of machinery and equipment other than a motor vehicle; the erection of structures and buildings and the installation of machinery;

- a guarantee policy relating to the failure of someone to discharge an obligation;
- a liability policy relating to incurring a liability;
- a miscellaneous policy relating to any matter not otherwise defined;
- a motor policy relating to the possession, use or ownership of a motor vehicle;
- an accident and health policy relating to disability, health or death events;
- a property policy relating to use, ownership or loss of or damage to movable and immovable property not otherwise covered; and
- a transport policy relating to the possession, use or ownership of a vessel or craft for conveying persons or goods by air, space, land or water, or the storage, treatment or handling of goods so conveyed.

This delineation follows current trends in product development in the industry.

The Act also identifies personal lines insurance which are short term business where the insured is a natural person.

You will learn more about these policies in a later topic that specifically discusses the various short term policies.

The Act is subdivided into parts and schedules of which the most important parts of and schedules to the Act are discussed below.

7.2 SHORT TERM INSURANCE ACT

Insurance companies in South Africa have to conform to the Companies Act 1973, as all other companies have to.

However, because of the type of business they conduct and because of the supervision from the Financial Institutions Office, certain exemptions are granted.

7.2.1 ACT

All short term insurers must comply with the Short Term Insurance Act. This lays down various regulations with which insurers must specifically comply. There is a special section dealing with Lloyd's.

AUTHORISATION

In terms of the Act an insurer must be registered to carry on each and every class of insurance business that it conducts.

7.2.2 REGISTRAR OF INSURANCE

The Minister of Finance appoints a Registrar of Insurance to carry out all powers assigned to him by the Act. The Registrar of Insurance operates from Financial Services Board. His duties are wide-ranging and insurers must comply with the following:

- submission of statements and accounts;
- statement of liabilities;
- statement of assets;
- solvency margin regulations; and
- commission rates for intermediaries.

STATEMENTS AND ACCOUNTS

Every registered short term insurer must submit to the Registrar:

within <u>four months</u> after the expiry of each financial year:

- an audited annual return, with full details (including statements of assets and liabilities) as provided by the regulations;

within one month after the expiry of each quarter:

- a spreadsheet showing gross and net underwriting results for each main class of business (Property, Transportation, Motor, Accident/Health, Guarantee, Liability, Contractors/ Engineering, and Miscellaneous);

within six months after the expiry of each financial year:

- a copy of any duly audited account or balance sheet required to be submitted to shareholders in terms of the Companies Act, or other legislation by which it is incorporated.

STATEMENT OF LIABILITIES

The annual statement of liabilities must include:

- the Rand value amount of claims outstanding;
- a reserve of the claims incurred but not reported; in short term insurance provision must be made for claims that have happened, but of which the company has not yet been advised; and
- the estimated liability for taxation.

The reserves may be net of all recoveries from reinsurers.

CLAIMS ESTIMATES

In the short term market an important function of the claims negotiator is to raise an estimate against claims that have been notified. The estimate should be realistic, as the insurer has to put this money in reserve so that it can fully meet its liabilities.

If too high,

- the company is reserving money that could have been used for the expansion of the business;
- it also affects the insurer's solvency margin as indicated later;
- the loss ratio of the company looks worse than it really is, which can affect confidence in the company; and
- lack of confidence can reduce the price of shares and investment from external sources.

If too low, then the insurer is giving false or misleading information to the Registrar as there may not be enough money in the reserves to cover claims.

There are far-reaching implications on an insurance company relative to the claims estimates and reserves which have been raised and insurers and representative are requested regularly to check that the amounts are correct and adjusted where necessary.

STATEMENT OF ASSETS

Local insurers must present a statement of their assets each year and foreign insurers must present a statement of their assets held in the Republic.

The information needed is quite detailed but some of the main points are:

- no amount may be included for goodwill; and
- no premium outstanding for a period of more than two months from due date may be included.

This demonstrates how important it is for the accounts department of the insurance company to ensure the collection of premiums. If a premium is outstanding and cannot be included as an asset, this again affects the insurer's solvency margin and ability to trade.

MELAMET COMMISSION

Following the closure of some short term insurers and difficulties that had been experienced within the market, a number of amendments were made to the previous Act, on which the present Act is based.

In 1988 the Melamet Commission investigated:

- the circumstances surrounding the collapse of the AA Mutual; and
- whether the (previous) Insurance Act provided adequate protection to policyholders and the general public.

The major factors which they listed as contributory to the collapse were:

- a shortage of capital and exceptional growth in premium income;
- lack of technical reserving;
- bad management and lack of technical control;
- bad underwriting;
- a failure to match overseas liabilities with corresponding currencies; and
- inadequate accounting.

From what we have already learned, it is necessary to realise how important each person's contribution in the company is. The steps he takes affect the performance of the company to a much greater extent than he realises. Perhaps the greatest area of influence is, however, on the solvency margin of the company.

7.2.3 SOLVENCY MARGINS

The solvency margin of a company is basically the difference between its assets and its outstanding liabilities. It is represented by the capital from shareholders and the free reserves of the company built up from retained profits.

The higher the amount of assets when compared to liabilities, the greater the solvency margin.

CONFLICT OF INTEREST

This need for a high solvency margin can cause a conflict of interest between the policyholder and the shareholder.

The policyholder wishes to see a high solvency margin because it gives him greater safety with the insurer he chooses.

The shareholder wants to see his company:

- write the maximum amount of business; and
- create the maximum utilisation of resources and this can equate with a much lower solvency margin.

SOLVENCY REQUIREMENTS

A local insurer carrying on short term business must hold assets with an aggregate value not less than its liabilities plus the greater of:

- R5 000 000; or
- 15% of the greater of:
  - its premium income in the previous financial year or
  - its premium income in the previous 12 months before the calculation is made.

Premiums and claims are calculated net of reinsurance.

CURATORSHIP

If the Registrar feels that a company's solvency margin is too low, he can put the company under curatorship. A decision will then be made as to whether the company can continue trading or not.

The solvency margin is therefore of utmost importance to the short term insurer.

SOLVENCY ASSET MANAGEMENT (SAM) FOR SHORT TERM INSURERS

In 2004 the FSB proposed a change to the accounting basis used by short term insurers to move more towards international standards. At this stage the matter is still to be finalised, with numerous industry consultation workshops with planned implementation in January 2014.
The essence of the change would be a migration from a minimum solvency margin approach to risk based capital as the measure and is more in line with international practice.

7.2.4 PARTS OF AND SCHEDULES TO THE SHORT TERM INSURANCE ACT OF 1998

The Act is divided into parts and schedules. The most important parts of and schedules to the Act are briefly discussed below.

PART I
Administration of the Act and the Office of the Registrar

Part 1 of the Act deals with administration and creates the Office of the Registrar and its general powers. The Short Term Insurance Act of 1998 provides for the appointment of a Registrar of Short term Insurance. The Registrar is the pivot of the administrative and procedural machinery of this Act. He or she is a public official charged with strict surveillance of insurance companies for the benefit of policyholders and the general public.

The Registrar exercises all the powers and performs all the duties assigned to him or her by the Act. The Registrar has statutory access to the Court which enables him or her to act, and in particular to enforce the legislation by way of Civil Court action. The Act also establishes an advisory committee and provides for its general functioning. The Registrar has the power to

- authorise short term business on receiving an application;
- issue a certificate of registration to an individual, authorising the person to carry out short term business;
- lay down specific conditions for conducting short term business;
- give notice that a publication, advertisement or brochure containing misleading information or information that is contrary to the public interest, may not be published or to instruct a company to cease publishing it;
- request information or appearance before the Registrar if the Registrar believes that someone is contravening the Act;
- apply to the Court for liquidation of a person who is contravening the Act, whether the person is solvent or not;
- prohibit short term insurers from carrying on business if certain conditions have not been met; and
- terminate registration in terms of particular conditions.

He or she also has the right to appear in Court

- to discharge a duty assigned by the Act;
- to compel a person to comply with or to cease contravening the Act;
- to compel a person to comply with a lawful request or directive issued by the Registrar;

- to obtain a declaratory order on a point of law relating to the Act; or
- in connection with any matter relating to short term insurance business when the Registrar considers it to be in the public's interest.

The Registrar has to submit an annual report on his or her activities to the Minister of Finance before the year ending on 31 December.

PART II
Registration of short term insurers

Part II of the Act deals with the registration of short term insurers. An application to carry on short term business will be granted under certain conditions determined by the Registrar. However, the application will not be granted

- if the applicant does not have access to the financial resources, organisation or management that is necessary and adequate for conducting business;
- if the directors of the insurance company are not fit and proper to hold the office;
- if the applicant is unable to comply with the Act; or
- if the registration would be contrary to the public interest.

In granting the application, the Registrar may lay down specific conditions. For example:

- that only specific short term policies may be issued;
- that policies contain or do not contain specific terms or conditions;
- that the value amount of the policies be limited to values laid down by the Registrar; and
- that short term reinsurance policies be entered into.

As pointed out earlier, the Registrar may terminate the registration of short term insurers, or under certain circumstances prohibit short term insurers from conducting business.

PART III
Business and administration of short term insurers

Part III of the Act empowers the Registrar to regulate the ancillary business activities of short term insurers when such activities pose a risk to insurance assets. This part of the Act also confers the power to the Registrar to continually delineate the businesses areas of the two insurance industries (short and life) to prevent further encroachment on each other's markets.

This part also precludes insurers from introducing particular types of capital into their capital structures. The Registrar may apply "fit and proper" testing to the executive management of short term insurers and may remove unsuitable insurers.

The following are some of the specific regulations in this part of the Act:

- **Limitation of business** - a short term insurer may not undertake to provide survival benefits or to provide long term insurance.

- **Principal office and public officer** - every registered insurer must maintain a principal office and appoint a public officer. The public officer must ensure that the short term insurer complies with the Act.

- **Appointing an auditor** - every insurer must have an auditor for its business as a whole. The appointment of an auditor is subject to the Registrar's approval. The Registrar may appoint an auditor if the short term insurer fails to do so.

- **Audit committee** - the board of directors of the short term insurer's company has to appoint an audit committee of at least three members of whom the majority is not employed by the short term insurer and of whom at least two are members of the board. The audit committee
    - assists the board of directors in evaluating the adequacy and efficiency of internal control systems, accounting practices, information systems, and auditing processes and may recommend measures to enhance the credibility and objectivity of financial systems;
    - facilitates and promotes communication between the board of directors and the internal audit staff; and
    - advises the board of directors on matters referred to the committee by the board

- **Share capital** - a short term insurer has to furnish the Registrar with full particulars of its shareholders when required to do so and is not allowed to issue debentures or shares without the Registrar's consent. A short term insurer is not allowed to issue share warrants.

PART IV
Financial arrangements

Part IV of the Act deals with the financial arrangements of short term insurers.

In terms of the Act, a short term insurer must at all times maintain its business in a financially sound condition by

- having prescribed assets to the value of its liabilities;

- providing for its liabilities; and

- conducting its business so as to meet liabilities at all times.

A short term insurer shall be deemed to have failed to comply with the above if

- it does not have the above prescribed assets; and

- it has not made provision for its liabilities.

A short term insurer that fails to comply with the above conditions must notify the Registrar within 30 days and supply reasons for its failure. The insurer may not pay dividends during the period it fails to comply with these conditions. The Act makes provision for the Registrar to enforce remedial action in order to assist a potentially ailing insurer in the early stages.

PARTS V-VII
Business practice, policy contracts and policyholder protection

Parts V and VI provide for the winding-up of short term insurers and judicial management and stipulate procedures for the amalgamation and transfer of business.

Part VII is aimed at protecting the consumer. Various protection measures are included in Part VII, for example the obligation to issue a personal lines policy document within 30 days. A mechanism is established to ensure that business practices comply with the Registrar's requirements. Subordinate legislation may be formulated by the Minister with the Registrar's and the advisory committee's assistance to deal quickly and in a focused manner with malpractices.

PART IX
Offences and penalties

Part IX sets out criminal offences in terms of the Act as well as the related penalties.

Schedules to the Act

For the purposes of this course, the following are the most important schedules to the Act:

- Schedule 1 describes the kinds of assets short term insurers may hold.
- Schedule 2 sets limitations as a percentage of total liabilities of various classes of assets. The following are examples of the limits (as a percentage of total liabilities) set out in the second schedule:
    - investment in ordinary shares: 50%
    - investment in Kruger Rands: 10%
    - deposit with anyone institution: 20%
- Schedule 3 indicates how assets and liabilities should be valued.

Besides the actual legal requirements, there is an ombudsman for the short term insurance industry to whom members of the public may turn for assistance if they believe their insurance company has not acted correctly. The ombudsman provides advice and makes recommendations. He or she is not in a position to make a ruling an insurance company has to follow, but most insurance companies abide by the ombudsman's recommendations.

7.2.5 INTERMEDIARIES/BROKERS

Earlier on we looked at the rates laid down in terms of the Act for commissions payable to intermediaries. We also looked at the need for a guarantee and the remittance of premium.

Section 55 of the Short Term Insurance Act provides that additional rules may be added from time to time.

7.3 POLICYHOLDER PROTECTION RULES

The Registrar of Short Term Insurance has used his powers to make rules to bring about the Policyholder Protection Rules (PPR). These Rules pre-date the FAIS Act and form the basis upon which insurers interact with their customers (or policyholders). In fact, the FAIS Act contains much of the same standards and principles as were first expressed in the PPR.

Application of PPR to Personal Lines Business (and small commercial business from 2017)

The Policyholder Protection Rules (PPR) apply to all policyholders who are natural persons and not acting for the purposes of their own business. In other words, the PPR apply to personal lines business and not to commercial or corporate business. However the proposed Replacement PPR seek to extend the PPRs to juristic persons whose asset value or annual turnover is less than the threshold values determined in terms of the Consumer Protection Act (CPA), as amended by the Minister of Trade and Industry from time to time.

The Rules set out basic conduct standards expected of short term insurers themselves and also of short term insurance intermediaries when interacting with policyholders.

Because the interaction with policyholders depends on a number of variables, the Rules are separated into different sections or "Parts".

PART III - BASIC RULES FOR DIRECT MARKETERS

A direct marketer is an insurer who undertakes business in the form of direct marketing but who is not registered as an authorised financial service provider.

Direct marketing is defined as the marketing of a policy by way of telephone, internet, media insert, direct or electronic mail, but excludes any communications that fall under the description of advertising. These provisions therefore apply to all insurers who transact business via outbound call centres.

A direct marketer must at all times render services honestly, fairly, and with due skill, care and diligence.

In making any contact arrangements, and in all communication and dealings with a policyholder, a direct marketer must act honourably, professionally, and with due regard to the convenience of the policyholder. A direct marketer must also, at the commencement of any contact, visit or call initiated by its representatives, clearly explain the purpose thereof.

Where any representation is made or information is provided to a policyholder by a direct marketer, it must be factually correct; be provided in plain language, avoid uncertainty or confusion, not be misleading and be adequate and appropriate in the circumstances of the relevant marketing, taking into account the level of knowledge of the policyholder.

Where provided in writing or by means of standard forms or format, the representation or information must be in a clear and readable print size, spacing and format and must disclose all relevant information including values, product type, restrictions or exclusions, charges, fees, commissions.

Direct marketers must have facilities available to record and store all verbal (voice-logging) and written communications between itself and its policyholders and must keep these records for at least five years after the termination of the contract with the policyholder.

In addition, there are a number of other items of information such as, for example, telephone contact details; the types of policies involved; the nature and extent of benefits offered; that must be disclosed.

Authorised financial service providers are required to provide this information in accordance with the FAIS Act.

OTHER RULES

The Rules also address the issue of void provisions on policies, effectively barring insurers from refusing claims only on the basis of polygraph tests, requiring arbitration for disputes and enforcing the period of grace for premium payments.

Contact details of the Ombudsman's office need to be supplied so that policyholders can access the OSTI.

The Rules also contain a section which prescribes that intermediaries are entitled to a written agreement demonstrating the intermediary appointment.

GRACE PERIODS

The PPR give policyholders a number of important protections. The primary amongst these, as has been seen above, is:

- the right to truthful and accurate statements about the insurance product;
- the disclosure of who the intermediary and who the insurer are;
- the remuneration received by the intermediary for placing the business;
- whether the intermediary has professional indemnity (PI) and fidelity guarantee (FG) insurance; and
- reminds the policyholder not to sign blank or uncompleted forms.

But arguably one of the most important protections afforded by the PPR is the introduction of a period of grace for policyholders to pay their premium.

The PPR requires each insurer to afford its policyholders a minimum 15-day period of grace within which to pay their premiums after the due date. This period of grace only operates from the second month of the policy.

This grace period, it should be remembered, only applies to personal lines business.

Time-barring clauses regarding rejected claims

Another important protection afforded by the PPR is the extension of time given to policyholders who wish to institute legal proceedings.

Now insurers have set turn-around times within which to notify policyholders of their decision to reject a claim, giving the policyholder the reason/s for the decision.

Thereafter the policyholder may make representations to the insurer about the decision to reject the claim.

The policyholder must also be informed of the right to lodge a complaint to the OSTI and to the FAIS Ombud, where applicable.

The insurer also has to explain what the time limit in the policy is for the institution of a legal challenge. This period must be no less than 180 days (about 6 months) after the 90-day period in which the policyholder made representations concerning the initial claim rejection.

Thus, after rejecting a claim, policyholders effectively have approximately 9 months to decide to institute legal action against the insurer for rejecting a claim.

In addition, the PPR grants a court the right to deem the time-barring clause unfair in a given situation and to condone the policyholder's non-compliance with the clause.

In this way, it can be seen that significant additional protections have been afforded to policyholders to assist them in getting their insurance policies, premiums and claims dealt with fairly and equitably.

PROPOSED REPLACEMENT PPR

In December 2016, the FSB published its proposed Replacement PPR. These would, when promulgated, entirely replace the existing PPR. Since this is a fundamental change to the existing regulatory landscape, we will deal in some detail with each chapter of the Replacement PPRs, as proposed even though many of the themes contained therein are not new and will be familiar to members of the industry. The commonality with the Treating Customers Fairly (TCF) initiative will be obvious to anyone familiar with TCF.

Chapter 2 Fair Treatment of Policyholders

As a preamble to this chapter, it is proposed that insurers are required to have appropriate policies and procedures dealing with the Fair Treatment of Policyholders. This is defined as meaning that the policies and procedures must achieve at least the following outcomes:

1. policyholders are confident that they are dealing with an insurer where the fair treatment of policyholders is central to the insurer's culture. This language is redolent of, if not identical to, TCF Outcome 1 and is clearly derived from it;

2. products are designed to meet the needs of identified customer groups and are targeted accordingly. This equates to TCF Outcome 2;

3. policyholders are given clear information and are kept appropriately informed before, during and after the time of entering into a policy. This equates to TCF Outcome 3;

4. where policyholders receive advice, the advice is suitable and takes account of their circumstances. This equates to TCF Outcome 4;

5. policyholders are provided with products that perform as insurers have led them to expect and the associated service is both of an acceptable standard and what they have been led to expect. This equates to TCF Outcome 5;

6. policyholders do not face unreasonable post-sale barriers to change or replace a policy, submit a claim or make a complaint. This equates to TCF Outcome 6.

Chapter 3 Products and Product Design

This chapter is entirely new. It provides that:

- product design must explicitly take into account the fair treatment of customers. This includes, but is not limited to, using adequate information on identified customer groups' needs;

- importantly, when insurers target products identified customer groups, the must also **limit access** to the product by customer groups form whom the product is likely to be inappropriate. This is likely to prove challenging for insurers;

- competent skilled persons must do due-diligence assessments that the products meet the PPR criteria;

- where products are to be white-labelled (see the next section for more detail on white-labelling), additional due-diligence must be done;

- new products must be signed off by a managing executive of the insurer before the insurer starts to market the product in question. Insurers will want to consider the additional exposure this requirement implies for the managing executive in question. There may be an impact in terms of an insurer's liability insurance, such as Directors & Officers liability;

- such sign-off by the managing executive of the insurer must confirm that the product, distribution method and disclosure documents are appropriate and take into account the fair treatment of customers.

Consumer Credit Insurance (CCI) – [Rule 3 of Chapter 3]

Chapter 3 Products and Product Design also proposes new rules concerning consumer credit insurance:

- insurers offering mandatory CCI must ensure that the product complies with CCI regulations made by the Minister of Trade and Industry;

- where a policyholder substitutes a credit provider's insurance with a policy of choice, the insurer must assist the policyholder to comply with the demands of the credit provider in relation to the substituted policy;
    - for example, the insurer must confirm to the credit provider that the policy is in force and that the credit provider has been recorded as the beneficiary, cessionary or loss payee on the policy;
    - such confirmation must be in writing and must be given within 60 days of the policy coming into force.

Cooling-Off rights – [Rule 4 of Chapter 3]

A cooling-off right has been proposed. This is entirely new to short term insurance where cooling-off rights have never existed before.

If the policyholder exercises the cooling-off right, all premiums paid must be refunded to the policyholder. The implications of this rule will have to be carefully considered by insurers, especially in covers that may be prone to anti-selection risk.

Negative Options prohibited – [Rule 5 of Chapter 3]

This rule proposes that where more than one option is available to a policyholder (such as excess structure, increases in sums insured, rate escalations, premium increases and the like), the insurer cannot stipulate that a particular term or condition will apply unless the policyholder explicitly selects a different term or condition.

Premium Determination – [Rule 6 of Chapter 3]

The process by which premium is determined (also referred to as rating), must be based on realistic assumptions. If this proposal is adopted in its current form, actuarial departments, underwriters and black boxes, where applicable, will have to be able to demonstrate the reasonableness of the assumptions that underpin the rating of the product's pricing.

In addition, the new rule proposes that insurers may no longer charge a fee in addition to the premium payable under the policy. The FSB's intention in this regard was signalled some time ago when the FSB issued a draft Information Letter in which it stated that it wished to declare the practice by insurer of charging a fee on top of premium as an undesirable business practice.

Consent to insure a life – [Rule 10 of chapter 3]

Another entirely new proposal is that consent of the life insured is required in order to insure that life. The risks associated with insuring the lives of persons who are unaware of this are obvious and there have been well-publicised abuses of this in the funeral business arena. Due to the fact that certain policies, such as personal accident, cover the death of an insured, the Regulator wishes to deal with the risk in the short term insurance environment.

Insurers will have to consider the application of this new proposed requirement on their product suites.

Certain classes of business (such as Personal Accident, Group Personal Accident, certain Travel policies and Hospital Cash Plans as well as elements of any of these in, for example, motor policies or domestic policies) will be affected by this proposal.

Chapter 4 – Promotion, Marketing and Disclosure

The proposed new PPR on Advertising [Rule 11] is discussed in detail below and is largely based on an Information Letter of 2015. Rule 12 deals with Disclosure and Record-keeping. Most of it carries over existing provisions in the current PPR. However, there are some new rules:

- Insurers must provide the minimum required information "in good time". This means that insurers must consider the importance of the information provided to the policyholder's **decision-making process** and must ask itself when the information may be most useful to the policyholder.

- Adequate information must be provided in respect of **more complex or bundled** policy features which are difficult for consumers to understand, especially regarding the costs and risks involved.

- Existing disclosure standards have been refined and the Replacement PPR now proposes customised and expanded disclosures for each **disclosure stage**, namely:
  - at point of entering into the policy;
  - promptly after inception;
  - ongoing disclosures; and
  - on renewal.

- **Significant or unusual exclusions** or limitations must be prominently and clearly mentioned. Unusual exclusions include:
  - deferred payment periods;
  - exclusions of certain conditions, diseases or pre-existing medical conditions;
  - waiting periods;
  - excesses;
  - limits on the amounts of cover;
  - limits on the period for which benefits will be paid;
  - restrictions on eligibility to claim such as age, residence or employment.

- Bundled products must show separate pricing for the main benefit and the supplementary benefits.

- Must state whether the bundled product is a prerequisite for entering into or being eligible for any other goods or services.

Chapter 5 – Intermediation (Distribution)

In addition to carrying over existing rules from the current PPR, a new Rule is proposed – rule 13.3 dealing with requests for information:

- If an insurer receives a request for information (eg claims history) from an intermediary authorised by the policyholder, the insurer has a choice to either:
  - provide the intermediary with the information requested even if the insurer does not have an intermediary agreement or relationship with the requesting intermediary; or
  - provide the policyholder with the information requested together with an explanation as to why the information was not provided to the intermediary.

Chapter 6 – Product Performance and Acceptable Service

This is a new chapter and Rule 14 thereof introduces extensive data management requirements for the insurer. These are somewhat similar to the binder regulations' data requirements.

- Insurer must have policy-level and policyholder-level data on a continuous access basis.
- At a minimum this must include names, ID numbers and contact details of all policyholders.
- This data must enable the insurer to properly identify, assess, measure and manage conduct of business risks to ensure the ongoing monitoring and consistent delivery of fair outcomes for policyholders.

Rule 15 requires an insurer to continually monitor a product line and to take appropriate remedial action where short-comings are identified.

The existing provisions concerning periods of grace for the payment of premium are carried over from the current PPR. This is contained in Rule 16. Insurers should note, however, the proposed expanded definition of "policy" to include certain juristic persons and should ensure that such persons also enjoy the same grace periods as personal lines policyholders, when the Replacement PPR become effective.

Chapter 7 – No Unreasonable Post-Sale Barriers

This is mostly a new set of requirements, with a few carry-over provisions from the current PPR relating to time-bars and limitations for the institution of legal proceedings.

Rule 17 is extensive and deals with detailed Claims Management requirements. These include:

- the establishment of a claims management framework against specified requirements;
- allocation of responsibility for claims management, ultimately, to the Board pf the insurer;
- claims escalation and review process;
- record-keeping requirements;
- monitoring and analysis of claims information. It is important to note that claims information must be used to manage conduct risks, to improve outcomes and processes and to prevent recurrences of poor outcomes and errors;
- communication with claimants;

- reporting of claims information;
- prohibition of certain claims practices such as:
  - dissuading a claimant from obtained services of an attorney or adjustor;
  - denying a claim without performing a reasonable investigation; or
  - denying a claim based on the outcome of a polygraph, lie detector or truth verification process.

Rule 18 of Chapter 7 deals with Complaints Management.

The Complaints Management Process must include:

- the establishment of a complaints management framework against specified requirements;
- allocation of responsibility for complaints management, ultimately, to the Board pf the insurer;
- complaints escalation and review process;
- record-keeping requirements;
- monitoring and analysis of complaints information. It is important to note that complaints information must be used to manage conduct risks, to improve outcomes and processes and to prevent recurrences of poor outcomes and errors;
- communication with complainants;
- reporting of complaints information;
- engagement with the Ombud;
- categorisation of complaints which must, at a minimum, include a breakdown of the following:
  - complaints about the design of a policy/service;
  - complaints about information provided to policyholders;
  - complaints about advice;
  - complaints about policy performance;
  - complaints about service to policyholders;
  - complaints about policy accessibility, changes or switches;
  - complaints about complaints handling;
  - complaints about insurance risk claims, including non-payment of claims; and
  - other complaints.

In the context of the proposed definition of a complainant including a potential policyholder, the above requirements must be designed accordingly to accommodate complainants who are potential policyholders.

Rule 19 of Chapter 7 deals with Termination of Policies.

This is a new proposed requirement and provides that if an insurer intends to terminate a policy for reasons **other than** non-payment of premium or a material change in the policyholder's risk profile which provides the insurer with a right to end the policy:

- the insurer must give the policyholder at least 30 days' written notice of the intended termination; and

- the insurer will **remain liable under the policy** until:
  - 30 days after the insurer receives proof that the policyholder is made aware of the intended termination of the policy; or
  - The insurer receives proof that the policyholder has entered into another policy in respect of similar risks as those covered under the policy that the insurer intends to terminate.

7.4 DEMARCATION REGULATIONS

There was, for quite some time, serious levels of confusion regarding the distinction between a medical scheme and a health insurance policy. The Medical Schemes Act of 1998 (Act no. 131 of 1998), while replacing all previous legislation on the subject, also went a long way towards clarifying and reinforcing certain issues that had been in dispute in the past.

In the effort to increase business, both short term and long term insurance companies started to encroach on the products of medical schemes. Short term insurance products are annually renewable products which cover a specified event – medical scheme products cover the cost or part thereof a medical procedure. Long term insurance products cover aspects pertaining to the life of a person, and any need that may arise from life events. Examples of these products would be Hospital plans and Gap Cover.

FOR EXAMPLE

A Medical Scheme will pay for the surgery to remove a breast lump, the cost of the analysis of the lump and the treatment related to the histological result, Cancer. As well as all the follow up care required in each year. The amounts that will be charged are set by the Health Professionals Council, and the amounts that are paid, are agreed to by the Council of Medical Schemes. Medical inflation started to grow more rapidly than Medical Schemes could afford to charge their members. Medical Schemes introduced low cost schemes to counter this problem, e.g. Primary Healthcare Products, which covered out of hospital cover leaving the member reliant on state hospitalization and treatment.

Both Long Term and Short Term Insurance saw the needs and the product gap. There were shortfalls in payment of medical treatment, e.g. hospitalisation. A product was developed, that if the policy holder was hospitalised for more than a specified number of days, a specified amount of money would be paid for the remainder of days that the policyholder was in hospital. The payments applied to the product chosen by the client, in terms of the premiums and product rules. This hospital cash product could be bought in both the Short Term and Long Term market. The Short Term product is annually renewal, and only pays for a specified number of hospital days in the year. A short term product is underwritten annually and may be declined by the insurer after a claim.

The Long Term product has a specified term of insurance, e.g. 15 years, during this time claims relating to the product outlines are paid, and the product cannot be cancelled by the insurer, unless it can be proved that there was non-disclosure of material/relevant medical information which would have changed the underwriting decision.

So there was encroachment on the business of the Healthcare sector which needed to be clarified. This debate has continued until the end of 2016. Finally, reached some form of compromise has been reached and the new draft regulations were published in the South African Government Gazette early 2017.

The regulations will prescribe what healthcare products insurers can market. The conditions are:

- open enrolment – this means anyone can join, no matter what their age or health status;
- insurers have very limited underwriting ability; and
- removing premium rating, so all members pay the same premiums irrespective of claims.

Circular 19 of 2017: Demarcation Exemption Framework published by the Council for Medical Schemes (CMS) – provides the regulations framework issued by the Financial Services Board, Department of Health and the National Treasury.

The Regulations determine that "certain insurance products that have elements of a business of a medical scheme shall be 'health policies', and 'accident and health policies' respectively." These products exclude primary healthcare products and hospital indemnity products.

The Regulations come into effect on 1 April 2017, whereby any insurer providing these products now fall into the ambit of the Medical Schemes Act, No 131 of 1998, however they provide for a two (2) year exemption period subject to certain conditions. CMS has developed a guideline for insurers who provide indemnity products that now fall into the business of a medical scheme and want to apply for exemption,

In a presentation by the FSB the following table was presented.

Demarcation Regulations				
Cover Type	**Not deemed to be business of Medical Scheme Business (Written under LTIA/ STIA – MSA does not apply**	**Exempted from MSA through the regulations**		**Deemed to be business of a medical scheme, not exempted from MSA through regulations**
		Can be written under LTIA	**Can be written under STIA**	
Not impacted products, e.g. dread disease	X			
Medical expense shortfall			X	
HIV, Aids, TB and Malaria testing and treatment		X	X	
Medical emergency evacuation or transport		X	X	
Frail care		X		
International travel insurance			X	
Primary Health Insurance				X

(Ferreira, J, 2016)

Existing health policies under the Long Term Insurance Act (LTIA) are expected to be aligned after the regulations come into operation.

Existing Accident and Health policies under the Short Term Insurance Act (STIA) are expected to be aligned by 1 January 2018.

HEALTH INSURANCE PRODUCTS

Health insurance products are developed using actuarial knowledge, forecasting future claims over the long term, they are underwritten on the applicants passed and current medical history, and the cover may be declined. Medical Schemes have very little scope to underwrite an applicant, and acceptance is compulsory. Providers of such products need to have a licence, and the management and selling of these products is also regulated by the Financial Services Board (FSB) under the Financial Advisory and Intermediary Service Act (FAIS Act).

Products that fall into this category are travel insurance, gap cover, dread disease products and hospital cash policies. They are cash based products independent of the cost of care and relate to a specified event.

7.5 OTHER STATUTES

Apart from The Short Term Insurance Act and The Companies Act, a number of other statutes affect the practice of short term insurance. The main ones are briefly mentioned below.

7.5.1 FINANCIAL INSTITUTIONS (INVESTMENT OF FUNDS) ACT

An insurer that invests, keeps in safe custody or otherwise controls or administers any funds or any trust property for any beneficiary or principal must do so with utmost good faith and must exercise proper care. It must not use the funds for any direct gain or any indirect improper advantage. It must declare its interest in investing, keeping, or administering the funds.

7.5.2 FAIS ACT

This Act allows the Registrar to examine or to appoint an inspector to examine the affairs of an insurer, where returns have not been submitted correctly, or where an auditor has reported an irregular or undesirable practice.

This Act provides for a Registrar of Financial Services Providers to be appointed by the Minister, and lays down a compulsory code of conduct for Financial Services Providers.

Provisions include:

- registration and licensing of Financial Services Providers;

- keeping proper accounting records, in which clients' funds are separate from those of the FSP; and
- keeping records of any complaints made against the FSP, and the outcome of these complaints.

The Office of the Ombud for Financial Services will consider and dispose of complaints in a procedurally fair, formal, economical and expeditious manner with regard to:

- the contractual and legal relationship between the complainant and the other party; and
- the provisions of FAIS.

7.5.3 VALUE ADDED TAX ACT, 1991

In South Africa, short term insurance is subject to VAT. All local insurers, reinsurers and intermediaries must comply with the Act.

VENDORS

VAT is payable by each and every vendor. A vendor is defined as:

> *"any supplier of goods or services with a taxable value of more than R1 000 000 per annum."*

And, unless exempt in terms of the legislation, is obliged to register with the Department of Inland Revenue.

Short term insurance falls into the category of services.

RETURNS AND TAX PAYMENTS

A monthly return must be submitted to the Receiver where the value of taxable supplies exceeds R1 000 000. For lesser amounts, monthly returns are optional, but these vendors must submit a return at least every two months.

Payment of the tax must be made within 25 days of the month following the relevant tax period. If not paid, a penalty and interest will be levied.

DEFINITION OF INSURANCE

The Act defines insurance as:

> *"insurance or guarantee against loss, damage, injury or risk of any kind whatsoever, whether pursuant to any contract of law and includes reinsurance."*

In terms of the Act money is exempt from the Act, but money insurance is not, as the contract of insurance is the underlying subject matter.

Personal Accident insurance is subject to VAT, for the same reason that money insurance is.

SASRIA is also subject to VAT at 14%.

VAT INVOICES

When a policy document or endorsement is issued a tax invoice is supplied.

- If the client is a vendor he can then claim a refund from the Receiver for input tax.
- The insurance company will be responsible for the payment of output tax to the Receiver.

Where the business is handled through an intermediary who is a registered vendor, then the intermediary can supply the client with a tax invoice. The tax invoice from the insurance company must then be destroyed. The insurer still remains responsible for the output tax.

COMMISSION

Commission is payable on the premium exclusive of VAT.

Where the intermediary is a registered vendor, VAT will be added to the commission.

Where the intermediary deducts commission from premiums and pays the insurer net, the premium bordereaux issued, will become the tax invoice in respect of the VAT charged on the commission.

An insurer paying commission as per the commission statement, where the intermediary has paid gross and not net, will self-invoice for the VAT included in the commission. The statement must conform with the Act and must include the intermediary's VAT registration number.

LOCAL REINSURANCE

Premiums paid to all local reinsurers are subject to VAT at the standard rate.

LLOYD'S

Premiums paid to overseas insurers and reinsurers are not subject to VAT. Commission and claims recoveries are zero rated. Insurance placed with local Lloyd's representatives is subject to VAT at the normal rate.

ZERO RATED

There are two rates provided for in the Act.

- The standard rate, which is currently 14%.
- The Zero rate, which is 0%.

CLAIMS

When an insurer makes an indemnity payment he will be entitled to claim an input credit in respect of the VAT portion of the claims, so long as the insurance contract was taxable. This does not apply when:

- payment is in respect of the supply of goods. These payments are excluded where it is restitution to the insured and where the insurer claims an input credit through the supplier's tax invoice;
- the supply of the insurance is zero rated;
- the person indemnified is neither a vendor, nor a resident of the country; or
- the payment is from a supply of goods outside the country, or for services performed outside the country.

The term indemnity is not defined in the Act but it is assumed to mean the settlement of a claim, other than for the supply of goods or services to the insurer, in making good the insured's loss. The insurer is, however, entitled to an input credit for any VAT charged to him by a vendor, provided he has a tax invoice.

ADMINISTRATION

The provision regarding suppliers' invoices for claims means that the insurer would have to separate indemnity payments from invoices for the supply of goods.

As this could lead to administrative problems, insurers have obtained agreement from authorities that, subject to the possession of a tax invoice, the insurer may combine indemnity payments and payments to suppliers to determine its input tax credit for claims. The credit can only be claimed once the payment has been made.

Insurers therefore in effect collect the input tax credit in bulk over all claims payments made within the period.

THIRD PARTY CLAIMS

Where the third party is a vendor the payment in settlement of a claim would not be deemed a service and therefore the vendor would not be able to claim a tax credit.

The insured who was at fault would have a constructive receipt and, if a vendor, would be liable for output tax. The insurer must therefore fully indemnify the insured by paying him the VAT portion of the claim. The third party would receive the damages portion only.

EXAMPLE

Third party vendor damages R10 000 - cheque sent.

Insured vendor liable for R1 400 output tax - cheque sent.

SALVAGE RECOVERIES

When a loss occurs there could be salvage recovered. This happens in motor insurance, and also in other forms of property damage. The salvage becomes the property of the insurer when they have indemnified the insured, or the third party in some instances.

Salvage recovered is subject to VAT in the same way any other form of supply is, but the payment need only be made when the insurer has sold the salvage. When the insurer sells the salvage a tax invoice must be issued by the insurer.

RECOVERIES FROM THIRD PARTIES

Recoveries from third parties are not regarded as consideration for supply of service and are therefore not subject to VAT.

CONCLUSION

VAT is a complex and difficult subject. It can cause great confusion among claims clerks, who have to work with it on a daily basis.

For the purposes of this course we have set out in the study objectives how deep your knowledge of the subject should be.

7.5.4 NATIONAL CREDIT ACT

The enactment of the National Credit Act no. 34 of 2005 came into effect from 1 June 2007. Effectively this is an amendment to the previous Usury Act of 1968 as well as the Credit Agreements Act of 1980, but it also contains some wide-reaching extensions.

While the thrust of this Act is to control the activities of money lending, mainly to private individuals, there is an impact on insurance, of the following:

- an extension to the concept of "free-choice" in the selection of the cover required, including houseowners cover, where the compulsion on borrowers to purchase a particular policy with set cover terms now allows the consumer considerable choice, but in consultation with the lender (this has in any event emerged as a challenge to the current wording of Section 43 of the Short Term Insurance Act since the FAIS Ombud ruled that the application of this in the strict sense was, in effect, a contravention of the provisions of the FAIS Act);

- control on the amount of cover (for example, credit life cover may only be on the basis of decreasing cover to meet the outstanding amount) which must be reasonable and not unreasonably costed; and

- a requirement that insurance premiums should be charged annually or monthly (only monthly for smaller loans).

It also requires short term insurers to submit a quarterly report to the National Credit Regulator.

7.5.5 CONSUMER PROTECTION ACT

This legislation was signed into law in April 2009, and came into effect on 1 April 2011. Insurance products, being governed by their own legislation, mainly the FAIS Act, have been temporarily exempted subject to the relevant legislation being adapted to comply with the provisions of this Act.

Substantial changes are expected to aspects of liability and related covers in the face of an expected upturn in these claims.

OBJECTIVES

The objectives of the Policy and the Act are to:

Promote

- a fair, accessible and sustainable marketplace for consumer products and services;
- responsible consumer behaviour; and
- a consistent enforcement framework relating to consumer transactions and agreements.

Prohibit

- certain unfair marketing and business practices.

Provide for

- improved standards of consumer information;
- harmonisation of laws relating to consumer transactions and agreements; and
- the establishment of the National Consumer Commission.

The effect of this Act is to import strict liability into the law and remove obstacles to the consumer's claim other than in those situations outlined above. The rationale is to protect the consumer from potential liability where historically the profits of production and sale outweighed the risk of liability to the producers. Strict liability accordingly ensures that a socially responsible attitude is adopted.

In summary

- Unjust unreasonable or unfair contract terms are prohibited.

- The supplier will not be able to contract out of liability unless he can demonstrate that he brought the full details and nature of the disclaimer to the attention of the consumer.
- The consumer has the right to receive goods that are reasonably suitable for the purposes of purchase and free from defect.
- The producer is liable for all harm including economic loss through product failure, defect or inadequate instructions or warnings.

BROKER'S DUTIES

- Provide all clients with correct advice.
- Negotiate an appropriate policy wording that includes pure economic loss.
- Encourage clients to take remedial steps including:
  - the tightening up of risk or quality controls;
  - increasing limits; and
  - revising of standard terms and conditions.

7.5.6 SECOND HAND GOODS ACT

This piece of legislation seeks to impose better controls on the sale of second hand goods, including pawn brokers, to curtail the proceeds of crime. The impact on the insurance industry and the way that insurers handle claims salvage is still being investigated.

7.5.7 PROTECTION OF PERSONAL INFORMATION (POPI) ACT

The Constitution gives every person a broad right to privacy[5]. The Protection of Personal Information Act, 2013 (POPI) gives effect to the constitutional right to privacy by providing for:

- rules for the processing of personal information;
- rights and remedies where personal information has been mistreated; and
- measures to ensure the promotion and enforcement of POPI.

Personal information is widely defined, but includes any information which relates to and identifies a living natural person or an existing juristic person (called a data subject). POPI differs from privacy legislation in many jurisdictions in that it protects the personal information of corporates as well as individuals.

Processing is anything done with personal information, including collection, use, storage, sharing and deletion.

5 Section 14 of the Constitution of the Republic of South Africa.

STATUS OF POPI

POPI has been in the pipeline for a number of years but is not yet fully in force. Certain sections commenced in April 2014, allowing for the appointment of an Information Regulator (Regulator) and the making of regulations. The members of the Regulator's office were appointed and commenced their duties on 1 December 2016. Once regulations have been published and the Regulator's office has been fully established, it is anticipated that a commencement date will be announced[6]. Organisations will then have 12 months from the commencement date to become compliant with POPI.

WHO MUST COMPLY WITH POPI?

Any person or entity which processes personal information in South Africa, or is domiciled in South Africa (called the responsible party), must comply with POPI.

POPI does not apply to the processing of personal information for purely personal or household activities (such as personal Facebook pages) or to personal information which has been de-identified (anonymised) to an extent that it cannot be re-identified. There are other exclusions for journalists and various public bodies in the performance of their duties.

> All South African **insurers** and **brokers** (or foreign insurers and brokers operating in South Africa) must comply in respect of the personal information of their insureds (both individuals and companies), employees, suppliers and any other party with which they engage in the course of their business.

RULES FOR PROCESSING PERSONAL INFORMATION

Chapter 3 of POPI sets out various conditions for the lawful processing of personal information. The most important ones are set out below.

Justification to Process Personal Information

Personal information may only be collected for a specific and lawful purpose related to the activities of a responsible party. Processing must be reasonable and not excessive in relation to that purpose. All processing must also be justified on one of the grounds in section 11 of POPI, namely where:

- the data subject has consented to the processing;
- the processing is necessary to conclude or perform a contract with the data subject;
- the processing complies with a law;

6 In a briefing statement on 13 February 2017, Pansy Tlakula stated that the Regulator intends for the zero draft of the regulations that has been prepared to be tabled in Parliament before the end of 2017 (http://www.justice.gov.za/inforeg/docs/sp-20170213-InfoRegBriefing.pdf).

- the processing protects a legitimate interest of the data subject, or is necessary to pursue the legitimate interests of the responsible party or a third party recipient of information; and
- the processing is necessary for a public body to perform its public law duties.

> In most instances in the insurance industry, processing of personal information will be justified on the grounds of **contract, law or legitimate interests**. For example, an insurer needs to know insureds' bank account details in order pay out claims *(performance under the insurance policy)*. Various types of personal information are necessary for the assessment of risk and claims *(performance under the insurance policy and legitimate interests)*.
> Consent should not be relied upon unless no other ground to process personal information exists, because it can be refused or withdrawn at any time. Where it is required, it must be specific, voluntary and informed.

Responsible parties must have an additional justification to process personal information of children and various categories of special personal information (race, religion, trade union membership, health or sex life, biometrics and criminal behaviour).

> Specific grounds apply to each category. For example, insurers may process health information where it is necessary to assess risk, perform under an insurance policy or enforce contractual rights and obligations. There are also general grounds applicable to all categories, such as where the processing is necessary to establish, exercise or defend a legal right or obligation. Where this is not the case, in most instances consent will be required to process special personal information.

Notification to Data Subjects

Responsible parties must take reasonable steps to ensure that data subjects are aware of certain matters regarding the processing of their personal information, including what information is processed, the purposes of processing, third parties to which the information will be disclosed and any intended cross-border transfers of the information.

> The most practical way to ensure compliance with this requirement is to have a **privacy policy** (on a website for example) to which data subjects are directed when their information is collected. For example, an insurer or broker could include a reference to their privacy policy on a policy application form.

Retention of Personal Information

POPI does not specify specific retention periods for personal information, but as a general rule, personal information may not be retained for longer than it is reasonable required for lawful purposes related to the responsible party's activities. Longer retention is permitted where required or authorised by law or a contract with the data subject or the data subject has consented to longer retention.

> Insurers, brokers and loss adjusters may have lawful purposes to keep personal information once the relationship with an insured has ended. For example, to defend possible claims from the insured.

Data Security

Security measures

POPI does not prescribe specific security standards. Responsible parties must take appropriate and reasonable technical and organisational measures to secure personal information against loss, damage, unauthorised destruction and unlawful access and processing.

- Technical measures include IT security controls and physical access controls.
- Organisational measures include policies and training of employees.

The measures taken will be regarded as appropriate and reasonable if the responsible party:

- identifies all reasonably foreseeable risks to personal information under its control;
- establishes and maintains appropriate risks against the risks identified;
- regularly verifies that the safeguards are effectively implemented; and
- ensures that safeguards are continually updated where necessary.

Any generally accepted information security practices which apply either generally or to a specific industry or profession must be taken into account.

Operators

A third party which processes personal information for or on behalf of a responsible party is called an operator. Operators have limited obligations under POPI and the responsible party remains liable for all processing of personal information by its operators.

Responsible parties must have written contracts with all operators which require them to take the same measures to secure personal information as the responsible party is required to take under POPI.

Loss adjusters and other assessors are operators for insurers to the extent that they process personal information in performing their mandate. This means that all contracts between insurers and operators must be written and include the security requirements above. These contracts could also include things like audit rights (to verify whether the loss adjuster is complying with the security requirements) and indemnities (to protect the insurer financially where damage is caused by the loss adjuster's failure to secure personal information.

Operators must notify the responsible party if they have a reasonable suspicion that a data breach has occurred, to enable the responsible party to comply with its own notification obligations (see below).

Notification of data breaches

If there is a reasonable suspicion that a data breach has occurred, the responsible party must notify the Regulator and affected data subjects. The Regulator may direct the responsible party to notify data subjects in a certain way, for example by publicising the data breach.

Data Subject Rights

Data subjects may request:

- confirmation whether a responsible party holds personal information about them;
- access to the records containing their personal information; and
- correction or deletion of personal information that is inaccurate, incomplete, excessive, outdated or misleading.

Requests for access to personal information must be made and handled in accordance with the procedures in the Promotion of Access to Information Act, 2000 (PAIA). PAIA also sets out grounds on which the responsible party may refuse to provide access to personal information.

All stakeholders in the insurance industry should have policies and procedures in place to deal with requests for confirmation, access, correction or deletion to ensure that they are handled in the proper manner.

CONSEQUENCES OF NON-COMPLIANCE WITH POPI

Non-compliance with POPI can lead to:

- complaints to, and investigations by, the Regulator;
- civil action for damages suffered by data subjects; and
- criminal action for offences committed (for which the penalties on conviction are fines, imprisonment or both) or an administrative fine of up to ZAR 10 million.

INTERSECTION BETWEEN POPI AND OTHER LAWS

Various other laws contain provisions dealing with the protection or disclosure of personal information in specific industries. POPI prevails over any other laws which are materially inconsistent with POPI, but if another law provides a higher or stricter standard of protection of personal information, the higher or stricter standard applies.

For example, POPI provides various grounds (above) on which personal information can be processed (including disclosed). Medical professionals are required in terms of their governing legislation to keep patient information confidential, unless the patient consents to disclosure, disclosure is required by a court order or non-disclosure would seriously threaten public health. Medical professionals cannot rely on the other grounds in POPI (such as legitimate interests) to disclose the information.

Various other laws also impose obligations on responsible parties which have an impact on their treatment of personal information. For example:

- Long term insurers are required to collect certain personal information of insureds under the Financial Intelligence Centre Act, 2001 (FICA) and allow the Financial Intelligence Centre access to records.
- Authorised financial service providers are required to maintain certain records under the Financial Advisory and Intermediary Services Act, 2002 (FAIS)
- Both FICA and FAIS contain specific record retention periods.

POPI allows responsible parties (including all insurance industry stakeholders) to comply with all of their obligations under other laws (unless there are materially inconsistent with POPI). This will include requirements of other regulators (such as the Financial Services Board) where the responsible party is legally obliged to comply with those requirements.

7.6 COMPULSORY INSURANCE

Governments throughout the world have introduced different types of compulsory insurance. There are varying reasons for this, but some of them are:

- the provision of funds;
- the easing of the State's burden;
- public attitude; and
- protection of the insured.

PROVISION OF FUNDS

When the courts award damages, this does not mean very much if the person liable has no funds to meet the award.

EASING THE STATE'S BURDEN

If the guilty party did not have funds, then there would be a moral obligation on the state's part to compensate the victim in some way. This would place a huge burden on the state coffers.

PUBLIC ATTITUDE

Public opinion has changed over the years and forced governments to act. If one considers the huge green lobby of today it has forced governments to rethink their plans for the planet and to enforce legislation to make polluters pay. The Exxon Valdez was a prime example of the public outcry following the oil slick in Alaska.

Oil pollution and nuclear risks are the two recent types of risk where government legislated to protect the public as a whole.

PROTECTION OF THE INSURED

This does not mean to say that when a person takes out insurance you make him more careful. That is a debate on its own. However, the insured will be exposed to all the expertise that is available to improve the risk and therefore assist in protecting people.

In terms of the insurance policy there will also be certain requirements with which he must comply. An example of this would be in motor insurance, where the vehicle must be roadworthy.

7.6.1 EXAMPLES OF COMPULSORY INSURANCE

Listed below are examples of Acts that have been passed and which have resulted in some form of compulsory insurance in South Africa. Note the insurance is not necessarily supplied by the State, but it is compulsory in that the insured must have protection or security if he is to trade, work, or live in the country.

- Road Accident Fund (1996)
- Nuclear Energy Act (1982)
- Prevention and Combating of Pollution of the Sea by Oil Act (1981)
- Unemployment Insurance Act (2001)
- Export Credit Insurance Corporation (ECIC)
- Compensation for Occupational Injuries and Diseases Act (1993)

The first and last are dealt with in other chapters. The remaining four are briefly explained below.

NUCLEAR ENERGY ACT (1982)

In terms of the Act insurance is not compulsory, but the licensee operating an installation must lodge a security with the State for claims emanating from an accident. The Act provides for government assistance in cases where claims cannot be met out of the security provided.

The Apportionment of Damages Act does not apply to nuclear damage and therefore, in general, contributory negligence would not be a factor.

OIL POLLUTION

The Prevention and Combating of Pollution of the Sea by Oil Act 1981, provides that no tanker carrying more than 2 000 long tons[7] of oil in bulk as cargo:

- may enter or leave a port in the Republic or arrive or leave an offshore installation in South African territorial waters; or
- if the tanker is registered in the Republic, enter or leave a port or installation in any other country,

unless it is properly insured, or proper financial security has been provided for, in the case of damage or pollution caused by the discharge of oil from such tanker.

7 A long ton is 2 240 pounds, about a thousand kilograms.

UNEMPLOYMENT INSURANCE ACT (2001)

Under the Act employees and employers each contribute to the Unemployment Insurance Fund (UIF). Contributions are 1% of salary by the employee, and 1% by the employer. The State contributes a further 25% of the total contributions up to a specified limit.

All employees (except those that do not qualify, or are paid on a commission only basis) must contribute to the fund. Domestic workers fell into the ambit of the scheme as from April 2003.

The ceiling income level was set at R14 872 per month in 2012 where it remains currently (in 2017) (SARS, 2017). Employees earning more than this level must contribute and can claim benefits, but based on the threshold limit and not on their actual earnings.

The benefits payable are based on a sliding scale, from 60% of earnings for lower paid employees, to 38% at the threshold level.

The benefits are in respect of:

- unemployment;
- illness;
- maternity benefits; or
- adoption benefits.

Payment in lieu of notice is deemed to be wages and training for employment is not regarded as unemployment. No benefit is payable if the person is unemployed because of a stoppage of work due to a strike or trade dispute, for as long as the stoppage continues.

Benefit is not paid if the person is:

- incapable of work;
- unavailable for work; or
- refuses to accept, or to apply for, suitable work.

EXPORT CREDIT INSURANCE

A feature of foreign trade is that the exporter might not receive payment for his goods because of political events outside the control of the buyer. This is not insurable in the general market.

The Credit Guarantee Insurance Corporation of Africa Limited was established by the major insurance companies, banks and financial institutions to act as a specialist company offering credit insurance, so as to promote trade with other countries.

Previously, the Government acted as reinsurer for political risks. From 1 July 2001, the Export Credit Insurance Corporation of South Africa (ECIC) was set up by Government to handle medium to long term credit risks. The Credit Guarantee Insurance Corporation of Africa Ltd will continue to handle short term export and domestic credit risks, without Government assistance.

CONCLUSION

The State has a vital role to play in protecting its citizens and there are certain types of risks which really are for the State to cover. In concluding, we need to mention some of the differences between the State type of insurance and commercial insurance underwritten in the market place, which are:

- mainly administered by Government;
- rates and contributions may be altered by Government;
- the State can supplement, by way of grants, the amount paid in contributions;
- the State guarantees the solvency of the scheme;
- in the case of UIF, COID and Road Accident Fund all persons affected must join the scheme;
- the rates of contribution vary, but are standard within classes;
- there is no underwriting of the risk;
- often no policies are issued, which reduces costs;
- premiums are frequently deducted at source, for example, earnings and fuel; and
- in the case of COID, claims are handled by a commissioner and not by the courts, which also reduces costs.

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Unemployment Insurance Act, 2001 (Act no 63 of 2001)

Value Added Tax Act, 1991 (Act no 89 of 1991)

QUESTIONS ON CHAPTER 7

Revision questions

Work through these revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. Who appoints the Registrar of Insurance?

2. What is the current solvency margin requirement for short term insurers?

3. What is the aim of the Financial Institutions (Investment of Funds) Act with regard to short term insurers?

4. Are recoveries from third parties subject to VAT?

Written questions

Attempt these questions after you have completed this chapter and its revision questions. Suggested answers to these questions are at the end of this book.

1. Briefly list the statements and accounts a short term insurer must submit to the Registrar in terms of the Short Term Insurance Act.

2. Describe the solvency requirements of a short term insurer in terms of the Short Term Insurance Act.

3. Explain how solvency margins are calculated and how incorrect estimates for claims affect these.

4. Explain Value Added Tax in relation to claims payments and recoveries.

5. List the differences between compulsory insurance and commercial insurance.

CHAPTER 8

PERSONAL INSURANCE POLICY

Learning Outcomes

When you have completed this chapter you should be able to:

- describe the cover available under the various sections of the personal lines policy;
- explain what is meant by houseowners, householders, all risks, personal accident and personal liability insurance;
- explain why a client requires the different types of insurance cover;
- explain the difference between a policy of inclusions and a policy of exclusions; and
- explain which policies in personal lines insurance are policies of inclusions and which are policies of exclusions.

8.1 PERSONAL LINES

Historically, new entrants to insurance often started their career in the personal lines or domestic insurance department. Today this is less usual. It is true however that in South Africa we tend to view personal lines insurance as not quite as skilled as commercial insurance.

Most people's first encounter with insurance is when they take out cover for their own house, car or flat. The Personal Lines Department is the department that handles the insurance covering;

- Houseowners (buildings);
- Householders (contents);
- All Risks;
- Personal Accident;
- Personal Liability; and
- Pleasure craft.

Personal Lines insurance also includes private motor car insurance, but in this book there is a separate chapter covering motor insurance.

We will look at the standard wordings available in the market today. It must be emphasised, though, that each company has a different personal lines wording and it is not the intention of the course to look at all these differences.

As a long term insurance practitioner you do not need to know short term policy wordings in detail, but you should know the type of cover available in the market.

There are also a range of specialised covers available, such as travel insurance to cover medical costs arising while out of the country, but only the more common or basic types are covered here, with some of the others being mentioned later on.

8.2 HOUSEOWNERS

The Houseowners policy is designed to cover the building which is a private dwelling house, in other words immovable property This is the place where people live and which is not used for business purposes.

8.2.1 DEFINITION

In the policy the property insured is defined as:

> *"the private dwelling, its outbuildings and landlords fixtures and fittings, the walls, gates, swimming pools and tennis courts."*

8.2.2 PREMIUM

EXAMPLE

A rate is normally charged on the sum insured in order to obtain a premium.

Sum Insured	R1 000 000
Rate	0,15%
Premium	R150

This would be the company's standard rate and any house that is of standard construction will be charged that rate. However, rates do vary between insurers.

8.2.3 DEFINING STANDARD CONSTRUCTION

Standard Construction is defined as

> "*the private dwelling built of brick, stone, or concrete and roofed with slates, tiles, metal, asbestos or concrete*".

If the house to be insured is of inferior construction, then additional premium will be charged, as it is more hazardous.

8.2.4 PERILS COVERED

The basic cover under the houseowners is to protect the insured against loss caused by the following perils:

- fire, lightning, explosion, earthquake;
- storm, wind, water, hail or snow excluding loss or damage:
  - caused by subsidence or landslip;
  - to gates fences or retaining walls;
- impact by animals, vehicles or falling trees;
- aircraft and aerial devices;
- bursting or overflowing of water tanks, pipes and apparatus. This includes damage to the pipes;
- theft or attempted theft of landlord's fixtures and fittings. If the building is let or sublet, theft is restricted to loss following forcible and violent entry to, or exit from the premises; and

- escape of oil from a fixed oil-fired heating installation. There is no cover for loss of oil from a portable or mobile oil heater.

These are the basic perils covered in terms of the average policy in the market today.

8.2.5 EXTENSIONS TO COVER

The following are a list of extensions which are commonly included free of charge. They can vary between companies.

- Loss of rent - this covers rent lost when the cause is one of the perils insured in terms of the policy.
- Liability to the public - if someone is hit by a roof tile which is not secured, he can sue you. This will give you cover for the amount the court awards.
- Accidental damage to the mains such as water, electricity, gas and telephone connections at the dwelling.
- Accidental breakage of fixed sanitaryware and glass - this covers, for example, broken windows and cracked hand basins.
- Costs following a loss for architect's fees, demolition and debris removal, as well as compliance with municipal building regulations, in the event of reconstruction.

8.3 HOUSEHOLDERS

This policy is designed to cover the contents of a private dwelling, in other words all moveable property. It does not cover items that belong to a business. If a client is working from home the insurer can be told about the business items and they may either:

- endorse the policy, or
- issue a separate business policy.

8.3.1 DEFINITION

Contents is defined in the policy wording as:

> *"household goods and personal effects of every description, the property of the insured or for which he is responsible or of any member of his family normally living with him, and fixtures and fittings, belonging to the insured or for which he is responsible, but not landlord's fixtures and fittings, all in the building described in the schedule."*

8.3.2 DEFINING THE BUILDING

The end of the definition of contents states that the items must be in the "... building described in the schedule".

This building is defined as:

> *"the private residence built of brick, stone or concrete and roofed with slate, tile, concrete, asbestos or metal, including all outbuildings used in connection with the building."*

Outbuildings are garages, carports, servants quarters, garden sheds and the like.

8.3.3 RATING FACTORS

The policy is again rated on a sum insured and a percentage is applied.

When rating Householders it is normal to use:

- the area where the house is; urban areas are usually more expensive than country areas because of the higher incidence of crime;
- the construction of the house; if it is anything other than standard, described in the definition, then a loading will be applied;
- the anti-theft protections; this is a key deciding factor for insurers to help them to decide whether or not to accept the risk, rather than a factor for a reduced or increased rate;
- the occupation of the insured; discounts for pensioners are available. The reasoning behind this is that the house is normally occupied during the day. There are also schemes for professional people because the claims experience may be better; and
- claim free group; this is quite common in Householders insurance, although not all insurers use claim-free groups.

8.3.4 PERILS COVERED

The cover under this policy is very similar to the Houseowners policy. The perils are:

- fire, lightning, explosion;
- earthquake;
- storm, wind, water, hail or snow;
- aircraft and aerial devices;
- bursting or overflowing of tanks, pipes and apparatus, but excluding damage to the pipes;

- theft or any attempt thereat, but excluding theft if sublet, unless there is forcible and violent entry or exit;
- impact by animals, vehicles or falling trees;
- escape of oil from fixed oil-fired heating installation; and/or
- malicious damage.

8.3.5 EXTENSIONS TO COVER

The above are the basic perils but, like the Houseowners policy, there are a number of extensions to the cover.

Some examples follow. For more details you should obtain copies of Personal Lines policy wordings available in the market and read through the various extensions.

- **Property elsewhere** - this is normally restricted to South Africa and some of the surrounding countries. It gives cover for goods belonging to a son or daughter, perhaps when they are away at university or college, or while the insured is away on business.
- **Accidental damage** - to television sets, CD and DVD players.
- **Household goods in transit** - cover here is for a limited amount, normally following an accident involving the vehicle. It is important to note that, in respect of theft cover, there must be forcible and violent entry into the vehicle.
- **Personal effects of guests** - this normally applies only to a limited amount and only if the guest has no personal insurance cover.
- **Liability arising as a householder** - for example, a visitor is bitten by your dog during a visit to your home. (See also Personal Liability later)
- **Cover for fire brigade charges** - the cost of the fire brigade when called to extinguish a fire.
- **Cost of hiring a watchman** - this is following a loss caused by an insured peril, for which purposes a security guard might be required.

It is not the intention of this course to repeat policy wordings, so we shall mention only a few of these. A complete examination of personal lines wordings is carried out in Personal Insurance Practice.

LOSS OF MONEY

One of the major restrictions to cover under the householders policy is that theft of money is very limited, normally to an amount of around R500. For theft of money there must be forcible and violent entry to the house.

CONCLUSION

Under the householders section there are other restrictions and exclusions. The main point to remember about both houseowners and householders is that they are policies of inclusion therefore, any occurrence not specified as a peril, is not covered.

8.4 ALL RISKS INSURANCE

The two types of cover we have just looked at are what we call premises risks. This means they are designed to cover the goods whilst at the premises, with very limited "away from the premises" cover.

Not all losses take place at the premises of the insured and cover is required whilst away from home.

8.4.1 AWAY FROM HOME

Think about the cover provided for an engagement ring. Most women wear their engagement ring all the time. They wear it when they are out shopping, or at the office, or even when on holiday at the beach. This is where All Risks insurance comes in.

8.4.2 ALL RISKS INSURANCE

All Risks insurance gives cover on a worldwide basis. In order to do this, it has been constructed to be a policy of exclusions. This means that any occurrence not specifically excluded, is covered. We therefore do not list what is covered, but rather what is excluded.

8.4.3 EXCLUSIONS

Policy wordings differ. The exclusions discussed in this topic are therefore typical ones. They include loss or damage:

- to sporting equipment whilst in use;
- from an unattended motor vehicle - it is only covered if there is forcible and violent entry;
- due to wear and tear - wear and tear is a gradual process. It does not apply when something is torn suddenly. Think of a jersey. If you catch it on the doorframe and it tears, the damage is covered. If the elbows wear away because it has been worn too often, there is no cover;
- due to mechanical or electrical breakdown - if a computer simply stops working it is not covered, but if it is dropped and broken there is cover; or
- of money, cheques, coins, documents or promissory notes.

8.4.4 RATING FACTORS

The All Risks section under a Personal Lines policy is designed to insure property that is not used for business purposes. There are two common designations provided which are:

- miscellaneous items; and
- items specified separately.

MISCELLANEOUS ITEMS (UNSPECIFIED)

It is normal to have a miscellaneous item to cover articles normally worn by a person, but excluding furs. There is also a monetary limit for any one article under this item and this can range from approximately R1 000 to R5 000. This will be expressed as a percentage of the sum insured.

EXAMPLE

Wearing Apparel and personal effects (Limit for any one item 25% of sum insured)	Sum Insured R10 000

ITEMS SPECIFIED SEPARATELY (SPECIFIED)

Items specified separately will have an individual rate applied to them. To reach a fair rate, the type of article insured must be looked at.

EXAMPLE

A camera is a very attractive item from a theft point of view, when compared with a pair of prescription sunglasses. These items would therefore be rated differently. The camera would cost more, because the risk is more hazardous.

8.4.5 EXCESSES

It is normal for an excess to apply to the All Risks section. An excess, or first amount payable as it is sometimes called, is an amount of money which the insured must pay each and every time there is a claim. This helps to avoid small claims and it gives the insured a reason to take more care and prevent losses.

8.5 PERSONAL ACCIDENT INSURANCE

The previous covers we have looked at are all policies of indemnity. However, the personal accident is a policy of compensation, because, it is impossible to put a price on someone's life and therefore impossible to indemnify someone against injury or death. We can only pay previously agreed compensation for injuries or death.

8.5.1 WHAT IS COVERED?

Personal Accident insurance compensates the insured, if they are injured or killed by violent, external and visible means as a direct result of an accident. There is no cover for illness.

Cover	Detail
Death Benefit	This must occur within a certain number of months of the accident for the benefit to be payable.
Permanent disablement	Depending on the degree of disability, a percentage of the death benefit will be paid, usually using what is known as the continental scale. A scale of benefits will be attached to the policy when it is issued. The benefit is to compensate the insured for the loss of a hand, or a toe or some other form of disablement, which is permanent, due to an accident.
Temporary total disablement	This is to compensate the insured when he is unable to work because of an accident. The benefit is normally payable for 52 or 104 weeks. It is usual for this to be based on weekly earnings and it would normally be based on the earnings of the insured. If the benefit was very large, underwriters would ask for details of the insured's wages. This prevents someone injuring themselves so that they can claim the benefit.
Medical expenses	The insured will select the amount of cover required.

8.5.2 EXTERNAL VISIBLE AND VIOLENT

This section generally causes some problems in interpretation. Take, for example, a man who picks up a box and in so doing injures his back. This is not covered as there was no violence. If, however, the box falls on his back and injures it, there would be cover.

Proximate cause can be difficult to determine. There have been, and will continue to be, many contentious cases, under this class of insurance.

8.5.3 AGE RESTRICTIONS

Cover is normally restricted to persons between the ages of 15 and 70 years old.

8.5.4 RATING

It is normal for cover to be sold in units of R10 000. This is the death benefit. Depending on occupation an amount is charged per unit. Cover for other benefits such as permanent or temporary disablement is usually related to the amount of the death benefit.

EXAMPLE

R10 per R10 000 unit.

The client wants R50 000 death benefit

Premium R500 per annum

8.5.5 CONCLUSION

The major point to remember under this section is that it is for injury and death arising from an accident. At one time, cover could be purchased for illness and death from disease, but this is virtually unobtainable in the South African short term insurance market. Cover is in respect of injury or death arising from violent, external and visible means as a direct result of an accident.

8.6 PERSONAL LIABILITY INSURANCE

The Personal Liability policy is designed to indemnify the insured or a member of his family who lives with him, for legal liability they may incur.

We have already mentioned liability cover under the householders and houseowners sections. The cover under these sections is specifically for liability incurred at the insured's premises. There are really three aspects involved:

- liability as the owner of the house (property owner's liability);
- liability as a tenant; and
- liability apart from the above (personal liability).

In personal insurance policies, all three of these might be combined in a single liability section, but property owner's liability is effective only if the building itself is insured under the houseowners section.

8.6.1 ADDITIONAL LIABILITY COVER NEEDED

Insurers recognise that the insured can incur liability apart from the house.

EXAMPLE

- You work in Johannesburg.
- One day while crossing a road, you cause an accident.
- The road is a one way street and, unfortunately, you look the wrong way.
- You step onto the road and a car has to swerve to avoid hitting you.
- In so doing, the vehicle hits a lamppost.
- The driver of the car sues you for the damages.

Remember that this would be personal liability cover. It does not extend to any kind of business or professional activity, or liability from the ownership or use of most kinds of vehicle. Under liability insurance, you must distinguish between the insured's liability, and the insurer's liability under the policy. The insured is personally liable to the third party, irrespective of the policy limitations.

Insurers may undertake the defence of the claim and negotiate settlement on behalf of their insured, but only up to the policy limit. If the final amount is more than the policy cover, the insured is responsible for the rest.

8.6.2 PREMIUM

The premium for this section is normally very small and cover can start at R1 000 000, but is often much more.

8.7 SMALL CRAFT INSURANCE

Many personal lines policies include a section to provide cover for small craft such as sailboats and motorboats used for private and pleasure purposes.

8.7.1 COVER PROVIDED

This is similar to a motor policy, and includes:

- damage to the vessel, by fire, theft, or accidental means;
- liability to third parties, including people in the water; and
- limited medical expenses for accidental injury to people on board.

Since this cover is for watercraft, a number of special extensions and provisos apply. These vary among insurers and are not detailed here.

8.7.2 PREMIUM

This depends mainly on the value of the boat, the size of the engine, and whether to be used on inland or coastal waters.

8.8 CONCLUSION

IMPORTANT NOTES on personal insurance

Personal policies can be issued to cover:

- one section only as in motor insurance;
- cover can be for several sections;
- the distinction between policies of inclusion and policies of exclusion must be noted;
- where the cover applies as houseowners and householders policies cover premises risks; and
- all risks policies are on a worldwide basis.

QUESTIONS ON CHAPTER 8

Revision questions

Work through these revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. What is the accepted definition of standard construction of a dwelling?

2. What are the main factors used to rate a Householders risk?

3. In what way is the nature of all risk cover totally different to that of the cover under householders?

4. What is the main difference between the liability cover that may be included in the houseowners section and the cover under the specific liability section?

5. What are the three main categories of cover under the typical pleasure boat insurance policy?

Written questions

Attempt these questions after you have completed this chapter and its revision questions. Suggested answers to these questions are at the end of this book.

1. List the benefits that are available under a Personal Accident policy.

2. Explain the different kinds of liability cover needed by private individuals.

3. Explain why the insured requires All Risks insurance, even though he has householders insurance.

CHAPTER 9

COMMERCIAL INSURANCE

Learning Outcomes

When you have completed this chapter you should be able to:

- list the advantages of Multi-Peril policies;
- list the standard exceptions to the Multi-Peril policy;
- list the general conditions to the Multi-Peril policy;
- define the different covers available under the Multi-Peril policy;
- list the perils covered under the different sections of the Multi-Peril policy;
- list the exclusions to cover under the different sections of the Multi-Peril policy;
- explain the difference between the legal definition of theft and the cover available under a theft policy;
- explain what a First Loss Basis is, with regard to theft insurance; and
- give examples of what can be covered under the Business All Risks Policy.

Earlier we focused on personal lines insurance and its components. In this chapter we shall look at the major classes of business written in the commercial area of the short term insurance industry.

We will examine the different types of cover available to business and commerce today, and how that cover operates on a practical basis.

As mentioned earlier, in South Africa the main policy wording used today is derived from the now obsolete Multimark III and we have based our wordings on this, since it still forms the basis of many commercial policies.

9.1 MULTI-PERIL POLICY

Historically, separate policies were issued for the different types of cover the client needed, all with different renewal dates and separate premiums. This was neither a cost effective nor an efficient way of handling insurance. Today the Multi-Peril policy solves this. The Multi-Peril policy is quite simply a number of policies amalgamated into one document. This method is convenient because:

- the insured does not have to worry about different renewal dates;
- premium is paid for all the insurance at the same time; and
- it is less costly to issue for the insurer.

STANDARD EXCEPTIONS

In the policy wording there are certain standard exceptions. These are exclusions that apply to all of the sections of the policy. The standard exceptions are:

- loss or damage arising from war, riot and labour disturbances;
- loss or damage arising from the use of nuclear materials; and
- cover for property also covered in terms of a marine policy.

These are not the only exceptions. There are also specific exceptions which apply to the different sections of the policy. These appear under the different sections.

GENERAL CONDITIONS

These general conditions set out the conditions under which the various parts of the policy are handled. These are as follows:

- the policy will be voidable if there has been misrepresentation or non-disclosure;
- the insured must take all reasonable precautions to prevent a loss;

- any event that may result in a claim must be notified to insurers immediately. Any claim involving theft must be reported to the police;
- the contribution condition;
- the subrogation condition;
- there is no cover for any fraudulent claim;
- the insured must enforce his rights against any third party involved; and
- a cancellation condition. This deals with what the insurer and/or insured must do if they wish to cancel the policy.

The court decision in the case of *Isando Foods (Pty) Ltd v Fedgen Insurance Company Ltd 2001 3 SA 1278 SCA* has highlighted the need to handle the insurance of property which is in the process of being transferred from one owner to the other very carefully.

In this case the courts refused Isando's claim for costs arising from fire damage to an extractor unit which was being purchased from Epic Oil Mills but which had not yet been completely transferred.

The court referred to past UK decisions in ruling that, prior to transfer of ownership, the new owner could only be held responsible for damage as a result of its own negligence, but that the existing owner was responsible for damage caused by vis major. This indicates how the standard policy wording "damage to the whole or part of the property ... owned by the insured or for which they are responsible ..." is to be interpreted.

9.2 FIRE SECTIONS

Formerly, insurance offices were organised into departments dealing with each of the main classes of insurance. With multi-peril policies, this no longer applies. For the purposes of this course, we shall discuss the different sections of the policy according to the main class of insurance covered.

9.2.1 INSURED PERILS FOR THE FIRE SECTIONS

Originally, the standard fire policy covered only fire, lightning and explosion. Other perils may be covered as optional extensions. Briefly, the perils are:

- fire;
- lightning;
- explosion;
- storm, wind, water, hail, snow;

- aircraft and aerial devices;
- impact by animals, trees or vehicles;
- earthquake;
- subsidence and landslip;
- sprinkler leakage; and
- malicious damage.

This section is designed for industrial, manufacturing and business risks that cannot be covered under Office Premises or Buildings Combined Policies. It is designed to cover buildings, contents and rent.

9.2.2 SUM INSURED

Mainly, cover is on a replacement value basis. For the different classes of property, the sum insured should be:

- **buildings** - based on the cost of rebuilding;
- **stock** - should be on the cost or purchase price and not the selling price; and
- **plant** - can either be on current value or reinstatement value conditions. This means that the insured can elect to have a kind of "new for old" cover, based on replacement cost.

9.2.3 BUILDINGS COMBINED

This policy is very similar to a Houseowners policy, but it is designed to cover business premises. It is for any building occupied for purposes considered less hazardous than the usual. Below are some examples of the type of risk that can be covered under this section.

- banks;
- art galleries;
- colleges;
- churches;
- flats;
- offices;
- schools;
- museums;

- libraries; and
- hospitals.

PERILS COVERED UNDER BUILDINGS COMBINED

The perils covered are:

- fire, lightning, explosion and subterranean fire;
- storm, wind, water, hail and snow, excluding:
  - subsidence and landslip
  - damage to gates, posts, fences and retaining walls;
- earthquake;
- aircraft and aerial devices;
- bursting or overflowing of water apparatus, including damage to the apparatus;
- impact by animal, vehicle or falling tree; and
- theft or any attempt at theft, if accompanied by forcible and violent entry or exit.

This policy is designed to cover the building and landlord's fixtures and fittings only. There is no cover for any other contents.

9.2.4 OFFICE PREMISES POLICY

This policy is very similar to a Householders policy. It is designed to cover the office complex and should not be used for a risk where the office is part of a factory, because the fire and theft risk might be very different.

PERILS COVERED UNDER OFFICE PREMISES

The perils covered are:

- fire, lightning, explosion and subterranean fire;
- storm, wind, water, hail or snow excluding damage arising from the articles undergoing a process which requires the application of water;
- earthquake;
- accidental damage to mirrors and glass which forms part of furniture;
- impact by animals, falling trees or vehicles; and

- aircraft and aerial devices.

The policy also covers loss of rent up to 25% of the sum insured.

Optional extensions are:

- malicious damage cover;
- riot and strike for property outside RSA and Namibia; and
- theft - the insured can choose full theft cover (similar to a Householders policy) or cover against theft following forcible entry or exit only.

Cover can be extended to include the cost of replacing or restoring documents that are damaged by an insured peril, as well as any liability the insured may incur because of their destruction.

Computers and other data processing equipment are excluded in terms of the policy wording, but can be included if specifically mentioned and insurers agree.

SUM INSURED

Insurance is on replacement value conditions and therefore the sum insured must reflect the cost of the article today and not when it was purchased.

9.2.5 BUSINESS INTERRUPTION INSURANCE

The covers we have looked at up to this point, all cover tangible property. The items insured can be touched and seen. If they are damaged they can be replaced.

But what happens if there is a reasonably large fire and the insured is either unable to operate at full capacity, or can only produce a smaller quantity of work than was being produced prior to the loss? In this case, a loss has taken place, but it is not one that can be touched or seen. As a result of this loss, the insured will have reduced turnover and his profit will probably be affected.

For this reason, Business Interruption Insurance was developed. It is also known as Loss of Profits insurance.

The purpose of Business Interruption Insurance is to:

- reimburse those charges that continue regardless of the reduction in turnover;
- meet the additional costs incurred to enable the business to recover more quickly, or to keep it operating; and
- pay the net profit that would have been earned if there had there been no loss.

The mathematics for adjusting a loss are clearly laid out in the policy wording, but many people find them quite complicated. The areas which cause problems are:

- the length of indemnity period, and
- the gross profit sum insured.

PERILS COVERED

Cover in terms of the Business Interruption section is for losses following the fire perils insured under the:

- fire section;
- office contents section;
- buildings combined section; and
- any other material damage insurance in respect of perils covered under the fire section.

Business Interruption insurance seems complex to many people, but for your purposes you need only a basic outline of some of the terminology.

INDEMNITY PERIOD

When cover is purchased, the insured must decide on an indemnity period. This is the time it would take for the insured to:

- get the business premises rebuilt or new premises found;
- get back any market share he may have lost; and
- rebuild the company's stocks to the same level they were at prior to the loss.

The indemnity period must be long enough to cover all this. Some factors the insured must look at are:

- availability of other premises;
- other companies manufacturing similar products;
- the availability of companies to which work can be out-sourced; and
- how dependent is the market on his product.

This will enable the client to better assess the indemnity period required.

GROSS PROFIT

The insured needs to work out his annual gross profit. The policy clearly defines Gross Profit. There are two bases that can be applied:

- **Difference Basis** - turnover plus closing stock, less the opening stock and uninsured costs; and/or
- **Additions Basis** - net profit plus standing charges.

The main problem comes when the indemnity period and gross profit are put together.

EXAMPLE

- Indemnity Period 6 months
- Annual Gross Profit R1 000 000

Note that even though the indemnity period is 6 months, the annual gross profit figure must be used.

For an indemnity period longer than one year, the insured must take the annual figure and multiply by the indemnity period.

A further example:

- Indemnity Period of 2,5 years
- the sum insured is R2 500 000.

Therefore R1 000 000 × 2,5 years = R2 500 000

UNINSURED COSTS/STANDING CHARGES

These are defined as:

- **uninsured costs** - costs that will vary in accordance with the loss, for example, packaging and postage, less stock to send out; and
- **standing charges** - costs that will not vary with the loss such as car leases, rent, bank charges and interest charges will still have to be paid.

ACCOUNTS RECEIVABLE

It is common for goods and services to be sold on credit. To manage these purchases and payments, the store or company must keep records of:

- who owes what;

- what has been paid; and
- what is still outstanding.

If something should happen to their records they would stand to lose money. This is the reason for Accounts Receivable or Book Debts insurance.

Application of Accounts Receivable

An Accounts Receivable policy operates on an all risks basis and is normally an adjustable policy.

The insured pays a deposit premium and declares to the insurer the amount of debts outstanding to them, the insured, either monthly or quarterly.

At the end of the period of insurance the premium is adjusted, with either an additional or refund premium being due.

Bad debts are not covered under this policy. These are debts that the insured's clients are unwilling or unable to pay.

This insurance exists solely to cover the insured against being unable to collect debts because of loss of the company records by accidental means.

9.3 ACCIDENT CLASSES

In the previous section, we looked at the cover available under the fire type policies. We now look at those contained under the accident classes.

9.3.1 GENERAL EXCEPTION

It is important to note that a general exception under most accident policies is that of collusion, or theft by employees.

What is the difference between an exclusion and an exception? Usually, an exclusion can be deleted from the policy and the peril covered for additional premium. An exception cannot be deleted as it always applies.

9.3.2 THEFT INSURANCE

We are continually being told how high the crime rate is in South Africa. In particular, there is a high level of violent crimes, such as armed robbery. The theft policy is available to protect the insured, however premiums are high, because of the losses incurred.

THEFT DEFINED

The law states that theft is,

> *"the act of taking someone's property with the intention of depriving him of it permanently."*

This is a very wide definition. Insurers restrict the cover to losses following forcible and violent entry or exit to or from the premises. Theft by shoplifting or unexplained losses are not covered.

IMPORTANCE OF FORCIBLE AND VIOLENT ENTRY OR EXIT

Forcible and violent is important as it means that:

- a hold up is included as part of the standard wording. Insurers recognise that there is nothing more violent than armed robbers holding a gun to your head; and
- cover is in respect to the contents of the building situated at the stated premises.

There is no cover for goods stolen from open yards or unprotected areas.

EXTENSIONS

Since the theft must be accompanied by violent or forcible entry or exit, there is usually damage to the premises. For this reason, there is limited cover for damage to the building following theft. This limit can be increased on request.

There is also cover for the cost incurred to take temporary measures to safeguard the remaining goods. For example, the hiring of security guards until the building is secured again.

UNDERWRITING CONSIDERATIONS

There are a number of things that the underwriter must consider before giving cover. These include:

- the area in which the risk is situated;
- the type of stock at the premises (jewellery is more attractive to thieves than bricks);
- the protections at the premises such as an alarm system or burglar proofing; and
- the first loss sum insured required.

FIRST LOSS SUM INSURED

Theft insurance can be for full value, but is normally written on a First Loss Basis. This means that the insured has to decide on the amount of goods thieves would be able to steal before being discovered.

Factors that influence this are:

- security - if there is an alarm system with armed response, the thieves will not have very long, before they are discovered; and
- the type of goods covered - jewellery is more easily moved than furniture. The first loss figure should take into account, how mobile the contents of his premises are.

MALICIOUS DAMAGE

The insured must also assess how susceptible the contents are to malicious damage as covered under the theft policy.

The Malicious Damage extension available under the Fire section covers deliberate wilful damage, but not loss or damage to property of any kind that is:

- stolen;
- damaged by thieves in an attempt to remove it; or
- damaged by thieves while breaking in or attempting to break into the premises.

In some cases the potential for theft may be very small, but the potential for malicious damage at the premises may be great.

CONCLUSION

With the current crime rate, insurers will continue to insist on greater protections and higher premiums, and will try to limit sums insured as much as possible.

9.3.3 BUSINESS ALL RISKS (BAR)

This is also called Commercial All Risks. It is the same as the Personal All Risks policy except that it covers property owned or used for business purposes.

EXAMPLES of Equipment which can be insured under BAR are:

- doctors' bags;
- professional photographers' equipment;
- tools and equipment;
- car radios in business vehicles;
- two way radios;
- travellers' samples; or
- cellular telephones.

IMPORTANT APPLICATIONS

Like the domestic all risks policy, this policy is one of exclusions. Great care should therefore be taken when underwriting this business. All too often policies are issued with an item covering

- tools and equipment sum insured R100 000
- rate 5%
- excess R500,00

This would be acceptable if this was the total value of tools. But it is common to find several workmen, each with R10 000's worth of tools insured under an item. The most expensive item could be R5 000 on its own.

The insured would therefore be paying a very small amount of premium for a large exposure.

An underwriter should therefore find out full details of all the items insured.

9.3.4 GOODS IN TRANSIT INSURANCE (GIT)

Goods in transit cover is designed to cover goods which are being delivered:

- by the insured; or
- to the insured.

The type of business that would require this cover is a local delivery service to South Africa and neighbouring countries. Overseas deliveries must be covered by Marine Insurance, described later in the course.

Even the local garage could need GIT cover for the collection of spare parts.

What is covered?

Cover is normally on an all risks basis, so any peril not excluded is covered. Cover can be restricted however to fire, collision and overturning of the vehicle and theft following these, at a reduced premium.

The goods are covered whilst:

- being loaded or unloaded;
- temporarily in storage during a journey; and/or
- in transit.

There is normally a basic excess and a hijacking excess included with Goods in Transit cover. Hijacking has become a very serious problem in recent years and this has forced insurers to apply the additional excess.

What should not be covered?

Goods in Transit cover is not designed to cover things such as workmens' tools that the insured plumber carries with him all the time. These must be covered under Business All Risks. The Goods in Transit policy is designed to cover stock, or goods consigned to a destination.

EXAMPLE

For example we spoke about the plumber.

- He will carry tools and equipment for doing his work.
- He will also carry piping, which he will use at the client's premises.
- He will occasionally have a kitchen sink or bathroom basis that he has to fit at the client's premises.

He could cover his tools under a Business All Risks and the sink or basin, which is not his permanently, under the Goods in Transit policy. The pipes could also be covered under Business All Risks because, whilst he does not carry the same piping with him all the time, he will be carrying piping.

9.3.5 MONEY INSURANCE

The intention of this cover is to indemnify the insured for money lost or damaged whilst:

- at the insured's premises, or
- being transported to or from the bank.

There are two limits under the money policy which are known as the major limit and the minor limit.

MAJOR LIMIT

The Major Limit is the full sum insured. This is:

- cover for money to and from the bank;
- cover for money whilst at the premises overnight, in a locked safe; and
- cover for money at the premises during the day.

The cover is limited to South Africa, Namibia, Lesotho, Botswana, Swaziland, Zimbabwe, Malawi and Mozambique.

MINOR LIMIT

The Minor Limit is normally restricted to an amount such as R5 000. This provides cover:

- while the money is in the custody of directors on the business of the insured (anywhere in the world);
- while at the home of any partner or director; or
- whilst on the premises of the insured, outside business hours and not contained in a locked safe.

CROSSED CHEQUES LIMIT

The policy automatically gives cover for crossed cheques up to an amount of R100 000. The policy wording may have 25% excess included if the cheque is not crossed not transferable or there may be a limit imposed for uncrossed cheques.

The incidence of cheque theft and fraud has been reduced with the use of electronic banking.

THEFT BY EMPLOYEES

Under the money policy, there is a limited amount of cover for theft of money by employees. The restrictions are:

- the loss must be discovered within 14 days of its happening; and
- cover only applies under this section if the insured does not have a Fidelity Guarantee policy.

9.3.6 FIDELITY GUARANTEE INSURANCE

This class of business is specifically designed to deal with fraud and theft by employees. It does not cover theft of money only, but also the theft of stock and goods.

The policy can be issued on one of three bases and these are:

- named persons basis where the name of the individual/s who may steal from the insured (example, John Smith. This does not mean that Mr Smith is suspected of dishonesty, but he is in a position of trust, where he has an opportunity to steal.);
- positions basis such as stock handlers; or
- a blanket basis - this covers all employees of the insured.

PREMIUM CALCULATION

The premium is based on:

- the number of employees;
- the sum insured; and
- the level of controls to prevent theft and how hazardous the risk is.

In this class of insurance, the level of hazard is judged by how easy it would be for staff to steal and also the levels of salary and wages paid to employees. If employees are well paid and treated well by an employer, there is less likelihood that they will steal from the employer. If wages are very low the employees may be tempted to steal to increase their wages and to survive in hard economic times.

The excess for this class of business is negotiated with the insurer and is normally:

- a % of the sum insured; or
- a % of the claim loss,

Premiums are high for this class of business as white collar crime is on the increase. It is also possible to purchase retroactive insurance which gives cover for losses which occurred during the previous period of insurance but which was only discovered after inception of the present policy.

9.3.7 GLASS INSURANCE

This insurance provides cover for the accidental breakage of glass. The cover is really designed for the breakage of plate glass windows, which are thicker than the sheet glass which you have in your windows at home, although usually not for glass over 6mm thick, which may need special consideration.

There is also cover for:

- damage to the window frames and any lettering or sign-writing on the glass;
- the cost of boarding up windows after a loss;
- plate glass shop counters; and
- mirrors.

SUM INSURED AND RATING

The policy is subject to average, and the sum insured should be the cost of replacing all the glass windows and doors and other items insured and not just the cost of one of these.

The rate is a percentage of the sum insured.

RENTED PREMISES

Where the insured rents premises it is important that he checks the terms of his lease to ascertain whether or not he is responsible for the glass at the premises.

9.3.8 GROUP PERSONAL ACCIDENT INSURANCE

Group personal accident insurance is the same as Personal Accident insurance, but is designed for companies that wish to insure their staff. The employer selects the cover required and the premium is usually rated as a percentage of, the benefit.

EXAMPLE

Death	R100 000	Rate	0,5%
Premium	R500		

A premium is charged for each of the benefits selected.

TYPES OF COVER

The table below shows the types of cover provided for the employees along with the details of how and when payments are made.

Cover	Detail
Death Benefit	Only applies if the person dies within twelve months of the accident and as a result of the accident.
Permanent disability	For this, a percentage of the death benefit is paid depending on the extent of disability.
Temporary total disability	This applies when the insured person is unable to work for a period of time. The benefit is normally payable for a period of 52 or 104 weeks, but can be up to five years, or for a period elected by the employer.
Medical expenses	These are the medical expenses incurred following an accident.

BASIS OF COVER

There are various options for the issuing of cover. The insured person can be covered either on a:

- 24 hour basis; or
- for occupational accidents only.

In addition, the policy can be issued to cover specified employees or a group of employees.

EXAMPLE

- John Smith, Sipho Thoba, Abdul Oman
- All truck drivers of the insured

INSURED PERSON

It is important to note that, in the event of a loss, the benefit is paid to the employer, who is the policyholder, on behalf of the employee. The employer is not entitled to keep the money, because in most cases he has no insurable interest in the life of the employee.

STATED BENEFITS

This is similar to Group Personal Accident, but instead of the benefit being a fixed amount it is expressed as a percentage of the employees' earnings. The table below gives an example of the benefits which could be payable under a Stated Benefits policy.

Cover	Detail
Death benefit	3 times annual salary.
Permanent disability	This amount is expressed as a percentage of Death Benefit, depending on amount of disablement.
Temporary total disability	100% of weekly wage for 102 weeks.
Medical expenses	This is the amount nominated at inception of policy.

OTHER DIFFERENCES

There is another major difference between Group Personal Accident and Stated Benefits policies.

Under Stated Benefits the amounts paid for Medical Expenses and Temporary Total Disablement are reduced by the amount of any benefit that is paid under the Compensation for Occupational Injury and Diseases Act.

We will discuss the COID Act later on.

9.4 LIABILITY

Every person (and every group of persons that constitutes a legal entity, such as a company or partnership) owes a duty of care to other members of the public or society.

If they are negligent and do not take care, and this results in injury or death of another person, then they can be held responsible at law to pay compensation to the injured person, or his estate.

9.4.1 PUBLIC LIABILITY COVER

If someone is injured or killed, then they or their estate must prove that the injury was due to negligence of the other party. If there is any disagreement, and negligence has to be legally proven, then the claim will have to go to litigation in order to reach a fair settlement.

Legal costs are extremely expensive and the public liability policy is designed to cover these costs as well as any damages awarded. It is important to realise that it is damages and costs for which the insured becomes legally liable.

EXAMPLE

- Veronica slips on oil that has been spilt on the supermarket floor.
- She injures her back and spends three weeks in hospital.
- She sues or takes legal action against the supermarket.
- The court orders the supermarket to pay R100 000 compensation, as well as all the legal costs.

The R100 000 and legal costs are the damages. It is the amount the court has told the supermarket to give her.

The Public Liability cover here is similar to the one that we studied under personal lines insurance. The difference is that this public liability policy is designed for business use.

LIABILITY ASSUMED BY CONTRACT

There is no cover for any liability the insured assumes by way of a contract or any other means, unless he would be liable for it by common law.

WHAT THE POLICY COVERS

The table below outlines the various types of liability that the policy can cover and provides an explanation for each.

9.4.2 PROFESSIONAL LIABILITY

The above does not provide cover for professional people who give advice to clients. This is a specialised type of cover, written by specialist companies within the insurance market. The type of cover they provide is as follows.

Type of Cover	Explanation	Example
Professional Indemnity	This is designed to cover people like doctors, lawyers and insurance brokers, and anyone else who can be held legally liable if they unknowingly give incorrect advice.	An example of this would be: • the insurance broker places cover on a motor car; • he does not disclose all the facts about previous claims to the insurance company; • there is a claim, and the facts are discovered by the insurers; • they repudiate liability; and • the client then sues the broker for the cost of the damage to the vehicle.

HOW INDEMNITY IS ACHIEVED

QUESTION
The public liability policy is a policy of indemnity, but how do we reach a figure that indemnifies the insured?

Answer
Indemnity, in this instance, is the amount the insured becomes legally liable to pay to the third party, including any legal costs the insured may have to meet to defend the case.

Indemnity is the amount, which the judge settles on. Not every case goes to court but, in an out of court settlement, an agreement will be reached between all the parties concerned. This will be based on previous awards made in court for similar types of injury.

AMOUNTS OVER THE LIMIT OF INDEMNITY

One very important point is that any award the court makes to an injured party is not limited to the limit of indemnity under the policy.

It is therefore important that the limit under the policy is high enough. Often, the amount of compensation is going into millions of Rands. Any amount not covered under the policy will have to be paid by the insured out of his own pocket. This can cripple the business and in extreme cases could lead to the business going into liquidation.

9.5 OTHER TYPES OF COVER

This topic covers those types of insurance that can be purchased with a commercial policy but which do not fall under the broad categories covered in previous topics. They are:

- Accidental Damage Insurance;
- Assets All Risk Insurance;
- Electronic Equipment Insurance; and
- Solvency Guarantees and Court Bonds.

9.5.1 ACCIDENTAL DAMAGE INSURANCE

The client will probably arrange fire, theft, money and public liability insurance. But, unless there is accidental damage cover there is still a gap in his cover.

This policy is designed to fill those gaps. It covers:

- accidental physical loss or damage to the insured property, other than as specifically excluded.

It is a section that needs careful reading but, for the purposes of the course, this is all you are required to know.

9.5.2 ASSET ALL RISKS AND ELECTRONIC EQUIPMENT INSURANCE

These policies are also known as Industrial All Risks and Accidental Material Damage. At this stage you only need to know of their existence. They are normally designed for very large corporate style accounts. They give wider cover than the normal Multi-Peril Policy.

They are designed on an exclusion basis. Any damage that is not specifically excluded is covered. Each policy is normally designed for the individual client.

The standard policy includes a section for the insurance of:

- loss or damage to the equipment on an All Risks basis; or
- increased cost of working and the reinstatement of data/programmes as a result of accident.

This is meant for the type of equipment in general use. More expensive or complicated applications would be insured in the Engineering department.

9.5.3 SOLVENCY GUARANTEES AND COURT BONDS

These are a form of suretyship. They guarantee that if the insured fails to pay an amount due under a contract, or fails to complete a contract, the insurer will pay.

It is therefore important that before issuing this type of guarantee, the insurer must be satisfied of the insured's solvency and ability to fulfil his commitments.

If an insurer has to indemnify the third party under this type of policy, they will then look to recover from the insured.

The main concern is that the insured company may have gone into liquidation. This is why the insurer will normally ask for collateral security, for example, the title deeds to the director's house together with a registered first mortgage bond, or other property. The insurance company can then attach the property and sell it to recover any money they have paid out.

EXAMPLES of these Guarantees are:

- Electricity Supply Guarantees - industry uses large amounts of electricity and the supplier of the electricity calls for a guarantee to make sure they are paid for the service.
- Performance Bonds - when a large contract is awarded, the principal can ask for a guarantee to cover extra costs, which have to be met, because of a breach of the contract by the contractor.
- Customs and Excise Bonds - imported goods and certain goods made in this country have duty payable on them. The Customs and Excise Department will not allow the release of these goods without the payment of this duty. This would slow industry down. To prevent this, a Customs and Excise Guarantee can be issued. The importer or manufacturer can then pay on account, with the insurer guaranteeing the payment to the Customs and Excise Department.

Chapter Reference List

Compensation for Occupational Injury and Diseases Act, 1993 (Act no 130 of 1993)

QUESTIONS ON CHAPTER 9

Revision questions

Work through these revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. On what is the sum insured under the commercial fire policy based?

2. What is another name used for business interruption insurance?

3. What is meant by standing charges?

4. What is the importance of the forcible and violent entry or exit clause in the commercial theft policy?

5. What kind of goods are generally covered under a business all risks policy?

6. What is the main difference between group accident and stated benefits cover?

7. How is indemnity achieved under a public liability policy?

Written questions

Attempt these questions after you have completed this chapter and its revision questions. Suggested answers to these questions are at the end of this book.

1. A potential client has requested details of the cover available to him under the standard policy wording. He manufactures bricks. In the form of a report, explain the various covers he may need.

2. Define theft from a legal point of view and from an insurance point of view. What is the difference?

3. Explain what can be covered in terms of the Business All Risks policy giving examples.