Topic 1: The life insurance industry

Study unit 1: Long-term industry bodies that affect the life insurance intermediary

1.1 Financial Services Board

The Financial Services Board (FSB) is an independent body that supervises institutions and services in terms of 13 Parliamentary Acts, which entrust regulatory functions to the Registrar of Long and Short term Insurance, Friendly Societies, Pension Funds, Unit Trust Companies, Stock Exchanges and Financial Markets in South Africa. These functions rest in the office of the Executive Officer, acting with other members of the executive and heads of the various departments.

The FSB is also responsible for the financial supervision of the Road Accident Fund. The FSB is controlled by a board appointed by the State President and has a Chief Executive Officer, who acts as Registrar, his deputies and chief actuary. The Board reports to the Minister of Finance.

The Executive Officer has wide regulatory powers. Regulatory actions include the authorisation and cancellation of financial services. He has formal powers of investigation with criminal sanctions in the event of obstruction, and if necessary, can apply to court for an interdict, or the curatorship of financial institutions. He can, in certain circumstances, also apply for the winding up or placing under judicial management of certain financial institutions, such as insurers and pension funds. The FSB must also be informed of any staff changes within the executive of insurance companies.

The FSB makes use of a Policy Board appointed by the Minister of Finance, with acts in an advisory capacity.

Provision is made for appeals against any decisions taken by the FSB through a properly structured appeal process. The appeal process includes notification of the appeal within 20 business days of the decision, accompanied by the required fee. Legal practitioners may represent an aggrieved person(s) at the hearing before the three person appeal board, but no appeals against appeal board decisions re allowed.

Another vital function delegated to the FSB by legislation is the licensing, administration and control of all financial services providers in accordance with the terms and conditions of the Financial Advisory and Intermediary Services (FAIS) Act. The FSB is funded by levies charged to the financial institutions over which it exercises authority. These levies are set by the FBS itself.

1.2 Life Insurance Ombudsman

The office of the long term Ombudsman came into existence on 1 January 1985, and is regarded as an effective and efficient alternative to resorting to legal processes. A complainant who remains aggrieved after a decision by the Ombudsman is free to commence legal proceedings, is so desired.

The Ombudsman take no instructions from anyone regarding the existence of his authority. It is specifically provided that he exercises his authority in a “spirit of independence, taking considerations of both law and equity into account”.

The Ombudsman acts as a mediator or conciliator who endeavours to bring about a settlement. He has recently been granted the power to act as an arbitrator by the FSB. The Ombudsman is vested with the authority to issue findings that are binding on insurers.

However, according to the first former Ombudsman, Mr Justice G Kotze, who was appointed Ombudsman in September 1986, not one of the 31 insures who support the scheme has ever declined to give effect to any advice regarding the disposal of a complaint. He expressed the view that "Conciliation, being a major tool used in the exercise of the Ombudsman's functions, frequently achieves a result favourable to insurer and insured alike".

The Ombudsman receives complaints submitted either verbally or in writing. After a complaint has been lodged, the Ombudsman calls on the insurer in question to reply to and submit all relevant documentation. On receipt of the insurer's reply, the complainant is given an opportunity to respond. According to Mr. Justice Kotze, telephonic hearings are seldom conducted, but can be arranged when necessary.

In cases where intricate medical, legal, actuarial and other problems arise during the consideration of complaints, the Ombudsman has the power to seek expert advice.

1.3 Association of savings and investments of South African

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

ASISA was formed in 2008 by members of the Association of Collective Investments (ACI), the Investment Management Association of SA (IMASA), Linked Investment Service Providers Association (LIPSA) and the Life Office's Association (LOA). These associations were disbanded and all assets and activities were transferred to ASISA.

The aim of this association are to:

- Work towards greater level playing fields;
- Create an environment enabling more holistic regulation;
- Become more consumer focussed;
- Collectively engage with government on policy issues.

1.4 Insurance Institute of South Africa

The Insurance Institute of South Africa was modelled on the Chartered Insurance Institute (CII) in London, and is affiliated to that body. The IISA has a full-time office in Johannesburg under the control of the chief executive.

With the closure of the College of Insurance at the end of 2006, the delivery of education and training has mostly been outsourced to preferred providers, with whom the IISA works in providing material, ensuring standards and professional membership.

The Institute is governed by a Board, comprised of the current President of the IISA, the Deputy President, the immediate Past President and the Honorary Treasurer, as well as several industry body representatives and members elected from the industry, assisted by the full-time executives of the IISA.

As with the CII, the major functions of the IISA include the awarding of diplomas and certificates to successful learners at various levels of professional membership.

1.5 Financial Planning Institute (FPI)

The Financial Planning Institute (FPI) was formed in 1982 as the Institute of Life Pensions Advisors (ILPA). The object of the FPI is to be a representative body, whose aim are to test, develop and protect the competence of persons engaged in the life insurance, pensions and health-care industries, and the associated or related fields of personal financial planning, health-care and employee benefits consultancy.

The aim of the FPI is to promote and advance the education of all its members, by the continued development of the study and practice of all the relevant principles.

The FPI is a properly constituted professional body, and its formation represented one of the most interesting and certainly one of the most significant developments in the history of professionalism in the financial services industry in South Africa.

The Institute is supported by intermediaries from the life and employee benefits arena and also internal staff and financial advisors operating in the broader field. It also covers those involved in the provision of advice on health insurance, medical aids, and so on.

Administration is handled by a small secretariat under the guidance of the Chief Executive Officer. Management is via an elected council under the control of the President of the Institute.

FPI members must pass a range of advanced examinations in the field of financial planning and are subject to a strict code of conduct as outlined in the Generally Accepted Professional Practice outline, known as GAPP. A disciplinary committee operates to handle complaints regarding misconduct.

Local Institutes elect their own councils and put on various events from time to time, including assisting students with their examination preparation, and holding breakfast or morning seminars with one or more guest speakers.

The FPI successfully completed negotiations during 1999 with the Charted Financial Planning organisation in the United States of America whereby all people who qualified with ILPA were allowed to convert their diploma and call themselves Chartered Financial Planners (CFP).

This is an internationally recognised qualification with recognition and chapters in over 30 different countries around the world. Affiliation with the CFP marque necessitated the name change of ILPA to FPI.

In 2001 the Association of Health Benefit Advisors opted to join forces with the FPI

1.6 Financial Intermediaries Association (FIA)

The Financial Intermediaries Association of South Africa (FIA) represents more than 15 000 licensed financial services advisers throughout Southern Africa. The origins of the FIA date back more than 50 years, with the organisation having recently evolved into a single, united national body representing the bulk of active licensed intermediaries in South Africa’s financial services industry.

The FIA's primary purpose is to represent, protect, promote and further the common interests of its members.

By belonging to the FIA, intermediaries can trust that they have the support of an influential organisation with the necessary stature and legitimacy to represent them at the highest levels of the industry, including regulatory bodies and industry associations.

The FIA enjoys a large and steady national membership comprising financial services intermediaries who cover the broad spectrum of financial planning.

All members of the FIA are authorised financial providers or representatives of such providers. In terms of the FAIS Act out members must adhere to all the requirements prescribed by the Act and its Regulations.

In a challenging and ever changing environment the FIA plays a vital role in influencing regulators and legislators with the promulgation of insurance laws, and to facilitate them an in-depth understanding of this complex industry which includes intermediation.

The FIA's primary purpose is to represent, protect, promote and further the common interests of its members.

1.7 Black Brokers Associations

Black Insurance Professional of SA (BIPSA) was officially launched in November 2004, and have been formally incorporated as a Section 21 Company

BIPSA's Executive Committee and its extended structures take the responsibility of contributing constructively to the transformation of the insurance industry seriously. Their vision is to create a demographically representative insurance industry both in leadership and ownership. Their mission is to accelerate transformation and development for black insurance professionals, and their values are:

- Probity
- Independence
- Professionalism
- Service
- Equity
- Urgency
- Entrepreneurship

BIPSA has the following strategic pillars:

- Development
- Entrepreneurship
- Transformation; and
- Insurance education / awareness

that form the objectives as a catalyst for transformation in the insurance industry.

BIPSA intends to introduce one of the largest, if not the largest, structured mentorship programmes in South Africa. Managers and leaders from across the industry are invited to act as mentors to learners from their own and/or other insurance companies.

BIPSA is hoping to ensure that black insurance professionals acquire the necessary skills and competencies to drive and influence both strategic and operational decision-making within the insurance industry.

Black Brokers Forum (BBF)

There is also an organisation known as the Black Brokers' Forum (BBF), which was formed early in 1999 with the aim of providing a home for previously disadvantaged brokers who were unable to meet the standards of existing broker organisations. It has since then opened its doors to any brokers, irrespective of colour, who are in this position.

Whilst the organisation still believes that it is in the best interests of its members to remain independent it has developed good working relations with other industry associations. The BBF has also made its voice heard by the authorities on a number of major issues affecting the intermediary.

Association of Black Insurance Brokers (ABIB)

The Association of Black Insurance Brokers (ABIB) also operates in the interest of black insurance brokers.

1.8 Institute of Retirement Funds (IRF)

This is a body set up to represent the retirement fund industry, largely made up of privately registered funds, state funds, insured funds run though the life insurers and brokers involved in the retirement fund field. The Institute has a small secretariat and fulfils a role in the dissemination of information regarding the industry as well as in lobbying on behalf of the industry.

Membership is via the fund rather than individuals, although the Institute does offer individual members a Diploma in Retirement Fund Management should they pass a series of examinations set and administered by Unisa.

The IRF concentrates on fund trustees and the administrators, insurers and benefit consultants.

1.9 Pension Lawyers Association

This body is made up of qualified legal people operating in the field of retirement funds.

The Institute of Pension Consultants and Administrators, an association formed by independent consultants and administrators in the Republic of South Africa which is directly concerned, though its

own specialised full-time staff, in giving advice on schemes or funds or administering such schemes or funds, for the provision of Group Employee Benefit programmes merged into the PLA in 2007.

1.10 Other Intermediary Groups

1.10.1 Agency Bodies

Although company agents in South Africa are clearly limited in their structures in the legal sense there are examples of some different structures.

Franchise Operations

Some of the larger life companies run their agency branches as separate business entities, or franchises, paying full broker commission scales but no other benefits. They leave it to the branch to arrange its own accommodation, administrative infrastructure and staff benefits. Such operations are still, however, agencies of the main employer.

Elite Corps

Many of the larger companies also allow the elite of their agency force to operate under a separate banner, often in conjunction with a franchise agreement, either in part or in full.

In many cases agents under such arrangements, although they are not able to obtain writing contracts with other companies, will form arrangements with agents of other companies or with brokers where some business may be placed elsewhere on a reciprocal basis or for an introduction fee where they believe that the interests of their client cannot be served through the products of their main employer.

1.11 Other Related Bodies

1.11.1 South African Reinsurance Offices Association (SAROA)

This is an association of companies that only transact reinsurance. A reinsurance company shares the risks that an insurance company accepts if the sum insured due if a claim becomes payable is more than the insurer can afford.

For this service the reinsurer shares in the premiums paid for the risk benefits provided. SAROA specifically considers insurance trends as applicable to reinsurers, as they tend to carry a greater portion of the larger risks than the direct writers of insurance do.

SAROA has since subsequently disbanded and the reinsurers now largely operate as a sub-section of SAIA, the body representing short term insurers.

1.11.2 South African Society of Insurance Medical Underwriters (SASIMU)

SASIMU is a society constituted with the express purpose of improving the communication between, and professionalism of, underwriters in the life insurance industry. The society was formed in 1992 and currently has branches in Johannesburg, Pretoria, Cape Town, Durban and Bloemfontein.

SASIMU also functions as the administrative body of the Institute of Life Underwriters. SASIMU actively encourages all life underwriters to achieve the status of a Fellow of the Institute of Life Underwriters.

The aims and objectives of SASIMU are:

(i) To be a representative body for the protecting and maintaining of ethical standards of persons engaged in the assessment of life, disability, health or miscellaneous long tern risks
(ii) To promote good fellowship amongst members of the society and other persons employed in the assessment of life, disability, health or miscellaneous long term risks
(iii) To disseminate technical knowledge and inculcate sound insurance risk assessment practices
(iv) To encourage the study of all matters relating to insurance and the assessment of risk and to recognise achievements and papers written by its members
(v) To arrange recognised examinations, specifically dealing with the assessment of life, disability, health or miscellaneous long term risks with the aim of promoting the achievement of the status of a Fellow of the Institute of Life Underwriters
(vi) To do such other lawful things as are incidental or conducive to the attainment of any or all of the above aims and objectives of the society

1.11.3 Association of Insurance Medical Officers of South Africa (AIMOSA)

The undertaking of medical examinations by practitioners for life insurance purposes is a specialised field and, therefore, in order to assist medical practitioners in becoming better qualified to fulfil this role AIMOSA was formed.

1.11.4 Pension Funds Adjudicator

The office of the Pension Funds Adjudicator is a statutory position created in terms of the Pension Funds Act.

The Adjudicator is appointed by the Minister of Finance is consultation with the Policy Board at the FBS. The main objective of the office of the Adjudicator is to dispose of any complaint received in a procedurally fair, economical and expeditious manner.

In order to achieve this, the Adjudicator may:

- Before investigating the claim, insist that the complainant first approach any organisation established for the purpose of resolving disputes in the pension fund industry that has been approved by the Registrar; or

- Investigate the complaint and may make a decision that will have the same standing as an order of a court of law.

Should the complaint have been referred to an established organisation in the pension fund industry and the complainant not be satisfied with the result, the complainant still has the right to refer the complaint back to the Adjudicator.

1.11.5 Ombud for Financial Services Providers

The Office of the Ombud for Financial Services Providers (FAIS Ombud) serves as a dispute resolution system through which complaints against FSP's or representatives can be processed. The office has been set up in such a way that the constitutional requirements of independence and objectivity are achieved. The process of dealing with complaints commenced when the final deadline for the registration of financial service providers expired.

The Ombud considers and disposes of complaints in a procedurally fair, informal, economical and expeditious manner, with due regards to:

- The contractual and legal relationship between the complainant and the other party; and
- The provisions of the FAIS Act,

The Ombud is empowered to:

- Award compensation for any financial prejudice or damage suffered by the complainant; and
- Issue a direction to a Financial Services Provider to take appropriate steps in relation to complaint.

It is important to remember that a determination by the Ombud has the effect of a civil judgment, and is executable through the ordinary judicial process. In addition, civil remedies are available in the form of class actions, and finally, criminal sanctioning is provided for through fines and terms of imprisonment.

1.11.6 Board of Healthcare Funders

The vision of the BHF is a private healthcare funding system that ensures lifetime access to comprehensive and affordable healthcare for the family of the average working person. Since its inception, BHF's primary focus has been to transform the healthcare funding industry association in such a way as to set it on a path to being a truly representative body which speaks with one voice in an extremely diverse community. BHF is not only poised to play a critical role within the SADC community, but also to make a meaningful contribution into the global arena

1.11.7 Council for Medical Schemes

The Medical Schemes Act of 1998 re-created a juristic person called the Council for Medical Schemes.

The Council is made up of 15 members, appointed by the Minister of Health, who takes into account the interest of members and of medical schemes when considering the appointments. Council members are chosen for their expertise in law, accounting, medicine, actuarial science, economics and consumer affairs. They may be appointed on either a full-time or part-time capacity.

One of the Council members will be appointed by the Minister of Health as the Chairperson and the members of the Council will select the vice-chairperson from amongst their ranks.

The Minister of Health is also responsible for the appointment of a Registrar and one or more Deputy Registrars of Medical Schemes after consultation with the Council. The Registrar, once appointed, is the executive officer of the council and in this capacity manages the affairs of the Council.

1.11.8 Insurance Sector Education and Training Authority (INSETA)

In March 2000 the Minister of Labour established twenty-five Sector Education and Training Authorities or SETAs which cover every sector in the South African economy. SETAs have replaced the thirty—three industry training boards.

The Insurance Sector Education and Training Authority or INSETA was established and represents the training and skills development interests of the sub-sectors within the insurance sector. These include:

- Short and long term insurance
- Pension funding
- Risk management
- Unit trusts
- Health care benefits
- Funeral benefits
- Reinsurance; and
- Financial intermediaries

The functions and responsibilities of SETAs are defined in the Skills Development Act, 1998. SETAs have to:

- Develop a sector skills plan
- Implement the sector skills plan
- Develop and administer learnerships
- Support the implementation of the National Qualifications Framework (NQF); and
- Undertake quality assurance
- Disburse levies collected from employers in the sector they represent and report to the Minister of Labour and to the South African Qualifications Authority (SAQA).

Chapter 2 - Legal and Tax Issues

2.1 Contractual Capacity

To have a contract one person must make an offer that can be accepted or declined by another person. Only once an offer has been accepted, is there a legal contract between the two people. No person is able to make an offer or accept the basis of a contract unless they have the ability to enter into a contract. This is known as contractual capacity. While most people have the ability to enter into a contract there are some who have only a limited contractual capacity and some who have no right or ability to enter into a contract at all.

2.1.1 Persons who have no contractual capacity

Insanity

A person who has been declared to be insane is said to be unpredictable and therefore incapable of being held responsible for his or her actions. Such person has no capacity to contract.

Person who are intoxicated

Any contract entered into by a person whilst under the influence of either alcohol or drugs is invalid and will be declared by the courts to be invalid from the beginning.

Minor children under age 7

In the past children under the age of 21 with said to be mine is but the passing of the Children's Act in 2007, the age of majority has been reduced to 18. There are two levels of contractual capacity applicable to minor children. Common law says that any child under the age of 7 is incapable of entering into any contract and so will need the help of a guardian for any contract even to open a bank savings account.

2.1.2 Persons with limited contractual capacity

Minor children ages 7 to 18

Current law says that any child over the age of 7 but still a minor (under the age of 18) has only a limited contractual capacity. Such a child will still need the assistance of a guardian for the signing of a contract but not for the opening of a savings account.

2.2 Insurable interest

There's a long history behind the needs to make sure that there is insurable interest when taking out an insurance policy. this need is probably the single most important difference between an insurance policy and a gamble.

For insurable interest to be present the person taking out the insurance policy must be able to provide tangible evidence if called upon to do so that he will suffer a financial loss in the event of the insured event happening. This evidence must be present at the inception of a life policy not necessarily at claim stage. The opposite is true for short-term insurance.

The need to show insurable interest can be traced back to the English Life Insurance Act of 1774 which was passed to prevent a “mischievous kind of gaming”. In essence, the act said that no insurance contract could be taken out by any person either natural or juristic on the life of another person unless there is an insurable interest. It also makes sure that no insurance contract could be taken out by way of Gaming or wagering. Any insurance contract that broke these rules was declared to be null and void or not legal.

The gaming act of 1845 while not making any specific mention of insurance or insurable interest said that all contracts or agreements whether verbal or in writing would be null and void if they were gaming or wagering. This was, in fact, the first time that all contracts made by way of Gaming or wagering were declared Void and unenforceable by law whatever their form or subject matter. The need for insurable interest is therefore well established in English law.

Insurable interest is no less important in South Africa than elsewhere. The Cape province decided in 1902 to use almost the exact wording of the gaming act of 1945 in the “Betting Houses, Gaming Houses and Brothels Suppression Act, 36 of 1902”.

The fact that wages or bets in the other provinces could not be enforced was based on Roman-Dutch law. The South African courts accepted the view of the Roman-Dutch writers from the end of the 18th century that all gaming or wagering contracts are enforceable. It, therefore, means that as a common law requiring proof of insurable interest is needed throughout South Africa.

While no mention of insurable interest appears in the South African Long Term Insurance Act of 1998 the legislation of our neighbour Botswana does. Whilst there is no actual definition of insurable interest the Botswanan legislation applicable to the insurance industry (which comprises chapter 46, 01 of the legal code) states, in Section 66;

Subject to the provisions of this at no policy of insurance shall be issued on the life or lives of any person or persons or on any other event or events whatsoever wherein the person all persons for whose use benefit or on whose account such policy or policies shall be made shall have no insurable interest.

An insurable interest shall be deemed to be had by -

A parent of a minor or the guardian of a minor but only to the extent as provided by section 77(a maximum of P2 000 on a minor who has not yet attained 16 years of age);

A husband on the life of his wife

A wife on the life of her husband

Any person on the life of another upon whom he is wholly all import dependent for support or education

A company or other person on the Life of an officer or employee thereof; and

A person who has a pecuniary interest in the duration of the life of another person in the life of that person to the extent only of that pecuniary interest at the outset.

2.2.1 When must insurable interest be present

In the case of Commercial Insurance Co vs Kern the court decided that- “The fundamental principle is that once the insured is deprived of his insurable interest in the insured car the policies is to have any validity”. This means that on a claim under a short-term contract the insurable interest must be established both at the time that the contract is taken out and also at claim stage.

In the case of Rixom vs Southern Life Association of Africa & Collins & Bain, the court decided that - “Insurable interest must be in existence at the beginning of the contract”. As this decision was about a life insurance policy it is now accepted as applying to all life policies. Any life insurance contract one must, therefore, prove insurable interest at commencement only.

When a person ensures his own life and then nominates someone else to receive the money when he dies such a beneficiary or cessionary once the life insured has died can claim without showing insurable interest and less the beneficiary or cessionary had actually taken out the policy and paid the premiums himself.

The insurable interest need not continue for the full term of the policy contract. Should a creditor ensure the life of a debtor the creditor will be able to receive the full value of the policy when they debtor dies, even if the debt has been paid in full at the time.

2.2.2 Examples of insurable interest

On the insured's own life

Insurable interest is irrelevant when the policy is in the insured own life. Insurable interest is really only needed as proof of the good faith of the people involved in the contract. What is generally accepted that every person has an unlimited insurable interest in his own life.

On the life of a spouse

It is usually accepted that there is an unlimited insurable interest between spouses. There may be no direct legal basis for this assumption but there has been a test case where this was accepted.

On the life of a Fiancée

There is some opinion that accepts that a person has some right to accept a financial advantage from the continued well-being of a Fiancée. And practice it is usually accepted that an engaged couple have the same level of insurable interest in one another's lives as a couple who have already married.

On the life of a relative

A dependent may have a legal right to claim support from a supportive relative and sew an insurable interest exists. In South African Law, both parents are under a legal Duty to support their children (legitimate and illegitimate). If they cannot support their children the duty passes to the grandparents.

Notes: only maternal grandparents can be held responsible for the support of an illegitimate child.

A person who cannot support himself as a result of either a mental or physical disability can claim support from a brother and/or sister if the parents are unable to provide it. A child must also support and infirm parent or grandparent. This legal duty creates an insurable interest. The insurable interest is based on and limited to the actual value of the loss of maintenance that might occur if the person providing the support dies. To establish the amount of insurable interest the age's state of health and wealth of both parties must be examined.

It has become common practice for parents to take out life insurance policies on the lives of their children for the purpose of covering possible funeral expenses that may arise in the future. Insurers in South Africa have generally accepted these proposals with the proviso that the level of life cover included with the application is at a reasonable level.

Note: parents in that do not have an insurable interest in the lives of their children under normal circumstances. The issuing of a policy is a concession made by the insurer(s) concerned. This does not make the policy invalid. Common practice over the years has made this an acceptable business practice provided that the level of life cover is justifiable.

A person may also have an insurable interest in the lives of his parents in law or family in law or against whom he may have a contractual or common law right of support. The insurable interest may even be further extended to any person who de facto supports the insured.

Creditor on the life of a debtor

A creditor has an interest in the continued health of a person who owes him money. In general, any contract where one person expects to get some benefit out of the continued health of another suggests a need for a legitimate contract of insurance. Insurance is allowed at least to the value of the debt plus some reasonable interest.

Business partners

Business partners create an insurable interest in each other's lives when they sign an agreement to pay money to the estate of a partner that dies. The agreement must be binding limits the insurable interest to the amount that must be paid to the estate of death. The same will apply to shareholders in a company and members of a close corporation.

Employers on their employees

An employer has an insurable interest in the Life of an employee if it can be established that the earnings of the company rely on the employee's skills or service. Remember however that a company can only ensure the life of a shareholder if the shareholder is an employee. Here the insurable interest is limited to the worth of that employee to the company and not the status as a shareholder.

Employees on their employers

An employee who has a contract for a fixed number of years at an agreed salary has an insurable interest in the life of his employer equal to the value of his future salary.

2.3 Principles of agreement

2.3.1 Mutual agreement (the meeting of minds or consensus ad idem)

For there to be a basis for the establishment of a valid life insurance contract between the proposal and the insurer there are a number of areas where agreement must have been reached. The proposer and insurer must have agreed on:

the proven identity of the insured person

The risk that has been insured against such as life cover only or with supplementary benefits

The amount for which the insurer will be at risk or sum insured

The value of the premiums Do by the policy owner in terms of the contract; and

The period of the insurance or the term of the contract

2.3.2 Caveat Emptor vs Uberrima Dudes

There are two distinct ways that contracts can be set up. They have a substantial legal differences.

Caveat Emptor

In all business dealings, one and it takes some form of contract even if most of these are simply verbal. Examples of these are the purchasing of a loaf of bread or a packet of chips from the local shop. Other contracts could be for large amounts such as the purchase of a car or a house.

All of these types of contracts will be based on caveat emptor or in English, “Let the buyer beware”. The terms and conditions offered by the salary term queried when you buy or else you accept that they are true and correct. There can be no come back unless the seller gives you some form of warranty.

It is often thought that there is a “cooling off” period when a major purchase is made. This is not correct. A cooling off period applies only to credit agreements that you may have signed. ASISA has a code of conduct in terms of which life insurance allow a cooling off period of 30 days during which an endowment or life cover policy may be cancelled without penalty.

Based on the principles of common law you will be able to apply to the court for relief In the event of deliberate fraud or Misrepresentation of the facts in a contract. However, ignorance of the law cannot be accepted as a valid defence. You are also expected to be aware of what you are signing or agreeing to at all times as "ignorance is no excuse in the eyes of the law".

Ubemma fides

The very nature of an insurance contract requires that the buyer (The proposer or insured) provides the seller (the insurer) with all the facts at his disposal. Non-Disclosure or misrepresentation of any of the facts will give the insurer the right to claim that the policy was void from the beginning (ab initio). Over the years of debate has arisen to the Insurance Contracts are contracts of utmost good faith (*Ubemma fides*) assembly contracts of good faith (bona fides).

The case of Mutual and Federal insurance company LTD vs Oudtshoorm Municipality (1985) finally cleared up this confusing principal. The Appellate Division decided that ignores good faith was an impractical concept since there can only be good faith or bad faith. A person may be less than honest but cannot be more honest than honest and utmost good faith was declared to be a meaningless concept in South African law.

With a contract, *Ubemma fides* it was accepted to that there was an obligation placed on the proposal to disclose all that he knows. The non-Disclosure of any material circumstance whether the proposal thought it was relevant or not would allow the insurer to avoid the contract from inception.

The implication of this and further Court rulings have resulted in the conclusion that the principle of *Ubemma fides* placed too heavy a responsibility on the proposal and the reasonable man test has been established.

2.4 Long-term Insurance Act 53 of 1998

2.4.1 Days of Grace

The Insurance Act provides that if an annual premium under a life policy has not been paid on her its due date the insurer must maintain the policy in Force for the full sum insured for a period of one month or for 15 days where the premium frequency is monthly or shorter. This is regardless of anything else agreed to and contained in the policy. Should the overdue premium be paid during the Days of Grace the insurer must continue the contract. If a claim occurs during these days of grace the insurer is entitled to deduct the unpaid premium from the claim amount. (Section 52(1)).

Should any premiums under a domestic life policy be unpaid and there is a remaining value which is greater than half of the average premiums do in the next 12 months the insurer must either issue a paid-up policy or apply for “non-forfeiture” rules such that the encashment value of the policy is used to pay the premiums to maintain the policy in force. When a paid-up policy is issued it must be issued free of any future need to pay any premiums. (Section 52(2).

2.4.2 Protection of certain Life Policies

Under the previous insurance act of 1943, there was specific protection for policies held by a wife on the life of her husband particularly where she was considered a minor and unable to contract in her own right. In terms of the new SA Constitution, this would have been seen to be discriminatory and so needed to be addressed.

When the Long-Term Insurance Act of 1998 was finally promulgated no protection of this nature was included in the act as it was no longer necessary. No mention has been made of the treatment applicable to any policy issued before January 1999 which was the date at which the new Long Term Insurance Act came into force.

2.4.3 Protection against Creditors

In the event of insolvency, insurance policies have some limited protection in terms of the Long Term Insurance Act. There are two situations that may arise here:

Insolvency before death

Insolvency of the estate of deceased

In the first situation, we included in the calculation of assets the encashment values of all the policies that are other property of the insolvent. This may be the property of an individual or in the case of a marriage in community of property the property of the joint Estate.

In the second situation, we included in the calculation of a claim value of all policies on the life of the deceased that when his property before his death and were payable to his estate.

In both situations it is only the first R50 000 of the totals due to that will be protected from creditors.

While we talk about policies owned by the insolvent either alive or deceased any policies ceded before the Insolvency him that can be shown to have been ceded to the advantage of creditors can be included in the insolvent Estate. Father any policies owned by a spouse married in community of property will also be included in the insolvent Estate.

Where a beneficiary has been nominated in a life policy the proceeds are not included in the deceased estate but paid directly to the beneficiary.

2.5 Miscellaneous restrictions and prohibition

2.5.1 Restricted insurance on children under 14

No insurer May ensure the life of a child under the age of 14 for any sum over:

R10 000 if the child is under 6 years or still unborn

R30 000 if the child is 6 years or older but under 14.

These amounts are cumulative and saw applied to the total cover on the life of the child with all insurance.

A payment that is bigger than the limitations can be paid out if

There are investment prophets included in the prophet policies that exceed the restrictions;

Or

A refund of all premiums paid plus interest compounded annually exceeds the restrictions

2.5.2 Limited relief for misstatements of age

In common law stating an incorrect age in a proposal form would be a breach of warranty and would entitle the insurer to cancel the policy. The Long-Term Insurance Act, however, rules that the insurer can only adjust the sum insured and any other benefits to the level that can be supported by the premium when this is recalculated using the correct age of the insured.

2.5.3 Only the rate table given to the registrar may be used

Every insurer must give the registrar of insurance a copy of every table of the rates of premiums it will usually charge. The insurer must also give details of the benefits it undertakes to sell as policies on the lives of normal individuals.

Having done so and the insurer is not allowed to use any other table or policy benefits unless:

The evaluator report so that it is actuarially sound, and

The insurer informs the Registrar.

This effectively prevents the insurer from providing any ones of discounts and/or special offers without first getting the approval of the Registrar.

2.5.4 No discrimination

Linked with the previous point is a ban on discriminating between two lives insured where they have the same life expectancy. This means that all persons of the same age who are expected to die at the same age must be offered the same rates and conditions.

It does not, however, apply to:

Reinsurance contract

Policies for large sums insured offered at preferential rates if these are known to the Registrar; or

Policies ensuring the lives of the employees of one employer on a group basis.

2.5.5 No inducements

No insurer or its employee's agents or intermediaries May pay any amount as an incentive to any person for taking out a life policy or to alter an existing one. This restriction applies to any direct or indirect offer that could be in cash or otherwise. Included in this restriction is also any discount or rebate of a portion of the commission or annual premium. Also, no person may knowingly accept such an incentive.

2.5.6 No credit for the first year's premium

No insurer May accept any proposal for life insurance if the proposal fails to offer to pay the first annual premium or a part thereof. Any payment offered for the first premium must be payable on the date of issue. Insurance do however have the right to accept an obligation for the policyholder to pay if the insurance satisfied that arrangements are in place to collect the premium for example by a debate or them or stop order.

2.5.7 Conditional selling

No person may lend money or provide credit and the insist that the loan or credit will only be granted if the borrower buys an insurance policy from the lender. Insisting that some form of security for the loan or credit is provided is, however, acceptable. Where a person borrows money or is granted credit the following conditions will apply:

The debtor can be required to provide security for the debt taking into account:

his creditworthiness

Any other security he may offer; and

Any other relevant information such as a guarantor

(b) where a new policy must be taken out:

The policy must be reasonable and related to the dept.; and

The debt must be allowed to choose his own insurer and use his own intermediary.

The type of policy can also be limited to a policy that only pays a benefit on the death or disability of the life insured. Should the borrower use an existing policy to cover the loan he must also be allowed to use his own intermediary to arrange the security cession of the policy and to make any changes that need to be made to the policy in order that adequate security on death or disability is included with the policy.

To ensure that the above conditions are complied with the policyholder must confirm in writing and before a security session can be lodged with the insurer that he:

Was it given written notification of his freedom of choice is as explained above

Exercised that freedom of choice; and

Was not subjected to any coercion or inducement as to the manner in which he exercised that freedom of choice.

2.5.8 Maximum commission scales

Part 3 of the regulations to the Long-Term Insurance Act 1998 set out the maximum rates of commission that may be paid to an intermediary. The regulations are referred to in section 49 of the act which further dictates that no consideration may be offered or provided other than the commission as laid down in the regulations.

2.6 Cause and circumstances of death

When it comes to the death of the insured the cause and circumstances are sometimes irrelevant. In most life policies the insurer must pay the claim regardless of whether the death was due to natural or accidental cause except where pre-existing illnesses have been excluded.

The occupation and/or activity that the life insured was following at the time of his death is often also irrelevant. There are however some causes of death that are excluded.

2.6.1 Death at the hands of the law

If the insurance policy is legally obtained but the insured is later convicted of a crime for which he is executed the insurer does not have to pay the claim.

2.6.2. Murder

The murder of the life insured is usually covered. However, it is a principle of our common law that no person can benefit by causing the death of another person. Therefore the murderer and anyone claiming through him can never benefit from the insurance.

2.6.3 Suicide

In South Africa suicide is not a crime. A person can also not be held liable if he encourages another to kill himself. However, the idea of suicide or the encouragement to commit suicide is against public policy. There is there for quite a lot of support for a limited suicide exclusion clause under a life policy.

Most if not all insurance in South Africa add a clause in the life policy that will cancel the contract if death is by suicide within a set period. This period is usually 2 years.

2.6.4 War service

The Long-Term Insurance Act says that no insurer May refuse to issue a policy to any person because he is performing or is likely to perform military service.

The insurer can, however, exclude death as a result of such a military action although the surrender value of the policy would still be paid out on death. Should cover for Death arising from military service not be included the insurer will usually refund premiums in the event of the death of the insured.

This is only applicable to policies issued after 21 June 1978. An insurer who is prepared to cover a person for military service Meyer charge an extra premium for the risk. Once the insured's military duties come to an end the policy owner may ask in writing for the extra premium to be cancelled. The insurer must agree but can exclude any further military activities.

2.7 Restrictions applicable to new business

Section 54 of the 1998 Long-Term Insurance Act states that:

A long-term insurer may not –

- Undertake to provide policy benefits or provide policy benefits
- Provide consideration upon the surrender of; or
- Make a loan upon the security of

A long-term policy contemplated in the regulations otherwise than in accordance with the requirements and limitations set out in the regulations.

The regulations mentioned in part 4 of the regulations to the Long-Term Insurance Act of 1998 and the important elements of this are summarised in the point set out below:

1. The minimum policy term must be 5 years (restriction period). Where a policy contradicts one of the roles explained here the minimum term to maturity must start again.
2. Life cover is not necessary. It is possible formed an insurer to issue pure endowment policies. Where the policy is a company owned policy it is not even necessary to nominate a token life insured.
3. It is possible to have more than one life insured on a policy. The policy may provide for the payment of benefits only on the death of the last dying.
4. One may substitute a life insured on a contract and delete the original life insured completely.
5. Policy owners are permitted 1 partial Surrender or loan against the policy during the first five years.
6. Increases in premiums are limited to a maximum of 20% per annum.
7. Payments of benefits other than as a result of a claim during the 5-year restriction period Are limited to the greater of the surrender value on a refund of contributions plus 5% interest.
8. Where a policy is fully surrendered during the restriction period the policy owner May only receive the total value of the policy if it does not exceed the value set out in point 7 above by more than R2500.
9. Benefits in terms of new policies can be paid during the restriction period if the claim is:
    a. A death claim
    b. Payment due on the birth of a child of the life insured;
    c. A disability claim; or

d. A claim in terms of a health insurance policy.

10. The rules do not apply to any policy used to underwrite benefits available from:
    a. A pension provident or retirement annuity fund;
    b. a friendly society; or
    c. A benefit fund;

Provided that is the benefits stay in the fund and I'm not ceded to a member. Benefits can be ceded to another fund similar to the one that the funds are currently invested in

11. There is a definition of an annuity included in the legislation and provided the definition is abided by the rules do not apply to an annuity. The definition means:
    a. Payment must be made at intervals not exceeding 12 months
    b. At least one of the payment must be made in the 31 days before to the end of the restriction period; and
    c. Payments in 112 month period may not differ from the payments in the 12 months he immediately preceding by more than 20% unless as a result of fluctuations within a linked investment portfolio.
12. The Minister of Finance May amend at any time by regulations published in the Government Gazette:
    a. The interest rate of 5%
    b. The minimum period of five years
    c. The escalation factor of 20%; or
    d. the number of loans or surrenders permitted in the restriction period which currently is 1 only.

2.8 Cessions

In order to fully understand cessions one needs to understand the status of an insurance policy document. Insurance policy documents are the evidence of legal agreements between the insured and the insurer. The document, therefore, represents whatever value they made be in the contract. This value is the property of the policy owner. As the policy document is the only legal representation of this value it is important that a record is kept of any transfer of the value. This is done by ceding the document and recording the session on the document and in the records of the insurer.

It is important to know the difference between an absolute cession and a security cession.

2.8.1 Absolute Cessions

In an absolute cession the cedent the person making the session transfers all his rights in the policy to another person(s) called the cessionary. The cessionary does not need to be a natural person it may be a company band or some other legally constituted body. In an absolute cession the cedent keeps no right whatsoever in the policy. The cessionary becomes the new owner of the policy. Only the cessionary May sue for the proceeds of the policy.

Some common absolute Cessions

Cession for value received

An endowment policy where the policy owner has been paying premiums for a number of years may have a substantial cash value. An investor can offer to buy the policy for its cash value from the policy owner. Once the purchase price has been agreed the transfer of the policy from the cedent to the cessionary can be done with an absolute Cessions for value received.

As a free gift

A policy can also be given as a gift perhaps to a loved one or family member.

In accordance with an agreement

Partners in a business often agree that on the death of one of the partners the other partner will purchase his interest in the business. To provide the funds for the purchase of the partners can use insurance policies on each other's lives. Often in a buy and sell agreement the buyers will be the proposers on the life insurance policy on the life of the seller. While this is common practice there is another way of arranging the insurance. The seller can propose a policy on his own life. As soon as the policy is issued his cedes the policy to the bottom in terms of the clause in the buy and sell agreement. This is then a session in accordance with an agreement.

In terms of a duly registered antenuptial contract

There are only certain limited protections available for an insurance policy in a marriage. These limited protections are restricted to a current maximum of R50 000 on the life of either spouse.

When two people decide to get married they need to set out the conditions of their marriage in an antenuptial contract. The future husband or wife can include a condition in the antenuptial contract that will cede a life insurance policy to his future spouse. This can be an extremely valuable gift and can be extended to any children or future children if it is also included in the contract. The advantages of this are:

Any policy ceded in terms of an antenuptial contract will be included in the estate of the deceased spouse. This will be so even if the estate of the deceased is insolvent. The policy will also be completely excluded when calculating any liabilities form estate duty and executor’s fees;

Any policy ceded in terms of an antenuptial contract will not be included in the estate of an insolvent spouse. As long as the antenuptial contract has been in existence for at least 2 years the policy will not be available for the payment of creditors regardless of its current value at the time. The value of the policy will also not be included when calculating the protection of available on any other policies that are to be included in the sequestrated Estate.

This form of cession should, therefore, be considered by every couple contemplating marriage.

2.8.2 Security Cessions

The cedent pledges the proceeds and value of the policy as security for a debt without giving up the ownership of the contract. This type of session is commonly used when a loan is taken from a bank. The cedent cedes the policy to the institution as security for the loan. Once the loan has been repaid the cession must be cancelled and the full rights of the policy will go back to the cedent.

2.8.3 Formalities attached to a cession

A contract of cession may be made I really although it has often been said that a cession is only complete when written confirmation of the cession has been handed by the cedent to the cessionary.

It seems to be generally accepted that the cession is not complete until the policy document has been given to the cessionary. However, it is only when there are competing claimants that this rule will apply. An uncontested cession will only be accepted as valid even if the cessionary does not actually have a policy document.

The insurer does not have to be told of the cession and cannot be held responsible if in such circumstances it pays to the incorrect party. In practice, however, the insurer will normally be informed and will add the cession to its records. Nonetheless, the party claiming that a session exists will be the one that has to prove it.

2.9 Beneficiaries

In South African law one person in a contract can promise the other person that he will award some benefit to a third person who is not part of the contract. This is a convenient way to include a third person as a beneficiary under a life policy. The contract between the insurer and the insured does not give any rights to the third person. He gets those rights only by accepting the benefit when it is offered to him.

The beneficiary under a life policy is only nominated to receive the proceeds of the life policy when they become due. He maybe even the insured himself or his Estate or a third person who was not included in the insured's contract with the insurer.

We cannot presume that a married person who takes out a policy intends to benefit his spouse and/or children. Where there is no nomination of a beneficiary of the proceeds will not be paid to a surviving spouse and/or child. The proceeds are paid to the estate.

While the insured is alive a policy payable to himself or his estate is an asset owned by him. It is his right to dispose of it as a legacy In His will. In this case, such policy can also be taken by his creditors and will become the property of the trustees if he were to be declared insolvent.

2.9.1 Third party as beneficiary

To include a third person as beneficiary and a policy we use the legal Maxim *stipulatio alteri*. The Proposal and the insurer agree with each other to pay the benefits of the policy to a third person.

The *stipulatio alteri* itself creates no contract between the insurer and the third person until such time as the third person accepts the nomination as beneficiary. A policy owner may change the nominated beneficiary while he is alive as often as he chooses unless the nomination is irrevocable.

A beneficiary may be nominated by name description or both. Where a name alone is used the nomination is clear. Where the nomination include a description (for example my wife) or is only a description confusion can Arise if the relationship between the policy owner and the third person changes.

In this solution, the courts have usually favoured the person who has been named as beneficiary. A nominated beneficiary does not have to be clearly identified at the time that the nomination is made. It is possible for a policy owner to simply nominate “my future children”.

2.9.2 Revocable nominations of beneficiaries

When determining the rights of a beneficiary in terms of an insurance contract one must first establish whether the nomination is revocable.

Before acceptance

Before the nominated beneficiary has been offered the proceeds of the policy and has accepted the benefit he has no rights. The insurer and insured can cancel or modify any benefits on the policy contract by Mutual agreement.

After acceptance

Once the nominated beneficiary has accepted the benefit offered to him (usually after the death) he gets the rights of a party to the contract. Benefits cannot be taken away without his permission and if the insurer fails to meet the claim he can Sue. However, the beneficiary also acquires corresponding obligations with his rights. As a result, should the insurer have been in a position to claim non-Disclosure or breach of warranty against the insured the same difference can be used against the beneficiary.

Time of acceptance

It is only the event insured against that the nominated beneficiary or his representative is given an opportunity to accept the benefit. Until the event insured against has happened and the beneficiary has accepted his nomination he will have no rights in the policy.

2.9.3 Irrevocable nominations of beneficiaries

Under an irrecoverable beneficiary clause, your beneficiary acquires full rights the moment he accepts the nomination in writing. This means that whilst the insured is alive he is not allowed to change or revoke nominations without the express consent of the beneficiary.

Conclusion

The importance of a beneficiary nomination should not be underestimated. Where there is a difference between the stipulations in a will and the nomination of a beneficiary on a life policy the court will favour the beneficiary nomination.

2.10 Beneficiaries and retirement annuities

It is possible to nominate a beneficiary who will then receive the proceeds of a retirement annuity if the purchaser dies before retirement. A retirement annuity contract is not a policy document but merely him a certificate of membership of the retirement annuity fund. The value that builds up in the fund belongs to the purchaser and he is entitled to indicate what his wishes are with regard the value after his death. Nominations cannot be irrevocable and will always be subject to the conditions imposed by the Pension Fund Act 24 of 1956 (as amended).

Retirement annuities are governed by the Pension Fund Act 24 of 1956 (as amended). In order to establish what is allowed for the nomination of a beneficiary on a retirement annuity, we must refer to this Act. The allocation of pension benefits on the death of a member before retirement as set out in section 37C.

Any benefit payable by the fund in respect of a deceased member will not form part of the assets in his estate. They must further be dealt with in the manner set out herein.

If the fund within 12 months of the death of the member becomes aware of or trace is a dependent or dependents of the member the benefit shall be paid to such dependant or in such proportions as may be deemed equitable by the person managing the business of the fund to such dependence.

If the phones do not become aware of or cannot trace any dependent of the member within 12 months of the death of the member and the member has designated a nominee who is not a legal dependent to receive the benefit or a portion thereof the benefit or portion thereof must be paid to the nominee. The designation of the nominee must have been in writing.

If the debts of the estate of the deceased exceed his assets the shortfall will be made up out of the proceeds of the retirement annuity and only the balance will be paid out to the nominee. The payment to the estate will be in the form of a commuted lump sum.

….

2. If a member has a dependent and has also nominated a beneficiary who is not a dependent the fund shall within 12 months of the death of the member pay the benefit to the dependent and the nominated beneficiary. It is the duty and responsibility of the person managing the fund to determine what proportions of the benefits will be paid to the relevant parties.

If the funds do not become aware of all cannot trace any dependent of the member within 12 months of the death of the member and if there is no nominated beneficiary or the nominated beneficiary has predeceased the member the benefit will be paid into the deceased's estate. Should there be no inventory submitted for the estate (the estate being too small and the member dying intestate) the benefit will be paid into the Guardian’s Fund. Payment will be in the form of a commuted lump sum.

2.11 Income tax and insurance

Since the discontinuance of the Sixth Schedule to the Income Tax Act the only policies that are affected by the income tax at all those that are owned by an employer on the Life of an employee. The policy needs to conform to the terms and conditions in Section 11(w) of the Income Tax Act. Should I not do so the policies will only need to be in line with regulation 4 of the long-term

insurance Act. There is no tax implication linked with policies that are controlled by regulation 4 only.

There are two sides to the tax implications of a policy that is affected by Section 11(w) of the Income Tax Act - the employer's and the employee's

2.11.1 Employer

In terms of Section 11(w) of the Income Tax Act, there will be allowed as a deduction" an allowance in respect of any premium which was actually paid by the taxpayer under any policy of insurance taken out upon the Life of an employee of the taxpayer". In the case of a company that he'd action will also apply if the policy is on the life of a director.

Provided that -

The policy was the property of the employer

Only the taxpayer was entitled to a benefit under the policy and there was no loan outstanding against the policy unless the loan was made by the taxpayer in order to obtain funds needed because the employee was in ill health infirmity incapacity or had retired or left

The policy in a term insurance policy or a policy that confirms that certain regulations that have been set by the Minister of Finance

The deduction will be limited in the case of a confirming policy to an amount equal to 10% of the remuneration of the employee or director.

Taxation laws amendment Act, 7 of 2010: Employer-Owned policies

Premiums on employer-owned life insurance policies such as a key person or deferred compensation policies will be tax deductible as from one January 2011 only if one of the two following conditions are met.

Condition 1

The premiums are included in the taxable income of the employee or director as a fringe benefit

Or

Condition 2

The policy is owned by the employer paid for by the employer is to receive the benefit. If there is a collateral (security) cession on the policy then the premiums May still be claimed as a deduction unless the cession is in favour of the life insured, his relatives or dependents.

The policy is taken out of the life of the employee or director to ensure that employer against any loss arising as a consequence of death disability or severe illness of the employee or director

The policy is a pure risk policy - there must be no cash value to the policy.

There must be no transaction operation or scheme in existence in terms of which the benefits will be paid directly or indirectly to the life Assured employee or director his relatives his estate or his dependents.

Practical implications- Existing Key-Person or Personal Liability Policies

If either of the two conditions are met then irrespective of whether or not the policy was originally set up as conforming or non-conforming and irrespective of whether the deductions are factually claimed as from 1 January 2011 the premiums will be fully deductible. The proceeds of policies that meet the conditions will be taxable to the extent of the premiums where deductible.

If neither of the conditions are met then irrespective of whether or not the policy was originally set up as conforming or non- conforming as from 1 January 2011, no premiums will be deductible. The proceeds of certain of the policies May still be taxable to the extent that the premiums were deductible under the old regime.

2.11.2 Employee

At retirement, the employee will not be receiving the proceeds of an insurance policy. The money received by the employee from his employer at retirement is in the form of a gratuity which can be funded from any source. The gratuity is included in the gross income of the employee.

The exemption granted by Section 10 (1)(x) of the Income Tax Act of a lump sum amount not exceeding R30 000 has been repealed. With effect from 1st of March 2011, a lump sum payment will be treated the same as payment received from retirement funds. The lump sum amounts will be exempted up to R300 000 and special rates will be applicable to any amounts in excess of R300 000. This falls in line with the new definition of severance benefits.

No exemption under the section will apply unless:

the person receiving the amount has attained the age of 55 years; or

The employee is relinquishing terminating losing repudiating cancelling or varying his office OR employment as a result of superannuation, ill-health or other infirmities; or

The employee is retrenched as a result of the employer seizing his business or down-sizing.

Where the taxable income of our taxpayer after having received the exemption still include an amount received by way of a gratuity the normal tax payable on the amount is calculated using Section 5(10). This is the rating formula section and allows the taxpayer to pay tax at the average and not the marginal.

2.12 Other General Taxation Issues

2.12.1 General overview

South Africa employs a range of methods of generating income for the government. The major types of taxation are as follows:

Income tax on the income and other earnings of private individuals and trusts

Company tax on profits made in a business and a Secondary Tax on Companies (STC) which is levied on dividends declared;

Value-added Tax (VAT) on most goods and services

Customs (excise) duties import charges, particularly special charges on various products such as petrol liquor and tobacco

Estate duty on the assets of deceased individuals with relatively large Estates

Donations tax on most transfers of assets via donations

Stamp transferrin and Company duties on a range of financial transactions including banking transactions credit agreements leases marketable security transactions insurance policies business registrations fixed property transfers trust registration and legal agreements

Other ad hoc income tax levies from time to time such as the special taxation Levy imposed to assist with the funding of the change in government in the “New South Africa”

Capital gains Tax

Toll road charges although these can probably be argued not to be taxed per se but fees paid to the concession holder for the upkeep of the roads

In the balance of this chapter, we deem income tax and company tax to be the most important considerations. A summary of the taxes relating to life insurance business is also dealt with.

2.12.2 Personal Income Tax

As from the 1st of January 2001 income tax is levied on all residents of South Africa, regardless of where there's income has been earned. Individuals who are natural persons are taxed on a sliding scale on their income.

In the 1995 budget steps were taken to ensure that income tax applies equally to all persons according to the late down tables although a separate scale applies to non-natural persons (excluding businesses), such as trusts.

The tax collection system has been continually modernised and administrative processes improve which enables SARS to process a taxpayer submission quicker and more efficiently.

Person's submit tax either through regular Pay As You Earn (PAYE) Holdings or through six-monthly provisional tax with a final recalculation at the end of the year, being 28 February of each year.

the process of calculating income tax is as follows:

Calculate general income

(remember to add specific inclusions such as lump sum proceeds annuities fringe benefits and other deemed income)

subtract exempt income

subtract deductions

Then apply the tax table to determine the tax remembering to take rebates off the amount in finding the tax payable from which any texts already paid during the year should be taken off to find the balance due.

Most foreign dividends received by individuals from foreign companies are taxable at a minimum effective rate of 15%.

Of particular importance is the fact that the proceeds of life insurance policies are not taxed in the hands of the recipient having already been taxed in the hands of the insurer, (except company and policies where premiums have been deducted for tax purposes) but there is no tax relief on premiums except for approved retirement funds (up to certain levels) and Permanent Health Insurance.

Lump-sum proceeds from approved retirement funds are partly tax-free compulsory annuities are full text and voluntary annuities are text only on the interest but not the capital portion thereof.

2.12.3 Corporate Tax

The corporate rate of tax of companies is 28% other than 4 certain organisations which are specifically given tax-free status and Mining and related companies (which are taxed separately) on non-dividend income.

Essentially all profits and incomes except dividends are included in the tax calculations but expenses incurred in the business (except those related to gaining dividends) are deductible. Rates of tax for certain categories of small business corporation's room's tax year comments after 1st of April 2001 traduced as an incentive to job creation.

The tax paid by businesses tend to be based on a flat rate (of 28%), with a concession of a two-tier rate for small business corporations. The qualifying Small business entity is now also paid tax had a further reduced rate.

A small business Corporation means any close corporation or private company the entire shareholding of which is at all times during the year of assessment held by shareholders all members who are natural persons, where -

The gross income for the year of assessment does not exceed a given maximum

Not more than 20% of the gross income of the company or close corporation consists collectively of investment income and income from the rendering of personal service; and

Such company is not an employment company.

The whole area of taxation of small businesses is consistently under review. For example and Innovation introduced in 2008 allows micro businesses to opt for a simplified turnover tax basis under which there is no liability for the First R335 00, and 3% on turnover above R750 000 per annum (2016/2017 tax tables).

Secondary tax on companies (STC) add 15% on dividends declared is paid as a Withholding tax on all dividends paid.

A Withholding tax is the amount of an employee's pay withheld by the employer and sent directly to the government as partial payment of income tax.

2.12.4 Taxation of Retirement Funds

The pension funds act and the income at make provision for the recognition of a number of different types of funds which are designed to give benefits on retirement death or ill health to members and/or their dependents.

However once approved under these acts there are certain conditions with which the funds must comply and these are set out in the attached tables later in this chapter.

These conditions are considered to be the most relevant and accordingly the following notes are intended to give the additional background and explanation not included in the tables themselves which of necessity must be brief form easy reference.

Eligibility

In the case of pension and provident funds membership of the scheme is compulsory for all new employees who are eligible in terms of the rules of the fund. For example, the rules May allow for

salaried employees to be members but not hourly paid employees. This is what is meant by stated categories of employees.

Benefit Description

This may be either defined benefit and fixed or defined contribution. The benefits in a defined benefit fund are based on salary and service whereas a defined contribution base that benefits on contribution and bonuses. In this context, bonuses mean any amount added to the contributions by way of interest.

Cash option at retirement

Note the main difference between a pension and a provident fund, is that under a pension fund only one-third of the retirement benefit may be taken as a cash lump sum, the balance must be a pension where is the full benefit may be taken in cash from a provident fund.

Tax deductibility

Employer contributions

Although the Income Tax Act states that the employee is entitled to deduct an amount equal to 10% of his wage bill from his taxable income in practice the authorities allow up to 20%. Note that the allowance covers all types of funds including medical aid schemes.

Employee contributions

The word retirement funding employment means employment which includes membership of a pension or a provident fund. Where the employee as a member of a pension and/or a provident fund the implications for the deductions of contributions to a retirement annuity fund must not be overlooked.

Note in terms of the gender equality practised in South Africa in accordance with the SA constitution there is no distinction allowed between men and women. A married woman is entitled to claim the same deductions as her husband if she is an income earner in her right.

Tax-free portion of any amount that can be taken as a cash lump sum at retirement

In the past, the tax-free portion of a lump sum taken from a retirement fund was calculated using a formula based on years of membership of a fund with certain Maxima applying according to the second schedule of the Income Tax Act. This is now based on the amount of such sum.

Since the situation of death and disability are treated as if retirement had occurred on the day before this will also apply for two benefits on death or disability before retirement.

A change in the text formulas in a second schedule allows for a special concession to certain government employees in terms of which the full benefits secured prior to 1998 could be taken as a tax-free lump sum.

2.12.5 Average and marginal Tax rates

Average rates

The average rate of tax is calculated by dividing the assessed amount of tax by the total taxable income

Tax due before rebates/Taxable income x 100 = Average Tax rate

As from 1st of September 1995, the average rate applicable is taken as the height of the average rate in the year of retirement and the previous year. This was introduced to prevent the practice of planning one's financial Affairs so as to severely reduce the average rate applicable in the year of retirement.

(b) Marginal rates

This is the rate of tax which applies to every additional R1 of income. Reference to a table of rates will show that the percentage rate of tax increases as the taxable income increases.

2.12.6 Taxation of life insurance policies

Apart from the tax on the front during the build-up in the insurer's hands, there is no tax payable on the proceeds of life policies held by natural persons.

Where a policy is owned by a company one of two situations may apply:

The company can pay the premium out of after-tax income (i.e. not deduct the premiums from corporate taxable income), in which case the proceeds will be paid out tax-free; or

The company can deduct the premiums from taxable income in which case the proceeds will be taxable in the company's hands.

The tax-deductible premium facility only applies to certain policies commonly called approved or regulation policies because they comply with the requirements laid down for approval of tax deduction by the Minister of Finance under Section 11(w) of the Income Tax Act.

2.12.7 Donations Tax

Donations tax is levied at a flat rate of 20% on gifts that another person or other organisation at any time during one's life (down from 25% before the introduction of CGT). Various exemptions are provided for, the most important of which are donations to spouses donations of up to R100 000 per annum in total by a natural person donations with no benefit arises until the death of the donor donations to certain institutions and property disposed of by a trust to its beneficiaries.

2.12.8 Capital gains Tax (CGT)

Capital gains on the Disposal of assets are included in taxable income.

Maximum effective rate of tax:

Individuals and special trusts 16, 4%

Companies. 22.4%

Trusts. 32.8%

Events that trigger a Disposal include a sale duration exchange loss death and emigration. The following are some of the specific exclusions:

Gain/loss on the Disposal of a primary residence (up to a given maximum);

Most personal use assets

Retirement benefits

Payments received in respect of original long-term insurance policies

Any game or loss on the Disposal of a motor vehicle for which you were the original owner

Annual exclusion minima capital gain all capital loss is granted to individuals and special trusts

Small business exclusion of capital gains for individuals (at least 55 years of age) of R1.8 million when a business with a market value not exceeding R10 million is disposed of

Instead of the annual minima, the exclusion granted to individuals is R300 000 in the year of death.

2.13 Policyholder protection rules

The original policyholder protection rules which came into effect in 2001 were introduced with far more detail than was originally intended. This was due to the delays in implementing the financial advisory and intermediary Service Act (FAIS) and was considered to be a temporary measure until FAIS was promulgated. Once this occurred the policyholder protection rules (PPR) needed to be changed. The revised policyholder protection rules came into force in 2004. The new version of the rules replaced the old rules in their entirety.

The main change to the PPR was the moving of the Disclosure requirements of providers other than direct marketers including the compulsory Disclosure document to under the FAIS General Code of Conduct.

The Disclosure rules for direct marketers still exist under the PPR.

The stated objectives of the PPR is to " ensure that Insurance Contracts are entered into executed and enforced in accordance with sound insurance principles and practice and are in the interests of

all the parties involved as well as the public interest if applicable". These rules cannot in any way affect or change the duty of any person as set out in terms of FAIS legislation or regulations.

2.13.1 Basic rules for direct marketers

UCI holder protection rules effective (from 30th October 2004) contain a comprehensive set of rules that must be followed by direct marketers regarding aspects such as:

Making contact with prospects

The representations (statements made) to prospects

Procedures and systems for record-keeping; and

Disclosures that need to be made

A direct marketer is an insurer who undertakes business in the form of Direct Marketing.

Direct Marketing is the marketing of insurance by way of telephone internet media insert or direct or electronic Mail but excludes any communication that falls under the description of advertising.

A direct marketer must at all times render service honestly fairly and with do skill and diligence. In making any contact arrangements and in all communication and dealings with a policyholder A direct marketer must at honourably professional IM and with due regard to the convenience of the prospective client.

Where any representation is made or information is provided to a policyholder it must be factually correct provided in plain language of void uncertainty or confusion and 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.

Direct marketers 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 5 years after the termination of the contract with the policyholder.

2.13.2 Cancellation of a policy by the insured

Where a policyholder has not yet received a benefit board and instituted a claim against a policy he may cancel the policy within 30 days and the insurer must no later than 60 days after having received the notice of cancellation refund the policyholder any premiums that it may have received. The only costs that may be deducted from the refund amount are those related directly to the provision of any risk benefits that the policyholder may have enjoyed before the cancellation.

2.13.3 Other Rules and Duties

The policy protection rules address the issue of void provisions on policies, effectively:

Boring insurance from refusing claims on the basis of the results of polygraph tests

Boring insurance from requiring arbitration for disputes; and

enforcing the period of Grace for premium payments.

Contact details of the relevant Ombudsman office need to be supplied.

An insurer must ensure that when it rejects or dispute a claim the policyholder is notified in writing of the reasons as a form and must be granted not less than 90 days to make representation to the insurer regarding its decision

Intermediary May allow a policyholder to sign a blank or partially completed application form from insurance.

Whenever an insurer agrees to a policy loan it must inform the policyholder of;

The interest he will be paying at the time that the loan is entered into

Whether the interest rate will fluctuate; and

What are the repayment arrangements are.

The insurer must also disclose to the policyholder-

The amount of policy loan and interest in relation to the value of the policy on a quarterly basis

The interest rate applicable to the policy loan and any changes thereto - also on a quarterly basis

When the loan is about to equal the encashment value of the policy

When the benefit under the policy is as a result of the policy loan equalling the value of the policy

6. On receipt of notification of a cession the insurer must disclose to the policyholder that the cession is recorded in the insurers records the nature of the cession and the name of the cessionary

7. No insurer or intermediary may ask or induce a policyholder to waiver any of his rights or benefits conferred on the policyholder by the terms and conditions of these rules.

Complaints Process

An insurer must within a reasonable time after the issue of a policy or the commencement date thereof inform the policyholder in writing of the details of any internal dispute resolutions systems and procedures that it has in place. The insurer must also at the same time provide the policyholder with the full particulars of the Long Term Insurance Ombudsman.

2.13.4 Assistance business group schemes

An assistance Business Group scheme means the provision of policy benefits under an assistance policy to a group where-

(a) Individual persons are policyholders
(b) No individual underwriting takes place
(c) The individual person whose life is insured is directly or indirectly paying premiums
(d) The policy may be cancelled by either party to the policy; and
(e) The policy has term cover only

It is normal practice that policies of this nature administered by a licensed Financial Service Provider FSP which has a written Mandate from an insurer to do the administration of the scheme. The FSP will handle:

- All enquiries
- Maintain administrative records
- Receipt premiums; and
- process claims

In accordance with the mandate which will be clearly stipulated in the agreement by the underwriting insurer.

The agreement entered into must contain at least the following clauses -

The premium Reitz to be charged by the insurer inclusive of commission payable by the insurer to an intermediary involved

Any fees to be added by any other party

If premiums are to be received by any person other than the insurer the agreement must contain at least the following:

The period within which such premiums will be paid over to the insurer

That the insurance the authority YouTube at any time ordered the books of the person receiving the premium

That the premium monies so received I handled as trust money

The scheme or administrator must provide the insurer with at least the following detail:

Names of policyholders and beneficiaries; and

Identity numbers of policyholders

If the scheme or administrator has the authority to pay claims it must set out the scope of schemes Om administrators powers to do so and the circumstances under which it may be done. The agreement cannot be cancelled by either party unless another insurer has provided written confirmation that it will take over the scheme.

Alternatively, the original insurer must provide the new insurer up with all the relevant information regarding the skin within 30 days of receiving confirmation that the insurer is prepared to consider the scheme.

The new insurance then also within 30 days of having accepted The Liability of the scheme comply with all Disclosure requirements by virtue of any legislation including the FAIS Act. The new insurance not allowed to impose any new waiting period to any existing policyholder on the scheme. A cancellation of an agreement to do so will only be effective if the registrar had been informed of the cancellation before it happens and is satisfied that all existing policyholders have been notified of the cancellation.

2.13.5 Other requirements of the policyholder rules

Termination

Where a policyholder has not yet received a benefit or instituted acclaim against a policy he may cancel the policy within a period of 30 days following the receipt by him of the summary that must be provided by the insurer in terms of section 48 of the long-term Insurance Act. the insurer must not later than 60 days after having received the notice of cancellation refund the policyholder any premiums that it may have received the only costs that may be deducted from the refund amount of those related directly to the provision of any risk benefits that the policyholder may have enjoyed before the cancellation.

Policy documents

An insurer must provide the principal officer trustees or managing person of a fund with a printed policy document for any fund policies that it may under right. It is the only way the insurer has obtained the approval of the registrar that this delivery may be postponed. The document must include all the conditions relating to discontinuance as well as a clear indication of all financial arrangements. This includes full details of all charges to be livid if the policy is terminated.

2.14 Financial Intelligence Centre Act (FICA)

This Act states as its objectives:

To establish a Financial Intelligence Centre and a counter-money laundering advisory council in order to combat money laundering activities:

To impose certain duties on institutions and other persons who might be used for money laundering purposes

To amend the Prevention of Organised Crime Act 1998 and the promotion of access to information Act 2001; and

To provide for matters connected therewith.

The DOC Act defines certain organisations that should be registered as “accountable institutions”. These definitions include:

A person who carries a long-term insurance business as defined in the Long-Term Insurance Act; and

A person who carries on the business of a financial services provider FSP requiring authorisation in terms of the financial advisory and intermediary services Act 2002 to provide advice and intermediary services in respect of the investment of any financial product but excluding short-term insurance and health service benefits.

The Act imposes certain reporting and recordkeeping duties on accountable institutions which must be complied with.

Learning Unit 3 – Life insurance – a product introduction

3.1 Principles of life insurance

3.1.1 Understanding insurance

An insurance policy is The Promise by the insurance company to pay the proceeds of a policy at a definite date or on the occurrence of a specified event, according to the written conditions stipulated in the policy contract in exchange for a premium payment.

3.1.2 Types of Life Insurance

The earliest life policies were issued for a term of one year only later long-term whole life and endowment policies were introduced. Premiums have been payable at yearly, half-yearly l, quarterly or monthly intervals.

Term insurance

Term insurance is the simplest type of life insurance policy issued. The period of the policy is limited to a definite term and the sum insured is payable only if death occurs within that term. In a term contract there is no element of investment and the premium covers only current insurance protection and expenses.

Decreasing Term insurance

This type of contract is term insurance with a decreasing sum insured and is often taken out in connection with a loan where the loan is gradually being repaid.

The sum insured is reduced on a fixed scale year by year. It is for example often used for mortgage bond cover so that where a person has borrowed money to buy a house the amount borrowed will be repaid if he dies before the borrowed money has been fully repaid.

Below is an example of cover under a decreasing term insurance which decreases at about the same rate that a mortgage dept. might decrease:

Image page 66

Decreasing term insurance is sometime sold under the name of “credit life insurance”.

The steadily increasing volume of instalment or credit sales of consumer goods(cars, TV's, fridges, lounge suites) has led to the introduction of policies designed to cover the outstanding debts on the debtor's death.

Claims are usually paid directly to the finance company on production of the agreement of the death certificate.

This form of insurance has also achieved remarkable growth in the covering of motor vehicle finance and often on an individual basis with minimal underwriting.

National Credit Act

The National Credit Act no. 34 of 2005 came into effect on 1 June 2007. Effectively, this was 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 intention of this Act is to regulate the activities of money lending, mainly to private individuals, it has impact on insurance, as listed below;

- An extension to the concept of free-choice in the selection of the cover required, including houseowner's 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 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 which must be reasonable and not unreasonably priced, for example credit life cover may only be on the basis of decreasing cover to meet the outstanding amount;
- A requirement that insurance premiums should be charged annually or monthly, and only monthly for smaller loans.

Whole Life insurance

As the name implies, whole life insurance covers the insured life not only for a given period but for the whole length of his life.

With -profit whole life policies had an added attraction, in that the bonuses, if added to the sum insured until the life insured retired, could then be surrendered to reduce or extinguish the remaining premiums.

The principal objective of the whole life insurance was protection in one form or another. Its most common employment was by the breadwinner for the protection of the family.

Professional people and others whose capital was used in their profession or business often effected whole life insurances of substantial amounts for inclusion in ante-nuptial contracts.

The policies then constituted a protection for spouses and children and could not normally be claimed by creditors in the event of insolvency.

It became common to arrange for whole life insurances to be made paid up automatically, for example by limiting premium payments to age 60, 65, 85.

Reinforced Whole Life

The need to provide cheap life cover on a permanent basis led to the development of the reinforced policy.

A whole life with-profits policy was supplemented by decreasing term insurance, the concept being that the bonus declarations added to the basic whole life cover value and so offset the decrease in the value of the decreasing term cover, thereby maintaining a level amount of cover, provided the insurers matched the anticipated bonus rate.

Below is an example

Image page 68

Pure Endowments

Pure endowments are issued for a fixed period to provide a stipulated sum (with or without profits) on a certain date in the future (the maturity date) if the policyholder is still living on that date. The policy does not include life cover as such and, if the policyholder dies before the maturity date, the beneficiary will receive:

- A return of the premiums paid plus the value of any investment growth there might have been; or
- A fixed rate of interest on the premiums paid.

These policies are often sold to persons who are uninsurable for health reasons or who do not require life insurance cover.

Endowment Insurances

Until the introduction of investment linked policies, endowment insurance was issued for a fixed period as a combination of a term insurance and pure endowment.

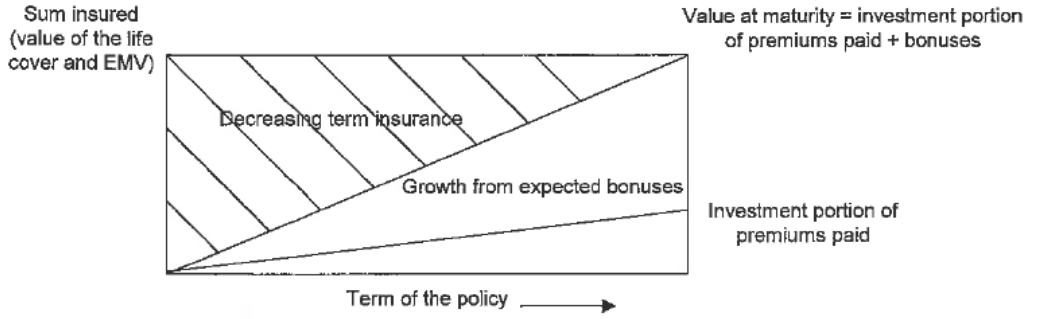
Example

An endowment insurance for R1 000 would provide for payment of R1 000 on the maturity date only if the life insured was living on that date (a pure endowment) or R1 000 on the death of the life insured provided it occurred before the end of the endowment term (the term insurance).

This was essentially known as a non-profit endowment.

Later developments in endowment insurance led to a combination of life insurance and assumed bonuses built into the anticipated end result. While this was still in essence a form of non-profit endowment policy. the actuary was able to allocate bonuses to the policy owner and charge a slightly reduced premium. This therefore meant that a non-profit policy had a large element of investment money built into the premium. This also meant that the longer the term selected, the larger the element of life cover money could be included in the premium. A very short term contract, for example ten years, was therefore mainly one of investment and was used mainly for things like providing for the education of a child.

A longer term contract, for example, 30 or 40 years, was considered mainly for its initial life cover element and was seen as an alternative to a whole life policy and used mainly for the protection of the dependants of the life insured if he should die early. It later assisted with some person's retirement savings. An example of an endowment insurance where the initial level of life cover was set at the same level as the anticipated payment at maturity is set our below:



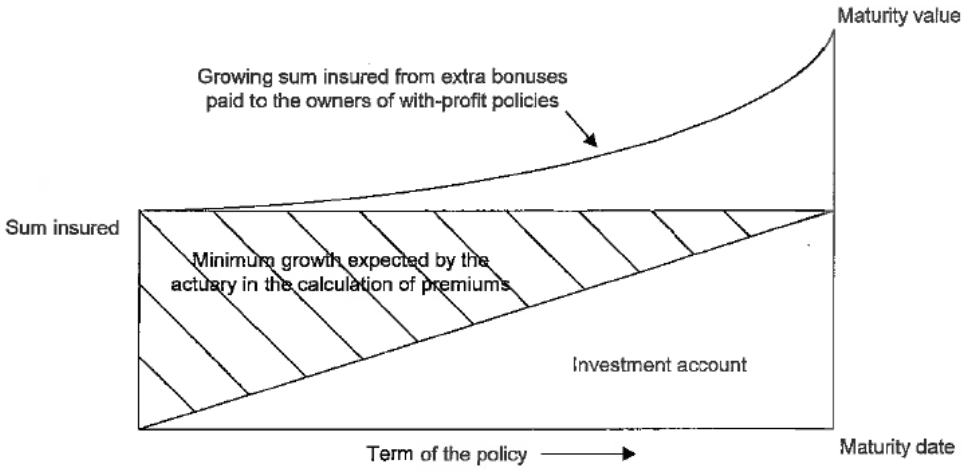
(EMV means the Estimated Maturity Value)

The final result depended on the bonuses that were used by the actuary to work out the end result as these bonuses were always a part of his original calculations. This meant that is the bonuses declared were higher than expected the policy owner would get more money than he had hoped for. Similarly a lower bonus rate would mean a lower maturity value than expected.

A policy that continued for a long time would be able to accumulate more bonuses, especially as they were usually declared annually.

Non-profit endowment policies fell out of favour due to the lack of real growth and so the life insurance industry had to come up with a solution. This led to the development of with-profit policies that became very popular because it led to the growth of the cover of the policies in line with the addition of bonuses.

Below is an example of a with-profit endowment:



Reinforced Endowments

The reinforced concept has also been applied to endowment plans, with the amount of decreasing term added serving to increase the initial cover level to an amount equal to the endowment's projected maturity value, thereby offering more cover for a lesser premium.

3.2 How a premium is determined

The premium of a life insurance policy is determined by an actuary. There are a number of factors that need to be taken into account in the determination of a premium. The three dominant factors are: mortality, expenses, and interest or investment return. Each of these three elements of the premium is dealt with in the sections that follow in this chapter.

Another function of the actuarial department is the regular valuation of the company's assets and liabilities in order to test the solvency of the insurer. The official valuation performed in accordance with the provisions of the Long Term Insurance Act is seen as a test of an insurer's financial strength and ensures that the interests of its policyholders are safe-guarded.

3.2.1 Application of Mortality tables

To calculate the life insurance premium for a 30 year old man, the actuary needs to know what the probability is of a man, aged 30, living until he reaches age 31. Assume that the probability is set out

in the mortality tables as 0,00028. This would mean that, out of a group of 100 000 men who are 30 years old, 28 are expected to die before their 31st birthday.

If each one of the 100 000 men were to buy a life policy of R10 000 cover for one year only, then the actuary will know that he will probably have to pay 28 claims. This will cost the insurer R280 000. The actuary would, therefore, have to charge an annual premium of R2,80 for the R10 000 life cover to each of the 100 000 men who buy a policy.

The actuary therefore needs to know these probabilities to calculate a life insurance premium. The probability of when death will happen is set out in the mortality tables that the life insurers use, and forms the basis of the calculation of life premiums.

The probabilities used to work out the mortality tables are based on average people. This means people who are not overweight, or not too healthy or too sick. These people are called standard lives insured. It is the duty of the underwriters who work for the insurer, to work whether an applicant for life insurance is a standard life insured who fits into the probabilities used for the mortality tables. The underwriters will ask for medical examination, or the completion of a non-medical declaration, to find out whether a person is a standard life to be insured.

Where a person is not a standard life insured, the underwriters will have to adjust the premiums that the insured will be asked to pay. Should a proposer for life insurance, who is one of our group of 100 000 men, have a heart-condition, it could mean that he has a 50% higher chance of dying before he turns 31. The underwriter will have to add at least 50% loading on the policy.

This means that in our example, this proposer would have to pay the following:

Normal premium : R2,80

Loading of 50% : R1,40

Total premium : R4,20

The proposer who is very healthy may have a better chance of living than the standard life insured used to draw up the mortality tables. Some life insurers will be prepared to consider a discount on the premium that standard life insured person should pay for a person healthier than the average person.

The mortality tables used by life insurers are generally not based on census statistics but on the actual experience of the life insurers.

In the business of life insurance, mortality tables have several uses in the calculation of:

- Premium rates;
- Rates for annuities;
- Reserve values; and
- Contribution rates for pension funds.

It is necessary to produce separate tables for use when calculating annuities.

When dealing with annuitants, one finds an automatic selection factor in that generally, only people in good health and who expect to live for a considerable time, will purchase an annuity. Accordingly, if the rates for annuities were based on ordinary life tables, one could find that the mortality was too heavy, and the life offices could face serious losses. It was, therefore, necessary to produce tables based on the mortality experience of annuitants.

The most widely used mortality, or life, tables are based on experiences of a number of different life offices. These tables are called standard tables and are published for general use. Interest functions are usually included for ease of application. However, offices may, in certain circumstances, prepare their own tables based on their particular experience. For example, an office that only operates at the top end of the market would probably experience a much lighter mortality than an office that meets the needs of those in high-risk occupations.

Standard tables are used, and these may then be artificially amended, in order to meet the particular needs of an office.

Due to the fact that mortality tables can be based on past experiences, one finds that by the time the data has been collected and the results published the experience to which it relates is already some years old. Over the years the trend has been for mortality to become lighter (better).

One therefore finds that the use of the standard tables is likely to produce a heavier than necessary premium rate. Nevertheless life office actuaries are reluctant to anticipate a trend which may not occur and will tend to rely on the published tables. The reverse of course, is the case with the tables of annuitants' mortality. Her life offices cannot afford to ignore the trend to lighter mortality, and will therefore adjust the standard annuitant tables to take account of the probable improvement in mortality and therefore longer period of annuity payments.

3.2.2 Impact of AIDS on mortality rates

The HIV/AIDS pandemic is a matter of particular concern to many African countries.

Particular aspects of the disease which make it especially difficult to handle include:

- The rapid growth of infected numbers ;
- The long period of incubation (7 to 10 years);
- The absence of any obvious signs of HIV during the first part of the incubation with the associated infectious potential during this period;
- The high cost of treatment, which includes psychological or social counselling, treatment of the conditions arising from the deficiency in the immune system, treatment of the AIDS virus itself and, ultimately the most of a prolonged stay in hospital;
- The social stigma attached to the disease and associated confidentiality issues;
- The fact that actual death is not caused by the AIDS virus itself but by a range of other opportunistic conditions such as tuberculosis (TB), pneumonia, and severe diarrhoea.

Morbidity

Mortality refers to a person's death or chances of dying. Morbidity is about a person's chances of being disabled. In the same way that the actuaries that work for or with life insurance companies have mortality tables that they can use to tell them what the chances are that a person of a certain age will die during the year, they also have morbidity tables that will tell them what that same person's chances are of being disabled. These morbidity tables can then be used to work out the premiums for any disability benefits that the proposer might want.

The impact of the HIV/AIDS pandemic on morbidity tables, and therefore disability contracts can also not be ignored. The introduction of the drug Retrovir (AZT) and other drug cocktail therapies has enabled medical science to slow down, to some extent, the progression of the disease.

3.2.3 Expenses

No business can operate without running expenses and a life insurance company is no exception.

There are underwriting expenses such as:

- Paying doctors to do medicals;
- New business acquisition expenses;
- Office accommodation costs;
- Underwriters;
- New business clerks;
- Claims assessors;
- Policy servicing clerks; etc.

All these costs have to be considered by the actuary and built into the premium rates that will be charged.

3.2.4 Investments

The third element that an actuary takes into account when working out what a premium must be is the investment return that he thinks that the investment manager will be able to earn a premium money. The actuary will assume that the investments will earn, at least, some money and so will use this as a discount when working out the premiums.

Note

The actuary who assumes a high rate of investment return, will be able to charge a cheaper premium. However, if the investments do not do as well as he thinks, there may be too little money for the life insurer to be able to pay claims. Because the Registrar of Insurance knows of this danger, he insists that the list insurance company's actuary does an annual valuation of assets and liabilities.

3.3 Valuations

To do a valuation, the actuarial department works out the value of the insurer's assets and liabilities. The official valuation that must be done regularly is a ruling of the Insurance Act. It is seen as a test of an insurer's financial strength and protection of the interests of the policy owners.

The results of the valuation (valuation report) must be sent to the Registrar of Insurance. The Registrar can ask for a valuation at any time. Life offices often carry out an internal valuation more frequently.

When doing a valuation the following play a special role:

- The rate of mortality that the insurer has experienced in the past and what it estimates will be experienced in the future; and
- The average rate of interest (investment returns) it has earned in the past on its assets, and what it estimates it will earn in future; and
- Expenses of running the business of the long term insurer.

A valuation puts a value on the assets and liabilities of an insurer.

3.3.1 Purpose of a valuation

Actuarial liabilities are defined as the policy reserves an insurer should have in order to hold the present value of future benefits it will be called upon to pay to its policyholders, when claims arise.

The main reasons for carrying out a valuation is to test the solvency of a life office - especially if there is any doubt about its financial standing. The official valuation performed in accordance with the provisions of the Long Term Insurance Act is a test of an insurer's financial strength. This, therefore, ensures that the interests of its policyholders are self-guarded.

The second reason for carrying out a valuation is to determine the amount of surplus funds available for:

- Distribution to policyholders by way of bonuses;
- To shareholders by way of dividends; or
- To the company's reserve funds to be held against future contingencies.

The value of assets are compared to the value of actuarial and other liabilities and the excess is the surplus available for distribution.

Thirdly, a valuation must be done if two or more insurers are planning to amalgamate or if any part of an insurer's business is to be transferred to another insurer. A valuation is necessary to settle the terms under which the merger or transfer is to be made. The valuation basis in this instance may well be different to that employed in either of the above circumstances.

Finally, a valuation must be done to test the effect of new premiums and products.

Where a surplus is experienced at the time of a valuation, it would not be imprudent to consider such a surplus as "profit". In calculating the surplus, certain assumptions have to be made. A true profit can only emerge if one is able to compare actual claims experience and expenses, against actual experience of premium received and interest earned, after the last policy has come off the books. All the valuation does is give the actuary a guide on which he can estimate the amount he may consider proper and reasonable to distribute, where applicable.

The amount of surplus depends on the assumptions used in the valuation of the assets and liabilities. A large surplus could be expect if high interest earnings are assumed, especially if low expenses are anticipated and a low rate of morality is also used. However, the danger then would be that there may not be a surplus available for distribution in the future.

Accordingly, the most actuaries, when carrying out an internal valuation, tend to use a strong basis. This means being conservative in their assumptions as to future interest earnings, mortality rates and expected expenses. Therefore, the actuary can anticipate maintaining, and possibly increasing, future bonus rates and shareholders dividends, as well as maintaining current premium levels on policies.

3.3.2 Reserves

The reserve value of a policy can be considered on the basis of past history or from the expectations of the future. Taking this further, the reserve value of a policy is the amount which at any point in time is made up of premiums and interest received to date, less claims and expenses, or the amount which is expected to cover the excess of claims and expenses over premiums and interest in the future.

Two methods which may be used in calculating reserve values are the prospective method and the retrospective method. The former taking cognisance of what is likely to happen in the future and the latter what has happened in the past.

Prospective method

Almost invariably the prospective method of calculating reserves is used in practice because it is simple, both administratively and in theory.

Under this method, the reserve value of a policy is calculated as the excess of the present value of future claims over the present value of future net premiums. The office net premiums is the actual policy premium, excluding expense loadings. The present value of future premiums is an amount calculated by discounting, at a rate of interest, each premium over the term of years, from when it is due back to the valuation date.

The present value of future claims is an amount made up of the sums insured under the policies discounted at a rate of interest. A mortality factor is applied to this to provide for anticipated death claims.

Retrospective method

In this method, the reserve is the amount by which the premiums paid to the date of calculation, accumulated at the valuation rate of interest exceed the accumulated value of claims. The equality between the two methods may be proved mathematically. If net premiums are used with the same assumed rates of interest and mortality the reserve values calculated under both methods would be the same.

3.3.3 Surplus

When the valuation is complete the difference in the amounts is the surplus or deficit on valuation.

If, as expected, there is a surplus it can arise from a number of sources:

- An expenses surplus will occur when the actual expenses incurred in running the business are less than the expenses assumed;
- Investment earnings surplus is the amount by which the interest actually earned on the assets of the insurer is greater than the interest earnings assumed.

The above are in fact the major causes of surplus as mortality is normally finely tuned to actual experience:

- A mortality surplus arises if the claims experience is less than that assumed;
- A surrender surplus happens when policies are surrendered and the reserve (liability) no longer needs to be held. A surplus will arise if the reserves released exceed the amounts paid out.

The greater part of any surplus is usually passed on to the policyholders. This may be by way of a declaration of bonus on the older conventional with-profit policies. The bonus will either be paid out or, be used to increase the policy reserves. The balance will go to contingency and unappropriated reserves.

3.3.4 Distributions to policyowners

In years past, it was quite common for the reserve accounts of insurers to accumulate vast funds. Policyowners were simply paid the contracted proceeds of the policy as and when required. This would be either when the term of the contract had expired, for example an endowment, or when the policy became a claim as a result of the death of the life insured.

Greater understanding of the way that policies were structured, however, led to a demand amongst policyowners for a share of the surplus that insurers were building up in the their reserve accounts. Policyowners soon became aware of the fact that the natural conservatism of the actuaries was resulting in extremely large reserve funds that essentially belonged to nobody. This was particularly in the case of a mutual insurer which has no shareholders. As a result of this demand insurers developed the concept of with-profit policies.

With-profit policies

Based on the results of a full valuation, the actuary who has established a surplus, can declare a profit that is to be paid to policyowners of with-profits policies. The balance of such surplus is then held in the insurer's reserve funds.

There "profits" became commonly known as bonuses that were due to with-profit policyowners. It was however, not money that was immediately available to the policyowner.

Bonuses were classed as being either vesting or non-vesting. The vesting bonus became an addition to the policy value which could not be removed and which increased death claim, loan and surrender values. Non-vesting implied that the bonus could be withdrawn id the actuary deemed this necessary as a result of a subsequent poor valuation result.

Often a combination of the two types of bonuses were declared, on the underlying basis that income already earned could be allocated as a vesting bonus. Capital growth would however be non-vesting and only be realised when policy became a claim (i.e. on death or maturity).

Due to the structure of the policies of those times, the bonus growth was expressed as an increase in the life cover of the policies and not necessarily an increase in the actual cash value of the policy.

A further refinement of the bonus structure was the introduction of terminal bonuses payable only on death or maturity. They were to encourage persons to continue with their policies and not to terminate early.

With-profit policies are seldom sold today, the preferred method of sharing profits with policyowners being through investment linked policies.

Linked policies

As the investment expertise of insurers improved, they diversified into different portfolios that specialised in specific areas, like for example:

- equities - shares on the Johannesburg Securities Exchange;
- Property;
- Capital investments - for example, government, municipal and utility bonds; and
- Cash investments; or
- Managed funds combining all of the above to optimise results.

As the performance of these portfolios started indicating better returns than policyowners were getting from their with-profit policies, demand arose for a share in these profits. The result hereof was the development of investment linked policies.

Insurers started making options available for policyowners to select a particular type of investment portfolio that their policies could be linked to. The valuation still took into account the assets and

liabilities of the insurer but these were now specified in terms of the policies linked to a particular investment portfolio.

Note that the growth was, however, often still linked to a minimum growth factor.

Under certain of the portfolios the policyowner who was more conservative in his investment outlook was still able to receive a minimum guaranteed return. Any balance of growth remained within the insurer as was in some cases paid out much the same as a terminal bonus.

Less conservative investors could choose to forfeit their guarantees and rely on the higher potential returns at maturity of for example, an equity portfolio. The natural progression of linked policies eventually led to the complete unbundling of policies and to the creation of policies designed in terms of the "universal" concept. Increased use was made of externally managed investment funds as the linked investment component.

This class of business provides for the systematic allocation of a portion of the premium paid (i.e. the investment allocation amount) to a given real or notional investment portfolio. Sometimes known as unit-linked contracts, unlike in the case of with-profit contracts, there is usually no additional premium charge made under this class of business for participation in the net gains made under the specific investment portfolio to which the policy contract is linked. However, a small charge is sometimes made where a guaranteed minimum maturity value is provided in contract.

Various forms of management charges may however, be made against the investment portfolio to which the policy is linked before the net performance is established. This net portfolio performance is then used in establishing the growth on the allocation amounts and hence is fixing the loan, surrender, maturity and other policy values. Where the full net portfolio growth is not allocated to the policy but retained for declaration in later years when the investment portfolio performance for a particular year is perhaps below average, such contracts are often referred to as being quasi-linked or smoothed bonus policies.

The high reserving requirements of with-profit business and its concomitant higher new business strain have made it increasingly attractive for insurers to sell such contracts in recent decades. Linked contracts create much less new business strain and can therefore be priced more competitively. Since the 1980s linked contracts have consequently become the dominant product form in most parts of the world. For this reason and for the expedient of simplicity, the illustrations which follow are linked contracts only. The structures of with-profit and non-profit contracts is however, very similar.

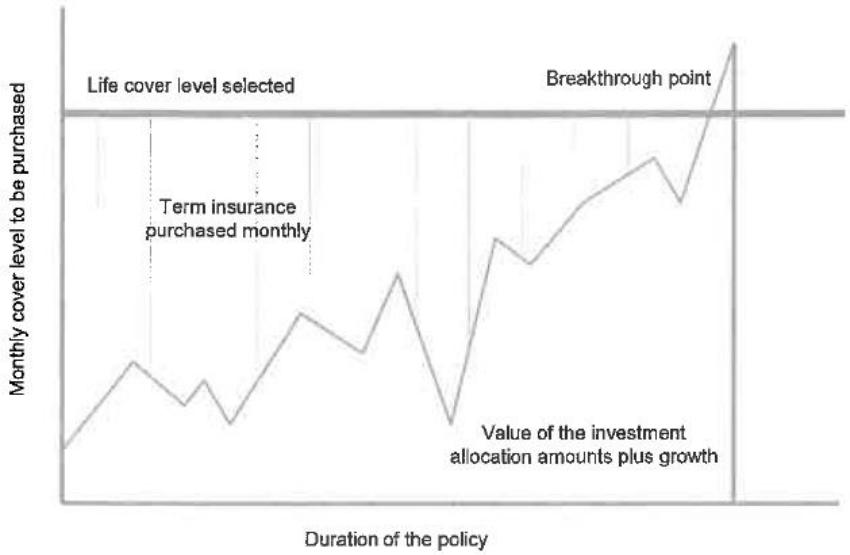
Universal Concept

The significant difference between the investment linked whole life or endowment contracts and the so-called Universal Life contract lies in the fact that the Universal Life policy owner may “unbundle” the component parts of the product (i.e. the allocation amounts and decreasing term insurance). A policy owner May select his own mix thereof as a proportion of the total premium paid. this mix can be changed such as the example, once the need for life cover has reduced after a dependence have become self-supporting, the proportion of life cover in the contract can be reduced in favour of an increase in the investment allocation amount. This would have the effect of increasing the cash value that will accrue to the policy owner on later maturity or encashment of the contract.

Universal Life contracts are therefore similar to traditional linked whole life and endowment products in their construction and operation, save that the advent of computers, it has become possible for every contract issued by the insurer to be individually tailored, administered and changed in light of the changing needs of each person injured.

In order to facilitate this flexibility, Universal Life products usually do not maintain a fixed rate of decrease in the decreasing term insurance component of the product. Instead, the amount of decreasing term insurance required to make up the difference between the total net value of the funds held (I.e. allocation amount plus growth to date) and the selected sum insured is purchased by the insurer every month. As will be clear from the illustration below, the amount of term insurance purchased by each period can both reduce and increase according to the Investment performance.

Universal Life contracts usually also maintain a separate” memorandum-type” account in which a record is kept of the expenditures and killed in terms of the contract as it progresses overtime. These expenditures are accumulated with interest and are set off against the value of the allocation amounts and growth thereon until fully expunged. An example of the next result as shown in the illustration Below and produces a similar results to traditional length whole life and endowment contracts but with the possibility of greater administrative flexibility. However, in many cases this greater flexibility create a less certain to him for the insured as Universal Life contracts often include provisions that permits the insurer to review its premium rates and benefits in the light of the actual expense, mortality and investment experience of this product class.



3.3.5 Supplementary or risk benefit policies

Sometimes sold as benefits supplemental to basic term, endowment or whole life policies and sometimes sold independently, risk benefit policies provide a variety of benefits to insured other than merely natural death claim benefits. These policies are also sometimes known as supplementary, ancillary, "ride" or "living" benefits and may be categorised as follows:

a. Accident Benefits

This type of benefit will pay an amount in the event of the accidental death or loss of hand, eye or foot of the insured. Premiums vary widely and are affected by the definitions given to accident, what constitutes the loss of a limb or eye and the range of activities, events or occurrences that are specifically excluded from cover. Accidental death benefits do not usually require the underwriting of the health of the insured and premiums are not generally affected by age.

(b) Disability or Health Insurance Benefits

As the name implies, disability benefits are payable in the event of the disability of the insured. A precise definition of what is meant by 'disability' is recorded in the insurance policy and such definitions are determined by the type or class of disability policy concerned. Sometimes also referred to as Health Insurance, these policies can be categorised as follows:

(i) Capital Disability Benefits

Also referred to as "Lump Sum Disability Benefits", "Accelerated Death Benefits" or "Occupational Disability Benefits", this risk benefit ensures that the sum insured (the death claim value) under the

basic policy to which it is attached is “accelerated” and paid in a single lump sum to the beneficiary (usually the policyowner) in the event of the disability of the life insured rather than upon his death. Calculation of the premium rate for this benefit is affected by age at entry, the term of the policy, the definition of disability, and the occupation of the insured and any specifically excluded activities or occurrences. Definitions of disability for this type of benefit usually fall into one of three categories:

- Own occupation definition - the insured must be so disabled as not to be able to follow his own occupation as stated in their insurance application or proposal form;
- Own a similar occupation definition - the insured must be so disabled as not to be able to follow his own occupation or a similar occupation for which they are suited by their training, status, knowledge and ability;
- Any occupation definition - the insured must be so disabled as not to be able to follow any occupation of whatever nature.

(ii) Major Medical Expense (MME)

Policies provided stated lump sum payments, irrespective of the actual cost of specifically defined medical treatments that may become necessary such as cardiovascular surgery, hip replacements and cornea grafts. Such policies may be viewed as a variant of lump sum disability policies but which do not have the effect of accelerating future death claim benefits as these do not exist under MME policies.

(iii) Waiver of Premium (WOP) Disability Benefits

This benefit provides that where a person is both the insured and the payer of premiums and where that person becomes disabled in terms of the given definition of disability, the insurer will waive all future premiums as an immediate benefit and then maintain the policy in force until normal expiry or maturity, with no further premiums payable by the policyholder.

The import of this is that Waiver of Premium policies are always made supplemental to basic life insurance policies as they provide for the waiver of future premiums payable for other benefits which may become due at a later stage.

Similarly, “Waiver of Premium on Payer’s Death or Disability” (WOPP) benefits are sometimes available where the insured and the payer of premiums are not the same person. (This type of benefit is used where it is important that a policy of insurance on another’s life remains in force whether or not the payer is able to continue premium payments.

(iv) Dread Disease Benefits

Also known as “Critical Illness Benefits”, “Trauma Benefits”, “Special Drawing Rights” or “Living Benefits”, these policies provide for the payment of a lump sum in the event of an insured suffering a disabling health event as defined in the policy. Here, disability is not defined in the traditional “Own”, “Own and Similar” or “Any” way. It is defined as having occurred if the insured suffers for example, heart attack, stroke, cardiovascular disease, cancer or other debilitating experience, whether or not such experience causes permanent or temporary disability. In most cases, dread disease benefits are sold as supplemental to a basic term, endowment or whole life policy and provide for a portion of the sum insured under such basic policy to be “accelerated” and paid on the occurrence of the defined event, such accelerated amount being deducted from the sum insured in the event of any future death or maturity claim.

(v) Terminal Illness Benefits (TIB)

This benefit is almost always sold as supplemental to a basic term, endowment or whole life policy and provides for the acceleration of the payment of the death claim benefit in the event of an insured being diagnosed as suffering from a terminal illness. The benefit is usually payable no earlier than one year prior to the anticipated date of death and having been paid, the policy to which it is attached is annulled and has no further validity.

(vi) Long Term Care (LTC) or Frail Care Benefits

Usually provide for the regular payment or release of a portion of the total sum insured where long term treatment or care is required to take place in a registered nursing home or equivalent.

(vii) Disability Income Benefits

Whilst all of the above disability benefits usually pay all or part of a stated total sum insured as a lump sum on the occurrence an insured event, disability income benefits provide a stated regular income during the period of a predefined form of disability. Sometimes known as “Permanent Health Insurance” (PHI), “Income Continuation”, “Income Security Insurance” or “Professional Provident Fund”, this type of policy provides a regular (usually monthly) income to the insured during a period of disability. This period may be limited in duration or may be for the whole of the remaining life of the insured. The premium and benefit may be so structured as to provide an income during permanent and total (PTD). Hospital Income Benefits’ (HIB) are another form of disability income benefit. The definition of disability in this case is confinement to hospital, during which a daily benefit is paid, irrespective of the nature or cost of the treatment received. The premium structure will be affected by the maximum period during which benefits will be paid, any initial waiting period and whether hospitalisation is defined as resulting from accidental causes only, or whether all causes of confinement are covered.

(c) Guaranteed Insurability Benefits (GIB)

The addition of GIB to a policy means that the insured may exercise an option at given intervals (usually every third policy anniversary) to increase the sum insured without having to provide

evidence of continued insurability (i.e. Health, occupation or recreation). Premiums for the optional additional sums insured are charged at the standard rate applicable to healthy lives of the same age for the same policy at the date on which the option is exercised. A modern permutation of this policy is the addition of an automatic annual upgrade (also known as “update” or “inflation adjustment”) of the sum insured by means of a pre-agreed percentage increase in the premium. (The Consumer Price Index is often used for this purpose.)

Whether sold as GIB or automatic upgrades, the applicable premiums for this benefit will be affected by the insurers’ estimate of the cost of effectively guaranteeing the future insurability of lives insured at standard rates.

Learning unit 4 - Retirement annuities, annuities and supplementary benefits

4.1 Introduction to retirement annuities

The Pension Fund Act and the Income Tax Act make provision for the recognition of a number of different types of funds. These are designed to give benefits on retirement, death or ill health to members of the fund and/or their dependants. Only two of these can, however, truly be called employee benefit funds.

The ongoing relationship between an employer and an employee needed in a pension, or a provident fund, provides the opportunity for the employer to contribute towards the benefits of his employees. These are covered in more detail elsewhere.

There are, however, other types of retirement funds that can provide valuable benefits to members without needing a continuous employer presence. In fact, with a retirement annuity fund the employer cannot make a meaningful contribution on behalf of a member at all. The member is the only party to the scheme, and no employer / employee relationship exists.

The marketing of retirement annuity funds is, in fact, completely different from the way that pension or provident funds are marketed. In the marketing of what have generally come to be known as employee benefit funds, pension and provident funds, the presentation of the scheme is made to a group of people who will normally make the membership decisions on behalf of the members or prospective members.

Membership of a retirement annuity, on the other hand, is sold to individual persons. The marketing of retirement annuities is generally undertaken by individual life insurance intermediaries, such as the agents of an insurer or a broker. Members are, in fact, often under the impression that they are purchasing an individual life policy.

While it is true that each member who elects to join a retirement annuity fund will be issued with a policy document, this document is, other than in the case of an ordinary life insurance policy, not proof of ownership buy simply proof of membership.

Note that while a retirement annuity purchased by an individual is in fact a person-to-person transactions much in the same way as with an ordinary life insurance policy, the member does not become the owner of a policy. He simply becomes an individual member of the retirement annuity fund set up and registered by the insurer.

4.2 Retirement Annuity Funds

Retirement annuities were first introduced in this country in 1960. An amendment to the Income Tax Act allowed taxpayers the right to deduct, in the determination of taxable income, current contributions made to an approved retirement annuity fund up to a maximum of, then, R600 per annum.

The amount allowable was thereafter steadily increased every few years, and is currently 15% of taxable income from non-retirement funding sources.

The introduction of retirement annuity funds has had a far reaching effect. It enabled self-employed persons, such as professionals, the opportunity to take out individual pension plans and obtain tax relief on their contributions.

Before this, the advantage had been enjoyed only by employees who were members of group pension schemes. Note that the term retirement annuity is in a way misleading, as the annuitant does not have to actually retire before the annuity begins. As long as he is eligible to retire, and the annuity contract has been approved by the revenue authorities, he can start receiving a benefit.

Should the retirement annuity fund have been approved by the revenue authorities, then the member can claim tax relief, up to certain limits, on the contributions. Contributions paid by members are invested by the life office in its untaxed policyholder fund which is currently taxed at 0% in accordance with the Tax on Retirement Fund Act, 1996.

In accordance with the terms and conditions of the Second Schedule of the Income Tax Act, there is also a beneficial tax treatment of the eventual proceeds. The combination of these tax advantages makes this type of contract extremely tax efficient. It is therefore an attractive investment, particularly for a taxpayer who earns a substantial income.

Recent rulings made by the Pension Fund Adjudicator in favour of clients in respect of early cancellations, has led to an agreement between ASISA and the National Treasury agreeing in principle on providing a minimum of 60% of the fund value at date of early cancellation.

4.2.1 Definition and Rules

A retirement annuity fund is defined in the Income Tax Act as

"Any fund (other than a pension fund, provident fund or benefit fund) which is approved by the Commissioner and, is registered under the provisions of the Pension Funds Act".

Approval should be applied for on an annual basis but, in practice, approval is automatic from year to year, unless there is an unapproved change. Any person, whether self-employed or not, and whether a member of any other fund, may become a member of a retirement annuity fund.

As is further set out in the definition of a retirement annuity fund the Commissioner may approve a fund subject to such limitations and conditions as he may determine. However, he must not approve a fund unless he is satisfied:

The fund is a permanent fund bona fide established for the sole purpose of providing life annuities for the members of the fund or annuities for the dependants or nominees of deceased members; and

that the rules of the fund provide:

for contributions by the members, including contributions made by way of transfer of members' interests in approved pension funds or other retirement annuity funds;

that not more than one-third of the total value of any annuities to which any person become entitled, may be commuted for a single payment, except where two thirds of the total value does not exceed R50 000; This means that if the fund value is less than R75 000 at retirement,

the member can be paid the full amount as a lump sum, and does not have to invest two thirds of it in an annuity.

(clauses were deleted.)

(clauses were deleted.)

that no member shall become entitled to the payment of any annuity or lump sum benefit contemplated in paragraph 2(a) of the Second Schedule prior to reaching normal retirement age;

This clause used to limit retirement to between 55 and 70 other than in the event of disability but was changed in 2008 to allow for later retirement. The Act includes a definition of normal retirement age, with a minimum of 55 but the maximum only defined in terms of the person becoming incapable of continuing to work.

(Clauses (vi), (vii), (viii) and (ix) were deleted.)

(x) that a member who discontinues his contributions prematurely shall be entitled with to

(aa) an annuity or a lump sum benefit contemplated in paragraph 2(a) of the Second Schedule payable on that date;

(bb) be reinstated as a full member under conditions prescribed in the rules of the fund;

(cc) the payment of a lump sum benefit contemplated in paragraph 2(b)(ii) of the Second Schedule where that member's interest in the fund is less than an amount determined by the Minister by notice in the Gazette; or

(dd) the payment of a lump sum benefit contemplated in paragraph 2(b)(ii) of the Second Schedule where that member emigrated from the Republic and that emigration is recognised by the South African Reserve Bank for purposes of exchange control;

(xi) that upon the winding up of the fund a member's interest therein must either be used to purchase a policy of insurance which the Commissioner is satisfied provides benefits similar to those provided by such fund or be paid for the member's benefit into another approved retirement annuity fund;

(xii) that save

(aa) as is contemplated in sub-paragraph (ii);

(bb) for the transfer of any member's total interest in any approved retirement annuity fund;

(cc) for the benefit contemplated in paragraph (b)(x)(cc);

(dd) as is contemplated in Part V of the Policyholder Protection Rules promulgated in terms of Section 62 of the Long Term Insurance Act, 1998 (Act no. 52 of 1998);

(ee) for any deduction contemplated in paragraph 2(b) of the Second Schedule, no member's rights to benefits shall be capable of surrender, commutation or assignment or of being pledged as security for any loan;

(xiii) that the Commissioner shall be notified of all amendments of the rules; and

(c) that the rules of the fund have been complied with.

4.2.2 Deduction of contributions

Current contributions by a member to any retirement annuity fund are deductible from his taxable income. The deduction is limited to the greatest of:

15% of an amount equal to the amount remaining of the taxpayer's income after excluding all income from retirement funding employment and deducting all deduction permitted, excluding the deductions for:

Section 11(n) (retirement annuities)
17A (farm land - soil erosion work)
18 (medical & dental expenses)
18A (donations to universities)
19(3) (the dividend deduction)
and paragraph 12(1)(c) to (i) inclusive of the 1st Schedule
(certain farming expenses)

One must be cautious when including dividends in the determination of the amount of non-retirement funding income of the taxpayer. As Section 10(1)(k) now exempts from tax most

dividends received by a person these dividends cannot be included in the income of the taxpayer and so must be ignored here.

or

(B) the amount, in any, by which the amount of R3 500 exceeds the amount of any deduction to which the taxpayer is entitled under Section 11(k)(i) in respect of the current year of assessment; the amount permitted as a deduction for current contributions to a pension fund

or

(C) the amount of R1 750

The distinction between retirement funding and non-retirement funding income can best be explained if we use the example of a person who earns a salary and belongs to his firm's pension fund, but also has another source of private income, for example, rent on a block of flats that he owns.

Example

Let us assume that the taxpayer earns a salary of R60 000 per year, and also earns a rental income on the block of flats of R240 000 per year. If the expenses (for example, rates and the repainting of the exterior) come to R40 000, the taxpayer will have R200 000 of non-retirement funding income. The taxpayer will be allowed to base the 15% mention is (A) of the formula on the R200 000

If we say that the taxpayer pays R1 000 to the pension fund per year then the amount that he can contribute to a retirement annuity fund will be the greater of.

15% of R200 000 = R30 000

or

(B) R3 500 - R1 000 = R2 500

or

(C) = R1 750

The taxpayer will be able to contribute, and claim R30 000 as a deduction to membership of a retirement annuity fund.

The distinction between the landlord of a block of flats and a farmer could best be explained if we were to imagine that the R240 000 earned in our example above was earned by a farmer. Should the farmer now have spent R40 000 on fighting soil erosion he would be able to claim it as a tax deduction in terms of Section 17A.

For the purposes of determining (A) in the Section 11(n) deduction (retirement annuity contribution), the full amount of R240 000 could, however, still be used and therefore (A) for our farmer would be R36 000 and not the R30 000 allowed to our landlord of the block of flats.

4.3 Annuities

One of the primary objectives of a retiree is the guaranteeing of a permanent and secure income for the retirement years.

There are a number of avenues that can be used to produce an income but none are more permanent, or secure, than an annuity purchased from an insurer. Those persons retiring from a pension fund will be required to accept an annuity, whether it be from the pension fund, or purchased from an insurer by the fund.

Note

The fund still retains the responsibility for the payment of the annuity, regardless of the source of the income to the pensioner.

Most people are on the lookout for an income plan which will provide them a systematic monthly income during their retirement days. Annuity investments are considered ideal in this regard mainly due to the fact that along with providing periodic income payouts for a definite period or in some cases, lifetime of the person, such investments also offer a sort of insurance cover to the individual concerned. What makes it surprising is that many people are largely unaware of the benefits offered by Annuity Investments.

Annuity Investments are extremely beneficial to the investor for two main reasons. In the first place, these investments provide a definite and guaranteed monthly income. Secondly, it helps the investor in saving money over a long term. It can also be seen that Annuity Investments are used by investors for other secondary causes such as taking care of the costs involved in a dependant's education and with the rising costs of a good education, saving for educational expenses is critical.

Annuity Investments have some attractive features which makes them stand apart from other types of investments. For example, these investments are not restricted by any contribution or income limits and the earnings through them are tax exempt. Another advantageous fact in relation to Annuity Investments is that if the investor outlives the period specified in the insurance contract, he is not liable for a premium.

If you are planning to invest in Annuities, it is really important that you understand more about this safe and stable type of investment. Basically, Annuity Investments are of three types - Fixed Annuity, Variable Annuity, and Indexed Annuity.

Fixed Annuities are those in which the interest rate accorded to the investor is on a fixed and guaranteed basis as per the initial contract. Even if the interest rate changes over time, it does so only as per the guidelines specified in the contract. These investments are extremely safe and low-risk and the investor can be assured of definite returns.

Variable Annuities on the other hand are based on the performance of mutual funds on which it is dependent upon and hence offers no guarantee as far as returns are concerned. The contribution of the investor are invested in specified mutual funds as per their choice, the returns of which are used to payout the investor periodically.

Indexed Annuities re the latest in such investments and are closely related to the financial index. Investors can select and closely monitor the functioning of the related financial index upon which their annuity is dependent. These type of investments come with a minimum annual interest so that even if the stocks crash, the investors are protected to a certain extent.

Annuity Investments are most certainly beneficial to the investor especially with regard to long term investments so that during their working years the money keeps growing in a totally tax free environment and after retirement, the investor can avail of the benefit of periodic and definite income which can sustain his lifestyle and various other financial requirements to a great extent.

4.3.1 Difference between a voluntary and compulsory purchase annuity

Any annuity arranged or paid by a pension fund is a compulsory annuity. Being a compulsory annuity has one very important implication for the annuitant as it must be for the rest of his life. There can be a guaranteed period linked to the annuity. This means that it will pay for a period of, for example 10 years, whether that annuitant survives the period or not. Should he survive beyond this period, the annuity will have to continue for as long as he lives.

The important implication that lies herein is the value of the annuity that can be obtained from the insurer. As the insurer knows that it is committed to the payment of an annuity for as long as the person lives, it stands to reason that:

the younger the person is at inception;

the healthier the person is at inception; and

whether the person is male or female;

will have a marked impact on the annuity that the insurer will be prepared to guarantee.

Should the annuity, however, be a voluntary purchased annuity, it means that the person who is purchasing the annuity is under no obligation to do so. He has simply decided to do so for the permanent and secure income that can be derived therefrom.

There are some implications that differ with a voluntary purchase annuity:

there is no need for the annuity to be permanent; and

subject to certain conditions, the capital repayment portion of the annuity will be tax exempt.

4.3.2 Annuities certain

The annuity certain is a voluntary annuity where the payment of purchase money provides annuity for a specified period of years, irrespective of the duration of life. If the annuitant dies during the period, the annuity continues to the end of the period. The annuity also cases at the end of the period, even through the annuitant may be living.

Some offices make provision for education by use of this contract. A capital payment secure an annuity certain to pay school fees as they fall due. The settlor, who may be any person, normally pays the capital to trustees. They in turn, purchase the annuity and send the annuity payments to the school, through the parent. If the payment is deficient the parent meets the deficit. Any excess is returned to the settlor, as is the unexpended purchase money is the child dies.

4.3.3 Immediate single life annuities

Payment of purchase money secured periodical payments during the lifetime of an annuitant and, unless otherwise provided, no return of any part of the purchase money can be made in the event of the early death of the annuitant. Payment of the annuity usually starts one month after deposit of the purchase money, and is deemed to be an immediate (payment) annuity. Such annuities are used for pension provision. They are suitable as an income yielding investment, where the forfeiture of capital in the event of early death of the annuitant is of little consequence, in view of the absence of dependants.

4.3.4 Guaranteed annuities

In many prospective purchasers of annuities hesitate to do so. This is because they will realise that, in the event of their early death, the price paid will be forfeited, and only a small amount will have been received by way of periodical payments. Due allowance for this risk is made, in the calculation of the rates offered. This has resulted in a need for some provision that removes, or at least minimises, the risk. Insurers have amended the guaranteed annuity to overcome the objections put forward that capital will be lost to the annuitant's estate at death. The longer the guarantee period, the smaller the amount of the annuity for a given purchase price.

The following are EXAMPLES of the contract available:

the annuity payments could be guaranteed for a fixed number of years and thereafter until death;

the balance of the purchase money, over and above the amount already paid out by annuity instalments, could be refunded to the annuitant's estate at the time of his death;

sufficient payments could be guaranteed to cover the return of the purchase money, and thereafter until death;

provision could be made for the return of part of the purchase money, for example one half, if death occurred within a defined period, for example, five years from entry. Otherwise, instalments would continue throughout life.

Each of these methods is met in practice, although (b), (c) and (d) are seldom granted.

4.3.5 Examples of plans involving annuities

A lump sum is invested to purchase two annuities. The first one is paid to the annuitant for his own use. The second one (a 10 year certain annuity) is paid into a 10 year pure endowment policy maturing (at, say an assumed compound growth rate of 10% per year) for an amount equal to the original purchase price for the two annuities.

These plans were originally devised in an effort to overcome the restrictions imposed by the Sixth Schedule of the Income

Tax Act. initially the Sixth Schedule laid down that although the minimum endowment term permitted was ten years in any event, the premium paying term could be a minimum of five years.

The schedule was subsequently changed, as a result of which minimum premium paying term was made ten years. With the abolition of the Six Schedule, the need for plans like this, have moved into the realm of specific application. You will therefore find that plans of this nature require an in depth knowledge investment strategy - something not covered within the scope of this course.

Back to back systems

A person might purchase a life annuity and use part of the proceeds as premiums for a policy on his life for a sum insured equal to the purchase price of the annuity. When he dies, the annuity stops and his estate (or his beneficiary) is paid the sum insured, thereby returning to his estate or beneficiary the full cost of his annuity.

Learning Unit 5 - Health care and funding in South Africa

5.1 Healthcare environment

The healthcare environment is complex. On the one side is primary healthcare services such as inoculations, assistance in routine childbirth, fundamental hygiene and treatment of minor ailments. At the other end is tertiary healthcare which is advanced, and usually very expensive including surgical treatment such as the transplant of human organs. These are often only available to those who are able to obtain some form of financial assistance, either from the State or covered by some form of health insurance cover.

South Africa, like many other developing countries is in a time of change. It is also currently undergoing a transformation in the healthcare sector, especially as introducing a National Health system is being considered. A key issue is in the balance between state provided health services and private sector provided services. Medical inflation for the last few years has been running at between 8-10% per annum, (Stats SA 2010), a rate which exceeds general inflation, with the result that South Africa is facing a major health care crisis. Medical cost inflation is a worldwide problem.

5.2 Funding of Healthcare

The risk of becoming ill is one of the most serious risks facing an individual. The two main ways of obtaining protection against this risk is through medical schemes and insurance. Medical insurance can be obtained from either a short term or long term insurance company. The older system is from medical schemes. Medical insurance is a more recent innovation. Until recently medical schemes were referred to as medical aid. Medical aid and insurance are different. A medical scheme is not a form of insurance. Medical schemes provide benefits to members of the scheme in terms of the rules which are governed by the Medical Schemes Act. Insurance provides cover in terms of a policy. Medical schemes are funded from contributions which are levied on members. Insurance companies charge a premium. The medical schemes levy is imposed on a community rating basis imposed by the Medical Schemes Act. Insurance premiums are risk related.

In a community rated systems cannot co-exist. If a risk rated provider enters the market, the premium payable to low risk individuals would be below that of the medical schemes levy. Consequently, low risk individuals would elect to move out of the medical scheme and move to the risk rated insurer. As more and lower risk individuals leave the medical scheme, the medical scheme would be forced to increase its levy to cover the high risk individuals. In the end two pools would exist. The medical scheme would be covering high risk individuals and the risk rated insurer the low risk individuals. Two separate risk pools would form. In a free market risk separation automatically takes place (Rothschild and Stiglitz 1976).

The Medical Schemes Act attempts to outlaw insurance from entering the medical schemes market and the Registrar of Medical Schemes attempted to obtain a court ruling to expel insurance from the market. The Registrar of Medical Schemes was successful in the High Court (*Registrar of Medical Schemes and another v Guardrisk and another* December 2006, 20). The decision was however overturned on appeal (*Guardrisk Insurance Co Ltd v Registrar of Medical Schemes and another* 2008 (4) SA 620 SCA). An attempt has been made to resolve the jurisdiction issues between medical schemes and insurance via demarcation regulations.

Insurers play a role in providing cover where medical schemes do not provide cover. Insurers provide gap cover.

When dealing with risk funding it is always important to distinguish between medical schemes and insurers. These two are completely different.

5.2.1 Covering medical costs

Medical schemes, play a vital role in covering medical expenses. There is an increasing divergence between the medical expenses they pay, and what practitioners usually charge. Obviously, this can place a severe strain on the finances of those affected, especially where major medical treatment is concerned.

This uncovered risk, the so called gap is a problem to many and is a need that insurers can fill. Plans are available which provide hospital cash benefits, as well as lump sum payments. These can be used, not only to cover the difference between actual costs and medical aid reimbursements, but also the innumerable other costs resulting from major surgery or prolonged medical treatment. This trend led policies by insurers which will have to confirm the demarcation regulations.

Major medical, or surgery benefit cover, cannot be related to the actual cost of the treatment, as reimbursement of actual costs falls within the exclusive domain of medical schemes. Therefore, policies either consist of a fixed maximum benefit amount with a listing of specialised operations for which a stated percentage of the maximum benefit will be paid out, for example, 100% for open heart surgery but only 10% for the removal of tonsils, or the cover is expressed in terms of units with a different number of units payable for various procedures. The reason for this approach is to relate the amount of the benefit payment to the likely costs of treatment based on a scale of assumed severity.

It is usual for insurance companies to offer this cover on this basis of:

- the life insured only;

- the life insured and spouse; or
- the whole family.

The exclusions are similar to those under the hospital cash plans. With some plans, a stipulated expiry age for the cover, similar to the hospital cash plan, is applicable.

5.2.2 Hospital cash plans

A number of insurance companies market hospital cash plans. Various versions of the plan are available. Essentially, they all provide payment of a daily amount while the policyholder, and/or any dependants, are hospitalised.

Premium rates are calculated according to age at entry, the amount of benefit required and whether the proposer's spouse, or spouse and children are included. Benefits for are usually restricted to children under the age of 25 and still dependant on the proposer. There are fixed minimum and maximum daily benefit amounts which can be purchased. Benefits, and the policy, cease at the expiry age selected by the proposer at the commencement of the policy. This is usually linked to the age 65, 70 or 75 next birthday of the proposer.

There are a number of exclusions and exceptions, for example:

- any pre-existing medical conditions will usually not be covered for two years after the commencement date;
- any sexually transmitted diseases;
- normal maternity confinement;
- cosmetic surgery, unless reconstructive, and treatment for obesity;
- hospitalisation caused by the abuse of drugs or alcohol; or
- hospitalisation caused by attempted suicide, self-inflicted injury or certain hazardous activities.

It is usual to quote rates per day of benefits. The benefits is often increased for days spent in intensive care, or if the policyholder is hospitalised whilst overseas. Cover normally only applies where the period of hospitalisation is longer than three days, which eliminates a high percentage of smaller claims. A maximum claim period is also sometimes applied, varying between six months and two years. With a relatively strict limit on the amount of cover that can be obtained under Hospital Cash Plans due to underwriting considerations and the rapidly rising costs of hospitalisation, these

plans are increasingly being seen as providing supplementary coverage to the client rather than full cover.

5.2.3 Role of Government

The government has indicated it wants to introduce a countrywide state-assisted health provision scheme at the level of primary healthcare, with selected facilities providing more advanced, specialist health services at affordable rates - the proposed National Health Scheme. The more affluent sector of the population tends to make use of private facilities.

The government is involved in a number of aspects but a detailed discussion of this matter falls outside the scope of this work (Reekie, 1997), Reekie (1999) can be consulted for a more detailed discussion on this issue.

5.2.4 Private providers

Private providers play a number of different roles which have an impact on health care

Drug manufacturers

Many companies operating in the field of manufacturing medicines in South Africa are local subsidiaries of international drug manufacturers. Apart from the provision of medicines, they also provide important education and training to pharmacists and other distributors of medicines, such as hospital dispensaries.

Chemists

Chemists, also known as pharmacists, supply medicines to the public, usually on the prescription of medical practitioners such as doctors or specialists. They are also able to offer certain medicines over the counter, without a prescription, and may even provide basic medical advice for simple, non-threatening ailments such as colds, coughs and itches.

Doctors

Many doctors is South Africa work as private practitioners, either as general practitioners (GP's) or dentists, who do basic diagnostic steps and provide treatments, or as specialists in one or more fields, such as eye specialists, gynaecologists, cardiologists and radiologists.

Private hospitals clinics

There are a variety of private clinics or hospitals in South Africa, mostly owned by large groups. They make use of a combination of their own support medical staff and private practitioners, who use their facilities to treat patients.

Medical Schemes

Medical schemes have to be registered in terms of the Medical Schemes Act. They are benefit funds, in that they take in monthly contributions from members and reimburse medical expenses according to set scales of benefits.

Medical assist

There are several companies providing an emergency treatment and transportation service, using fleets of cars, small motorboats, helicopters and small aircrafts to take trained paramedics to the site of an emergency, and to transfer the patient to the appropriate medical care centre. Access to such a service is often a part of some schemes.

5.2.5 Key issues

Several major issues are a source of constant debate within the healthcare environment.

Changing level of state health involvement

Whilst it may seem advantageous to ensure that the State is able to provide adequate healthcare facilities for all, it must be remembered that this can only be funded out of taxation revenue and often is not the most efficient delivery system.

Uneven distribution of healthcare expenditure

Most of an individual's healthcare expenditure will occur after the age of retirement. In fact, the amount spent on medical care up to age 65 is often only 20% of the total that will be spent by the average individual.

This places a tremendous strain on the financial resources of retired people, already often under pressure from post-retirement inflation which outstrips pension adjustments.

Another factor the uneven distribution of medical expenses between the averagely healthy individual, and the person who is born with some form of costly health impairment of is involved in a serious accident that results in extensive medical requirements.

As a rule, the 80/20 principle applies - 80% of the medical expenses will generally be incurred by 20% of the population.

Cross-subsidisation

It should be accepted that any medical aid or medical insurance scheme must, by definition, allow a certain degree of cross-subsidisation from the healthy to the ill, otherwise individuals would simply take care of their medical costs through private savings accounts.

Under medical aid schemes it is normal for the younger members to subsidise the older members. Similarly, it is generally accepted that separate rates for males and females to reflect the different healthcare service usage by the sexes is not necessary. Smokers also do not pay more than non-smokers, and little attempt is made to rate according to other habit or occupational classes.

Cross-subsidisation also frequently occurs between those with large dependant families and single members. New generation health insurers are increasingly tending to apply differential rates to eliminate some of the cross-subsidisation.

Increasingly, funds are finding that the rate of growth of new members is not keeping pace, through a combination of the trend to lower population growth rates and through the younger, healthier members opting not to join a medical scheme. This is placing a severe strain on the funding process, which is made worse by the fact that people are tending to live longer than before and, hence, there is a higher number of older members.

Insurance principles versus primary care

It is a standard principle of insurance that the correct risks to insure are those which arise relatively infrequently, frequently enough to derive a reasonable costing basis for the insurance cover, and which result in high costs. Frequent occurrences, which do not result in undue financial hardship at the time of their happening, are best borne by the individual's out of savings or cash flow.

Some health insurance schemes, which operate according to insurance principles as a whole, advance the argument that this should mean that the individual is responsible for the day-to-day costs of GP consultations, and pharmacy prescriptions, either out of a special medical savings scheme or out of pocket. Chronic illness and surgery, on the other hand, should be the domain of the insurer.

Out of pocket expenses on health by South African consumers rose from around R1 billion in 1993 to over R37, 5 billion in 2010.

Medical aids work on a different basis, assuming that all medical expenses should be covered, since they are involuntary on the part of the individual.

Fraud and abuse

It is known that the South African healthcare system is prone to fraud and abuse. In some cases, doctors or other suppliers, take advantage of the uninformed nature of their patients to over-prescribe treatment, or even to simply charge for services not rendered.

Patients are known to have been in cahoots with providers to create medical bills for fictitious services, with the medical aid payment being split between the parties.

Similarly, abuse take place when patients seek the services of a doctor for a simple ailment, rather than consulting a pharmacy direct, because un-prescribed medication would be for their own account.

Employer's liability

Much as employers have assumed an obligation towards pensioners in the provision, it is clear that the rising costs of medical care, and the usage made of these services by pensioners, is increasingly becoming similar issue. Where precedents have been set, it is fair to assume that pensioners will claim that they have an expectation of continued benefits.

Liabilities to the employer then consist of whatever portion of the contributions is carried by them, plus the cost implications of the impact of the claims that may be submitted and the resultant possibility of general contribution increases.

Possible treatment of this liability can be handled through:

- increasing pensions;
- the withdrawal of the subsidy;
- reducing scheme benefits;
- funding for the benefits;
- paying a lump sum on retirement to settle the liability;
- offering a defined Rand benefit; or
- agreeing on a defined contribution level only.

5.3 Legal controls on the healthcare environment

5.3.1 Legislative outline

Healthcare schemes must be registered under the Medical Schemes Act. they came into force in 1998. Earlier, the Melamet Commission of Enquiry, recommended considerable deregulation of the industry. Medical aids previously had been allowed to work strictly on the statutory scale of benefits (RAMS) with guaranteed, direct payments of accounts. Changes introduced as a consequence of the Commission's regulations laid down minimum and maximum benefits. Implementing the Commissions' recommendations resulted in far more innovation, and the birth of new generation schemes. Much of the Commission's recommendations was reversed with the passing of the 1998 Act which in turn was based on a White Paper (1997) as discussed by Reekie (1997; 1999).

One innovation was the introduction of savings linked to medical schemes. Medical schemes offer cover for the most serious medical costs on an insured basis. Low cost / high frequency costs such as general pharmacy expenses are either left to the member to pay on their own account or covered out of a type of savings account under which a regular monthly contribution from the member is invested in a medical savings account.

There is considerable debate taking place on the ongoing nature of medical services. In particular, the government is seeking to implement some form of centralised medical scheme funded through a form of compulsory membership, which would be similar to an extra health taxation.

As discussed above, it is also common for some of the health care business to be offered by registered insurers, which must be registered in terms of either the Long Term Insurance Act of the Short Term Insurance Act and licenced for a class of business which permits health insurance products to be sold. Insurers must also be registered in terms of the Companies Act.

Other legislation which has a direct bearing on the business, includes the:

- Occupational Health and Safety Act:
- Labour Relations Act;
- Basic Conditions of Employment Act; and
- Compensation for Occupational Injuries and Diseases Act (COID).

As a rule, legislation sets out only the broad parameters under which the various registered providers operate. The details and requirements are contained in regulations issued by the minister governing the more day to day controls.

5.3.2 Medical Schemes Act 1998

The activities of registered medical scheme are largely governed by the Act through the Council for Medical Schemes. The Act defines a medical scheme as a scheme established with the object of making provision for the:

- obtaining of any service by members thereof and by dependants of such members;
- granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of any service; or
- rendering of a service to members thereof or to dependants, either by the scheme itself or by any supplier of a service or group of suppliers of a service in association with or in terms of an agreement with the scheme.

The scope of the services to be provided by a medical scheme is also defined in the Act and includes:

- physical or medical examination;
- diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- giving of advice in relation to the treatment of a health condition;
- prescription of any medicine, appliance or apparatus related to a health condition; and
- nursing or midwifery.

Services also include ambulance services and accommodation in a hospital or nursing home as necessitated by the person's medical condition. Key areas covered by the Act, apart from the financial reporting include:

- requirements for the rules concerning the management of the scheme, such as;
    - The basis of the calculation of the membership fee;
    - details of how benefits will be handled for retired members and the dependants of deceased members;
    - powers of the officers of the scheme;

- 20% of encumbered assets must be held in interest bearing investments, and some rulings on the use of funds, for example medical schemes may operate their own hospitals or pharmacies, may seek insurance cover for their liabilities, and so on;
- details of the powers of the Registrar and the requirements for a Board of Trustees to be set up for each scheme.

Note that medical or hospital insurance plans carry the normal commission according to short term or long term insurance legislation, whilst other scheme providers tend to pay intermediaries through a component of the scheme held as insurance or the provident fund portion.

Many of the requirements of the Act are included in the regulation of the Act such as:

- minimum and maximum benefits;
- the administration fee that may be charged by a scheme;
- commission due to intermediaries who introduce members to a scheme; and
- the minimum number of members that will constitute a new medical scheme.

The Act stipulates that the Minister must allow interested parties a 90-day period wherein any comments may be submitted to any proposed regulations. It is only where the medical schemes industry will be detrimentally affected by the delay that the Minister is allowed to issue an immediate regulation.

Prescribed minimum benefits

The Medical Schemes Act provides for minimum benefits which each fund must provide, from the date of commencement of the Regulations. It also provides for the prescribed minimum benefits (PMBs) package that medical schemes must offer in terms of the Act. These, are well as a list of 270 diagnostic, treatment and care procedures, are contained in an annexure to the Regulations

The objective of specifying a set of prescribed minimum benefits within the regulations is two-fold:

- to avoid incidents where individuals lose their medical scheme cover in the event of serious illness, and the consequent risk of unfunded utilisation of public hospitals; and
- to encourage improved efficiency in the allocation of private and public health care resources.

The Department of Health recognises that there is constant change in medical practice and available medical technology. Consequently, the Department monitors the impact, effectiveness and appropriateness of the prescribed minimum benefits provisions.

A review is conducted at least every two years by the Department that involves the Council for Medical Schemes, stakeholders, provincial health departments and consumer representatives. In addition, the review focuses specifically on development of protocols for the medical management of HIV/AIDS.

These reviews provide recommendations for the revision of the regulations and the list of prescribed minimum benefits on the basis of:

- inconsistencies or flaws in the current regulations;
- the cost-effectiveness of health technologies or interventions;
- consistency with developments in health policy; and
- the impact on medical scheme viability and its affordability to members.

Any benefit option that is offered by a medical scheme must reimburse in full, without copayment or the use of deductibles, the diagnostic, treatment and care costs of the prescribed minimum benefit conditions specified in the annexure in at least one provider or provider network, which must at all-time include the public hospital system.

Prescribed treatment for a specified list of chronic conditions is covered under the prescribed minimum benefits package.

Financial reporting

Section 35 of the Medical Schemes Act of 1998 outlines the requirements for the financial reporting of registered schemes.

The financial statements must be prepared annually, within 6 months of the end of the tax year of the fund, and submitted to the Registrar. Copies must also be made available to members.

This required financial statements include:

- a balance sheet;
- an income statement;
- a cash flow statement;
- a report from the auditor; and
- various other returns as may be required by the Registrar

Additional information that must be provided to the Registrar includes:

- details of the members and their dependants;
- the number of registered members and their dependants for each month of the year;
- an analysis of the benefits paid during the year under the main provider categories;
- an analysis of the other benefits types paid out;
- an analysis of specialist services;
- an analysis of administrative expenses;
- bad debts written off and the provision made for future bad debts;

- an analysis of the investments held by the fund; and
- a schedule of debtors.

According to the guidelines issued by the South African Institute of Chartered Accountants, the statements should fairly represent the business of the scheme and should contain an explanation of all material information.

5.3.3 Taxation

The current taxation approach to medical services in South Africa is somewhat disjointed with the use of a benefit fund for medical benefits having been prevalent where the fund was in fact not a medical aid registered in terms of the Medical Schemes Act.

Such a fund is described in paragraph "c" of this definition of a benefit fund in the preliminary part of the 1st Schedule of the Income Tax Act as:

- *"any fund (other than a pension fund, provident fund or retirement annuity fund) which, in respect of the year of assessment in question, the Commissioner is satisfied is a permanent fund bona fide established for the purpose of providing sickness, accident or unemployment benefits for its members, or mainly for this purpose and also for the purpose of providing benefits for the dependants or nominees of deceased members."*

Recent legislative changes have in fact stopped the registration of new schemes under paragraph "c" of the definition of benefit funds in the Income Tax Act.

In order to clarify the situation as it currently exists, we will therefore look at the taxation approach applied to the employer and employee separately.

Employer expenses

Expenditure by an employer on medical service for an employee in terms of a registered medical aid scheme, ranks as a deduction in terms of Section 11(l) of the Income Tax Act. This section allows as a deduction against the income of an employer:

- *"any sum contributed by an employer for the benefit of his employees to a pension, provident or benefit fund."*

The amount paid by the employer, and permitted as a deduction is based on a percentage of the approved remuneration of the employee in question. The Commissioner is required to approve any deduction of an amount that is equal to, or less than, 10% of the approved remuneration of the employee.

The Commissioner does, however, have the discretion to approve deductions that are in fact greater than 10%. It is now common for a deduction of up to 20% to be considered normal. Where the Commissioner can be convinced that a greater level of deduction is justified, he has used this discretion to allow deductions of as high as 20% to 30% of the total cost to the employer of the equivalent of employee's remuneration.

Properly structured and registered medical schemes fell into the category of benefit funds and contributions to a medical aid or a medical scheme specifically set up and registered as a medical aid in accordance with the Medical Schemes Act, were (and still are) tax deductible.

With the changes brought about, the employer is not able to register a benefit fund for the provision of medical benefits, other than a medical aid scheme, to its employees. As the employer can argue that the expense of providing medical benefits is an expense incurred in the production of income, the deduction will be allowed in accordance with Section 11(a) of the Income Tax Act which is the general deduction formula.

Employee expenses

In accordance with Section 18 of the Income Tax Act:

1. *Any taxpayer, who is a natural person, is allowed to deduct from his income expenses of a medical nature*

Tax treatment of medical scheme contributions and other medical expenses

The National Treasury and the South Africa Revenue Service (SARS), in consultation with the Department of Health, undertook a review of the tax treatment of medical expenses, and the tax treatment of medical scheme contributions and other medical expenses was changed with effect from 1 March 2006.

Below is a summary of the tax dispensation of contributions to medical schemes and other medical expenses.

1. Taxpayers 65 years and older and retired individuals

It is important to note that taxpayers older than 65 years continue to be able to deduct all medical scheme contributions and other medical expenses from their taxable income. Also, individuals who took early retirement, but still enjoy medical scheme coverage paid for by their former employers, will continue to enjoy this as a tax-free benefit.

2. Taxpayers 65 years or younger

Three types of medical expenses qualify for preferential tax treatment:

a. Contributions to medical schemes

- Members of a medical scheme can make contributions to the medical scheme themselves, their employers can make the contributions or contributions can be split between an employee and the employer. In the past, the employer's contribution qualified for preferential tax treatment, no taxable value was placed on the employer contribution to the extent that it did not exceed ⅔'s of the total contribution. The member making medical scheme contributions out of his own pocket was not entitled to the same preferential tax treatment for such contributions. In terms of the new legislation, all (i.e. 100% of) contributions qualify for preferential tax treatment, irrespective of who makes the contribution. This preferential tax treatment is limited to a monetary amount of R286 for the individual and first beneficiary and R192 for each additional beneficiary, applicable in the 2016/2017 tax year.

Example 1

Mary is employed and her employer pays ⅔'s of her total medical scheme contributions. She is married and does not have any children. The total medical scheme contribution for her and her husband amounts to R2 400 per month. Her employer contributes R1 600 and she pays R800 from her after-tax salary. With effect from 1 March 2015, she has to pay tax on R1 028 of the employer's contribution as the legislation states that only R572 of her medical scheme contributions (R286 each for her and her husband) will qualify as being tax exempt.

Example 2

Dumisa is self-employed, married and has four children. He is a member of a medical scheme and his family of six is covered by this scheme. His total medical scheme contribution amounts to R3 700 per month or R44 400 per year (R1 200 for him, R1 00 for his wife and R500 for each of his first three children, the fourth child is covered but no contribution is payable). In terms of the legislation, Dumisa will be able to deduct R1 340 (R286 x 2 + R192 x 4) from his monthly income, or R16 080 per annum, for income tax purposes.

(b) *Medical expenses paid by individuals (including medical scheme contribution paid by the individual)*

Medical expenses paid for by the taxpayer in excess of 7, 5 percent of his income, are tax-deductible. This threshold excludes medical scheme contributions which qualify as a tax deduction under subsection (a). Where a taxpayer has a disability, or has a dependant with a disability, all medical expenses of the family unit will also be tax deductible.

Example 3

Vusi is single and his employer pay ⅔ of his medical scheme contributions. His total monthly medical scheme contribution is R750 of which his employer pays R500. Vusi's contribution towards his medical scheme is therefore R250. In addition, he incurred other out of pocket medical expenses (due to an unforeseen injury) of R2 000. These expenses were not covered by the medical scheme. The cost of his medical expenses for the year was therefore R5 000. In terms of the legislation the employer contribution to his medical scheme coverage will remain tax-free. He will also be allowed to deduct medical expenses exceeding 7, 5 percent of his income. His salary is R50 000 per annum and he is therefore allowed to deduct all deduct all medical expenses in excess of R3 750.

The cost of his actual medical expenses is R5 000 and he may therefore claim R1 250 (R5 000 less R3 750) as a tax deduction for this particular tax year.

(c) *Employer provided medical treatment*

Currently, no taxable benefit will arise for the employee where the employer provides medical treatment to employees at their place of work. Such medical treatment is normally covered under a company's occupational health initiative. However, should the medical treatment be provided to employee's families, employees would be liable to pay tax on the value of the benefit. Where the employer pays for medical treatment for the employees and/or his family and this treatment is provided at a place other than the employee's workplace, the employee will have to pay tax on the value of this benefit.

In terms of the tax dispensation, all benefits derived from employer provided medical treatment (on- and off-site) will be tax-free in the hands of the employee, provided certain criteria are met. Only Prescribed Minimum Benefits may be provided tax-free at an off-site location. In cases where the the off-site employer provided medical treatment constitutes the business of a medical scheme is must be granted exemption from complying with the requirements of a medical scheme by the Registrar of Medical Schemes in order to qualify for tax-free treatment. Where the off-site medical treatments does not constitute business of a medial scheme it may be provided tax-free if it is only provided to employees, or their immediate dependants, who are not members of a medical scheme.

Example 4

John is not a member of a medical scheme and he and his wife are HIV positive. His employer funds a confidential off-site HIV/AIDS programme for its employees and their immediate families at a monthly cost of R500 per person treated. John and his wife participate in this employer programme and receive free medical treatment. Currently John is liable to pay income tax on the monthly fringe benefit of R1 000 and the confidentiality of the programme is jeopardised due to this tax charge. In terms of the amended income tax legislation John will receive this benefit tax-free provided the above mentioned criteria is met.

3. Who qualifies as a dependant

The Income Tax Act was amended to include a definition of dependant for purpose of medical scheme contributions. This definition is in line with the definition of dependant in the Medical Schemes Act and recognises the fact that an individual may want to extend coverage to persons other than his immediate family. Medical scheme contributions made by the taxpayer to cover his parents or other persons in his care will qualify for preferential tax treatment.

However, in the case of out of pocket medical expenses only expenses incurred in respect of immediate family members, for example, spouses and children will qualify for preferential tax treatment. This more restrictive definition also applies to employer provided treatment and is aimed at limiting abuse and to favour wider medical scheme coverage.

Taxation of funds

Growth on funds held by a medical aid scheme or a benefit fund other than a provident fund are not taxed.

The interest on a medical savings account is currently not taxed, although mention has been made of a possible change to this in the future.

The tax on growth is a pre-funding instrument using a provident fund is the same as for any provident fund - currently 0%.

5.3.4 Inspection of Financial Institutions Act and the FSB

The Registrar of Medical Schemes has all the power and duties conferred or imposed in terms of the Inspection of Financial Institutions Act of 1962. Included in these powers are the right to lodge applications to court for the cancellation and suspension or dissolution of funds.

The Registrar may cancel the registration of a fund:

a. if he is satisfied that the fund has ceased to exist; or

b. if he has agreed that the fund was registered by mistake.

The Registrar may apply to court for the cancellation or suspension of the registration of a fund if:

a. the fund has wilfully violated any provision of the Medical Schemes Act; or

b. after investigation, he is of the opinion that cancellation or suspension is necessary.

The Registrar may also apply to court for the winding up of a fund if he is of the opinion that there is no satisfactory solution to a fund in an unsound financial condition.

5.4 Healthcare products

5.4.1 Traditional Medical Schemes

The contributions paid in by members usually vary according to their salary band, and size of the family covered. They are adjusted over time, to take into account the actual claims experience of the members.

Before 2004 there were two tariffs. One was used by the medical aid companies, and was negotiated by the Board of Healthcare Funders. The other was negotiated by the South African Medical Association (SAMA), and used by doctors. In 2004, the Competition Commission outlawed the setting up of tariffs. From then on, medical aids and providers such as doctors and hospitals set their own tariffs.

Unit August 2010, the National Health Reference Price List (NHRPL) was used as a cost guideline for healthcare providers such as doctors and hospitals, and the funders which are medical aid schemes.

As a result of a court case, the guidelines set by the NHRPL were set aside, and a free market scenario emerged where healthcare providers charge what they feel is appropriate, and healthcare funders pay what they feel is appropriate. It is hoped that a more definitive pricing system will be reinforced to bring uniformity to the healthcare industry.

It is common practice for schemes to offer members a choice of cover, varying from a low cover plan, where relatively strict limits are imposed in return for a lower membership fee, to a full comprehensive plan at a far higher contribution level.

5.4.2 Health Insurance Products

Typical plans include the following:

- a hospital plan, which pays out a fixed amount for every day or night spent in a hospital, often with double benefits if intensive care is required;
- major medical cover, which pays out cash sums for various types of major surgery undergone, with the amount varying according to the perceived complexity, and hence cost, of the treatment.

5.4.3 Managed Healthcare systems

Managed healthcare operators try to manage the cost side of the equation through a variety of different efforts, while Preferred Provider Organisations (PPO's) seek to do the same thing by selecting only certain providers in the various categories (hospitals, GP's, opticians) and striking price deals with them in return for the volume of patients referred. In extreme cases this even extends to the PPO owning the facilities, such as the hospital, and employing the providers on a salary basis.

5.4.4 Demarcation of Health Insurance and Medical Schemes

The area of the demarcation of medical schemes and health insurance needs to be carefully managed, as there is a fair amount of confusion about it in the market.

The matter has hardly been resolved satisfactorily, although the Council for Medical Schemes and the Financial Services Board were eventually able to agree on an "Agreement on the demarcation between the business of a medical scheme and health insurance". The agreement was issued as a joint press statement on 7 September 2000. Since this date, considerable work has been done on drafting regulations which will set out the demarcation between medical schemes and insurers.

Agreement on the demarcation between the business of a medical scheme and health insurance

- The Council for Medical Schemes and the Financial Services Board (FSB) are in agreement on the demarcation between the business of a medical scheme and health insurance.
- Both the Council and the FSB recognise that a key feature of the business of a medical scheme is the fact that it indemnifies individuals against health care expenses.
- Health insurance is voluntary cover paid from after-tax income to protect individuals against unforeseen health events. Medical scheme business is voluntary cover partly paid out of before-tax income, which aims to indemnify people the actual expenses incurred in respect of a relevant health service - as defined in the Medical Schemes Act.
- The Medical Schemes Act governs medical schemes business and health insurance business is governed by the Long and Short Term Insurance Acts.
- Health insurance is based on a health event, which should only be triggered by the diagnosis of a health condition. The amount of the benefit payable on health insurance must not be retrospectively determined, but must be determinable at the occurrence of the event. The benefits payable by a health policy must therefore not relate directly to the cost of treatment of the event or the condition.
- In any instance where the business involves the undertaking of a liability to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service, then that business constitutes medical scheme business. This includes situations where a fixed sum per day is paid for a hospital stay, or where benefits are determined with reference to medical procedures or services.
- The Council and FSB emphasise that at any time where policy benefits take the form of hospitalisation and/or the payment of medical costs, that business will be regarded as medical scheme business.
- Health insurance may not offer cessions to services providers. Benefits must be paid to the policyholder and may not be paid by health insurers to service providers in return for services rendered.

- Health insurance may not be sold on a condition basis to members of a medical scheme. No reference to a medical scheme can be made in the marketing or sale of health insurance products.
- Both parties have committed themselves to properly monitor the environment to ensure that no products are created that will infringe on the agreed demarcation.

In this regard the Registrar of Medical Schemes and the Registrar of Insurance have agreed to develop a memorandum of understanding that will guide effective implementation of the agreed demarcation. A joint working group will be formed for this purpose.

The Registrars have furthermore, agreed on a set of guidelines that interested parties can take into account to ensure compliance with the legislation.

Both the Council and the FSB are committed to ensuring that all attempts should be made to ensure that the legitimate rights of policyholders are secured.

In this regard, the two registrar will, explore a phased approach together with interested parties to ensure that relevant policyholders are dealt with in an appropriate manner.

In something of a landmark ruling, a court ruled that short term insurance cover schemes aimed at topping up medical aid schemes by providing cover for the gap between the tariff amounts charged according to the National Health Reference Price List (NHRPL) and the actual amount charged, are not acceptable as insurance policies, and such cover would have to be the domain of medial aids. However, this decision was subsequently overturned on appeal. It is understood that the authorities are no relooking at the legislation in order to again seek to address the issue and gain better control over benefits offered, as they believe that insurers providing underwritten benefits are basically “cherry-picking” the better lives, leaving medical aids to pick up the more sickly members.

5.5 Administration of Medical Schemes

5.5.1 Underwriting issues

The setting of the levy to health cover is made somewhat more complex because the basis is community rating. The scheme may cover a family unit, which may include the immediate extended family of a member, who are dependent on the member, such as grandparents, rather than an individual. Although the Medical Schemes Act does not allow schemes to exclude new members entirely, it is common practice to require information about the state of health of a new member.

Dependent on the information provided, it is not uncommon for existing ailments to be excluded from a scheme's benefits. These exclusions are generally implemented even though rates are normally adjusted on an annual basis in order to fairly reflect the claims experience of the members.

In the same way as a group life scheme, medical aid administrators will view compulsory membership groups under relatively large schemes differently to individual - voluntary - applications.

Medical aid administrators generally also offer a free cover facility to compulsory membership groups, varying in approach according to the size of the group.

Where a new member is seeking cover for the first time schemes will often impose a three-month waiting period during which subscriptions are payable but benefits cannot be enjoyed. This is a way of limiting anti-selection be people who have already become aware of a medical condition before seeking cover.

Transferring members who are seeking to move from one compulsory scheme to another compulsory scheme when changing jobs must be accepted immediately where they have been a member, or a dependant member, of another registered scheme for a continuous period of two years.

Another time when a form of underwriting is used by medical aids is where an existing member is seeking to upgrade the nature of the cover enjoyed from one with relatively low benefits to one with fuller cover. Usually this is only allowed on the anniversary of the scheme, while some schemes allow only one upgrade during the member's entire period of membership. Medical insurance plans naturally use standard underwriting procedures, whereas new generation health insurers tend to use a kind of simplified underwriting approach.

It is common to place a nine month exclusion on pregnancy and maturity benefits, and even a 12 month exclusion on special dentistry.

Underwriting seeks to achieve the following:

- a reduction in the variability of experience, thereby reducing the risk factor and allowing lower overall charges;
- a better alignment of the premium with the risk;

- a reduction or elimination, of the anti-selection factor; and
- protection of the risk pool of the members.

The main concerns linked to underwriting of this approach are that:

- they could lead to certain people not being to obtain health insurance, often the people who need it most;
- even where cover is available, the process tends to group people of similar risk profile so that eventually to good risks all drift into a low-priced scheme and the remaining bad risks have no cross-subsidisation benefits and may not be able to afford the benefits.

5.5.2 Administration of Medical Schemes

Medical aid administration is a critical aspect of the service provided.

Functions performed included:

- handling of queries;
- receipt of claims from, either the service providers, or the member for reimbursement;
- checking for valid membership of the individuals to whom the service is to be provided;
- checking on the reasonableness of the services claimed and the relevant service cost codes which define the rates allowed for the various services;
- checking on ceilings for similar claims
- Processing and paying the claim; and
- preparing statistics and records for the monthly statements sent to members

5.5.3 Administration of Health Insurance Plans

The administration of health insurance plans is much the same as that for medical aids, although with health insurance plans the policy wording will play a greater role. It is also possible that the administrators will need to handle any reinsurance claims where the benefits exceed the limits that the insurance company can afford, or is prepared to carry.

5.6 Financial aspects of healthcare schemes

5.6.1 Costing principles

The costing principles of a traditional medical aid scheme are somewhat different to those of an insurance scheme

Medical aids

Medical aids tend to work on simplified group rating scales. A typical structure is shown below but it must be clearly understood that the prices quoted are purely an example and have no bearing on real costs to members:

Member	Principal member's monthly income				
	1000-2000	2001-3000	3001-4000	4001-5000	5001+
member	400	650	900	1 050	1 200
m+1	420	670	920	1 070	1 220
m+2	440	690	940	1 090	1 240
m+3	460	710	960	1 110	1 260
m+4 (or more)	490	740	990	1 140	1 290

Most schemes offer members a choice of three or four different types of scheme, each with a higher level of benefits, thereby duplicating the scale several times.

Insured schemes

Under the more insurance oriented schemes, there is more of an attempt to assess the individual experience and to cost for this

Insurance plans taken through a life company tend to have guaranteed rates which vary with the age at commencement of the principal member but are then level for the full period of cover, usually to age 60 or 65. Individual claims experience cannot change this.

However, it should be noted that these plans offer a fixed benefit level, so that over time the insured may expose himself to a share of the costs as medical services charges rise. Recent developments in policy design, now allow the insurer to review to premium rates for the group as a whole, based on long term claim payments.

Cover arranged through a short term insurer would have a similar initial rate structure but individual claims records are checked on an annual basis. This may result is higher rates being offered on renewal, or event in the cover being terminated.

Schemes marketed through life insurers generally offer fixed rates for the term of the cover, but reserve the right to adjust the actual charge on an annual basis to take into account medical inflation experienced.

Fixing of the employer's contribution

It is usual for employers to subsidise a part of the medical scheme costs, generally on a 50/50 basis. The issue of whether the different categories of employee are enjoying different levels of subsidisation from the employer, is a complex one. One way of solving this is through an overall package approach to remuneration which takes into account the employer's actual contributions. Insurance providers claim that by pricing more closely to the individual risk they are eliminating much of this problem in their product design.

5.6.2 Handling cross-subsidisation

There are four main components of the move to reduce cross-subsidisation. They are:

- using underwriting to equate the premium and the risk more closely;
- adopting a structure which allows for class groupings - by age, sex, occupation;
- making use of medical savings accounts or similar devices to curtail the overall fund's share of some risks; and
- allowing a drift of good lives into low-priced schemes and others into schemes priced according to risk profile.

Whilst these may well help to stop the young and healthy lives from opting out of health insurance schemes, they also have an adverse impact on the sickly and the aged. New generation schemes are also making considerable inroads into the elimination of cross-subsidisation.

5.6.3 Prefunding

The rapid escalation of healthcare costs, after normal retirement due to the increased usage as well as the medical cost inflation rate, has resulted in several attempts at creating funding mechanisms to cover these costs through contributions made during the working years.

Whilst it could be said that this is only a small part of the greater retirement planning issue, it is also clear that the reality is that it needs specific attention.

One of the more innovative approaches being used, is to link medical services usage during one's working years to contributions made to healthcare insurance plans, allowing individuals to build up a kind of credit account to be drawn on after retirement.

Other attempts include specific pre-retirement funding by means of set contributions, usually into a provident fund, because of the long term security, as well as the tax efficiency that these schemes offer.

A major concern in these efforts is often the direct link which is often observed between pre- and post-retirement medical costs. This means that it is those who have the higher costs during their working lives, who are also likely to need more medical services in retirement.

5.7 Managed care concepts

5.7.1 Principles and issues

Managed care seeks to control the costs of medical attention through various means. Key issues include:

- the basic right of the individual to seek out the medical service which he chooses;
- the aspect of personal privacy surrounding medical records and treatment;

- the right of the medical practitioner to be free to prescribe the kind of treatment that he believes is appropriate for each patient without undue pressure or persuasion;
- the potential for medical practitioners to perhaps under-service patients where they are carrying the financial risk themselves, resulting in both a deteriorating service level and, ultimately, higher costs involved in recovering lost ground or due to an inability to cure the problem in the early stages.

5.7.2 Physician/Provider behaviour models

Considerable research has been done into the attitude of medical practitioners, who are seen to be crucial in the overall decision concerning the nature, and hence the cost, of the treatment that patients are to be subjected to. In this it is generally accepted that, whilst the patient is theoretically in charge of the entire process and is hence ultimately responsible for the kind of treatment and level of treatment to be supplied, the specialist nature of the medical practitioner's knowledge often mitigates against the patient really having much say. It is unlikely that a physician will want to prejudice his professionalism by laying out options for the patient to choose from.

5.7.3 Vehicles in healthcare management

Various devices have been tried to overcome escalating costs, due to over-servicing. Some of the main methods are outlined below.

Copayment

This is when the patient is held responsible for a set percentage of each medical bill. Studies in the USA by the Rand Corporation have shown that this system is pretty effective in limiting costs, while not having a serious impact on the quality of the healthcare through patients opting not to go for the appropriate attention.

Medical Savings Accounts

The individual contributes towards a fund from which medical expenses are paid but, as the fund is owned by the individual, there is a direct responsibility and motivation to limit the claims.

Experience has shown that this approach has much the same success rate as the copayment scheme, although practically it is only used in conjunction with some form of full insurance of the more major medical entualities, which the personal fund could not pay.

Clinical guidelines and professional education

This method seeks to achieve to appropriate level of service through a combination of patient education, and service provider guidelines, which serve to create a more realistic level of understanding of the practical balance in the decision about treatment. It has been found to be more successful in situations where there is considerable variation in the quality of service providers.

Utilisation review

This is a method of control in which a qualified third party checks the level of service being applied either:

- before the service is actually provided; or
- as a form of case management during the overall treatment process; or
- as a retrospective control, partly in the form of an audit of the bill

Capitation

With the capitation system the service provider is contracted to provide the service for a flat fee and is hence encouraged to find the most suitable balance between cost saving and effectiveness - the latter will include the potential for a prolonged period before recovery is complete which would normally add to the overall costs.

The effect of the capitation system has been shown to be relatively successful and some schemes include some form of bonus or incentive scheme package to further control delivery decisions.

Service bundling

This is really compromise between full fee-for-service and capitation in that it bundles a range of services to be provided at a fee. A complication which arises in practice is where referrals are made

to providers outside of the agreement, which result in added costs being incurred by the patient outside of the prepaid bundle.

Networks

In their extreme form, these are Mutual Health Organisations (MHO's) or Preferred Providers Organisations (PPO's), in that they work along the lines of a selection of various providers, restricting the member's choice to boost volumes to the selected providers within the network in return for price advantages without sacrificing service levels. The capitation system of payment is sometimes used.

5.7.4 Lifestyle management concept

A growing concept, which is gaining considerable support in developed countries, such as the United States of America, is the idea of disease management.

In broad terms it rests on two principles:

- prevention is better than cure; and
- The key to proper healthcare is total and continuous management of the individual's health.

The three major components of disease management are:

- provider networks;
- care management, which includes education of the patient, provider and payer; and
- outcomes measurement in terms of adherence to procedures, patient satisfaction, quality of life and cost / quality of medical services.

A major part of this is the building up of a lifelong medical history on individuals so that health charges can be detected at an early stage.

Benefits often include items such as medical advice lines and weight-loss or fitness programs.

Because preventative treatment is often cheaper than the ultimate cure once a condition has manifested itself, this is seen to be a more viable solution. Another key benefit of this approach is that it is seen to offer an improved level of lifestyle to the individual, who does not suffer the effects of health problems as often or as severely as under the cure approach.

Learning unit 6 - introduction to underwriting

6.1 What is underwriting?

6.1.1 Definition

Selection or underwriting in the context of a life insurance proposal or application is the term used to describe the consideration given to an application for insurance to determine whether or not the policy applied for should be issued.

The acceptance of an applicant for either life of health cover involves a transfer of risk from the insured to the insurance company. By purchasing a life policy, the applicant substitutes a small, certain loss - the premium - for a larger, uncertain loss - usually the beneficiary's loss of future financial support due to the early death of the life insured. In this way, the life policy transfers the risk of financial loss due to premature death of the insured individual from the policyowner's dependants or named beneficiary to the life insurance company.

The process used to determine an individual's probable degree of risk of loss is called underwriting. Each life insured is charged a premium rate that corresponds to the risk that the person presents to the company. Therefore someone with a higher risk of death, for life insurance purposes, and for health insurance a higher risk of accident or illness, pays premium than someone with a lower risk.

6.1.2 Basis of sound underwriting

The mortality profit made by a life insurer is relatively small when compared with the profit which can be made on the investment front. All insurers need to maintain a careful selection of lives, otherwise the expected small mortality profit could turn into an unexpectedly large loss.

The underwriting standards of all insurers are tending to become more lenient as more statistics become available and the risks of many diseases are improved as the result of modern medicine and

surgery. The ever widening scope of non-medical schemes illustrates this feature and it is true to say that most life offices come within the average band.

However, while some insurers remain very stringent and selective as a definite policy, other insurers on the other hand are known, as a deliberate marketing policy, to be extremely generous on substandard risks. This means that these insurers tend to attract the most impaired lives.

In addition we have seen the development of professional reinsurance companies who specialise in the insurance of sub-standard risks, enabling direct insurers to reinsure certain substandard risks with them.

Although the direct insurer largely loses the benefit of any profit from this form of business they manage to please sales and marketing agency connections by accepting substandard risks at attractive rates.

6.2 Introduction to underwriting

One of the basic principles of life insurance is that the premium paid by each insured life is sufficient to cover the risk which he brings to the life insurance fund. In order to implement this, a mortality table is used in calculation of standard premium rates applicable to average lives, where the potential mortality risk is unlikely to be heavier than that in the mortality table.

Each risk is assessed individually be the underwriter and, if it appears that the mortality is no heavier than the mortality rate used in premium calculation, the proposal is accepted at the standard rate of premium, as the risk is average. When the proposer for insurance is a heavier mortality risk it is described as under average or sub-standard. In these circumstances standard premium rates wouldn't be allowed, therefore the proposal is accepted on special terms, declined or delayed, according to the circumstances.

There are a number of factors that influence the assessment of a risk and an underwriter must take care to ensure that each factor is carefully assessed before a decision on the acceptance of a proposer is made.

The following are the factors that influence assessment of the risk:

- the proposer's age and gender;
- the proposer's physical health;

- the proposer's medical history;
- family medical history;
- occupation; and
- hobbies and leisure activities of a hazardous nature.

In some cases, environment, moral hazard, and the possibility of foreign residence or travel are relevant. Underwriting standards vary considerably between insurers, nevertheless all underwriting is subject to the same basic principles.

Policies of life insurance and disability insurance are long term contracts. When assessing the risk the underwriter must look ahead and take into account future deterioration of the proposer's physical condition, arising from his medical history or present state of health. The risk premium is fixed at the inception of the contract and the insurer cannot increase it at renewal or refuse to accept a renewal premium if it is tendered within the days of grace allowed for payment.

Even where the issued policy is a universal policy the insurer is not permitted to re-evaluate an insured on an individual basis. The basis of a review and adjustment of premium rates as a result of increased risk factors, such as an even higher than anticipated spread of an illness, is always based on the overall portfolio of policies held by the insurer and never on an individual basis.

When assessing the risk, relevant features must not be considered in isolation but in relation to each other.

Example

A person with a history of chest disorders who works in a dusty atmosphere is a higher risk than a person with a similar history working in the open air. Heredity may play a part as there is sometimes a predisposition for certain illnesses to run in families or conversely for longevity to run in families.

Risk are assessed mainly on the basis of:

- mortality in life insurance;
- morbidity in disability insurance;
- occupation and medical condition in personal accident insurance; and
- medical condition and medical history in hospital and major medical insurance.

There is considerable difference between mortality and morbidity from an underwriting perspective.

Muscular rheumatism for example, does not increase the sufferer's mortality rate, but it certainly increases the sufferer's morbidity rate as he is likely to be disabled from time to time. In this case normal rates would be offered for life insurance, whilst a permanent health insurance policy would not provide a benefit for at least the first 26 weeks of incapacity arising from muscular rheumatism.

6.3 Objectives of the underwriter

In making underwriting decisions and assigning proposed insureds to the appropriate risk classes, the underwriter's objectives are to approve and issue a policy that is:

- equitable to the client;
- deliverable by the intermediary; and
- profitability to the company.

6.3.1 Equitable to the client

As each application for insurance is received, the insurance company must determine the degree of risk and must change a fair premium for this risk.

Analysis of a group individuals of a particular age and sex indicates a wide variation in physical health, occupation, hobbies and other factors. For example, in a group of one hundred 35 year old males applying for R100 000 cover, perhaps 98 are in good health and two have a serious health impairment that is likely to increase their risk of early death.

If all one hundred males paid the same premium for their insurance cover, the 98 healthy ones would be subsidising the higher risk represented by the two in poor health. Such an arrangement would not be equitable.

Therefore the men with a higher risk of early death should be charged a higher life insurance premium than the others. This principle holds true for any impairment that causes an individual to have a higher risk of loss than other individuals of the same sex and age.

An understanding of how various factors influence mortality enables the underwriter to identify applicants who present comparable mortality risks and to classify these applicants accordingly. Classifying the lives insured in this way enables the insurance company to charge each individual policyowner an equitable premium proportionate to the degree of mortality risk he presents to the company.

6.3.2 Deliverable by the intermediary

The buyer makes the ultimate decision as to whether a particular policy is acceptable. If the buyer chooses not to accept the policy when the intermediary attempts to deliver it, that policy is said to be not taken up.

One of the many reasons a policy may be considered not taken, is because of an unfavourable underwriting decision, that results in a higher-than-anticipated premium charge. For example, if the underwriter has decided to change a higher-than-normal premium for the cover or the limit the amount or type of supplementary benefits or riders applied for, then the applicant may reject the policy.

For a policy to be acceptable to the buyer, it must satisfy three basic requirements:

- the policy must provide benefits that meet the buyer's wishes;
- the cost of the cover provided by the policy must be within the buyer's financial means; and
- the premium to be charged for the cover must be competitive in the marketplace.

The third requirement listed above is particularly important, because the life insurance industry is very competitive, especially in the area of pricing. The price that an intermediary quotes to a client, is generally based on the company's standard premium rates. The intermediary may have difficulty delivering the issued policy to a client, if the underwriter's decision has made the policy more expensive than the premium rate the intermediary originally quoted to the buyer.

When this is the case, intermediaries may exert pressure on the underwriter to lower the price. If the insurer does not yield, the intermediary may take the proposal to a competitor that offers a more deliverable decision. When intermediaries attempt to put pressure on an underwriter, and no change in the decision is possible, the underwriter must be able to explain the reasons for his decision with credibility.

6.3.3 Profitable to the insurer

An underwriter must make decisions that are profitable to the insurer. All insurance companies require sound underwriting to ensure favourable financial results. The profitability of an insurer is, to a large extent, built into the rate structure established by its actuaries.

Although underwriters are not directly involved in establishing an insurer's premium structure, underwriters decisions are very important in producing actual mortality results that coincide with the actuaries' mortality projections.

6.3.4 Service and speed

Prompt application approval and policy delivery are vitally important. Each day that goes by, after the client has completed the application, gives the applicant an opportunity to reconsider the buying decision, even if a premium has been paid in advance.

The management systems available provide reports about overall time service patterns to company executives, so that when serious delays seem to be occurring corrective action can be taken immediately.

Underwriters must balance the demand for prompt turnaround time with appropriate analysis of risk information.

Most laboratories today use electronic transmission of completed blood and urine results, and these are received by the insurer directly via an electronic link up with a particular laboratory. This service ensures that the test results remain confidential and prohibits easy access from any third party who may wish to alter the results. Confidentiality of personal information is crucial and must be adhered to at all times.

Once all the necessary dates has been attained, the underwriter might find that the case is substandard, and send all the details to the reinsurance companies for their opinion. The reinsurers are also in competition with each other to provide the best possible terms for the applicant, in the shortest possible time.

A 24 hour turnaround is usually expected with the pressure of trying to reduce this as much as possible. The direct office underwriter then has to decide which reinsurer's terms he is happy to accept and generally shares the business with the reinsurer, or in some cases where the risk is highly substandard, requests that the reinsurer retains 100% of the risk.

6.4 Selection of risks

6.4.1 Establishing risk classes

By using available statistics on mortality, a life company actuary is able to establish a number of different categories, known as risk classes, to accommodate the varying degrees of risk presented by groups of individual's applicants.

A risk class is a group of insureds who present an equivalent mortality risk to the insurance company.

The underlying concept involved in pricing an insurance product is that past mortality experience can be used to predict future mortality experience if:

- a large enough number of people apply for insurance; and
- these people can be placed within relatively homogenous groupings for the purpose of developing a premium structure.

A schedule of premium rates for life and health insurance is based on the assumption that the future mortality and morbidity rates anticipated by the actuary, and those rates actually experienced by the insurer, will generally be comparable to past mortality and morbidity rates. This assumption will generally hold true if individuals, who exhibit similar degrees of risk, are grouped together in large enough numbers for the laws of probability to operate.

The different risk classes used by life insurance companies can generally be grouped as the standard, substandard, preferred and non-smoker classes.

- The standard class includes individuals whose anticipated mortality is regarded as average.
- There are usually several substandard classes that include individuals with impairments, any aspect of their health, occupation, avocation or lifestyle that can be expected to shorten their lifespan.
- The non-smoker class uses only one factor - whether an individual smokes, usually cigarettes, to determine whether that individual is a better-than-average mortality risk.
- The preferred class, on the other hand, is based on many factors in addition to whether the applicant smokes.

- There may be some overlap between the preferred class and the non-smoker class. Both classes include individuals whose anticipated mortality is lower than standard mortality.

6.4.2 Need for selection

The selection process is necessary if we accept the principle that every life insured should contribute his fair share toward the risk involved. Only applicants who are exposed to comparable degrees of risk should be placed in the same premium class.

The fact that mortality varies with age, makes it necessary to have premiums that vary with age for a given plan of insurance. The process of selection and classification of risks is necessary to reflect the fact that individuals of the same age may be classified into groups that will give widely different mortality results. For example a person suffering from insulin dependent diabetes has a higher mortality risk than someone of the same age and gender who suffers from mild obesity.

In any group of individuals of the same age, some are exposed to greater risks of death because of occupational or hobby activities. The great majority are classed as a standard risk, as they have had some minor illnesses, or have minor physical defects, but none that affect longevity to any great extent. Those that are free from even the slightest impairment are preferred.

Knowledge of the way the various factors influence mortality enables the underwriter to classify applicants into groups that will give relative mortality rates very close to those that are anticipated. Those subject to a higher than normal mortality are said to be substandard or impaired and their chances of survival from year to year are reduced.

6.4.3 Risk selection

Underwriting specifically considers each applicant on his unique characteristics. No two individuals are alike. The underwriter's placement of individuals into risk classes is based on many factors. Company guidelines, developed from statistics concerning these factors' effects on mortality, determine the underwriter's decision regarding the selection and classification of individual-proposed insureds.

The underwriting decision must often be objective, however, since the guidelines do not always apply to the special set of circumstances and the uniqueness of a given individual.

In addition to classifying individuals selected for insurance coverage according to the different degrees of risk they present to the insurer, underwriting helps guard against anti-selection. Anti-selection, or selection against the insurer, is the tendency of people who have a greater than

average likelihood of loss, to be interested in obtaining or continuing life or health cover to a greater extent than others.

For example, there is a tendency for some people who are in poor health, or who work in a hazardous occupation, to want to purchase life cover. Underwriters must be careful to guard against possible anti-selection, in order to ensure that all individuals accepted for cover are placed in the appropriate risk classes. This will result in those people insured being charged an equitable premium for the risk they present to the insurer.

6.5 Underwriting guidelines

One of the most important prerequisites to sound underwriting is consistency. Consistency is necessary for two main reasons:

- for the underwriter to achieve the mortality results projected by the actuaries; and
- for members of the company's field force, and any supporting brokers to predict to some degree the underwriting decision on individual applications, especially in cases involving impaired risks. The intermediary can then take applications from proposed insureds with realistic expectations about the probable underwriting decision.

In order to assure consistent underwriting, and to achieve the mortality results assumed on the premium calculations, underwriters follow guidelines based on the insurer's rate structure, mortality experience and financial objectives.

6.5.1 Numerical rating system

This method of underwriting assigns numerical values to individual applicants, based on the degree of risk they present to the insurer. These numerical values are then used to determine the appropriate risk class in which to place the applicant, and the appropriate premium to charge. The numerical system works on a debit and credit system to a number of impairments that have been determined to have a greater, or a lesser, impact on the mortality risk presented by the applicant.

The underlying principle in the numerical method of medical selection rests on the assumption that the average risk accepted by an insurer has a value of 100% and that each of the factors that make up a risk shall be expressed numerically in terms of an extra mortality percentage. It is 100% certain that we will all die someday.

The total of these extras where there is more than one impairment involved, shall be determined by taking various debit or credit criteria into consideration. Allowance must be made for the interdependence of two risk factors, and whether they exacerbate the risk to a greater or lesser degree.

This method assumes that the final decision is consistent with good judgement, hence an underwriter should have a sound medical knowledge. An accumulation of credits, for example, does not necessarily mean that a substantial and important debit will be nullified. Hazards which are a temporary nature would need to be rated with a temporary loading.

6.5.2 Underwriting manual

The underwriting manual provides background information on impairments, and serves as a guide to suggested underwriting action when various impairments are present. Most insurers emphasise that the suggested actions listed in their manuals are intended to be flexible and may be modified by the underwriter according to individual circumstances.

In order to prepare an underwriting manual, extensive experience with various types of risks and impairments is needed, and therefore the reinsurers were the first to produce these manuals.

Most manuals also include a laboratory section which lists basic laboratory test data and a normal range of values for the most commonly used laboratory tests.

Indexes usually include a list of synonyms and derivative terms for impairments and corresponding page reference.

Limitations of underwriting manuals

Although the underwriting manual has a significant place in the underwriting function, the manual should not be used as an absolute authority for several reasons:

- when the underwriters are faced with a combination of different impairment, they must have a sound medical knowledge in order to be able to determine whether the combination of risk factors greatly increases the risk, such as smoking and cancer, as cigarettes are known to be carcinogenic. However with the combination of cancer and obesity, obesity does not have a direct impact on cancer;

- the task of keeping an underwriting manual up to date is formidable and time consuming, especially in light of the rapid pace of medical advances, and information in such manuals if often dated and, reflects the experience from risks accepted at least five years;
- manuals generally reflect the anticipated extra mortality for age 25 or 30 through to 55 or 60. Therefore, to assess a risk on either side of these age limits requires some modification of the manuals suggested ratings.

6.5.3 Underwriting policy and company objectives

One company may be writing business among certain groups who carry comparatively large policies, hoping to offer cover to this section of society on a favourable cost basis. Another company may undertake to provide insurance for all levels of society, so that as many members as possible may enjoy the benefits. One company may go for a niche market, hoping in that way to enjoy economics that more than make up for the limited growth that is possible. The underwriting policy that is adopted must be in keeping with each individual company's objectives and target market.

6.5.4 ASISA HIV testing protocol

The original AIDS agreement was introduced as a direct result of the threat to the financial soundness of life companies posed by HIV/AIDS. Life offices were required, in the absence of a negative HIV antibody test result, to impose an AIDS exclusion clause on all life policies of R200 000 or more.

The exclusion also applied on all disability income policies of R2 000 per month or more, and on all business overhead disability income policies of R8 000 per month or more. The rapid escalation of HIV positive numbers is South Africa necessitated a rethink of the numerical figures to be used before an HIV-test must be undergone.

Some life offices had reduced the sum insured above which an HIV-test became mandatory to as low as R50 000, while other life offices were calling for tests where the sum insured exceeded as little as R20 000.

The HIV testing protocol replaced to original AIDS agreement and no longer stipulates at what level an HIV-test becomes mandatory, it simply provides guidelines on the application of the tests.

What is interesting is the attitude taken by the industry to no longer enforce an HIV/AIDS exclusion clause on life and lump sum disability cases, even under those policies which had already been issued with an HIV/AIDS exclusion. The reasons for this, is in the difficulty in getting the true cause of

death disclosed on death certificates, where the HI virus may be involved. Furthermore it advances the use of antiretroviral (ARV) treatment, to prolong the lifespan of those who are infected, which makes the disease treatable, in a similar way to other chronic conditions such as diabetes, according to some commentators.

This is more than likely only applicable to policies with relatively low life cover as an insurer would be inclined to decline acceptance of a proposal with a large sum insured, if the proposer refuses to undergo an HIV-test.

Many life offices avoid having to deal with an AIDS exclusion clause, by simply insisting on an HIV-test with all policies providing life or disability cover. The reasoning behind this thinking is as a result of the following:

- policies providing life cover that will only be issued after a negative HIV-test result has been produced will remain in force if the insured should become infected with the HI Virus after the inception of the policy. It is only where periodic HIV-tests are required as a continued guarantee of cover, that the life cover on the policy might be reduced if a positive HIV-test is submitted by the life insured;
- an insurance company will be able to refuse payment, only where it can be shown that there was a material non-disclosure in relation to HIV status before the policy was issued. In these instances, the insurer would never have been at risk anyway, because the policy would not have been issued, or only issued on special terms, if the insurer had been informed of the actual state of health of the proposed life insured;
- AIDS is very seldom stated on a death certificate as the cause of death. This would therefore, make it very difficult to enforce an AIDS exclusion clause. The insurer may elect to rely on the World Health Organisation's (WHO) list on AIDS related conditions, but this is one step removed, and will make the AIDS exclusion clause difficult to enforce.

Whatever the approach of the insurer, it must subscribe to a testing protocol that ensures that test results are treated in a confidential and sensitive manner. In particular, positive test results must not be divulged to any person, other that the doctor nominated by the proposer. All positive test results and all refusals to undergo a test must also be recorded in the ASISA's life registry.

Where an HIV antibody test is performed and the result comes back as a negative, the proposer must be informed of this fact if the proposal is declined for any reason unconnected with HIV/AIDS.

A niche long term player has actually announced a specific life plan for HIV positive people.

6.6 Profile of an underwriter

The underwriting team could be said to include the intermediary, the medical examiner, the lay underwriter and even the actuary for the bases on which the underwriting is done.

For the actual evaluation process, the co-operation of a medical advisor is valuable, in as much as the probable length of life of a human being depends to a large extent on medical factors, such as:

- past illnesses;
- state of nutrition;
- mode of living; and
- General state of health.

An underwriter without medical knowledge cannot adequately assess, even with good guidelines, all probabilities of death and survival associated with a number of diseases or other abnormalities.

It is, in effect, the duty of the underwriter to perform all those functions involved in the underwriting process, for which the doctor's specialist knowledge is not absolutely essential.

6.6.1 Functions of the experienced underwriter

An underwriter must have a well-founded store of knowledge on the technical, legal and medical basis of life insurance, and be thoroughly familiar with the objectives of underwriting and the company's administrative procedures.

The general function of an underwriter includes:

- the continuous acquisition, evaluation and indexing of information from various publications which could be of underwriting significance;
- the formulation and, where necessary, amendment of underwriting rules and the consistent enforcement of these;
- the design and/or adaption of application forms and other documents relating to ascertaining the applicant's state of health;

- the processing and examination of individual application for insurance in order to arrive at a sound underwriting decision;
- the establishment and maintenance of close contact with company management agency staff and the claims and actuarial departments.

Since underwriting is constantly changing, the underwriter must ensure that he is adequately informed regarding any new developments and tendencies within the field. Changes may occur in many different areas such as:

- **Medicine:** increasing importance of new kinds of medical treatment and advances in operative techniques, for example, hip replacement prostheses;
- **epidemiology:** the diminishing importance of communicable diseases such as diphtheria and increasing importance of new diseases;
- **Technological advances:** dangers to atomic energy, new technologies in racing and diving;
- **travel:** the ever growing number of aviation and road traffic accidents;
- **legislation:** changes in taxation laws may increase or decrease the demand for life insurance or make certain types of cover more attractive;
- **economics**: during times of recession, care should be taken in the underwriting of disability benefits. The insured population may be more tempted to claim on their benefits when they are feeling the economic squeeze;
- **Political situation:** crime has a direct impact on claims experience for traumatic deaths and on disability claims for, post-traumatic stress disorder. The underwriter must bear this in mind when underwriting certain occupations, such as policemen and taxi drivers who are exposed to violence;
- **marketing situation:** new types of policies and benefits may be developed and these may be developed and these may in turn involve new underwriting criteria and considerations.

In order to keep abreast of such developments in these various fields, the underwriter must do a great deal of purposeful reading including insurance journals, suitable publications from the World Health Organisation, and medical journals.

In order to ensure that information is not only acquired but that it also is available when needed, a simple but efficient system of collecting, summarising, classifying and indexing the relevant information should be developed.

Frequent discussions with the medical advisor and other professional colleagues, will further broaden the underwriter's horizon. It will also provide an indispensable asset for the underwriter in terms or information, who often is obliged to maintain authority under pressure.

Establishing and consistently enforcing reasonable and purposeful underwriting rules, and adapting them periodically to changing circumstances, is an important duty of the underwriter. This includes:

- age limits, as well as amount limits for medical and non-medical acceptance;
- rules setting out how applications must be completed;
- the choice of medical examiners;
- rules for obtaining Personal Medical Attendant reports; and
- rules for dealing with applications for reinstatement of lapsed policies. These rules are essential for effective administration.

While even the best rules will not in themselves prevent anti-selection, the knowledge that such rules exist and must be complied with, is a constant reminder to the intermediaries that the company means to exercise control over the quality of its new business.

Design of application forms

The design of application forms and other forms used in underwriting is closely linked to the need for good underwriting rules. The underwriter must develop the ability to draft forms and questionnaires that are simply worded, well arranged and sufficiently comprehensive to elicit essential underwriting data from an honest applicant.

The design of good forms is a skill which presupposes a thorough knowledge of the subject matter, good judgement, a sense of balance and some experience. Forms, such as the medical examination form, should only be designed in conjunction with the medical advisor.

In certain cases, it is essential that the company's legal advisor be consulted, or that he drafts certain sections of a form, for example the declarations or warranties. Specimen forms found in books or journals can be used for reference, but never copied, because no specimen form designed by someone outside a company, can fully meet that company's individual needs.

Processing of application forms involves a large number of duties which underwriters need not necessarily perform personally, but with which they should be thoroughly familiar. This is because

some of the data being processed may also have underwriting significance. Underwriters must satisfy themselves that the company's underwriting rules have been met.

He needs to:

- take note of the introducing intermediary and examining doctor, in cases where medical examinations were carried out;
- compare the relevant signatures;
- take note of the plan of insurance requested;
- take note of the sum insured;
- pay attention to the reasons for the cover, and the insurable interest; and
- carefully evaluate the medical factors, including occupation, sporting activities, as well as amounts of existing cover.

Underwriters should be able to determine whether the applicant is a first class risk or substandard, or even uninsurable. They should also be able to prepare all files that must be reviewed by their seniors or the medical advisor, so that the senior underwriter can devote his time and knowledge to examining the concerning aspects of the risk.

6.6.2 Queries

Many queries arise in the daily work of an underwriting department. Applications are often incomplete, additional information may be necessary, and there may be inconsistencies requiring clarification. Such queries necessitate much correspondence which must be conducted with competence and skill, and in such a manner that there is no avoidable delay or loss of business.

Underwriters should, therefore, know how to conduct correspondence, telephone and other conversations, and generally secure the efficient and prompt cooperation of those from whom information is required.

The importance of correctly assembled, and intelligently sifted, underwriting information can hardly be overstated. No item of information should be ignored, but it is the underwriters prerogative to decide the importance that should be attached to each item of information.

It may happen, for example, that is the case of a known hypertensive applicant, a medical report is submitted which shows normal blood pressure readings. It is the underwriter's responsibility to decide what weight should be attached to the information, in relation to the overall picture of that particular risk.

The progress of medical science has resulted in many previously uninsurable risks becoming insurable with loadings. More favourable underwriting decisions have become possible in respect of certain impairments. For some companies, such changes of underwriting practice may be possible only in collaboration with a reinsurer. There is, however, no doubt that a slow, but progressive, improvement of underwriting standards is possible for every company.

The alertness, speed and efficiency of a company's underwriting service can be a valuable asset in assisting to implement a company's new business expansion. The better that the underwriters are able and willing to explain to principles that guide them in their work, the better the image of the underwriting department will be within that company.

6.6.3 Relationship with claims department

A special relationship with the claims department may be very beneficial to the underwriter.

It is important that the insurer follow a consistent policy, and practice in the handling of claims. An insurer that neglects proper claims investigation, or is afraid to refuse bad claims, cannot hope to be successful in its underwriting.

Many members of the public will not bother to make true and complete declarations, if they have reason to think that there will be no penalty for non-disclosure or misrepresentation. It therefore stands to reason that underwriters are interested in the company's policy of and practice in, handling claims. The underwriter also often gains valuable knowledge from a study of claims documents. The study of these documents may illuminate some weakness in the underwriting procedure, or decision that can be remedied for future business.

6.7 Medical terms

Underwriters must be familiar with medical terms, so that they are aware of their significance in relation to the risk which has to be assessed. Since many medical terms are derived from Latin or Greek, their approximate meaning should be apparent to anyone who has a basic knowledge of a few prefixes and suffixes together with the medical synonyms for various parts of the human body. The following lists may help in the understanding of some of the terms encountered.

PREFIX		PART OF BODY		SUFFIX	
a- or an-	without	aden	gland	-aemia	blood
anti-	against	arteri(a)	artery	-algia	pain
brachy-	short	cardi(a)	heart	-asm	condition
brady-	slow	cephal(e)	head	-cele	tumour
dys-	difficult	cerebr(um)	brain	-ectomy	removal
ecto-	outer	chole	bile	-esis	state
endo-	within	derma	skin	-ism	condition
hydro-	water	enter(a)	intestines	-itis	inflammation
hyper-	excess	gast(e)r	stomach	-mania	madness
hypo-	deficiency	haem(a)	blood	-oma	tumour
leuco-	white	hepa(r)	liver	-osis	disease
melan-	black	myo(s)	muscle	-otomy	opening
meta-	change	nephr(os)	kidney	-philia	affinity
pan-	all	neur(on)	nerve	-phobia	fear
peri-	around	os	bone	-rhoea	flow
poly-	excess	ot(os)	ear	-sepsis	putrefaction
scler-	hard	phleb(os)	vein	-troph	stimulating
steno-	contracted	vas	blood vessel	-uria	urine
tachy-	rapid	pulmo	lung		
		ren	kidney		

Some **Examples** of compound words obtained from the above list are:

- *endocarditis - inflammation within the heart;*
- *dermatitis - inflammation of the skin;*
- *nephrectomy - removal of the kidney;*
- *adenoma - tumour of a gland;*
- *myalgia - muscle pain*

6.8 Reinsurance

Reinsurance is an arrangement, usually with a reinsurance company, in terms of which a portion, or all, of the risk on the life of a person is passed on to the reinsurance company, in return for which an appropriate premium is paid.

Reinsurance is a separate contract of insurance between two insurers. One, the first or direct insurer, has an insurable interest in the life insured. This is the obligation it has to pay the sum insured if the insured event occurs. The other insurer, usually called the reinsurer, in turn accepts all or part of the risk.

The main reasons for reinsurance are:

- protection against large losses which may be unaffordable, or at least highly unattractive;
- Stabilisation of financial results through the reduction of fluctuations in claims;
- protection against an accumulation of claims from one source, or a series of related sources;
- to assist with the financing of new business strain;
- to allow the pooling of certain classes of risk from around the market, which may allow such risks to be more favourably underwritten than if they were left to the individual direct insurers; and
- other specialist services offered by the reinsurers.

If a life insured, with a very large life policy dies in the first year or two of the policy's existence, the insurance company would have to pay out a considerable sum of money. This could disrupt the financial planning and projections of the insurer.

While it is true that if the life insured lived longer than expected the life company would stand to make a profit thereby, prudent financial control dictates that the life company should offset or reduce the large initial risk involved.

6.8.1 Retention

The amount at risk on any one life which a company decides to carry itself is known as its retention. There is no hard and fast rule for calculating retention, but it is generally related to the capital structure of the company, the adequacy of its reserves and the average sum insured on each life that is covered.

In the early years of a life company the expenditure associated with its establishment and promotion is likely to be considerable. A newly established life company will, therefore, seek to reinsure a greater proportion of the risk carried than in the case of longer established companies.

In the early stages of its existence, the number of lives insured is likely to be small, and the actual number of deaths occurring is unlikely to correspond with those expected to occur. Reinsurance therefore assists in offsetting this risk.

The costs of acquiring new business are high, in many cases up to 135% times the first year's premium. The capital of the company is required to finance this deficit, which is known as the New Business Strain.

In the case of non-medical business, where the life to be insured is not subject to careful medical investigation, the mortality is likely to be higher than in the case of selected lives. There will be a tendency to over-reinsure rather than to under-reinsure.

A typical example of the amount to be retained, per life in the case of a new life company with capital of R100 million, would be of the order of R1 000 000. This amount would increase from time to time, as the company expands. It is also possible to have different levels of retention for different ages of life insured and/or according to the type of policy issued.

Limit of retention

Most life offices observe what is known as a limit of retention, that is, they retain the whole of the risk in any particular case up to an amount, which is their limit of retention. Any sum over this is reinsured with another office or reinsurer.

Note that the whole risk is accepted by the original office, and the contract which the insured has completed, is with the original office. However, that portion of the insurance above the office's limit of retention, is reinsured with a reinsurer.

An **Example** will make this clear.

Suppose the limit of retention is particular office is R200 000. A proposal is received for R300 000 and is accepted by the office. The balance of R100 000 is then reinsured with a reinsurer.

The reinsurance contract is between the two office, and the insured's contract is with the first office only. He is not a party to the reinsurance and, usually is not even aware of it. The retention may also be reduced for certain classes of insurance, for advanced ages at entry and for substandard risks.

6.8.2 Main types of reinsurance

Treaty reinsurance

In terms of such an arrangement, agreement or treaty, made between the reinsurance company and the life company, the reinsurer agrees to accept, and the company agrees to cede, all amounts in excess of a certain retention limit. This retention limit is decided upon at the time of negotiating the treaty. Remember that the amounts at risk on previous policies on a particular life insured, will also be taken into account in determining the retention in a particular case. The life company is concerned with the amount it may have to pay out per life insured, and not per policy.

The advantage of a treaty is that a life company will be secure in the knowledge that its reinsurance requirements are provided for, and the associated administration in connection with the reinsurance procedure is reduced. The life office develops a more intimate relationship with its treaty reinsurer, and is able to benefit from other services offered by the reinsurer.

Facultative reinsurance

We have seen that under a treaty arrangement the life company is obliged to cede (reinsure) all of its business falling under the reinsurance arrangement with a particular reinsurer and the reinsurer is obliged to accept such business.

The life company may be unwilling to tie itself to such an arrangement and prefer to arrange its reinsurance requirements on a policy by policy basis. In this event there is no automatic cover provided by the reinsurer, and the life company submits details of each particular policy, including medical evidence, to a reinsurer of tis choice.

Terms for the reinsurance of the particular policy are then agreed upon, such as premium and commission, and the reinsurance comes into effect. This method is the exception rather than the rule, chiefly because of the greater administration involved.

Facultative reinsurance will also apply where the risk of a particular life to be insured does not fall within the scope or agreed parameters of an existing reinsurance treaty. It must then be dealt with on a facultative or individual basis.

Learning unit 7 - Policy servicing

A person who buys a life insurance policy generally hopes to have to wait a long time before he needs the money. Consider that the proceeds of a policy are normally only paid in the event of the death or disability of the life insured.

It is only with an endowment policy that the policyowner can look forward to a predetermined date on which the policy will pay a large amount of money to him. However, even with an endowment policy, the policyowner will have to wait for at least five years before the policy can mature. It is only on earlier death or disability that a policy can pay a benefit before the expiry of the policy term. Regulations to the Long Term Insurance Act is very clear on the fact that no life insurance company may sell a policy that has a term of less than 5 years, if there is a savings element, other than a retirement annuity.

It is very important that every life insurer has an efficient department that can maintain its policies and keep in contact with the policyowners. This department must also be competent in providing assistance to any policyowner who may experience problems with his policy, or who may want to make changes to any of his policy's details.

In most life insurance companies this department is known as the policy servicing department.

While it is self-evident that every life insurer will need to have some form of policy servicing department, it is important to appreciate the way the departments are structured and managed will differ from insurer to insurer. The market that an insurer concentrates in will dictate the services that its policy servicing department will need to provide, and will therefore affect the structure of the department. However, even though there are differences between the policy servicing departments of the different insurers, there are certain roles and functions that will need to be provided by the policy servicing department of every insurer.

These roles and functions entails:

- **conforming to legal requirement**

Anything that is done by the policy servicing department will have to abide by the statutory laws and regulations of the Republic of South Africa. All insurers who operate in South Africa have to be registered as local insurers. Legislation that has the most relevance to life insurance includes:

- the Long Term Insurance Act,
- the Income Tax Act and
- the Pension Funds Act.

There are a number of other pieces of legislation as the Companies Act that must also be complied with.

- **acting in accordance with the conditions of the policy document;**

Once a life insurer accepts a proposal form, the insurer will print a policy document with the details of the contract entered into, and send the document to the new policyowner as proof of the contract. The policy document will include all the terms and conditions of the contract, as well as a description of the benefits that have been included in the policy.

Whenever a policyowner wants to alter the policy, or submit a claim against the policy, it is the responsibility of the policy servicing department to ensure that the change or claim is allowed in accordance with the terms and conditions contained in the policy document.

- **abiding by the company's practice.**

Staff within the policy servicing department must be well versed with company practice in areas such as, the granting of loans against existing policies, and the interest to be charged thereon. This is to ensure that no mistakes are made when advising a policyowner.

Beneficiary Changes

When one realises that the majority of payments made by a life insurer are death claims, one begins to understand the importance of the nomination of a beneficiary to the policy owner. The deceased policy owner will have nominated a beneficiary to receive the proceeds and may change the name of this beneficiary whenever he wishes.

It is the responsibility of the policy servicing department to record the amendments of any beneficiary nominations.

If this is not done correctly, it is possible that the policy benefits may be paid to the wrong person when there is a claim. This could result in legal action being taken against the insurer. If it can be shown that the insurer was informed of the change, but did not react correctly, the possibility of having to pay the claim twice becomes a real danger.

Any outright cession will cancel a beneficiary nomination. Should the policy cession at a later stage therefore be cancelled, the policy proceeds would be paid to the estate of the decreased if no new nomination of a beneficiary is made by the policyowner.

A policyowner who receives back from the cessionary a previously ceded policy document, should appoint a new beneficiary. This must be done even if the beneficiary is the same as the one nominated prior to the cession. In following this action, there can be no doubt as to the intended recipient of the proceeds of the policy in the event of a death claim.

Policy alterations

If we accept the fact that a policyowner who is 20 years old when he buys a life policy could live to the age of 73, the policy will have been in force for 53 years before it becomes a claim. During this long period it is very likely that the policy owner ideas about the policy and its intentions will change.

He might originally have bought a small policy that would have been enough to settle any debts he may have had if he had died. If the policyowner were however, to get married after the policy commenced, he would soon realise that the amount of life cover included in the policy was inadequate.

With the universal type policies it may be unnecessary for the policyowner to purchase a new policy if more life cover is required. The policyowner could simply ask the insurer to change his existing policy by adding more life cover. Any increase in cover will be subject to satisfactory evidence of health being provided to the underwriters of the insurer.

Once the underwriters have approved the amendment to the policy, their underwriting criteria may include the life insured having to undergo a medical examination, in which case the policy servicing department will have to issue an amendment to the policy document and send it to the policy owner.

Record maintenance

It is very important that the insurer keeps an accurate record of all the changes that are made to a policy.

One of the most important duties of the policy servicing department is the keeping of accurate records, and keeping these records up to date. Insurers maintain an accurate data-base of all their client details.

Policyowner queries

Any call centre agent, or clerk in a branch office, will be able to answer general queries that a policyowner has, by checking on the system.

Whenever a policyowner has a query about his policy that cannot be dealt with by the branch personnel the query will be sent to the policy servicing department. It is then the duty of a clerk in the policy services department to call for the file, check on the records and reply to the policyowner.

Premium collections and procedures

Most life insurers have a special premium accounts department that is responsible for the collection of premiums. This department will also keep an accurate record of the premiums that have been paid by the policyowner. Premiums can be collected by debit order, or stop order, and even cash. Cash payment is losing popularity is the industry, due to the risks and costs involved in handling cash, fraud and money laundering.

The policy servicing department, however, has the responsibility to ensure that the premium requested by the accounts department is correct and has not been changed as a result of a policy alteration of inflation escalation.

7.1 Policy document

In contractual law there in a need for an offer and acceptance of the offer, in order for a contract to come into being. When a proposer fills in an application form for a life insurance policy he makes an offer to the life insurance company, asking them to accept him as a policyowner. The underwriters of the life insurer will check the information on the proposal form and, if the information provided is acceptable, will agree to enter into the contract on behalf of the insurer.

The policyowner will require proof that a contract has been entered into. The life insurer will therefore issue a policy document as proof of the contract and give the document to the policy owner.

The policy document is only evidence of the contract. The proposal form filled in by the proposer and any medical evidence asked for by the underwriter is also a part of the contract.

Should the policyowner lose the policy document, or if it is destroyed, the contract between the policyowner and the life insurer will not be jeopardised. The policyowner will be able to ask the policy servicing department to issue him with a replacement of the policy document.

According to the Long Term Insurance Act of 1998, it is no longer necessary that an insurer issue every policyowner with a policy document. A detailed summary, posted directly to the policyowner, may be printed instead. However, if a policyowner asks for a policy document, one must be printed and sent to him.

7.1.1 Details of the policy document

The name and the business address of the life insurance company is reflected at the beginning of the policy document.

The information in the policy document will begin by reminding anyone that looks at the document that the proposal form and declaration signed by the proposer in the proposal form are the basis on which the insurer issued the policy, and that the insurer will continue to use this information as the basis of the contract.

The front page of the policy document is normally a schedule that provides all the details of the policyowner, life insured and benefits to be provided by the policy.

The data when the proposal form was signed, and the date of commencement of the cover in terms of the insurance policy, are also stated in the schedule. Other information normally included in the schedule will be:

- the life insured's date of birth;
- whether the age of the insured was admitted or not, for example, whether proof of age was provided with the proposal form, which can be a certified copy of an identity document;
- details of the premium due for the benefits to be provided;
- how often premiums must be paid, for example, monthly, quarterly, half-yearly, annually or once only;
- any premium escalation factor included to combat inflation;
- the sum insured;
- any sum insured escalation factor included to combat inflation, this escalation factor may be equal to but will never be greater than the premium escalation factor;
- the name of the nominated beneficiary, if any; and
- any special conditions that apply to the policy, such as an exclusion for hang-gliding.

Policy schedule

A typical schedule might look similar to the example shown below. Every insurer will have its own schedule format and this might look a little different from the example provided here.

SCHEDULE

Policy number	ABC 2468
Date of proposal	10 February 2008
Date of commencement	1 March 2008
Policyowner	John Smith
Life insured	Mary Smith
Date of birth of life insured	25 April 1968
Age admitted	No
Nominated beneficiary	None

PREMIUM DETAILS

Initial premium	R100,00
Premium payment frequency	Monthly
Annual escalation of premium	10%

BENEFIT DETAILS

Universal life cover	R100 000
Capital disability	R100 000
Annual escalation of benefits	5%

Waiver of premium on the death of the premium payer – John Smith

SPECIAL CONDITIONS

Any capital disability claim that results from lower back problems are excluded

Operative clause

The operative clause of the policy is a promissory clause. It is a promise that the insurer undertakes to pay the benefits of the policy if the reason(s) why the policy was incepted and issued by the insurer occur while the policy is in force.

For example

The policy is a whole life policy with R100 000 life cover that will pay when the life insured dies. The operative clause will be the insurer's promise to pay the benefit, so long as the policyowner pays the premiums.

Attestation

The insurer accepts a contract based on the proposal form submitted by the proposer. As proof of its acceptance of the proposal, and its entering into a contract, the insurer will print a policy document in which is stated what has been accepted. To ensure the validity of the contract, there will be printed in the policy document the signature of a person who works for the insurer and who has the authority to agree to the issuing of the policy. Often this is the signature of the Managing Director, Chief Executive Officer or Company Secretary.

The signature will be linked to the operative clause, which commits the insurer to pay the sum insured when the reason for which the insurance was taken out occurs, such as the death or disability of the life insured.

General conditions

The rest of the policy document will explain to the policyowner what the conditions of the insurer's acceptance of the contract are. These are usually standard conditions, and are included in every policy document that the insurer prints for a policyowner.

An example of one of the condition is that the insurer will want the policyowner to know that only 30 days of grace will be allowed for the late payment of a premium that is due. It will explain that if the premium is not paid within the days if grace then, subject only to certain conditions that are dealt with later, the policy will lapse.

Special conditions

The special conditions provide the policyowner with all the details regarding the specific benefits that he requested be included in his policy. The conditions under which a claim will be paid are explained, as well as any of the exclusions that will apply.

Any unique exclusions, such as claims due to back problems where the proposer has a history of back problems, will be indicated in the schedule.

Other unique exclusions that will be indicated on the schedule could be an exclusion for the loss of eyesight, if the proposer indicated on the proposal form that he was already blind.

Take special note of the exclusions in a policy document. There are very few exclusions that apply with the basic life cover that is included in a policy, usually only suicide in the first two years that the policy is in force is excluded.

With any supplementary benefits that may be included to the basic life cover of the policy, most life insurers will have a number of exclusions.

These might include:

- driving while under the influence of alcohol;
- contravention of the law;
- flying other than as a fare-paying passenger on a recognised airline;
- self-inflicted injury, regardless of whether the insured was sane or insane at the time; and
- wilful exposure to danger unless this occurred in an attempt to save the life of another.

7.2 When premiums stop

There are a lot of reasons why a policyowner might decide to stop paying premiums on a policy that he owns. The accounts department will be the first to notice that the premiums are not being paid, when the debit or stop order is returned unpaid to them. The accounts department will then generate a double debit or stop order, in an attempt to bring premiums up to date.

Should the double deduction however, also be returned unpaid, the accounts department will issue no further debits or stop orders. As far as they are concerned, the premium payments have ceased, and they will now only react on a new written instruction from the client to deduct any further premiums.

The intention of the policyowner should be to carry on paying the premiums for as long as they are due, but it sometimes happens that circumstances change and the payment of premiums stop. The policy servicing department can handle this in a number of different ways. It is important to understand the principles behind policy cash values, and the reasons why it takes a while for a policy to build up a cash value.

7.2.1 Initial expenses

Many life insurance companies offer a policy called a pure endowment which provides no life cover or any benefits other than an investment account. With one of these policies, the policyowner shares in the profits that the investment managers of the life insurer make.

However, the main business of a life insurer is to provide policies that give the policyowner protection against catastrophes such as the life insured's death or permanent disability. These benefits have both initial and ongoing costs.

The life insurer will use a part of the policyowner's premiums to buy these benefits. The life insurer needs to make sure that:

- there is a policy service department that can maintain the status of the policy so that the policy will be claimable if a claim should occur;
- the proposer who submits a proposal is underwritten by the underwriting department to ensure that the risk being offered is one that the insurer is prepared to accept; and
- a policy document explaining all the terms and conditions of the contract between the policyowner and life insurer, is printed and sent to the policy owner.

The life insurer will not only have staff in the policy servicing and accounts departments to look after existing policies. It will also have to have a number of other specially trained people in its New Business department, such as underwriters to process new applications for life insurance policies.

There will also have to be a Claims department, with specially trained people who will need to check to make sure that a claim is valid and not fraudulent.

The biggest expense is however, the expense of processing application for new policies. The following are some of the costs that have to be paid:

- **the cost of underwriting the application**

This will include the salaries of the underwriters as well as the fees paid to any doctors and/or specialists who are asked to examine the applicant if the underwriters need more information to make a decision.

- **having sales offices all over the country;**

Life insurance policies are often sold by intermediaries. If these intermediaries work for the life insurer they will need to have offices, as well as back-up staff, like secretaries and receptionists. If the intermediaries that sell the policies are brokers the life insurer will need to have a staff of broker consultants who visit the brokers to make sure that the brokers will sell policies for the life insurer. The broker consultants, who are employees of the life insurer, will also need a back-up staff of secretaries and receptionists. Broker consultants also earn a basic salary, and/or commission, and are given company cars or a car allowance so that they can do their work.

- **the new business expenses at head office;**

Once a proposal has been accepted, the information about the new policy must be captured into the system. It is, however, still necessary that all the original documentation that goes with a new application, like the proposal form and any medical examination reports that may have been asked for by the underwriters, is kept in a file at head office.

- **the printing and postage of the policy document;**

- **commissions.**

Intermediaries who sell life insurance policies are usually not paid a salary by the life insurer or brokerage that they work for. They are paid a commission that is based on the amount of premium that a policy owner will pay on any new business that the life insurer accepts and the term of the policy.

Life insurers will charge these expenses to their policies and deduct them for the premiums that the policyowners pay.

There are basically two different methods used by life insurers to charge for their expenses. These are known as:

- up front recovery (or front-end loading; and
- aggregated charging.

Up-front recovery

Where an insurer uses this methods, the insurer applies all the premiums paid by the policyowner until the costs it has incurred have been paid. Only once the costs have been repaid, will any investment allocation amounts be paid into the policy's investment account.

The premium charged on a term insurance policy are worked out in such a way that the life insurer will only be fully repaid when the policy ends. This means that there will, in fact, never be any extra money to pay into an investment account. This is one of the reasons why term insurance policies do not build up any cash values.

Aggregated charging

Where an insurer uses this method, the insurer's actuary works out what the costs have been, and divides this cost by the number of years that the policy will run.

Note that where the policy is a whole life policy, the actuary will usually divide the cost by 30 years or the number of years from the life insured's current age until he turns 75, whichever is the shorter period. Once this amount has been determined the insurer will, on an annual basis, deduct the amount, plus a reasonable interest factor, from the premium that is paid by the policyowner.

The difference with this method, as opposed to the upfront method, is that the policy will immediately start building funds within its investment account. As only a part of the premium is being used to recover expenses, the rest will be paid into the policy investment account.

If the policyowner should stop paying his premiums at any time before the life insurer has recovered its costs, the insurer will claim the rest of its expenses out of the policy's investment account plus interest to date.

If the policyowner decides that he wants to cancel the policy and so claims the money in the investment account, the life insurer will first need to recover the balance of its expenses with interest. The money due to the policyowner will only be such amount as remains in the investment account after the insurer has recouped the balance of its expenses.

7.2.2 Cash values

A policyowner can ask the life insurer at any time what the cash value of his policy is. The life insurer's policy servicing or branch staff will be able to provide the policyowner with an answer. The cash value will be the net current value of the investment account of the policy. The cash values shown is the value of the investment account, and is not guaranteed. As has been mentioned earlier, there will be no cash value with a term insurance policy.

7.2.3 Surrender value

There is a difference between the surrender value and the cash value of a policy. The cash value of a policy will be the current value of the investment accounts of the policy. The surrender value of a policy is that amount of money that a policyowner will receive out of the investment account if he decides to cancel the policy

If we were to look at the two different ways that life insurers recover expenses we will get a better idea of the differences between the cash and surrender values of a policy.

Up-front recover ("Front-end loading")

Where an insurer uses this method, there is usually very little difference between the cash value and the surrender value of a policy. As the life insurer recovers all its expenses before an investment account will be started, the policyowner will be allowed to draw the value of the investment account if he decides to cancel, the policy. The only reason why the surrender value may be slightly less than the cash values, is because the life insurer will have certain administrative expenses that have to be paid for when a policy is cancelled.

Aggregated charging

Where an insurer uses this method, there will usually be quite a large difference between the cash value and the surrender value of the policy, especially if the policy is still fairly new. Here the life insurer allows the investment account to start straight away, and only recovers a part of its expenses every year. There will, therefore, still be a large portion of the expenses outstanding, if the policyowner decides to cancel the policy early.

All of these expenses will be deducted from the investment account of the policy before any money that is left over will be paid to the policy owner. For this, there might be a big difference between the cash value and surrender value of a policy from a life insurer using this method to recover its expenses. Note that most life insurers use this method, as there is a clear advantage to the policyowner, who has the immediate accumulation in an investment account.

It is only with a policy that has been running for a long time that the cash and surrender values might be almost the same. This is because the life insurer will already have recovered most, if not all, of its expenses.

So when will a policy accumulate a surrender value?

A policy will accumulate a surrender value once the life insurer has recovered all its costs from the cash value. As was mentioned when we looked at the initial expenses that a life insurer has, these included the commission due to the intermediary and the other new business acquisition expenses incurred.

The commission paid is based on the premium to be paid and the duration of the policy. The longer that the policy will run, the more commission that the intermediary will earn.

Because of this a policy will often have a surrender value as follows:

If the term of the policy is	**Surrender value will accumulate after**
less than 10 years	1 year
between 10 and 20 years	2 years
more than 20 years	3 years

Naturally, a term insurance policy will never have a surrender value as it has no investment element.

Important information

No matter how long the duration of a retirement annuity contract may have been, the policyowner will not be able to take the cash values that have built up out of the policy.

This would be a contravention of the Income Tax Act, where the definition of a retirement annuity fund includes the requirement that benefits may not be paid to a member before reaching age 55, unless the member is totally and permanently disabled.

He must wait, at least, until he is over 55 years of age and decides to retire from the retirement annuity fund. It is only if he is permanently disabled, or is, that a retirement annuity fund can pay a benefit before the member of the fund is, or would have been, over the age of 55 years.

Here again however, the full cash value will not usually be made available to the policyowner. Unless the fund value is less than the currently stipulated minimum, he will not be allowed to receive more the ⅓ of of the proceeds in cash. The balance must be used to purchase a life annuity.

7.2.4 Minimum values for long term policies

Amendments to part 5 of the regulations to the Long Term Insurance Act (minimum values)

An amendment to Part 5 of the Regulations to Long Term Insurance Act regulates minimum long term policy benefits in terms of causal events. Part V of the Regulations is that part of the Policyholder Protection Rules that deals with the cancellation of policies and the resultant minimum benefits and maximum charges.

In terms of the regulations, a causal event occurs when:

a. the policy becomes fully paid-up;

b. the basic premium is reduced, without the policy coming to an end or becoming fully paid-up;

c. the remaining policy term or premium-paying term is reduced, without the policy coming to an end or becoming fully paid-up;

d. the policy is surrendered in part other than for a Section 14 transfer or because the risk benefit under the policy has come to the end of its period;

e. a fund member policy is surrendered in part in terms of a Section 14 transfer;

f. a fund member policy is surrendered in full, other than in terms of a Section 14 transfer or the term coming to an end, or reaching its maturity date; or

g. a fund member policy is surrendered in full in terms of a Section 14 transfer.

At the same time, Regulation 30 of the Pension Funds Act, which deals with compulsory inclusions in the rules of the fund, has been amended to ensure that, for funds under which the benefits are wholly or mainly provided via fund policies, the fund's liability to members in the event of a causal event, as defined in the revised Regulation V of the Long Term Insurance Act, is limited to the

proceeds of the policies but also placing the onus on the fund's board of management to ensure that proper investigation of the charges under such policies is undertaken and that members are advised accordingly.

The requirement for pure endowment (investment) policies issued in 2009 are yet more restrictive, with the maximum penalty being effectively limited to 15%.

7.2.5 Lapses

If a policy does not yet have a surrender value, it usually means that the life insurer has not yet recovered all its expenses.

If a premium is therefore not paid during this early part of the contact, or during the days of grace allowed by the insurer, there will be no money to protect the benefits and the policy will be stopped by the insurer. In the life insurance industry we say that the policy has lapsed.

7.2.6 Automatic premium loans

Where a policy has been in force for long enough for there to be a surrender value, the insurer will use the surrender value to automatically pay the premiums and thereby keep the policy benefits going for as long as possible.

This is known as an Automatic Policy Loan (APL) or a Non-Forfeiture Allocation (NFA). This will help the policyowner as the policy will remain in force even if the premiums are in arrears.

However, when the surrender value of the policy is exhausted, the policy will lapse and all benefits will be lost to the policy owner. Most life insurers have a clause in their general conditions that tell the policyowner that the insurer will use the surrender values for an automatic premium loans, if the premium payer stops paying the premiums.

If the policy is retirement annuity contract there will be no automatic non-forfeiture. The policy will automatically be made paid up if there is a cash value.

7.2.7 Paid up policies

With a paid up policy the surrender value that has built up in the policy can be used in a number of different ways:

- the surrender value can be used to pay premiums for as long as there are funds remaining;
- the surrender value can be used to pay for a smaller benefit (sum insured) that will continue for as long as the original policy would have done; or
- the policyowner can ask that all the life cover and other benefits with the policy are cancelled.

With this last option, the surrender value of the policy will be treated as an investment-only policy with the insurer, which will pay out on the date that the original policy would have matured, or when the policyowner surrenders the policy. With this option, the policyowner will have the advantage that the investment will grow as part of the investments of the insurer.

7.2.8 Revival conditions

If the premium payer starts paying the premiums again while the policy benefits are being paid for by an automatic policy loan, the insurer will usually allow the policy to carry on as if nothing had happened.

There will however be a loan against the policy's cash value that should be paid back. The premium payer can do this by paying an extra premium until the loan is repaid. Should the loan not be repaid, then the loan plus interest, will be deducted by the insurer later when a claim is to be paid.

If the policy has lapsed, however, reinstatement is a different matter. The policy owner seeking reinstatement with have to re-apply for the insurance cover and provide any fresh medical evidence that the underwriters might require.

The life insurer naturally has the right to reinstate a lapsed policy.

7.3 Policy loans

There are many reasons why a policy owner may decide to stop paying the premiums on his policy. From time to time, many people go through tough periods where money is tight. Since insurance policies are meant to give ongoing protection and benefits the cancelling of a policy just to cover a short term cash flow problems is not a good idea. To help policyowners through tough times, insurers offer loans against the security of most endowment and whole life policies.

Insurers are usually happy to grant the policyowner a loan if a policy has a surrender value. The value of the loan will be limited to a percentage of the surrender value of the policy.

Depending on the life insurer, the loan value will be between 80% and 95% of the surrender value of the policy.

A loan given by a life insurer is not taken directly out of the investment account of the policy that belongs to the policy owner. The life insurer will want the policy to be able to continue its growth and, in order to do so, the policy investment account needs to remain an integral part of the policy. The loan is, therefore, paid by the insurer from money retained in its reserve account. The surrender value of the policy is only used as security for the life insurer.

Because of the way that the loan is structured by the insurer, there are some conditions that the policy owner must agree:

- interest will be charged on the loan at a rate set by the life insurer. The money belongs to the life insurer's shareholders or mutual policyowners and so they will want to see some return on their investment. The loan will come out of the life insurer's corporate funds where shareholder and excess policy owner moneys called reserves are invested; and
- the policyowner does not have to pay the loan back by having to pay higher premiums but this is one of his options. The loan can be repaid as a lump sum when the policyowner has money or can be deducted from the subsequent proceeds of a claim.

7.4 ASISA Codes of conduct

The member offices of AISSA (Association of Savings and Investments SA) have, over the years, formulated codes of conduct on most aspects of their business as life insurers.

These codes, to which all member offices subscribe, are constantly updated to meet changing circumstances. Summaries of the codes are given below.

7.4.1 Code on policy quotations

This Code was intended to ensure that policyholder expectations created as a result of illustrative policy benefits are reasonable and do not result in the industry's image being damaged.

The new guidelines contain the following key provisions:

The Code is intended to ensure that policyholder expectations of benefits and premium rates, created by quotations presented in the sales process, are reasonable (given the economic environment and policy charging structure) and do not damage the industry's image.

Specific objectives with the Code are to:

- regulate the use of projected values;
- demonstrate the consequences of early termination;
- show the effect of all expense charges on the overall investment return;
- show the expected impact of premium rate review after the expiry of the guaranteed term.

7.5 ASISA Standards

Further to the ASISA Codes there are also agreed standards to which ASISA Members subscribe, such as the:

1. ASISA Standard on Complaints Resolution;
2. ASISA Statistics Standard;
3. HIV Testing Protocol 2013;
4. ASISA Standard on Replacement;
5. ASISA Standard: Calculation and Disclosure of Total Expense Ratios and Traction Costs;
6. ASISA Standard on Unclaimed Assets;
7. ASISA Standard on Genetic Testing; and
8. ASISA Standard on Living Annuities.

These standards are available from the ASISA website and are updated regularly.

7.5.1 ASISA Standard on Complaints Resolution

Introduction and Aim

The aim of this Standard is to set out basic minimum steps which members should follow in dealing with complaints internally in order to ensure effective and fair resolution of customer complaints. Members should also identify and act on any trends coming out of complaints, customer surveys and feedback from the Ombud schemes.

Each member has its own administrative process when it comes to handling complaints so the requirements herein may be incorporated into pre-existing structures. The Standard applies in respect of all retail products (CIS, LISP, long-term insurance and retirement funds) offered by members.

When a customer contracts the company at any entry point, the responsible operational department should try to solve the problem, without undue delay. Should the problem be solved to the satisfaction of the customer, it would not be necessary for it to be escalated.

However, should the customer remain unsatisfied, the process set out below should be followed.

This Standard is effective from 1 February 2012.

Process

1. If the problem cannot be resolved at the entry level, there should be an escalation process to enable the customer to be put in contact with someone who can deal with their complaint.
2. Each company should have a designated Complaints Handling Function (CHF), whose members have decision-making power to resolve a complaint. This could for example encompass an Office of Internal Arbitration.
3. The CHF can be constituted at the discretion of member offices, as deemed appropriate, e.g. a company may choose to have a CHF for each business unit.
4. The CHF should make decisions that are objective and that promote equity and fairness.
5. All complaints should be logged for future reference.

6. A complaint should only be regarded as closed if resolved to the satisfaction of the customer or once the CHF has made a final decision.
7. Contact details of the relevant Ombudsman should be included in the communication of the final decision to the customer.

Communication

8. Acknowledgement of receipt of a complaint should be done within 3 working days.

9. Complaints should be attended to an effort must be made to resolve it within 20 working days. To solve the complaint however, can take much longer, but it is of utmost importance that the customer should have the name and contact details of a person dealing with the complaint.

10. The outcome of the complaint must be communicated to customers in a way that is fair, clear and not misleading.

11. To ensure that customers have full knowledge of the complaints handling procedures contact details where complaints should be addressed should be communicated.

7.5.2 ASISA Statistics Standard

The objective of this standard is to facilitate the timeous and appropriate statistics submissions to the ASISA office by member companies of Collective Investment Scheme, Foreign Collective Investment Scheme, Linked Investment Service Provider, Life Office, Zimele Claims Fraud and Forensic statistics.

All raw data received by ASISA will be regarded as confidential, unless specifically specified within this standard that such data is available to ASISA members and/or the public.

ASISA members are responsible to ensure that all appropriate personnel have current copies of this standard and have full understanding of their requirements.

7.5.3 HIV Testing Protocol

The purpose of the HIV Testing Protocol is to ensure that the life industry follows the highest standards in all aspects of HIV screening of applicants for life insurance. This Standard applies to all HIV tests performed by ASISA member offices. It addresses issues such as identification,

confidentiality, informed consent, pre- and post-test counselling, transmission of test results and accreditation of test kits and laboratories.

7.5.4 ASISA Standard on replacement

The member life offices of ASISA have agreed to this Standard for the purpose of providing Rules to govern those instances where one member life office (the replacing insurer) has or intends to replace a policy or policies of another member life office (the replaced insurer).

ASISA members will be required, in their implementation of the Standard, to ensure that all outcomes are in accordance with the requirements of Treating Customers Fairly (TCF): right culture, targeting, information, advice, delivery as well as post-sale
treatment.

Learning unit 8 - General overview and principles of claims

8.1 Verification of information

One of the first procedures to be followed by the claims staff upon receiving a claim against a policy, is to verify all information relevant to the policy contract. This includes calling up the file and checking the information provided at the inception of the contract with the information provided with the claims documentation.

This is not “underwriting at claims stage”. The aim and objective is merely to verify information and to check that no non-disclosure of a material fact that could have affected the assessment of the risk occurred.

8.1.1 Insurable interest

Insurable interest can be defined as the legal right to insure and means that the proposer must have an actual, recognised relationship with the person to be insured, as a result of which he would suffer a financial loss if the event being insured against occurs.

It is the responsibility of the underwriter to check that insurable interest exists at the inception of the contract.

Should it however, appear to the claims clerk when a claim arises that insurable interest was accepted during the proposal stage based on false information, the claim must be very carefully assessed. If it is found that the false information provided would have had a material influence on the decision to accept the proposal, or not to accept the proposal by the underwriter, the claims clerk should recommend to the claims committee that rejection of the claim be considered.

8.1.2 Personal particulars

Verification of personal particulars is only necessary in those areas where incorrect information provided at inception would have had a bearing on the underwriting of the proposal. Information such as name, postal address and nominated beneficiary, whilst important, would probably not have led to the underwriter imposing a loading or rejecting the proposal. The personal particulars dealt with below could well have led to such a decision.

Age and Gender

Where these have not been confirmed they need to be at claims stage.

Smoking habits

There is a significant difference in rates for smokers and non-smokers. It is therefore essential to check that anti-selection did not take place. Unfortunately it is very difficult to obtain proof that the information provided during proposal was incorrect, and only in cases where irrefutable evidence can be found, is it possible that the values be adjusted.

Occupation

Only in cases where conclusive proof is found that incorrect information was provided intentionally in order to obtain better benefits or rates, will recalculation be done or, in extreme cases, repudiation of the claim be recommended.

Part-time activities

The claims clerk should check to see whether incorrect information was provided internationally at the proposal stage in order to obtain better benefits or rates. Where this is the case it is likely that repudiation of the claim should be recommended.

Health aspects

Where a policy has been reinstated within the last 12 months it is imperative that all aspects of the insured's health be checked and verified. The reason for this is the possible non-disclosure of a deterioration of the health of the insured in the declaration of continued good health that was required at the time of reinstatement.

It is also advisable that the insured's health be checked and verified if the period before maturity of the policy is greater than the periods indicated here:

- for death claims - 5 years;
- for disability claims - 10 years;
- for dread disease claims - 10 years;
- for accident benefit claims - not required unless there is a suspicion that the insured may have suffered from some ailment that may have resulted in the accident, such as epilepsy.

The reason for this is that the claim has resulted in the insured falling outside the averages used by the actuaries in determining the premiums to be charged. As the norm is no longer applicable to the insured the reason for this should be established, where possible. This is not to say that the claim is invalid. The claims assessor does, however, owe it to the insurer and the other policyholders to investigate all situations that do not conform to expected standards.

The claims assessor should request a medical report from the insured's personal medical attendant (PMA) or any other doctor or institution that may possibly be in possession of information.

Where any claim results from unnatural causes, the medical report will not be necessary. It is however important to still check for false claims.

Should there be a suspicion that information has been concealed cases will be checked in the usual way.

Where a client's portfolio contains policies for which a medical report is not required, the finalisation of these claims will not be delayed.

If it comes to light that concealment was an issue under policies that have already been paid out, the benefits paid are very seldom reclaimed unless everything points to fraud being the sole intention. The decision to litigate on the repayment of the claim is a decision usually made by the executive committee of the life insurer. The investigation of the information provided at inception must be carefully checked to ensure that claims are fairly dealt with.

AIDS exclusion clauses

Life insurers will usually decline to accept a person who is already HIV positive. However, they will not decline a pay a claim where the life insured contracted AIDS after the policy was issued.

Note the earlier mention of the fact that no ASISA member office may use HIV/AIDS exclusion clauses for claims under new business, nor may they enforce any exclusion that may previously have been imposed in older policies for basic life and disability benefits. The claims assessor must always check for an HIV-positive status if any risk benefits were subject to AIDS clauses.

There are a few specially designed policies in the market which can be sold to HIV positive people, the rates being suitably loaded to cope with the reduced lifespan expectations. AIDS is also sometimes listed as a dread disease for policies with this kind of cover.

Where a policy has been in force for longer than 10 years and information regarding AIDS cannot be obtained from the available medical documentation, the PMA report is usually waived if this is the only way of obtaining this information. The benefits of the doubts is then granted to the insured, and the claim is paid on the assumption that the deceased was HIV-positive at claims stage but not at application stage.

8.2 Impact of non-disclosure

An insurer has the right to repudiate a claim if the proposer misrepresented or failed to mention a material fact. It is assumed that the proposer is in possession of all the facts on which the insurer's liability will be based. In general, failure to provide all relevant information and applying the principle of the utmost good faith enables the prejudiced party to repudiate the validity of the contract.

The duty of disclosure puts the emphasis on material facts and reasonableness. According to legal principles, a fact is of material importance if, in the opinion of the reasonable man, it would have influenced the reasonable insurer's initial decision.

The test is not what the reasonable man would regard as a reasonable fact, but whether the reasonable man would believe that the information should have been disclosed.

In light of the above, all information that was not disclosed must be tested by the claims assessor against the following questions:

- Would the information have materially influenced the terms on which the policy was accepted?

Information will be classified as material if the risk would only have been accepted with a 25% or greater additional mortality assumption or if exclusions would have been imposed.

- Did the proposer have the information at his disposal and is it reasonable to have expected that the information be disclosed when answering the questions on the proposal form?

It is not for the proposer to decide whether the information is material - the test is objective. The interpretation of the information rests with the insurer and not with the insured. Where the answers to the two questions above is "YES", the claim should be rejected, irrespective of whether the cause of the claim relates to the non-disclosure.

8.2.1 Proof of non-disclosure

Where concealment is proven, the claim will usually be dealt with according to one of the following options:

- Further medical information can be requested as it pertained during the proposal stage. (For example, ECG, blood-pressure readings). If the required information is not available, the claim will be rejected and all premiums paid forfeited. Where the policy's waiting period (if any) has expired, the cash value can be paid. Every reasonable effort will be made to determine terms rather than simply rejecting the claim. The terms could be assumed to be the heaviest that can be offered for the case is question.

- Where the requirements can be provided and usual terms can be determined, the claim can be considered for an adjusted benefit. If a premium loading would have been applicable, the premium can be kept constant and the benefits reduced pro rata.
- If it is found that information which should reasonably have been disclosed and which might materially have influenced the acceptance of the risk was not disclosed at application stage, then the claim should be rejected, irrespective of whether the non-disclosed information relates to the cause of the claim or not. This is so because notwithstanding the fact that the cause of the claim may have been unrelated to the undisclosed information, had this information been know, at application stage, the contract would never have come into force in the first place and therefore would not now be the subject of the claim. The effect of non-disclosure may therefore be the outright repudiation of a claim, the cause of which might otherwise have been acceptable in terms of the contract.

8.3 Establishing the validity of a claim

In an insurance contract it is necessary to state the perils against which cover is given, so that the intention of the parties is clearly defined. Where the peril against which cover is given is the death of the insured, the validity of the claim is fairly simple to establish.

There are very few exclusion applicable to a death claim and, once these have been eliminated, the validity of the claim is beyond dispute. Where the claims assessor is, however, faced with a claim for one of the many other benefits available from a life insurer, the validity of the claim needs to be seen against a number of different factors such as:

- whether the condition for which the claim has been submitted is covered by the benefit under which the claim has been instituted;
- whether the cause of the condition for which the claim has been submitted does, or does not, fall within the benefit. A careful investigation of the cause of the disablement, injury or condition for which the claim has been submitted must be undertaken, to ensure that the cause does not fall into one of the exclusions linked to the benefit claimed against; and
- whether the cause of the condition stated in the claimant's declaration is the proximate cause of the condition, or whether some other factor, that is not covered by the definition of the benefit, is the cause thereof.

All contracts of insurance that include benefits such as:

- the supplementary benefits available;
- Permanent Health Insurance; or

- Health and Hospital Insurance (as a few examples),

are subject to conditions, which in insurance frequently state that certain causes of loss, or certain results of an otherwise insured peril, are excluded.

The reasons for this are:

- The extended cover may warrant an additional loading which was not included in the original determination of the premium, or
- the peril may be one that insurers regard as a fundamental risk that is more properly dealt with by the State, such as war risks or nuclear explosive devices.

It is necessary therefore, that the claims assessor examines the cause of the condition claimed against in some detail as it also fundamental to the insurance contract that the insurer is liable only for losses proximately caused by an insured peril.

The same principles apply to life insurance as they do to the short term industry. It is perhaps relevant to consider that as the short term industry deals more with loss of tangible items than is the case in the life industry, and it is often easier to make a short term claim than in a life insurance claim. Nonetheless, the principles are common.

The application of the doctrine of proximate cause is often complex matter, as evidenced by the volume of legal cases dwelling upon it. There is usually a chain of events leading up to a claim, and one way to look at the proximate cause is to consider the first event in the chain, and to ask oneself what is likely to happen next.

By repeating the process at each link in the chain, one will arrive at the loss if there is an unbroken chain, showing that the original cause was the proximate cause. If in that chain there is an excluded peril, then there is no insurance cover for the loss, unless the policy wording moderates the rule.

Should another peril start to operate from another source, the same procedure must be followed and, on the facts of the individual case, it must be decided which is the dominant effective cause of the claim. If there are two equal or nearly equal concurrent causes, local courts have held that there is no claim if either one of the causes is excluded in the policy contract.

8.4 Other unlawful acts

The general rule of public policy that prevents a person from benefiting from his own criminal acts, also operates to prevent a claim being paid to a person who has murdered another, on whose file he holds a policy (*Prince of Wales Insurance Association Co. vs Palmer, 1858)*. This does not apply where the murderer was insane (*Re. Batten's Will Trusts, 1961*).

A further case (*Re. K. Deceased, S/J/Col 129, p 132*), emphasises that this rule also applies to manslaughter, where death was an unintended consequence of a deliberate act.

Example

In the case a wife threatened her husband with a shotgun, which then went off and killed him. Another interesting case also arose on this subject (Hewitson vs The Prudential Insurance Co. Ltd). Here Mrs Hewitson was the owner of a policy on the life of Mr Hewitson. Together they took part in an armed robbery, although their guns were actually imitations.

The robbery failed and Mr Hewitson was shot and killed in the course of trying to escape. Mrs Hewitson claimed under the policy. The court decided the Mr Hewitson's death was caused by his own criminal act, the attempted armed robbery. It was also held that, as Mrs Hewitson was an active participant in that crime, it would be contrary to public policy that allow her to benefit as a result of that crime, and the insurers were not held to be liable to pay the proceeds to her.

8.5 Early claims

Premium rates are determined by actuaries using assessments and assumptions that are based on the law of averages. Where a person dies very shortly after having taken out a life policy, the death will fall outside the norm used in the actuarial assumptions.

The claims assessor would therefore, identify the claim as falling outside the average and may even consider that the time and cause of death are suspect.

This is not to say that the claim will be repudiated. It does, however, mean that the claim will be investigated very thoroughly and any discrepancies of information received dealt with extra carefully.

8.5.1 Claims before cover commences

Death before date of cover

Most companies work on the basis that the date of commencement of cover on a new life insurance policy is the last occurring of:

- the inception date requested in the proposal by the proposer;
- the date on which the first premium is paid; or
- the date of notice of acceptance.

If the life insured dies before the date on which cover commences, the claim will sometimes be considered if:

- all documents were already in the life insurer's possession. For this purpose documentation in the hands of a marketer or broker will also be considered as being in the hands of the life insurer; and
- the risk would have been accepted based on the information in the proposal documentation; or
- the proposer or insured accepted the terms expressly or by implication, for example, by paying an extra amount for an increased premium, or by permission for a loading before terms were known, if the risk was acceptable in terms other than ordinary rates;
- a cash premium was submitted with the proposal, and there was no request for the inception date to be later than the first of the following month;
- death occurred during the month preceding the inception date; or
- premiums were to be paid by debit order or stop-order, and the ability to pay can be established beyond reasonable doubt.

Immediate cover

Life insurers are aware of the fact that life insurance is bought as a result of the establishment of a need by a marketer, broker or insured. The client, being made aware of the need, wishes to ensure that, should anything happen to him, his family will be adequately catered for.

Unfortunately, the process of underwriting and issuing a policy can take some time and therefore, some life offices have decided to grant all applicants a measure of protection while the process of issuing a policy is being undertaken.

Where a fully completed proposal form is submitted together with the first premium is cash or EFT, immediate life cover is sometimes granted on receipt of the proposal. This benefit is, however, usually subject to the following limitations:

- the selected policy commencement date must be within 30 days of the receipt of the proposal form;
- the immediate cover will expire when a risk assessment is given, or any evidence required for risk assessment such as medical, financial, occupational and/or hobby evidence, is outstanding for longer than 21 days;
- the immediate cover is not applicable to proposals where the life to be insured is older than 60, or is a substandard risk in any form;
- the immediate cover is usually not applicable where a proposal for life insurance is being considered simultaneously by another life office;
- Non-disclosure of any information that, in the opinion of the underwriter is material to the risk assessment, will render the immediate cover benefit void;
- death caused by any condition, illness, occupation or pursuit that, in the opinion of the underwriter of the life office was material to the risk assessment, will not be recognised as a valid claim;
- all normal policy conditions that will apply to the policy, when issued, will also apply to the immediate cover benefit;
- should a proposal not be proceeded with for any reason, any immediate cover which was in effect will be charged against the premium paid on the basis of a level term insurance contract;
- the amount of immediate cover available is usually the sum insured requested on the proposal excluding any supplementary benefits amounts. It is however, normally subject to the following further limitations:
    - on any term insurance policy, the immediate cover is usually restricted to 50% of the sum insured that has been applied for;
    - an overall maximum for the amount of immediate cover depending on the life insurer, is normally applicable.

Disability and other supplementary benefit claims before the date of cover

Immediate cover normally is only applicable to the basic life cover applied for on the proposal. Any payment of a supplementary or risk benefit will be at the discretion of the life office's claims committee. The recommendation made by the claims assessor will have a bearing on the decision made by the committee.

Generally speaking, life insurers tend to treat these types of claims in a similar way to death claims that happen before the cover starts. The help of the underwriting department must, however, be called in by the claims assessor to determine whether the policy would have been issued with the supplementary benefits requested.

Should the underwriting decision have been to decline the supplementary benefits, then it stands to reason that an ex-gratia payment would place the claimant in a better position than he would have been if the policy had been issued under normal conditions. That is not the intention of this facility.

Deterioration in risk before date of cover

During the period of time between the submission of the proposal and the issuing of the contract, the proposer must inform the insurer of any changes to the information provided on the proposal form. The underwriting department bases its decision on the acceptability of the life insured on the information contained in the proposal form.

Should this information change and the proposer not inform the underwriters, the omission can be construed as non-disclosure of a material fact, with the resultant repudiation of a claim.

Should the deterioration of the life insured be so severe that a decision to decline the policy is likely, the claims assessors may be approached to consider an ex-gratia payment of a claim. This would depend on the policy having a supplementary benefit covering the life insured for disability. The risk must be reconsidered based on the latest information and the policy amended if necessary.

8.5.2 Reinstated policies

When a debit order is in operation and a premium request is returned unpaid by the bank, the outstanding premium will usually be paid out of the investment account, and the policy will continue as if premiums had never been in arrears. Policy claims that arise during this period will be considered as usual.

Should a policy, however, reach a stage where no further funds are available in the investment account to pay the premium, the policy will enter a state of lapse and no claims will be considered. The lapse will, however, be dated from the date on which the last premium was paid.

This automatic non-forfeiture process will not apply to policies that have not yet built up sufficient funds in their investment accounts. Policy owners can determine whether their policies have funds in their investment account by establishing whether the policy has a surrender value or not. A surrender value is an indication that the policy's investment account has a positive balance.

8.5.3 Death by suicide

Most SA life policies have a suicide clause which states that a death claim as a result of suicide during the first 24 months of the contact will be repudiated. Special consideration should therefore be given to claims where it appears that the cause of death is suicide.

The burden of proving that suicide was the cause of death, is on the life office. Once concern is that the coroner's findings are not always conclusive proof.

Example

The case of Walsh vs Legal & General Insurance Society Ltd. (1935), illustrates the difficulties which can arise. The life insured died when he fell from a train during the first year of a policy which excluded suicide within the first year.

There was no other passengers in the compartment and examination of the carriage door showed no effect that might have allowed it to open of its own accord. In view of these circumstances, the coroner's verdict was, 'suicide while of unsound mind". Legal action was brought to claim the sum insured. It was held that the coroner's verdict was not conclusive proof of suicide and that, as the life office could not positively prove it was suicide, they were liable.

Suicide after reinstatement

In most cases today policies that are reinstated with or without proof of good health, with or without the exclusion of claims, will be subject to the suicide exclusion period recommencing from the date of reinstatement.

Learning unit 9 - An introduction to retirement funds

9.1 Origins and history of retirement funds

In traditional cultures the elders were considered productive and respected members of society until their death. They were highly valued for their accumulated wisdom, insight and experience. Nobody considered "retiring" them because they were integral to how traditional society functioned. Their roles may have changed as they aged, but they always has an important role to play.

As industrial society developed people continued working until their health failed. Life spans were simply too short to support an extended period of leisure and there was no mechanism to financially support life without income because no state pension system existed. The concept of retirement planning hadn't taken form yet.

All the changed in the UK in the early 1900's when "social security" was created. Shortly thereafter companies and governments began offering pension plans to supplement social security. Around the same time average life spans were beginning to extend beyond 65 years. This combination of factors increasing longevity and financial programs that provided resources to support a period of leisurely old age, created the first phase of retirement planning.

9.1.1 Definition of a retirement fund

A retirement fund is a systematic plan set up for a defined group of persons, usually the employees of a business enterprise. The purpose of a retirement fund includes the following:

- primarily to provide a retirement benefit, either as a lump sum, or a regular monthly payment or a combination of the two options, that will provide an income until death to a member who has passed the retirement age that is agreed between the employer and the employee representatives.
- to provide a lump sum payment or monthly income to persons who, for reasons such as ill health, are no longer able to remain actively in employment; and
- to provide for the dependants of an employee who might die before he reaches retirement age and, sometimes, even after retirement has been reached, if there are still dependants.

In its simplest form, a retirement fund is a fund of money, or assets, built up by the contributions of the employer and employees over the working lifetime of the employees, in order to provide a retirement benefit for the employee when he reaches retirement age.

There are however, a number of points in the definition that need to be further explained. These are as follows:

- a retirement fund is usually set up by means of an agreement reached between an employer and his employees;
- in the case of a retirement annuity fund however, no employer is involved but the purpose remains the same; and
- the purpose of any retirement fund is to provide some form of benefit for the members of the fund or their dependants when they can no longer earn their own income.

Most funds do not limit benefits to money at retirement but also include other additional features such as an early payment of the benefit as a result of:

- ill health;
- physical disability caused by an accident; or
- death - in which case the benefits may be paid to the dependants of the member until they can take care of themselves. Where the dependants include a surviving spouse the benefits, if paid as a pension, may continue for as long as the survivor lives.

Note that the definition makes mention of the fact that the benefit can paid as:

- a lump sum; or
- a regular monthly payment; or
- a combination of these two options.

In order to have a clear understanding of the reasons for the difference between the two, the difference between a provident fund and a pension fund, as well as the different ways that they can be paid to the member, are set out below.

While a pension and a provident fund are both defined as a retirement fund, there is an important difference in the way that benefits can be paid to members at the time of their retirement.

Provident Fund

A provident fund may pay the total value of the accumulated benefits due to the member as a single lump sum. There are a number of factors that may make this option attractive. With a provident fund, once the benefit has been paid to the member, the member has no further claim against the fund. The money paid out to the member will, therefore, have to last him for the rest of his life.

Pension Fund

A pension fund on the other hand, is not allowed to pay more than ⅓ of of the accumulated value due to the member as a lump sum on retirement. It is only where the value of the accumulated benefit is under a statutory minimum that the lump sum may be paid out as a single amount. The balance of the money must be used to purchase an annuity (or save as a preservation fund) for the retiree that will provide a monthly income for the rest of his life. The member does not have to take the ⅓ of in cash, but may use the full value of the benefit to buy an annuity. This will result in a greater monthly income for the retiree.

A retirement fund is set up in terms of a registered set of rules that will determine who makes the decisions about:

- Structure of the fund;
- the value of contributions; and
- eligibility criteria.

In terms of the Pension Funds Act, a retirement fund must be registered with the Registrar of Pension Funds whose offices are at the Financial Services Board (FSB). The rules must also be approved by the Commissioner for Inland Revenue if tax relief on contributions and benefits is required.

9.1.2 History of retirement funds

When people worked in small groups and communities, the relationship between employee and employer was often close and of a premature nature. The employer felt morally obliged and responsible for the continued well-being of an employee who could no longer work. In a sense the employee remained part of the community or family and was provided for by means of a regular salary, even though he was no longer working, that was paid by the employer until the former employee died.

Another early form of retirement provision was that when an employee retired, a condition of appointment of his successor was that the successor had to pay a portion of his salary to the retiring employee for as long as that person lived. This system worked satisfactorily, and was practical amongst highly paid employees whose income was more than adequate for their own needs. When an attempt was made to extend such a scheme to the lower paid employees, it became impossible to ensure that payments were made.

These early retirement provisions were most unreliable and unsatisfactory and so the formal retirement fund was created. In its original form, these funds were financed on a pay-as-you-go principle, so that those on retirement were paid out of contribution being collected from those who were still at work.

The onset of industrialisation and modern medical technology changed all this. There were larger groups of employees working in highly organised industries. Efficiency and productivity become key factors. Employers could no longer afford inefficient or unproductive people. The notion of no longer employing people who fell into one of these groups became a fact of life. Employers preferred employing younger, more energetic people to do the work in order to maintain productivity and therefore competitiveness.

Several of the older people were left to fend for themselves, or became a burden to their families. Some sympathetic employers did however, recognise that if an income or annuity could be provided, the service of the old or infirm could be terminated more readily. As there was at this stage, no formalised structure of retirement funds, the employer in order to provide this income or annuity, simply took it out of his profits whilst he could.

The logic behind the system was that the cost of the retirement benefit could be offset by the overall improvement in efficiency of the business enterprise, due to the replacement of the older employees by younger and more energetic people. This is how the early concept of a retirement payment was born. The problem with this system was that many employers could not maintain these regular payments out of profits when business conditions deteriorated.

A further concern, both amongst employees and the government, was the fact that unscrupulous employers could renege on commitments made to employees and leave them destitute in their old age.

It is interesting to note that as far back as the early 1920's, the Government of South Africa was already concerning itself with ways and means of supervising the activities of retirement funds. There were two main factors which influenced government in deciding that some form of control over retirement funds was necessary.

- Firstly, when an employer asks his employees to contribute towards the cost of retirement benefits, or when the employer effectively guarantees a scale of retirement benefits, the employer should set up a form of trust fund which is adequate to meet all claim against the fund as they fall due.
- Secondly, the care and support of the aged was becoming an increasing problem. It was consequently in the interest of government to encourage the establishment of private retirement funds and to ensure, as far as possible, that such funds remained in a position to meet their liabilities.

The question of legislation was raised on many occasions, and finally in 1953 the wheels were set in motion. Retirement funds are today governed by the Pension Funds Act No 24 of 1956 (as amended), which came into operation on 1 January 1958. All retirement funds must be registered in terms of the Pension Funds Act. While the legislation is called the Pension Funds Act, it in fact exercises control over all forms of retirement funds, being pension, provident and retirement annuity funds.

At the time of the passing of the Pension Fund Act, South Africa was the first country in the world to have a comprehensive Act that controlled such funds. It is interesting to note that some countries still exercise control over their retirement funds though their tax authorities only.

The aim of the Pension Funds Act is to provide for the registration, incorporation, regulation and dissolution of funds. In more basic terms, the Act is there to protect the rights of members, to ensure minimum solvency standards and to ensure that the fund always has enough assets to meet its liabilities to members.

Within the context of the legislation controlling retirement funds, the Pension Funds Act and the Income Tax Act both have an important role to play. The Pension Funds Act does however, not concern itself in any way with the tax relief on contributions, the taxation of benefits or the taxation of investments made by the investment manager with the money held within the retirement fund. This is dealt with in the Income Tax Act.

9.2 Negotiations with staff representatives

South Africa is a country where labour has become a major player in the decision making process. The National Economic, Development and Labour Council (NEDLAC) was created by government with the specific intention of providing a forum where business, labour and government negotiators could mediate on all matters relating to a better understanding between the key role players.

A typical example of the role played by NEDLAC was the lengthy negotiations entered into at the forum before the Labour Relations Act, 1995 was passed through parliament.

If one were to look at the labour unrest linked to the results of the deadlock within NEDLAC between business and labour over the terms and conditions of the Basic Conditions of Employment Bill during 1997, then one can appreciate the power that labour has acquired since the initial creation of the labour union movement in the mid 1970's. This is further evidenced by the strikes held by Government and the Private Sector employees.

The predominance of the Council of South Africa Trade Unions (COSATU) in the dispute over the Basic Conditions of Employment Act does not mean that they were, or are, the only labour representatives in the country.

An implication of the Labour Relations Act, 1995 was the creation of the need to establish workplace forums, which does not necessarily need a union representation, in any workplace in which an employer employs more than 100 employees.

The unilateral creation of a retirement benefits plan by an employer for his employees, is therefore, unlikely to happen in the current business environment. The employer, having decided that the creation of a retirement benefit plan is in the best interests of both the business enterprise and its employees, will want to deal within a negotiation forum on the structure of the fund.

The first important decision that needs to be addressed is the composition of the employee representative group. The structure of the employee representative group will, to a large extent be determined by the number of employees and their geographic positioning, all staff concentrated in one establishment or divided into branches at all the major centres. Where there is already a large trade union representation it is also only natural that the trade union concerned would wish to be a part of the negotiation team.

With the introduction of Sections 7A to 7E of the Pension Funds Act, any new fund registered after 19 April 1997 must spell out the composition of the management board with its rules and regulations. The initial defining of the management board and the arranging for an election of representatives may possibly be the best solution to the creation of an employee representative body. This body could then negotiate on the benefits to be included in the fund and form the member elected element of the management board.

There is no doubt that the employer and employees will need to have lengthy discussions on the number of representatives on the board. Where many distant branches are involved a resolution regarding representation on their behalf will also need to be resolved. It is also becoming a fairly common practice that trade union representation on the board is determined by the percentage of staff, within the organisation, that they represent.

Should there be a 40% trade union membership amongst the employees and the number of member elected board members set a 5, the trade union would be permitted to appoint 2 of the 5 member elected representatives. Where a fund has been in existence for some time the number of pensioners on the scheme may be large enough for them to be entitled to vote their own representative(s) on the management board.

The members of the fund are entitled to appoint at least 50% of the board members, in terms of Section 7A of the Pension Funds Act. The employer is entitled to appoint the balance of the board members.

The employer appointed board members must be given a clear mandate within which to negotiate on the position of the employer with regards the provision of benefits and should then enter into the

negotiations that will result in the creation of the retirement fund. The employer's position will no doubt largely be dictated by the cost of any benefits that it will need to bear.

In a retirement fund where the employer has a minimal or no, funding obligation it is even possible that the management board is made up entirely by member elected representatives. With possibly one or two employer appointed members purely to monitor proceedings.

The structuring of the fund and all the future decisions would be made entirely by the member representatives. This position is, however, unlikely as it tends to be the norm amongst current retirement fund structures that the employer bears the bulk of the costs of any administration and pays for any ancillary benefits linked to the fund.

9.3 Employer contribution options

The employer’s primary contribution option will be a result of whether a defined contribution or a defined benefit fund is selected by the negotiating forum. The employer’s representatives will, however, have been given a clear instruction regarding the type of fund preferred by the employer.

9.3.1 Defined benefit funds

In a defined benefit fund, the end benefit is fixed in terms of the rules and, in a pension fund, is often expressed as a percentage of the member's final salary at eh date of retirement.

The end benefit is also fixed in terms of the rules. It is just that the percentage of the member’s final salary at the date of retirement, fixed in terms of the rules, will be a far higher percentage, as no further annuity will be paid after the benefit has been paid out to the member. Remember that this is not an interest rate.

When dealing with a defined benefit fund, the second part of the equation is related to either years of membership or service, as defined in the rules of the fund.

*To better understand the equation let us look at a simple **EXAMPLE** of:*

- *a member who is aged 35 at the time that he joins the scheme;*
- *earns salary, of R4 000 per month (R48 000 per year) at the time of his retirement;*
- *is entitled to a pension percentage of 2% in terms of the rules of the fund, OR*
- *in the case of a provident fund a percentage of 20% in terms of the rules; and*
- *is now retiring at age 65.*

To calculate the **pension fund** provision:

If the formula in terms of the rules of the fund states that the pension at retirement will be 2% of final salary for each year of membership then the resultant pension would be:

2% x R4 000 x 30 (being 65 - 35) per month

OR

60% x R4 000 per month

OR

R2 400 per month

To calculate the **provident fund lump** sum:

you must use the annual income of the retiring member. Therefore, if the formula in terms of the rules of the fund states that the provident fund lump sum benefit at retirement will be 20% of final salary for each year of membership then the resultant lump sum would be:

20% x R48 000 x 30 (being 65 - 35)

OR

600% x R48 000

OR

R288 000

Defined benefit retirement plans have to use the services of an actuary to determine the amount of money needed by the fund to pay for the benefits promised in the rules. Once this amount has been worked out it is converted into the necessary monthly contributions needed to meet the funds future obligations.

At the time that the rules are negotiated, the size of the contribution that will be made by each member is decided. This is normally expressed as a percentage of the salary earned by the member, and will be written into the rules. The actuary will, therefore, be able to establish how much the members will be paying into the fund.

This amount is deducted by the actuary from the total amount needed by the fund, leaving the balance of the cost which is met by the employer's contributions. Therefore the employer's contributions become the variable factor in the equation.

With the trend toward defined contribution fund, and the inherent risks that an employer is faced with in running defined benefit funds, there are very few defined benefit funds still in operation. Mainly in large corporations do these benefits exist.

9.3.2 Define contribution funds

Defined contribution funds take the same three factors into account, but they are applied in a very different way. The member's contributions are also negotiated and fixed when the rules of the fund are drawn up.

The decision is then written into the rules, usually as a percentage of salary, of say, 5%, 6% or 7%.

The important difference between the two types of funds is that in a defined contribution fund. The employer's contributions are usually also fixed in a similar way, although not necessarily on a matching rand for rand basis.

The employers contributions may still need to be altered, however, as they are usually subjected to any changes that may be experienced in the costs of administration and the ancillary benefits, costs that are traditionally paid for by the employer.

The impact felt by the employer on the changing costs of administration, and the ancillary benefits included in the retirement fund, will depend, to a large extent as too whether the fund has an internal or external costing structure.

With an internal costing structure the employer's contribution is set at a fixed percentage. All the expenses for administrative costs, and the ancillary benefits, are deducted from the employer's contribution to the fund before the remaining money is handed over to the investment management team.

The danger inherent in this system is the very real possibility that increasing costs caused by, for example:

- increased administration fees; or
- increasing premiums for the ancillary benefits as a result of the aging of the members on the workforce,

may result in the total contribution paid by the employer being inadequate to meet these expenses. This could result in a real erosion of the benefits due to members, as a portion of their own contributions may end up being used to meet expenses.

In order to avoid this situation, a scenario that will be identified when a fund is valued by a valuator, it may be requested of the employer that they increase the level at their contributions or revert to an external costing structure.

With an external costing structure, the employer's contribution is set at a fixed percentage, all of which is added to the employee's contributions and handed to the investment management team for investing. The costs of administration and any ancillary benefits that may be incurred by the fund, are treated as an additional expense that is paid by the employer.

The drawback of this system, in the view of the employer, is the fact that the employer's contribution rate is no longer fixed, as is the assumed situation in a fixed contribution fund. Escalating costs of administration and/or ancillary benefits, for the same reasons as were mentioned above, may well result in the employer having to increase its contribution rate beyond the fixed rate negotiated at the inception of the fund.

It must, however, be noted that the very nature of a defined contribution fund, be it internally externally costed, will make it highly unlikely that the employer's contribution rate will escalate much beyond the rate negotiated at inception. Certainly the risk to the employer of an increase in contributions is far greater with a defined benefit fund.

The contributions available for investment, when paid by the employer and the employee, are handed over to the investment management team which invests the money. A record is kept of the contributions made by each individual employee, and the corresponding employer contributions, and this money, together with the interest earned while it is invested, provides a lump sum value at the retirement date of the member.

It can therefore be seen that the value of the retirement benefit received by a member at retirement on a fixed contribution fund becomes the variable factor.

9.3.3 Defined contribution versus Defined benefit

Whether the retirement arrangement is set up as a defined contribution, or as a defined benefit fund, will depend on the needs or the members and of the employer. While the employer would like to concentrate on his contribution options, the needs or the members, when entering into negotiations at the inception of the fund, will also need to be considered.

The final decision will have to rely on the negotiating abilities of the employer and employee representatives who need to arrive at a proposed retirement fund with benefits and cost structures that are acceptable to all the parties concerned.

You should not look at the following section as a comparison of the merits and demerits of the funds, but as a statement of differences.

Negotiations at the inception of the fund will need to take many factors into amount before a decision is made on the type of fund to be implemented. A large number or defined benefit funds have, ever the last few years, converted to defined contribution funds.

There are a number of reasons why this has occurred.

The differences between a defined contribution and a defined benefit fund must not be seen as a comparison between provident and pension funds. It is possible to have a defined contribution, or defined benefit arrangement, under either a pension or a provident fund.

Some of the important differences between defined contribution and defined benefit funds are that:

- defined contribution funds have an easily calculated member share of the fund;
- defined benefit funds allocate resources according to need. This leads to cross-subsidisation between the members, dependent on their ages;
- the accumulation of the value in savings account (defined contribution), is more easily appreciated than benefits based on concepts, which are more difficult to understand (defined benefit);
- defined contribution funds can be more flexible about retirement ages without the imposition of early retirement service penalties, since the method automatically has a penalty in that there is less time for benefits to accumulate;
- defined contribution funds tend to provide a stable contribution liability for employers, whereas defined benefit funds usually present an open-ended contribution liability to employers.

The above are some of the reasons that resulted in the demand for, and acceptance of, the conversions from defined benefit to defined contribution funds.

This should not, however, be seen as an indictment against defined benefit funds as, they too, have certain advantages that should not be overlooked:

- the risk of poor investment returns are borne by the member under defined contribution funds; and
- defined contribution funds make retirement planning more complicated, whereas a defined benefit as a percentage or multiple of final salary.

It should be clear that the decision as to which fund is implemented will depend on the needs of the members and the employer.

9.3.4 Employers and socio-economic pressures

The emergence of organised labour movements in the 30's, led to a condemnation of pension funds because of the way that benefits were paid to retired members.

Recognising the fact that many employees, particularly those affected by the apartheid laws of the time that would not allow their families to live with them, returned to rural communities upon their retirement, the payment of a monthly pension was deemed to be unsuited to their situation and administratively burdensome.

Members who retired to rural communities, and who were required to collect monthly pension cheques, were faced with a number of difficulties that made the receipt of a lump sum at retirement a lot more attractive.

Many employers were probably not even aware of these problems, but they were, however, very:

- wealth in rural communities is today, still to a large extent, measured more by the number of cattle, sheep, goats and chickens that you possess than by the amount of money that you have in the bank;
- cultural tradition and personal aspirations meant that many employees aspired towards eventually owning their own home and being able to cultivate the land and build their wealth further, even if only after retirement;
- home addresses of people within rural communities are often stated as % the XYZ Trading Store. This store may be as much as a day's walk away from the home to which the member has retired;
- as there is often no bank within the vicinity of the trading store or post office the trader may charge as much as 20% as a handling fee for cashing in the cheque; and
- the need to transport essential foodstuffs back home may be more than the retiree can manage.

On the other hand, a lump sum payment made at retirement will provide the following solutions to the member who retires back to a rural community:

- the member will return with the means to purchase the cattle, sheep, goats and chickens needed to accord him the status of a wealthy man within the community;
- having the means to purchase the wealth required he will be allotted a tract of land by the local chief on which to build his own home;

- the wives, children and extended family of the returned member will farm the tract of land provided seeing to the need for all the basic foodstuffs that may be required.

This led to labour unrest and a fairly extensive conversion of pension funds into provident funds. The ratio of registered provident to pension funds is approximately 8:1.

It is interesting to note that, with the easing of the movement of people between rural and urban communities as a result of the abolition of apartheid, fewer people are moving back to the rural environments of their birth, and are retiring within urban areas. This is leading to a subtle shift back to a need for an ongoing income after retirement.

9.4 Preservation funds

Before the advent of preservation funds, a person had the following options available on withdrawal before retirement from a pension or provident fund:

- to remain a paid-up member of the employer's fund, if so permitted by the rules;
- to take the withdrawal benefit in cash. Premature access to retirement benefits by a person may lead to the squandering thereof before retirement; or
- to transfer the benefit directly to a retirement annuity fund with no tax consequences. This option precluded any access to the retirement funds before the age of 55.

The general response of the insurance industry to the shortcomings of the aforementioned options was the introduction of pension and provident preservation funds. These have since become entrenched in the legal definitions of the Income Tax Act.

These are pension and provident funds, respectively, to which members of existing pension or provident funds can transfer their accumulated benefits under certain circumstances.

These funds are then available for the preservation and continued growth of the retirement benefits of employees who have withdrawn from their own pension or provident funds. The reasons for this could:

- as a result of having resigned from their employment; or

- having been retrenched; or
- having been faced with the actual winding up of the pension or provident fund that they may have belonged to.

A person may transfer from a pension fund to a pension preservation fund, or from a provident fund to a provident preservation fund. No provision exists, however, for a direct tax-free transfer from a pension fund to a provident preservation fund.

In the past the employer, with whom the employee was terminating employment, had to become a participating employer in respect of the preservation fund, in order for the employee to be eligible to transfer his benefits to the preservation fund. However, this restriction has subsequently been removed to encourage more open choice.

In essence, the advantages that are enjoyed by a person who transfers from a pension or provident fund to an equivalent preservation fund are as follows:

- no tax liability on transfer;
- one withdrawal from the preservation fund is permitted - either partially or total - prior to retirement age. A member transferring his benefits from a pension or provident fund to an equivalent preservation fund must, however, understand that the total value of benefits due must be transferred. A member who elects to withdraw from a retirement fund and take the benefits as a cash amount, will be able to receive a portion of any withdrawal benefit tax-free, although the sum is limited to an overall ceiling amount from all withdrawals. This tax free concession is currently R35 000. Members have taken advantage of this concession, and instructed the funds from which they have withdrawn that a lump sum amount should be paid to them and the balance transferred to a preservation fund. The revenue authorities have indicated that this will be considered the one withdrawal from the preservation fund, and that no further withdrawal will be allowed;
    - the cash withdrawals allowed in terms of Section 37D will be treated by the Receiver of Revenue as the one withdrawal and the member of the preservation fund will therefore not be allowed to make a further withdrawal until retirement. Where a sum is transferred to a non-member ex-spouse under a divorce agreement, the amount will not count as the member's one withdrawal.

9.5 Benefits provided by the state

The Social Assistance Act of 1992 combined all the laws that applied to social aid schemes into one Act. One of the laws that was included was one that dealt with social old age pensions.

There are now known as social grants and are available only to those who pass a “means test” that limits benefits to the poor. South Africa does not yet have a contributory national pension fund. The government does however, allocate money in the annual budget that provides benefits to those people who need them.

The amounts of the social grants are looked at every year. Increases in the amounts that are to be paid are normally announced by the Minister of Finance in the annual budget speech. The amounts of social grants are low.

Social security covers a variety of public and private measures that provide cash and/or benefits in kind, to secure a minimum income for individuals who, due to loss or earnings capacity resulting from illness, disability, old age, retirement, child rearing are left in a vulnerable position.

The Social Assistance Act states that it is aligned with the State’s position on the fundamental human rights enshrined in the Constitution. It created a single pension delivery system that is “non-discriminatory, protects and respects the dignity of all people, and makes information accessible to them”.

9.5.1 Kind of grants

(a) Old age grants

Payable to men and women who are 60 years of age and older, all whom will be subject to the means test before their grants are approved. (R1 500 per month as from 2016 - add R20 for persons over 75.)

(b) Grant-in-aid allowance

If the physical or mental condition of a person who is getting a social grant is so bad that he needs to be looked after all the time an additional amount per month may be paid. When this extra allowance is applied for a medical certificate must be sent with the application. R350 per month as from 2016)

(c) War veterans

Anyone who was in any military, naval or air service during the wars that South Africans have fought in can apply for a war veteran grant when they reach the age of 60 years or older if they are unable to maintain themselves because of a mental or physical disability caused by the wars.

All people that apply will have to qualify with the means test. The war veteran's grant is slightly larger than the amount received as a normal social grant. War veterans applying for their grant must submit their discharge certificates. (R1 520 per month as from 2016)

(d) Disabled persons

The grants are paid to people who are 18 and older, who are disabled for six months and more who cannot support themselves because of the nature of their disability. R1 500 per month as from 2016)

(e) Foster child

Persons who act as foster parents for children who have been taken away from their parents for their own safety or children who have been orphaned and need special care that cannot be provided by an orphanage (for example, new-born babies) can claim a special social grant for every child in their foster care. The appointment as a foster parent must be ratified in court and the foster parent will have to qualify for the grant in terms of the means test. (R890 per month as from 2016)

(f) Child support

A primary caregiver who cares for a child or children (up to a maximum of six children) who are under the age of eighteen can apply for a special child-support grant. (R350 per month as from 2016)

(g) Care dependency grant

For persons who take care of a child who has a severe disability and is in need of full-time and special care. The care dependency grant covers disabled children from birth until they turn 18. (R1 500 per month as from 2016)

Learning unit 10 - The use of insurance in the business environment

10.1 Key-person insurance

The term key-person is one that applies to company employees who, should they die or leave, will:

- be difficult to replace;
- effect the profits of the enterprise;
- result in a reduction of production or sales;

- result in costly training of a replacement; or
- require a possible change in management.

Once the role of a key-person in an organisation has been established, it becomes possible to decide on the value of the person. It is often difficult to do this in Rands and Cents and so the following may assist as a guide.

10.1.1 Establishing the value of the key-person

Where it is not possible to accurately assess the loss that a key-person will mean to an employer, it is normal to use a multiple of his basic salary to determine the sum insured, for example, 5 or 10 rimes his gross annual salary.

Alternatively, only the actual loss, but also the costs that will be incurred in the recruitment and training of a replacement are taken into consideration.

10.1.2 Key-person and deferred compensation

Premiums payable on the life of an employee by an employer are an allowable deduction if certain rules and conditions are met. This deduction is then made in terms of Section 11(w) of the Income Tax Act. Both a key-person and a deferred compensation policy are employer-owned policies. Both these policy provisions therefore, need to be considered when deciding on the benefits to be added to a policy. The employer, who owns the policy and pays the premiums, must be made aware of the implications of using one policy for both of the above provisions.

Assume the employer has undertaken in terms of a service agreement, to pay the proceeds of the policy to the employee's beneficiaries on death. The employer could then find that the money that had been earmarked for use in replacing the employee is no longer available.

10.1.3 Income Tax Act

Section 11(w)(ee)(B) of the Income Tax Act, restricts the size of the premium that the employer may deduct if the policy has a maturity benefit. A deferred compensation policy needs a maturity value, and so utilising one policy for both purposes will limit the size of the life cover and benefits available.

In terms of Section 11(w) of the Income Tax Act, there will be allowed as deduction *"an allowance in respect of any premium which was actually paid by the taxpayer under any policy of insurance taken out upon the life of an employee of the taxpayer"*. In the case of a company, the deduction will also apply if the policy is on the life of a director.

Where a policy premium is allowed as a deduction in terms of Section 11(w), the proceeds of the policy are fully taxable, on receipt, in the hands of the employer.

This will apply whether the employer chooses to claim the tax deduction under Section 11(w), or not. The only way that an employer can avoid the payment of tax on the proceeds of a policy, owned by the employer, on the life of an employee, is to contract for what is commonly known as a "non-conforming" policy.

Where there is an estate duty liability on the proceeds of the policy (for example, in a family company), it is the practise of the revenue authorities to tax only the net proceeds of the policy i.e. after any estate duty payable has been deducted.

The impact of taxation on the proceeds of a key-person policy can be severe. A company or close corporation, for instance, currently pays tax at a flat rate of 28%. It is advisable to take this cost into account when determining the level of life cover required on the life of the key-person.

Taxation Law Amendment Act, 7 of 2010: Employer-owned policies

Premiums on employer-owned life insurance policies such as key person or deferred compensation policies will be tax deductible as from 1 January 2011, only if one of the two following condition are met

Condition 1

- The premiums are included in the taxable income of the employee or director as a fringe benefit.

OR

Condition 2

- The policy is owned by the employer, paid for by the employer and the employer is to receive the benefit. If there is a collateral or security cession on the policy then the

premiums may still be claimed as a deduction, unless the cession is in favour of the life insured, his relatives or dependents.

- The policy is taken out on the life of the employee or director to insure the employer against any loss arising as a consequence of the death, disability or severe illness of the employee or director.
- The policy is a pure risk policy which means there must be no cash value to the policy.
- There must be no transaction, operation or scheme in existence in terms of which the benefits will be paid directly or indirectly to the life assured employee or director, his relatives, his estate or his dependents.

Practical implications - Existing key-person or personal liability policies

If either of the two conditions are met, then irrespective of whether the policy was originally set up as conforming or non-conforming, and irrespective of whether the deductions are factually claimed, as from 1 January 2011 the premiums will be fully deductible. The proceeds of policies that meet the conditions will be taxable to the extent that the premiums were deductible.

If neither of the conditions are met, then irrespective of whether the policy was originally set up as conforming or nonconforming, as from 1 January 2011 no premiums will be deductible. The proceeds of certain of the policies may still be taxable to the extent that the premiums were deductible under the old regime.

10.1.4 Estate Duty Act

In terms of Section 3(3) of the Estate Duty Act property which is deemed to be property of a deceased, in this case a key-person, includes-

a. the proceeds of any domestic policy insurance upon the life of the insured. This will not be the case in respect of any policy where -

i. the Commissioner is satisfied that:

- the policy was not taken out by, or at the insistence of the deceased;
- no premium of the policy was at any time paid by the deceased;
- none of the proceeds of the policy will be paid to the estate;
- none of the proceeds of the policy will be paid to, or used for, the benefit of any relative or dependant of the deceased; and

- none of the proceeds of the policy will be paid to any company which at any time was a family company in relation to the deceased.

A family company is defined as a company, not listed on the stock exchange which at any relevant time was controlled, or capable of being controlled, by the deceased and one or more family members.

It is the duty and obligation of the intermediary to ensure the client is provided with the best possible advice in order to receive tax relief on the premiums.

It is also important to ensure that the estate of the deceased is not burdened with an additional estate duty liability. In practise the employer would settle any estate duty liability reflected against the policy. This will however, only aggravate the burden imposed by the tax due on the policy proceeds. Care must be taken to include this factor where a family company is involved when establishing the life cover requirement.

10.2 Deferred compensation

There are two ways in which services can be unexpectedly terminated.

The one is untimely death or disability, the reason for key-person insurance, and the other is the employee's resignation. No employer can retain the services of an employee who wishes to leave. What the employer can do however, is to provide the employee with incentives to stay.

These incentives could come in a number of guises:

- a company car;
- staff mortgage bond subsidies;
- attractive holiday incentives, for example, overseas trips;
- high salaries;
- good bonuses; and
- free meals and entertainment allowance.

While the above incentives are attractive, they leave the employer with two basic concerns:

- an employee can negotiate a similar or better package with his new employer; and
- every one of the benefits listed above increases the tax liability of the employee.

With the high rate of tax in this country, top earners are paying tax at a marginal rate in excess of 40%. Adding more incentives to a package therefore will essentially reduce the real earnings of the key-person. It is also possible that the key employee has reached an age where the incentives listed above may no longer be necessary or attractive. It is important then that the employer find some way in which:

- the employee can be rewarded without any additional tax liability being created;
- the reward is of such a nature that the employee can see some real current, or future benefit; and
- the reward becomes an incentive for the employee to remain in the services of the employer.

The development of deferred compensation packages, funded by life insurance, has evolved as a result of certain tax concessions available to the employer and the employee. It is possible to fund a deferred compensation fund from other sources, such as profits in the year of retirement or share investments, but these other avenues would not be able to compete with life insurance because of the Section 11(w) deductions available. Employees are also happier knowing that their benefits are based on the returns of a life office, and not on the fluctuations of the business market.

There are two side to any deferred compensation fund: the employer's and the employee's:

10.2.1 Employer's position

As was mentioned when we looked at key-man insurance, the Income Tax Act (Section 11(w)) will allow as a deduction *"an allowance in respect of any premium which was actually paid by the taxpayer under any policy of insurance taken out upon the life of an employee of the taxpayer".* In the case of a company the deduction will also apply if the policy is on the life of a director.

This allowance is restricted in that any policy used must abide by the terms of a government notice (GN R2408) to be a "conforming policy". The deduction of the premiums of a conforming policy are further restricted to an amount equal to 10% of the remuneration of the employee or director.

A further point, which is often not appreciated by intermediaries and their clients, in the fact that where a policy premium is allowed as a deduction in terms of Section 11(w), the terms and conditions set out in Part 4 of the Regulations to the Long Term Insurance Act do not apply. The proceeds of a conforming policy will therefore be fully taxable in the hands of the employer.

On the retirement of the employee, the conditions of a Service Agreement, entered into between the employer and the employee, will require that the employer pays an amount equal to the proceeds of the policy to the employee. This being a condition of service, the employer will be permitted a deduction of the gratuity paid under Section 11(a) - expenditure incurred in the production of income, not of a capital nature. One therefore finds that the proceeds of the policy, which were included in the gross income of the employer, are now allowed as a deduction against that same gross income, effectively creating a tax neutral position for the employer.

10.2.2 Employee's position

In order to ensure that the employee is not taxed on the value of the premiums paid on the policy by the employer, as if they were income accruing to him, certain rules have to be obeyed:

- the employee must not be entitled to any benefit under the policy other than those benefits as set out in the Service Agreement. These benefits must only be due to the employee as a result of the termination of his services; and
- no salary sacrifice will be possible by the employee. Section 7(1) of the Income Tax Act incorporates into the income of a taxpayer any income which is due and payable to a taxpayer, even though such income has been invested or otherwise dealt with on his behalf. It will be argued that any salary sacrifice made by an employee to fund a deferred compensation scheme, would be construed as an investment made on the employee's behalf.

Provided that these rules are complied with, the position of the employee will be the same as it was prior to the institution of the fund.

It must be noted that at retirement the employee will not be receiving the proceeds of an insurance policy. The money received by the employee from his employer at retirement is in the form of a gratuity which can be funded from any source. The gratuity is, therefore, included in the gross income of the employee.

With effect from 1 March 2011 a lump sum payment is treated the same as payment received from retirement funds. The lump sum amounts will be exempted up to R300 000 and special rates will be applicable to any amounts in excess of R300 000. This falls in line with the definition of severance benefits.

No exemption under this section will apply unless:

a. the person receiving the amount has attained the age of fifty-five years; or

b. the employee is relinquishing, terminating, losing, repudiating, cancelling, or varying his office or employment as a result of superannuation, ill-health or other infirmity; or

c. the employee is retrenched as a result of the employer ceasing his business or down-sizing.

It can be seen that a deferred compensation fund has many advantages for both the employer and the employee. Setting up a scheme for the mutual benefit of both parties requires that the terms and condition s are in writing. Where the employer is a company it will be necessary to have a board resolution for the records.

10.3 Preferred compensation (restraint of trade)

A key-person in any organisation can cause a major disruption if he should leave unexpectedly. The key employee's vacant position might be difficult to fill. In addition, the knowledge and expertise that he may be able to impart to a competitor, could also seriously damage the market share that the employer has prior to the termination of the employee's services.

Deferred compensation funds have been set up at a number of different employers, specifically to encourage the employees to stay until normal retirement age.

Whilst this fund has proven to be very attractive, both to the employer and the employee, there are certain circumstances in which a deferred compensation fund is not the best solution to the problem.

Let us look at a few of these instances:

- in some industries, such as the advertising industry, it is normal for employees to move from one employer to another. Much as any agency may wish to retain the services of a particularly talented employee, the retention period would seldom stretch to normal

retirement age. This is because the nature of the enterprise requires a constant flow of new ideas and therefore new talent;

- the employer may be a tax-exempt institution such as a Section 21 company, and so will not be able to reap any benefit in terms of the tax relief applicable. It would therefore, be more appropriate to concentrate on the tax position of the employee;
- the age of the employee may be such that the period to normal retirement age may be considered too long, so the plan would not be an incentive for the employee to remain in the service of the employer.

The solution to any one of the above concerns is to adapt the employer owned fund in such a way that the employee will feel that a real benefit can be reaped for remaining in the service of the employer.

The design of a preferred compensation scheme is such that both the employer and the employee will be aware of the benefits. Whilst the scheme is marketed as a unique package, it is important to bear in mind that the policy used can be an ordinary life insurance policy (endowment on whole life). It is also possible to add any of the money supplementary or risk benefits available to the policy for the benefit of the life insured and, where applicable, his family.

The employer and the employee will for example further agree in writing to the following:

a. the employer shall pay the employee a special non-retirement funding, salary increment,

b. the employee shall, after having paid the tax due on the special increment received, purchase a policy of life insurance; and

c. the employee is required to cede the policy to the employer as security for the special increment received.

10.3.1 Employer's position

The employer will pay to the employee a special salary increment in lieu of the premium that he is to invest in a deferred compensation policy. By making the increment non-retirement funding, the employer will avoid the additional costs that are incurred with a normal increment, for example, the employer's contribution to the pension fund.

An employer is permitted to claim salary expenses as a general tax deduction in terms of Section 11(a), being expenses incurred in the production of income. The employer will, where applicable, therefore claim the additional salary expense.

10.3.2 Employee's position

The employee receives a special salary increment from his employer. This increase is only granted by the employer because he expects the employee to remain in his service for a minimum period of 10 years, for example. To ensure that this is in fact the case the employer will require that the employee uses the special increase to purchase a life insurance policy.

The policy must then be ceded to the employer as security for the employee's undertaking to remain in service with the employer.

The cession must be a security cession and not an outright cession. The importance of this is that ownership will not be transferred with a security cession and the policy will remain the property of the employee. As the employee is a natural person the investment account of the policy will be placed in the individual policyholder's fund which is taxed at a lower rate than the company owned policyholder's fund.

The policy, when taken out by the employee, must be taken out as a normal policy in accordance with the conditions contained in the Regulation to the Long Term Insurance Act. This will ensure that the proceeds will then be fully redeemable and tax-free in the hands of the employee at maturity.

The employee will not be able to claim any of the premiums as a tax deduction. It is necessary to first determine the tax due on the increment and then to ensure that the balance is utilised for the premiums.

As the employee is the one taking out the policy, and as the ownership will remain with the employee, the employee is able to take out any normal policy that may fit his needs. Any supplementary benefits available can also be added. Naturally, no retirement annuity contract can be used for this purpose, as a retirement annuity cannot be ceded.

10.4 Sinking funds (Capital asset replacement plan)

Unlike land and buildings, plant, machinery, motor vehicles, office equipment, are wasting assets with a limited time-span usage. Because of this, it is accounting policy to depreciate capital assets at a fixed amount each year for their expected life span.

The depreciation of these assets reflects the estimated annual cost of wear and tear, and is tax deductible in determining the company's taxable income which is gross income less deduction, upon which tax is assessed. In practice these assets may still be capable of functioning reasonably effectively. Although depreciation is a cost, the charging of it does not involve any cash outlay.

The ensure that enough funds are available to replace these assets, cash amounts equal to the depreciation charge must be invested in a sinking fund, usually provided through use of a pure endowment policy.

10.4.1 How is this done?

The annual depreciation charge is matched with an annual payment into a pure endowment policy for a term of at least 5 years. Because there is not life cover on a pure endowment the company will not be able to deduct the premiums and therefore the proceeds will be tax free eh received by the company at maturity.

In accordance with the condition stipulated in Part 4 of the Regulations to the Long Term Insurance Act, there is also no need for a policy to have a life insured if there is no life cover included in the policy. The company, therefore, owns the policy as an asset, and no outside influences, like the death of the nominated life insured under a historic policy, will affect the date of maturity.

Sinking funds, in addition to replacing capital assets, are the ideal way for a company to save for employee bonus schemes. Duly authorised body corporates can also make use of sinking funds to fund repair and maintenance costs.

10.5 Buy-and-sell agreements

Unless adequate provisions are made within a business entity, the death of any one of the parties involved creates major areas of concern for the survivors. The primary concern is in the area of the control over the deceased's interest or share in the enterprise.

It would be far simpler for all concerned if the sole proprietor, partners, members in the close corporation, or shareholders in a private company arranged for the continuity of their business entity while they were still able to do so. The most effective way of doing this is through a buy-and-sell agreement. In the case of a sole proprietor, the agreement can be with a valued employee, or even a competitor, as is sometimes found amongst pharmacists.

The most efficient way of funding any agreement reached, is to use life insurance policies on the lives of the people who are party to the agreement.

10.5.1 Sole Proprietor

The sole proprietor is, by definition, a one-man operation and so on the death, or retirement, of the sole proprietor, the business will cease. The business may, at that stage, have established itself in the community, have a large asset base and employ a number of people. The sole proprietor would, therefore like to see the continuity of his work.

The only way that this can be done is to arrange for a purchaser of the enterprise while the sole proprietor is still active in his occupation. A forced sale on death, or a sale at retirement, will almost never realise the true value of the business.

The most likely purchaser of the business of the sole proprietor is a key employee who knows the customers, is familiar with the operation, and has established his credibility in the community.

The problem would be the raising of the finances for the purchase price. A purchasing agreement commonly known as a buy-and-sell agreement, funded by life insurance that matures at the retirement age of the sole proprietor and has sufficient life cover to cater for prior death, is the solution.

The other option is a buy-and-sell agreement with a competitor in a similar line of business, who incidentally, possibly has a similar problem. Here there two parties can agree that the business of the first dying will be purchased by the survivor, who can then, when the time is right, sell the business at its true value. The survivor also could appoint a competent manager and retain the business.

10.5.2 Partners, members and shareholders

A partnership, close corporation or private company all have purchasers available to buy the interest in the enterprise from a deceased co-owner’s estate. The problem of having sufficient funds to purchase the interest may, however, be an issue at the time. The only way that this can be overcome, is by setting down all the conditions applicable to the sale of the interest of a partner,

member or shareholder on his death, in a buy-and-sell agreement, and funding the agreement with life insurance.

The buy-and -sell agreement will ensure that the executor of the deceased's estate is obliged to fulfil the conditions of the sale. No clause in any will set up by the deceased will be able to override the terms and conditions of the buy-and-sell agreement.

The buy-and-sell agreement is drafted after the value of each partner's interest has been calculated. The type of life policy used will often be dictated by the personal circumstances of the individual partners, as well as the value placed on the partnership.

Term insurance is advisable for affordability, especially when a new business is being started up, as expenses are usually higher at this stage. Being inexpensive, one can opt for a 5 or 10 years convertible term policy that can be converted at a later stage when higher premium can be afforded. A limitation of this type of cover is that should the term run out, the client has to convert the plan, or it will expire.

The timing may not be appropriate, therefore a renewable convertible term policy could be more appropriate with the premium increasing at each renewal date.

Another type of cover is universal whole life insurance. The premium is (subject only to a negative review) constant throughout the duration of the policy. It also provides cash values after a number of years. The benefit of having cash values is that where the business is sold or ceases to operate, the cash pay-outs from the policies can be an added benefit to the partners. The policies of the last few years, offering whole of life cover without investment, or free-standing disability / debility or dread disease cover, are a cost effective way of funding the provisions of buy and sell agreements.

Buy-and-sell agreements have become an accepted part of sound planning for most small businesses. The awareness of the need has resulted in many businessmen arranging their agreements through their attorneys which would be correct in all the legal implication. What has been found on occasion, though, is that there is an omission in arranging the needed life insurance to fund the provisions of the agreements.

10.6 Preference share capital redemption plans

Preference shares are generally used by a company to raise money. Whilst a preference shareholder obtains certain rights against the assets of the company they usually have no voting rights with

regards the running of the company. In other words, they cannot vote at the annual general meeting where the board of directors are elected.

Holders of preference shares are entitled to a participation in the profits of the company before the declaration of a dividend to ordinary shareholders.

Preference shares can be either cumulative or non-cumulative. Where they are cumulative, and a dividend is not declared during a financial year, the preference shareholders must he paid their arrear dividends in the next year, before a dividend can be declared. They, in effect, become creditors against the future profits of the company.

Preference shares usually bear a fixed minimum annual rate of dividend, and this rate cannot be changed unless the majority of the preference shareholders agree. One therefore finds that, while there is a higher level of security in preference shares, the return on the investment may not be as high as it would have been if the investment had been in ordinary shares. Preference shareholders have a prior claim to the repayment of capital upon the winding up of the company.

Preference shareholders will find that their shares either have a redemption date, at which stage the company will repay the capital at a specified redemption price, or a conversion clause allowing the conversion of all or a part of the holdings into ordinary shares, again at a specified price. This is usually also linked to a specified date.

Should the issued preference shares be redeemable, the company will redeem them either out of the profits that are, at that stage, available for dividends, or out of the proceeds of a fresh issue of shares that are issued specifically for this purpose.

Another option that the directors could investigate, is the setting up of a sinking fund for the repayment of the capital required to redeem the preference shares. As the redemption is at a specific price on a predetermined date, it is possible to plan ahead by investing in a sinking fund with a premium that will provide sufficient capital at the required maturity date.

10.6.1 How is this done?

The annual premium is based on a quotation for an endowment policy that will provide an illustrative maturity value at the selected maturity date.

In accordance with the conditions in Part 4 of the Regulations to the Long Term Insurance Act there is no need for a policy to have a life insured if there is no life cover included in the policy. The company, therefore, owns the policy as an asset, and no outside influences like the death of the nominated life insured under a policy will affect the date of maturity.

At maturity, the proceeds of the policy will be tax free in the hands of the company, and will be used to redeem most or all of the preference shares.

The advantage to the company of utilising a policy of insurance will be the fact that either:

a. no new issue of shares will be required to raise the capital for redemption; or

b. normal dividends can be issued as profits will not be needed to be saved for redemption.

10.7 Contingent liability insurance

A private company, or close corporation (cc), will on occasion need to borrow money. The reason for the borrowing is not what is important in this scenario, but what is of vital importance to the directors, or members in the case of a CC, is the personal surety that he may be required to sign. It is not unusual that a bank will insist that the directors of a private company pledge their personal assets, where the bankers feel that the assets of the business provide insufficient security.

By signing a surety in his personal capacity, the director effectively binds his personal estate for the liabilities of the business. On the death of the director, the load will be recalled and the business will need to repay the loan. Should this not be possible, the business will need to exercise one of the following options:

- find an alternate director who can replace the deceased as an alternate guarantor;
- find alternative collateral security acceptable to the creditor; or
- come to an alternative arrangement with creditor for the repayment of the loan.

Should the business be unsuccessful in its attempts to make alternative arrangements, the creditors may claim the full outstanding debt directly from the personal estate of the deceased director.

In order to avoid the personal estate of a director being liquidated for the settlement of business debts, it is prudent that the business takes out policies of insurance on the lives of any directors who may have signed personal sureties.

10.7.1. How is this done?

The director(s) agree that a policy of insurance is taken out by the business of his life, on the conditions that:

- premiums are paid by the business;
- any surplus remaining after the settlement of the secured debts may be retained by the business;
- a written agreement is entered into between the business and the director, that compels the business to use the proceeds of the policy(ies) to settle the amount owing to the creditors; and
- creditors accept the plan, and provide a written undertaking to cancel the personal surety provided by the director on the repayment of the debt.

As the total and permanent disability of a director may result in the creditor losing faith in the business's ability to repay the loan, it is perhaps also advisable that permanent disability insurance be included with the policy.

Setting up a contingent liability plan can safeguard, not only the estate of a deceased director, or member of a close corporation, but also the business against financial hardship, should he personal guarantor pass away suddenly.

10.8 Impact of Capital Gains Tax (CGT) on business insurance solutions

The introduction of Capital Gains Tax (CGT) has resulted in may people looking at their assets, and wondering what impact this tax has on the real value of these assets.

Whether it be a partner who has funded a buy-and-sell agreement with insurance policies, or an employee who has elected to receive some form of deferred or preferred compensation scheme in lieu of an annual salary increment, people will be looking at the potential impact of CGT on their future lump sum receipts.

As a result of policies being taxed in the hands of insurers before they are paid out, persons need no declare the proceeds of insurance policies for the purposes of the payment of any capital gains tax.

Note that this does not, however, apply in the case of a second-hand policy where the proceeds will have to be declared as a capital gain or a capital loss.

The way in which policy proceeds are to be dealt with for the purpose of CGT are stipulated in paragraph 55 of the Eighth Schedule:

A person must disregard any capital gain or capital loss determined in respect of a disposal that resulted in the receipt by or accrual to that person of an amount -

a. in respect of a policy as defined in Section 29A with an insurer as defined in that section, where that person-

i. is the original beneficial owner or one of the original beneficial owners of the policy;

ii. is the spouse, nominee, dependant as contemplated in the Pension Funds Act, 1956 (Act No. 24 of 19556), or deceased estate of the original beneficial owner of the relevant policy and no amount was paid or is payable or will become payable, whether directly or indirectly, in respect of the cession of that policy from the beneficial owner of that policy to that spouse, nominee or dependant; or

iii. is the former spouse of the original beneficial owner and that policy was ceded to that spouse in consequence of a divorce order or, in the case of a union contemplated in paragraph (b) or (c) of the definition of "spouse" in Section 1 of this Act, an agreement of division of assets which has been made an order of court;

b. in respect of any policy taken out on the life of an employee or director as contemplated in Section 11 (w);

c. in respect of a policy that was originally taken out on the life of any other person who was a partner of that person, or help any share or similar interest in a company in which that person held any share or similar interest, for the purpose of enabling that person to acquire, upon the death of the other person, the whole or part of-

. that other person's interest in the partnership concerned; or

i. that other person's share or similar interest in that company and any claim by that other person against that company, and no premium on the policy was paid or borne by that other person or any connected person in relation to that other person;

d. in respect of a policy originally taken out on the life of a person, where that policy is provided to that person or dependant by or in consequence of that person's membership of a pension fund, provident fund or retirement annuity fund.

10.9 Recommended additional reading

The student who wishes to know more about insurance for business will find that a number of books are available to assist with further reading. A few of these have been listed below.

"The Financial Advisers Development Series"

by M Botha, I du Preez, WD Geach, b Goodall and L Rossini published by Butterworths.

"Entrepreneurial Law"

by HS Cilliers, ML Benade, JJ Henning, JJ du Plessis, PA Delport, JSA Fourie & L de Koker published by Butterworths.

Learning unit 11 - Estate planning

Definition - Estate planning is defined as the arrangement, management, securement and disposition of a person's estate so that he, his family and other beneficiaries may enjoy and continue to enjoy the maximum from his estate assets during his lifetime and after his death, no matter when death may occur

The estate of a person is the net worth of a person at any time. It is the sum of a person's assets less all liabilities at a given time.

Assets include:

- legal rights;
- Interests; and
- Entitlement to property of any kind.

The purpose of estate planning is to ensure that the distribution of a person's property at the time of death is done in terms of the client's wishes and that the person's beneficiaries receive their portion of the estate in the most cost effective way by minimising taxation implications as far as possible.

Effective estate planning requires knowledge of:

- Estate Duty Act;
- Capital Gains Tax;
- donations tax;
- matrimonial regimes; and
- law relating to wills and trusts.

In addition to providing financial security, estate planning also encourages individuals to make important decisions such as:

- appointing a guardian for minor children;
- preferred healthcare practices; and
- Securing funeral arrangements.

11.1 Estate duty

Whenever an individual dies, it becomes the responsibility of the person that winds up his estate, known as the executor, to settle any outstanding debts that may have been left by the deceased.

Once these debts have been settled, there is a final tax that is levied upon the estate, and once this has been paid the executor can pay the balance of the estate to the beneficiaries in terms of the will of the deceased. There are, however, certain special deductions and an abatement allowed before the amount of estate duty needs to be determined. In the process of working through this chapter, we will be able to establish on which of the worldly goods of the deceased, the executor will need to levy the estate duty.

The Estate Duty Act (no. 45 of 1955) (as amended) was promulgated with the express purpose of imposing a final tax (known as estate duty) on the estate of a deceased person.

Estate duty is levied at a flat rate of 20% on the dutiable amount of any deceased person's estate. The calculation of the dutiable amount is done as follows:

Determine *gross estate by valuing all the property and deemed property of the deceased*

less *S4q residue*

less *S4A reduction*

equals *dutiable estate*

Property includes all assets, whether movable, or immovable, including insurance policies on the life of another person, fiduciary and usufructuary rights enjoyed prior to death and annuities which the deceased was receiving and which now pass on to someone else.

Deemed property includes policies of life insurance payable to the estate but excluding policies payable to a child or spouse in terms of an ante-nuptial or post-nuptial contract, policies taken out for buy / sell insurance purposes where validly set up and policies taken out by persons other than the deceased and under which the proceeds are not payable to the estate or to the family of the deceased. It also includes lump sum benefits from retirement funds, donations, claim from an accrual marriage contract and some other less common items.

Annuities from retirement funds to which the deceased belonged, which became payable as a result of the deceased's death, are not included.

A set procedure for valuing annuities and usufructuary interest is laid down.

There are numerous deductions, the most important of which are:

- assets which accrue to a living spouse (by means of a will), funeral and deathbed expenses;
- an accrual claim due to a surviving spouse;
- property situated outside of the country if acquired from a non-South African source;
- bequests to approved institutions;

- income tax payable or lump sums due from a retirement fund;
- premiums paid by another person or company for a life policy on the deceased life, plus 6% per annum compound interest; and
- the value of a usufructuary interest on property from a deceased spouse's estate. Usufructuary is a term for a person who has the right to enjoy the products of property he does not own.

11.1.1 Dutiable amount of an estate

Once all the deductions have been claimed, one is left with the net value of the estate. In order to determine the dutiable amount of the estate, one must now deduct from this net value an amount of R3, 5 million (as from 2007). On any amount that now remains, the executor will be required to pay Estate Duty.

11.1.2 Who is liable for the payment of the Estate duty?

It is the responsibility of the executor of the estate to ensure that the estate duty is paid to the Commissioner of Inland Revenue, who collects the duty on behalf of the state. The estate is not, however, fully liable for all the duty payable.

Where a beneficiary in terms of the will of the deceased receives a fiduciary, usufructuary or other like interest, including an annuity not charged against property, the beneficiary is liable for the estate duty. On all other property, the executor is liable to pay the estate duty out of the estate.

Where an insurance policy is payable directly to a beneficiary, the proceeds of the policy are exempt from estate duty.

Where the estate of the deceased includes a commuted lump sum from a retirement annuity or pension fund, the beneficiary is liable for any estate duty on the amount received. Should the commuted value be paid into the estate the executor will be liable for the duty.

The executor, whose responsibility it is to ensure that the estate duty is paid, is entitled to recover the duty payable from any beneficiary who becomes liable for the payment of the duty.

11.1.3 Rebate in respect of death in rapid succession

Where any portion of the duty that is to be levied is based on the value of any goods in respect of which duty was already levied on the death of another person who died within the 10 years prior to the death of the deceased, the duty which attributable to the value of the intended goods is further reduced according to the following scale.

If the deceased dies within two years after the death of the first deceased - 100%

If the deceased dies more than two years but at the most four years after the death of the first deceased - 80%

If the deceased dies more than four years but at the most six years after the death of the first deceased - 60%

If the deceased dies more than six years but at the most eight years after the death of the first deceased - 40%

If the deceased dies more than eight years but at the most ten years after the death of the first deceased - 20%

However, this rebate may not exceed the amount of the duty which is attributable to the property as a result of its inclusion in the dutiable estate of the first deceased.

11.2 Capital Gains Tax

For capital gains tax purposes, a natural person is treated as disposing of all of his assets on the day before death. Capital Gains Tax will, therefore, be levied on the growth in the value of the assets, while estate duty will be levied on the net value of the deceased estate. It is one of the many duties of the executor of an estate to settle any tax liability due by the deceased before the estate can be wound up.

At death of a natural person, the day immediately before his death is regarded as the last day of the tax year. The final tax assessment prepared for the deceased by the executor will need to include

any capital gain, or loss, that may have arisen as a result of this disposal of the assets of the deceased due to his death.

Note that the annual exclusion from any capital gain during the year of assessment in which a taxpayer dies, is R300 000 in 2016.

Once this final assessment has been submitted, and all outstanding taxes have been paid, SARS will issue the executor with a tax clearance certificate. Having received this certificate, the executor can continue winding up the estate in the normal way.

Note that there may be cases where a significant capital gains tax charge arises due to the growth in the value of assets, although the deceased estate is heavily in debt and possibly not liable for estate duty.

NOTE

This may have an impact on the liquidity of the deceased estate, resulting in the assets having to be sold to meet the CGT liability. Paragraph 41 of the Eighth Schedule of the Income Tax Act provides an opportunity for an heir to acquire an asset, provided that he accepts a part of the corresponding CGT liability.

For example, where the CGT due exceeds 50% of the net value of the deceased estate, as determined in accordance with the Estate Duty Act and before taking the CGT into account, the executor of the deceased estate is required to dispose of some assets to pay the tax due.

However, an heir or legatee who would have been entitled to the asset(s) to be sold, may accept both the asset(s) and the liability, on condition that the portion of CGT exceeding 50% of the net asset value, of the estate as determined by the Estate Duty Act, is paid by him.

The liability must be paid within three years of the executor obtaining permission (from SARS) to distribute the asset, and will bear interest, at the rate prescribed from time to time by the Minister of Finance

It can be seen that any estate plan should take into account the potential liability for capital gains tax that can arise on a person's death. Therefore capital gains tax planning is also an important factor in deciding who will get which assets, as this will have an effect on the CGT liability of the client.

11.3 Donations Tax

Donations tax in 2016 is levied at a flat rate of 20% on the market value of any property donated. The first R100 000 of property donated by any individual in each year is tax exempt.

Dispositions between spouses and donations to public benefit organisations are tax free.

Any person who in their business capacity gives gifts is limited to casual gifts of R10 000 in total per annum.

11.4 Matrimonial regimes

A matrimonial regime is a property system or systems of property ownership between spouses. These systems provide for the creation or absence of a martial estate. If a martial estate is created the following considerations are made:

- how and by whom it is managed;
- what properties are included in the estate; and
- how it will be divided and inherited at the end of the marriage.

It is therefore very important to consider the marital status of the client during an estate planning process.

In South Africa the following laws need to be considered:

- the Marriage Act 25 of 1961 - which prescribes certain formalities when parties wish to marry and which prohibits certain marriages;
- the Recognition of Customary Marriages Act 120 of 1998 - which recognises certain traditional unions which form part of the culture of African people; and
- the Civil Union Act 17 of 2006 - which allows for the same sex union.

There are 3 different Marital Regimes in South African Law which are:

- marriages in community of property;
- marriages with an antenuptial contract - which are out of community of property; and
- marriages with an antenuptial contract including an accrual.

11.4.1 Marriages in community of property

As a general rule it can be said that all marriages entered into in terms of common law, create communal property and are therefore in community of property. Unless the parties to a marriage specifically request an antenuptial contract, they are married in community of property.

This means that on the termination of the marriage, either by death or divorce, the joint estate shared equally between the parties, irrespective of the value of their respective contributions to the estate.

All assets as they exist on the date of marriage are joined into one communal estate. Any property or assets acquired by either spouse during the marriage become part of the communal estate. These acquisitions are referred to as the community of profit or loss.

The Matrimonial Property Act 88 of 1984, provides the joint administration of the communal estate, in which spouses may not alienate, pledge or negotiate any other right on the communal property without the other spouse's consent. In this context includes:

- physical immovable or movable property;
- shares;
- debentures;
- insurance policies;
- fixed deposits; or
- similar assets.

Inheritances and gifts received from 3rd parties have however been excluded from the communal property.

11.4.2 Marriages in terms of an antenuptial contract

An Antenuptial Contract is a legal document which is drawn up and signed with an attorney and registered at the Deeds Office before two parties are named. If the parties intend not to be married in community or property, then this contract must be agreed before they marry.

This is a contract which details:

- the terms of possession of assets;
- treatment of future earnings;
- control of the property of each party; and
- potential division of the assets and property if the marriage is later dissolved.

Each party has, and maintains, a completely separate estate. Irrespective of who puts what into the marriage, the party who owns the estate is the owner of its contents before, during and after the marriage.

This clearly gives parties absolute independence of contractual capacity and protects the estates of each party against claims by the other party's creditors, but there is no provision for any sharing whatsoever. A party who contributed to the other party's estate whether in cash or otherwise would have a heavy onus to prove that he or she was entitled to anything from that party's estate on dissolution of the marriage.

Where for example, one party stays at home to raise children and does not contribute financially towards the marriage, and the other spouse works and accumulates assets, the former may find him or herself with nothing and no claim to the assets of the latter. Spouses in marriages concluded out of community or property prior to 1984 may find relief from this situation in the courts; those marrying out of community of property thereafter will not.

11.4.3 Marriage in terms of an antenuptial contract including accrual

The Matrimonial Property Act 88 of 1984 brought into being the accrual system which allows for the sharing of assets, but allowing each party in the marriage to retain their contractual independence and separate estate.

Under the accrual system, should the marriage dissolve, the value of the assets of both estates are combined and split between the parties as follows:

- each party retains their own original estate; and
- at dissolution each estate is calculated separately. The monetary value of the smaller estate is subtracted from the larger estate and the difference is split equally.

11.5 Divorce Act no. 70 of 1979

Until 1 August 1989, a spouse's interest in a pension, provident or retirement annuity fund was not considered to be part of the gains of divorce. Of course, legally the particular retirement fund is the real owner of the member's interest until withdrawal or retirement from that fund.

In the case of pension and provident funds, withdrawal happens when employment ceases. For retirement annuity funds, this applies at retirement or on earlier disability of the member. It can however, be as a result of the untimely death of the member.

The size of these pension interests at date of divorce is often substantial. Severe prejudice has been caused to many spouses, who were unable to share in the considerable value of these funds on divorce. In many cases, the build up of a retirement fund is the biggest asset of the marriage.

The SA Law Commission recognised this inadequacy in the divorce legislation. This resulted in the Divorce Amendment Act (Act no. 7 of 1989) which came into effect on 1 August 1989. The Act deems the pension interest of a spouse to be part of his assets, and therefore part of the patrimonial benefits of a marriage which are subject to a redistribution on divorce.

Pension interest

In relation to a party to a divorce action who is a member of a pension fund (excluding a retirement annuity fund), means the benefit he would have been entitled to if he had withdrawn from the fund (i.e. the benefit due if he had resigned from his employment) on the date of divorce.

Retirement Annuity

in relation to a party to a divorce action who is a member of a retirement annuity fund, means the total amount of all contribution made by the member to fund from his joining the fund to the date of divorce plus simple interest at the rate set out in Section 1(2) of the Prescribed Rate of Interest Act (Act no. 55 of 1975).

The Act applies to all marriages, other than marriages concluded out of community of property after 1984, in terms of which the antenuptial contract excludes community of property, profit and loss and the accrual system. Marriages in terms of antenuptial contracts to this effect completely exclude the sharing by each spouse in the patrimony of the other.

Should the member of a pension or retirement annuity fund therefore die before he retires, the executor of the estate will need to be aware of the possibility that the deceased may have been previously married. Should this be the case, and should the divorce have included a distraction of the pension interest, the former spouse of the deceased could end up being one of the major creditors of the estate.

On the other hand, a person who becomes aware of the fact that a former spouse has died, must ensure that any claim against the estate, for the pension interest that he may be entitled to, is submitted in time.

In 2007 this matter was changed and the spouse of the member has the option to immediately claim the share of the benefits at the time of the divorce.

Where a non-member spouse elects to take the proceeds in the form of a cash sum rather than preservation, the tax liability accrues to that non-member ex-spouses.

This is not treated as the one normally allowed withdrawal against a preservation fund.

As things stand, the change applies retrospectively, to earlier divorces as well.

11.6 Last will and testament

Dying without a will (i.e. dying intestate) can result in a long and drawn out process in trying to determine who will inherit the assets of the deceased person. In order to ensure that the assets go to the person you would wish to see inherit, it is therefore best to make sure that at the time of death a valid will exists.

While a person can in theory leave his estate to any person or institution to whom he may wish, there are certain claims against the estate that will override his wishes.

1. Any creditors of the deceased will be asked by the executor to lodge their claims against the estate. The first and principal creditor will be the Receiver of Revenue to whom all outstanding taxes must be paid before any other payments can be made.
2. A testator (client) has an obligation to maintain and educate his minor children. After the payment of creditors this obligation must be catered for before any legacies and bequests can be awarded.
3. In terms of the Maintenance of Surviving Spouses Act (no. 27 of 1990) a surviving spouse has a claim for maintenance against the estate of a first dying spouse. Should the spouse be excluded from the will they can lodge a claim with the executor for a share of the assets.

This is based on providing for a continued standard of living, similar to that enjoyed before the death of the deceased. Should there be an earlier claim by dependent children these claims will be dealt with at the same time. Where there is a dispute the Master of the Supreme Court will refer the matter to court.

4. Any spouse married in community of property is automatically entitled to a half share of the combined estate. This is not an inheritance, but is considered the surviving spouse's rightful property. Where the couple were married out of community of property, the surviving spouse retains their own assets.

Should the marriage however, have included the accrual system, in accordance with the Matrimonial Property Act the surviving spouse, in the event of disinheritance, will have a claim against the estate for one half of the accrual. A disinherited spouse will be treated as an ordinary creditor and will receive the accrual at the same time as other concurrent creditors, but before any distributions as set out in the will.

An important point to note is the fact that any long term insurance policy that includes a nominated beneficiary will not normally be affected by the terms and conditions of the will or any other testamentary instrument.

11.6.1 Formalities required in the execution of a will

There are certain formalities that must be abided by in order for a will to be considered the valid last Will and Testament of the deceased.

The condition that are explained herein are not only applicable to the will itself; any codicil or amendment to the will must also abide by these same conditions in order for them to be considered as a valid addition or amendment to the will of the deceased. It is always assumed unless the contrary is proved, that any amendment made to a will is brought about after the original will was executed.

(i) The will must be signed at the end by the testor. Should the testator be unable to sign, he may appoint some other person who may sign on his behalf. This other person must however, sign the will in the presence of the testator and can only do so when the testator is satisfied with the contents.

(ii) The signing of the will be the testator (or his nominated representative), must be done in the presence of two or more competent witnesses, who must all be present at the time of signing of the will.

(iii) The witnesses must attest and sign the will in the presence of the testator and of each other. It the will has been signed by another person on behalf of the testator, that person must also be present while the witnesses sign.

(iv) Where the will consists of more than one page, it is necessary that each page (and not only the last page) is also signed by the testator, or his appointed representative.

NB - Whilst it is no longer required that the witnesses attest to and sign every page (other than the last page), there is still a school of thought that recommends that they do so.

(v) Where the testator is unable to sign, he may appoint some other person who may sign on his behalf. Alternatively, he may sign the will by making his mark thereon. Should the will have been signed in either of these manners, it is necessary that a Commissioner of Oaths certifies that he has

satisfied himself as to the identity of the testator and that the will so singed is the will of the testator. The Commissioner of Oaths will be required to sign every page of the will. Certification is only possible where the mark is made by the testator, or where the will is signed by the testator's appointed representative in the presence of the Commissioner of Oaths.

Should the testator die after the will is signed by an appointed representative, or where the testator has only made his mark, a Commissioner of Oaths may still certify the will as being a valid document, provided he can satisfy himself as to the identity of the testator and that the will is, in fact, the last will and Testament of the testator.

It may happen that a person dies before the formalities required for the signing of the will are completed. Provided that a court can then be convinced that the draft document placed before it was intended as the last will of the deceased, the court can instruct the Master to accept the document as the will of the deceased.

11.6.2 Effect of divorce or annulment of marriage on a will

Where a person has a will, and then dies within three months after his marriage was dissolved by either a divorce, or an annulment in a competent court, it is not a foregone conclusion that the ex-spouse will inherit.

The will, will in fact be implemented in the same manner as it would have been implemented if the ex-spouse had died immediately prior to the dissolution of the marriage. It is only where it appears from the will that the testator intended to benefit his previous spouse notwithstanding dissolution of the marriage that the previous spouse will be entitled to benefit.

11.6.3 Maintenance of Surviving Spouses Act no. 27 of 1990

Where a marriage is dissolved by death, the surviving spouse has a claim against the estate of the deceased spouse for the provision of reasonable maintenance until his or her death or remarriage, in so far as the surviving spouse is not able to provide therefore from his or her own means and earnings.

The claim for maintenance by a surviving spouse has the same order of preference as would a claim by a dependent child. It will be treated concurrently and where necessary, the two claims be reduced proportionally.

The executor may if he deems it to be necessary, enter into an agreement with the surviving spouse, heirs and legatees whereby the executor creates a trust, or imposes an obligation on an heir or legatee, for the benefits of the claim of the surviving spouse.

In order to establish the reasonable maintenance needs of the surviving spouse, the following factors should be taken into account:

- the amount in the estate of the deceased available for distribution to heirs and legatees;
- the existing and expected means, earning capacity, financial needs and obligations of the survivor; and
- the standard of living of the survivor during the marriage and his or her age at the death of the deceased.

A **legatee** is a person to whom the deceased has left a specific item or items, or a sum of money, as a specific mention in his will.

A **heir** is a person who has been mentioned in the will as one who is to share in the residue of the deceased's estate after the payment of all debts and legacies.

11.6.4 Entitlement of a surviving spouse and descendants

Should a descendant of a deceased who, together with a surviving spouse is entitled to benefit from the estate of the deceased renounce his right to receive a benefit, the benefit will vest with the surviving spouse. A minor, or mentally ill descendant, will be unable to renounce his right to inherit.

Where it is ruled that a descendant is disqualified from inheriting from the estate of the deceased, the estate will devolve on the basis of the laws of intestate succession as if the descendant had died immediately before the death of the deceased.

Where a descendant of the testator would have been entitled to a benefit in terms of the provisions of a will if he had been alive at the time of the death of the testator, so he has predeceased the testator, the descendants of the descendant will, unless otherwise indicated in the will, inherit his portion of the estate in equal shares.

11.6.5 Interpretation of wills

In the interpretation of a will, unless it is otherwise stated, an adoption child is regarded as being born of his adoptive parents and not of his natural parents.

The fact that a person may have been born out of wedlock is ignored when determining the relationship to the testator.

Should the testator have mentioned his children in his will, it will include all those who are alive at the time of his death as well as any children who may already have been conceived at that time and who are later born alive.

11.6.6 Competency to make a will

Every person sixteen years or older may make a will unless, at the time of making the will, he is mentally incapable of appreciating the nature and effect of his act. The burden of proof that he was in fact mentally incapable, rests with the person making the allegation.

11.6.7 Competency of persons involved in the execution of a will

The following persons shall be disqualified from receiving any benefit from the will.

a. Any person who attests and signs the will as a witness.

b. Any person who signs the will on behalf of the testator.

c. Any person who writes out the will (or any part thereof) in his own handwriting.

d. Any person who is the spouse of such person as mentioned in a, b or c above.

Notwithstanding the above it is possible that, under certain circumstances, the disqualification is set aside and the person will be permitted to receive the benefit.

These special cases are set out below.

a. A court may declare a person or his spouse to be competent to receive a benefit from a will. The court must be satisfied that the person or is spouse did not defraud or unduly influence the testator in the execution of the will.

b. A person or his spouse who, in terms of the law relating to intestate succession, would have been entitled to inherit from the testator of there had been no will shall not be disqualified to receive a benefit from the will. The value that will be received by that person or his spouse is not to exceed the value of the share that person or his spouse would have been entitled to in terms of the law relating to intestate succession.

c. A person or his spouse who attested or signed a will as a witness shall not be disqualified if the will concerned has been attested and signed by a least two other competent witnesses who will not receive any benefit from the will concerned.

It must be clearly understood that the nomination in a will of a person as executor, trustee or guardian is regarded as a benefit and the conditions set out for disqualification would also apply in these instances.

11.6.8 Wills drawn up in a foreign country

Any will executed in a foreign territory will be valid in South Africa, provided that it conforms to the internal law of the state or territory in which it was executed.

It is further necessary that the testator was, at the time of the execution of the will or of his death, domiciled or habitually resident in the state; or must have been a citizen of that state.

These conditions will not apply to a will made by a South African citizen unless the will has been set out in writing.

11.6.9 Summary of the will signing procedure

a. Every page of the will must be signed, or initialled, by the testator.

b. The last page must be signed by the testator and at least two competent witnesses.

c. The will must be dated on the last page.

d. The testator and the witness must all sign at the same time in the presence of each other.

e. Testators must be over the age of 16 years.

f. Witnesses must be over the age of 14 years.

g. People who are named as beneficiaries, executors or administrators, and also their spouses, must no witness a will.

h. Additions or changes to a will must be legible and must be signed in full by the testator in the margin opposite the addition or change. Initials will suffice.

i. Only the original will need be signed.

j. For future reference, record the date of the will on the copy.

11.7 Intestate succession

It fairly often happens that a person dies without having drawn up a will. It is also possible that the Master of the Supreme Court may rule that certain conditions set out in a person's will don't conform to acceptable criteria and he can then declare the will (or a part thereof) to be invalid. When this happens, the deceased is said to have intestate and the Intestate Succession Act no 81 of 1987 (as amended), will determine who will inherit the worldly goods of the deceased once the estate has been wound up.

The conditions of the Intestate Succession Act will only apply in instances where it is not possible to abide by the conditions of the deceased's will. This may be because there isn't one, or because the beneficiary has died before the testator or testatrix, or because the Maset has declared the will, or a part thereof, invalid.

a. Where a person is survived by a spouse, but not by a descendant, the surviving spouse will inherit the entire intestate estate.

b. Where a person is survived by a descendant, but not by a spouse, the descendant will inherit the entire intestate estate.

c. Where a person is survived by a spouse and a descendant-

i. the spouse will inherit an amount equal to the greater of a child's share of the intestate estate or an amount which is fixed from time to time by the Minister of Justice in the Government Gazette, in 2013 this amounted to R125 000;

ii. where the set down amount is greater than a child's share the descendant will inherit the residue, if any, of the intestate estate.

d. Where a person is not survived by a spouse or a descendant, but is survived -

. by both parents, the parents will inherit the intestate estate in equal shares;

i. by one parent, the surviving parent will inherit one half of the intestate estate and the descendants of the deceased parent will share the other half of the estate. Should the deceased parent not have any descendants the surviving parent will inherit the entire estate.

e. Should the deceased not be survived by either a spouse, a descendant or a parent the following will occur:

. the intestate estate will be divided into two equal shares. One half will be shared by the descendants of the mother and the other half will be shared by the descendants of the father;

i. where only one of the deceased's parents left other descendants, those brothers and sisters will share the entire intestate estate.

f. Where the deceased in not survived by a spouse, descendants, parents or descendants of parents any blood relations who are related to the deceased to the nearest degree will inherit the intestate estate in equal shares.

In terms of the Intestate Succession Act, illegitimacy will not affect the capacity of one blood relation to inherit from the intestate estate of another blood relation.

Where, however, a child is adopted, the adopted child is now deemed to be a descendant of his adoptive parent/s and not of his natural parent/s. Therefore, an adopted child will have no claim against the intestate estate of a natural parent, unless the natural parent is also an adoptive parent or was, at the time of adoption, married to the adoptive parent.

In determining the value of a child's portion, one divides the monetary value of the estate by the number of children plus one. The plus one is for the surviving spouse's share, where applicable.

Where the deceased is predeceased by one or more of his children, the share due to the predeceased child shall devolve upon the descendants of that child. Should the child have died, leaving no children, the child will not be included in the determination of the value of a child's portion, and the estate will be shared by the surviving children.

In a situation where an adopted child can only inherit from the intestate estate of an adopted parent, the adopted parent will also be considered to be an ancestor of the child and will be in a position to inherit from the intestate estate of an adopted child should that child die first.

Should a descendant of a deceased who, together with a surviving spouse is entitled to benefit from the intestate estate of the deceased renounce his right to receive a benefit, the benefit will vest with the surviving spouse. A minor, or mentally ill, descendant will be unable to renounce his right to inherit.

If there is no surviving spouse, a descendant is disqualified from inheriting from the intestate estate of the deceased, the estate will devolve as if the descendant had died immediately before the death of the deceased.

Traditionally, the intestate succession did not apply to the black population which provided for the inheritance in terms of their traditional culture, which allows for the inheritance to be limited to males and direct according to the family tree or line.

Polygamous Marriages

A Cape High Court ruling in 2008 concluded that, where a man in a polygamous marriage dies intestate, each of his wives would be able to inherit.

11.8 Further factors affecting estate planning

It is also possible that, as a result of claims against the estate, the executor may not be able to carry out the final wishes of the deceased. Some of these factors will be considered here, particularly where the use of life insurance may assist in avoiding complications.

11.8.1 Claims against the estate

The executor is responsible for the settlement of all the debts that the deceased may have left behind. Should there be insufficient liquidity in the estate, the executor may need to convert some of the assets of the deceased into cash, in order to pay the outstanding debts. This may be to the detriment of the beneficiaries and, therefore, the provision of liquidity needs to be a priority of the deceased whilst he is still able to do so. One must, however, tread with some caution. The proceeds of life insurance policies paid to the estate as beneficiary will, generally, form part of the estate of the estate of the deceased. Therefore, where there is a substantial estate, the proceeds of the policies could increase the estate duty liability of the deceased's estate.

11.8.2 Creation of a testamentary trust

The will of the deceased may make a provision for the creation of a testamentary trust. There are a number of reasons why this may have been done.

a. The beneficiaries may lack the needed business or investment experience needed to continue the operation of the deceased's business. The business is therefore, placed in the care of trustees who will ensure not only the continued well-being of the business, but also the security of the beneficiaries.

b. The deceased may wish to ensure that the assets he leaves behind are passed on the successive beneficiaries, and are not squandered by his heirs.

c. A testamentary trust is probably the most efficient way of passing on assets within an estate to minors, without leaving the assets in the control of an appointed guardian. The assets are placed in the care of the trustees, who ensure that the assets, and/or income, are available for the continued maintenance of the minors until the minors have achieved the required age, at which stage they may inherit. This age (whilst usually age 21) is set by the testator and, on occasion, has been as high as age 45. With the passing of the Children's Amendment Act in 2007, this is likely to tend towards 18 in future.

d. Where the deceased leaves property (like a farm), which is difficult or impossible to divide, the property may be placed in a testamentary trust to ensure the continued operation of the asset. Should there be no trust, the executor may be forced to sell the asset in order to be able to give the heirs their share of the estate, as set out in the will.

11.8.3 Estate planning instruments

Donations

By making a donation of an asset whilst still alive, the planner is able to peg the value of the asset donated at its current value. There are a few facts that need to be considered before this route is taken:

(i) the planner must relinquish the control over the asset. He would therefore, be unable to exercise any direct influence on the management of the asset;

(ii) donations tax will be due upon the value of the donation. A donor may donate an amount of up to R100 000 per annum that will be exempt from donations tax. On any further amount donated in the same year the donor will be liable for donations tax at the current rate of 20% in 2016;

(iii) the donation will be included in the estate of the donor at the value at the time of the donation. Any further appreciation of the asset will happen outside the estate and in the hands of the recipient.

Inter-vivos trusts

The creation of an *inter-vivos* trust occurs during the lifetime of the planner. The planner (creator of the trust) enters into a contract with the trustee/s whereby the creator donates, or sells, certain of his assets to the trust. The trust is set up in order to administer the assets for the benefit of any designated beneficiaries.

The creator will be able to maintain a certain level of control within the trust if he is appointed as a co-trustee. Any appreciation in the value of the assets held by the trust will thereafter accrue to the trust.

Where the transfer of the assets was by means of a donation to the trust, the creator may be liable for donations tax at the time of the donation. The assets will, further, be included in his estate at the value of the donation at the time of his death. The increase that may occur in the growth of the assets may well cancel out any donations tax that may be due, if one considers the amount of estate duty that could be saved.

Selling an asset to the trust does not mean that the trust will need to find the money at the time. The creator can agree that the trust should owe the money to him, payable only upon his death. In the will of the creator, the planner can then make the value of the loan a bequest to the trust.

It is important that the trust provision contain clear instructions with regard to the handling of the assets. Should the creator retain some means of control, whereby he is able to dispose of the assets during his lifetime or at his death, the assets will be included in his estate at their actual value, and the purpose of the trust will have been defeated.

Private companies

A further means whereby the planner of an estate can limit the growth within his estate is by forming a private company. Once the company has been formed, the planner can sell the rapidly growing asset to the company.

The sale con take place on a loan account basis with a reasonable rate of interest being charged. The company then owes the purchase price to the seller, who can make the value of the loan a bequest to the company.

The company, when being formed, may be structured as follows:

(i) 200 non-cumulative, non-profit sharing preference shares at R1 each, held by the planner and

(ii) 100 ordinary shares at R1 each, held by the beneficiaries of the planner.

All shares are to have normal voting rights. The reasons for this form of structure are as follows:

(i) the holder of the preference shares should have no more than 74% of the voting rights within the company. Should he have a greater percentage he would be in a position to increase the number of ordinary shares within the company, and could choose the take some of these up himself. This could affect the value of his preference shares;

(ii) by structuring the company in this manner, the growth of the asses within the company will be attributed to the ordinary share. The growth will, therefore, be for the benefit of the planner's beneficiaries, while the preference shares will only retain their nominal value. Estate duty would be saved in the estate of the planner;

(iii) the creation of the loan account within the company will mean that, while the planner is no longer the full owner of the assets, he will still be in a position to keep control of his sold assets.