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About the authors

Liz Still has written about investments and the medical scheme industry for over 20 years. In 1998, 1999 and 2000 she wrote ‘Profile's Unit Trust Handbook’, a beginner’s guide to unit trusts. As a result of this work she joined equinox.co.za, an online investment company as Head of Research and Web Editor; a position she held for 12 years. This involved interviewing unit trust fund managers and writing about the investing and regulatory environment for the company website. During this time she was also an investment committee member for the Equinox Fund of Funds portfolios and a trustee of the Equinox Retirement Fund.

While studying for her CFP ® qualification she identified a need for a guidebook on the health sector in South Africa and proposed this idea to Profile Media. This gave rise to the publishing ‘Healthcare in South Africa’, an annual handbook now in its 10th edition. Liz is a research and media consultant to selected health sector and wealth group clients and over the years has worked with a leading medical scheme, a hospital group and two asset management and advisory firms. She has also been a television guest on a number of programmes as an independent commentator on both the unit trust sector and the health sector.

This is her first foray into writing about the insurance sector and she has enjoyed it immensely. The CFP qualification was never completed but remains on the ‘to do’ list.

Gareth Stokes is a specialist finance writer who has written on countless topics in insurance and investment. He started his writing career as the managing editor for Fleet Street Publications (FSP) where he produced a number of monthly investment newsletters including the prestigious ‘Zurich Club’ – later ‘SA Investor’ – and the share tipping sheet, ‘Red Hot Penny Shares’. In 2006 Gareth self-published a book titled ‘Fear, Greed and the Stock Market’, which was a basic guide to investing in ordinary equities through the JSE.

After leaving FSP in 2007, Gareth embarked on a freelance writing career. He continued to write extensively for FSP and worked as the first editor of its weekly finance digest, ‘Money Week SA’, which was for a time distributed in hard copy in news agents throughout South Africa. Gareth also worked on the firm’s weekly newsletter, ‘Investor’s Digest’, which shared new ideas in value investing with its subscribers.

Aside from contributing to a number of sponsored features in the Mail & Guardian and BDFM Gareth’s main line of work was with Insurance Publications cc as the editor for fanews.co.za. Over the six years beginning 2007 Gareth contributed between four and seven articles to Insurance Publications cc each week, covering diverse financial services topics under the financial planning, healthcare and insurance disciplines. He also contributed to two fortnightly ‘blogs’ marked at ‘Stokes’ Stage’ and ‘Straight Talk’ where he shared general economic and socio-political views with readers online, often specific to the financial services sector. On the back of this writing Gareth was shortlisted as a finalist, in multiple years and for various categories, in both the Sanlam and Citadel financial journalism awards.

In 2013 Gareth accepted a full time post as the Communications Manager for the Financial Intermediaries Association of Southern Africa (FIA) where he acts as editor, publisher and occasional writer for the intermediary magazine, FIA Insight. He continues to write a regular freelance column in the UK-based risk management publication, Commercial Risk Africa, for which he was recently shortlisted as a finalist in the 2016 Continental Re Pan-African Reinsurance Journalism Awards.
Foreword

There are many news publications that report extremely well on the insurance sector, insurance companies and their financial results and appointment of senior employees. The idea for 'Short Term Insurance in South Africa 2016' was born of the sheer frustration of many unsuccessful searches for an overview, or dashboard view of the industry looking through a multi-decade lens. There was also very little information on the changing market share of short term insurance companies and possible reasons for these changes.

Fulfilling the objective sent Liz Still and Gareth Stokes, the co-authors of this book, on a months-long journey into the world of insurance, insurance companies, insurance brokers and policyholders.

This book is the culmination of many hours of research, and is as thorough an examination of the short term insurance sector as can be fitted into 400 pages. The book is aimed at insurance professionals, financial intermediaries and their clients, consumers and students of insurance. It is written in an easy style that makes it possible for anyone with an interest in insurance to dip in and out of the various chapters at their leisure.

'Short Term Insurance in South Africa' includes chapters on insurance fundamentals; the history of insurance; the business case for insurance; and insurance regulation to name a few. Chapter six provides an overview of the major firms in the South African insurance and insurance broker markets; a task that proved as difficult to research as it was to write. It is the author’s objective that the book should successfully touch on all aspects of the short term insurance landscape, including its history; key concepts and terminology; the business case for insurance; types of insurance; domestic and international trends in insurance; the regulatory environment and much more.

To complete this work the authors have relied extensively on figures published by the Financial Services Board in its annual short term insurance reports; company annual reports and a wide range of online resources. Care has been taken to reference these resources wherever possible.

This book would not have been possible without support from firms in the short term insurance sector and we wish to thank the authors wish to thank the advertisers who made the project possible. Thank you to Aon SA, Allianz, Camargue, Centriq, Discovery Insure, CIB, Global Choices, Guardrisk, Hollard, KEU, King Price, Momentum Short-term Insurance, Mutual & Federal, Oakhurst, Santam and Sasria SOC Limited.

The authors would also like to acknowledge the contributions from a number of individuals who have assisted with advice and guidance in pulling this extensive project together. In alphabetical order, special thanks go to Pieter Aucamp, Peter Atkinson, Brian Benfield, Michael Stoker, Laurian Stokes, Barry Taylor and Prof Robert Vivian. Thanks also to the short term insurer and insurance brokers who participated in the S&S Analytica / Bluestream informal survey on the domestic broker market. Finally, thank you to Lorey Lourens who spent hours on the design and layout of the finished product.

We hope that you enjoy reading this comprehensive guide to the South African short term insurance industry as much as the authors enjoyed writing it.
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SHORT TERM INSURANCE
in South Africa 2016

Liz Still & Gareth Stokes

Published by

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Chapter 1

Insurance fundamentals

The concept of insurance is seamlessly woven into the fabric of modern society. Both individuals and firms go about their day-to-day business without giving their insurance policies more than a fleeting thought, because they are confident these policies will perform when needed.

Although volumes have been written on insurance few authors truly acknowledge the influence that the insurance market has had on the global socio-economic landscape. Insurance, more specifically short term insurance, provides individuals with the ‘peace of mind’ that their personal assets are protected and allows business to prosper in spite of the many risks they face.

But what exactly is insurance? The journey to a better understanding of the world of insurance begins with a simple definition, namely that insurance is the equitable transfer of the risk of an uncertain but measurable loss event, from one entity to another, in exchange for money.

Insurance is sold by an insurance firm (the insurer) and is bought by a policyholder (a person, firm or juristic entity also referred to as the insured). The amount of money that changes hands to secure an agreed sum of insurance cover is called the premium.

Insurance is thus a contract that offers financial ‘security’ for a wide range of risks at an agreed price. It is recognised and valued as an important risk management tool that provides protection for both individuals and firms against financial losses.

A more technical definition for insurance is that of a risk mitigation option that involves risk sharing, or a form of contingent capital that is similar to purchasing an option, in which the policyholder (the insured) pays a small premium to be protected from a potential significant loss.

Insurance is broadly discussed under three headings depending on the nature of the protection provided. These headings include life insurance, medical insurance and short term insurance (also called non-life or property & casualty insurance).

Life insurance
Life insurance centres on a contractually agreed compensation that is payable to the insured (or the insured’s named beneficiaries) following death or an unforeseen critical illness or disability event. This field of insurance is out of scope for this book.

Medical insurance
Medical insurance is a contract between an individual and an insurer to cover the costs of general practitioners, medical specialists and in-hospital treatments. Most medical insurance policies provide cover for the insured and his family who are collectively referred to as beneficiaries.

South Africa (SA) does not follow the global convention of considering medical insurance alongside short term insurance, choosing instead to view it as an entirely separate field of protection under the ‘medial aid’ or ‘medical schemes’ label.

Furthermore, local regulations require medical scheme membership to have a community rated premium. Medical schemes are therefore not allowed to apply commercial underwriting in that they are prevented by law from excluding those who constitute a higher risk to the insurer, for example if they are older, or smokers, or sicker, or play dangerous sports etc.

The South African medical insurance environment is regulated by the Council for Medical Schemes (CMS) while other broad insurance categories fall under the ambit of the Financial Services Board (FSB). Demarcation regulations are being developed to clearly define the roles and accountabilities of stakeholders in the medical schemes versus traditional insurance fields.

Rising private healthcare costs have meant that medical schemes are frequently unable to meet all of their beneficiaries’ healthcare expenses. A number of health insurance products offering a variety of benefits following hospitalisation have sprung up to close this ‘shortfall’. At 30 June 2016 there were four life insurance products and eight short term insurance products that the regulators felt crossed over into the health insurance space. Demarcation will be discussed further in chapter 11, 12 and 13.
Travel insurance, which includes compensation for medical expenses incurred while abroad, is an exception to the rule and is discussed under the short term insurance heading. There are also a number of health insurance products that provide pay outs following hospitalisation that are currently included in the short term insurance product universe.

**Short term insurance**

Short term insurance is designed to compensate an individual, firm or juristic entity for financial losses caused by or consequent to damage or theft to property (buildings, contents, motor vehicles and other assets) following an unforeseen event. It also compensates for other risks such as business interruption, personal and public liability, insurances of the person and health expenses. The short term insurance industry is regulated by the FSB in terms of the Short Term Insurance Act (Act No. 53 of 1998) – the STI Act.

Short term insurance has evolved to compensate firms for a range of non-traditional risks including consequential loss (business interruption cover), loss due to negligence (directors’ and officers’ cover), loss due to certain types of criminal activity (cyber liability cover) and legal liability among others. Types of short term insurance policies will be discussed in detail in chapter seven.

The average consumer should have some knowledge of life insurance products, funeral policies and personal lines short term insurance products. Personal lines insurance provides protection against accidental damage or theft of personal belongings such as a motor vehicles or household contents. It also extends to provide cover for buildings, legal liability, personal death and accident and health expenses.

Insurance companies have spent billions of rand on print, radio and television advertising campaigns over the past decade with the result that personal lines and outlier products such as credit life insurance and legal insurance are also quite familiar domestically.

While the definition of insurance appears quite simple, the workings of the insurance industry are complex. This book will explain short term insurance by firstly examining important concepts in insurance before taking a look at the history of insurance, the business of insurance and the evolution of insurance regulation, among other topics.

### 1.1 Critical insurance concepts

This book would be incomplete without a discussion of two key statistics concepts that are fundamental to the world of insurance, namely the ‘bell curve’ and the ‘law of large numbers’.

**The bell curve**

The bell curve – also called the normal distribution or Gaussian distribution – is the most common type of distribution for a variable. Its name is derived from the fact that the graphical representation of a normal distribution of a variable is bell shaped (refer to figure 1.1).

The bell-shaped structure of the normal distribution was suggested by Abraham de Moivre in 1730. He also discovered the concept of standard deviation, which together with the bell curve makes up the law of averages – an essential ingredient of modern techniques for quantifying risk. The bell curve was popularised by German mathematician and physicist Karl Gauss who used it to analyse astronomical data.
A bell curve can be plotted for virtually any set of data including test scores, repeated measurements of equipment, height of school students in a particular grade or investment returns or short term insurance claims data. Important features of a bell curve include:

- The bell curve for a given set of data has a centre located at the ‘mean’ or ‘top of the bell’;
- A data set’s standard deviation determines how spread out the bell curve is, the larger the standard deviation, the more spread out the curve;
- A bell curve is symmetric and each half is a mirror image of the other;
- A bell curve follows the 68-95-99.7 rule, 68% of the data lies within one standard deviation of the mean – 95% within two and 99.7% within three.

**Case Study**

**Bell curve example**

The following simple case study offers readers a ‘bell curve’ 101. Suppose we consider 1 000 financial advisers who sit the FSB’s Regulatory Examination. Their marks are plotted on a graph with the x-axis (horizontal) being divided into percentages in 10% intervals up to 100%. On the y-axis (vertical) we tally the number of advisers who scored in each results range. If 10 advisers scored between 90% and 100% we mark 10 on the graph etc.

If our mean score is 70 and our standard deviation is 10 we can use the 68-95-99.7 rule to determine that 68% of students (680) would score between 60% and 80% on the test. Two times the standard deviation is 20. If we subtract and add 20 to the mean we have a test score range of between 50% and 90%.

We would expect about 95% of students (950) to score between 50% and 90% on the test. A similar calculation (using three times the standard deviation) tells us that effectively everyone scored between 40% and 100% on the test.

Actuaries use the bell curve to assist with their modelling of the probability of a certain risk event occurring. The extreme events (often referred to as outliers) appear on the far left and far right of the curve because they occur infrequently; with the normal or more everyday risks arranging around the middle of the curve.
The use of bell curves in insurance

Early insurance companies changed how the construction industry viewed the cost-benefit analysis of including certain safety features in buildings. They created actuarial data that encapsulated the likelihood of an event, its potential cost to the building owner and the effectiveness of specific safety features in preventing the event from occurring.

Using this data they could offer a discount on insurance premiums to construction firms and other businesses that implemented the most effective safety features. The construction and insurance industry worked together to create bell curves that showed the risks encountered based on certain practices.

Firms that stayed close to the ‘mean’ or within one standard deviation from the ‘mean’ were seen as operating at an acceptable level of risk. Firms near the edge of the bell curve had unacceptable levels of risk and had to make changes before their insurance cover was put in place.

The law of large numbers

The law of large numbers is a statistical axiom that assists insurance companies in setting appropriate premiums. It states that the larger the number of exposure units independently exposed to loss, the greater the probability that the actual loss experience will equal the expected loss experience.

An alternative phrasing of the law is that the observed frequency of an event more nearly approaches the underlying probability of the population as the number of trials approaches infinity.

The premise this law is based on can be traced back to the mid-1500s but it was only in 1703 that Jacob Bernoulli (1655 – 1705) completed an acceptable mathematical proof. The proof was published posthumously in his ‘Ars Conjectandi – The Art of Conjecture in 1713’, eight years after his death.

It is easier to understand the law of large numbers by using a real world example. Take for example a factory that produces stainless steel pans with each pan exposed to the same risks as it proceeds through the production line.

The chief engineer, based on his observation of numerous pre-production trials, predicts that five pans out of 2,500, the total production per eight hour shift, will fail the factory’s rigorous quality control standards.

A quality controller can therefore expect five faulty pans per eight hour shift, though this is not guaranteed – he might find four, or six or even 15 on a particular shift. What the law of large numbers says is that should he work enough shifts his total experience will trend towards five pans per 2,500.

Insurance companies use the law of large numbers to reduce their risk volatility by pooling a large enough number of policyholders together in an insured group. The size of the insured group corresponds to the predictability of the losses.

By way of an example a motor vehicle insurer that has 1,000 policyholders based in the Johannesburg metropolitan district may predict 10 claims of R 100,000.00 per year. With such a small policyholder base its actual experience might be eight, ten or even 15 claims and its worst case loss could be as much as R 1.5 million (or R 1,500.00 per policyholder).

If the same insurer grows its policyholder base to 10,000 then, by the law of large numbers, its actual claims experience will be much closer to the predicted 10 claims of R 100,000.00 per 1,000 policyholders. So it might experience 95 to 108 claims over the year for a worst case loss of R 10.8 million (or R 1,080.00 per policyholder).

One of the conclusions from the preceding ‘law of large numbers’ example is that volatility risk – or the uncertainty of losses – is higher for a smaller insurance book. Reducing this volatility risk is ‘top of mind’ among insurers.

The more cars insured, the more accurately can be predicted the number of cars likely to be damaged or stolen. It is this aspect of probability theory that enables the insurer to cope with variations in the pattern of expected versus actual losses.

The mechanisms behind short term insurance

How does short term insurance work? An insurance company (the insurer) and an individual or firm (the insured) enter into an insurance contract that states the nature and value of the goods insured, the risks or loss events that are insured against and the premium that will be charged to provide the cover.

The basic premise of short term insurance is that the insured must be placed in the same financial position following a loss event as existed prior to it. This prevents an insured from being unduly enriched following a loss event by
overstating the value of the loss or by attempting to claim for the loss on more than one insurance policy. (Exceptions exist in personal accident and health policies which will be discussed later in the book).

For insurance to work each insurer must hold enough capital to meet its financial obligations to all of its policyholders. An insurer’s capital requirement is met by pooling the premiums contributed by all of its policyholders into a risk pool or float.

If the insurer’s float is too small to accommodate the actuarial modelling of the risk then the insurer will take out reinsurance (insurance for insurers) or part-insure the risk alongside other insurers. The calculation of the capital required is based on comprehensive actuarial modelling that is out of scope for this book.

Why do individuals and firms buy insurance? A policyholder purchases insurance to move from a state of financial uncertainty to one of financial certainty. In so doing the policyholder spreads the risk of a loss amongst a group of like-minded policyholders.

Risk and risk management
Risk, risk management and types of risk are critical concepts to gain a deeper understanding of insurance.

What is risk? In the investment world risk is the chance that an investment’s actual return will be different than expected and includes the possibility of losing some or all of an original investment. A fundamental concept in the investment space is the relationship between risk and return, namely that the greater the amount of risk that an investor is willing to take on, the greater the potential return should be. The reason for this is that investors need to be compensated for taking on additional risk.\(^\text{10}\)

The concept of risk as it pertains to insurance is distinct from the risk that is understood and embraced by investors, though insurance companies also have to understand and quantify investment risk due to the fact that they invest clients’ premiums in the bond and equity markets.

Risk, from an insurance perspective, is best described as the potential of losing something of value. The value that individuals and firms attribute to their assets can increase or decrease based on the risks inherent in certain actions or inactions, whether foreseen or unforeseen.\(^\text{11}\)

It is more common to encounter discussions about risk in the commercial sector. Here risk is generally thought of in terms of any event or trend that could impact on a firm’s ability to carry out its business. Firms should be aware of the risks specific to their operating environments as well as the economic, political and social risks that exist in the broader macroeconomic environment.

Risk management is the practice of identifying, managing, measuring and mitigating risk and has evolved as a discrete field of study and practice. It is fundamental to the insurance industry, from the pricing of individual contracts to the management of insurance and reinsurance companies to the overall regulation of the industry.\(^\text{12}\)

Nowadays firms allocate huge resources to develop risk management strategies to help manage the risks associated with their businesses and the environments they operate in. The objective of risk management is not to eliminate risk and volatility, but to understand it and manage it.\(^\text{13}\)

A firm will start by assessing the various risks that could impact its operations before taking steps both to reduce the chance of the identified risk events occurring and minimise the damage should they occur. Insurance policies are valuable tools used by risk managers to protect their firms from losses that follow from foreseen or unforeseen risk events.

Further comment on the word ‘foreseen’ is necessary at this point because it could be argued that damages due to a foreseen loss event are uninsurable. Although this argument is technically correct the reality is that an insured cannot avoid every foreseen risk. It is also true that foreseen losses have an element of uncertainty to them in both the timing and quantum of the loss.

Instead, both the insured and the insurer have a duty to reduce the likelihood or quantum of loss following a foreseen loss event via a risk management process that is carried out during the assessment and underwriting of the insurance cover. An insurance policy then serves as a safety net for losses that could not be avoided despite the best efforts of all parties.

There are a myriad risks that need to be considered in structuring an insurance policy which vary from one field of insurance to the next and from one insured to another. The risks that insureds will have to be aware of include market risk, credit risk, operational risk, interest rate risk and mortality risk to name a few.

The insured, often with assistance from an insurance broker or representative, must assess the risks that they face to ensure that these risks are included in the insurance policy. The insurer, together with its underwriter, must then assess the risks
proposed by the insured, insurance broker or representative to be placed on cover based on the likelihood and severity of such risks.

It is important for risk stakeholders to also distinguish between the damage caused due to the risk event and the damage caused as a result of it. In the case of a warehouse fire, for example, the loss due to the fire event would include the value of the building and its contents.

The damages consequent to the fire event include the cost of temporarily relocating the warehouse, claims that may arise due to the insured’s inability to meet its contractual arrangements and a variety of costs related to business interruption.

Why is it important for insurance companies to measure risk? The insurance business model is quite simple. The cash collected from policyholders by way of insurance premiums plus the amount generated by way of investment income on the insurer’s capital reserves must exceed the cash paid out to compensate policyholders following loss events and the insurer’s underwriting expenses.

Underwriting expenses include all of the expenses incurred by the insurer in administering and selling its insurance policies.

**Profiting from insurance**

An insurer’s profit can be reduced to a simple equation:

\[
\frac{dy}{dx} = \lim_{h \to 0} \frac{y(x+h) - y(x)}{h}
\]

**Formula for calculating insurer profit**

\[
\text{Profit} = \text{Earned premium} + \text{Investment income} - \text{Incurred loss} - \text{Underwriting expenses}
\]

Insurers face an ongoing struggle to attain a balance between premiums collected, claims paid and underwriting expenses with the remaining margin accruing to shareholders.

There are a number of ways in which an insurer can increase its profit. It could, for example, increase its earned premium by charging policyholders more. This practice does not work in a competitive free market environment and usually results in the insurer losing market share as its policyholders seek cheaper cover elsewhere.

Better alternatives for the insurer include to improve its underwriting practices (the conditions on which the insurer will accept a specific risk) and to invest the premiums they collect from insured parties more efficiently. Insurers care about risk and the management of risk through carefully considered underwriting because it has a direct link to the profits that they generate.

Among the greatest risks faced by short term insurers is that of catastrophic loss, whether due to natural or manmade causes. This risk has increased significantly in recent years due to demographic trends such as urbanisation combined with the increased frequency and severity of natural disasters.

By way of illustration global reinsurer, Munich Re, reported approximately US$90 billion in catastrophe losses – from more than 1 000 events – in 2015, of which US$27 billion was insured. Although this represents the lowest annual catastrophe loss on record since 2009 the inflation-adjusted average for the period 1985 to 2014 is US$130 billion per annum. Insured losses amount to approximately US$34 billion per annum for the same period.

Insurers domiciled in SA are quite fortunate that the country has extremely low natural catastrophe risk when compared with insurers in Asia-Pacific, Europe and the United States.
Counting the cost of catastrophe losses in 2015

Major natural catastrophe events in 2015 include the 25 April earthquake in Nepal – measuring 7.8 on the Richter scale – causing damage estimated at US$4.8 billion. More than 9 000 people lost their lives, 500 000 were made homeless and thousands of buildings were damaged (including many at historically important sites). Global reinsurer, Munich Re, estimates that only US$210 million was insured.

When evaluating the loss caused by a natural disaster insurers differentiate between the total loss (also referred to as economic loss) and the insured loss, the former being the total economic cost of the catastrophe and the latter being the portion of that cost that is insured. There is a wide gap between the total assets in an area versus the total sum insured on those assets.

A number of major weather-related catastrophes that occurred during 2015 were attributed to the El Niño weather phenomenon, which caused drought and heatwaves in South America, Africa and South East Asia. The reinsurer estimates overall losses due to El Niño for the year at US$12 billion, of which only US$880 million was insured.

The relatively low insurance coverage in emerging markets is contrasted by experiences in North America, where the year’s most costly (to insurers) natural catastrophe took place. During February 2015 a series of winter storms in the North Eastern United States and Canada caused overall losses of some US$2.8 billion, of which US$2.1 billion was insured. The reinsurer estimates total losses to the US economy from winter storms in 2014/15 at US$4.6 billion, with US$3.4 billion insured.

Quantifying risk

Having identified the risks facing an individual or firm the focus turns to measuring it. Risk is measured as the expected total cost of an undesirable outcome. To calculate risk the insurer has to combine the probability of various loss events along with an assessment of the corresponding damage for each such event into a single total loss. The formula for ‘measuring’ risk is:

\[
\text{Risk} = \text{Probability of a loss event occurring} \times \text{Expected loss in case of the event}
\]

The risk in more complex situations can be calculated by summing the probability and expected loss for each comparable loss event. As a simple example consider an insured vehicle with a value of R 100,000.00.

If there is a one in 10 chance that the vehicle sustains minor damage of R 5,000.00 following an accident and a one in 1 000 chance that it is totally written off, then the total risk would be calculated as the sum of each probability. So R 5,000.00 x 1/10 + R 100,000.00 x 1/1 000 = R 500.00 + R 1,000.00 = a total loss expectancy of R 1,500.00.

Insurers employ actuaries to do the complex financial modelling required to measure their risk exposures and determine appropriate levels of capital reserves and premiums for the protection of their policyholders. These calculations are out of scope for this book.

It is up to the insurer to estimate the likelihood, frequency and severity of a specific loss event in relation to its insured book, based on past events. This estimation will vary considerably from high frequency low severity loss events such as motor vehicle accidents in a given motor pool to the low frequency high severity failure at a coal-fired power station.

The measurement of risk varies from one insurance stakeholder to the next depending on their respective roles. Regulators and rating agencies focus on the extreme downside of risk, where the very existence of an insurer is in doubt.
An insurance company executive and its shareholders have a greater interest in near-term scenarios and tend to focus on acceptable levels of risk that should yield a certain profit or a manageable loss.

**Risk analysis used in other sectors**

David van Dantzig (1900 - 1959) was a Dutch mathematician who introduced some of the risk analysis techniques commonly used in fields such as nuclear power, aerospace and the chemicals industry. His insurance ‘link’ stems from his work on probability and statistics, specifically on the Delta Works flood protection project in the Netherlands.

The Delta Works is a complex system that consists of 13 dams and 10 250 miles of dykes constructed between 300-plus structures, including barriers, sluices, locks and levees. Work started in the early 1950s and was eventually completed in 1997 at a cost (then) of US$5 billion. It is today recognised by the American Society of Civil Engineers as one of the Seven Wonders of the Modern World.

The project aimed to reduce flood risks following the catastrophic North Sea flood of 1953 which resulted in 1 835 fatalities in the Netherlands and the flooding of 9% of Dutch farmland. Other countries were also severely impacted by the catastrophe. The Delta Works project reduced the probability of a similar flood to a one in four thousand years event.

Van Dantzig’s contribution to the flood control project was as simple as to consider the probability of damage in addition to the cost of damage. Project funding was then diverted to the areas based on both the probability of damage and the quantum of the likely loss following a flood event.

The Netherlands’ flood protection system provides interesting insights into man’s relationship with risk. As early as 1937 the country’s department of public works warned that populations in certain low lying areas were at risk to flooding following high seas or storm; but it took until 1950 for a couple of river mouths to be ‘closed off’ under a project known as the Delta Plan.

The 1953 North Sea floods triggered immediate action. A mere 20 days after the catastrophe a Delta Commission was established to advise on the execution of the Delta Plan, with the Delta Works being one of the results.

**Matching risk to insurance premiums**

All short term insurance premiums are based on an assessment of risk and it is common knowledge that premium and risk are closely correlated.

SA’s Ombudsman for Short Term Insurance explains the trade-off between premium and risk quite eloquently: ‘Short term insurance involves an agreement between an insurer and a policyholder in which the former agrees to insure a risk in return for a premium, the insurer limits its exposure (and the price charged to the insured) by implementing cover exclusions and making the cover dependent upon the terms and conditions of the insurance policy.’

An insurer will begin by establishing a base premium by conducting a study of the claims histories of groups of people with similar characteristics. This claims history gives it an idea of the basic level or risk inherent in that group. It will then vary the base premium for each new policyholder by considering a number of carefully chosen factors in a process known as risk rating.

In the case of an individual insurer wishing to cover a motor vehicle against all risks the following factors might apply: Crime statistics for the insured’s suburb; statistics specific to the vehicle (including anti-theft devices, performance, safety and type); the intended use of the vehicle; the primary driver of the vehicle; the primary driver’s experience; the primary driver’s prior driving offences; the insured’s insurance record etc.

The information requested from the potential insured before issuing cover for a motor vehicle varies from one insurer to the next. If the insured fails to provide honest and accurate information to the insurer, a risk arises that the premium charged for the cover is insufficient. This can result in complications should the insured need to claim against the policy.

Technology has revolutionised risk rating across the insurance segment. One of the best examples of this can be found in the personal lines motor segment where telematics devices are now in common use. A telematics device can be installed in an insured vehicle to provide a continuous stream of information relating to driver behaviour.
This information is assessed by the insurer in ‘real time’ thanks to the processing power and ‘big data’ capabilities of 21st century insurance computer systems. The ability to store, collate and assess terabytes worth of data has made it possible for insurers to risk rate for individuals and distinguish them from the pool by way of their good or bad driving characteristics.

Telematics devices have enabled a range of benefits to both the insurer and the insured. One example is the immediate dispatch of emergency services and insurer-approved tow trucks to an accident scene following a ‘crash detection’ warning from the telematics device. Insurers are also experimenting with influencing their clients’ behaviour through rewards programmes that are in turn linked to telematics data.

### European Court of Justice on gender-based risk rating

A March 2012 ruling by the European Court of Justice (ECJ) determined that insurers, both in the life and non-life sectors, could not differentiate between men and women when setting insurance premiums (performing risk ratings). The ECJ effectively outlawed the use of gender as a risk rating tool from 21 December of that year.

Short term insurers traditionally offered lower premiums to women drivers due to the evidence-based lower risks that they presented. The impact of gender on risk rating, remembering the direct link between risk and premium, is illustrated by the confused.com/Towers Watson 2010 Car Insurance Price Index which is based on observations from the United Kingdom.

At the time the index revealed a 40% gap between the average comprehensive motor vehicle insurance premium paid by men and women drivers in the 17-20 year age group. At December 2010 the average young man was paying GBP 2,976.00 per annum compared to just GBP 1,694.00 per annum for the average young woman.

The ECJ decision accelerated the trend of insurers basing their risk rating ‘engines’ on observations of driver behaviour as measured and monitored by in-car telematics devices. Local insurer Discovery Insure, a relative newcomer to the SA short term insurance market, launched its business on the back of a telematics risk rating model with all of the associated risk benefits.

### The role of actuaries in insurance modelling and forecasting

Assuming its claims experience and operating expenses are within expectations an insurance company can achieve its profit target by simply pricing its policies correctly. It could therefore be argued that setting the insurance premium is the most important component of a short term insurance business.

Insurers employ actuaries to calculate the expected costs for providing cover to a group of insureds by studying the past experience of the current group or a group similar to it. Frequency and severity distributions are derived from past experience to develop a loss distribution or an estimate of how many losses at each level of severity are likely to occur for a given period. A likely claims payment distribution is then extrapolated from this data based on an insurers’ policy provisions.

In their paper on ‘Risk and Insurance’, Judy Feldman Anderson and Robert L. Brown describe the role of an actuary as determining net premiums, gross premiums and the capital the insurer should hold to ensure that claims and expenses can be paid as they arise. They add that the actuary must always reflect on whether past experience can be relied upon as an accurate predictor of likely future outcomes.

Estimates for inflation, interest rates and investment returns are worked into all of the abovementioned financial models based on both past experience and the prevailing economic outlook.

The financial modelling allows the actuary to determine a net premium sufficient to cover the probable claims against an insurer. A gross premium is then calculated to off-set the insurer’s expenses and provide for its anticipated profit plus a margin for unanticipated claims.

Another function performed by the actuary, according to Anderson and Brown, is to determine whether the insurer’s current capital is sufficient for the risks that it has committed to cover. This is a two-step process that begins with an estimate of the capital necessary for a particular insurance cover and then extends to consider the estimated cash flows due to claim payments, premiums collected, expenses and other incomes to ensure solvency at each point in a period.
Risk pooling
There are a number of reasons why an insurer’s actual losses might exceed its predicted losses. Aside from the risks inherent in too small a policyholder base a motor vehicle insurer may, for example, have to pay out multiple policyholders following a freak loss event such as a hailstorm.

Macroeconomic factors outside of an insurer’s control can also wreak havoc on predictions. Short term insurers in SA have recently struggled to keep claims expenses under check due to the severe devaluation of the rand against the US dollar.

Against this trend the predicted cost of each insured event quickly escalates with the result the insurer cannot meet all of its obligations out of the policyholders’ premiums. In such event the insurer has no choice but to service its claims liability out of capital reserves.

Global financial services regulators go to great lengths to ensure that the banks and insurers under their supervision maintain adequate solvency margins. The European Union’s Basel Accords (beginning with Basel I and currently Basel III) and SA’s Solvency Assessment and Management (SAM) regulation are but two examples of the steps that are taken to ensure that financial services firms hold a sufficient margin of assets over estimated liabilities.

The sharing and pooling of risk are important strategies in reducing the need for an insurer to dip into its capital in order to service claims. A number of insurance companies may join forces to form a pool from which similar risks are compensated. This pool of accumulated capital will provide protection to the insurance companies involved in that pool should a catastrophic loss event occur.

The risk pooling concept has its roots in the so-called cooperative pooling that was found in farming communities. If someone’s barn burned down and a herd of milking cows was destroyed, the community would pitch in to rebuild the barn and to provide the farmer with enough cows to replenish the milking stock. The practice has since been formalised in the insurance industry.

This chapter has up until now considered insurance concepts from an insurance company perspective. There are also a number of concepts that apply from the insured’s perspective, beginning with that of insurable interest.

Insurable interest
The concept of insurable interest is central to all insurance decisions. For an insurable interest to exist the insured must derive a financial or other kind of benefit from the continuous existence, without impairment or damage, of the insured object.

The concept is quite clearly illustrated with reference to the short term insurance motor, householders and homeowners policy categories, collectively referred to as personal lines insurance. A motor vehicle owner (policyholder) has a clear insurable interest in the vehicle whether it is owned outright or is being paid for by way of a hire purchase or leasing agreement.

There is a definite financial impact following loss due to accident, hijacking or theft; but the insured also derives benefit from the use of the vehicle for travel to and from work. Likewise if an insured’s home is damaged by fire or flood there is a significant financial impact to repair or replace the premises.

It is wrong to assume that insurable interest attaches to the ownership of the insured goods. In the case of goods in transit a logistics company or warehouse might have an insurable interest in the goods despite not being the beneficial owners. For this reason the definition of insurable interest usually extends to owners, caretakers or those with a direct interest in the insured goods or persons.

It is, for example, possible for a business to take out a key person insurance policy on the life of its chief executive officer. The business does not own the key person but has a direct insurable interest in that person’s continued presence at and contribution to the firm.

Where the owner of a motor vehicle or house has financed the purchase through a hire purchase or home loan the financing institution retains an insurable interest in that asset to the extent of the outstanding capital portion of the loan. It is for this reason that banks often insist that insurance policies are in place as part of the finance agreement.

The following examples illustrated how the insurable interest might pass from the owner of the goods to another party:

- **Risk incidental to transit:** Where a seller undertakes to make delivery of the goods to the buyer, risk attendant to the system of transportation or voyage contemplated may be borne by the buyer or the party responsible for moving and storing those goods, unless the parties agreed to the contrary.
Risk attributable to fault by either party: Any damage or loss which arises as a result of the fault or neglect of the seller or the buyer or their respective agents as the case may be shall be borne by the party at fault.23

Insurability
A number of other measures must be satisfied to make insurance possible, collectively referred to as conditions for insurability. For example, insurance can only be offered when the timing or occurrence of a loss is unpredictable or unknown while both the likelihood and magnitude of the loss need to be relatively predictable. Mehr and Camack’s ‘Principles of Insurance’ identifies seven concepts that describe whether a risk is insurable or not.24

- There must be a large number of similar exposure units: Since insurance operates through the pooling of resources, the majority of insurance policies are provided for individual members of large classes – think motor vehicle insurance – to allow insurers to benefit from the law of large numbers in which predicted losses are similar to the actual losses.

- There must be a definite loss: The loss takes place at a known time, in a known place and it must be due to a known cause. The classic example is the death of an insured person on a life insurance policy though fire, motor vehicle accidents and worker injuries all easily meet this criterion. The time, place and cause of a loss should be clear enough that a reasonable person, with sufficient information, could objectively verify all three elements.

- The loss must be sudden, accidental and unforeseen: The event that results in a claim should be sudden (to eliminate deterioration due to wear and tear), accidental (outside the control of the beneficiary of the insurance cover) and unforeseen (impossible to predict with any real certainty). Life insurance is slightly different in this regard because death is foreseeable, only the timing is unpredictable.

- The loss must be large: The size of the loss must be meaningful from the perspective of the insured. Insurance premiums need to cover the expected cost of losses and the cost of issuing and administering the policy, adjusting losses and supplying the capital needed to reasonably assure that the insurer will be able to pay all claims.

- The premium must be affordable: If the likelihood of an insured event is so high, or the cost of the event so large, that the resulting premium is large relative to the amount of protection offered, then it is not likely that the insurance will be purchased, even if on offer.

- It must be possible to calculate the loss: The probability of a loss and its attendant cost must be at least estimable or calculable. Probability of loss is generally an empirical exercise while cost has more to do with the ability of a reasonable person in possession of a copy of the insurance policy and proof of the loss associated with a claim presented under that policy to make a reasonably definite and objective evaluation of the amount of the loss.

- There should be a limited risk of catastrophic losses: Insurable losses are ideally independent and non-catastrophic, meaning that the losses do not happen all at once and individual losses are not severe enough to bankrupt the insurer.

The insurability debate extends to the insurer which must be able to charge a premium high enough to cover both claims expenses and the insurer’s operating expenses. On the flipside of insurability, we have un-insurability.

Risks that are too large cannot be insured because it would not be feasible for the insurer to offer cover at an affordable premium. It is also not possible to insure a risk if it cannot be quantified at policy inception as an insurer cannot calculate an appropriate premium for an open-ended liability at some future date.

Insurance law and the contract for insurance
SA’s insurance law is a combination of rules peculiar to insurance; rules applicable to all contracts (the law of contracts); and general contractual rules relevant in the insurance context.25

South African insurance law is governed predominantly by Roman-Dutch law with English law having a ‘strong persuasive authority’. In respect of contracts English law has no binding authority although it has been argued that many principles of English insurance law are still being adhered to today.26

This book will not focus on insurance law as there are numerous excellent texts dedicated to the topic. It makes sense, however, to include a brief discussion on the conclusion and consequences of insurance contracts.

A contract for insurance is an undertaking between an insurer and an insured. In terms of this contract the insurer offers a level of cover at an agreed premium, subject to a range of exclusions and endorsements, which the insured agrees to be bound by. More specifically it is said that a contract for insurance exists once the insurer and insured have agreed on the
person or property to be insured, the event insured against, the period of insurance and the amount of the premium. These ‘essential’ components were confirmed by the Court in *British Oak Insurance v Atmore (1939 TPD 9)*.

The insurance contract is set down in writing and delivered to an insured as an insurance policy or insurance policy wording which is often accompanied by a policy schedule (a brief summary of the contract). It is important to note that the policy is the only evidence of the contract which is actually formed by a combination of the quotation and correspondence related thereto as well as the application form and occasional communication between insurers and insureds referring to special terms and conditions arising from the underwriting.

The insurance contract is the product that an insurer ‘sells’ to the end-consumer and contract certainty is therefore fundamental to doing business in the short term insurance sector. SA’s short term insurers have created and applied various base contract wordings over time, including the standardised multi-peril Multimark policy wordings which appeared in the commercial insurance market in 1987. Insurers derived their own policy wordings – often quite similar to the Multimark wordings – when that policy was retired in 2007.

### Multimark standard policy wording

A major milestone with respect to the design of insurance contracts in SA was the 1987 introduction of the Multimark policy. Multimark offered a standardised policy wording that included multiple classes of insurance. The policy wording was relevant to all insurers active in the multi-peril commercial insurance market, with individual insurers able to amend the covers contained therein by way of endorsements.

Although there was no requirement for its use the Multimark framework was used extensively by insurers. It was updated over the years via the Multimark II and finally Multimark III policy wordings. The Multimark framework made way for a Standard Business Policy Guidelines (SBPG) document – from which individual insurers developed their own policy wordings – in 2007.

It was then that the South African Insurance Association (SAIA) decided to discontinue the in-force Multimark III policy due to concerns that a market agreed wording contravened section 4(1)(b)(i) of the Competitions Act (Act No. 89 of 1998) – the CPA Act. The CPA Act prohibits agreements between or concerted practices by competitors regardless of the pro-competitive or efficiency benefits it may bring.

SAIA is the representative body of the South African short term insurance industry and will be discussed in more detail in chapter 13. At 30 June 2016 the association had 59 members comprising all categories of short term insurers, including reinsurers.

Today SBPG forms the basis for most commercial policies while an alternative approach referred to as the buildings combined model is more appropriate for smaller firms.

The discussion of many short term insurance concepts differs slightly with context. A common division in the South African market is between personal lines insurance (insurance aimed mainly at individuals) and commercial or corporate insurance (insurance for firms and other juristic entities).

It is often claimed that the concept of a personal lines multi-peril policy, a Multimark-type policy for individual insureds, was invented in SA. A personal lines multi-peril policy provides different types of standard insurance cover under a single policy with a single combined premium. So, for example, the policy might include a combination from personal motor, homeowners, householders, all risks, personal accident and personal liability.

The policy wording may also include non-contractual information by way of disclosures required by the Financial Advisory and Intermediary Services Act (Act No. 37 of 2002) – the FAIS Act. The disclosures that should be included alongside the insurance contract are set out in the General Code of Conduct, which is subordinate legislation to the FAIS Act. These disclosures are not viewed as part of the insurance contract. These disclosure requirements are discussed in more detail in chapter 11.

### Plain language

The modern insurance legislation has evolved with consumer protection as its central focus. In SA this evolution has culminated with the inclusion of the principles-based Treating Customers Fairly (TCF) regulation. TCF requires that six principles or outcomes guide the interaction between product suppliers, financial services providers and their clients within the broader financial services environment.
TCF should be viewed alongside the general legislation aimed at ensuring consumer protection, most notably the Consumer Protection Act (Act No. 68 of 2008) – the CPA. Together these Acts champion the use of consumer-friendly ‘plain language’ in contracts between insurers and the insured. The idea is that policy wordings do away with the technical jargon so often associated with the industry.

A second requirement of the consumer protection legislation is that exclusions and limitations of liability in the insurance contract are explicitly brought to the policyholder’s attention. Insurance companies have a responsibility to ensure that their policyholders’ expectations of cover are met and must accept responsibility for the products they offer.

Local short term insurers have already worked certain of the plain language requirements into the sector’s Policyholder Protection Rules (PPR) which is a subordinate legislation to the STI Act.

The PPR requires that policy wordings be available in the most commonly spoken languages, free from excessive insurance jargon. It also suggests the use of ‘easy to read’ marketing material to explain restrictions, exclusions, warranties and the scope of cover in plain language.

While policy wordings can be communicated in plain English it is clear they can never be totally simplified.

**Proximate cause**

The insurance contract is an agreement between the insurer and the insured in which the insurer indemnifies the insured from losses caused by clearly defined risk events. It makes sense therefore that determining the actual cause of loss or damage is fundamental to resolving a claim in terms of this contract.

Proximate cause is a key principle of insurance and is concerned with how the loss or damage actually occurred and whether it is indeed as a result of an insured risk.\(^\text{27}\) It is defined in English law in the case *Pawsey v Scottish Union & National Insurance Company* (1908) as ‘the active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any new or independent force’.\(^\text{28}\)

In layman’s terms proximate cause is that event that leads to the event that causes the loss or damage. Unless the insured can demonstrate proximate cause the insurance contract cannot perform.

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**Case Study**

Bill is a senior executive at a photocopier manufacturer. His boss falls ill and Bill agrees to stand in for him at a presentation to an important customer. He arrives at the customer’s office to find that he has left his presentation slides at his desk. He rushes to his car and races back to retrieve the slides. On his drive back he makes a call to his colleagues via his hands-free phone to let them know he is running late for the presentation. A few minutes later, and within sight of his office, a dog walks into the road. Bill swerves and his car leaves the road before coming to rest against a tree with significant damage. Bill puts in a claim for the damage caused to his vehicle due to an accident. What caused the accident and is the subsequent damage covered under his comprehensive motor vehicle insurance policy?

1. Agreeing to stand in for his boss;
2. Leaving the presentation slides at the office;
3. Driving back to the office to retrieve the presentation slides;
4. Placing a telephone call while driving back to the office;
5. The dog walking across the road;
6. The evasive action that Bill takes to avoid hitting the dog; or
7. The collision of the motor vehicle with the tree.

Points one through four are easily dismissed as remote causes that have little, if anything, to do with the accident. These points may have set in motion a chain of events but cannot be considered the proximate cause due to new and independent events occurring subsequently. Even point five cannot on its own have caused the incident either, as it is followed by a new and independent event, being Bill’s evasive action.

The proximate cause in the above example is found in point seven (the closest event to the damage), namely the physical impact of the motor vehicle with the tree. There would have been no damage to the vehicle were it not for

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\(^\text{27}\) It is defined in English law in the case *Pawsey v Scottish Union & National Insurance Company* (1908) as ‘the active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any new or independent force’.\(^\text{28}\)
this event. Having identified the proximate cause the focus turns to whether the policy provides cover for accident-related damage to the vehicle and whether any other policy exclusions apply.

Examples from offshore insurance cases provide additional insight. In *Roth v South Easthope Farmers’ Mutual Insurance Co. (1918)* lightning damaged a building and weakened a wall. Shortly afterwards, the weakened wall was blown down by high winds. Lightning was considered to be the proximate cause.

And in *Gasgarth v Law Union Insurance Co. (1876)* fire damaged a wall and weakened it. Several days later a gale blew down the weakened wall. It was held that fire was not the proximate cause in this case. The length of time elapsed following the event and the loss event makes the world of difference.

It is worth noting that the proximate cause need not be the last item in a series of events. If in the previous example the tree had fallen over following the accident and caused damage to a neighbouring building, the proximate cause would still be the car hitting the tree – and not the tree hitting the building.

The burden of proof following a proximate cause lies with either the insured or the insurer and depends on what aspect of the policy is under review. It is up to the policyholder to prove or demonstrate that an insured risk such as accident or theft was the cause of the loss or damage for which a claim is submitted. The insurer, meanwhile, has to demonstrate or prove the exclusion that it relies upon to repudiate the claim.

An exception to the above is found in the All Risks policy space where the insured does not have a burden of proof relating to the cause of the damage to an insured item. The burden of proof then falls upon the insurer, which will have to determine the cause of the loss in order to apply its exclusion.

**Moral hazard and adverse selection**

Insurance companies face a number of risks that relate to human behaviour. Moral hazard and adverse selection are two such examples that also occur in the fields of economics and risk management. In either case one party (the insurer) is disadvantaged due to the behaviour of the other (the insured).

Moral hazard stems from a change in the insured’s ‘character’ after the contract of insurance is concluded. It is closely linked to the type of insured asset and the extent of the possible loss or gain to the insured following a loss event.

There are countless examples of business owners torching their premises during times of hardship in an attempt to win a quick settlement from their insurer. Likewise many insureds damage their personal assets to abuse discrepancies between the insured and economic values of said items. It is thus clear that an immoral act by an insured – a moral hazard – can increase both the frequency and severity of loss due to an insured risk.

Insurers can sidestep moral hazard at the underwriting stage by insisting on tough exclusions on the type of assets they will insure. They may, for example, insist on audited books before insuring a business as a going concern or refuse to insure vacant and unoccupied buildings for fear of the insured intentionally setting fire to these premises to obtain an insurance recovery.

Moral hazard can even arise as a consequence of insurance! For example, a homeowner might take fewer precautions against storm and flood damage if he or she is secure in the knowledge that any damage subsequent to an extreme weather event will be covered by the insurer.

Adverse selection occurs when the insured has more knowledge about the risk factors it faces than the insurer. An insured may, for example, know of some latent defect in an asset that would increase the probability of its failure and neglect to mention this fact to the insurer. The asymmetry of information would lead to an incorrect pricing of the risk to the insured’s benefit and to the insurer’s detriment.

Adverse selection is also referred to as anti-selection and is a common feature in the life insurance and medical insurance industries. To illustrate by way of example consider the case of a smoker and a non-smoker who enter the market for a life insurance policy. It is common knowledge that mortality rates for smokers are poorer than those for non-smokers with the result insurers charge a higher premium to smokers, all else being equal.

In the event the smoker lies on his application for cover, by stating that he does not smoke, he will benefit from the same low premium as the non-smoker. The insurer is disadvantaged by the resulting adverse selection – the incorrect pricing of premium for a known risk. Adverse selection also affects consumers because the smoker achieves more value from his premium relative to the non-smoker.

Neither moral hazard nor adverse selection can be overlooked in insurance and should be considered when conducting a risk assessment.
1.2 Terminology for 21st century insurance

The insurance policy

The insurance policy – also referred to as the policy wording – is an integral part of the contract for insurance. Most insurers have detailed standard policy wordings that can run into hundreds of pages. The insurance policy sets out the conditions, exclusions and terms that make up the agreement between the insurer and the insured.

The insurance policy is accompanied by a policy schedule which ‘personalises’ the insurance policy by identifying the insured (who is covered) and the insurer (who provides the cover) and describing specific risk parameters.

The policy schedule additionally notes the type of insurance, the period of insurance, the limits that apply, the sums insured and the excesses that apply to specified sections of the policy. It also notes the premium due per insured line and in total.

Additional clauses, exclusions, warranties or endorsements that are unique to the policyholder may also appear in the policy schedule though they are frequently attached as endorsements to the schedule.

The schedule is not a standalone document and should always be read in conjunction with the policy wording. It is common practice that the information supplied by the insured during the underwriting process (whether in writing in the application for cover or by way of a voice-recorded telesales call), the policy schedule and the policy wording are considered collectively when examining the contract for insurance.

The principle of indemnity

There are two main methods that a short term insurer applies in determining the appropriate value of a loss, namely indemnity or reinstatement.

The principle of indemnity applies to categories of short term insurance policies where an insurer agrees to compensate an insured for the losses or damages suffered by the insured due to specified loss events.

Indemnity is a fundamental principle of short term insurance and requires that the insured be returned to the same state financially (after the application of excess or other contractually agreed deductions) that he or she was in prior to the loss event, immediately following it. The principle further holds that the insured may not profit from an insured loss.

Under indemnity insurance the event insured against is uncertain and must occur in order for the loss to be determined. An insurer will compensate the insured following receipt of a claim against the insurance policy. This compensation, also called a settlement, can be made by way of repair, replacement or the payment of a cash sum.

The principle of indemnity is meant to be settled on a ‘like for like’ basis with the result that the insurer and insured often ended up in disputes over the fair value of old equipment due to allowances for depreciation and wear and tear. To pre-empt such disputes personal lines insurers introduced a ‘new for old’ clause in their policies, whereas commercial insurers introduced a reinstatement value condition or reinstatement value condition clause.

Indemnity does not apply in the health and accident insurance categories or in the life insurance world where the concept of capital or non-indemnity insurance applies. In such cases the insurer agrees to pay a specified amount, whether by way of a lump sum payment or recurring monthly payment, upon the occurrence of an event. An example is an income protection policy that agrees to compensate the insured R 20,000.00 per month until retirement following his or her permanent disablement.

Non-indemnity insurance usually relates to the person of an insured or a third party, more specifically providing cover for that person’s life, health of mind and health of body and limbs. In such cases there is certainty that the event insured against will occur but the timing is uncertain. The settlement amount is predetermined and is unrelated to the loss suffered.

Contribution and subrogation

There are two insurance principles that apply alongside that of indemnity. Contribution is applicable in situations where there are two or more insurance policies covering the same asset requiring the insurers concerned to share the cost of the indemnity payment. In order for contribution to apply the following must hold: Each of the policies must be a contract of indemnity; each of the policies must be issued to the same party who must have an insurable interest in the goods; and the peril causing the damage must be the same.

Subrogation is an insurance principle that allows an insurer to stand in the place of the insured and avail itself of all legal rights and remedies of the insured to recover damages from a third party. This principle reinforces the indemnity
principle by allowing the insurer to attempt to recover any payment that it has made in honouring its contract of indemnity with the insured from the third party or parties that contributed to the loss.

The same principle enforces the insurer’s right to claim against the insured so as to ensure that the insured does not benefit from a double recovery following a claim. It would be wrong, for example, for the insured to start recovery proceedings against a third party having already received full compensation for his or her loss from the insurer.

A few rules for subrogation include that the insured cannot make a profit out of a loss by recovering it twice, that the insurer cannot recover more from the third party than what it paid to the insured in settlement of the claim and that subrogation only applies to contracts of indemnity.

**Editor’s note**

The easiest way to describe subrogation is to consider a motor vehicle accident between an insured and a third party. In this case assume that the accident was caused by the third party, who skipped a red traffic light in full view of a number of witnesses. The insured holds a comprehensive motor vehicle insurance policy with Insurer A which includes a subrogation clause.

Following the accident Insurer A compensates the insured for the damage to his or her motor vehicle. This means that the insurer has upheld its responsibility in terms of the ‘contract for indemnity’ that it has with the insured. Because the insurance policy includes a subrogation clause the insurer now has the rights to pursue the third party to the accident for the amount that it paid to settle the insured’s claim.

The application of the principle of subrogation is one of the main reasons that insured’s are told not to admit liability following an accident, because in doing so they may affect the insurer’s subsequent attempts to recover monies from the third party.

**New for old**

The ‘new for old’ concept applies to the buildings and contents insured under a personal lines policy as well as to buildings, equipment, machinery and other specified assets insured under sections of commercial insurance policies.

If a policy includes a ‘new for old’ clause then an insured item will be replaced with a new item, regardless of age, following theft or damage that renders the asset beyond repair. For example if you television is destroyed by a lightning strike the insurer will replace it with a brand new equivalent model. The compensation paid by an insurer following loss or damage to goods is stipulated in the policy wording and / or policy schedule.

The term ‘new for old’ does not necessarily appear in modern policy wordings. Instead insurers indicate that the amount of compensation will be based on the replacement value of similar new goods.

Parties to the insurance policy accommodate this arrangement by making sure that the insured values stated on the policy schedule are always accurate. The insured can make an annual adjustment to sums insured on household contents, for example, which adjustment should be a reasonable estimate of the replacement value ‘new for old’ of the household contents.

It can be argued that the ‘new for old’ concept contributes to moral hazard, but for the most part this issue is dealt with via sound underwriting practices at policy inception.

An example from the short term insurance market where ‘old for new’ does not apply is the tyre replacement policies sold at tyre fitment centres countrywide. These polices adjust compensation for damaged tyres based on the “wear and tear” of the tyre per the policy conditions and terms.

**Aggregation of claims**

Aggregation of claims (AOC) is a mechanism whereby an insurer with an indemnity limit on a ‘per claim’ basis can minimise its exposure to numerous related claims being made against it. Without an aggregation clause an insurer would have to pay in respect of each similar claim even if its total exposure exceeded the sum insured under the policy as a result.

Although more frequently encountered in the life insurance industry AOC is relevant to short term insurers that cover liability, including professional indemnity policies and most broad-form liability policies. How is AOC applied? It helps if we begin with the ‘why’ first.
Take for example a professional indemnity policy with a maximum limit of R3 million for any one claim. Now imagine what would happen if the policyholder were to face eight separate claims for ‘negligent advice’ totalling R 800,000.00 each. The insurer in this case has a potential exposure of R6.4 million on a policy that was priced for a maximum of R3 million in claims.

The aggregation clause ensures that an insurer does not incur a liability greater than it intended by treating the eight separate claims as one claim limiting the insurer in this case to its R3 million AOC policy limit. The treatment of separate but related claims is done in accordance with the aggregation clause as contained in the policy wording.

An aggregation clause could include all claims arising out of ‘any one act, error or omission’ or ‘out of any one event’ or ‘any one occurrence’ on the one hand versus all claims arising ‘directly or indirectly out of the same original cause or source’ on the other.

It is most likely that the aggregation clause will apply in the determination of excess. The treatment of excess in this regard can lead to a form of arbitrage wherein the insurer resists aggregation for multiple small claims to claw back an excess from the insured in each case. The insured will in turn argue for aggregation. The converse holds for multiple related large claims.

There is no need for an aggregation clause where a policy limit is written as an annual aggregate, though there may still be a clause to govern whether one or several excesses are payable in the case of related claims.

**Policy exclusions and endorsements**

Policy exclusions refer to any events, losses or damages that are not covered on the insurance policy. Exclusions can be quite exhaustive and vary from one insurer to the next, as well as from one type of insurance cover to the next. Exclusions – sometimes referred to as exceptions – are noted in the policy wordings, but can appear in the policy schedule too.

An insurance policy will contain general exclusions that apply to the entire insurance contract and specific exclusions that apply only to sections of cover. An insurer might exclude any loss caused by a specific risk event, such as loss or damage due to political riot, or it may specify an omission or commission by the insured that would render a claim on the policy void. The following are some examples of general exclusions that might appear in an insurance policy:

- **Confiscation by authorities:** An insurer will not compensate the insured for losses due to confiscation of their goods by lawful authorities.
- **Consequential loss:** An insurer will not usually compensate for loss that is consequential to the insured loss. For example, the insurer will compensate for the damage caused by a motor vehicle accident but not the loss of income due to the insured missing a paid-for presentation.
- **Events deliberately caused:** For obvious reasons the insurer will not compensate the insured for any loss or damage caused by deliberate actions by the insured or any person on the insured’s behalf.
- **Fines and penalties:** An insurer will not be held liable for punitive damages, fines or penalties that the insured is held liable for.
- **Fraud, dishonesty and misrepresentation:** An insurer will not pay if there is evidence of fraud, dishonesty or misrepresentation by the insured and can in fact claim back monies paid out on claims that are subsequently found to be dishonest.
- **Gradual deterioration:** The policy excludes losses arising out of progressive or gradual deterioration. Returning to our example of a combustion engine the insurer would be within its rights to refuse cover for mechanical breakdown if it determined that the engine manufacture’s maintenance schedule was not followed.
- **Reasonable foreseeability:** There is no cover for liability arising out of acts which the insured could reasonably have foreseen would lead to a claim. For example if an insured chose to run an internal combustion engine knowing full well that its cooling system was inoperable and that this would result in overheating and possible seizure.
- **Third party infrastructure failure:** There is generally no cover for liability arising out of the failure of third party equipment which is not under the insured’s control – this applies to both electrical and mechanical failures. The best example of this type of exclusion would be an insurer’s refusal to pay a claim due to loss or damage following a utility-based electrical outage.
War, riots, labour strikes or terrorism: Most South African insurers include a general exclusion for loss or damages suffered due to war, riots, labour strikes or terrorism. Special risks insurer Sasria SOC Limited offers coupons to cover such risks. These coupons are sold separately to the policy of insurance but will be indicated in the policy schedule.

Editor’s note
This book does not set out to describe all of the possible exclusions for every type of short term insurance policy. To do so would be virtually impossible. Some of the exclusions will be mentioned in this chapter, while others will be discussed in chapter seven where types of insurance are examined in more detail.

Endorsements are added provisions to an insurance policy that change the policy’s terms or conditions. An endorsement can be initiated by an insurer to change or vary the cover offered under a section of the policy – or it can be prompted by the insured by way of a request to add or remove items from the policy or change their values.

Endorsements are usually included as additional pages appended to the policy schedule which must in turn be read in conjunction with the policy wording. Common types of endorsements are those that add coverage for special events, name additional parties to the policy or restrict coverage based on specific criteria.

An insured can, for example, add a named driver to his comprehensive motor vehicle insurance policy, which would be completed by way of an endorsement to the policy. Endorsements are legally binding changes to the insurance policy and copies of these endorsements should be kept with the policy schedule.

Onus of proof
It is a general legal requirement that the insured must prove that a particular loss event is covered under the insurance policy. In the event the insurer refuses the claim in terms of one of its policy exclusions, then it is up to the insurer to prove the events that fall under this particular exclusion.

For a practical example of ‘onus of proof’ consider the policyholder that crashes their comprehensively insured motor vehicle on the way home from a late night corporate function. In submitting the claim to the insurer the policyholder provides proof of the accident in the form of a case number obtained from a local police station following the accident.

The case number alongside the insurer’s claim form and subsequent assessor’s report is all evidence in support of the insured’s claim. Such accident is covered under the policy and the insured will have to treat and honour the claim as valid.

If, however, the insured wishes to refute the claim based on a suspicion that the insured was driving under the influence of alcohol – a valid exclusion on the policy – then it will have to be able to prove this suspicion beyond a reasonable doubt.

There is an exception to ‘onus of proof’ in the general insurance environment. If an insurer refuses a claim based on its riot, war or nuclear disaster exclusions then it is up to the insured to prove that the claim was not due to an excluded event. Ironically the situation reverts to normal when dealing with SA’s special risks insurer, Sasria SOC Limited, where the ‘onus of proof’ with regards exclusions once again falls upon the insurer.

The application of excess
An excess, also referred to as the ‘deductible’, is the first amount payable by an insured in the event of the claim. It is a vital component of modern insurance policies because it is treated by the insurer as an uninsured portion of the risk.

The insurer by its application of the excess clause effectively transfers a portion of the risk that it would otherwise have to carry, to the insured. An excess may be used to eliminate minor losses that are uneconomical for the insurer to process or to give the insured a financial interest in not claiming. The policyholder is responsible to pay the excess at the time of claim settlement and often pays this amount to the company that is providing the repair or replacement on the insurer’s behalf.

Excess has evolved into a valuable tool used by insurers to offset higher risks, particularly in the field of motor vehicle insurance. Consumers experience this risk offset as a reduction in premium and are often unaware that the lower price has consequences.

A thorough understanding of the excesses applied to an insurance policy is necessary to make a like for like comparison between one insurer’s premium and the next. If Insurer A and Insurer B both offer a comprehensive premium of R500 per month for motor vehicle C, but Insurer A’s excess for a total loss is R 2,000.00 and B’s is R 3,000.00 – then all else being equal the insurance cover offered by Insurer A is better value!
It is not uncommon to find multiple excesses in motor vehicle insurance policies including a general (or first) excess, an excess for drivers under the age of 25, an excess if the driver has held a license for fewer than two years etc.

**Underinsurance**
It is imperative that the policy schedule reflects an accurate and up to date replacement value for all assets on cover under the policy. A failure in this regard will result in the policyholder being underinsured and the average clause being applied in the event of a claim.

In layman’s terms should an underinsured policyholder suffer a loss and subsequently claim from the insurer for this loss, the insurance pay-out will be less than the cost to replace the item. The same holds true for insurance pay-outs for repairs to damaged items due to the compensation being reduced by the principle of average (discussed below).

**The principle of average and the average clause**
A short term insurance policy usually includes a general average clause to indemnify the insurer should the value of an insured item at the time of the loss turn out to be greater than that stated by the insured or insurance broker on the policy schedule.

A general average clause reads as follows: 'If the property insured is, at the commencement of any damage to such property by any peril insured against, collectively of greater value than the sum insured thereon, then the insured shall be considered as being their own insurer for the difference and shall bear a rateable (proportional) share of the loss accordingly. Every item, if more than one, shall be separately subject to this condition.'

In plain English – if the value of the insured property (whatever it may be) at the time of the loss or damage is greater than the sum insured as reflected on the policy schedule then, in the event of a total loss, the pay-out is limited to the sum insured.

In addition any claim for a partial loss will be borne proportionally by the insured in line with the percentage of the underinsurance. The average clause is applied per the ‘principle of average’ or ‘law of average’. It is applied to prevent underinsurance, to ensure that the insurer receives a full premium for the risk it carries and to ensure fair outcomes for insured and insurers in that each party accepts a fair share of each loss.

The average clause is included in policy wordings as a specific condition for all policies in the fire and associated perils class including fire policies, buildings combined, office content, business interruption, homeowners, householders and certain accident policies such as business all risks. It also applies to general unspecified items with a collective sum insured, personal all risks and electronic equipment.

The average clause does not apply to motor vehicle insurance, medical gap cover and legal liability among other short term insurance classes, nor does it apply to policies that are written on a ‘first loss’ basis or for assets that are insured on an ‘agreed value’ basis. Readers should note that the average clause only comes into play when a partial loss occurs. A total loss will simply be compensated according to the sum insured as specified on the policy schedule.

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**Case Study**

**Illustrating the average clause**

To illustrate consider a set of drums insured by a musician on a personal all risks policy for R 140,000.00 a value provided by the insured to the insurer and recorded as such on the policy schedule. The drum kit is damaged while in transit and the musician receives a bill totalling R 40,000.00 to repair it.

Upon assessing the claim the insurer determines that the true replacement cost of the drum set is R 200,000.00. (It should be noted here that the insurer calculates the replacement value of the policyholder’s personal goods as the cost to replace like-for-like with a new item).

The drum set is underinsured by 30%, calculated by the dividing the difference between the sum insured and the replacement value (R 200,000.00 – R 140,000.00 = R 60,000.00) by the actual price (R 200,000.00). Due to the 30% understatement of the insured value the insurer will apply the average clause and reduce its pay-out by the same percentage. The insured will thus only receive R 28,000.00 (R 40,000.00 less 30%, or R 12,000.00) as compensation for the damage to the drum set.

Had the entire drum set been stolen while in transit the insurer would have settled the total sum insured of R 140,000.00, leaving the insured to make good on the remaining R 60,000.00.
Shared liability, apportionment

Determining liability following a multi-vehicle accident presents challenges for insurers. Under the common law South African insurers relied on a ‘last opportunity rule’ which held that the person who had the last opportunity to avoid the accident was totally liable for the resultant damage.

By the 1950s it was clear that the rule was unsuitable so the Apportionment of Damages Act, 1956 (Act No. 34 of 1956) – the AOD Act – was passed. The AOD Act stipulated methods for the apportionment of damages in proportion to the perceived fault of each individual involved in an accident. It is clearly stated, however, that the Act cannot operate to defeat any defence arising out of contract – nor can it be relied upon to increase the amount of damages beyond any maximum prescribed by agreement or law.

To understand the Act one must first consider the concept of contributory negligence, defined as a doctrine of common law in which if a person suffers damages in part due to his or her own negligence, the injured party would not be entitled to collect any damages from another party who supposedly caused the accident. While other jurisdictions have replaced contributory negligence with a comparative negligence test, SA has instead included provisions for the ‘apportionment of liability’ in cases of contributory negligence.

From Chapter 1(1)(a) of the AOD Act: ‘Where any person suffers damage which is caused partly by his own fault and partly by the fault of any other person, a claim in respect of that damage shall not be defeated by reason of fault of the claimant...’ The damages claim will instead be ‘reduced by the court to such an extent as the court may deem just and equitable having regard to the degree in which the claimant was at fault in relation to the damage.’

In practice, claims assessors from each of the insurers that are party to the multi-vehicle accident agree the damages and then apportion these to their respective policyholders in accordance with the Act. In the event agreement cannot be reached the matter may end up in court, where the same principles would apply.

Both the common law and the Act were at times replaced by a knock-for-knock agreement that was signed by the majority of South African insurers (see the note below). Following an accident each insurer would make good the damages of its insured, regardless of fault. The innocent party was then able to recover his or her excess from the other insurer. Knock-for-knock only applied if all of the vehicles involved in the accident were comprehensively insured by a signatory of the agreement.

Editor’s note

In an attempt to avoid lengthy disputes over insurer liability following a multi-vehicle motor accident, and to speed up claims settlements, a number of SA insurers became signatories of a knock-for-knock agreement.

The agreement was a legal binding agreement between signatories (motor vehicle insurers) that each would pay the cost of repairs to its policyholders’ vehicles following an accident, regardless of fault, provided that the vehicles involved were also insured for accidental damage. It was first agreed to in the 1970s, was subject to a number of improvements and cancelled in 2013. As of 2016, the agreement is no longer in place.

The major benefits of the agreement included quicker settlement of claims and a reduction in the legal and administrative costs involved in determining each insurer’s liability. Top among the challenges was that the knock-for-knock agreement did not extend to the payment of excesses which meant that the ‘no fault’ driver had to recover his or her excess from the guilty driver by corresponding with the respective insurers. This made it difficult of the ‘no fault’ insured to keep his or her no-claim bonus intact. Another issue was that the agreement did not apply if one of the insurers on risk for an accident was not a signatory to the agreement.

Sa’s first knock-for-knock agreement was put in place in the 1970s and adopted by virtually all short term motor insurers active in the market at the time. The agreement was amended from time to time with an important change being the stipulation that all insureds involved in an accident had to be comprehensively insured for the agreement to apply. Interest in the knock-for-knock agreement waned over the years with insurers questioning its relevance and eventually raising concerns over the possibility of it breaching provisions in the Competitions Amendment Act (Act No. 1 of 2009).

The country’s largest short term insurer by market share, Santam, terminated its participation with effect from 1 October 2005. By the beginning of 2013 there were only nine SAIA-member insurers that remained signatories to the agreement. SAIA discussed the continued viability of the arrangement at a number of technical committee meetings held during the year, which discussions prompted another five resignations.
A final decision to cancel the knock-for-knock agreement was taken at the association’s Board Committee: Motor meeting, held 15 August. The agreement was cancelled with effect from 30 September 2013. Accidents occurring since that date have been subject to the normal rights of recourse in terms of the common law and the AOD Act.

Avoiding underinsurance
There are a number of steps to take to avoid being underinsured. These include:

- Complete an accurate upfront assessment of asset values with assistance from valuation professionals and documentary backup where necessary;
- Conduct an annual review of the sums insured on the policy schedule to ensure assets are valued at current replacement values;
- Conduct an annual inventory of assets to ensure that new items are added and old items removed from the policy schedule;
- Seeking assistance from an insurance broker to clarify any valuation grey areas; and
- Complete a valuation of any specialised items (jewellery) or specialised classes of insurance (business interruption) in accordance with the policy endorsements stipulated by the insurer.

Who is the insured?
The insured is the individual or firm named on the policy schedule as the policyholder. In personal lines insurance the insured may include members of the policyholders’ family as well as persons who reside with the policyholder. Some sections in an insurance policy may require the naming of a beneficiary. The beneficiary is named by the insured but is not a party to the insurance contract.

The rights and responsibilities of the insured
The insured has a number of rights and responsibilities in terms of the contract of insurance. It is the insured’s right to expect the insurer to perform in terms of the insurance contract. This right includes being put in the same financial position (less any excess) following a valid claim for an insured loss event as prior to it.

An insured also has the right to object to an insurer’s full or partial rejection of a claim within a period of 90 days of receipt of the rejection letter. A further six months is allowed from the expiration of the objection period to institute a legal challenge by way of serving summons against the insurer.

Rights vest with an insured provided he or she complies with the conditions and terms in the insurance policy. The insured has the responsibility to:

- Provide the insurer with accurate, complete and truthful information when initiating cover. Insurers refer to this information as material information because it affects their risk assessment of a new insured and therefore the setting of exclusions, limits and premiums. Material information is defined as information that a reasonable person would deem relevant to share with the insurer to accurately assess risk. In most cases this information centres on the insureds’ insurance history including periods of prior insurance, reasons for being in the market for insurance cover, previous cancellations of insurance covers, previous insurance claims etc.

- Read and understand the policy schedule and policy wording with respect to the conditions, excesses, exclusions, sums insured and terms relevant to the insurance contract. This includes checking that the sum insured is adequate to avoid the application of the average principle (discussed elsewhere in this chapter).

- Inform the insurer of any changes to or inaccuracies in the data held by the insurer. This requires that the insured carefully checks the policy schedule and subsequent amendments or endorsements provided by the insurer and timeously corrects any errors that may appear including the description or use of insured goods, value of insured items, addresses relevant to covers, named drivers etc.

- Carry out any improvements to assets as indicated by the insurer in order for the cover to begin. In personal lines these improvements usually take the form of installing anti-theft devices in motor vehicles or radio-linked burglar alarms at homes. Commercial policies may stipulate specific risk management initiatives such as the installation of sprinkler systems in factories, changes to racking in warehouses, changes to storm water drainage in industrial complexes etc.

- Take reasonable care to prevent or reduce damage to any insured items and to mitigate insured risks wherever possible.

- Notify the insurer of any claim by providing detailed information as stipulated in the policy wording, usually within 30 days of the loss event. It is also usually indicated that the insured should report claims following
crime or traffic accidents to the police in order to obtain a case number, which must be provided to the insurer as part of the claim.

- Pay the insurance premium free of any deduction, failing which cover ceases. The insurance premium can be paid on a monthly or annual basis, though most personal lines policies stipulate the former. Premiums are paid in advance and the first premium must be paid for the cover to incept. Thereafter a monthly premium payment is necessary to renew the policy on a month-to-month basis. (Insurers vary in their treatment of the non-payment of premium, but the policy will inevitably be cancelled as a result).

Who is the insurer?
The insurer is the issuer of the insurance policy. The insurer performs according to the policy wording alongside any co-insurer or reinsurer named.

The rights and responsibilities of the insurer
An insurer has the right to cancel the insurance policy at any time, subject to a reasonable notice period (typically 30 days).

In the event an insurer finds the material information provided by a client at policy inception is incorrect it has the right to refuse the claim, cancel the policy, avoid the policy (declare it null and void and refund premiums as if the contract never existed) and / or pursue the insured for compensation. If upon assessing a claim the insurer finds that the insured has not complied with the conditions and terms of the insurance contract then it has the right to repudiate the claim. It also has the right to vary the pay-out by way of a part settlement of the claim. An insurer has a number of responsibilities to the insured, including to:

- Provide notification of any changes to the policy conditions, exclusions and terms – and specifically any increase in the premium. The notification period most commonly adopted by insurers is 30 days.

- Evaluate and settle claims in a professional and timely fashion and pay compensation to the insured as stipulated in the policy wording. It is common for insurers to pay for the repair, replace the item or pay out a cash settlement to the insured. Terms vary from one insurer to the next, but often include the right of an insurer to stipulate a repairer or supplier of its choice.

- Notify the insured in writing of its decision to reject or partially reject a claim and offer an internal dispute resolution process should the insured wish to object to its decision.

- Participate in the dispute resolution processes of the Office of the Ombudsman for Short Term Insurance and abide by the decisions reached by it. Not all short term insurers participate in the Ombudsman structures, but the office ‘covers’ the bulk of personal lines and small business insurance written in SA.

Life insurance versus short term insurance
It is important to understand the difference between life (long term) and non-life (short term) insurance.

Life or long term insurance
This segment of the insurance market can be thought of as ‘life’ insurance because it relates to the policyholder’s life or person and as ‘long term’ insurance because the policy, once put in place, cannot be cancelled or reviewed by the insurer unless premiums are not paid.

Policyholders make monthly or annual premium payments for the term of the life policy, or until such time as the policy performs. One of the main differences between life insurance and short term insurance policies is that the terms and conditions in the former case are reviewed on an annual or even monthly basis, whereas in the latter case they remain in force for the policy term.

A life insurance policy can be ended voluntarily by the insured giving notification of his or her intention to cancel or surrender the policy. In such cases the policyholder surrenders any future benefit on the policy but will be entitled to any cash value on the insurer’s books after penalties. The underlying policy or contract is cancelled following surrender.

In the event the insured fails to make the monthly premium payments he or she is said to lapse the policy. Another option for the insured in the event the life policy premium becomes unaffordable is to make the policy paid up.

The South African life insurance industry is further segmented into life investment products and life risk products. Life risk insurance provides cover to the insured and / or his or her beneficiaries upon a certain event.
The main events covered on a life risk insurance policy are the death of the insured, an event that leads to permanent or temporary disability of the policyholder (as defined in the policy wording) or the diagnosis of the policyholder with a critical illness (again as defined in the policy wording).

Funeral policies are sometimes listed under this section as a type of death benefit, but fit more appropriately in the assistance business or micro-insurance categories. The following definition, summarised from the recently enacted Insurance Bill, 2016, provides a crash course on the micro-insurance concept.

‘Micro-insurance includes insurance business conducted in a number of classes and sub-classes of both life insurance and short term insurance where the value of the life insured does not exceed the maximum amounts prescribed by the Act (for life insurance); or in respect of which the aggregate value of the insurance obligations under an insurance policy does not exceed the maximum amount prescribed by the Act (short term insurance).’

A life investment policy is a savings vehicle intended to provide a lump sum or monthly income payments at a future date and can include endowments and life annuities.

**Short term insurance**

Non-life insurance – known in SA as short term insurance and in the US and UK as property & casualty insurance – is intended to protect individuals or firms against a wide spectrum of losses and damages that are caused by or occur consequent to predetermined loss events.

The most common risks covered by short term insurance policies include loss or damage to accident, hijacking or theft of a motor vehicle; loss or damage to buildings and contents due to accident, fire or theft; third party liability; and personal accident. Hospital cash plans and gap covers as well as travel insurance fall into the short term insurance category too.

A short term insurance policy is usually renewable on either a monthly or an annual basis, with some nuances with regards the payment of premium. For example, a policy can be renewable annually but payable monthly. For the most part the insurance contract renews automatically on a month-to-month or annual basis.

However each renewal serves as a reminder for insured and insurer of their duties to the other. An insured should use such renewal to consider any disclosures that should be made to the insurer including changes in items or sums insured. The insurer meanwhile must consider whether the premium is still appropriate for the risk presented by its policyholder.

A failure to include a renewal clause in a short term policy document can lead to difficulties in the even a claim is disputed. This fact emerged in a recent insurance matter that came before the Supreme Court of Appeal. The Court ruled that in the absence of a renewal clause the insured’s duty to disclose to the insurer fell away once the contract was entered into.

Short term insurance can be broadly split into personal lines, commercial lines and corporate insurance. The FSB regulates the insurance industry and publishes annual and quarterly numbers split into personal lines and corporate insurance. It also provides a summary of short term insurance turnovers under eight insurance types, as stipulated by the STI Act. We cover the types of short term insurance policies in detail in chapter five and revisit the topic in chapter seven.

**Medical insurance**

SA differs from many other countries in that it separates medical insurance from short term insurance. Consumers obtain medical insurance by joining a private medical scheme (or medical aid) which is vigorously regulated by the Council for Medical Schemes (CMS). The CMS is headed up by a chief executive who acts as the registrar for medical schemes and reports to the Minister of Health.

Certain health insurance policies such as hospital cash plans and hospital ‘top up’ covers are currently offered by both the short term and life insurance sectors. The CMS is not happy with this discrepancy and is seeking to limit the insurance sector’s role in healthcare insurance by way of demarcation regulations. Demarcation is discussed briefly in chapter 11, 12 and 13.
1.3 Key insurer functions

Previous works on insurance have identified various factors that are critical to the success of an insurer. These can be summarised as risk selection, risk management, risk acquisition and investment.

- **Risk selection**: An insurer will succeed if it can select risks that ‘make sense’ to and is able to cover these risks at the right price. From a functional perspective this stage involves the assessment of risk and the enforcement of exceptions and exclusions through effective underwriting. It also involves innovative product design to enable appropriate risk selection in the market place.

- **Risk management**: Although often confused with the management of an insureds’ risks, this function actually vests with the insurer and involves effective claims management and the reinsuring any unwanted risks. In other words the insurer must apply sensible risk management strategies across its book of insured risks.

- **Risk acquisition**: There is an age old adage that holds, insurance is sold, not bought. Risk acquisition is the art of ‘selling’ insurance policies via an appropriate sales channel (whether direct or intermediated) as well as the effective marketing of an insurers’ risk offering.

- **Investment operations**: An insurer generates income either from premium or from the returns that it earns on its capital reserves or ‘float’.

At a purely operational level the preference is to describe an insurance business under four headings, namely claims, distribution, product development and underwriting. Other functions such as finance, marketing and human resources are carried out at an insurer in much the same way they would be in any other business.

Claims and underwriting is where the proverbial ‘rubber hits the road’ at most of SA’s larger short term insurers. Given the critical nature of these functions it is not unusual for an insurer to employ a chief claims officer and chief underwriting officer at executive level.

It is also unlikely that any major insurer would exist without a product development division. This division is responsible for product innovation that differentiates one insurer from the next and gives a particular insurer an edge in both the risk selection and risk acquisition function.

Short term insurance distribution has not changed much in the past decade and still takes place in one of two ways. It is either ‘sold’ by an insurance broker (in the so-called intermediated distribution model) or it is sold directly by the insurer to the end consumer online or by telephone.

Traditional insurers using insurance brokers for distribution still dominate the commercial insurance segments although more recently some of the direct insurers have begun offering turnkey solutions to small and emerging businesses. Direct
Insurance fundamentals

insurers meanwhile have made steady progress in the personal lines space and arguably write more than half of all short term policies to individual insureds.

The line between intermediated and direct insurance has become increasingly blurred and most major South African insurers operate both traditional (intermediated) and direct insurance ‘stables’. For example traditional insurer Santam owns 100% of direct insurer MiWay, traditional Mutual & Federal owns 100% of direct insurer iWyze and Telesure Holdings owns both a traditional insurer Auto & General and a direct insurer (Budget Insurance).

Some insurance brokers that are unquestionably part of the intermediated distribution channel have adopted technologies to interact with their clients – on the insurers’ behalf – in much the same way as a direct insurer would. The traditional visit from a suited broker is a thing of the past.

References:

SHORT TERM INSURANCE in South Africa 2016

Liz Still & Gareth Stokes

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Chapter 2
The history of short term insurance

This chapter gives readers a brief account of how the short term insurance market evolved over the last 3 000 years.*
The history of insurance mirrors and dovetails the development of trade, financial systems, stock exchanges and a body of law that, together were the enablers of the expansion of Europe from 1000 BC to the present but especially after the industrial revolution which is dated to have started in 1760.

Insurance offers protection to individuals and companies, so that they can concentrate of business risks and innovation which might otherwise be deemed too risky because of insurable risks. In his book, ‘Against the Gods: The Remarkable Story of Risk’, the late Peter L Bernstein writes very eloquently about how an understanding and mastering of risk is core to the progress of modern times. He sets the dividing line between ancient and modern times at the mastering of risk.

He explains the mastery of risk as ‘… the notion that the future is more than a whim of the gods and that men and women are not passive before nature’. Up until the time of the Renaissance, people perceived the future as little more than a matter of luck or the result of random variations, and most of their decisions were driven by instinct.

He writes that the theory of probability enabled people to rely less on superstition, not because they were more rational but because the understanding of this concept enabled risk takers to make rational, mathematically based decisions. Showing the world how to understand risk, measure it and weigh up its consequences, enabled early traders to convert risk taking into one of the prime catalysts that drives modern, Western society.

‘Against the Gods’ charts the close relationship between gambling, ‘the very essence of risk taking’ and games of chance. Bernstein wryly notes that many passionate Renaissance gamblers were also mathematicians, and were therefore highly motivated to examine such issues as the rules of probability, the laws of large numbers and the rules of statistical sampling and inference.

The rest of chapter 2 is available in the hard copy version of Short Term Insurance in South Africa which can be ordered online at www.analytica24.co.za. Any enquiries can be directed to info@analytica24.co.za

This “light” version of Short Term Insurance in South Africa was made possible with the kind support of Aon South Africa.
Chapter 3  
The business case for insurance

The business case for short term insurance can be demonstrated from a consumer’s perspective, from an insurer’s perspective or from a general economic perspective.

Why do private individuals buy short term insurance?
The answer to this question is embedded in the economic constructs that most Western economies are founded upon. South Africa (SA) and many of its middle income and developed world peers have adopted capitalism as a cornerstone of their economic markets.

SA’s economy is therefore based on the private ownership of capital and production inputs as well as on the production of goods and services for profit. The quantity of goods and services supplied is essentially determined by supply and demand in the general market with minimum intervention from the state.

Individuals under a capitalist system offer their skills in return for a monthly wage and, once their costs of living are met, begin accumulating wealth by saving and investing, by purchasing property and other fixed assets and by acquiring various personal items.

A benefit of a capitalist system is that those who cannot afford a property or motor vehicle outright can enter into an agreement with a bank or other financial services institution to finance their purchase.

Thus the modern family in a capitalist system might own a house, two motor vehicles and an assortment of household goods that are partly funded out of their accumulated wealth (savings), but mostly funded by borrowings such as home loans, hire purchase agreements, personal loans and credit cards.

This family might own a home worth R1 million offset by a home loan of R 800,000.00; two vehicles worth R 300,000.00 with outstanding hire purchase payments of R 250,000.00 and an assortment of personal goods valued at R 200,000.00 that are fully paid for. The same family probably has a net income after tax, debt servicing and living expenses of a few thousand rand per month.

What happens if one of the cars is written off following an accident or the house burns down? The family could continue to meet their ongoing bond or hire purchase obligations out of their monthly income, but would have no means of replacing the car or house.

The need to protect personal assets against unexpected risk events that could result in severe damage or total loss is clearly indicated. A short term insurance personal lines policy transfers the risk of loss or damage to the households’ personal assets to an insurance company in exchange for an affordable monthly premium.

A private individual thus purchases insurance to protect his or her accumulated wealth from an unforeseen loss event. Throughout this book we refer to the short term insurance that a private individual buys as personal lines insurance. The three main categories of insurance included under this insurance category are homeowners (cover for buildings), householders (cover for household contents) and motor vehicle insurance.

It should be noted that banks and other financial institutions refuse to lend money for ‘big ticket’ items without some guarantee that the financed asset is protected from risk. This is why vehicle finance transactions must be accompanied by proof of insurance and why home loan issuers insist on proof of homeowners (buildings) cover alongside each housing bond.

It is also not uncommon for banks to request that home loan account holders provide evidence of life insurance to cover the outstanding balance on the home loan in the event of death. Certain retailers, particularly those that sell household goods on credit, sell credit life insurance policies at point of sale to cover the outstanding repayments in the event of the purchasers’ death.

Why do firms buy short term insurance?
A firm participates in the capitalistic system in much the same way that an individual does, except that it is tasked with accumulating wealth for its shareholders, who may be individuals or other firms.

In its simplest form a business can be conducted as a sole proprietorship wherein the individual and the business are virtually indistinguishable. Quite often a sole proprietor will insure his or her assets under a personal lines policy with the relevant items notarised for business use.
Larger and more complex businesses, such as sole proprietors in the construction or hospitality sectors, will typically take out commercial insurance policies. The firms’ primary concern is with the protection of assets following a risk event that leads to damage or total loss.

A key difference between a private individual and a firm is that loss or damage to a firm’s assets may result in a loss or reduction in the firm’s income stream as well as impact on its customers and employees. It must therefore also insure against financial losses and liabilities that might arise as a consequence of the risk event. Commercial policies therefore offer covers that go beyond assets only to include business interruption, key persons insurance and liability insurance to name a few.

In today’s litigious world the protection afforded the business or private individual by liability insurance serves as a great motivator to take out insurance cover. Both business and private individuals are at risk of being sued under delict or contract in which case settlements could run into millions of rand.

The world of commercial insurance is complex and ranges from turnkey covers for specific business types (such as insurance for guesthouses or fuel stations) to cover for airlines, freight forwarding and logistics concerns, multi-year construction projects and nuclear power stations to name a few. The most common types of commercial insurance cover will be discussed in chapter seven.

A private individual and firm might have different motivations for purchasing insurance cover, but both do so out of a desire to manage risk. They both place their trust in the insurance company to manage their premium alongside that of other policyholders’ premiums in such a way that any claims against the insurer following a risk event can be met.

The link between insurance and the general economy
A final word on the business case for insurance is that without insurance the world would be a very different place. The reason is that the insurance company offers a safety net for the entrepreneurs, business owners and risk takers who, over centuries, have built today’s economy.

Prof Robert Vivian, Professor of Finance and Insurance at the University of the Witwatersrand, describes an insurance firm as a beacon of inspiration to promote economic growth and a foundation around which an economy can rally. He adds that insurance companies enable economic growth by removing risk-imposed restrictions.

Economic activity and insurance are therefore inextricably intertwined. The first ocean-going traders would not have embarked upon their voyages had they not insured their goods with like-minded businessmen, nor would any 21st century manufacturer ship goods abroad without goods in transit, debtors and marine insurance in place. Likewise no major construction project – whether for a new bridge, manufacturing facility, railway line or shopping centre – would be feasible without insurance cover in place.

3.1 Assessing and pricing for risk
In order to perform its function an insurance company must assess the risk that it intends providing cover for and price correctly for that risk. An accurate assessment of the risk includes the size of the risk (the amount of compensation the insurer has to pay following a risk event), the identification of the risk factors that might result in a loss and the expected frequency and severity of such loss.

The probability of a risk and risk factors
Risk factors vary from one type of insurance cover to the next and the factors that must be considered before granting an individual cover for a motor vehicle are totally different to those that must be considered prior to writing a commercial policy for a logistics firm.

That said the basic insurance principle remains unchanged in that insurance is offered when the timing or occurrence of a loss is unpredictable, but the likelihood and magnitude of the loss are relatively predictable.

Modern insurers make use of complex risk modelling techniques to assist them in interrogating the risk factors that each new insured introduces to their pool of policyholders. The question that the risk model seeks to answers is simple: How likely it is that an insured will make a claim (the claim frequency) and how much will that claim be for (the size of the claim)?
Our discussion on the determination of risk appropriate premiums is simplified by narrowing our focus to personal lines motor vehicle insurance and cover for loss or damage consequent to fire. In the real world insurance companies will use teams of actuaries or bespoke actuarial models to set premiums for new insureds and to adjust premiums for policyholders. Modern insurance companies have leveraged technology to allow for real-time adjustments to their risk rating systems and enable them to apply customised risk profiles to individual policyholders.

The answers to these insurance risk questions are necessary to calculate insurance premiums. Short term insurers that are active in the personal lines motor vehicle insurance space have the benefit of years of experiential data which allows them to accurately classify the risk that each potential insured presents and to then charge an appropriate premium for that risk.

Determining the appropriate premium is easier said than done because the risk presented by a potential insured can vary based on personal circumstances (age, gender, credit ratings, insurance claims history, type of car and its storage and use); driver ability and behaviour; the level of cover and benefits requested and an array of market conditions that are beyond the insurer’s control.

Some of these risk factors are expanded upon in the following list of motor vehicle insurance premium influencers:

- The value of the motor vehicle remains the most important component of the insurer’s risk assessment as it closely correlates with repair and replacement costs;
- The type of motor vehicle including details of the vehicle manufacturer, model, body type, engine size and vehicle age are important and may give clues as to the likelihood of the vehicle being stolen or hijacked;
- The age and driving record of the driver is a strong predictor of whether a policyholder will make a claim or not, with younger drivers generally being seen as riskier ‘bets’;
- The gender of the driver is factored in by certain insurers on the basis that women drivers tend to be more careful and offer less risk – SA’s 1st for Women, a short term insurance brand owned by Telesure Investment Holdings, has built its business on this premise (readers can refer to the information box titled ‘European Court of Justice on gender-based risk rating’ in chapter one for more on the use of gender in risk rating);
- An insured’s claims history (and motor vehicle accident history) is important in determining the correct premium and the industry will charge a higher premium for someone with a poor claims record;
- The intended use, frequency of use and kilometres travelled by the vehicle are important in correctly determining risk. Private users or low mileage vehicles will attract lower premiums compared to those in business use or with high mileage;
- The location of the insured’s house and place of work as well as the location and security measures at the place where the vehicle is parked when not in use;
- Risk mitigation steps such as anti-theft (car alarms, immobilisers, steering locks) and tracking devices installed by the insured will reduce the premium;
- Driver ability and behaviour are integral to modern risk engines that obtain and analyse data from in-car telematics devices to risk rate individual policyholders; and
- The type of cover and benefits provided also affect premium, with comprehensive covers costing more to insure than third party, fire and theft covers.

In the case of a motor vehicle insurance policy the traditional insurer gathers information about the abovementioned risk factors during the underwriting stage. It will also revisit many of these questions during the policy renewal process. Underwriting includes the identification, assessment and mitigation of risk as well as the setting of a risk appropriate premium for that risk.

SA’s leading short term insurer by market share, Santam Limited, defines underwriting as the process of examining, accepting or rejecting insurance risks and classifying or segmenting the accepted risks in order to charge the proper premium for each.

The potential insured provides most of the underwriting data when applying for insurance on the motor vehicle by way of a written or telephonic application. This information might be provided directly to the insurer by the insured – for example in an online or telephonic application – or through an insurance broker or underwriting management agency (UMA).

There are many misconceptions about the insurers’ application of the risk information gathered during the underwriting process. Top among these is the perception that the colour of a vehicle might influence the premium (it should not) or the...
notion that a driver’s insurance will cover him or her for accidents when driving other vehicles (most policies offer cover on a per vehicle basis, with named drivers for each insured vehicle).

**Size of risk**
The price or replacement value of the asset has a major bearing on the risk and therefore the risk premium. It should be noted that most insurers will assess the size of the risk at policy inception and reassess this upon policy renewal, whether monthly or annually.

The important premium components introduced earlier in this chapter – namely insurance risk and size of claim – are revisited each year in line with the insurer’s experiential data, its risk forecasting model and the track record of individual insureds.

Keeping with our personal lines motor vehicle insurance example it is unlikely that the expected claims frequency will change much from one year to the next. It is also true that while insurers are aware of the chance of unexpected natural catastrophes such as hailstorms or floods – both events that can result in massive spikes in motor vehicle claim’s values and volumes – they cannot reprice policies in anticipation of such risk events.

Given that the expected claims frequency remains constant from one year to the next, insurers have to focus on repricing for the size or severity of expected claims. South African motor vehicle insurers face significant repair cost inflation running into double digits due to rapid increases in the cost of original equipment (OE) replacement parts and the labour rates charged by panel repairers. Significant local currency devaluation against the US dollar through 2015 and the first quarter of 2016 has added to this inflationary pressure.

Motor vehicle insurers base their annual insurance premium escalations on a number of complex factors including the vehicle’s value, the estimated frequency and severity of damages (repair costs tend to go up even if a vehicle’s value has declined), estimates for repair cost inflation for the coming year and changes in the risk rating of the insured (due to a new home or work address; changes in vehicle usage; or evidence-based changes in driver behaviour, for example).

To illustrate consider a vehicle with a replacement value of R 150,000.00 in year one. The insurer obtains the necessary risk information from the insured and sets a premium of R 550.00 per month. The insured has no claims during the year. At the second year policy renewal the insurer forecasts repair cost inflation of 12% and reprices the premium based on this assumption as well as on the fact that the value of the vehicle has depreciated by, say, 10% to R 135,000.00.

Increases in the sum insured due to repair cost inflation have a much higher impact on the total premium than decreases due to lower trade values. In the above example the insurer would probably pass on a double digit increase based on 95% of total claims being for repairs and just 5% for replacements. The calculation would be 95%×12 – 5%×10 or 11.4% - 0.5% or 10.9%

Since affordability is a major competitive factor, particularly in the market for personal lines insurance, insurers have come up with various ways to reduce the premium that they charge. The simplest technique to reduce the insurer’s risk exposure is to allow the policyholder to take on a portion of the risk by way of an excess.
The application of excess varies from one policy type to the next and can be customised to suit the individual policyholder. An insurer may for example stipulate a first excess of R 2,500.00 on a motor vehicle policy, meaning that the first R 2,500.00 of any loss event is for the insured’s account.

If a driver consents to a first loss excess of R 2,500.00 the insurer can reduce the price of the asset for which it must provide cover by the same amount and in turn reduce the premium payable. Other methods to reduce premium centre on smarter underwriting by way of better risk selection, risk mitigation and smarter management of repair and replacement costs.

Competitive forces in the domestic insurance market have an impact too, with many insurers offering unsustainably low premiums to win market share. At the same time premium increases are kept to a minimum to retain existing clients.

**Risk mitigation**

There’s an English adage that goes ‘prevention is better than cure’. In the insurance world the refrain goes that risk mitigation is better than incurring claims. A very important first step in risk mitigation is risk selection and there is no better way to avoid risk than to simply refuse it. In extreme cases individuals with poor claims histories may thus find themselves uninsurable.

If an insurer is prepared to take on the risk the second step is to consider what risk mitigation measures can be put in place to reduce the risk further. Risk mitigation measures are identified during the underwriting process and must be implemented in order for the risk to be on cover. Most readers will be familiar with the basic risk mitigation requirements set out in their short term personal lines insurance policies including anti-theft and tracking devices in motor vehicles and burglar bars and radio linked alarms at their homes.

As a more complex example consider a goods distribution warehouse that wishes to procure cover for its contents and structures. The insurer – or more typically the insurance broker – will visit the site to assess the risks that apply to the warehouse with respect to loss or damage to the goods contained therein or damage to its structure. A number of ‘recommendations’ will follow from this site inspection, including:

- **To mitigate the risk of theft** –
  - Installation of burglar bars;
  - Installation of a radio-monitored alarm; and
  - 24-hour perimeter security.

- **To mitigate the risk of fire damage** –
  - Changes to warehouse racking layout and height to reduce the volume of combustible goods stored per floor area;
  - Changes to the sprinkler system including more sprinkler nozzles, increased pumping capacity and additional on-site water storage;
  - Installation of early warning system such as monitored smoke detectors and heat-sensing cameras;
  - Relocation of pallet storage or waste disposal facilities; and
  - Application of fire retardant paints.

- **To mitigate the risk of water damage** –
  - Raising lowest storage shelves from the ground;
  - Checking warehouse roof and guttering; and
  - Rerouting external storm water runoff where necessary.

The list of risk mitigation measures is endless and varies from one type of insurance policy to the next. Please note that the word ‘recommendations’ is in quotation marks because in most instances cover on the insurance policy will only incept once the necessary risk mitigation measures have been put in place.

An insurer will be within its rights to repudiate a claim following a fire at the abovementioned warehouse if the recommended changes were not made. This is because the premium is determined on the assumption that all of the agreed measures are put in place.

It is quite common for insurers to mitigate risk by increasing the excesses applicable for certain insurance covers. So, for example, if the owners of the abovementioned goods warehouse were not prepared to upgrade the sprinklers system the insurer might agree to provide the cover on condition that a first excess, perhaps as much as 15% of the value of the insured goods, be payable following damage to the goods due to fire.

This technique is commonly applied in the personal lines motor insurance segment too, where additional excesses are charged for drivers in different age bands, for example. Certain insurers will allow an insured to elect a voluntary excess in addition to its compulsory excess in return for a reduction in premium.
The South African short term insurance sector is extremely competitive with a number of insurance companies vying for market share. Insurers soon realised that the easiest ‘sell’ came by way of offering the most affordable premium, but were not always transparent about how such low premiums were achieved.

Insurance consumers are therefore advised to study their insurance quotations carefully to make sure that the premiums they are comparing are based on similar levels of cover. This requires a comparison of the insured items and their values, the risks for which these items are covered and the excesses payable at claims stage.

A saving of R 50.00 per month on monthly premium of R 1,000.00 seems good value until you discover that the excess payable on the cheaper policy is R 1,000.00 higher than that on the more expensive one. The policy with the lower premium would have to be in force for 20 months for the monthly premium savings to compensate for the higher excess charged in the event of a claim.

Insurers can reduce their risk by getting rid of unprofitable books of business. They do so by notifying a group of policyholders that they are no longer economic to insure or by aggressively hiking the premium to such an extent that the cover becomes unaffordable for these policyholders. In a sense the premium or price can itself be used as a risk mitigation tool.

### 3.2 The economics of insurance

South African insurers pay out hundreds of billions of rand in claims each year. For insurance to remain economically viable the sector must collect more in premiums than it pays out. Repeated failures to balance the annual premium less claims and expenses equation would result in bankruptcy.

The challenge for the broader short term insurance sector is to be able to meet all of the claims incurred by its policyholders due to ordinary risks while at the same time building up a capital buffer for years when catastrophes, whether natural or manmade, result in a massive surge in claims volumes and values.

**SA insulated from catastrophe risk**

SA is fortunate that it does not suffer the extent of natural catastrophe experienced in North America, Europe and the Asia-Pacific region. Insurers in those markets pay out billions of dollars due to storms, hurricanes, tropical cyclones and other adverse weather events.

Locally our natural catastrophes are limited to unseasonal rain, severe hailstorms and drought. In 2012 Santam reported losses of almost R280 million due to hail damage. This was the highest year on record at the insurer since a R50 million inflation- and exposure-adjusted loss in 2004.³

A year later, in November 2013, the Gauteng province was hit by two severe hailstorms. Short term insurer Mutual & Federal registered 856 claims after the 11 November 2013 storm with more than 1 000 claims lodged following the second storm on 28 November.

The second of these storms has since been acknowledged as one of the worst weather catastrophes on record in SA, with total claims across the insurance sector estimated at more than R1.6 billion following the event.

**Profit and underwriting margins**

The fundamental principles of insurance were introduced in chapter one. In order to get to grips with the economics of insurance we will revisit some of these principles including the equation to measure an insurer’s profit.
Formula for calculating insurer profit

\[ \text{Profit} = \text{Earned premium} + \text{Investment income} - \text{Incurred loss} - \text{Underwriting expenses} \]

In the above equation underwriting expenses include all of the administrative, acquisition and other costs incurred by the insurer in operating its business and selling and administering insurance policies.

The next few paragraphs will consider how it is possible for an insurer to protect all of its policyholders against commercial fire risk and still make a profit. To begin with the insurer should possess historical data on fires at commercial properties in certain geographical areas. This data can be used to estimate the probability and frequency of loss events for a group of insureds.

By combining this information with the sums insured, the severity of previous fire losses and other risk mitigation tools, such as excess, the insurer can set a premium that should exceed both the expected cost of claims and its underwriting expenses. But there is one more requirement that must be met in order to offer this cover profitably.

According to the law of large numbers an insurer’s actual claims experience will trend towards the estimated claims experience the more insureds it has. A profit is thus made more certain by insuring a large enough number of commercial clients against fire risk.

Insurance companies have to collect enough money by way of insurance premiums to cover the amount of money that they will have to pay out to their insureds under all of the insurance policies that they issue.

Unfortunately the best laid plans can be undone by a single unexpected catastrophe. Imagine, for example, if an insurer offered fire cover to a number of large firms operating out of the same industrial park. In the event a fire destroys multiple properties in this precinct the insurer will face claims well in excess of its anticipated maximum claims.

The same risks exhibit in personal lines portfolios where severe hailstorms or floods can result in multiple claims for damage to motor vehicles and private residential property. Insurance companies can reduce their exposure to catastrophic risk through reinsurance (insurance for insurers) or by entering into coinsurance agreements with other insurers.

Reinsurance policies are purchased and coinsurance arrangements entered into in order to mitigate the risk that claims following a catastrophic loss event might exceed an insurer’s accumulated capital. Details about insurance premiums, reinsurance premiums and other risk arrangements are recorded in the insurance company’s financial accounts.

Income from insurance activities

Insurer financial statement will be covered in detail in chapter eight, but it is worth considering some of the basic concepts now. The shareholders of an insurance company will find details of its profit performance in the income statement and statement of comprehensive income.

A first observation is that where general businesses refer to revenue in their income statements, insurers refer to net written premium (NWP). It is standard for insurers to report their NWP as gross written premium (GWP) less reinsurance premium (RP). A further adjustment – unearned premium at the end of the year is subtracted from the unearned premium at the beginning of the year – is made to calculate the net earned premium (NEP).

Calculating an insurer’s net earned premium (NEP)

\[ \text{GWP} \text{ (The total amount of premium written in a given year)} = R \ 100.00 \]
\[ \text{Less: } \text{RP} \text{ (The total amount placed by the insurer with a reinsurer)} = (R \ 10.00) \]
\[ \text{NWP} \text{ (The total premium retained by the insurer)} = R \ 90.00 \]
\[ \text{Less: Changes in unearned premium} = (R \ 1.00) \]
\[ \text{NEP} \text{ (The net earned premium for the year)} = R \ 89.00 \]
In this calculation GWP is the sum of premiums that an insurer is contractually entitled to receive from the insured in relation to contracts of insurance as well as premiums from other insurers in relation to inwards reinsurance contracts, also referred to as premiums written and received before deduction of reinsurance ceded.

RP, meanwhile, is the premium paid by the ceding company to the reinsurer in consideration for the liability assumed by the reinsurer – or in simpler English is the amount the insurer has paid to a reinsurer to insure itself against excess risk.

 Readers should also be aware of the definitions of ‘earned premium’ and ‘unearned premium’. Earned premium is the proportion of premium attributable to the periods of risk that relates to the current accounting period – in other words the written premium adjusted by the unearned premium provision at the beginning and end of the accounting period. Unearned premium is the portion of premiums attributable to the periods of risk that relate to subsequent accounting periods and which are carried forward to such subsequent accounting periods.

Insurance companies are no different to their business peers in that they exist to generate a return for their shareholders. This return is reported as a profit (or loss) which is then assessed by shareholders using a number of variables and investment criteria.

An insurer can improve its profitability by increasing its revenue (writing additional business or increasing premiums on existing business), reducing its claims costs (writing a better quality business or managing its claims better), reducing its operating costs or any combination of these.

Insurance executives and the accountants, analysts and auditors who study insurer annual reports have introduced a number of measures to scrutinise insurer results. These include the claims ratio, acquisition cost ratio, expense ratio and combined ratio.

- **Claims ratio**: The sum of the claims divided by the NEP for the period under review
- **Acquisition cost ratio**: The sum of all acquisition costs divided by the NEP for the period under review.
- **Expense ratio**: The sum of the expenses (excluding claims) divided by the NEP for the period under review. Some analysts will include acquisition costs in this ratio, in which case it would probably be notarised as the total expense ratio.
- **Combined ratio**: The sum of the claims, acquisition and expense ratios. This ratio measures whether an insurance company is profitably underwritten i.e. that the premium received from its policyholders is less than the losses and expenses incurred in issuing and honouring their policies.
- **Underwriting margin**: The combined ratio can be used to calculate an insurer’s underwriting margin which is essentially an insurers underwriting profit (or loss) divided by the NEP for the period under review.

\[
\text{Underwriting margin} = 100\% - \text{Combined Ratio}
\]

**Underwriting profit or loss**: A combined ratio of less than 100% means that the company generates an underwriting profit whereas a combined ratio of more than 100% implies an underwriting loss.

There are many factors that may contribute to an insurer reporting an underwriting loss. A greater than expected loss following a weather-related catastrophe or a decision to accept riskier business to secure additional market share are two examples. It should be noted that an underwriting profit or loss is specific to an insurer’s underwriting activities and, by definition, excludes any income from investing activities.

**Income from investing**
The second part of an insurer’s income stems from its investing activities. An insurer earns investment income on its ‘float’, which is described as its premium income less immediate operating expenses, as well as on its capital reserves. These large cash sums are typically invested in quality fixed income securities or in blue chip shares which generate a mix of interest and dividend income for the insurance firm. The income section of the annual accounts will also include gains or losses on investments at fair value.
Correlation of GDP growth and insurer prospects
The profit outlook for an insurance firm is closely correlated to that of both the domestic and global economy and each firm has to focus on its operational efficiencies within the broader economic context.

There is a very simple model that short term insurance company executives can use to predict their premium growth, namely by adding the forecast for consumer price inflation (CPI) and the forecast for country GDP growth plus a couple of percentage points to compensate for SA’s emerging market risk.

Predicting premium growth
A prediction for premium growth for the SA short term insurance industry for 2016 (based on data at 31 December 2015):

\[
\text{Growth} = \text{Inflation (CPI)} + \text{Forecast GDP} + \text{Emerging Market Risk Premium} \\
= 6.8\% + 1.4\% + 2.5\% \\
= 11.3\%
\]

Insurers wrestle with a number of factors that are unique to the country market within which they operate, including government and regulation. Government’s management of SA’s economy has been under the spotlight for many years and has led to sometimes insurmountable challenges for domestic insurers.

The systemic issues introduced by poor management of municipal infrastructure are case in point. Risk mitigation efforts are negatively impacted by poorly maintained road infrastructure, ill-equipped fire stations, neglected water mains and inadequate storm water drainage to name a few. Financial mismanagement is a major bugbear too with only 131 of 467 auditees in the Auditor General’s 2014/15 report receiving clean audits and a staggering R936 million lost to fruitless and wasteful expenditure.

The rise in regulation following the 2008 Global Financial Crisis (GFC) is also being felt domestically as new regulations affecting banks and insurers are introduced hand over fist. SA’s insurance industry which is already massively regulated to safeguard financial services consumers is currently being subjected to a full blown prudential and market conduct overhaul.

The costs of compliance with new regulations in addition to capitalisation requirements introduced by SA’s Solvency Assessment and Management (SAM) regulation will impact on both the industry’s structure and the operational architecture of insurance companies. Read more about the burden of regulation in chapters 11, 12 and 13.

The insurance cycle or underwriting cycle
The Financial Services Board (FSB) publishes an underwriting margin for the entire short term insurance sector on a quarterly basis. A chart of this underwriting margin going back a number of years reveals an insurance cycle or underwriting cycle, defined simply as the fluctuations or ‘ebb and flows’ in the industry’s underwriting result over a period of time.
There does not appear to be any correlation between the economic or business cycles and the short term insurance underwriting cycle, though the latter is definitely more volatile. A number of studies have shown that the cycle varies widely from one insurance type and country market to the next.

From a microeconomic standpoint the underwriting cycle is influenced by the number of insurers, their market share, types of insurance product and the interaction between supply and demand. It should be noted that supply drives prices in the short term insurance market and that high price cycles are typically broken by the entrance of new competitors and increased insurance capacity.

The underwriting cycle plays out over a number of years as the industry – driven by industry-specific forces – transitions between so-called hard and soft markets, or from boom to bust.

A hard market (where prices and profits are high and coverage restricted) is characterised by increasing insurance premiums, stringent underwriting criteria, reduced insurance capacity and fewer local competitors. Under these conditions insurers’ underwriting profits improve significantly leading to an industrywide boom.

A soft market (where prices and profits are low and coverage is expanded) is characterised by lower insurance premiums, reduced underwriting criteria, increased insurance capacity and increased competition among insurance carriers. These factors combine to impact negatively on the industry’s bottom line with an extended soft market gradually eroding profits and ending in a bust scenario.

How does the market transition from soft to hard? Towards the end of the soft market insurers exercise more care in selecting risks (by implementing tougher underwriting conditions) and begin pricing risk more appropriately. This practice results in a gradual turnaround in the underwriting performance.

The boom times begin as insurers are able to charge higher premiums and achieve positive underwriting results. Insurers get greedy at this stage and try to write more policies to take advantage of the profit on offer, counterintuitively lowering premiums and relaxing their underwriting standards to do so.

The promise of easy profit lures new competitors into the market, sending premiums even lower as each firm scrambles to win or maintain its market share. At the same time new capital arrives to snatch up a share of the higher underwriting margins on offer, boosting insurance capacity.

Lower premiums lead to a squeeze on insurer profits and the industry soon finds itself back in a soft underwriting environment with margins reducing until the bottom of the cycle is reached. Insurers respond during this stage by reinining in costs and attempting to grow business through acquisitions and mergers; but remain fearful of increasing premiums lest they lose market share.

It is not uncommon for the industry to languish in a soft cycle for a number of years. The cycle is usually broken when an unexpected catastrophe event drives some of the weaker players from the market, which exit allows the remaining insurers to reprice their businesses appropriately as well as select risks more sensibly, which kicks off the next hard cycle. And so the cycle repeats.

Numerous studies have been written on the underwriting cycle. Although it is adequate to understand the hard and soft markets already described it is possible to divide the cycle into four phases defined by movements in price, quantity and reported profits.

- **Stage I:** Hard market or crisis which marks the transition from low to high profitability;
- **Stage II:** Low availability, high premium levels and high profitability;
- **Stage III:** Gradual erosion of premium and profitability; and
- **Stage IV:** Low premiums, low profits and abundant quantity.
In 2006 insurance giant Lloyd’s published a report based on a survey of more than 100 underwriters that identified ‘managing the underwriting cycle’ as the top challenge facing the insurance industry at the time. This remains true to the current day.

The impact of competition and surplus capacity
An understanding of the term ‘insurance capacity’ is crucial for an understanding of the business of insurance. Capacity refers to the amount of exposure that an insurer is willing to place at risk whether for a single risk or entire book of business. Insurance capacity, also called underwriting capacity, is determined by an insurers’ financial strength and is often seen as a proxy for its financial strength.

There are a number of alternatives available to insurers that wish to write risks that exceed their capital-backed underwriting capacity. The first – coinsurance – is the division or sharing of a risk among two or more competing insurance firms and is quite common on major construction projects due to the huge sums insured. The second – reinsurance – involves ceding some of the risk to a reinsurance firm (in other words the insurer purchases its own insurance).

Reinsurance enables an insurer to increase its total sum insured across a wide range of risks without having to source additional capital. It is also a cost effective way for an insurance company to protect itself from an infrequent catastrophic loss event. An insurer benefits from reinsurance in that it can partially transfer some of its risks off balance sheet, thereby reducing its regulated surplus capital requirements.

At present the global reinsurance market is awash with capital due to a combination of multiple years of better than expected catastrophe claims and post-GFC quantitative easing. Excess capacity among reinsurers results in soft insurance market conditions characterised by increased competition and low insurance premiums.

At the time of writing SA’s short term insurers remain plagued by surplus capacity. ‘Insurance Banana Skins 2015’, a report by auditing firm PwC, found that the short term insurance market was depressed due to surplus capacity. The report also stated that reinsurers are most concerned with soft insurance market conditions created by surplus capacity and new types of capital.

It is interesting to note how various macroeconomic factors intertwine with and impact on insurance. For example the new types of capital mentioned earlier include hedge funds and pension funds seeking better yield from so-called insurance linked securities.

The soft market has been exacerbated by the low turning point in SA’s interest rate cycle. Low interest rates have a negative impact on insurers because they reduce both investment yields and the value of capital. Short term insurers thus suffer a dip in their investment income at a time when underwriting margins are already under fire due to lower premiums, a consequence of the surplus capacity just mentioned.
The soft insurance market cycle will eventually turn, but it is difficult to predict when. There is a growing view among short term insurance and reinsurance analysts that 21st century trends around product pricing, segmentation and sophistication will dampen future transitions from soft to hard cycles.

3.3 Selling insurance

Introduction

There is a school of thought that holds that life insurance is sold and not bought. A consumer must therefore be convinced to purchase life, critical illness or disability cover by an insurance company’s advertising campaign, an agent of that insurer or an independent broker (or financial adviser).

This certainly appears to be the case in SA where life insurance brokers and financial planners have done a great job in improving insurance penetration among the country’s high income groups. SA’s life insurance sales performance is no doubt assisted by cultural factors that ensure good uptake of funeral policies in the low income market.

Does the same ‘sold and not bought’ assertion hold in the short term insurance segment? A gut response to this question is “no” because short term insurance is such an important enabler for wealth creation in both the personal and commercial markets for all the reasons mentioned in the introduction to this chapter.

An individual who wishes to purchase a new motor vehicle or buy a house with borrowed money has to take out insurance to obtain financing. Likewise short term insurance is a prerequisite for most major commercial ventures, especially where project finance is required. A short term insurance policy is virtually non-negotiable in order to complete such transactions.

But the requirement to purchase a short term insurance policy does not exist in the broader personal lines and commercial markets, particularly where the assets in question are already paid for. It is in these areas where short term insurance is ‘sold and not bought’ and persuasion from an insurer, agent of the insurer or short term insurance broker makes the world of difference.

The same can be said for both the low income consumer segment and the informal business sector where the lack of access to financial products, poor financial services education and affordability all contribute to a poor uptake of short term insurance products.

A quick look at the mix of life and short term insurance business in SA; insurance penetration figures for SA and the rest of Africa; and SA’s contribution to the global insurance market may provide some additional insight to our ‘selling insurance’ discussion. Readers should refer to the ‘Size of SA’s insurance market’ information box below.

Size of SA’s insurance market

SA is confirmed as Africa’s dominant insurance power in Swiss Re’s ‘Sigma No 4/2015: World Insurance in 2014’ study. It shows that SA contributed more than 70% of the almost US$70 billion in combined life and short term insurance premiums generated in Africa in 2014.

One interesting differentiator between SA and the rest of Africa is the dominance of its life insurance sector as measured by GWP. KPMG reports that the life segment accounts for approximately 80% of all insurance premiums in the country.

This observation reflects in the insurance penetration numbers as measured by GWP (excluding cross-border premium) and expressed as a percentage of country GDP. SA’s total insurance penetration (life plus short term) stood at 14.1% in 2014, with 11.4% in the life insurance sector and just 2.7% in the short term insurance sector. Africa as a whole records 2.8%, 1.9% and 0.9% on the same three measures.

SA may be the dominant insurance market on the African continent, but the country’s share of the total world insurance market was just 1.03% in 2014. The 53 other Africa country markets contribute less than half a percent. SA’s life insurance sector accounts for 1.5% of global life premium and the short term sector 0.44% of global short term premium. This is a good indicator of the potential for growth in the short term insurance segment.
Swiss Re goes on to rank SA at 34th in the world for its total insurance density of US$ 925.00 per capita per annum. This figure is further broken down into 10th for life insurance at US$ 748.00 per capita and 30th for short term insurance at US$ 177.00 per capita. While SA’s insurance density far exceeds that of other African country markets it lags the US (US$ 4,017.00) and the UK (US$ 4,823.00) by quite some margin.

According to the Swiss Re ‘Global insurance review 2015 and outlook 2016/17’ study there is still growth on offer in the Sub-Saharan Africa region, but growth patterns will differ significantly from one country to the next.

The three largest economies in the region currently act as a drag due to poor economic growth prospects. SA, for example, is weighed down by ongoing electricity shortages, labour unrest, low export prices and high unemployment.

The conclusion is that short term insurance is both bought and sold. Those that buy insurance do so out of necessity to progress with their personal or commercial wealth accumulation plans. For the remainder, who make up a massive proportion of the total potential short term insurance market, the adage ‘insurance is sold and not bought’ holds true.

There is significant growth on offer in the short term insurance market as personal wealth levels increase and the previously uninsured become better informed of the need to protect their assets. Short term insurers will have to make significant and ongoing efforts to leverage the various distribution channels available to them to make sure that their solutions reach this market.

This is the only way that SA will move from being a world leader in terms of insurance penetration to a market where insurance consumers purchase an equivalent amount of cover to their developed world peers.

**Short term insurance distribution**

If we proceed on the basis that insurance is sold and not bought then the next step is to reflect on how short term insurance products reach the market. The insurance industry refers to the process of taking insurance product to market as distribution and most insurers employ a variety of distribution channels (multi-channel distribution) in their quest for market share.

Historically marketing channels and distribution methodologies grew out of a need to distribute policies beyond an insurer’s geographic reach. In the US the need followed from the rapid expansion of human settlements from the East Coast into the West. In order to reach these new markets insurers created networks of agents, assigning them specific geographic areas, and set up branch offices managed by general agents, later known as managing general agents (MGAs). The MGA concept closely mirrors that of the UMA in SA today.
Agents and MGAs, who were beholden to their insurer, were soon joined by independent insurance brokers who could source and sell policies from more than one insurer. Insurers have since developed direct marketing channels to reach potential clients without assistance from agents, brokers or MGAs.

Other popular distribution methodologies include the bancassurance model wherein an insurer partners with a bank to distribute products to the banks’ clients; retail insurance, which involves the sale of an insurance product through a conventional retail outlet; and mobile insurance, which is the sale and marketing of insurance product over mobile phone devices.

The most basic determinant of channel type is in the answer to the following question: ‘Was the insurance policy purchased directly from the insurance carrier or was the purchase facilitated by an intermediary?’ The words ‘intermediary’ and ‘broker’ are used interchangeably throughout this text.

Modern day short term insurance distribution channels are defined by the relationships between the insurance company and end consumers and influenced both by the complexity of the insurance product and the sophistication of the client.

Editor’s note

At the time of writing the legal definition for intermediaries in the long term and short term insurance disciplines were unclear. The FSB published a Retail Distribution Review (RDR) discussion paper in November 2014 wherein it set out to address this uncertainty.

By April 2016 the RDR Phase 1 implementation had been postponed until 2017; although the consensus during industry discussion seemed to be to refer to short term insurance intermediaries as either insurance brokers or insurance agents. An insurance broker would offer policies from multiple insurers whereas an agent would represent policies of one insurer only.

The independent broker definition was dropped due to it being impossible for a short term insurance broker to operate in a truly supplier independent way.

The market for complex commercial insurance product is dominated by traditional insurers who distribute insurance via intermediated distribution channels whereas in the personal lines space, where the insurance offering tends to be simpler, the balance is shifting in favour of direct insurers that distribute via call centres and the Internet.

We will consider various distribution channels in the paragraphs that follow. In each case we distinguish between the channel (how insurance is sold) and the structures in place to facilitate the sale.

Direct insurance distribution

Direct insurance is insurance without an intermediary. The consumer purchases the policy directly from the insurance carrier unassisted by either a short term insurance broker or an agent of the insurer. Interaction between the consumer and insurer is typically through a telesales agent employed by the insurer.

The commoditisation of short term insurance personal lines policies started in the motor vehicle insurance class and swiftly spread to personal lines homeowners and householders policies. To commoditise is the act of making a process, good or service easy to obtain by making it as uniform, plentiful and affordable as possible. In the insurance sector a product can be thought of as commoditised when one insurer’s offering is virtually indistinguishable from the next.  

The commoditisation of personal lines insurance classes means that competing insurers can develop and package insurance products that offer comparable covers that are easy for consumers to understand and can be sold with the minimum of sales input. The insurance policy can be bought “off the shelf” or sold over the telephone by telesales agents. Some classes of insurance are so commoditised that it is literally possible to package and sell solutions in a retail outlet or by way of SMS messages carried on conventional GSM mobile phones.

Technology has been a major enabler for commoditisation and has contributed to the rise of the direct insurer. It started with advances in call centre capabilities and reached a pinnacle with the invention and subsequent exponential growth of the Internet. Nowadays the terms ‘direct insurance’, ‘telephone insurance’ and ‘online insurance’ are used interchangeably, with each being part of an insurer’s direct channel.
The following marketing wording nicely captures the direct insurance concept: ‘By harnessing the power and convenience of the Internet, we aim to empower you, the South African consumer, to quote and buy your insurance online – as well as to manage your financial services portfolio online or through our telescentres – at your convenience’.  

The mechanics of direct insurance is fairly simple and involves the consumer applying for cover by way of a telephone conversation with a telesales agent employed by the insurance carrier, or by filling in a quotation form online. Underwriting decisions and policy administration are still handled internally by the insurance carrier, though it is quite common nowadays for insurers to include a sophisticated automated underwriting process as part of their direct channel.

Consumers who buy insurance direct are self-advised and must take extra care to study their policy wordings to ensure that they comply with the terms and conditions imposed by their insurer. The consumer will also have to initiate future interactions with the insurance carrier in the event of changes to the risks on cover or other policy-related matters.

The South African Insurance Association (SAIA) offered the following guidelines for traditional insurance companies that were intent on selling via a direct insurance channel:

- Be decisive about channel choice and make a commitment to direct distribution;
- Make ‘simple, fast and accurate’ core to the solution;
- Products must be simple to reduce the number of questions, trailing documents and on-boarding requirements;
- Design for multi-channel from the beginning to include seamless transitions from online to call centre;
- Build digital marketing as a core competency;
- Create pricing sophistication and offer competitive pricing as part of the total value proposition;
- Improve customer confidence in the online purchasing process; and
- Test and learn before scaling.

**History of the direct channel**

Direct writing emerged as a concept in the US in the early 1900s where mutual companies concentrated on selling insurance to farmers. From the 1920s insurers began offering motor vehicle insurance directly to these agriculture ‘bases’. US insurance giants such as State Farm, Nationwide, American Family and Farmers were born in this way.

Nowadays the term ‘direct writer’ has a slightly different connotation in that it refers to insurers selling directly to consumers through the mail, Internet or telephone. GEICO, one of the largest auto insurance companies that today markets directly to consumers, started in 1936 as the Government Employees Insurance Company, selling to government employees.

Douw Steyn, founder of Telesure Holdings, is credited with SA’s first foray into modern day direct insurance via the group’s wholly owned subsidiary, Auto & General (A&G). The insurer, which was established on 1 June 1985, disrupted the South African market by introducing paperless, computerised and voice-recorded underwriting for its personal lines business in the mid-1980s.

It introduced a computer-based personal lines policy known as Excel-10 in 1986 and entered the world of direct telephone marketing through its Teleplan product soon thereafter. Santam Limited entered the fray around the same time with its Teleplex offering.

Incentives – subsequently banned – were used to entice customers to transact for their insurance cover by telephone. In the early 1990s A&G’s marketing blurb read: ‘Show us your policy purchased telephonically at a lower rate this month and receive a 750ml bottle of sparkling wine from us.’

Santam reportedly offered a premium reduction of up to 30% on its Teleplex product thanks to ‘rationalising administrative processes’.

The next evolution of direct insurance was triggered by the arrival and widespread adoption of the Internet. Existing insurers saw the value in deploying their business processes and systems online while new entrants saw the gap to enter the market thanks to the efficiencies achieved through selling and administering short term insurance products online. Both established players and new entrants continued to rely on call centres to back up their online offerings.

OUTsurance (83% held by RMI Holdings) was launched in 1998 and Budget Insurance (also part of Telesure Insurance Holdings) was born in the same year. Telesure subsequently launched Dial Direct in 2003 as a tele-insurer coupled with extensive online systems and processes. All three of these brands started out by offering personal lines insurance products. OUTsurance subsequently entered the direct business insurance segment in 2003 and added direct life cover (death, disability and critical illness) in 2010.
Santam also got in on the act and launched its direct insurance offering through a 25% stake in MiWay in 2008. By 2011 MiWay was a wholly owned subsidiary of the insurer. Mutual & Federal meanwhile had followed suit with a direct offering of its own when it opened iWyze in 2010.

Direct insurance has proven extremely popular as illustrated by the quick uptake among personal lines consumers over the past two decades. MiWay reached 140 000 policies in its first three years. More recently King Price – launched in 2012 – signed on 10 000 policyholders in its first six months. This start-up has achieved phenomenal 50%-plus year-on-year growth and is on target for R770 million in GWP in 2016 from just R63 million in 2013.

Traditional insurers came in for a lot of criticism from insurance brokers for entering the direct insurance market. However the phenomenal growth in direct-only business confirms the market share erosion that traditional insurers would have suffered had they done nothing.

The Philadelphia Contributionship for the insurance of houses from loss by fire

There is evidence of direct short term insurance offers being made to the public as early as the mid-1700s. In February 1752 Benjamin Franklin published a notice in his newspaper, The Pennsylvania Gazette, inviting members of the public who were interested in ‘subscribing to the terms and conditions of a new mutual fire insurance company’ to attend a meeting.

The first meeting was held around April of that year following which a mutual insurance firm was established under the name Philadelphia Contributionship for the Insurance of Houses from Loss by Fire. The Contributionsship’s first policy was issued in June 1752. The firm was granted permission to incorporate in 1768 allowing Franklin to add the title ‘insurer’ to a long list of titles that included statesman, scientist, inventor and author.

The Contributionship is credited with improvements in building standards at the time due to its refusal to insure houses that presented unacceptable fire risks providing us with an early example of risk mitigation in action.

Surveyors were sent to inspect each building upon receipt of which the firm’s directors would set an appropriate premium. Policyholders paid a deposit that was refundable at the end of a seven year period after allowing for deductions for a survey, policy and fire mark.

A US-based insurer founded in 1810 was the first to attempt direct distribution via the postal service. The Hartford had an agency network; but wished to sell its policies in areas that were not serviced by the network. It thus decided to place advertisements inviting people to apply for cover directly to its company secretary via the US postal service. This early foray into direct mail insurance was a failure.

Intermediated insurance distribution

Intermediated insurance distribution takes place through an insurance intermediary, more commonly referred to as a short term insurance broker. The broker introduces a policyholder to an insurer in return for a regulated commission.

Per the Short Term Insurance Act (Act No. 53 of 1998) - the STI Act - the commission cap that applies in the short term insurance market is 12.5% for motor and 20% for all other policies. The industry experience is that these ‘capped’ commissions are today applied as standard.

Other fees that can be paid by an insurer to an intermediary include binder fees, outsource fees and section 8(5) fees. These fees, which are currently under regulatory review, will be discussed briefly in this chapter under the broker remuneration heading.

Short term insurance brokers play an important part in the broader insurance sector. In ‘Direct insurers versus brokers’, an article in Insurance Times & Investment News, February 2005, Anton Ossip, then CEO of Alexander Forbes Personal Services, describes the role of an insurance broker as ‘to act in an advisory capacity to educate, inform and to service the insured’.
He adds that the service offered by a broker to an insured includes assessing his or her needs, advising on the most appropriate insurance product (one that aligns with the insured’s requirements) as well as ensuring that the insured is well-informed of all the clauses in the contract, thus minimising the likelihood of a repudiation of the claim.

Intermediaries introduce approximately 65% of GWP in the short term insurance personal lines class and virtually all of the business in the commercial lines class in SA. In an interview with industry magazine FA News, Ian Kirk, then CEO of short term insurer Santam Limited, said that intermediaries played a crucial role in the growth of the insurer’s commercial lines business: ‘The truth is that this class of business cannot be written directly; some of the direct players think it can, but it is very difficult’.

**History of intermediated distribution**

Insurance brokers owe their existence to the growing complexity of the business world and the insurance needs these introduced. In the US, short term insurance broking firms started appearing in the late 19th century with a notable being Johnson & Higgins in New York in 1845. The firm became part of what is now Marsh Inc. in 1997. Marsh has offices in SA today.

The United Kingdom has an incredibly rich insurance history, partly discussed in chapter two. Much of this history centres on Lloyd’s, which is neither an insurance firm nor an insurance broker. Lloyd’s is actually a corporate body governed by the Lloyd’s Act of 1871 and subsequent Acts of UK Parliament.

Located in London, Lloyd’s serves as a marketplace within which financial backers come together to pool and spread risk. These backers are known as underwriters, members or – more traditionally – ’names’. Insurance brokers play a major role in Lloyd’s success in that the 219-plus Lloyd’s brokers assisted its 94 syndicates in writing £ 25.3 billion of gross premiums in the 2014 financial year.

Readers with an interest in history will find volumes written on Lloyd’s, which has its roots in the Lloyd’s Coffee Shop (established 1688) with the ‘brand’ being established in marine shipping by around 1730, the Lloyd’s List first published in 1738; and the Lloyd’s Society formalised in 1774. Lloyd’s brokers started targeting the US market in the late 1890s.

### Direct versus intermediated business in SA, 2014

The total GWP in the South African short term insurance market came in at R90.8 billion for 2014. Of this premium some R46.8 billion is written in the personal lines class. The premium written for the personal lines motor class contributes R27.2 billion to that total.

In other words personal lines motor is the single largest class of insurance in SA comprising 30% of total GWP and 58.1% of GWP in the personal lines category. How much of personal lines motor premium is written by direct versus intermediated insurers?

At the end of 2014 the split was 40% direct (R10.8 billion) versus 60% intermediated (R16.4 billion). GWP in the non-motor personal lines class stood at R19.6 billion shared between direct insurers (R5.6 billion) and traditional insurers (R14 billion).

It is worth noting that when the personal lines property class is added to the equation and the total personal lines class is considered, the split changes to 35% direct versus 65% intermediated. This confirms the focus by direct insurers on the highly commoditised personal lines motor class.

An assessment of the short term insurance sector from 2009 to 2014 confirms a gradual increase in the direct share of total GWP versus intermediated, with growth in the former of 15% per annum and the latter of 7% per annum over the five years.

Total sector-wide GWP has grown from R68.7 billion to R100.4 billion; direct written business from R8 billion to R17 billion; and intermediated business from R60 billion to R84 billion. Direct premiums have thus climbed from 13.3% of the total short term insurance market in 2009 to 20.2% in 2014.

Overarching trends in technology, consumerism and demographics will over time tip the scales in favour of direct over intermediated business. The UK experience is that approximately 85% of personal lines motor business is ‘lost’ to intermediaries due to it being written either by direct insurers or through insurer-linked aggregators.
The direct versus intermediated insurance debate

The stakeholder who stood to lose the most following the introduction of the direct insurance distribution channel – whether by mail, telephone marketing or online – was the insurance broker. As early as 1989 ‘the trend towards using direct mail as a method of marketing in both the short term and life assurance markets had become a factor of concern for brokers’.

The main concern then, as it is today, was that short term insurance brokers’ earnings are impacted as more policies are sold through non-broker channels. Insurers, on the other hand, are not too concerned about where their new business originates from.

Traditional insurers that introduced direct marketing channels were at pains not to alienate their broker networks. Early adopters even tried to encourage brokers to write business using the systems and processes introduced as part of their direct channels. But the direct insurers had no such qualms.

During the late 1990s and early 2000s the direct insurers spent hundreds of millions of rand on advertising campaigns through which the image and reputation of insurance brokers was severely compromised. They painted insurance brokers as greedy middlemen who had little interest in their clients’ wellbeing and earned excessive commissions on their premiums.

It was left to SAIA, the insurers’ representative body, to intervene in this direct versus intermediated war. The association informed its short term insurance members that marketing efforts should be directed towards improving the industry’s image and reputation amongst the consuming public. Industry has respected this request, though the legacy of ‘cut out the middleman’ advertising will remain for some time.

The irony, lost on most consumers, is that the marketing expenditure of the direct players probably exceeded the commissions that their intermediated competitors were paying at the time. An assessment of the FSB’s 2002 Annual Report showed that the total average expenses were almost identical in the direct versus traditional insurer space. Commissions paid by traditional insurers are largely offset by marketing expenses incurred by the direct insurers.

In May 2011 Kirk told FAnews Online: ‘There is a perception that if you buy direct your insurance will be cheaper and if you go the intermediated route it is more expensive, but this is not the case’. Broker commissions account for around 15% of the monthly premium which expense is often matched by the direct insurers’ advertising spend.

Ossip told Insurance Times and Investments, February 2005: ‘If a broker is not used to facilitate the service and product delivery, the service costs are redirected elsewhere into extensive marketing and advertising campaigns and call centres, all adding up to notably higher expenses’.

Various pros and cons of the two distribution models have been debated over time. Direct insurers would argue that customers save money by cutting out the broker whilst the traditional insurers believe that the value of advice and services contributed by their intermediaries exceeds the fees and commissions being paid to them.

Another pro-intermediary argument is that broker advice is invaluable in ensuring that customers understand what they are buying, because insurance policies vary significantly from one insurer to the next, even when they are providing cover for the same assets and risks. Brokers also act as a liaison between the insured and insurer at claims stage.

The perception that direct insurers were less inclined to settle claims against their policies than traditional insurers appears to have been dispelled with the inclusion of claims repudiation statistics in the Ombudsman for Short Term Insurance (OSTI) annual report, since 2014.

Although the OSTI warns against using these statistics as a basis for comparison it would appear, by and large, that once a claim is reported the customer claims experience is similar from one insurer to the next, regardless of distribution preference.

Differences between the claims pay-out ratios reported by direct versus intermediated insurers must therefore vest in the repudiation process, the reduction in claims due to customers eager to receive their no-claims incentives or perhaps in the application of higher excesses.

The SAIA suggested that traditional insurers could respond to the increasing popularity of direct distribution channels in one of three ways:

- Innovate – searching for growth: Direct insurance is an opportunity to innovate and search for growth by leading the direct-to-consumer trend;
o Wait and see – aware of the direct threat but slow to implement strategic changes: Proceeding cautiously so as not to upset broker networks;
o Wait it out – believing old approaches will prevail: ‘These insurers continue to depend on the personal relationships between their intermediaries and customers to win in the market’.

It would appear that the large traditional insurers Santam and Mutual & Federal opted to play ‘catch up’ in that they were aware of the benefits of the direct channel, but preferred to proceed with caution in order not to alienate their extensive broker networks. Zurich Insurance decided to wait it out and continues to be a broker intermediated business to this day.

The modern insurance environment has evolved to include insurers that distribute through intermediaries only, those that have both intermediated and direct insurers within group, direct insurers that have broker divisions and insurers that write business in the direct space only.

3.4 The role of the insurance broker

A short term insurance broker is a person or company registered as an adviser on matters of insurance and as an arranger of insurance cover with an insurer on behalf of a client. There are many individuals who provide short term insurance advice as sole proprietors, but the trend is towards insurance broking practices (also called insurance brokerages or insurance broking firms) that comprise administrators, individual brokers and compliance officers.

SA’s short term insurance brokers must comply with provisions in the STI Act and the Financial Advisory and Intermediary Services Act (Act No. 37 of 2002) – the FAIS Act. The FAIS Act is accompanied by a General Code of Conduct which is quite prescriptive with regards the activities that an intermediary must perform.

The FAIS Act requires that each and every broking practice is licensed by the FSB as a Financial Services Provider (FSP). Each FSP must have at least one key individual (KI) and can have any number or representatives (Reps), all of whom must be registered with the FSB. A broker trading as a sole proprietor must be licensed as a KI.

Brokers are often the first line of insurance education for customers partly due to their role in advising on insurance needs and partly due to the rigorous requirements of the FAIS Act.

### Interesting fact

**Renaming regulation**

The FAIS Act was initially considered as the Financial Advisor’s Bill, the Regulation of Retail Investment Service Provider Bill and the Financial Service Providers Bill. It was eventually promulgated as the Financial Advisory and Intermediary Services Act (Act No. 37 of 2002) and came into effect from 30 September 2004.

### Why use a broker?

A short term insurance broker performs critical services for both insurer and policyholder including assisting with the placing of risk, claims processing and accounting for insurance premiums. It is important that a broker or broking firm establish a trust relationship with their clients.

Cost is a major driver of short term insurance consumption behaviour, followed by the purchasing experience and peace of mind that assets are adequately protected. An insurance broker scores better than a direct insurer under each of these headings.

- **Cost**: The quotation that the broker obtains for the client is often better than that of the direct insurer. Reasons for this include the relationship between brokers and insurers and the ability that independent brokers have to shop around for the best premium on offer. A broker-introduced policy carries less risk to the insurance company than a direct policy due to the additional assistance offered to the client during the underwriting stage. An advised client can avoid costly mistakes such as purchasing the wrong type of cover, insuring assets at the wrong value or failing to implement the necessary risk mitigation solutions.

- **Purchasing experience**: Obtaining an insurance quote from a direct insurer or an insurance broker is quite similar these days, with both channels often making use of online or telephone-assisted processes. The big differentiator for the insurance broker is when the client needs assistance with non-standard cover or a detailed explanation of the cover provided. Brokers are also more adept at handling changes throughout the life of the policy.
Peace of mind: A consumer has limited assurance that he or she has purchased the correct cover when transacting on a direct insurance platform, whether online or assisted by an insurer telesales agent. The broker is better able to inform the consumer about the types and extent of cover as well as any exclusions, excesses and risk mitigation requirements that the insurer might apply. This ‘peace of mind’ is a major ‘win’ for brokers over direct insurers.

Claims assistance: Brokers really shine at claims stage when their relationship with both client and insurer combines with their broad knowledge of insurance processes to ensure a seamless and hassle free resolution. An insurance broker will go way beyond what the direct insurer’s support desk does in expediting claims or fighting for the policyholder in the event the insurer shows reluctance to pay out.

The above points illustrate how much value the short term insurance broker can add in the market for commoditised personal lines insurance. When it comes to complex policies offered in the commercial lines class, brokers leave the direct insurance firms in their dust.

Some of the larger short term brokers go so far as to write their own policy wordings, agreed to by their carrying insurer, which can ensure that certain clients receive cover and terms that are more appropriate to their needs than the policies offered by the insurers.

SMEs will find a good insurance broker indispensable and will typically do business with smaller brokerages or sole proprietors. Large multinational firms conducting their business in SA will usually favour big brokerages that have global reach and have a strong actuarial, advisory and benefits management offering.

Services that short term insurance brokers perform for clients

- Conduct assessment of the insurance needs;
- Obtain quotations from recognised insurers and assist in choosing from these;
- Obtain cover and explain the financial implications, policy wordings and insurer details (this cover must be placed directly with an insurer or through an authorised UMA);
- Notify the policyholder timeously of –
  - Changes in policy conditions, or new endorsements;
  - Cancellation of the policy;
  - Projected increases in premiums;
  - Non-receipt of premiums;
- Obtain prior permission from the policyholder to alter their portfolio or cancel or replace their policy; and
- Render assistance in complying with the insurer’s claim procedures and liaising between policyholder and insurer until such time as the claim is settled.

Additional services and premium collection

A short term insurance intermediary is allowed to collect premiums on an insurer’s behalf subject to section 45 of the STI Act, read with regulation 4.1 of the regulations under the Act. In terms of the regulation premium can be collected in a number of ways:

- Paid by the policyholder direct to the insurer;
- Collected by the client’s insurance broker and paid over to the underwriter, in which case –
  - The broker must be authorised by the insurer to collect premiums, there must be only one broker in the chain and there must be a premium guarantee in place.
  - Where the broker is authorised by the insurer to collect premiums, the prompt payment by a client of premium to the broker is seen as prompt payment to the insurer.
- Administered by a premium collection agency; or
- Funded by a premium finance company and paid annually.

The Intermediaries Guarantee Facility Limited (IGF) was established by the short term insurance industry in order for intermediaries that were involved in premium collection to provide the necessary security. A guarantee premium is calculated on a sliding scale and is paid by the intermediary annually upon renewal or at first application.

The RDR, currently underway, has proposed changes to the intermediaries’ role in respect of premium collection: ‘Where certain ongoing services present particular conduct risks, limitations will be placed on which intermediaries can perform these functions – in particular, insurance premium collection will be limited to qualifying intermediaries only’. 
RDR’s ‘Proposal F’ reveals that the standards ‘will include operational capability requirements and standards relating to remuneration for the service and mitigation of conflicts of interest’. In determining a fee the regulator has deemed that premium collection will be considered as one of many services that qualifying intermediaries can provide on behalf of the insurer.

The value of short term insurance and advice

Insurers and their short term insurance broker partners add significant value both to consumers and to the broader economy. According to short term insurance brokerage, Marsh, the benefits of insurance cover far outweigh the disadvantages.

‘Insurance permits businesses and home owners to recover quickly after major negative events and protects purchases like homes, motor vehicles and valuables – it plays an important and unique role in the daily lives of millions of people so it is imperative to have an insurance industry that is sustainable, innovative and competitive’.

Momentum Short-term Insurance observes that the core value of having an insurance policy is the financial protection the policyholder receives in the event of unforeseen situations – knowing that there is a safe-guard and cover against a financial loss helps to reduce anxiety and fear: ‘Life’s many uncertainties are what make short term insurance necessary and with the right insurance policy in place, the insured can quickly recover from a financial loss’.

The value of an insurer is undeniable; but difficult to measure. From a strict economic perspective we might comment on the R43.172 billion paid out by short term insurers to settle claims in 2014. More difficult is how one goes about measuring the value contributed by short term insurance brokers?

The consensus is that the value of a short term insurance broker stems from the advice that he or she brings to the table at policy inception (underwriting), renewal and claims stage. After extensive reading we submit the following bullet points to substantiate the claimed ‘value in advice’:

- A broker will be able to facilitate the making of a well-managed insurance programme that accounts for the policyholders’ unique needs and risk profile, while matching their available budget – Aon South Africa.
- A broker will ensure that there are no surprises waiting for the policyholder at claims stage and will be able to confirm exactly what the policyholder is covered for and whether any exclusions or special conditions apply – Aon South Africa.
- A broker with sector-specific experience is invaluable in ensuring that the policyholders’ cover is adequate for the exposure to risk and that there are no further exposures under any exclusions and conditions that may exist on the policy – Aon South Africa.
- The best approach is to use a qualified intermediary who understands the business and its value chain – the intermediary will have the required knowledge and experience to provide the best solution to adequately mitigate the risks the business does not want to self-insure – Mutual & Federal.
- Consumers should appoint a qualified and reliable insurance broker who will establish the client’s risk and affordability appetite in order to tailor the insurance policy to include an excess structure that best fits the client’s profile which will, avoid financial strain when it comes to claims stage – PPS.
- When it comes to shopping for insurance, there is really no beating the help and guidance of a professional insurance broker to protect the policyholder’s interests, point out all the important aspects of the cover and make sure there are no unwelcome surprises at claims stage – Aon South Africa.

The value that an insurance broker adds to the short term insurance sector is well documented. Kirk spoke extensively about the benefits to consumers of an insurance broker during Santam’s 2011 brand relaunch. He observed that personal lines consumers receive a great deal of assistance from intermediaries at claims stage: ‘A broker’s client benefits from emotional support, administrative assistance and the broker’s relationship with the insurer at this critical time’.

Traditional insurers have long held that the perception created amongst consumers that brokers do not add value are incorrect. Brokers more than earn their fees by searching for competitive quotes in the market, by advising clients on the necessary cover and the correct insured value and by assisting clients at claims stage.

While direct and traditional insurers cannot be compared like-for-like it is generally true that direct insurers pay out less in claims and have higher rejection rates. As a result direct insurers are more profitable than their traditional insurer peers. The argument that consumers save fees by ‘cutting out the middleman’ is easily dismissed by comparing acquisition costs. Savings made by direct insurers in keeping their distribution function in-house are offset by their significant advertising budgets, for example.
Broker remuneration
Short term insurance brokers receive an as-and-when commission that is collected from their clients as part of their monthly insurance premium. The party responsible for premium collection will collect premiums from policyholders and pay the necessary dues to the insurer and insurance broker after subtracting its fees.

Commissions are stipulated as regulations under the STI Act and have been pegged at a maximum of 12.5% on motor vehicle insurance premiums and 20% on all other insurance classes for some time. The short term insurance sector’s Policyholder Protection Rules (effective from 1 July 2001) require that the commissions paid to brokers be disclosed to policyholders.

The FSB has considered deregulating the commission paid to short term insurance brokers by revoking the statutory maximum. As far back as 2000 the FSB Policy Board ‘gave their support in principle to the removal of commission maxima, provided consumer education programmes are commenced’.

Two years later the FSB announced their intention to ‘remove the statutory ceiling on payment of commission to intermediaries on commercial and corporate business in the short-term insurance industry’. It was proposed that this would happen following the implementation of the FAIS Act.

But by 2007 it was clear that the de-capping of commission was no longer on the agenda, as the de-capping of commissions was not reconsidered during the year. More recently the remuneration of financial advisers and short term insurance brokers is under the microscope as part of RDR.

Among the RDR proposals is that brokers charge an advice fee in addition to commission in which case the current commission levels may change. There are more significant changes afoot with regards remuneration arrangements for binder and outsource agreements.

Binder agreements and binder fees
A binder agreement is an agreement between an insurer and a third party – a short term insurance broker or UMA – as stipulated in section 48A of the STI Act. Binders in the long term insurance sector are regulated under section 49A of the Long Term Insurance Act (Act No. 52 of 1998), but will not be discussed in this book.

Under a binder agreement an insurer mandates a third party (also called the binder holder) to perform certain functions on its behalf. The binder holder ‘acts’ for the insurer. Provisions for binder agreements were first introduced as regulations to the STI Act by the Insurance Laws Amendment Act (Act No. 52 of 1998), but will not be discussed in this book.

The new regulations clearly set out which entities can enter into binder agreements as well as the functions that they can perform for the insurer. Per the latest regulation only a non-mandated intermediary (short term insurance broker) or UMA can enter into a binder arrangement.

A ‘mandated intermediary’ is an independent intermediary that holds a written mandate from a potential policyholder or policyholder that authorises the intermediary, without having to obtain the policyholder’s approval, to perform any act – including termination – in relation to a policy that legally binds the policyholder.

A ‘non-mandated intermediary’ is defined as a representative or independent intermediary other than a mandated intermediary or UMA. Readers should note that the definition of a non-mandated intermediary is peculiar to the binder field.

The four functions that binder holders might perform for an insurer include entering into, renewing or varying an insurance policy; determining the wording of a policy; determining the premiums under a policy; and settling claims under a policy.

The third party earns binder fees in return for performing the functions stipulated in the binder agreement. In terms of the regulation, binder fees must be reasonably commensurate with the activity performed and allow for a reasonable rate of return. An important rule is that the binder holder cannot add any charge to the insureds’ gross premium.

The regulations stipulate a number of functions for which a fee cannot be earned, including refusing to renew a policy; rejecting or refusing to pay a claim or part thereof; terminating, repudiating or denying policyholder liability; or...
declaring a policy void. Such stipulations were introduced to prevent conflicts that arose due to the non-mandated intermediary acting both as an agent for the policyholder and as a binder holder for the insurer.

Binder fees are under review in the FSB’s RDR discussion paper. At the time of writing it seemed almost certain that binder fees would be capped.

Other fees payable to brokers

Short term insurance intermediaries can charge a section 8(5) fee, also described as a ‘broker fee’ or ‘policyholder fee’. This fee is levied over and above any commission, binder or outsource fee provided that the amount of the fee is disclosed expressly and separately to the policyholder.

The Financial Services Laws General Amendment Bill (or Omnibus Bill) provides for the deletion of section 8(5) from the STI Act. However the section will only be removed once the RDR process is completed. Per the regulator: ‘The current provision allowing for additional fees over and above commission, through section 8(5), will be removed’. It is envisaged that intermediaries will negotiate an advice fee with their clients to replace the section 8(5) fee.

At the same time as the new binder regulations took effect the governance of remuneration for other outsourced services was dealt with by Directive 159. This directive requires that outsource fees must be reasonable and commensurate with the actual function or activity when an insurer outsources an aspect of its insurance business, excluding intermediary services, to another party.

The regulator stipulates that an outsource fee must:

- Be reasonable and commensurate with the actual function or activity outsourced;
- Not result in any function or activity in respect of which commission or a binder fee is payable being remunerated again;
- Not be structured in a manner that may increase the risk of unfair treatment of policyholders; and
- Not be linked to the monetary value of insurance claims repudiated, paid, not paid or partially paid.  

Broker representative bodies

SA’s short term insurance brokers are represented by the Financial Intermediaries Association of Southern Africa (FIA). The FIA is SA’s only trade association for intermediaries and it is estimated that 80% of SA’s intermediated short term insurance premium is written by its members. The FIA serves various functions for its intermediary members, including:

- Improve and promote the image and standing of the intermediary and the broader financial services sector;
- Represent intermediaries’ interests with regard to existing and future legislation that may impact their businesses;
- Consult members on proposed regulation and – based on this feedback – influence the regulatory process through discourse with the regulators and public comment;
- Establish relationships with other national and international bodies or organisations that have similar objectives; and
- Provide information to members that assists in their profession.

FIA members are also obliged to conduct their business in terms of the FIA’s Code of Conduct. This code strives to ensure that intermediaries maintain a professional relationship with their clients, one another, regulators and product suppliers.

There is more information about broker bodies, insurer associations and standards accreditation agencies in chapter 14.

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**Case Study**

**Personal Lines Insurance**

**Case study: How does personal lines insurance work?**

**Step 1: Consumer identifies a need**

The personal lines insurance process begins when a consumer decides that he or she wants protection from the financial loss due to the potential damage to or loss of a personal asset. This want is often triggered by a decision to purchase a motor vehicle or house on credit. In either case the bank or finance institution, which has a substantial interest in the asset, will insist that insurance is in place.
The decision to purchase personal lines cover also has some cultural roots, with a frequent admission along the following lines: ‘My parents had insurance cover on their house, motor vehicles and personal goods so I did the same as soon as I moved out into a home of my own’.

**Step 2: Consumer chooses an insurance platform**

Once the need is identified the consumer must decide where to purchase the necessary personal lines insurance cover. It is common practice nowadays for banks (in the case of home loans) or F&I consultants (in the case of motor vehicle finance agreements) to offer to arrange insurance on the consumers’ behalf. But consumers are well within their rights to refuse these offers and arrange the necessary insurance cover themselves.

There are two channels available to consumers who prefer to make their own insurance arrangements. Either they can purchase insurance directly from an insurer or they can do so with assistance from a short term insurance broker.

**Step 3: Requesting an insurance quote**

*From an insurer:* The consumer will request a quote from the short term insurer of his or her choice by either telephoning the insurer or completing its online quotation form. A third option in this category is to request quotes from an insurance aggregator which provides multiple indicative quotes from a number of insurers.

Whichever of these options is followed the consumer will eventually interact with a telesales agent employed by the insurer who will ask a series of underwriting questions. Based on this discussion the insurer will make an offer to insure the consumer’s assets for a certain premium.

*From an insurance broker:* The processes and systems operated by today’s tech-savvy short term insurance brokers are of such high standard that the consumer experience will be quite similar to that discussed above. The process begins when the consumer telephones, emails or completes the broker’s online quotation form. The insurance broker will also contact the consumer to obtain any additional underwriting information.

But the process differs slightly from this point because the insurance broker will not provide an instant quote. An insurance broker has contracts with a number of insurers and will contact one or more of these insurers to determine where the consumer will receive the best combination of insurance cover for the premium charged. The broker receives these quotes back from the various insurers and will then contact the consumer to inform him or her of the outcome.

**Step 4: Accepting the quote, going on cover:**

The consumer must decide whether he or she is happy with the quote provided by the insurer or insurance broker. Once a quote is accepted the insurance cover can start immediately though it is important that the insurer pays the first premium instalment when it falls due.

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**Commercial Insurance**

**Case study: How does commercial insurance work?**

Commercial insurance is more complex than personal lines insurance and there is seldom a ‘one size fits all’ solution. For this reason the preference is to structure commercial insurance policies with assistance from a short term insurance broker.

The typical process is for the business owner or management team to contact the insurance broker and request for commercial insurance cover. Once in place this cover will be reviewed by the insurance broker on an annual basis.

The short term insurance broker will conduct a detailed assessment of the risks presented by the business and make a recommendation to the business owner or management team with regards a range of necessary covers.
The structuring of a commercial insurance policy requires lengthy negotiations between business representatives, the insurance broker and the ultimate risk carrier which may include one or more UMAs or insurers. A final solution will involve numerous difficult decisions about types of insurance cover and sums insured as well as the exclusions and excesses that will be applied.

It is unlikely that the quote will be finalised without the insurance broker completing an on-site inspection of the business and holding detailed discussion with the business owner or management team. The final quotation will often be delayed until such time as specialist risk consultants and representatives from the insurer’s underwriting department satisfy themselves with aspects of the business, the assets that must be insured and the various processes that the business engages in. Upon acceptance of the quote the insurance broker will also play a part in ensuring that the various risk mitigation interventions indicated in the policy wording are put in place.

Direct insurers have started offering commercial insurance solutions to SMEs in specific sectors. They do so by including all of the cover that the typical business in a sector would require. It is unlikely, however, that a directly written policy will pick up on all the nuances of a modern business’ risk profile and for this reason the preference is for short term insurance brokers to handle this area.

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Chapter 4

Insurance as a component of the financial services industry

Insurance companies have a dual character that is reflected on their balance sheets. They sell insurance policies, an activity that creates liabilities and they invest, which creates assets.

Insurers maintain reserves that cover claims and future benefits and provide margins for insured events. To supplement the protection obtained from their reserves, insurers may choose to pay out part of the premiums they receive to reinsurers, which in turn then cover the insurers for their major risks. The objective of this chapter is to give an overview of this important aspect of the insurance business.

An insurer earns investment income on its ‘float’, which is described as its premium income less immediate operating expenses, as well as on its capital reserves. These large cash sums are typically invested in quality fixed income securities or in blue chip shares which generate a mix of interest and dividend income. The income section of the insurer’s annual accounts therefore also includes gains or losses on investments at fair value.

Insurance companies perform best in an environment of GDP growth - where there are increasing levels of private and government expenditure and in the number of new insurable assets - moderate inflation and positive and upward trending interest rates. The insurance business model works best when interest rates are positive. Policyholders transfer risk to insurers in terms of a contract where it is agreed that compensation for loss will be provided if a particular event occurs in the future.

In a low interest rate environment, the risk taken on by the insurer becomes more acute and premiums therefore rise. The present global negative interest rate environment, with negative 10 year bond yields in many developed countries including Japan and Sweden and decade long low rates in significant countries such as the United States and Germany signals difficult times for global insurers and their clients.

The rest of chapter 4 is available in the hard copy version of Short Term Insurance in South Africa which can be ordered online at www.analytica24.co.za. Any enquiries can be directed to info@analytica24.co.za

This “light” version of Short Term Insurance in South Africa was made possible with the kind support of Aon South Africa.
Chapter 5
Types of insurers and their functions

The purpose of this chapter is to consider the overarching types of short term insurance companies that ply their trade in South Africa (SA). It should be read in conjunction with chapter six, which provides a detailed discussion of the domestic insurance landscape.

What is an insurer?
The appropriate short term insurance definitions are found in the legislation. The Short Term Insurance Act (Act No. 53 of 1998) – the STI Act – begins by describing short term insurance as the business of providing or undertaking to provide ‘policy benefits’ under ‘short term insurance policies’. A short term insurer is further described in section 1 of the STI Act as an entity registered or deemed to be registered as a short term insurer under the Act. The bulk of the STI Act then sets out to describe the activities that a short term insurer engages in by expanding on the terms ‘policy benefits’ and ‘short term insurance policies’.

In other words the STI Act defines a short term insurer by its activities rather than providing a concise description of what an insurer is. This focus on activity-based definitions explains the regulator’s no nonsense approach when deciding on an industry stakeholder’s role, their standard refrain in this regard being: ‘Don’t tell us what you are, tell us what you do’. Of course to describe a short term insurer as ‘that which the Act defines it to be’ is not helpful to the layperson trying to learn more about insurance. It is a common complaint that the law is self-serving and that the words and definitions used in law appear to deviate from their everyday use. Prof Robert W Vivian, Professor of Finance & Insurance at the School of Economic and Business Sciences, University of the Witwatersrand, provides some guidance on the matter.

He says that the golden rule to interpreting statutes, or any legal document, is in the first instance to accept that words are given their ordinary meaning, which in turn informs the interpretation. A court will first establish the normal meaning of a word or phrase and then question to what extent a definition in the Act changes that meaning. We have thus borrowed from the opening chapter of this book to flesh out our definition of a short term insurance company, or insurer, namely: ‘A licensed financial services provider that is in the business of providing protection for individuals and firms against the financial losses that occur following unforeseen but quantifiable loss events’.

The phrase ‘short term insurance’ is used interchangeably with ‘non-life insurance’ though the preference locally is to use the former. Many offshore markets including the United States refer to short term insurance as property & casualty insurance.

Types of short term insurers
With the ‘what is a short term insurer?’ question taken care of we can expand our discussion to consider different types of short term insurers. The STI Act provides a definition of ‘policy benefits’ and a list of types of ‘short term insurance policies’ but steers short of categorising insurers based on these definitions. This task is left to the Financial Services Board (FSB) which was established by section 2 of the Financial Services Board Act (Act No. 97 of 1990) – the FSB Act. The FSB took over the functions previously performed by the Financial Institutions Office (FIO).

The FSB is conferred wide powers of supervision and enforcement over the short term insurance industry. In terms of section 13 of the FSB Act the FSB must appoint a registrar (executive officer) and a deputy registrar (deputy executive officer) of short term insurance, which persons have the powers and duties provided for by or under the STI Act or any other applicable law. The FSB, through the registrar, holds a watching brief over the short term insurance sector.

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<th>Year</th>
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<td>Mr. Piet Badenhorst</td>
<td>1996-2000</td>
<td>Mr. Rick Cottrell</td>
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<td>2000-2005</td>
<td>Mr. Jeff van Rooyen</td>
<td>2006-2008</td>
<td>Mr. Rob Barrow</td>
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<td>2008 - present</td>
<td>Mr. Dube Tshidi</td>
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<td>Mr. Mashudu Munyai</td>
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<td>2008 - present</td>
<td>Mr. Jonathan Dixon</td>
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The FSB Act and STI Act are two components of SA’s comprehensive financial services legislative environment. Insurance regulation is continuously evolving in order to promote a fair, safe and stable insurance market for the benefit and protection of consumers.

**Editor’s note**

Much of SA’s insurance legislation is currently being reviewed and rewritten as the financial services sector moves towards a so-called Twin Peaks model of financial sector supervision. One major change is that the STI Act and the Long Term Insurance Act, 1998 (Act No. 52 of 1998) – the LTI Act – will be merged into one piece of legislation. The process is already underway with the tabling of the Insurance Bill, 2016 in January 2016. The ongoing evolution of the insurance regulatory environment is covered in more detail in chapters 10, 11 and 12.

The regulator’s first delineation of the short term insurance market was to distinguish between primary insurers and reinsurers. We will revisit these insurer types later in this chapter to first allow for a more detailed assessment of insurer activities or types of ‘short term insurance policies’ as defined in the STI Act.

## 5.1 Types of short term insurance policies

The Insurance Act (Act No.27 of 1943) described six policy types. When this Act made way for the STI Act in 1998, two policy types were added with the result the South African insurance sector today comprises eight broad policy types. These include property policies, transportation policies, motor policies, accident and health policies, guarantee policies, liability policies, engineering policies and miscellaneous policies. The policy types are defined in section 1 of the STI Act as follows:

- **Property policy**: A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if an event, contemplated in the contract as a risk other than a risk more specifically contemplated in another definition in this section relating to the use, ownership, loss of or damage to movable or immovable property occurs; and includes a reinsurance policy in respect of such a policy;

- **Transportation policy**: A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if an event, contemplated in the contract as a risk relating to the possession, use or ownership of a vessel, aircraft or other craft or for the conveyance of persons or goods by air, space, land or water, or to the storage, treatment or handling of goods so conveyed or to be so conveyed, occurs; and includes a reinsurance policy in respect of such a policy;

- **Motor policy**: A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if an event, contemplated in the contract as a risk relating to the possession, use or ownership of a motor vehicle, occurs; and includes a reinsurance policy in respect of such a policy;

- **Accident and health policy**: Is a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if a disability event, health event or death event, contemplated in the contract as a risk, occurs. Such policy may not offer benefits other than a stated sum of money nor may it encroach on the business of medical schemes as described in the Medical Schemes Act (Act No. 72 of 1967) – the MSA. The demarcation between medical schemes and insurers is discussed in greater detail in chapter 12.

- **Guarantee policy**: A contract in terms of which a person, other than a bank, in return for a premium, undertakes to provide policy benefits if an event, contemplated in the policy as a risk relating to the failure of a person to discharge an obligation, occurs; and includes a reinsurance policy in respect of such a policy.

- **Liability policy**: A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if an event, contemplated in the contract as a risk relating to the incurring of a liability, otherwise than as part of a policy relating to a risk more specifically contemplated in another definition in this section, occurs; and includes a reinsurance policy in respect of such a policy.

- **Engineering policy**: A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if an event contemplated in the contract as a risk relating to the possession, use or ownership of machinery or equipment, other than a motor vehicle, in the carrying on of a business; the erection of buildings or other structures or the undertaking of other works; or the installation of machinery or equipment, occurs; and includes a reinsurance policy in respect of such a policy.
Miscellaneous policy: A contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if an event, contemplated in the contract as a risk relating to any matter not otherwise defined in this section, occurs; and includes a reinsurance policy in respect of such a policy.

Armed with these policy types the STI Act goes on to define a short term policy as an engineering policy, a guarantee policy, a liability policy, a miscellaneous policy, a motor policy, an accident and health policy, a property policy, a transportation policy or a contract comprising a combination of any of those policies; that includes a contract whereby any such contract is renewed or varied. The STI Act stipulates that it will be up to the registrar to determine to which policy type (as defined in section 1) a policy or policies offered by an insurer belong. The STI Act further identifies the following sub-categories for primary insurer activity: Personal business, commercial business and corporate business. Insurance business is divided up under these sub-categories based on the policyholder or purchaser of the insurance cover.

How are the policy types reported on?
The FSB publishes two reports that update industry stakeholders on results in the short term insurance sector. Together these reports provide a comprehensive overview of SA’s primary insurance and reinsurance markets. These reports include:

- A quarterly report on the results of the short term insurance industry which includes results for each of the FSB-defined insurer types including primary insurers – further differentiated into typical, captive, cell captive and niche insurers – and reinsurers.
- An annual report on the results of the short term insurance industry which provides a detailed breakdown of both primary insurer and reinsurer results under each of the eight policy types as well as under the personal business, commercial business and corporate business headings.

Insurers and reinsurers are required to submit both quarterly and annual returns to the FSB and must maintain a statutory surplus asset ratio as defined in the STI Act. From 2016 insurers will have to comply with new solvency requirements as developed by the FSB’s Solvency Assessment and Management (SAM) initiative. SAM is SA’s equivalent of Solvency II, a European Union (EU) directive that codifies and harmonises EU insurance regulation and more specifically EU insurers’ capital requirements.

5.2 Primary insurers

The FSB distinguishes between primary insurers (which category includes typical insurers, cell captive insurers, captive insurers and niche insurers) and reinsurers. The reinsurer concept is quite easy to understand and we consider this type of insurer in detail in point 5.8 below. Labels such as general insurer, traditional insurer and even conventional insurer are more commonly used than primary insurer which begs the question: What does the regulator mean by primary insurer? The short answer is that if a firm is ‘carrying on the business of an insurance company’ and ‘dealing directly with the public’ then it is considered a primary insurer.

Typical insurers, captive insurers, cell captive insurers and niche insurers, whether they sell policies directly to the consumer or sell policies through an intermediary, are all sub-types of the primary insurer type and categorised based on the types of policies they mainly offer. It is perhaps easier to think of a primary insurer as any insurance company that is not a professional reinsurer. Once the reinsurers are identified – and there are not that many domestically – all other licensed insurance companies can simply be listed under the primary insurer label.

The phrases multi-line and mono-line provide a useful additional descriptor for a primary insurer. A multi-line insurer, also referred to as a multiple line insurer, is a short term insurance company that offers two or more of the eight insurance policy types discussed earlier in this chapter, whereas a mono-line insurer offers only one of the policy types. Readers should also be aware of the term composite insurer, the meaning of which varies with context. It is most often used to refer to an insurer that holds both a life and a non-life insurance license. The South African regulator stopped issuing composite licenses decades ago and the last composite insurer licensed to operate domestically closed its doors in the late 1990s.

For reporting purposes the registrar allocates the primary insurers to the various sub-types based on the primary insurer’s business model, the products offered and its target market. The regulator continuously reassesses the categorisation of the primary insurers and reallocates them to the appropriate sub-type as their business models change.

There is another distinction in the primary market for short term insurance that is not addressed either in the FSB’s financial reports or the STI Act. This distinction centres on the insurer’s distribution methodology. A direct insurer
sells insurance policies directly to the public by telephone or via the Internet whereas a traditional or intermediated insurer relies on short term insurance brokers or an agency distribution force to advise consumers and facilitate the sale.

Consumers and primary insurers

We can expand our understanding of the primary insurance market by considering how consumers interact with the world of insurance. Their opinions exhibit as insurer brand recognition, which is in turn a product of the individual insurer’s advertising and marketing initiatives.

The ‘Sunday Times Top Brands 2015’, a survey of approximately 3 500 consumers aged 18 and over, ranks SA’s top short term insurance brands as Discovery Insure, OUTsurance, Auto & General (A&G), Santam Limited (Santam), Mutual & Federal (M&F), MiWay and Budget Insurance. The business category produces a slightly different picture with Santam, OUTsurance, Mutual & Federal, Hollard and Zurich making up the top five.

A quick scan of SA’s top 100 advertisers in 2011 and 2012 identifies brands such as Budget Insurance, Hippo, Hollard, MiWay, Outurance and Santam as the big spenders in the short term insurance space. With the exception of Hippo, which is an aggregator and not an insurer, the above brands are all primary insurers licensed with the FSB. It therefore seems fair to assume that consumers recognise those short term insurers that have the largest advertising budgets.

Budget Insurance is a direct insurer that is part of the powerful Telesure group; MiWay is a direct insurer that is wholly owned by the traditional insurer Santam (also the country’s largest insurer by market share); Hollard is a traditional insurer (and currently occupies second place on the domestic market share tables); and Outurance is a direct insurer that is part of the FirstRand Group. We take a closer look at the dynamic of the SA short term insurance sector in chapter six.

The advertising statistics and brand awareness surveys suggest that South African consumers are more aware of brands in the so-called direct insurance channel due to these brands dominating the advertising expenditure tables over a number of years.

The FSB defines its primary insurer sub-types as follows.

- Typical insurers are defined as those insurers who offer most types of policies to, mostly, the general public.
- Cell captive insurers are defined as those insurers who offer insurance structures on a cell ownership basis for first party and third party cell owners.
- Captive insurers are defined as those insurers who offer cover of the risks of the owners only.
- Niche (specialist) insurers are defined as those insurers that offer, mostly, specialised cover only, in certain niche markets.

Each of the primary insurer sub-types will be explained in more detail in the paragraphs that follow.
5.3 Typical insurers

A typical insurer is defined as an insurer that offers most types of policies to, mostly, the general public. This seems like a perfectly straightforward definition until we place the domestic insurance market under the microscope. Most of the domestic insurers offer most types of policies to private individuals and to firms. So unless we expand the concept ‘general public’ to include firms, or relax the phrase ‘to, mostly, the general public’ we risk eliminating almost all insurers from this category. It is clear that the FSB considers the business insurance market to fall into the ‘to, mostly, the general public’ area.

Typical insurers therefore include those insurers that offer most the eight policy types in the personal business, commercial business and corporate business space. The big insurance brands in the direct and intermediated insurance space mostly feature under the typical insurer category. According to the FSB’s latest quarterly report on the results of the short term insurance industry, which covers the period ending 31 December 2015, there are 31 operational typical insurers in SA.

5.4 Captive and cell captive insurers

Although captive and cell captive insurers are indicated in the legislation there are no specific legislative provisions that recognise captive insurers. The FSB however provides definitions as follows:

- Captive insurers are defined as insurers that offer cover for the risks of their owners only. In SA captive insurers are referred to as wholly owned captives. The FSB lists eight operational captive insurers at 31 December 2015.
- Cell captive insurers, also called cell providers, are defined as those insurers who offer insurance structures on a cell ownership basis for first party and third party cell owners. The FSB lists six operational cell captive insurers at 31 December 2015.

The captive and cell captive concepts have an interesting history in both the global and South African context.

Captive insurers

A captive insurer is one that only insures the risks of a parent firm or group of firms. It is owned by a parent firm and is predominantly, if not exclusively, utilised to provide cover for the risks of the owner. Another way to think of it is that the parent firm has a captive insurer at its beck and call.

![Figure 5.3 – South African captive insurer arrangement, Escap SOC Limited](source: S&S Analytica, 2016)

Offshoots from the pure captive insurer include offshore captive insurers and onshore captive insurers. These definitions relate to where the captive insurer is located in relation to the parent firm as well as how the premiums paid to the captive insurer and profits generated in the captive insurer are handled from a tax and accounting perspective.
Captive insurance is a form of self-insurance for the parent firm. It offers an alternative to traditional risk financing products such as purchasing an insurance policy from a conventional insurer. Escap SOC Limited (Escap) is a contemporary example of a South African onshore captive insurer that insures state-owned power utility Eskom Holdings SOC Limited (Eskom). Why does Eskom opt for a captive insurer when it could place its risk with a mix of traditional insurers and reinsurers?

The structure allows the insured, in this case Eskom, to control the pricing and delivery of its insurance cover and share in the resultant profit. Instead of just paying an annual premium to a traditional insurer for a predetermined level of cover, Eskom can pick and choose how its premium is structured. Insurers refer to this process as unbundling the premium.

The captive insurer structure also allows traditional insurers to pass costs on to the insured. In our example Eskom will still turn to traditional insurers or reinsurers to cover its largest potential losses, while the smaller losses can be covered and reimbursed by Escap. According to Michael Mead, in his article ‘Captives 101: What are they and why do I want one?’ a captive can create the illusion of control for the insured, while eliminating nuisance costs for the insurer.

History of the captive insurer
Where did it all start? It can be difficult to conclusively identify a business innovation, but research supports that the captive insurer concept was born in the United States. There the word captive, as it relates to insurance, was first coined by Frederic Reiss (1924-1993). Reiss, a property engineer turned insurance broker, is credited with inventing the modern captive and ensuring that the concept became an established practice in the insurance industry worldwide. He established a firm called American Risk Management in 1958 and later founded International Risk Management Ltd in Bermuda, in 1972. While in Bermuda he formed the ‘captive of captives’ facility known as Hopewell International, the first established captive management organisation. This firm was dominant in the Bermuda captive insurance scene between 1972 and 1976 and was considered well ahead of its time.

SA entered the captive insurer space in the late-1970s when major industrial companies began to establish their own captive insurers. The business model was born out of necessity and became popular due to the operational challenges introduced by international sanctions and SA’s strict exchange controls. Large industrial, manufacturing and mining firms were exposed to major currency risks due to their reliance on imports for equipment, plant and production materials. The South African Reserve Bank (SARB) – with approval from the insurance regulator at the time – eventually allowed these firms to establish captive insurers predominantly in foreign jurisdictions. These were known as offshore captive insurers. These jurisdictions offered favourable tax regimes, though nowadays they must conform to international minimum tax standards under the Organisation for Economic Cooperation and Development’s (OECD) ongoing overhaul of international tax architecture.

Trouble in the captive insurer ‘paradise’
The offshore captive insurer structure was brought into question following an unrelated inquiry into the insolvency of short term insurer AA Mutual Insurance in May 1986. Government appointed a judicial commission of inquiry chaired by Justice David Melamet (Melamet, 1988) to investigate the insurer’s collapse. This commission became aware of the existence of captive insurers and recommended they be investigated as possible tax avoidance structures. The result was a second judicial commission (Melamet, 1992) which contributed to a better understanding of the SA captive insurer industry.

The collapse of AA Mutual Insurance
In May 1986 AA Mutual Insurance (AAMI) was declared insolvent. The fallout from the collapse of the composite insurer, which offered both life and short term insurance, extended well into the 1990s. All claims by the insurer’s short term policyholders were eventually settled while the life business continued as the AA Life Insurance Company. The AA Mutual collapse was investigated by Melamet, 1988. The commission concluded that ‘bad management and lack of controls’ were to blame for the failure and singled out Warren Plummer (the last AAMI managing director) as the main culprit. The commission held that Mr. Plummer manipulated the insurer’s accounts to make it appear more solvent than it was. Criticism was also levelled at Natie Kirsh, the last chairman of AAMI, for irregular payments to Plummer. Another issue raised by the commission was the undue delay at the Financial Institutions Office (FIO) in checking insurers’ returns.

Delays of more than two years were common and it was alleged that the FIO had not checked the 1980, 1981, 1984 and 1985 returns submitted by the AAMI, despite its solvency margin hovering below 20%. Concerns were...
also raised with the failure of the broader insurance sector to warn the FIO of AAMI’s difficulties despite it being common knowledge in industry circles.

Melamet made recommendations with regards future staffing at the regulator’s office and suggested that financial institutions had at least two executive directors or senior members of management in attendance at board meetings. The Melamet report triggered a step change in the South African regulatory environment that started with the promulgation of the FSB Act in 1990. This Act established the FSB to take over insurance regulatory functions from the FIO. A decade later the LTI Act and STI Act replaced the very dated 1943 insurance statute.

**Benefits of captive insurers**

The owner of the captive insurer enjoys a number of benefits including the economic benefit of sharing underwriting profits that are normally retained by the conventional insurer; having the ability to self-insure high frequency risks; having the ability to insure low frequency but high severity risk where coverage would usually be unobtainable; and direct access to reinsurance markets. Other benefits include greater control of risk management programmes, a better understanding of loss control within the parent firm and the ability to self-insure a larger quantum of risk over time. Despite these benefits it is not clear that a captive insurer provides an improved risk solution to its owner compared to engaging with a conventional insurer.

The lower cost debate is inconclusive and there is no hard evidence that supports that the captive insurer model is cheaper than buying cover from a conventional insurer. It can be argued that the premium charged by a captive versus conventional insurer should be at a similar level because the solvency of the insurer must be guaranteed in either case. One major difference between these risk management approaches is that the owner of the captive insurer will have to make an initial capital investment to create the captive structure. As a result the captive insurer structure should be viewed by the parent firm’s shareholders as speculative and long term in nature.

**Captive insurers in SA**

There are only a handful of wholly owned onshore captives remaining in SA. SA’s power utility Eskom operates an onshore captive insurer, Escap, while state-owned weapons manufacturer Denel SOC Limited operates a captive insurer known as Densecure SOC Limited. Local fuel company Engen Petroleum Limited also has a captive insurer, Enpet Africa Insurance Limited. Retail giant Pick ‘n Pay used to operate an onshore captive insurer but chose to close it in favour of a cell captive insurer structure under the Guardrisk cell captive insurance license. The FSB has relaxed some of the license conditions for onshore captive insurers and they are now allowed to underwrite staff vehicles on a staff scheme, for example. That said there is presently very little appetite for this type of insurer structure in SA.

The offshore captive insurer structure died a natural death due to SA multinationals being able to capitalise and insure their offshore operations on the international market. Eskom liquidated its offshore captive insurer, Gallium Insurance Company Limited, during the utility’s 2010 financial year: ‘The need for Gallium, as our offshore captive insurance company, has been reviewed in terms of our risk financing strategy and is no longer required’.

**Cell captive insurers**

A cell captive insurer, also known as a cell provider, offers insurance structures called cells to first party or third party cell owners. Each cell owner, whether a first party or third party cell, obtains a ‘cell’ in the cell captive insurer and then satisfies its insurance needs or offers insurance products through that cell. The various ‘cells’ are considered independent of the cell captive insurer when insolvency occurs.

The cell captive insurer operates as an onshore facility that provides for the legal, as distinct from statutory, ring-fencing of the assets and liabilities of each of its cell owners into the cell structure, usually by way of a shareholder’s agreement. The insurance solutions offered by a cell captive insurer are collectively referred to as Alternative Risk Transfer (ART). The FSB places conditions and restrictions on a cell captive insurer’s license whereas a conventional insurer is simply registered for the agreed classes of insurance business. There is nothing in the current legislation that prevents a cell captive insurer from also conducting business as a conventional insurer.

Guardrisk Insurance Company Limited is SA’s best known cell captive insurer. It bills itself as ‘the country’s leading provider of cell captive business and alternative risk transfer solutions’ and manages more than 270 cells on behalf of both first party and third party cell owners.
Types of cell captive insurers

Cell captive facilities can be divided into first party or third party cell captives. A first party cell captive – also referred to as single-parent or group cell captive – is exactly the same as a wholly owned captive insurer except that it is held in a cell. In layman’s terms the policyholder and the cell owner in a first party cell captive are one and the same. A first party cell provides cover for the cell owner’s assets, is capitalised by the cell owner and can only pay claims to a maximum of the funds available in the cell. Retailer Pick n’ Pay is a first party cell owner under the Guardrisk cell captive license. Its ‘2013 Integrated Annual Report’ notes that the group’s assets are insured against loss with cover being taken out above predetermined self-insurance levels. It uses its Guardrisk cell structure to give effect to its commercial insurance needs.

With a third party cell captive the cell owner issues insurance policies to third parties. A third party cell provides cover for assets belonging to third parties. Claims made against the cell owner’s assets, is capitalised by the cell owner and can only pay claims to a maximum of the funds available in the cell, with the cell captive provider being ultimately liable. So, for example, a motor manufacturer that owns a cell under a cell captive insurer might offer insurance to its customers on a self-branded policy that is underwritten by that insurer. These insurance policies would typically be ‘sold’ by the F&I (Finance & Insurance) agents at the motor dealerships – refer to the HSM case study below.

BMW Financial Services (BMW FS) is an example of a third party cell owner under the Guardrisk ‘cell captive license. BMW FS owns a cell under Guardrisk’s insurance licence that enables it to offer insurance policies to its clients. These policies are underwritten by Guardrisk which carries the ultimate risk. Two other cell captive structures are worth a mention. A rent-a-captive occurs when a cell provider capitalises a cell for a cell owner in return for fee or share of profit while a mutual or group captive is a cell that is shared by a number of stakeholders with similar interests.

Shareholder agreements

The roles and responsibilities of the cell provider and the cell owner are set out in the shareholder agreement. This agreement covers operational issues, sharing of risks and the sharing of profits through preferential dividend payments as well as the issue of preference shares to the cell owner. The cell provider must assess the opportunity, advise the cell owner on its initial capital requirement and then monitor this capital on an ongoing basis. Profits and losses are offset against the capital amount with excess capital being refunded. Any capital shortfall will have to be corrected by the cell owner.

Editor’s note

The FSB is currently busy with an investigation into practices and structures in the cell captive insurance segment. It published a discussion paper titled ‘Review of cell captive insurance and similar arrangements’ in 2013 and consultation with the industry in this regard is at an advanced stage. One proposal likely to have a big impact on the industry is that all ‘similar arrangements’ currently operated by insurers must be regularised by applying for cell captive licenses.
The main difference between a cell captive arrangement and a similar arrangement is that in the former the cell owner holds a specific type of shares in the insurer, usually a cell captive insurer whereas in the latter the shares are held in a direct or indirect holding company of an insurer.

**History of the cell captive insurer**

It is thought that the cell captive insurer concept was born in SA in the early 1990s. Certainly the business model that was developed locally at the time, consisting of a promoter with a core team of people coupled with multiple cell owners – all ring-fenced via shareholders’ agreements – was unique. The shareholder’s agreement is quite clear as to the responsibilities of the cell owner (the business) and the cell captive insurer or cell provider. Profits in the cell can be paid back to the cell owner subject to approval by the cell captive insurer’s board.

The STI Act does not provide for cell captive insurers but the concept is recognized by the FSB, which publishes statistics for cell captives in its quarterly report covering the short term insurance sector. The cell owner must comply with the regulatory requirements in that its cell must be sufficiently capitalised and remain solvent at all times. Cell captive insurers, meanwhile, must comply with all of the regulatory requirements that any conventional short term insurance company would. Readers may note that cell captive insurers also exist in the life insurance sector where they would fall under the Long Term Insurance Act (Act No. 52 of 1998). The structures and purposes are similar to those found in the short term insurance space, but out of scope for this book.

The major difference between SA-based and offshore-based cell captive insurers is the way in which the cell structures are set up. In the United Kingdom the cells established under a cell captive insurer are created by statute through a Protected Cell Company (PCC) arrangement, while locally they are formed through shareholder’s agreements under the Companies Act (Act No. 71 of 2008). PCCs were developed in 1997 in Guernsey and now exist in Jersey, the Cayman Islands, the Irish Republic and Bermuda as well as other domiciles around the globe. A PCC is a legal entity that is subdivided into a core, which contains the capital for the whole of the entity, and individual cells which have the option to be capitalised individually or by utilising the core funds. The assets of each individual cell are statutorily segregated so that a claim against one cell cannot be covered by the assets of another.

**Case Study**

**High Street Motors’ cell captive insurer**

High Street Motors (HSM) is a successful motor dealership that trades from 120 dealer floors across SA. The holding company decides that it would like to offer its customers a branded motor insurance policy as a convenience when they purchase a motor vehicle. It is too expensive for HSM to create a branded insurance product in the conventional market so they turn to the most viable alternative. HSM approaches a cell captive...
insurer, Motor Vehicle Cell Insurance (MVCI) Limited, and enters into a shareholder agreement with it. Under this agreement HSM becomes the owner of a third party cell which operates under MVCI’s cell captive insurer license. HSM can now market and offer a branded insurance product – let’s call it HSM Insurance – through its own cell structure, but underwritten by MVCI on its insurance license. A customer who buys insurance at an HSM dealer will receive an insurance policy issued in the name of HSM Insurance; but underwritten by MVCI.

Benefits of first and third party cell captive insurers

Firms that make use of first party cell captive structures usually face difficult or expensive-to-insure risks. Aside from the cost benefits linked to efficiencies of scale the cell owner benefits from the cell captive insurer’s ability to access both local and offshore reinsurance markets on its behalf. This is a great addition to the cell owner’s risk management strategy as an ordinary insured cannot go directly to the reinsurance market. Firms that have significant risk management requirements will normally have a risk financing structure in place. They can achieve this through a wholly owned captive, through other ART structures or through a cell captive insurer that operates in a well-regulated environment.

Economic benefit plays a role too. A conventional insurer makes an underwriting profit and retains it, whereas in the cell captive insurer environment the cell owner shares in the underwriting profit alongside the cell captive insurer. The cell owner therefore receives a share of profits by way of dividends as well as investment income on the premium and other assets ‘ring-fenced’ in the cell structure.

In the example of a motor dealer that is the owner of a third party cell the risk may be retained by the dealer (15%), by the cell captive insurer (15%) and by the reinsurer (70%) – or in any combination agreed to by the participants. The cell captive insurer would thus share in 15% of the underwriting profits. The cell captive insurer makes its money by charging each cell owner a management fee (for running the insurance business); an investment fee (or a portion of the return from the funds managed on behalf of the cell owner) and by taking a share in the underwriting risk as a conventional insurer.

Affinity business and the ‘white-labelling’ concept

The benefits of a third party cell captive structure extend to the following ‘nice to haves’. A cell owner can use the structure to improve the retention on their client base, add value to their respective loyalty schemes and boosts brand awareness. This is particularly true for the cells that are established on behalf of affinity businesses. An affinity business is a non-insurer enterprise that offers products, services or membership to a homogenous customer base. Examples include the store loyalty cards operated by clothing retailers such as Edgars or Foschini. These retailers can make use of a cell captive structure to distribute insurance products on the back of their existing strong relationships with their customers.

Affinity schemes usually offer a mono-line insurance product that is branded under the name of the affinity business, whether a cell phone operator, clothing retailer or a motor dealer. The cell captive insurer remains in the background and is not the dominant brand in the eyes of the consumer. Examples of affinity businesses offering insurance include Edgars’ funeral benefit policies, Mr Price’s cancer policies and Vodacom’s mobile phone handset cover. The first two examples are life insurance products while the third is a short term insurance product. At the higher end of the consumer market BMW FS offers a BMW FS-branded motor vehicle insurance product through its third party cell structure under the Guardrisk cell captive insurer license. The insurance is offered to customers at its various motor dealerships and is underwritten by Guardrisk.

A discussion about affinity schemes is incomplete without considering the practice of white-labelling. White-labelling is a recent concept that has developed on the fringes of the cell captive insurer market and involves a cell captive insurer underwriting an insurance product for a non-insurance business which then markets that product under the non-insurance brand. Both affinity schemes and white-labelling are currently under regulatory scrutiny and their future is under discussion as set out in the FSB’s ‘Review of cell captive insurance and similar arrangements’ discussion document.

The regulator has raised a number of concerns. It is not happy that customers are unaware of the underlying insurer on the cover they are purchasing and is uncomfortable that a non-insurer such as a general retailer or telecommunications firm can ‘sell’ insurance to the man-in-the-street without offering advice. In their view the fact that the product and product provider are licensed does not protect the ill-informed consumer. Another issue that the regulator has flagged is with the branding on policy documents. The FSB would prefer that brand exposure for the cell owner and the cell captive insurer be ‘equal’ in both the affinity scheme and white-labelling space. As currently proposed ‘the name of the insurer will need to be prominently disclosed in all marketing material and policy documents and the insurer details be given for all queries, complaints and other recourse’.
Cell captive insurers in SA
The position of cell captive insurers in SA was extensively covered by Bawcutt (1997). At the time Guardrisk was singled out as the leading cell captive insurer, a situation that holds to this day. At 31 December 2015 the group boasted 270 cell captives with the bulk of its first party cell captives domiciled in either Mauritius or Gibraltar.

Centriq Insurance Company Limited (Centriq) is another major competitor in the cell captive insurance space with 22 UMAs trading on its license at the 30th of June 2016. It is wholly owned by Santam. Other players include RMB Structured Insurance, which focuses on a different segment of the market involved with the financial structuring of large banking clients and Hollard Insurance, which operates via so-called ‘similar arrangements’ that mimic the formal cell captive structure.

Captive and cell captive trends
There is an established trend away from wholly owned captive insurers towards cell captive insurers. The main factor driving this trend is that it is materially less costly to administer a cell captive than a wholly owned captive. A cell captive insurer has the capacity and infrastructure to service multiple cells and only incurs marginal costs for each new cell that it adds.

It will take some time for the FSB to complete its assessment of the cell captive insurer marketplace and even longer for new regulations to be promulgated. At this stage it seems likely that all insurers offering a cell facility, whether through a traditional structure or by way of a ‘similar arrangement’, will have to apply for a cell captive insurance license.

5.5 Niche and specialist insurers
The term niche insurer and specialist insurer are used interchangeably, but we will use the word niche throughout. A niche insurer is defined as ‘an insurer that offers, mostly, specialised cover only, in certain niche or specialist markets’.

Another term often used to describe insurers in this class is mono-line. The FSB reported 33 operational niche insurers in SA at 31 December 2015.

Some of the best examples of niche insurers can be found in the market for trade credit insurance. In the simplest possible terms an insurer operating in this area offers its policyholders protection against unpaid invoices. Trade credit insurance solutions are especially useful for export businesses in insuring their sales and covering their risks on a case-by-case basis. Firms such as Coface SA Insurance Company and Credit Guarantee Insurance Corporation are specialist providers of trade credit solutions that operate under mono-line insurance licenses that are authorised for guarantee business only.

The guarantee business is home to another niche insurer known as the Intermediaries Guarantee Facility Limited (IGF). This facility was established by the short term insurance industry specifically to provide cover to intermediaries that collected premiums or held funds on an insurer’s behalf. The rationale for the fund was to provide insurers who outsourced premium collection to intermediaries with the required security in terms of section 45 of the STI Act, read together with regulation 4 thereto. Intermediaries have to provide proof of cover from IGF before an insurer will authorise them to collect premiums on its behalf. Legal Expenses Insurance SA, better known as LegalWise, is another niche insurer that provides cover for almost any violation of an individual’s rights. Policyholders enjoy legal protection up to a specified sum insured in return for a renewable monthly premium. The insurer is licensed under the miscellaneous business class.

Confusion sometimes arises with the definition of a niche insurer versus that of the Underwriting Management Agent (UMA) which we introduce in more detail in section 5.7 below. Both the UMA and niche insurer offer specialised insurance policies based on their product expertise or knowledge of a particular consumer market.

A quick look at the ownership structure of UMAs simply adds to the confusion due to many being owned by insurers, having been formed when expert employees at those insurers went into business for themselves. The main difference between a UMA and a niche insurer is that the UMA – whether of a general nature (offering a variety of policies) or a specialist nature (offering one cover only, say broad-form liability cover) – is always an agent for an insurer and is not a licenced insurer. Whether the UMA is piggybacking on an insurer license or operating as a third party cell owner under a cell captive insurer licence the ultimate liability for its policies lies with the insurer.
5.6 The underwriting management agency

A discussion on types of insurers is incomplete without considering the underwriting management agency (UMA). The simplest possible definition of a UMA is that it is an agent of the insurer. It is an entity that is authorised by an insurance company to accept classes of risk on the insurer’s behalf as if it was the insurer. In other words the UMA performs an underwriting function on behalf of an insurer. The UMA occupies a space between the insurance company and the short term insurance broker. It provides an alternative structure from which insurance companies can offer complex and specialist classes of insurance business. Crudely put a UMA is a type of outsourcing arrangement similar to the cell captive structure, wherein the UMA piggybacks on the infrastructure and resources of the general insurance license holder.

The insurance company, meanwhile, benefits from the specialist skills, knowledge and expertise of the UMA without having to build or develop this capacity in-house. Instead of handling complex or niche lines of cover such as aviation, liability or marine insurance in-house the insurer can appoint a UMA to sell this type of insurance cover on its behalf. Under the current regulatory environment a UMA can operate under an insurer license or a cell captive insurer license. There are local insurers that have built their entire business around the UMA model. Centriq, which operates under a cell captive insurer licence, is one such example and is a major player in the domestic UMA space.

The insurer helps the UMA by providing it with access to its insurance licenses, reinsurance capacity and technical capabilities and experience. In the case of a cell captive structure there are additional benefits in that the UMA retains independence while sharing in the underwriting profits and investment income.

History of the UMA

We can trace the history of the UMA structure to the United Kingdom where the concept was first named as Managing General Agencies (MGAs). The MGA is defined by the UK-based MGA Association as: ‘An agency whose primary function is the provision of underwriting services and whose primary fiduciary duty is to its insurer principal’. The MGA enables an insurance company with spare risk capital, but a shortage of in-house expertise, to authorise somebody else to act on its behalf. There are more than 250 MGAs in operation in the UK, at present accounting for more than £5 billion in gross written premium (GWP). GWP is the total insurance premium collected by an insurer from its policyholders.

Locally we can trace UMAs back some three decades to 1985 when Stalker Hutchison & Associates was founded as a local liability cover alternative to London-based Lloyd’s. The firm merged with Admiral Underwriting Group in 2008 and today trades as Stalker Hutchison Admiral (SHA), SA’s largest and oldest UMA. Motor Underwriting Agency – today known as MUA – was established in 1988 as a specialist UMA for the high net worth personal lines motor market.

In the early days the South African UMA landscape was dominated by a handful of highly specialised engineering, liability and marine professionals. By the late 1990s and early 2000s the arrival of so-called commoditised UMAs led to a boom in UMA numbers. Commoditised UMAs focus on categories of insurance where competition is tight and differentiation between one insurer and the next is limited, for example motor insurance.

UMAs in present day SA

There are approximately 110 true independent UMAs in existence in SA today. This estimate excludes administrators and insurance brokers that claim to be UMAs, but are actually operating through insurers by way of binder arrangements. It also excludes juristic representatives and divisions of UMAs. The South African Underwriting Managers Association (SAUMA) counts 68 of the true independent UMAs among its membership. SAUMA is a voluntary not-for-profit association for independent UMAs writing short term insurance.

How is a UMA ‘born’?

The UMA structure came about quite naturally as a way to match the operational needs of the insurer with the entrepreneurial desires of experienced employees. Skilled practitioners who are keen to remain in the industry when they reach retirement age or employees with entrepreneurial flair who believe their division can perform better as a standalone entity will often approach the insurer to allow them to ‘go it alone’.

The insurer often views such proposals as an opportunity to reduce its operating overheads while at the same time protecting its market share. It will still benefit from the insurance policies sold by the UMA while reducing its staff and administrative costs. Another reason for establishing a UMA is the identification of consumers’ insurance needs that are not met by an existing insurer’s product range.

There are two favoured business models for UMAs. The first is to create a cell structure in which both the UMA and the cell captive insurer underwrite a share of the risk. The second is to create a pure provider structure in which the UMA does not have to underwrite a share of the risk on its balance sheet. In this scenario the insurer (or cell captive insurer) authorises the UMA to write 100% of its business on the insurer’s (or cell captive insurer’s) license. Centriq, a wholly owned subsidiary of Santam, is SA’s largest independent provider of outsourced UMAs.
The reason most commonly held up by an insurer to motivate a UMA solution is that it is too costly in terms of remuneration, operating overheads and the human resources function to acquire, manage and retain the specialist skills necessary to offer a complex or niche insurance policy type. SA is currently struggling with a major shortage of specialist insurance skills, which shortfall is temporarily addressed through the UMA structure. The insurer would rather entrust an appropriately resourced UMA to provide services to the broker market with the result that both the broker and consumer benefit from improved service while the consumer receives a fairer premium. A smaller entity that operates at ‘arm’s length’ from the insurer can speed up the underwriting, policy administration and claims processes.

Innovation drives success, the birth of a UMA

Camargue Underwriting Managers – Camargue – is a specialist underwriting insurance firm that was launched in 2001 with the vision of shaking up the industry with dynamic insurance solutions. The UMA operates out of a building that it owns in Melrose, Johannesburg and made history by selling its first policy via satellite phone at the summit of Mt Kilimanjaro’s Uhuru Peak. Today the group boasts approved coverholder status at Lloyd’s, with Lloyd’s participation on its binders at 75% and the balance placed locally with Compass Insurance Company.

Camargue was founded by current MD, Mitch Marescia, who is described as an insurance maverick. He reflects upon where it all started: ‘That incredible first day of operation in August 2001 – an incredible 19 350 feet above sea level – marked the start of an exhilarating journey and that kind of innovation has become the hallmark of our business. Today we are still recognised as a provider of risk management solutions and specialised insurance products to a broad spectrum of industries in SA. In addition we are able to boast an A+ global rating’.

From a small start-up the business has expanded to 50 staff members who have permanent positions and contracts with the group. Today, with an extended network of over 400 legal professionals, risk managers, arbitrators and risk analysts the group is well-equipped to assist clients with all related business needs. Camargue’s products are distributed through a network of some 1 300 brokers.

‘Like most new businesses, there were times in the first two years where closing the doors became a very real possibility. We were however committed to taking insurance to new heights and in recognition of the fact that it would be impossible to take on the big insurance companies head on, we pursued a unique more sustainable financial business model, one that has become known as the “M³” principle,’ says Marescia.

Camargue aims to manage, mitigate and migrate (“M³”) the critical business risks of each client in a process that goes beyond a risk transfer policy to one of risk solutions. Many industry recognition awards and affirmations have further ratified the success of this approach. To help brokers understand that the product Camargue sells does not just transfer risk was achieved through the implementation the Liability Academy for Brokers (LAB). More than 19 500 LAB seats have been filled since its inception making the venture a commercial success that has also contributed to the growth of Camargue.

As the UMA celebrates its 15th year, Marescia reflects: ‘We opened our doors for business with a small team and big dreams. Undeterred in our aspiration to remain the best provider in our niche market, we firmly believe that the combination of our independent strategy, experienced underwriting team and the backing of our business partners will ensure that we continue to realise this ambition’.

The business of a UMA

The UMA business model is fairly simple. The UMA will pay its carrier (the insurer) a license fee of say 4% on a book of insurance business valued at R100 million. A ‘book of business’ is insurance parlance for all the active policies initiated by a particular insurer, insurance broker or UMA with the value of the book being the sum of the annual GWP on all of the policies. In return for this fee the carrier will take care of some or all of the UMA’s capital management, reinsurance and compliance needs. The responsibilities of the various parties vary from one business model to the next. A symbiotic relationship is formed because the UMA cannot run an insurance company while the insurer does not have the capacity to handle the sales, underwriting and policy administration functions within that specialist insurance field. The UMA becomes the ‘feet on the ground’ for the insurance carrier.
The UMA does not sell an insurance policy directly to the insured but rather underwrites a single type of insurance policy, example aviation insurance, on behalf of the insurer, often through an insurance broker channel. It may also perform a range of binder functions and other services that are outsourced to it by the insurer as stipulated in a binder agreement. An independent insurance broker can also enter into a binder agreement with a UMA or an insurer.

Binder functions include but are not limited to the determination of policy wordings, premiums and policy benefits plus the settlement of claims under a short term insurance policy. (Binder regulation is discussed briefly in this chapter and is covered in greater detail in chapter 11). The FSB is quite prescriptive when it comes to the functions that a binder holder may perform. It provides the following summary of the five main functions, per ‘FSB Information Letter 3 of 2013 – Annexure A2’:

- Enter into, vary or renew a short term insurance policy, other than a short term reinsurance policy, on behalf of that insurer;
- Determine the wording of a short term policy;
- Determine premiums under a short term policy;
- Determine the value of policy benefits under a short term policy; and
- Settle claims under a short term policy.

UMAs do not earn commission and are instead remunerated by the insurer for fulfilling the binder functions and other services on behalf of the insurer, as contractually mandated. They are also able to share in the profits of the insurer.

**Regulation of UMAs**

All UMAs are financial services providers (FSPs) that must apply to the FSB for a license per the requirements in section 8 of the Financial Advisory and Intermediary Services Act (Act No. 37 of 2002) – the FAIS Act. UMAs must comply with the relevant insurance legislation and both the FSB’s binder regulations and outsourcing directive. A binder is a contract that is drawn up between the UMA and the insurer in which the obligations of one party to the other are clearly set out. A UMA binder (or commercial binder) is quite distinct from the binder that is concluded between an insurer and an insurance broker. In fact UMA binders are so different to broker binders that there are some stakeholders who believe that the FSB should have implemented two sets of binder regulations, one for specialist UMA binders (commercial binders) and one for broker binders.

The biggest difference between the specialist UMA and insurance broker binder agreement is that the UMA often plays a strategic role that goes beyond merely ‘binding’ a policyholder on behalf of the insurer. The UMA is ‘on risk’ where results are concerned because it shares in the losses while its management team often signs personal sureties and guarantees. In contrast the broker takes its binder fee with no strings attached. Finally, the UMA ‘binds’ for a single insurer while the broker ‘binds’ for many.

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**Figure 5.6 - Differences between UMA binders and broker binders**  
(Source: S&S Analytica, 2016)

<table>
<thead>
<tr>
<th>S&amp;S Analytica, 2016</th>
<th>UMA binder (commercial binder)</th>
<th>Broker binder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is the binder holder?</td>
<td>UMA</td>
<td>Insurance broker</td>
</tr>
<tr>
<td>What is the binder holder’s main role?</td>
<td>To sell a policy on behalf of the insurer, binding the insurer to the risk</td>
<td>To sell a policy on behalf of the insurer, binding the insurer to the risk</td>
</tr>
<tr>
<td>What risk does the binder holder take on?</td>
<td>The UMA is ‘on risk’ for the binder business as it shares in losses with the insurer – senior management often signs personal sureties and guarantees</td>
<td>The broker is not on risk for the binder business</td>
</tr>
<tr>
<td>How is the binder holder remunerated?</td>
<td>Binder fee and share of the profits and losses on the binder business</td>
<td>Binder fee only</td>
</tr>
<tr>
<td>Who is the binder holder ‘bound’ to?</td>
<td>Can enter into one binder agreement with a single insurer - there are exceptions to this rule, including when an insurer is in ‘run off’</td>
<td>Can enter into multiple binder agreements with one or more insurers</td>
</tr>
</tbody>
</table>
SA’s binder regulations could be used as a case study of the difficulty in covering multiple insurance practises with a one-size-fits-all piece of regulation. As they currently stand the binder regulations may be too generic for the complex industry they were designed for. The FSB does not report UMA results in its quarterly or annual report as these numbers reflect in those of the carrier insurer. An example of this is SHA which operates as a UMA for Santam. Santam’s GWP will reflect on the FSB’s annual report while SHA’s GWP will appear in the liability insurance line that is reported as part of Santam’s numbers.

Brokers or consumers looking to conduct business with a UMA should consider their shortlisted firms’ reputation and track record. A first check is always to contact the insurer to make certain that a UMA is indeed an agent of that insurer. Secondary checks can be carried out at the UMA’s industry association, SAUMA, or at the FSB.

**UMA trends**

The UMA market has come full circle over the past three decades. It started with an exodus of specialist insurer divisions into the UMA space, was followed by the entry of commoditised insurance offerings and now sees many of these players being brought back in-house. Aquarius Underwriting Managers is one example. The firm separated from Hollard Insurance to offer specialised insurance solutions to high net worth individuals, but was subsequently merged back into the insurer.

Prospects for the true niche players remain rosy due to extreme skills shortages in technical insurance fields. Skills in areas such as aviation, liability and marine insurance are in short supply with many experts nearing retirement age. The specialist UMA model is the perfect model to ward off the looming skills crisis, at least for the immediate future. Commoditised UMAs, however, find themselves under severe pressure. The market is extremely competitive at present with the result that ‘price taking’ UMAs struggle to remain profitable. There has been a definite movement of commoditised UMAs back into the main insurer stable beginning in 2014. Specialist UMAs that lack critical mass are also returning to their carriers or being ‘gobbled up’ by merger activity.

The decision to return to the carrier is influenced in part due to UMA margins coming under increasing pressure and in part by the carrier’s desire to mitigate compliance-related risks. UMA margins are also under threat due to the FSB’s stipulation with regards the section 8(5) policy administration fee, as contained in the ‘FSB Information Letter 2 of 2012’, and the willingness of insurers to hand out binders to all and sundry in an attempt to maintain market share.

Both the UMA and insurer face a myriad risks that are introduced by the regulatory framework. The insurer is exposed to reputational risk in the event the UMA flouts the regulations, which risk is better managed in-house.

At the date of publication section 8(5) of the STI Act still allows for brokers to collect a policy administration fee from their clients provided that it is specifically agreed to by the client, is disclosed, is not a duplication for which remuneration has already been paid and that there is nothing to prevent the client from opting out of the fee. The future of the section 8(5) fee will be determined by the regulator’s ongoing Retail Distribution Review (RDR), phase 1 of which has been pushed out until January 2017. Proposal UU of the RDR clearly states: ‘The current provision allowing for additional fees over and above commission, through section 8(5) of the STI Act, will be removed’. The regulator is steadfast in its position that the repeal of section 8(5) will go ahead, though it has indicated that further consultation will take place regarding the effective date of the repeal together with consultation for an appropriate fee mechanism to replace it.

**5.7 Reinsurers**

The layperson’s definition for a reinsurer is simply an ‘insurer for an insurer’ while reinsurance can be viewed as an insurance policy purchased by an insurer. An insurer pools all of its policyholder premiums in a capital reserve account, from which it has to honour all claims. The size of the capital reserve determines an insurer’s capacity for risk. In other words the capital that the insurer holds determines how much business the insurer can write – how many policies it can issue and the total amount of risk these policies can cover.

The amount of capital that an insurer must maintain for the level of risk that it takes on board is dealt with in the regulation under the statutory solvency margin requirement. South African insurers must comply with capital and solvency requirements as stipulated by the regulator from time to time, with the latest instruction in this regard being the SAM (Solvency Assessment and Management) programme which was due for implementation with effect from the 1st
of January 2016. Major progress has been made on SAM; but the implementation has since been pushed out until the 1st January 2017 to first allow for both the Financial Sector Regulation Bill and the Insurance Bill to be processed by Parliament.

**What does the law say about reinsurance?**

The STI Act’s definition for an approved reinsurance policy is rather technical and we include it below for completeness only.

> "An approved reinsurance policy is any proportional short term reinsurance policy in terms of which the reinsurer is liable for the liabilities of a short term insurer under short term policies and any non-proportional short term reinsurance policy which remains in force until the liabilities under short-term policies have expired, entered into by the short-term insurer with another short term insurer, if the policy benefits under that short term reinsurance policy are to be provided in the Republic; an insurer by virtue of section 2 of the Export Credit and Foreign Investments Re-insurance Act (Act No. 78 of 1957); Lloyd's underwriters in accordance with Part VIII of the Act; or an insurer under a reinsurance policy in terms of which the reinsurer furnishes security in the form of money; an irrevocable guarantee or a letter of credit issued by a bank and in the form prescribed by the Registrar against losses which may be occasioned by the failure of the reinsurer to discharge its obligations under the said policy or by the termination of such policy for any reason."

As with most legalese the above is quite difficult to grasp. It might be simpler to rely on a more basic definition of reinsurers as insurers who offer specialised cover only to primary insurers by way of a reinsurance policy. This basic definition aside the functions that reinsurers perform in primary insurance markets are quite complex. We can expand upon the reinsurer definition by considering the product that reinsurers offer to their insurance clients. Reinsurance is insurance that is purchased by an insurance company (ceding company) from one or more other insurance companies (called reinsurers) directly or through a broker, as a means of risk management.

The ceding company and the reinsurer enter into a reinsurance agreement which details the conditions upon which the reinsurer would pay a share of the claims incurred by the ceding company. The reinsurer is paid a reinsurance premium by the ceding company, which issues insurance policies to its own policyholders.\(^2\)

With the collapse of the South African Reinsurance Offices Association (SAROA) local reinsurers do not have a dedicated industry association. Some active reinsurers have chosen instead to be members of the South African Insurance Association (SAIA) and are served by that body through a specialist reinsurers’ board committee. This body focuses on issues that are specific to reinsurers in the South African market.

**Why is reinsurance necessary?**

If an insurer exceeds its solvency margin it can either stop writing new business, find a way to increase its capital, share risks with other insurers or approach the reinsurance market. Reinsurance is a valuable tool that allows an insurer to issue more policies with higher limits than it otherwise could, by transferring part of the risk of loss to a reinsurer or group of reinsurers. Reinsurance not only assists in smoothing insurer company results and reducing the amount of capital an insurer requires to provide risk cover, but also serves as a method of risk diversification by limiting the maximum loss that an insurer can incur.

It is possible for an insurer to reinsure part of its risk at a lower premium than it charges the insured, something referred to as reinsurance arbitrage. There are a number of reasons why reinsurers can offer more competitive premiums than the insurer including economies of scale, operating in ‘softer’ tax or regulatory environments and having better underwriting expertise and claims data. The field of reinsurance is a science built around actuarial models that are strictly monitored with a range of controls in place at both insurer and underwriter. Modern day insurers employ teams of actuaries to crunch the numbers and make sure they set premiums correctly and maintain the necessary solvency.

The statistical calculations required to determine how much an insurer should charge each policyholder for cover and how much it needs in its capital reserve to honour all possible claims against it in a given period are out of scope for this book.

**Benefits of reinsurance**

Reinsurers are a crucial part of the insurance sector. This type of insurance business contributes to the stability of insurance markets and by association to the wider economy. A short term reinsurance policy serves multiple functions, including improving insurer risk profiles, financial soundness, the diversification of exposures and greater domestic market underwriting capacity. These are all common sense benefits of a free market system that allows local insurers to participate in global reinsurance risk pools to reduce claims volatility.

Reinsurance is necessary because few insurance companies could remain solvent if they had to compensate hundreds of policyholders following a ‘worst case’ or catastrophic event. Were it not for reinsurance it would not be possible for an
insurer (or even groups of insurers) to cover large single-event risks such as damage to a coal-fired or nuclear power station. Most SA insurers have a reinsurance programme in place. These programmes have many benefits, including:

- It allows the insurer to decrease its risks by spreading loss events among multiple firms (insurer plus reinsurer or group of reinsurers);
- It enables the insurer to increase its capacity by taking on more policyholders and higher insured values;
- It provides the insurer with protection following a catastrophic loss event such as fire, flood or hailstorm, which results in a large proportion of that insurer’s policyholders claiming; and
- It prevents financial shocks due to a run on an insurer’s capital following a catastrophic loss event.

A layperson’s take on reinsurance

Reinsurance is incredibly complex and there are entire textbooks dedicated to this aspect of the insurance world. To assist readers in understanding the basics we include a simple case study involving a Gauteng-based motor car insurer – Prestige Car Insurance (PCI) – with 2 000 policyholders and insured vehicles valued at R650 million, though PCI will calculate its total loss exposure on this book of business to be significantly less, probably in the region of R40 million. To keep things simple we assume an insured value of R 325, 000.00 per vehicle. PCI complies with the South African legislation and has the necessary capital reserves in place to satisfy the local regulators.

PCI collects annual premiums from its policyholders totalling around 6.5% of the insured value. This means that it can expect approximately R42.250 million in premium each year. As discussed elsewhere the insurer has to utilise this premium to cover all of its operating costs, to pay any claims against its policies and to make a reasonable underwriting profit. Assuming the cost of running its 18-person head office is R25 million per annum the insurer only has R17.250 million from which to compensate its policyholders for losses. The problem is that an unexpectedly high claims experience due to a catastrophe event (such as a severe hailstorm) or a spike in vehicle crime could quickly wipe out this amount. If PCI has to pay out more than R17.250 million in the year it will report an underwriting loss. It will also have to dip into its capital reserves to pay-out claims and may then risk falling below the regulated statutory reserve requirements.

One of the techniques that insurers employ to protect themselves, by way of smoothing out their claims experience, is to enter into a reinsurance contract with a reinsurer. In other words PCI will go to the reinsurance market and pass some of the risks associated with its 2 000 policyholders to a reinsurer, which is typically much larger and better capitalised. A reinsurer has a better view of certain risk and additionally benefits from economies of scale due to it dealing with dozens of similar insurers. It would have information about the claims experiences of 100 000 policyholders rather than the 1 000 on PCI’s book, making it easier to predict and price for losses.

PCI decides to enter into a reinsurance policy with Absolute Vehicles Re (AV Re), whereby PCI ‘cedes’ or passes on some of the risk on its books to the reinsurer. From this point on the discussion becomes more complicated because there are numerous ways in which the risk might be shared. At the outset a decision must be taken as to whether the reinsurance type will be proportional or non-proportional and whether the method of reinsurance will be facultative, obligatory treaty or a contract of indemnity. The discussion of reinsurance terminology is out of scope for this book.

To conclude this case study, PCI enters into a non-proportional reinsurance agreement of the obligatory treaty type with AV Re. Under this arrangement part of the risk of each motor vehicle that PCI underwrites is automatically ceded to AV Re in return for a non-proportional share of the premium. PCI will take the first 20% of any loss and AV Re will make good the remaining 80% up to the total sum insured. In return for this arrangement PCI pays a reinsurance premium totalling 2% of the insured value, or R13 million. Net premium income reduces from R42.250 million to R29.5 million, but PCI’s risk exposure is significantly reduced.

In the extreme example of 60 insured vehicles being written off following widespread flooding the total loss will be R22.750 million. Without reinsurance PCI would have to pay the entire amount to its policyholders and would immediately find itself in an underwriting loss position. R42.25m premium less R25m operating expenses less R19.5m claims leads to a shortfall of R2.25m. The situation is totally different with reinsurance in place. The reinsurance contract requires that AV Re makes good on any loss exceeding 20% of the sum insured, so in this
case it would have to compensate PCI’s policyholders to the tune of R15.6 million while PCI would only have to pay out R3.9 million. PCI’s underwriting position is stronger, since R42.25m premium less R13m reinsurance less R25m operating expense less R3.9m claims leaves a surplus of R350,000.00.

Global reinsurers
The world’s largest global reinsurers include Munich Re, Swiss Re, Hannover Re, Lloyd’s and General Re. Each of these insurers reports GWP in excess of US$15 billion per annum.

Reinsurers in SA
Many of the global reinsurer brands have a presence in South Africa. At December 2015 the following reinsurers were licensed by the FSB to conduct business in South Africa:

- African Re
- Emeritus Re
- General Re
- GIC Re
- Hannover Re
- Munich Re
- SCOR

Local versus offshore reinsurance
Reinsurance is a vital component in the short term insurance model. In fact without the ability to ‘share’ risk among other insurers, reinsurers and offshore reinsurers there would be myriad cases where local insurers would be unable to provide cover at all. Insurance for coal-fired power stations is a case in point. South Africa’s Medupi power plant was conceptualised in 2007 with a price tag of some R80 billion, but estimates for its finished cost now range from between R154 and R300 billion (2015 rand). Compare this to the R100 billion gross short term premium income generated by SA’s primary insurers in 2015 and it becomes clear that the short term insurance market is not large enough to cover all of the country’s risks. The international insurance market and reinsurance into the international market is essential.

The FSB has been uncomfortable with certain offshore reinsurance arrangements. Their concerns centre on whether reinsurers, especially reinsurers operating outside SA, will be able to meet their obligations as they fall due. SA’s regulator has repeatedly referenced the different standards of supervision that non-resident reinsurers may be subject to in their home jurisdictions. There have even been accusations of undesirable regulatory arbitrage and an un-level playing field in the reinsurance market.

Local versus offshore reinsurance, the future
The capacity of the local market for reinsurance has long been of concern to local insurers. It is in this light that certain key changes relating to reinsurance markets have been included in the Insurance Bill, 2016. The Bill, which was tabled by the Minister of Finance in Parliament on 28 January 2016, will replace substantial parts of the STI Act and the LTI Act that relate to prudential supervision.

Among the objectives of the Insurance Bill is to enhance the financial soundness and oversight of the insurance sector through higher prudential standards, insurance group supervision and stronger reinsurance arrangements. For example, the participation of foreign insurers in the South African market will be broadened by allowing them to operate on a branch basis, thereby improving reinsurance capacity, competition and the spread of reinsurance risk. The Insurance Bill also declares that reinsurers will be allowed to have composite licences (both life and non-life insurance business under the same license) in respect of risk business. This Insurance Bill must still be referred to Parliament’s Standing Committee on Finance (SCOFA) before a further round of public comment.

5.8 Sasria SOC Limited
Sasria SOC Limited was established in 1979 to provide insurance cover for special political risks such as political riot and terrorism. The special risks insurer’s establishment provides us with a case study of how the insurance industry evolves to accommodate socio-political and socio-economic realities.

South Africa was in political turmoil during the 1970s and 1980s as citizens protested the unjust Apartheid system. At the time insureds only enjoyed limited cover for damage caused by riot or strike by way of the riot, strike and malicious damage (RSMD) extension to the property policies offered by conventional insurers. As SA’s protest activity became more violent, insurers became uneasy about their ability to provide adequate cover for property losses that ensued from riot and strike events and terrorism. It was felt that the losses following a major event would be potentially catastrophic to the insurance sector.
Since there was no appetite in the domestic insurance market to provide cover for this level of risk another way had to be found to offer protection to insureds. Government, in cooperation with the South African Insurance Association (SAIA) thus formed the South African Special Risk Insurance Association (Sasria) as a separate institution to provide insurance cover for special political risks.

Sasria was capitalised by participating insurers whose liability was limited to the amount of their initial capital commitment. At its inception Sasria traded as a section 21 NPC (not for profit) company. It was also granted special favour by government which stepped in as the insurer of last resort and awarded Sasria a tax exempt status. To date government has not been called upon as reinsurer of last resort for Sasria.

There were some early teething troubles. Local insureds were not forced to take out Sasria cover and many took advantage of the pricing discrepancy between this cover and that available on the London market through Lloyd’s. As the Lloyd’s premiums became more expensive the problem of adverse selection arose. The public would purchase ‘cheap’ political unrest cover offshore when the risk was low and then cancel that cover in favour of relatively cheaper Sasria covers whenever political unrest increased. Government was quick to address this issue by introducing the Reinsurance of Damage and Losses Act (Act No. 56 of 1989) which made it a criminal offence to purchase political damage cover, except from Sasria.

Sasria became a wholly state-owned insurance company in 1998 when government nationalised the insurer in terms of the Conversion of SASRIA Act (Act. no 134 of 1998). In the same year its mandate was extended to offer cover for non-political perils such as strikes and labour disturbances. As a wholly state-owned short term insurance company Sasria is represented by the Minister of Finance. As is the case with all licensed insurers it reports to the country’s non-banking financial services industry regulator, the FSB.

The managing director of SAIA served a dual role as managing director of Sasria until 1992. At present the insurer is headed by a managing director with a strong executive team and overseen by the Sasria board. Cedric Masondo is the current MD and has been at the helm of Sasria since May 2011. Before him Karen Pepler served as the acting MD for a period of 12 months. Today known as Sasria SOC Limited, the special risks insurer provides cover for an entire spectrum of special risks including civil commotion, public disorder, strikes, riots and terrorism.

**How does Sasria work?**

Sasria offers an insurance product that covers the insured for a range of special risks including civil commotion, public disorder, strikes, riots and terrorism. The major difference between Sasria and the other insurers described in this book is that Sasria does not sell its covers directly to the end-customer.
Instead the state-owned insurer enters into agreements with other short term insurance companies which become Sasria’s non-mandated intermediaries (NMIs). These NMIs represent Sasria covers to the end customer by attaching a Sasria ‘coupon’ to their own policies. The coupon outlines the cover, terms and conditions and is technically considered a policy subordinate to the underlying conventional insurance policy.

To protect the insurer the underlying conventional policy contains a reverse ‘onus of proof’ term which holds that if a loss occurs and it is not clear if it was caused by a person who was politically motivated, then the presumption is that the person is politically motivated and Sasria becomes liable.  

The administration of Sasria cover has always been left in the hands of the existing conventional insurance company. The insurer-issued property policies were thus modified to include an exclusion known as the SAIA exclusion which excluded all claims due to damage caused by politically motivated persons, including the usual war damage exclusion. The NMI performs multiple functions for Sasria – including the necessary day-to-day administration and premium collection – in return for which Sasria pays them a fee. This fee is currently pegged at 12.5% and is referred to as the Sasria binder fee.

Sasria’s interaction with the customer is limited to the claims pay-out stage; but even there the process differs from that seen in everyday insurance practice. An insured who suffers a loss due to a special risk event must first submit a claim to his insurer (Sasria’s NMI) which will determine whether the claim relates to a Sasria peril before submitting the claim to Sasria on the insured’s behalf. Once the claim is verified Sasria will compensate the insured for the loss.

Intermediary versus non-mandated intermediary

It is important not to confuse the intermediary (insurance broker) that sells insurance cover on behalf of an insurer with the NMI that offers Sasria’s special risk covers. In this scenario the insurer is the NMI that acts for Sasria and adds the Sasria coupon to its insurance policy. If the insurer (the NMI) makes use of an intermediated distribution channel (i.e. sells its policies through an intermediary) then the ‘sale’ of the Sasria coupon is facilitated by the insurance broker. The insurer, as NMI, continues to receive its binder fee from Sasria while the intermediary also receives a broker fee which is collected and paid over to it by the NMI on Sasria’s behalf. The intermediary fees paid by Sasria with effect from 1 July 2015 were communicated in Sasria Circular 465 as follows:

- An intermediary policy fee of 13% is payable for new business, renewals and endorsements on material damage, business interruption, money, goods in transit, contract works and marine coupons;
- An intermediary policy fee of 12% is payable for new business, renewals and endorsements on motor coupons; and
- A ‘Sasria Wrap’ intermediary fee of 15%.

Sasria SOC Limited’s strategic and legislative mandates

Sasria has a clearly stated strategic mandate, namely: ‘Our broader strategic mandate as a business is to contribute to South Africa’s economic stability, growth, development and transformation – particularly in the financial and insurance sectors – and so contribute to our government’s National Development Plan (NDP)’. The insurer has performed incredibly over the years, producing significant profits that are ploughed back into government thanks to Sasria being wholly-owned by the state.

SA has a volatile history and is currently in the grips of unprecedented levels of service delivery and other socio-political demonstrations. Over the first half of 2016 protests and rioting have led to substantial significant damages to buildings, vehicles and other assets. This is where Sasria’s legislative mandate comes to the fore. It exists ‘to insure all the people and businesses that have assets in South Africa, as well as government entities, against special risks that may lead to the loss of or damage to their assets caused by events related to or following civil commotion, public disorder, strikes, riots and terrorism, which all have the potential to lead to possible catastrophic financial losses’.
5.9 Credit guarantors

Most consumers have a basic understanding of credit due to their exposure to bank credit cards, store credit facilities and hire purchase agreements. Credit is the ability of a customer to obtain goods or services before payment, based on the trust that payment will be made in the future.

Trade credit is defined as credit that is extended to a firm by another firm that is prepared to supply goods or services today in return for payment at a later date. It is an integral part of the financing structure that developed economies employ to facilitate domestic and international trade and an important tool for enabling economic growth.

**Credit guarantee example**

A South Africa-based company that manufactures bicycles can supply its goods on credit terms both domestically and offshore. A typical arrangement is for the supplier firm to offer credit terms of 60 or 90 days – meaning that the purchasing firm has 60 or 90 days from receipt of the bicycles to make payment. The purchasing firm becomes a debtor of the supplier firm to the value of the goods or services supplied.

There are many risks that a firm should assess before entering into a trade credit transaction. Top among these is the real possibility that the purchasing firm defaults on the payment. An assessment of the purchasing firm’s ability to make payment is therefore critical. Payment default risk escalates when goods or services are exported because of the cost and complexity in recovering debts in an unfamiliar market. Supplier firms can ensure ‘peace of mind’ for their credit transactions by taking out trade credit insurance from one of many credit guarantors in operation domestically or internationally.

**What is trade credit insurance?**

Trade credit insurance is insurance for a firm’s debtors. It offers protection to manufacturers, traders or providers of services against the risk that a purchasing firm (debtor) does not pay due to bankruptcy or insolvency, or pays late. The product is designed to offer protection to firms engaged in both domestic and export credit trade transactions.

A trade credit insurance policy will perform according to the terms and conditions contained in the policy document. The policy usually pays out a percentage of between 70% and 95% of the outstanding debt per the type of cover purchased. Numerous factors are considered when structuring the policy including the profit margins on the goods sold, expected profit per transaction, typical order value and the insured’s appetite for loss. A client should take out the maximum cover available subject to its primary trade. A firm producing and supplying volume-based petroleum products with a very small profit margin would want to ensure a higher rate of cover (say 90% of invoice) whereas a bicycle manufacturer that runs a 50% gross profit margin might be comfortable insuring just 70%.

**Trade credit insurance in action**

Trade credit insurance policy terms are fairly standard. The insured must typically experience a period of ‘persistent default’ before it can submit a claim. Upon receipt of the claim the credit guarantor will attempt to collect payment by negotiated or legal means for a period of up to six months after delivery of the goods or services. In the event the payment cannot be collected the credit guarantor would indemnify the firm on the parameters of the policy. Where a liquidation or bankruptcy occurs the insured would typically receive compensation within 30 days.

Trade credit insurance is essential for credit managers who wish to control risks, improve debtors’ payment behaviour and monitor their firms’ overall credit exposures. It has also been hailed by many as a valuable tool for the facilitation of international trade. Without this ‘tool’ deals would have to be concluded on a pre-paid or cash-on-delivery basis, or not at all.

**Benefits of trade credit insurance**

Firms benefit from taking out trade credit insurance in that banks offer larger credit facilities with more favourable terms; they have the confidence to pursue higher risk transactions in unfamiliar markets; and they have ‘peace of mind’ that cash flow will not be adversely impacted due to swift pay outs following a debtor’s insolvency. There are a range of functions related to the offer of credit insurance and most credit guarantors build their insurance offering around extensive databases of trade and credit-based information.
What is a credit guarantor?
A credit guarantor – also referred to as a credit insurer – is a firm that offers insurance against debtors’ default. The protection offered by a credit guarantor is typically referred to as credit insurance or trade credit insurance, though the more descriptive debtors insurance is also frequently used. SA-based credit guarantors also make reference to a trade credit guarantee.

The trade credit insurance market
The global market for trade credit insurance is significant with the top three firms accounting for approximately 85% of the estimated €6bn in trade credit insurance GWP for 2014\(^{20}\). Estimates are that the penetration of trade credit insurance in the developed market is between 5% and 6% of trade with SA at approximately 7%.

The take up of credit insurance in Africa has been slow due to the reliance by many Africa-based producers on cash as a means of settlement. There are also a range of economic, political and infrastructural issues that make it difficult for credit guarantors to offer cover in developing markets. It is, for example, not uncommon for a credit guarantor to go ‘off risk’ in certain African countries based on political or economic risks in that country.

Credit guarantor brands in South Africa
There are a number of credit guarantors offering their product to SA-based supplier firms, including multinationals with a local presence, multinationals with working agreements through local firms and local credit guarantors. Three multinational brands account for approximately 85% of the global trade credit insurance market.

- Euler Hermes is the world’s largest credit insurance provider. It is backed by global insurer Allianz and has offices in over 50 countries including South Africa.
- Coface was established in 1946 as a French government-sponsored institution. In 2006 it became a wholly owned subsidiary of Natixis, the financing, asset management and financial services arm of the France’s second largest banking group, BPCE Group. Coface is present in 67 countries including South Africa and has a strategic presence in another 33.
- Atradius celebrated its 90 year anniversary in 2015. The group formed out of the merger between NCM (Nederlandsche Credietverzekering Maatschappij) and Gerling Kreditversicherung, but today its major shareholder is Spanish-listed Grupo Catalana Occidente S.A. The firm does not have an office in South Africa, but trades here through a cooperation agreement with CGIC (Credit Guarantee Insurance Corporation Africa limited).

The local credit insurance market is dominated by CGIC. It is interesting to note that major insurers Mutual & Federal and Santam as well as reinsurer Munich Re are shareholders of CGIC. Other local players include Lombard Insurance and CIS.

Selling trade credit insurance
Credit guarantors sell their products directly to purchasing firms or via an intermediated distribution channel, typically made up of larger in-country and multinational short term insurance brokers. In SA trade credit insurance is distributed through specialist credit brokers or general short term insurance brokers that are licensed to sell the product. Key players in the domestic market include Marsh, Aon, Willis and JLT although smaller niche international brokers Prestige and SA-based Cinque also feature.

Cinque is the South African partner of the International Credit Brokers Alliance (ICBA); the world’s largest team of independently-owned, specialist trade credit insurance brokerages. Established in 1999, ICBA currently has offices in 25 countries on five continents. ICBA partners combine local service and expertise with global co-ordination to provide trade, credit and political risk insurance solutions for multinational companies.\(^{21}\)

Prestige Credit Insurance Consultants (Pty) Ltd was established in 1997. The team at Prestige Credit is dynamic with extensive experience in the credit insurance field. The broker is associated with all major credit insurance institutions in Southern Africa and specialises in tailor-made credit insurance policies.\(^{22}\)

There is a trend in emerging markets for smaller players to group together in associations which can then better service large clients or play a role in global credit insurance programmes.
References:
1. The Short-term Insurance Act (Act No. 53 of 1998)
2. Financial Services Board Act (Act No. 97 of 1990)
5. DUFFY CR (2004), ‘Held Captive - A History of International Insurance in Bermuda’
10. Eskom Annual Report 2009
Chapter 6

The South African short term insurance landscape

Chapter five provided an overview of the different types of short term insurance businesses and policy types as described in the legislation. In this chapter we discuss various factors that impact on short term insurers, introduce some of the main brands conducting business in South Africa (SA) and provide some insight into the size of the domestic insurance market. An attempt is also made to rank the major insurers by license and by brand.

The final section of the chapter is dedicated to SA’s short term insurance brokers who play a valuable role as a link between the insurer and the customer. An attempt is made to rank the major insurance brokers in the market. The ranking presents challenges due to the unavailability of comparable broker annual reports, with the result that the book relies on a perception survey of selected large insurers and insurance brokers.

6.1 Economics, demographics and transformation

SA's short term insurers are not insulated from the economic environment and must consider the prevailing economic, political and societal trends in their strategic planning. In no particular order their planning must accommodate expectations for economic growth, inflation, interest rates, currency fluctuations and regulatory change to name a few.

The economic environment

GDP is an important component of short term insurers’ premium growth because it translates directly into the growth in insurable assets in the domestic economy. SA’s real annual GDP slowed to just 1.3% in 2015, the lowest on record since 2009, and is likely to dip below 1% in 2016. In its April 2016 World Economic Update the International Monetary Fund (IMF) adjusted SA’s GDP growth forecast to just 0.6% for 2016 and to 1.3% for the next year. The organisation lists plunging commodities prices, a slowdown in the Chinese economy and the impact of the ongoing nationwide drought as among the reasons for the decline.

The key constraints to economic growth are well documented and include government policy uncertainty, poorly developed and maintained infrastructure, skills shortages, energy constraints and high unemployment. There has been little improvement in these areas over the past few years.

This lacklustre GDP growth performance has seen SA slip from its long held position as the largest economy in Africa to third place, having been passed by Nigeria late in 2014 and by Egypt in May 2016. While SA is struggling the IMF has pencilled in 1.8% and 2.8% growth in Nigeria over the next two years.

Short term insurers also keep a close watch on both business and consumer confidence indicators. The reason is that falling business and consumer confidence has an immediate negative impact on retail and credit sales. Mid-2016 SA’s consumers were under tremendous pressure due to rising inflation, rising interest rates and a volatile currency. The Bureau for Economic Research (BER) consumer confidence index registered at -9 in the first quarter of 2016, just a few points better than the -15 registered in the third quarter of 2015 which was the lowest outlook in more than 14 years.

As inflationary pressures continue unabated it is clear that the country is in a rising interest rate cycle. The turning point occurred at a low of 5% in Q1 2014 and the South African Reserve Bank (SARB) has hiked rates six times since then, reaching 7% at end-April 2016. The SARB has made it clear that it will continue its policy to hike interest rates in order to keep inflation under check. An increase in the repo rate has a negative impact on disposable income due to SA’s high debt levels; but has some positive spin-offs for insurers who earn more interest income on their invested capital. Inflation meanwhile is being driven by a combination of the depreciating rand and higher food prices as a consequence of drought. The rand fell 10% against the US dollar in 2014 and another 34% in 2015, impacting both consumers, by fanning inflation, and short term insurers, through higher claims costs.

Ratings agencies

In the final quarter of 2015 two global ratings agencies, Standard & Poor’s (S&P) and Fitch, warned of an imminent downgrade to SA’s sovereign credit rating – an assessment of SA’s foreign currency government debt. At the time they rated SA at ‘BBB—’ which is the lowest ‘investment grade’ level. A decision to downgrade will see the country re-rated as ‘junk’ or sub-investment grade. A third agency, Moody’s, had also threatened a downgrade but chose instead to change its outlook for SA to negative and leave its rating unchanged at ‘Baa2’. SA remains two notches above ‘junk’ on its measure.

A slide to ‘junk’ status would have a major impact on all businesses operating in SA and could be particularly devastating for multinational firms. In its 2015 Integrated Report, insurer Santam Limited (Santam) noted that its credit rating, which was in turn limited by SA’s sovereign rating, had impacted negatively through subdued renewals at its Santam Re
Information

Sovereign ratings mayhem

One of the consequences of a sovereign ratings downgrade would be that foreign fund managers and offshore-domiciled corporate boards may have to reconsider their investments in South African assets. This is an inevitable consequence of the risk mitigation strategies that global firms’ governance structures put in place to protect their investors or shareholders. A ratings downgrade coupled with the massive burden imposed on global financial services firms due to regulation could result in an exodus of financial services brands, particularly international banks and insurers, from our shores. At the time of writing a number of established banks and insurers were already weighing up their continued participation in the SA market.

Barclays Plc, Old Mutual Plc and Zurich Insurance Holdings are among a growing list of multinational firms that are in the process of reviewing and / or restructuring their African and South African assets. Barclays has indicated that it will sell a substantial slice of its 62.3% share in Barclays Africa to sidestep the capital and solvency requirements introduced by global regulation. Basel II is particularly tough on European firms with banking operations in offshore markets.

Old Mutual Plc has confirmed that it will split its South African business into four parts, one of which is Nedbank Limited, a banking group with a market capitalisation of close to R90 billion. The three other businesses include Old Mutual Emerging Markets (which owns short term insurer Mutual & Federal), Old Mutual Wealth and Old Mutual Asset Management. Zurich is merely reviewing its African operations in an attempt to align with its overarching global business strategy. Meanwhile JSE-listed diversified financial services firm, MMI Holdings, is considering an exit from unprofitable country markets on the continent.

Due to the ongoing global and domestic regulatory pressure we are witnessing unprecedented corporate change. This could be accelerated by the looming threat of a downgrade to SA’s sovereign rating.

Ratings agencies are concerned about SA’s rising debt levels against a backdrop of economic policy uncertainty from the South African government. The hope that the ‘2013 National Development Plan – A 2030 Vision for SA’ would address policy uncertainty and drive economic growth seems largely misplaced. The 480-plus page document acknowledged government’s policy shortcomings and identified nine primary challenges that SA must address to achieve its goals. It was hoped that the National Development Plan would enable SA to triple real 2010 GDP, reduce unemployment to 6% and shrink inequality – as measured by the Gini coefficient – from 0.69 to 0.6 by 2030.

The financial services sector is fortunate that policy guidance from National Treasury and the Financial Services Board (FSB) is reasonably clear, though this should not deflect from the impact of regulation on the country’s short term insurers and insurance brokers. Regulation has had and will continue to have a significant impact on SA-domiciled insurers.

The list of regulation in various stages of development and implementation at the 30 June 2016 include the Solvency Assessment and Management (SAM) programme, the Treating Customers Fairly (TCF) regime, binder regulations, the Retail Distribution Review (RDR) and the FSB’s cell captive review. National Treasury is also readying a micro-insurance bill and putting finishing touches to its demarcation regulations. These are over and above the Financial Sector Regulation Bill, the Insurance Bill, the Conduct of Financial Institutions Bill and other new laws that will follow from the extensive review and rewrite of existing insurance legislation to accommodate the move to a Twin Peaks model of financial market regulation. The SA regulatory environment is discussed in chapters 10, 11 and 12.

The impact of demographics on insurance

Demographics are defined by investopedia.com as ‘the study of a population based on factors such as age, race, gender and economic status as well as level of education, level of income and employment, among other factors’. In the South African context demographics are important in measuring government’s progress towards normalising society post-Apartheid. Following years of white minority rule measures such as economic status, level of education, level of income and employment have all been skewed along racial lines. Some of the policies put in place to redress the wrongs of the past will be discussed under the transformation sub-heading below.
Race-based legislation passed by the post-Apartheid government requires companies to report extensively on their progress towards transforming their workforces to reflect SA’s overall demographics. Some insurers include the number of white and black employees as well as the number of male and female employees under each race classification in their annual reports. Others go further by providing racial breakdowns at different management levels within the firm. Measuring progress towards transformation goals aside, it is easy to see why demographics matter to financial services firms and more specifically to short term insurers. Simply put, demographics define the market to which they offer their product and services. It also serves as an important measure of access to financial services and financial inclusion across income levels. We will begin by considering the broader financial services environment before narrowing our discussion to the short term insurance sector.

National Treasury identified ‘expanding access through financial inclusion’ as a policy priority as early as 2011. Among their goals is to promote sustained economic growth and development through a stable financial services sector that is accessible to all. The core focus is to improve access to the poor, vulnerable and those in rural communities. Progress towards these goals is tracked by the demographic and financial inclusion data provided by the likes of Statistics SA and FinScope, among others. According to the ‘2015 FinScope Consumer Survey’ the level of financial inclusion in SA stood at 87%, with some 31.2 million adults holding a bank account and / or other formal non-bank financial product or service. The survey further revealed that 77% of this population is ‘banked’ and just 3.4% rely exclusively on informal mechanisms to manage their money.

It is important to differentiate between access to financial products and the quality of this access. FinScope observes that half of the financially included adults are thinly served: ‘The high level of thinly served amongst the financially included population is driven by low usage of digital payments, for example, only 13.7 million (37%) of adults use digital payments on a monthly basis of which 63% opt to use the traditional brick and mortar branches to pay bills, send remittances or transfers’. Another alarming fact is that 5.5 million adults have two or more funeral cover policies from different providers.

The FinScope survey provides limited insight into short term insurance penetration, reporting that 18.5 million people are insured, though only 6.6 million of these insureds have non-funeral insurance. It observes that 2.45 million consumers have short term motor policies (down from 2.8 million in 2014) and 1.4 million consumers have household contents cover (down from 2.2 million in 2014).

Hollard Insurance Group (Hollard) observed that few insurers had understood the low income market’s needs or succeeded in overcoming the challenges of developing value-for-money insurance solutions that balance small premium levels and sustainable profitability. The insurer believed that low income earners were ill-informed about the benefits of formal insurance products and did not find traditional sales channels suitable.

In their ‘2014 Africa Insurance Trends survey’, PwC identified the emerging black middle class as the most important demographic factor for both the long term and short term insurance sectors. Changes in literacy and education and the expansion of the working population were also mentioned, though the latter does not apply in SA where official unemployment hovers around the 25% mark. Africa’s evolving demographic is such that 450 million workers are projected to join the workforce between 2010 and 2035. Meanwhile according to British Broadcasting Corporation only 54% of the South African working-age population is available to work, compared to an average of 74% across the OECD. This statistic reflects the high proportion of adult South Africans who have given up on any prospect of finding work.

From an SA short term insurance perspective consideration should also be given to rapid urbanisation, income inequality and rising unemployment. There is, for example, a notable decline in the uptake of a range of insurance covers due to quality and affordability issues. Levels of income and rising unemployment both contribute to this trend. Demographic trends are important to short term insurers because they provide clues as to how the businesses must change, operationally, to remain competitive. According to PwC both data analytics (to better understand consumer trends) and direct distribution channels will become important demographic-linked differentiators.

The impact of urbanisation on insurance

Demographics and urbanisation go hand-in-hand and there is a definite trend in SA of rural populations moving into cities in search of better opportunities. World Bank statistics suggest that SA’s urban population stood at 64% in 2014, up from 54% in 1994. Rapid urbanisation has both positive and negative consequences for the short term insurance sector. On the plus side it leads to concentrated economic activity, making it easier for insurers to take their product to market. On the negative side urbanisation can lead to social unrest, unemployment and poverty as well as a concentration of assets, with the result that insurers’ total risk exposures to catastrophic events are much higher.
Growth opportunities in Africa

Africa is among the fastest growing regions in the world. Africa’s GDP, US$2.4 trillion in 2013 is expected to climb to US$3.9 trillion by 2020, with household spending following suit. Africa’s consumers spent US$1.8 trillion in 2013 and this sum could rise to US$2.4 trillion by 2020. Much of this growth is on the back of increasing populations, with the working age population forecast to rise from 628 million in 2013 to 1.2 billion by 2040.  

Half the population of Africa will be living in cities by 2030. The ‘World Urbanisation Prospects: 2014 Revision’ suggests that the continent will be home to five megacities by 2030, including Cairo (24.5 million), Kinshasa (20 million), Lagos (24.2 million), Luanda (10.4 million) and Johannesburg (11.9 million). The benefits of urban over rural living include better infrastructure and healthcare provision and vastly improved purchasing power. All of this is great news for SA’s banking and insurance firms. McKinsey estimates that there are new corporate and investment banking opportunities in Africa totalling US$28 billion between now and 2030. The challenge for SA banks will be to increase their market share to 20% from the current 12%. Another US$10 billion could accrue to retail banks that broaden their offerings to reach low income customers, particularly through digital channels.

The outlook for retail insurance is equally upbeat, with as much as US$20 billion in premiums up for grabs for SA firms entering Africa. McKinsey estimates that these combined financial services opportunities could add as much as US$2.2 billion to SA’s annual GDP by 2030, creating up to 45 000 jobs. SA’s diversified financial services firms were the first to test Africa’s receptiveness to SA-backed investments. There have been a number of acquisitions, joint ventures and mergers in the short term insurance sector, frequently spearheaded by the investment and life insurance divisions within the large diversified financial services firms.

Transformation and Broad-Based Black Economic Empowerment (B-BBEE)

The South African government requires that firms comply with a number of laws aimed at addressing economic imbalances in the financial services sector post-Apartheid. Section 12 of the Broad-Based Black Economic Empowerment Act (Act No. 53 of 2003) – the B-BBEE Act – requires the major stakeholders in each economic sector to develop an overarching transformation charter. The transformation charter should set out transformation guidelines for the relevant sector. SA’s Financial Sector Charter (FS Charter) came into effect in January 2004 as agreed at the National Economic Development and Labour Council (NEDLAC) Financial Sector Summit in August 2002.

The B-BBEE Act also provides for each sector to create a code alongside the charter. The financial services sector’s Financial Sector Code (FSC) had to be approved and published by the Minister of Trade and Industry in the Government Gazette. Requirements for the draft code are set out in section 9(5) of the B-BBEE Act, while section 9(1) contains requirements for the final code.

The Minister of Trade and Industry gazetted the FSC on 11 November 2012, effective from the 26th of that month. The FSC is a transformation policy based on the terms of the B-BBEE Act to promote social and economic integration and improve access to the financial services sector. It is also known as a Sector Code of Good Practice, sharing the same status as the general B-BBEE Codes of Good Practice, published by the Minister of Trade and Industry in February 2007.

The FSC was slightly different from other sector codes in that it included a ninth element – access to financial services – to rate or ‘score’ a firm’s B-BBEE performance. Other sector codes only have eight elements: Ownership, management control, employment equity, skills development, preferential procurement, empowerment financing, enterprise development and socio-economic development.
National Treasury’s February 2011 policy document refers to the FSC, which was at that stage already well-progressed:

‘Government will act to ensure the implementation of the transformation objectives of the FSC, focusing on greater access for the poor and the promotion of broad-based black economic empowerment’. NT states that the sector transformation objectives can be achieved without undermining financial stability or promoting reckless credit practices. Financial services firm measure their transformation per the legislated methodologies set out in the B-BBEE Act – more specifically under the DTI Codes of Good Practice published as regulations thereto – and the FSC.

Sa’s main short term insurers make extensive reference to transformation in their annual reports. Hollard notes: ‘In a South African context, Broad-based Black Economic Empowerment (or B-BBEE) is both a social imperative and an opportunity for companies to contribute to a better future’.

The insurer adds that it embraces its role in the transformation of the South African economic landscape. In its ‘2015 Integrated Report’ the country’s largest short term insurer, Santam said that it would focus on the diversification of both its workforce and supplier channel through 2016. Its ‘targeted enterprise development initiatives and investments’ would go hand in hand with a ‘strategic focus on uninsured markets underpinned by wide consumer education initiatives’.

<table>
<thead>
<tr>
<th>Element</th>
<th>Available points</th>
<th>Weighting</th>
<th>Primary reference</th>
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<tr>
<td>Ownership</td>
<td>14 + 3 bonus</td>
<td>14%</td>
<td>Code series FS100 to be read with the Code series 100 of the Generic Code</td>
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<tr>
<td>Management control</td>
<td>8 + 1 bonus</td>
<td>8%</td>
<td>Code series FS200 to be read with the Code series 200 of the Generic Code</td>
</tr>
<tr>
<td>Employment equity</td>
<td>15 + 3 bonus</td>
<td>15%</td>
<td>Code series FS300 to be read with the Code series 300 of the Generic Code</td>
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<td>Skills development</td>
<td>10</td>
<td>10%</td>
<td>Code series FS400 to be read with the Code series 400 of the Generic Code</td>
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<tr>
<td>Preferential procurement</td>
<td>16</td>
<td>16%</td>
<td>Code series FS500 to be read with the Code series 500 of the Generic Code</td>
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<tr>
<td>Empowerment financing</td>
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<td>15%</td>
<td>Code series Fs600</td>
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<td>Enterprise development</td>
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<td>5%</td>
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<td>3%</td>
<td>Code series FS700 to be read with the Code series 700 of the Generic Code</td>
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<tr>
<td>Access to financial services</td>
<td>14</td>
<td>14%</td>
<td>Code Fs800</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 + 7 bonus</strong></td>
<td><strong>100%</strong></td>
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</table>

Figure 6.1 – The Financial Sector Code scorecard
(Source: National Gazette No 35914, 26 November 2012, Volume 569, p13)

Figure 6.2 – The Financial Sector Code B-BBEE Scorecard
(Source: National Gazette No 35914, 26 November 2012, Volume 569, p14)

<table>
<thead>
<tr>
<th>B-BBEE Status</th>
<th>Qualification</th>
<th>B-BBEE Recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One Contributor</td>
<td>≥ 100% on the FSC Scorecard</td>
<td>135%</td>
</tr>
<tr>
<td>Level Two Contributor</td>
<td>≥ 85% but &lt; 100% on the FSC Scorecard</td>
<td>125%</td>
</tr>
<tr>
<td>Level Three Contributor</td>
<td>≥ 75% but &lt; 85% on the FSC Scorecard</td>
<td>110%</td>
</tr>
<tr>
<td>Level Four Contributor</td>
<td>≥ 65% but &lt; 75% on the FSC Scorecard</td>
<td>100%</td>
</tr>
<tr>
<td>Level Five Contributor</td>
<td>≥ 55% but &lt; 65% on the FSC Scorecard</td>
<td>80%</td>
</tr>
<tr>
<td>Level Six Contributor</td>
<td>≥ 45% but &lt; 55% on the FSC Scorecard</td>
<td>60%</td>
</tr>
<tr>
<td>Level Seven Contributor</td>
<td>≥ 40% but &lt; 45% on the FSC Scorecard</td>
<td>50%</td>
</tr>
<tr>
<td>Level Eight Contributor</td>
<td>≥ 30% but &lt; 40% on the FSC Scorecard</td>
<td>10%</td>
</tr>
<tr>
<td>Non-compliant Contributor</td>
<td>&lt; 30% on the FSC Scorecard</td>
<td>0%</td>
</tr>
</tbody>
</table>
Insurer Santam has a level 3 B-BBEE status while its parent group Sanlam Limited has a level 2 B-BBEE status. Hollard meanwhile enjoys a level 4 status. A short term insurer’s transformation programme will typically include the diversification of key stakeholder groups (employees, intermediaries and suppliers); improving access to products through innovative product design and new distribution methodologies; and investments in the community.

### Information

**Accelerating the pace of transformation and B-BBEE**

The transformation legislation is intended to be fluid and the Department of Trade and Industry (DTI) has already reviewed the B-BBEE Codes of Good Conduct as published on 9 February 2007. It fired the latest salvo in the battle for transformation with a revised set of codes on 11 October 2013. At the National Summit for B-BBEE in October 2013, the DTI explained that ‘the new Codes of Good Practice are aimed at fostering real black economic empowerment in the economy, rather than empowerment on paper’. Industry was given 12 months to transition from the ‘old’ to the ‘new’ set of codes.

The major change under the new codes is the decision to reduce the eight elements (or nine in the case of the Financial Sector Code) previously used to calculate a firm’s B-BBEE scorecard to five. Going forward management control will include the old employment equity rating, while ‘preferential procurement’ and ‘enterprise development’ will be combined as ‘enterprise and supplier development’. The calculation of B-BBEE scorecards is out of scope for this book, but readers should note that the new codes introduce much tougher criteria for firms to achieve high B-BBEE ratings. An insurer must now meet sub-minimum targets for three priority elements (ownership, skills development and enterprise and supplier development) or its B-BBEE rating is automatically downgraded one level. The weighting of the ownership element has increased and it is much more difficult to qualify for ownership points.

Firms with turnovers of less than R10 million are known as exempt SMEs and are exempted from all B-BBEE requirements. Firms with a turnover of between R10 million and R50 million are known as qualifying small enterprises (QSEs) which benefit from ‘enhanced recognition criteria’ under the new codes. QSEs will, however, be subject to the same five elements as large firms with a slightly softer sub-minimum requirement to avoid being automatically downgraded one level.

6.2 **The short term insurance market**

Now that some of the big picture issues have been addressed our focus turns to the performance and make-up of the South African short term insurance sector. Audit firm PwC’s analysis of South African short term insurer results for the year ended December 2015 points to a continued improvement in the industry’s key performance measures. They record a 12% increase in Gross Written Premiums (GWP) while the claims ratio (58.7%) and underwriting margin (10.8%) were both stronger. GWP is the total value of short term insurance premium ‘bought’ by policyholders from insurers. The combined ratio – the sum of acquisition costs, expenses and claims as a percentage of earned premiums – came in at 89.2%. Readers will remember from chapter 3 that the underwriting margin is equal to 100% less the combined ratio – or 10.8%.

The audit firm confirms that there is limited GDP-linked growth on offer with the result that short term insurers have focused on three areas over the past few years, namely expansion into Africa and other offshore markets; the acquisition of non-performing books by smaller insurers from larger insurers; and the rebalancing of books in favour of growth lines from personal lines to commercial insurances. Personal lines business remains extremely competitive with GWP growth in that sector limited to inflation. The PwC report only considers three of the country’s major insurers, namely Mutual & Federal, OUTsurance and Santam. At first glance the R52.1 billion in GWP reported by these firms is significant, but one must bear in mind that around R7.5 billion is contributed by OUTsurance’s Australian and New Zealand businesses.

This means that the PwC assessment only reflects around 40% of the domestic market. For a better picture of the SA market we need to consider the FSB figures which will be put under the microscope later in this chapter.

**Supply and demand dynamics**

Short term insurers attribute recent positive improvements in the underwriting result to the absence of serious catastrophe losses. During 2013 insurers paid out approximately R2.4 billion in catastrophe-linked claims, whereas
2014 was limited to a Gauteng earth tremor. 2015 was also reasonably benign from a claims perspective. Most short term insurers are focusing on underwriting and claims management to rebuild their profit margins.

On the underwriting side the focus has turned to the re-pricing of premiums to correctly reflect the risk that the insurer is taking on cover. Premiums were kept artificially low due to a combination of excess liquidity in the market and strong domestic competition. From a claims perspective insurers are reducing costs and improving efficiencies via tighter controls of their supply chains. There is also evidence of insurers using premium increases as a tool to force high risk policies from their book. The process is referred to in the industry as ‘culling’ as policyholders that are unhappy with big premium increases take their business elsewhere.

Insurers have also been helped on the pricing side by the continued overcapacity in reinsurance markets combined with innovative structures to reinsure catastrophe risks. Aon Benfield’s ‘Reinsurance Market Outlook’, published in April 2016 confirms that the global supply of reinsurance still comfortably exceeds global demand. At 31 December 2015 global reinsurer capital totalled US$565 billion. It also notes that alternative capital markets now contribute upwards of 40% of the available global reinsurance capital. Two favoured alternative reinsurance instruments are catastrophe bonds and collateralised reinsurance. Total alternative reinsurance capital increased to $72 billion, made up of collateralised reinsurance of US$35.6 billion; collateralised Industry Loss Warranties (ILW) of US$8 billion; sidecar ILW of US$4 billion; and catastrophe bond insurance of US$24.4 billion.

Aon Benfield noted that the global insurers remained on a strong footing at the beginning of 2016 with just over US$4.1 trillion in combined assets: ‘The operating performance of major insurers and reinsurers remained solid [through2015], aided by below average insured catastrophe losses, the economic recovery in the US and exposure growth in emerging markets’.

As discussed in chapter 3 an abundance of capacity results in a soft insurance market wherein insurance premiums remain under pressure. This is good for consumers who spend proportionally less to place the same risk on cover, but not for insurers who struggle to achieve a balance between the premiums they charge and retaining their market share. The underwriting performance of both domestic and global insurers is currently better than expected given the soft underwriting cycle, as evidenced by surplus capacity and slow premium growth. What this shows is that insurers can beat soft markets thanks to factors such as lower catastrophe losses and emerging market growth, which both fall outside of the supply and demand equation.

The remainder of this chapter will focus on the South African insurance market with its offshore business stripped out of reported premiums wherever possible. All of the assessments that follow are based on FSB Short Term Insurance Annual Reports unless otherwise stated.
Much of this chapter is based on statistics taken from FSB’s Short Term Insurance Annual Reports, the FSB quarterly insurance reports and insurance companies’ annual and interim reports. There are a number of important considerations when analysing the statistics contained in these reports.

**Insurer year ends**
As a general rule any FSB-reported statistic that relates to licensing (new licences, licence withdrawals and curatorship) occurs in the calendar year of the annual report in question. When you read the ‘FSB Short Term Insurance Annual Report’ for 2014 the report will thus reflect the licensing transactions that took place between 1 January 2014 and 31 December 2014 (the calendar year).

The FSB reports totals for gross written premiums, incomes, expenditures, etc. based on individual insurer results in their latest financial year ending within the report’s calendar year. Where an insurer’s year end is on 30 June, for example, the ‘FSB Short Term Insurance Annual Report’ for 2014 will contain numbers for that insurer for its full year ending 30 June 2014. As a result the FSB report does not reflect the exact value of total gross written premiums for the entire industry over a given calendar year, but rather a close approximation for that number. The value in the FSB annual reports stems from the consistent and comparable capture and collation of insurer data over a number of years.

**Insurance licence versus insurer brand**
The FSB publishes results per insurance licence and care must be taken when assessing market share. Charts published in this chapter indicate whether the associated statistics are produced by insurer group or per insurance licence. As an example Santam and its wholly owned subsidiaries Centriq and MiWay operate under separate short term insurance licences and their results are reported separately by the FSB. To achieve an accurate market share each of their contributions must be combined under the Santam group.

**Market share by insurance licence**
Sa’s short term insurers posted R100.352 billion in GWP for 2014. To get a better understanding of the domestic short term insurance market we need to find out how this premium is divided up among the various insurance firms. As already mentioned we can consider this question based on the contribution by each FSB-issued license or by the ‘ownership’ of these licenses. To begin with the book considers the contribution of the top 15 insurance licenses and their results are reported separately by the FSB. To achieve an accurate market share each of their contributions must be combined under the Santam group.

**Figure 6.4 - Contribution to GWP by insurance licence, 2014**
(Source: FSB)

<table>
<thead>
<tr>
<th>2014 GWP (R billion)</th>
<th>Percentage of total market, R103bn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santam</td>
<td>19.8%</td>
</tr>
<tr>
<td>M &amp; F</td>
<td>8.9%</td>
</tr>
<tr>
<td>Hollard</td>
<td>7.4%</td>
</tr>
<tr>
<td>Guardrisk</td>
<td>6.9%</td>
</tr>
<tr>
<td>OUTurance</td>
<td>6.0%</td>
</tr>
<tr>
<td>Zurich</td>
<td>6.0%</td>
</tr>
<tr>
<td>Absa</td>
<td>3.5%</td>
</tr>
<tr>
<td>A &amp; G</td>
<td>3.4%</td>
</tr>
<tr>
<td>AIG</td>
<td>3.1%</td>
</tr>
<tr>
<td>Centriq</td>
<td>2.2%</td>
</tr>
<tr>
<td>Standard</td>
<td>2.0%</td>
</tr>
<tr>
<td>Allianz</td>
<td>1.9%</td>
</tr>
<tr>
<td>Escap</td>
<td>1.9%</td>
</tr>
<tr>
<td>MiWay</td>
<td>1.4%</td>
</tr>
<tr>
<td>Regent</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
There has not been much movement among the top five domestic short term insurer licences as measured by GWP over the past decade. Santam and Mutual & Federal have taken ‘gold’ and ‘silver’ respectively each year going back to 2005, while brands such as Guardrisk, Hollard, OUTsurance and Zurich have consistently featured in positions three to five. Figure 6.5 below shows the change in market share by insurance licence type over the past decade. Readers should bear in mind that this reflects the position in 2014 and that significant events have taken place in the domestic market since, most notably the acquisition by Hollard of Regent. Refer to the information box that appears in a couple of pages titled, ‘Hollard already the second largest ST insurer in SA’.

**Figure 6.5 – Contribution to GWP by insurance licence, 2005–2014 (R billion)** *(Source: FSB)*

Market by insurance brand
The picture is slightly different when we focus on insurer brands rather than insurer licences. In figure 6.6 we consider the top 12 insurance brands based on a rough calculation from FSB statistics at the end of 2014. The top five now consists of Santam, Mutual & Federal, Hollard, Guardrisk and OUTsurance. For an insurer to increase market share by half-a-percent requires around R500 million in additional premium earned. It is unlikely therefore that Santam’s dominant position in the domestic market will be challenged in the foreseeable future. There is plenty of potential for change in positions two through five as firms in these rankings are separated by less than R3 billion in GWP.
Santam has cornered the South African short term insurance sector with the largest share of market going back decades. The insurer was founded in 1918 and listed on the JSE in 1964 under the non-life insurance sector. It reports GWP under three divisions, namely Santam Commercial & Personal, Santam Specialist and Santam Re, Santam’s wholly-owned direct insurance brand, MiWay, trades on its own short term insurance license, as does Centriq – also 100% owned by Santam – which contributes to the Santam Specialist division.

The 2014 FSB rankings based on GWP per short term insurance licence shows Santam in first place with 19.8% of the market. Adding to that the market share of Centriq in 10th (2.03%) and MiWay in 14th (1.46%) gives Santam more than 22% of the total short term insurance sector in SA. Another insurance brand that benefits from multiple insurance licenses is Telesure Holdings, which comprises Auto & General, Budget Insurance, Dial Direct and 1st for Women. The combined contribution from Telesure Holdings puts it in sixth position – immediately after OUTsurance. It pushes Zurich Insurance into seventh.
Figure 6.7 plots the sum of the Santam brands (bar graph with values indicated top of each bar) and the other major brands on the left axis. Santam occupies top slot for the duration of the period under review. Unlike in figure 6.6, Mutual & Federal slips from second place in 2010 and 2011. This is due to the impact of Hollard’s ownership of Etana being reflected in the numbers at the time. The diagram does not reflect the recent purchase by Hollard of Regent Insurance.

Hollard already the second largest ST insurer in SA

In October 2015 Hollard acquired Regent Group from Imperial Holdings for a consideration of R2.3 billion. Regent holds both long term insurance and short term insurance licences in various country markets in Africa, including SA. The combined contribution of Hollard and Regent (which had the 15th largest market share by license in 2014) would put the merged short term insurer in outright second place in terms of domestic short term insurance market share, per the FSB’s 2014 statistics. This fact will only reflect once the FSB’s 2016 Short Term Insurance Annual Report is published. Hollard also owns 21.8% of Lombard Insurance Holdings and 39.9% of Legal Expenses Group – correct at 30 June 2016.

Insurers under the spotlight

Santam: Santam is 62.5% owned by life insurer Sanlam Limited, is headquartered in Cape Town and employs more than 5 300 people. The insurer’s success is attributed to it using multiple distribution channels including its 2 700-strong broker network and its growing direct channel, MiWay. Santam has opened up 13 insurance licenses across Africa, India and Malaysia thanks to its partnership with Sanlam Emerging Markets (SEM).
Mutual & Federal: SA’s second largest short term insurer per the 2014 FSB rankings is Mutual & Federal with 8.86% of GWP. Mutual & Federal is the oldest surviving insurance company in SA – though it has only traded under this ‘name’ since the 1970s. The insurer started in March 1831 as the South African Fire and Life Assurance Company, was acquired by the London & Lancashire around 1895, and then absorbed by the Royal Group in 1962. Following the ‘domestication of foreign companies’ which started in the 1960s, Royal’s South African interests were merged into SA Mutual Fire & General Insurance company, as Old Mutual’s short term insurance business was then known. The Mutual & Federal brand evolved as a combination of Mutual (in the Old Mutual Group) and Federal (from the Federal Insurance Corporation).

Hollard: SA’s third largest short term insurer per the 2014 FSB rankings is Hollard Insurance with 7.45% of GWP. Hollard is SA’s largest privately owned insurance group. It was established in 1980 and provides short term, life and investment products through its Hollard Insurance and Hollard Life Assurance operations. Hollard has operations in 10 countries and more than six million policy holders. The group is headquartered in the historic Villa Arcadia in Parktown, Johannesburg and employs almost 3 000 people.

OUTsurance: Is the fifth largest short term insurer in SA with a 6.03% share of total GWP per the FSB’s 2014 statistics. It is also SA’s largest direct insurer having been established in February 1998 and initially offering personal lines motor and householders insurance directly to the public. The group expanded into the commercial short term insurance sector in 2003 and into the life insurance market in 2008. OUTsurance Holdings Group is 83.4% owned by the Rand Merchant Insurance Holdings (RMI) Group. The OUTsurance group in turn comprises of 100% of OUTsurance, 49% of OUTsurance Namibia and 93% each of youi Australia and youi New Zealand. The contribution of the insurer’s offshore businesses will soon dwarf its South African operations. For the purposes of this book we consider the insurer’s South African GWP as reported to and by the FSB.

Zurich Insurance SA: Zurich, currently sixth on the short term insurance ranking as measured by 2014 license market share has an interesting history. Its parent, Swiss-based Zurich Insurance Group, was formed in 1984 when Eagle Star of London was taken over by British American Tobacco (BAT) Industries and subsequently merged with BAT Industries financial services businesses. The SA ‘link’ to this transaction was the JSE-listed Eagle SA which had formed out of the merger of Eagle Star and two other insurance firms in 1968. SA Eagle was rebranded Zurich SA in 2007 with Zurich Insurance Group as its major shareholder. The group bought out the remaining minority shareholders and delisted the company in 2015. Zurich has lost market share in recent years. Early in 2016 Zurich announced that it was conducting a review of its global businesses that would include a decision on whether the South African operation was aligned with its overarching strategy.

Expanding into Africa
A number of South African insurers have interests in the rest of Africa, though they have found entering new markets ‘tough’ due to cross-border regulatory differences. In Santam’s case the bulk of its Africa exposure is through its effective shareholding in investments made by Sanlam Emerging Markets, a division of Sanlam. Figure 6.8 clearly illustrates Santam’s interests in Botswana, Burundi, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda and Zambia.

<table>
<thead>
<tr>
<th>Entity invested in</th>
<th>Country</th>
<th>Santam effective shareholding, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific &amp; Orient Insurance Co. Behard</td>
<td>Malaysia</td>
<td>15.4%</td>
</tr>
<tr>
<td>Shriram General Insurance Co. Ltd</td>
<td>India</td>
<td>7.0%</td>
</tr>
<tr>
<td>BIHL Insurance Company Ltd</td>
<td>Botswana</td>
<td>20.5%</td>
</tr>
<tr>
<td>NICO Holdings general insurance subsidiaries</td>
<td>Malawi &amp; Zambia</td>
<td>21.6%</td>
</tr>
<tr>
<td>NICO Holdings general insurance subsidiaries</td>
<td>Uganda</td>
<td>29.3%</td>
</tr>
<tr>
<td>NICO Holdings general insurance subsidiaries</td>
<td>Tanzania</td>
<td>18.1%</td>
</tr>
<tr>
<td>Soras Assurance Generales Ltd</td>
<td>Rwanda</td>
<td>22.1%</td>
</tr>
<tr>
<td>Socar SA Burundi</td>
<td>Burundi</td>
<td>7.3%</td>
</tr>
<tr>
<td>FBN General Insurance Ltd (previously Oasis Insurance Plc)</td>
<td>Nigeria</td>
<td>12.3%</td>
</tr>
<tr>
<td>Enterprise Insurance Company Ltd</td>
<td>Ghana</td>
<td>14.0%</td>
</tr>
<tr>
<td>Gateway Insurance Company Ltd</td>
<td>Kenya</td>
<td>10.9%</td>
</tr>
</tbody>
</table>
Hollard Insurance reports a split in GWP in its short term insurance business of 83.4% SA versus 16.6% in the rest of Africa, shared between Botswana, Mozambique and Namibia. Zurich Insurance SA has a wholly owned subsidiary in Botswana; but the contribution by Botswana to the parent is fairly inconsequential. From its 2014 Annual Report (year ended 31 December 2014) it reports R177.3 million from Botswana and R3.520 billion from SA – with the former contributing just 4.7% to GWP. This was down from 5.8% for the 2013 financial year.

Reinsurer brands and market share
The SA reinsurance industry is small but not insignificant. According to the latest published FSB statistics the sector accounted for GWP totalling R8.725 billion in 2014. Multinational brands dominate the sector with Hannover RE and Munich RE occupying first or second place while Africa RE has occupied third position consistently since 2010. SCOR Africa has likewise occupied the fourth position since 2010. These four brands account for 99% of the domestically written reinsurance. Another international brand, Swiss RE, ceased its South African short term reinsurance activities in 2009, though it still has a limited presence in the domestic reinsurance market.

The insurance sector by policy type
Under the previous statute – the Insurance Act of 1943 – the short term insurance sector was described under six policy types. Two policy types were added by the Short Term Insurance Act (Act no. 53 of 1998) – the STI Act. The STI Act redefined the existing policy types and added liability business and engineering business to the mix. Engineering business includes insurance such as machinery breakdown insurance and construction insurance of large projects whereas liability insurance is a blanket descriptor for a range of covers including directors & officers, employer liability, product liability, professional indemnity and public liability to name a few.

### Information

**Redefining the short term insurance policy landscape**

The Insurance Bill will create additional classes of short term insurance business and increases the eight policy types provided for in the STI Act to 17. The word ‘class’ will be replaced by ‘policy type’ over time. Each class is further divided into sub-classes. The new situation is illustrated in the following table:

<table>
<thead>
<tr>
<th>STI Act, 1998 Class</th>
<th>Insurance Bill, 2016 Class</th>
<th>Sub-Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor</td>
<td>Motor</td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Property</td>
<td>Property</td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Agriculture</td>
<td></td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Engineering</td>
<td>Engineering</td>
<td>-</td>
</tr>
<tr>
<td>Marine</td>
<td></td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Aviation</td>
<td></td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Transport</td>
<td>Transport</td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Rail</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Legal expense</td>
<td></td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Liability</td>
<td>Liability</td>
<td>Directors &amp; officers, employer liability, product liability, professional indemnity, public liability, aviation, engineering, marine, motor, rail, transport, personal and other</td>
</tr>
<tr>
<td>Consumer credit</td>
<td></td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Trade credit</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Guarantee</td>
<td>Guarantee</td>
<td>Commercial lines</td>
</tr>
<tr>
<td>Accident &amp; health</td>
<td>Accident &amp; health</td>
<td>Individual personal lines, individual commercial lines, group</td>
</tr>
<tr>
<td>Travel</td>
<td></td>
<td>Individual personal lines, individual commercial lines, group</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Miscellaneous</td>
<td>Personal lines, commercial lines</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>Reinsurance</td>
<td>Proportional in respect of a class or sub-class referred to above, or non-proportional in respect of a class or sub-class referred to above</td>
</tr>
</tbody>
</table>
Readers should note that the statistics in this book reflect the situation in the STI Act, thus referencing eight policy types only.

The insurance sector by policy type
The eight policy types set out in the STI Act include:

- Property business;
- Transportation business;
- Motor business;
- Personal Accident & Health business;
- Guarantee business;
- Liability business;
- Engineering business; and
- Miscellaneous business.

The FSB is mandated in terms of section 5 of the STI Act to produce a comprehensive annual report for the South African short term insurance sector. This book has referenced the information published in the insurer annual reports to produce the following overview which approximates the state of play in the short term insurance market at the 31st December 2014.

Figure 6.10 confirms the dominance of the motor and property classes in the South African short term insurance marketplace. These two policy types made up almost three quarters of the GWP in 2014. It is worth noting that the bulk of the motor class is generated in the personal lines space with estimates of personal lines motor at R27.2 billion, so 65% of the motor class or 27% of the total short term insurance market. This is an amazing statistic given that only a fraction of SA’s motor vehicle fleet is on cover.

The eight graphs in figure 6.11 provide some insight into the domestic short term insurance sector as well as an opportunity to reflect on the overarching trends in the domestic economy. With the exception of miscellaneous, all policy types have produced compound annual growth rates (CAGRs) in excess of inflation over the nine-year period. This growth should be interpreted against the backdrop of the major consumer boom that has played out in SA over that time, largely due to the emergence of a strong black middle class. Rising consumerism results in more assets that require insurance as evidenced by the impressive growth in motor (+10.73% per annum between 2005 and 2014) and property (+10.07%). SA’s economy also performed reasonably over this period with 3% average annual GDP growth between 2005 and 2014 while CPI averaged 6.05%
Figure 6.11 confirms a rising trend among employed individuals to supplement their medical aid schemes by purchasing various health insurance covers which explains the impressive compound annual growth in the accident & health policy type (+16.23% CAGR). The rapid growth in this category also reflects the declining efficiency of the public sector. Policy types such as engineering (+8.22% CAGR), guarantee (+7.63% CAGR), liability (+11.55% CAGR) and transport (+11.43% CAGR) have all performed admirably too. The above-inflation growth in insurance premium reflects the prevailing consumer price inflation (CPI) and economic growth in SA over the period.

It should be noted that the acceleration in the engineering class occurred in the boom times between 2004 and 2008. SA recorded GDP growth in excess of 4% in 15 of the 18 quarters between 2004 and mid-2008 before the events of the Global Financial Crisis (GFC) halted progress. Since then this category of insurance business has been stagnant due to a combination of subdued global economic growth, depressed commodity prices and the slow pace with which government is awarding large infrastructure tenders. The decline in miscellaneous (-7.35% CAGR) is most likely due to improvements in insurer systems that allows for more accurate reporting by policy type rather than a physical decline in insurance business, a fact confirmed by the 9.15% CAGR in total GWP.
Personal lines versus corporate and commercial insurance
The short term insurance industry makes a distinction between personal lines, commercial and corporate business. The personal lines class includes all short term insurance that is sold to individuals whilst commercial and corporate insurance refer to policies sold commercially, to business. The STI Act defines commercial insurance as ‘short term insurance business in respect of which the policyholder is a legal person’; but the legislation does not go further in providing a distinction for reporting the premium written under the commercial and corporate headings. Most short term insurers view commercial insurance as the cover they provide to small, medium and large businesses across a range of business sectors.

Corporate insurance is seen as the top tier of insurance business, as described in Zurich Insurance’s 2013 Integrated Report: ‘tailored short term insurance solutions to large corporate and multinational enterprises’. Clients in this category usually purchase risk management consulting services such as risk control and self-insurance in addition to taking out traditional insurance cover. The Financial Intermediaries Association of Southern Africa (FIA) applies a unique definition of corporate business to assist it in completing its annual awards survey. It advises its short term insurance broker members that ‘the corporate segment is defined by commission income exceeding R 400,000.00 per single client – you are in the corporate market if you handle clients that each pay R400 000 in commission or fees (or more) or each pay annual premium of R2 500 000 (or more)’.

It is not uncommon for modern insurers to report their results under only two headings, namely personal lines and business. The FSB Annual Reports, however, include a summary per insurer of the policies written under each of these categories. Per figure 16.13 the premium for the 2014 year was split 48.2% to personal lines, 33.7% to commercial and 18% to corporate.

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**Figure 6.12 – Top three insurers by policy type per insurer license, 2014**

(Source: FSB)

<table>
<thead>
<tr>
<th>Policy</th>
<th>First</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor</td>
<td>Santam 9,070m</td>
<td>M&amp;F 4,208m</td>
<td>OUTsurance R 3,977m</td>
</tr>
<tr>
<td>Property</td>
<td>Santam 7,368m</td>
<td>M&amp;F 3,375m</td>
<td>Absa R 2,354m</td>
</tr>
<tr>
<td>Accident &amp; Health</td>
<td>Guardrisk 1,862m</td>
<td>Rand Mutual 1,012m</td>
<td>Monarch 458.18m</td>
</tr>
<tr>
<td>Liability</td>
<td>Santam 1,237m</td>
<td>Guardrisk 658.36m</td>
<td>AIG 425.33m</td>
</tr>
<tr>
<td>Transportation</td>
<td>Santam 716.13m</td>
<td>Guardrisk 413.03m</td>
<td>Hollard 267.77m</td>
</tr>
<tr>
<td>Engineering</td>
<td>Santam 1,069m</td>
<td>M&amp;F 583.47m</td>
<td>Hollard 367.42m</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Legal Expenses 633.94m</td>
<td>Guardrisk 433.20m</td>
<td>AIG 284.26m</td>
</tr>
<tr>
<td>Guarantee</td>
<td>Credit Guarantee 1,069m</td>
<td>Lombard 583.47m</td>
<td>Coface 367.42m</td>
</tr>
</tbody>
</table>
Independent rating of insurers, the FIA Awards

The FIA carries out an annual survey of its broker members to determine SA’s best short term insurers and underwriting management agencies (UMAs) in the intermediated channel. The survey focuses on the perceptions, views, expectations, awareness levels and opinions of FIA members on insurers with regards to product quality, service quality, relationship quality and overall satisfaction. The objective is to determine the top performing insurers rated on intermediary satisfaction independently, without any influencing or tied loyalty, in the industry. The 2016 FIA Awards, held on 2 June 2016, was the 18th Annual Awards ceremony, with the results conducted using a consistent methodology over the past 11 years. The following table provides a snapshot of Awards winners going back a decade. It reflects the brand dominance in the marketplace for traditional insurance.

![Figure 6.13 – 2014 Insurance premium split into personal lines, commercial and corporate](source: FIA)

![Figure 6.14 – FIA Awards Winners, 2007 - 2016](source: FIA)

### Short term insurer of the year

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Lines</td>
<td>M&amp;F</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Hollard</td>
<td>Santam</td>
<td>Hollard</td>
<td>Hollard</td>
<td>Santam</td>
<td>Santam</td>
</tr>
<tr>
<td>Commercial Lines</td>
<td>Hollard</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Etana</td>
<td>Santam</td>
<td>Hollard</td>
<td>Hollard</td>
</tr>
<tr>
<td>Corporate</td>
<td>M&amp;F</td>
<td>Zurich</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
<td>Santam</td>
</tr>
</tbody>
</table>

### Underwriting manager of the year

|------|------|------|------|------|------|------|------|------|------|------|

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**Source:** FSB
6.3 Changes in short term insurance brands and brand ownership

There have been many developments in the South African short term insurance market in recent years. These include a handful of new arrivals as well as dozens of acquisitions, disposals and mergers. In the paragraphs that follow we highlight some of the major events that have taken place domestically, though we acknowledge that it is impossible to cover every significant happening in the space allocated.

Recent activity, 2000 until present day

- **2015, Hollard acquires Regent:** In October 2015, Hollard Insurance announced that it had agreed terms to purchase the Regent Group from Imperial Holdings for R2.3 billion. Nic Kohler, CEO at Hollard said that the deal, which included Regent’s life and short term businesses, was the culmination of an extensive due diligence process. ‘Through the due diligence process, we were able to verify our view of the synergies between Hollard and Regent in the life, commercial and personal lines areas – we think the Regent business is a sound strategic fit and the deal will be value enhancing for all parties,’ said Kohler. The deal was still subject to final regulatory and Competition Commission approvals at 30 June 2016. From a short term insurance perspective the addition of Regent (15 in the market by 2014 GWP) to Hollard’s portfolio will see the insurer take over the mantle of SA’s second largest short term insurer from 2015, behind Santam but ahead of Mutual & Federal.

- **2014, MMI Holdings acquires Guardrisk:** Diversified insurer MMI Holdings, which also owns an insurance license under its Momentum Short-term Insurance division, announced its intended acquisition of cell captive insurer Guardrisk from Alexander Forbes in November 2013. The transaction valued Guardrisk’s business at R1.6 billion. MMI CEO, Nicolaas Kruger, said that the acquisition was ‘an important milestone to support [MMI’s] strategic intent to diversify [its] business to enable further growth – the transaction enables MMI to provide a comprehensive and exciting suite of specialist insurance solutions in the alternative risk transfer space to large corporate clients and brokers’. MMI undertook the transaction to bolster its short term insurance offering and to enhance the group’s overall diversification in the broader financial services sector. A decision was taken to keep the Guardrisk brand intact and the business trades today under the same name and insurance license as a wholly-owned subsidiary of MMI. Following the necessary approvals from the registrars of long term and short term insurance and the Competitions Commission, Guardrisk was incorporated into MMI Holdings in March 2014.

- **2014, Hollard acquires Etana:** Etana has quite an interesting history for a business that was an independent operation for just more than five years. The story began in late 2007 when a decision was made to ‘spin off’ Hollard’s commercial business. As a result Etana was established in April 2008 as an intermediated commercial and corporate insurer on its own insurance license. It was initially owned by Hollard Insurance Group (49.9%) and by Etana Holdings (50.1%). The latter’s shareholding grew to 60% over the next few years. The insurer did brisk business and trebled its GWP during its first three trading years. Hollard’s executive, no doubt impressed by the insurer’s stellar growth, reconsidered their shareholding in the brand in 2013. A decision was taken for the Hollard Group to buy back the 60% of Etana that it did not already own and merge Etana into the Hollard Insurance business.

Motivations for the deal included overlaps between the respective businesses and the need to consolidate scarce skills. There was also a desire to create greater choice for policyholders and enhance innovation in both the commercial and corporate insurance segments. ‘The combined entity draws together two substantial skill sets in a skills-constrained market; creates an expanded product range; and raises underwriting capacity – all of which position us very well in what is a difficult market’, said Kohler. FSB approvals were obtained in January 2014 and the full operational integration of the brands was completed in the first half of that year. The Etana brand was dropped and the business is today known as Hollard Broker Markets, a division within the Hollard Group.

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**Interesting fact**

**Hollard brings its UMA partners on board**

One of the defining trends in the Underwriting Management Agencies (UMA) sector has been that of insurers bringing their UMA brands in-house. Hollard Group has been particularly active in this regard. In its 2014 financial year it completed the acquisition of two of its UMA partners, Scintilla, in the construction and engineering insurance market, and Astra, in the marine insurance market. A year later the group added Aquarius Underwriting Managers and Execuline Motor Underwriting Managers to the fold. These UMAs were leading providers of personal lines solutions to affluent clients. In a statement following the acquisitions, Willem Smith, MD at Hollard
Personal Lines said that while Hollard had been a shareholder in the businesses for some time they had to avail of the opportunity to fully harness the synergies that existed between the UMAs and the insurer.

Insurers have offered a number of reasons for this trend. In its ‘2014 Integrated Report’ Hollard notes that the decision to bring its partners on board was motived by the need ‘to retain the rarest of skills and to ensure that its newly-formed division, Hollard Broker Markets, was able to offer a comprehensive, one-stop shop for brokers servicing commercial or corporate clients’. The insurer’s take on pending regulatory reforms also played a part. It noted that ‘binder regulations and the anticipation of amendments to those regulations in 2015, as well as the impending Retail Distribution Review, have meant that Hollard needed to evolve its partnership model’.

2012, the launch of King Price Insurance: It takes a great deal of capital to establish a new insurance company. For this reason new entrants to the sector have typically been funded by parent firms in the diversified financial services space. This is true especially in the direct insurance space where the likes of i-Wyze and MiWay were bankrolled by Mutual & Federal and Santam respectively. One notable exception is King Price Insurance which launched with great fanfare in 2012. The firm was capitalised by Francois van Niekerk of the Mertech group and Stefan van der Walt of Nikon. The insurer offered a personal lines motor policy with depreciating monthly premiums, creating a marketing hook that resonated with South African motorists. As a result King Price went from a start-up with GWP of R63 million in 2013, to R540 million in 2015 and being on target to achieve R770 million in GWP in 2016.

From AIG to Chartis and back to AIG, 2012

Another fascinating story involves the ‘chopping and changing’ between the AIG and Chartis brands. AIG SA, active in the SA market from as early as 1962, was rebranded as Chartis in 2009. Chartis is the property & casualty (short term insurance) unit of US-based American International Group (AIG). By November 2012 a decision was taken to drop the Chartis brand and return to the better known AIG. The initial name change was perhaps a kneejerk reaction to distance the business from its parent which was, at the time, in financial difficulty following losses linked to the 2008 GFC. At the time AIG received more than US$180 billion in government loans and credits to avoid collapse.

2008, the launch of MiWay Insurance: Direct insurer MiWay was launched in February 2008 as a joint venture between traditional insurer Santam, its parent Sanlam (which held 68.75% of the venture) and JSE-listed financial services firm PSG. Santam purchased PSG’s shareholding early in 2010 before acquiring Sanlam’s share in the business for a consideration of R240 million in 2010. MiWay became a wholly-owned subsidiary of Santam from 1 January 2011. Santam poured massive resources into MiWay during its start-up years. It had to wait more than three years for the start-up to declare its maiden profit in the half-year to June 2012. Santam revealed that the direct insurer had achieved a net insurance result of R16 million from R500 million in GWP. At the time MiWay had approximately 140 000 active policies and constituted just more than 5% of Santam’s total GWP. The business has grown significantly since then and the initial investment appears to have paid off. MiWay contributed R107 million to Santam in 2014 and a further R219 million in 2015. By end-December 2015 it had grown its business to more than 240 000 policyholders. GWP improved from a mere R146 million in 2010 to almost R1.75 billion in 2015.

2004, Royal & Sun Alliance sells its stake in Mutual & Federal: Old Mutual Plc upped its stake in SA-listed insurer, Mutual & Federal to 88% following a decision by Royal & Sun Alliance to sell its 37% holding in the insurer in January 2004. The deal was concluded for £ 100 million on 20 January of that year. Old Mutual subsequently acquired the remaining 12% and delisted the company on 8 February 2010. Mutual & Federal has an impressive local history and can trace its roots to the South African Fire and Life Assurance Company in 1831. SA Fire and Life was eventually acquired by London & Lancashire, which was in turn absorbed into the Royal Group. Mutual & Federal was formed in 1970 following the merger of Royal Group with SA Mutual Fire and General.

2002, St. Paul Insurance exits SA: The St. Paul, part of a Minnesota-based insurer, announced its intended departure from SA in 2002, just five and a half years after opening its first South African office in Cape Town. (St. Paul was incidentally the first foreign-owned insurer registration in SA for 26 years). As part of its review the group also announced an exit from its medical malpractice business, globally.
2001, Santam acquires Guardian National: Guardian National, which was majority owned by Axa (53%) and Liberty (40.6%), was bought by Santam for an agreed R1.58 billion on 11 January 2001. The deal was subject to the usual approvals from the Competition Commission and the FSB. Guardian National brought with it a shareholding in Admiral Underwriting (14%), Guardian Direct (100%), Guardrisk Insurance and Guardrisk Life (30% each), Associated Marine Underwriting (50%), Lion of Africa (50%), Special Risks Underwriters (52%) and SA Aviation Insurance Managers. Many of these brands are still operating to this day. This transaction was important because it gave Santam (then with 19% of the South African short term insurance market) the necessary clout to take over the number one position from Mutual & Federal. At the time of the acquisition Guardian National accounted for 14% of the market.

The 1980s and 1990s
The dominant insurance brands that traded in SA in the 1970s and early 1980s left the country due to a combination of worldwide economic sanctions and socio-political pressures that prevailed during the Apartheid years. In fact there was so much change that only nine of the 20 leading insurance brands trading in SA in 1984 remained in 2000. An article in ‘Insurance Times and Investments’, published September 1999, reported that ‘companies that had disappeared during the 13 intervening years included: AA Mutual, Aegis Insurance, General Accident, National Employers General, President Insurance, Protea Insurance and Shield — most at the time considered substantial companies in their own right’.

A recap of some of the major comings and goings during that time make for interesting reading and informs our understanding of the short term industry that exists today.

1999, Standard General Insurance, disposal: In 1999 Italian giant Assicurazioni Generali SPA — also known as the Generali Group — decided to exit the South African market. It sold Standard General Insurance (Stangen) to Capital Alliance Holdings (CAH) for R146 million, effective from 1 January 1999. Stangen ceased writing short term business with effect from the 1st July of that year. Stangen had a rich history. Established in 1943 it became part of the Generali Group in 1951. Under the leadership of Cesare George Cavalieri it grew to 25 branches country-wide between 1958 and 1989. Paulo Cavalieri (one of Cesare’s sons) joined Stangen’s management team but was subsequently head-hunted by American International (now AIG South Africa) before moving to Hollard Insurance and later starting Etana. Stangen was the last composite insurer operating in SA.


1998, Guardian National acquires Aegis Insurance, acquisition: Aegis Insurance, at the time SA’s fifth largest insurer, was acquired by Guardian National effective from 1 January 1998. Aegis’ business included personal lines and small-to-medium commercial business with GWP of around R800 million. Aegis was previously owned by RMB Holdings, Momentum Life and Aegis Share Option Trust. Aegis in turn held 14% of Admiral.

1998, Commercial Union and General Accident, merger: Commercial Union of South Africa (CUSAF) and General Accident (operating only on a short term license in SA) were both owned by UK-based composite insurers. On 25 February 1998 their respective parents announced an in principle agreement for a global merger. This gave birth to a new company, CGU, which was at the time the largest insurer in Britain and the ninth largest in Europe. The intricate web of insurer ownership is illustrated by the fact that CUSAF was still busy with its assimilation of Protea Life following the 1996 merger of Sun Alliance and Royal Insurance, both based in the UK. Sun Alliance owned SA-based Protea Assurance while Royal Insurance owned a share in Mutual & Federal. Mutual & Federal had taken on Protea Assurance’s short term business at the same time, from 1 November 1996.

1995, African General Insurance, closure: African General Insurance closed down its operation on 30 June 1995 after a decision was taken to run off its portfolio. All in-force insurance policies were cancelled with effect from 31 August 1995 and all outstanding claims were settled. The insurer was owned by Future Bank (14%), Fabcos (24%) and Aegis Insurance (62%).

1995, AGF SA, closure: This small insurer took a decision to cease its short term insurance operations mid-1995 after failing to attract additional capital to achieve the necessary solvency margins. Market commentators were in awe of the short duration of this venture. AGF’s short term business was established on 1 February 1993 out of ACA Insurers Limited (formerly Atlantic and Continental Assurance). It survived for little more than two years.
6.4 Insurance distribution

The main activities that a short term insurer must carry out in order to remain in business include claims, distribution, policy administration and underwriting. It is possible for an insurer to outsource all or some of these functions to third parties by way of binder or outsource agreements. This section of the book focuses on the insurance distribution function which deals with how a policy is sold to the customer. At present there are two main forms of insurance distribution, described as intermediated insurance or direct insurance. Intermediated insurance involves the sale of an insurance policy through an intermediary that is either an insurance broker or an agent of the insurer.

Intermediated insurance still dominates the South African insurance environment with approximately 80% of total GWP originating from the intermediated distribution channel. Short term insurance brokers enter into contracts with a number of short term insurers in order to offer their clients a range of cover options. These contracts spell out the business arrangements between the insurance broker and the insurer; though the commission payable to the brokers is capped by the STI Act.

Insurance brokers can also enter into binder agreements or outsource arrangements with an insurer wherein they agree to handle certain administrative and underwriting functions on the insurer’s behalf for an additional percentage of the GWP. Binder agreements and outsource arrangements are discussed briefly in chapter 11.

Much of the agency business is written via Underwriting Management Agencies (UMAs) which came to the fore in the late-1980s. An insurer and UMA enter into an agreement wherein the insurer authorises the UMA to accept risks and settle claims on its behalf. The industry refers to this arrangement as the insurer ‘lending its pen’ to the UMA. UMA agreements are distinct from the binder agreements that insurance brokers enter into, as discussed in chapter five. The UMA structure creates an additional layer in the insurance distribution landscape in that they too can write policies directly or via an intermediary. So one might have an independent insurance broker selling insurance for a UMA where the eventual policy is underwritten by the carrying insurer. A UMA does not receive commission for selling insurance; but rather shares in the underwriting profits with the insurer per agreement. A commission will still be paid by the insurer to the broker that originates the business through the UMA.
Direct insurance involves the sale of a policy directly from the insurer to the customer, supported by internal sales staff, and enabled by modern telesales or web-based infrastructure.

Information

Short term insurance brokers dominate the market

More than 80% of SA’s total short term insurance business is introduced by brokers. This means that R84 billion of the R103 billion GWP reported by the FSB for 2014 falls under the intermediated distribution heading. The remaining 2014 GWP, totalling R17 billion, was sold via the direct channel. Industry analysts suggest annual growth of around 7.5% per annum in the intermediated insurance market and of around 12.5% per annum in the direct space. This means that intermediated business should have increased to R90 billion for the 2015 year versus R19 billion for the direct channel. The mix of direct versus intermediated business changes slightly in the market for personal lines insurance, where direct insurers contribute 35% of GWP. Direct insurers thus accounted for R16.3 billion of the R46.8 billion in personal lines business in 2014.

Ranking SA’s short term brokers

Prof Robert Vivian notes that ‘the South African short term market is traditionally considered to be broker dominated, meaning that most of the business is placed via independent insurance brokers’. In addition to this the short term insurance broking environment is extremely competitive with thousands of independent brokers writing business in the personal lines, commercial and corporate sectors – or a combination of the three. There are few statistics available from which to rank domestic short term insurance brokers due to a dearth of broking firms being listed on the local exchange; there is thus no requirement for them to publish their annual accounts.

The local business units of the large multinational firms operating in SA are generally not large enough to be reported on a standalone basis in their parent’s annual reports, which means the SA operations of the likes of Aon, Marsh and Willis Towers Watson are not publically available either. For similar reasons the results from local brokers that are owned by listed companies are seldom reported separately in the annual financial statements. One exception is PSG Insure which reports its annual results as a division of JSE-listed financial services giant, PSG Group Limited (JSE: PSG). PSG Insure reported R2.2 billion in business placed for its 2016 financial year. This would give the broker approximately 2.5% of the intermediated short term insurance premium written in 2015, based on our R90 billion estimate for the total size of this market.

How do the rest of the local insurance brokers measure up? S&S Analytica, the publishers of this book, assisted by Bluestream Research, undertook an informal perception survey of some of SA’s larger short term insurance brokers and insurers in an attempt to better understand the market. This is the first survey of its kind and we hope that by including our results we can begin a more open discussion about the valuable contribution that short term insurance brokers make to the insurance sector and the broader economy. We look forward to brokers’ inputs on this year’s survey findings and will certainly consider formalising and extending the survey in 2017.

The results presented over the next few paragraphs are based on replies to informal questions sent to selected large short term insurance brokers and insurers. The market share and the rand value of business placed by these brokers with their insurance carriers have been estimated based on responses to these questions. (Brokers that appear in table 6.15 did not necessarily participate in the survey). The results are an approximation of the intermediated distribution segment of the South African short term insurance market as perceived by some of SA’s large brokers and insurers mid-year 2016. We have not ranked the insurance brokers but rather slotted them into six tiers based on our estimate of their respective sizes.

Readers should note that large short term brokers rely on a mix of commission from the business that they place with their preferred insurance carriers and fees paid by their clients. We refer to ‘business placed with insurance carriers’ rather than GWP throughout this section. It is possible to estimate commission income by assuming a 50:50 split between motor and non-motor; but it is not possible to estimate fee income from binder agreements, outsourcing arrangements and / or other consulting activities.
The survey suggests that there are six short term insurance brokers that each place total business with their respective insurance carriers exceeding R1.75 billion per annum. We refer to these firms as tier 1 or mega brokers. In our estimate the tier 1 firms account for approximately 21% of the intermediated market, totalling around R19 billion of the R90 billion placed in 2015. The bulk of the business introduced by these brokers is commercial in nature.

Tier 2 brokers place business totalling between R1 billion and R1.75 billion per annum and we believe that one of the four bank brokers falls into this category – though it is difficult to independently verify the banks’ short term business – alongside one multinational and two domestic broking firm. Brokers that we estimate to place business totalling between R500 million and R1 billion fall into tier 3, with around 10 broker firms in that space – possibly more. We believe that tier 1 and tier 2 can be considered large or mega brokers, with those in Tier 3 described as medium-to-large brokers.

Medium brokers fall into tier 4, placing between R250 million and R500 million and tier 5 placing between R50 million and R250 million. We estimate around 20 broker firms in tier 4 and 130 in tier 5 for a total of 150 medium brokers. Finally we include all brokerages placing R50 million or less in the small broker category, identified as tier 6. Our view of the South African insurance broking market – based on the S&S Analytica / Bluestream perception survey – is shown in figure 6.15 below.

<table>
<thead>
<tr>
<th>Broker</th>
<th>Business placed by broker with insurance carriers (est.)</th>
<th>Share of 2015 market (est.)</th>
<th>Broker category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marsh</td>
<td>&gt; R3.5bn</td>
<td>5.5%</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Aon SA</td>
<td>&gt; R3.5bn</td>
<td>5.1%</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Standard Bank Insurance Brokers</td>
<td>&gt; R2.5bn</td>
<td>3.3%</td>
<td>Tier 1</td>
</tr>
<tr>
<td>PSG Insure</td>
<td>&gt; R2.2bn</td>
<td>2.5%</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Absa Insurance &amp; Financial Advisers</td>
<td>&gt; R2.2bn</td>
<td>2.5%</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Indwe Risk</td>
<td>&gt; R1.8bn</td>
<td>2.2%</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Willis Towers Watson</td>
<td>&gt; R1bn</td>
<td>1.7%</td>
<td>Tier 2</td>
</tr>
<tr>
<td>FNB Insurance Brokers</td>
<td>&gt; R1bn</td>
<td>1.7%</td>
<td>Tier 2</td>
</tr>
<tr>
<td>Garrun Group</td>
<td>&gt; R1bn</td>
<td>1.3%</td>
<td>Tier 2</td>
</tr>
<tr>
<td>+ one more tier 3 broker</td>
<td>&gt; R1bn</td>
<td>1.3%</td>
<td>Tier 2</td>
</tr>
<tr>
<td>JLT</td>
<td>&gt; R500m</td>
<td>1.0%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Nedbank Group Insurance Brokers</td>
<td>&gt; R500m</td>
<td>1.0%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>FirstEquity</td>
<td>&gt; R500m</td>
<td>0.8%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Libra Brokers</td>
<td>&gt; R500m</td>
<td>0.7%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>GIB Insurance Brokers</td>
<td>&gt; R500m</td>
<td>0.6%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Price Forbes Brokers</td>
<td>&gt; R500m</td>
<td>0.6%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Econorisk</td>
<td>&gt; R500m</td>
<td>0.5%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>+ three more tier 3 brokers</td>
<td>&gt; R500m</td>
<td>1.5%</td>
<td>Tier 3</td>
</tr>
<tr>
<td>RBS</td>
<td>&gt; R250m</td>
<td>0.4%</td>
<td>Tier 4</td>
</tr>
<tr>
<td>Integrisure</td>
<td>&gt; R250m</td>
<td>0.4%</td>
<td>Tier 4</td>
</tr>
<tr>
<td>+ 18 more tier 4 brokers</td>
<td>&gt; R250m</td>
<td>6.4%</td>
<td>Tier 4</td>
</tr>
<tr>
<td>+ 130 more tier 5 brokers</td>
<td>&gt; R50m</td>
<td>18.3%</td>
<td>Tier 5</td>
</tr>
<tr>
<td>+ 7 000 more tier 6 brokers</td>
<td>&lt; R50m</td>
<td>40.6%</td>
<td>Tier 6</td>
</tr>
</tbody>
</table>
From the information presented in figure 6.15 we can estimate that the South African short term insurance broker segment comprises approximately 10 large or mega brokerages with business placed in excess of R1 billion per annum; followed by approximately 10 medium-to-large brokers with business placed between R500 million and R1 billion. There are around 150 medium brokers, placing R50-R500 million; and finally the bulk of the segment, some 7000 small brokers, placing less than R50 million.

As already mentioned it is difficult to estimate the range of incomes that the broker firms are generating. If we consider commission only, based on a 50:50 split between motor and other insurance types, tier 1 brokers should be generating more than R285 million per annum; the tier 2 brokers R165-R285 million; the tier 3 brokers R82.5-R165 million; the tier 4 brokers R40-R82.5 million; and the tier 5 brokers R8-R40 million. The final category, the tier 6 brokers, would probably earn up to R8 million in commission per annum. Other fee-based income including for binder and outsource functions as well as income on invested capital would have to be added to this amount.

Main players in the domestic short term insurance broker market

- **Aon SA**: Is the South African division of Aon Plc, a leading global provider of risk management, insurance and reinsurance brokerage services. The group also offers human resources solutions and outsourcing services. The group has an employee base of 72 000 people working in more than 120 countries. Client-focussed delivery is a key differentiator for this global broker: 'Because each of our client groups has unique needs, our professionals—coordinated by strategic account managers or relationship managers – specialise by product, function and client industry'.

- **firstEquity**: Founded in 2006, firstEquity set about challenging the status quo of insurance broking in SA. Co-founders Seamus Casserly and Vis Govender have since made major inroads into a segment of the domestic insurance market that was concentrated in the hands of a few multinational broking firms. The broking firm differentiates its offering by handling complex business and client interactions 'with a focus that is absent in the larger broking firms'. Over the past decade firstEquity has made steady progress towards its ambition to take the corporate and commercial short term industry by storm.27

- **Indwe Risk Services**: Is a leading personal, business and specialist risk and insurance advisory business. The firm was established in 2006 out of a merger between Thebe Risk Services and Prestasi Brokers, each with
impeccable short term insurance heritage. Thebe Risk Services was established in 1903 as Hoskens Insurance and in 1992 became the insurance arm of Thebe Investment Corporation whereas Prestasi Brokers was established in 1972 and largely held by Pamodzi Holdings. Indwe boasts a growing personal insurance book and continues to secure new business through its commercial and corporate portfolios. A major differentiator between Indwe and other short term brokers is that it operates an extensive branch network with ‘touch points’ in all of SA’s major and secondary metropolitan areas.

- **Marsh SA**: This is the SA-based business of multinational broker, Marsh, which is in turn a wholly-owned subsidiary of New York-listed Marsh & McLennan Companies (NYSE: MMC). Marsh SA services a wide range of clients including high net-worth individuals, SMEs, large corporates and multinational clients. Marsh SA is among the largest short term broking houses in SA. Marsh has taken note of the country’s B-BBEE rules and qualifies as a level 2 B-BBEE contributor with an effective 26.48% black ownership. Although the international business has been in existence since 1871, Marsh only entered SA in 1999 following a joint venture with First Bowring Insurance Brokers (now FNB Insurance Brokers). Marsh SA, currently trading as Marsh (Pty) Ltd, acquired Alexander Forbes Risk Services in 2011.

- **PSG Insure**: Part of JSE-listed PSG Holdings, the PSG Insure brand is involved in the provision of insurance advice and the underwriting and administration of short term insurance policies in both personal and commercial lines. PSG Insure comprises three main activities including short term insurance (through its 60% share in Western Insurance Holdings), short term administration and short term insurance distribution. The growth in headcount in at PSG speaks volumes as to the potential in this market segment with an increase from 651 in 2015 to 728 currently.

PSG Insure contributes 33.1% to group income and has achieved CAGR of 28% in recurring headline earnings between 2013 and 2016, from R19 million to R40 million. The division’s overall contribution to the domestic short term insurance space is commendable with R941 million in GWP from Western, which is in turn held 40% by Santam. The rise of its insurance broking business is equally impressive with a 17% surge in GWP between 2015 and 2016, to stand at R1.549 billion. The group reported an additional R749 million in GWP on its short term insurance administration platform for a total R2.298 billion in short term insurance premiums under administration at end-February 2016.

- **Risk Benefit Solutions (RBS)**: RBS was established in 1998 with just 26 staff at the end of its first year. Today it employs more than 150 people and is a leading independent financial services advisory firm. It operates throughout SA and offers advice in a number of financial services disciplines, including insurance and risk services, employee benefits, wealth management and health. The group has merged with a number of established short term insurance brokers over the years.

The core principles of the business remain a strong emphasis on service excellence and a desire to build and maintain relationships with clients. The firm offers the following motivation for purchasing insurance through a short term insurance broker: ‘A broker has no direct gain from selling you a particular product so you can trust that he or she really is recommending the right product for your needs. Brokers are trained, licenced and able to advise you about any fine print, loopholes and pricing in the insurance policy – they do not carry the risk of having to pay out your claim so their primary concern is the fair and prompt settlement of your claim – in short, brokers really do have your interests at heart.’

- **Willis Towers Watson SA**: Willis is the brand name of Willis Limited, the world’s oldest insurance broker and risk advisory practice dating back to 1828. The SA business is a specialist corporate risk management and insurance broker which counts some of the largest JSE-listed companies among its clientele. It is 26% owned by an empowerment shareholding, NMT Group. Willis differentiates its offering by employing top risk specialists: ‘Our chosen market focus requires that we employ highly experienced career risk and insurance practitioners, with in-depth skills and expertise supported by global best practice and innovation – our personnel enjoy long term relationships with their peers in insurance markets locally and internationally.’ Globally the group has more than 18 000 employees in 400 offices. The global business is listed on the US-based Nasdaq exchange as Willis Towers Watson (NASDAQ: WLTW).

Lloyd’s brokers
Lloyd’s operates a representative office in SA which authorises local short term insurance brokers to operate as Lloyd’s correspondents. A Lloyd’s correspondent is a broker that can place risk with the Lloyd’s underwriters, who operate out of London. Readers should note that Lloyd’s is not an insurer but rather an insurance market where brokers can negotiate a premium for specific risk, which is in turn then placed on cover through the Lloyd’s structures. The nature of this relationship required separate handling under the domestic insurance laws and the STI Act therefore permits Lloyd’s to conduct short term insurance business in SA, via its correspondents.
The FSB publishes a list of Lloyd’s approved correspondents in its short term insurance annual reports. It also reports on the business placed by local Lloyd’s correspondents via the Lloyd’s market. In the past each Lloyd’s correspondent had to provide an annual report to the regulator, but nowadays reporting is through a single consolidated report submitted to the FSB by the representative office. GWP reported by the representative office includes business placed by both local and non-local brokers. The amount of business placed by Lloyd’s correspondents is not insignificant and runs to more than R3 billion in the latest FSB report. Figure 6.17 shows the total premium in this segment as well as the split between local and non-local brokers. This premium is not included in the total GWP for the local industry.

![Figure 6.17 Business placed by Lloyd’s underwriters, 2005 – 2014](Source: FSB)

The emergence and impact of the direct model

The direct model appears to have come full circle. In its 2015 Integrated Report, insurer Santam notes that its direct insurance model is maturing, although it remains the fastest growing division in the group. An irony not lost on short term insurance brokers is that the so-called traditional or intermediated insurers have aggressively entered the direct insurance space. At present it would seem that intermediated and direct insurance distribution will continue to coexist.

As mentioned earlier in this chapter the intermediated channel accounts for approximately 84% of total GWP in the SA market, with direct insurers making up the remaining 16%. Thus 2014 GWP is split between direct and intermediated insurers in the ratio R17 billion to R84 billion. Direct insurers enjoy a slightly larger share of the short term insurance personal lines market due to the commoditised nature of insurance products in that space. Cover for motor vehicles, homeowners (buildings) and householders (household contents) are much easier to sell online with telesales support due to the limited need for advice. The main direct players in the market at June 2016 are shown in figure 6.18.
The advent of technology and big data – coupled with growing demands from information-hungry regulators – has forced insurance industry stakeholders to rethink how they collect, share and process data. Big data is evident in the recent field of telematics, which involves the collection of various data points from a GPS or similar device installed in an insured’s motor vehicle. These devices can provide real-time data about the speed, changes in speed (acceleration and deceleration) and location of an insured vehicle, all of which must be processed, stored and analysed in order for the insurer to fulfil on its innovative product designs. The broader insurance industry will have to analyse, generate and process volumes of data that were before unheard of with the result that big data will become an integral part of the short term insurance landscape going forward.

In SA the requirement to transfer data between broker, UMA and insurer is also of concern. The requirement is built into the regulation by way of binder agreements, the Solvency Assessment and Management (SAM) regime and other rules and regulations. Both the exchange of personal information between broker and insurer and the sharing of information about capital and risk between insurer and regulator will require major improvements in data flow.

The South African Insurance Association (SAIA) and the FIA realised the need for a comprehensive system to assist their respective members in complying with new data requirements. In 2009 they established a joint venture known as STRIDE SA RF (Pty) Limited. This venture was owned by various industry stakeholders from the insurance and insurance broking sector. STRIDE is an acronym for Short Term Insurance Data Exchange and was tasked with creating a system for real-time, efficient and cost effective communication across the short term insurance industry. Over time a solution was built to enable the secure delivery of data between insurers and binder holders.

This solution consisted of a short term insurance data standard, which was developed and put in place by ACORD, and a mechanism to securely and uniformly transfer or ‘switch’ data from the sending firm’s computer server to the receiving firm, namely STRIDE. The FIA and SAIA gave up their respective shareholdings in STRIDE in 2015.
and the venture was subsequently purchased by the Financial Services Exchange (PTY) Ltd, trading as Astute. Astute now holds the majority shares alongside short term insurers Hollard, Mutual & Federal and Santam. Astute has a 15-year track record in delivering switching and data exchange services to the financial services industry.

STRIDE is today known as ASTUTE Short Term Exchange (Pty) Limited and it counts a number of insurers, insurance brokers and UMAs among its clients. It creates efficiencies and costs savings across the broader financial services environment to the ultimate benefit of all industry stakeholders.

References:
2. Finscope South Africa 2015 Consumer Survey
14. FSB Short Term Insurance Annual Report 2014
15. VIVIAN RW (2007), from the Handbook of International Insurance, Chapter 14 [p717], ‘South African Insurance Markets’
22. VIVIAN RW (2007), from the Handbook of International Insurance, Chapter 14 [p721], ‘South African Insurance Markets’
Chapter 7

Different types of insurance cover

Armed with a clearer understanding of the South African short term insurance environment it is time to focus on the types of insurance policies offered by local insurers. This chapter features brief discussions about a range of insurance cover that is offered to consumers under both the ‘personal lines’ and ‘corporate and commercial’ categories. The latter categories are often lumped together by insurers as business insurance. We also consider specialist lines such as engineering, liability, marine and travel insurance.

The domestic market for insurance is complex and it is quite common for product development teams to offer innovative enhancements that differentiate their otherwise standard insurance offerings from those of their competitors. For this reason the book makes no attempt to identify all of the policies that can be bought domestically nor does it serve as a platform to compare one insurer’s offering to the next.

It is even difficult to compare the relatively simple comprehensive motor policy offered by Insurer A with a similar policy offered by Insurer B due to variances in the ratings methodology, excesses and exclusions applied by each insurer. This is one of many reasons why a short term insurance broker is so valuable in assisting consumers in matching their short term insurance needs to the types of cover available as well as in structuring the most efficient portfolio of short term insurance product.

What follows is a brief discussion of insurance policies per the Short Term Insurance Act (Act. No 53 of 1998) – the STI Act – after which the types of cover offered by local insurers are discussed in more detail. An attempt has been made to include the policy types most typically sold in the personal lines and business segments.

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Chapter 8

Insurer financial statements

A financial statement is a formal record of the financial activities and position of a business, person or other entity. Although financial statements vary in complexity the norm is to include a statement of financial position (or balance sheet); a statement of comprehensive income (or income statement); a statement of changes in equity and a cash flow statement.

South Africa’s listed companies typically produce an interim set of financial statements every six months followed by a set of annual statements, incorporate in an annual report or integrated annual report, after each year end. Firms listed on exchanges in the United States and on major European bourses may also produce quarterly financial statements to meet demand from potential investors and analysts in those markets. More recently the trend has been towards providing integrated reports in addition to the financial statements.

In this chapter we consider the basic components of the insurer financial statements including the statement of financial position, statement of comprehensive income, statement of changes in equity and statement of cash flows. Not to be missed is the section on important analytical tools and concepts that are applied by insurance industry analysts in unpacking insurer financial statements!

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Chapter 9

International and South African insurance trends

The objective of this chapter is to give readers some insight into the trends, challenges and opportunities facing short term insurers. Both short term and long term insurers have to take a multi-decade view of their business models and constantly scan the horizon for threats and opportunities.

A core function of successful insurers is determining the price of new insurance policies in order to compensate for risk. Up till very recently, the only information that was available to inform this process was based on an analysis of past claims. Insurers had to distinguish between three types of uncertainties or risk:

• Those uncertainties for which there are reliable probability distributions base on past claims. Actuaries would use techniques such as probability analysis to compute data such as age, gender, credit scores into risk categories or profiles, from which pricing models would be developed;

• Those uncertainties that could be imagined, but for which it was impossible to agree on probability distributions: In most cases ‘unquantified risk’ would be classified as ‘too high risk’; and

• Those uncertainties that could not be imagined: These were described by Donald Rumsfeld as ‘things that we do not know that we do not know’ and by Nassim Nicholas Taleb, author of ‘The Black Swan’ as ‘black swans’.

New technology is altering the fundamental nature of the insurance business. Data from in-vehicle devices and wearable heartrate monitors, for example, is making it possible for risk calculations to be based on personal data, as opposed to group profile data. Increased transparency and better quality data makes it possible for insurers to set pricing and premiums for individual clients based on their profile rather than on that of an insured group. Data retrieved from new sources as wide ranging as DNA studies and satellites is allowing insurance companies insight into the types of risk previously thought unquantifiable.

It is likely that those policyholders that voluntarily engage with new types of telematics and agree to be monitored by them will benefit from lower premiums. In theory, this will lead to a virtuous cycle, where customers reduce their exposure to risk over time, which will lead to still lower premiums and even a reduced need for insurance. This may compel insurers to look for new risks further along the risk curve.

Over the next pages we examine the often intriguing trends that affect how insurers develop product and price risk, including the move to customer-centric systems; the Fintech revolution; demographic changes; climate and environmental change; and regulation and compliance.

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Chapter 10
The Regulatory Environment

The World Economic Forum (WEF) ‘Global Competitiveness Report 2015-2016’ ranks South Africa (SA) 12th out of 140 countries in terms of its financial market development. This measure consists of eight metrics including financing through local equity markets (1st in the world), regulation of securities exchanges (2nd), availability of financial services (6th) and soundness of banks (8th).

SA’s weakest performances under the financial market development measure relate to the affordability of financial services (21st in the world), ease of access to loans (32nd) and venture capital availability (47th). It is also worth noting that SA ranks first for the strength of its auditing and reporting standards and has top 20 performances for the efficiency of its legal framework, both in settling disputes and the ability to challenge new regulation.

SA would not perform so well against these WEF measures were it not for its developed financial services regulatory environment. The country’s world class regulatory framework has evolved over decades and is continually being fine-tuned by policymakers at National Treasury (NT) and the Financial Services Board (FSB).

To further our understanding of the regulatory environment – and more specifically the insurance regulatory environment – we must take a crash course on the terminology and processes that apply to South African law making.

This is a crucial chapter for any reader keen to understand the workings of financial sector regulation in SA. After a quick dip into ‘Law Making 101’ we delve into the basics of primary and subordinate legislation and then outline the role of the Financial Services Board, National Treasury and various dispute resolution mechanisms.

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Laws currently in force in the short term insurance sector

Armed with a thorough understanding of the regulatory environment we can turn our attention to the laws that are currently in force in the short term insurance sector. We will discuss new planned or pending legislation and policy under a separate header in chapter 12.

Editor’s note: “The financial services regulatory environment is complex with a range of primary and subordinate legislation impacting either specifically or indirectly on short term insurers and insurance brokers. It is impossible to discuss all of the laws and regulations currently in-force in this text, likewise it would be difficult to include the myriad amendments that are made by the regulators from time to time. In the pages that follow we provide an overview of the main Acts and regulations in-force at the time of writing, being 30 June 2016.”

Since the early 2000s the financial services sector has been caught up in a wave of legislative reform under one of two overarching trends. The first is the adoption by the regulators of a pro-consumer focus and the second a desire by regulators to reduce market risk. Incidentally, the consumer is singled out as a major beneficiary of reduced market or systemic risk. For the most part these regulatory changes are spearheaded by the Minister of Finance – though National Treasury (NT) and the Financial Services Board (FSB) or by the Department of Health – via the Council for Medical Schemes (CMS).

Pro-consumer sentiment is also the driving force behind the FSB’s principles-based Treating Customers Fairly (TCF) regime and, more recently, the Retail Distribution Review (RDR). TCF takes an outcomes-based approach to regulation that seeks to ensure that specific, clearly articulated fairness outcomes for financial services consumers are delivered by financial institutions while RDR proposes far-reaching reforms to the regulatory framework for distributing financial products to customers.

The first pro-consumer law applicable to the South African financial sector was the Financial Advisory and Intermediary Services Act (Act No. 37 of 2002) – the FAIS Act, which was followed by the Consumer Protection Act (Act No. 68 of 2008) – the CPA. Meanwhile the body of law aimed at addressing market or systemic risk in the financial services section is being introduced under a broad methodology known as Twin Peaks, elements of which are referenced throughout this book.

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Chapter 12

Proposed new laws and policy objectives affecting short term insurers

South Africa is one of many countries embarking on significant financial services sector legal reforms. Others include Australia, the United Kingdom, the United States and various markets in the European Union. The catalyst for this unprecedented world-wide regulatory reform was the 2008 Global Financial Crisis (GFC).

The purpose of this chapter is to give readers an overview of proposed regulations that are part of the major changes. The first part of the chapter is dedicated to giving an overview of Twin Peaks and the implementation of the Treating Customers Fairly regime. The second part of the chapter briefly touches on other legislation in the pipeline that is not part of this large scale shift. National Treasury (NT), the Financial Services Board (FSB) and the Financial Regulatory Reform Steering Committee (FRRSC) have stressed that policy change and proposed new laws will be phased-in over three different periods, so as to allow for maximum stakeholder engagement.

It is very confusing to understand how the new regulatory regime proposed by NT fits together. A good document to read for an overview of the grand plan is ‘A safer financial sector to serve South Africans better’, referred to by the Minister of Finance in the February 2011 Budget Speech and formally approved by Cabinet in July 2011. This was one of the first documents prepared by NT on the proposed changes.

Twin Peaks has become the shorthand for the planned comprehensive revamping of SA’s financial sector regulation. It proposes the introduction of a dual regulated financial services sector (hence the phrase ‘Twin Peaks’). A Prudential Authority (PA) housed in the South African Reserve Bank (SARB) will oversee prudential aspects of regulation while a separate regulator will oversee the conduct of the businesses in the sector. The FSB will step in as the market conduct regulator and will be renamed the Financial Sector Conduct Authority (FSCA).

NT, the chief architects of the change, propose that the two regulators will ensure that customer funds will be better protected against systemic risk (through interventions by officials based at the SARB) and that customers will be sold fit for purpose, appropriate products by advisers whose interests are aligned with theirs. The ultimate objective is that the prospect of using taxpayer funds to protect the economy from systemic failure is reduced.

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Chapter 13

Industry associations

There are a number of associations and professional standards bodies that serve the short term insurance sector. These bodies share many characteristics; membership is usually voluntary and most associations and professional standards bodies are run on a not for profit basis. It is also common to have a small executive team, funded by a combination of membership fees, fundraising, conference fees and sponsorships on the back of membership-related activities.

Differences in the types of organisations include the fact that professional standards bodies are concerned with improving and maintaining the level of professionalism and quality of service amongst their members, while associations usually have a broader mandate. Their members are normally competitors in the same industry and convene to promote common interests or stand together against common threats while complying with the provisions of the Competition Act, 1998 (Act 89 of 1998). The information for the organisations listed below was for the most part sourced from websites. They are listed in alphabetical order.

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- **Talent:** Shifts in traditional employment models, employee expectations, and talent acquisition remain top management concerns.
• **Data & Analytics**: Analytics’ value is increasing due to more connectivity, underinsured emerging risks, and an innovation deficit.

• **Capital**: An uncertain global economy is experiencing a wave of consolidation, acquisition, and geographic expansion driven by the flow of alternative capital.

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Chapter 15

The Glossary

It is standard practice to provide a glossary with a textbook type reference. We include below a limited set of the words and terms that readers may encounter while paging through ‘Short Term Insurance in South Africa’. These definitions have been sourced from the Internet, from annual insurer reports and from South African regulation, among other sources. Specific acknowledgement is given to the FSB, Santam and Sasria (for their annual report glossaries and related publications); BusinessDictionary.com, Investopedia.com; IRMI.com; Wikipedia.org and Inseta. We have, for the most part, altered the definitions by rewording or adding additional insights to them.

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