1. FOREWORD and INTRODUCTION

The South African Insurance Association ("SAIA") is the representative body of the non-life insurance industry in South Africa, through its members representing approximately ninety percent of the industry in terms of premium income, at all levels and with all stakeholders.

SAIA and its Members are actively committed to a growing and sustainable non-life insurance industry which is resilient, contributes positively to the economy, inspires confidence in stakeholders and offers products and services that add real value to the market.

This revised version of the SAIA Code of Conduct (the Code) was launched on DD MONTH YEAR.

The purpose of the Code is to promote ethical standards and good business practices in the non-life insurance industry and to give an indication to its Members of the guidelines to be followed to achieve these standards.

The Code has been enhanced and updated to ensure its continued relevance and that of its objectives in the changing non-life insurance business and regulatory landscape.

The revised Code focuses more on principles and standards rather than rules. The SAIA Board is of the view that this focus will position the outcomes envisaged for Policyholders with more clarity and enable SAIA Members to use the standards as guidelines for achieving the desired outcomes.

Included in this Code is a section on recommendations for Member participation in achieving the non-life insurance industry's transformation objectives. This reflects our industry commitment towards accelerated and meaningful transformation of our industry, contributing to an inclusive economy.

SAIA is tasked with the duty to monitor its Members' compliance with the Code and to exercise certain powers as part of its role to encourage, monitor and report on compliance with the Code.

SAIA recognises the roles played by different stakeholders in the non-life insurance industry and how each contributes to the sustainability of our industry. Accordingly, this Code encourages Members to require its agents and service providers to adopt applicable aspects of the Code.

The Code is a living document, and SAIA with input from its Members, will continue to improve the document so that it accommodates the changing landscape and remains relevant.

2. THE PURPOSE OF THE CODE

2.1 The Code is not intended to be legally binding. It is rather intended to set out principles and standards of desired conduct for all SAIA Members.

2.1.1 The purpose of this Code is to:

2.1.1.1 Promote ethical standards and good business practices in the non-life insurance industry.

2.1.1.2 Give clear and specific conduct guidelines to be followed by Members that provide non-life insurance products to current and potential Policyholders.

2.1.1.3 Promote an awareness and understanding of the non-life insurance industry to all stakeholders.

3. BENEFITS OF AN INDUSTRY CODE OF CONDUCT

3.1 An effective code of conduct is important to:

3.1.1 Instil confidence in current and potential Policyholders in the insurance industry and the broader financial sector.

3.1.2 Encourage self-imposed ethical and professional business standards and practices by its Members.

3.1.3 Assist in the elimination of improper practices.

3.1.4 Protect current and potential Policyholders by facilitating the on-going development of appropriate products and services.

3.1.5 Codify best practice which sets the benchmark for proper conduct by Members.

4. THE OBJECTIVES OF THIS CODE

4.1 The objectives of this Code are to:

4.1.1 Commit Members to high standards of conduct.

4.1.2 Enhance the image and reputation of, and promote trust and confidence in, the non-life insurance industry.

4.1.3 Promote sound, informed, professional and ethical relationships between Members, and between Members and current and potential Policyholders.

4.1.4 Provide for the fair and effective resolution of complaints and disputes between Members and Policyholders in relation to compliance with the Code.

4.1.5 Contribute towards a sustainable non-life insurance industry.

4.1.6 Promote transformation and financial inclusion in the non-life insurance industry.

4.2 These objectives must be pursued with due regard to current legislation and regulation, acknowledging that an insurance policy is a contract based on good faith.

5. DEFINITIONS

5.1 **"ARB"** means the Advertising Regulatory Board.

5.2 **"Authorised Agent"** means a person authorised by a Member to provide financial products and services on behalf of the Member **(**Example: financial intermediary).

5.3 **"Co-Insurance Arrangement"** means an insurance arrangement whereby two or more insurers share the same risk.

5.4 **"ICB"** means the Insurance Crime Bureau**.**

5.5 **"Member"** means a non-life insurer that is a member of SAIA.

5.6 **"Policyholder"** means a person who holds a non-life insurance policy or a person to whom the benefit of a non-life insurance policy extends.

5.7 **"Reinsurer"** means a Member of SAIA that conducts reinsurance business.

5.8 **"SAIA"** means the South African Insurance Association NPC, the representative industry association for the non-life insurance industry.

5.9 **"Service Provider"** means a person authorised by a Member to provide a specific service. Example, an investigator, a motor body repairer, etc.

6. APPLICATION OF THIS CODE

6.1 This Code applies to all SAIA Members.

6.2 The Code applies to reinsurers and Sasria, where applicable. Where no direct relationship exists between reinsurers/Sasria and their clients, the specific clauses in this Code that relate directly to the business relationship between Members and their clients do not apply.

6.3 Where there is a conflict or inconsistency between this Code and any applicable law, the law always prevails. Members must inform SAIA immediately they become aware of any conflict or inconsistency between any legislation and this Code.

6.4 Under a Co-Insurance Arrangement where one or more insurers in that arrangement is not a SAIA Member, this Code will apply to the extent that is practicable having due regard to the nature of the co-insurance arrangement.

6.5 Where this Code imposes an obligation on Members in addition to obligations under any law, the Member must comply with this Code except where doing so could lead to a breach of the law concerned.

7. TRANSITIONAL ARRANGEMENTS

7.1 Members must formally adopt this Code for compliance within their own companies within six months from the date this Code takes effect.

7.2 A Member may submit a request for an extension to comply with the Code and SAIA will consider the request for an extension based on the merits presented in the request.

8. GENERAL MEMBER RESPONSIBILITIES

8.1 A Member must:

8.1.1 Comply with the Code and implement procedures and systems to ensure compliance.

8.1.2 Comply with all applicable laws and regulation.

8.1.3 Hold and maintain all licences, registrations and approvals required by law.

8.1.4 Conduct its business in an honest, fair and transparent manner.

8.1.5 Ensure that it has the necessary expertise, skills and infrastructure to conduct its business.

8.1.6 Train its employees on the provisions of this Code.

8.1.7 Take reasonable steps to inform its Authorised Agents and Service Providers of and ensure that they adopt applicable elements of this Code.

8.1.8 Implement procedures to ensure that Authorised Agents and Service Providers inform current and potential Policyholders of the identity of the Member for whom they are acting and the service they have been instructed to provide.

8.1.9 Create awareness of its SAIA Membership and its commitment to this Code.

8.1.10 Monitor and assess its compliance with this Code and rectify non-compliance as soon as possible.

8.1.11 Report compliance with this Code to SAIA as required from time to time.

8.1.12 Cooperate with SAIA and/or the SAIA Code of Conduct Complaints Committee when investigating any alleged non-compliance with the Code, and / or complaints.

8.1.13 Accept the decisions and/or sanctions of SAIA, the Complaints Committee, and/or the appointed person in the case of appeals.

8.1.14 Actively commit to the realisation of transformation in and financial inclusion for the non-life insurance industry.

8.1.15 Actively support SAIA's consumer education programme in addition to their own consumer education programmes.

8.1.16 Comply with the SAIA Code of Motor Salvage as contained in this Code, if it is applicable to the Member's business.

8.1.17 Preserve the confidentiality of Policyholder information. Such information must only be disclosed as required or permitted by law, as approved by the Policyholder, where it is in the public interest or for crime combating purposes, as requested by SAIA or the Regulators.

9. INCLUSIVE GROWTH AND TRANSFORMATION

Principle

As the representative of its member non-life insurers, SAIA is committed to the transformation of the South African economy and believes that accelerated growth is best achieved in an economy conducive of inclusive growth. To achieve this, SAIA has adopted a proactive approach by developing and adopting an industry transformation strategy. Industry priorities are identified and approved by the SAIA Board and subsequently, serve as a guide for member alignment with own transformation objectives.

Standards

9.1 To deliver on transformation objectives for the non-life insurance industry, Members shall:

9.1.1 Take accountability by driving transformation, by:

9.1.1.1 Adopting the Financial Sector Code (FSC) as a compulsory reporting framework for the non-life insurance industry participants.

9.1.1.2 Adopting the industry transformation strategy set by SAIA, as a guideline when developing member transformation strategies and aligning opportunities with the industry objectives where appropriate.

9.1.1.3 Supporting the provision of credible industry transformation data by improving member internal data collecting and storing for the purpose of reporting to SAIA and the Financial Sector Transformation Council (FSTC).

9.1.1.4 Adopting and adhering to the SAIA transformation reporting requirements as approved by the SAIA Board.

9.1.1.5 Collating and submitting the required annual verified transformation data to SAIA and the FSTC.

9.1.1.6 Collating and submitting periodic transformation data to SAIA on a regular or ad-hoc basis as may be required for the purpose of measuring, monitoring and reporting on the industry transformation progress. The frequency of the submissions will be determined on an ad-hoc basis and communicated through SAIA MD Circulars.

9.1.1.7 Collaborating and participating in industry initiatives by contributing to the required financial and non-financial resources where possible.

9.1.2 Support the improvement of Black representation at all Management and Control sub-elements, by:

9.1.2.1 Identifying opportunities and implementing strategies to advance transformation of member Board and executive management teams.

9.1.2.2 Aligning internal employment equity strategies in line with the FSC targets, including improvement of representation of African and Black women in totality at all levels of management.

9.1.2.3 Aligning skills development strategies to respond to industry skills gaps and in support of the FSC's Management and Control element objectives.

9.1.2.4 Participating in industry bodies regarding increasing the number of Black professionals in the relevant skill sets.

9.1.2.5 Identifying opportunities to participate in Government initiatives aimed at advancing skills development, particularly youth such as the Youth Employment Service (YES) Programme and the funding of tertiary education.

9.1.3 Support industry commitment to drive transformation of preferential procurement by:

9.1.3.1 Increasing spend with Broad Based Black Economic Empowerment (BBBEE) compliant suppliers and in line with the requirement of the FSC and industry transformation objectives i.e.; support of Black motor and property claims service providers.

9.1.3.2 Identifying opportunities and supporting industry projects to transform the industry value chain.

9.1.3.3 Identifying opportunities to maximise supplier value by aligning procurement strategy with Enterprise and Supplier Development (ESD) strategy and in line with the industry transformation objectives where appropriate.

9.1.3.4 Participating in industry approved ESD projects, by providing the required financial and non-financial support, where appropriate.

9.1.4 Support and participate in the sector / industry financial inclusion projects, and in line with the recommendations as contained in Clause 10 below, where appropriate.

10. FINANCIAL INCLUSION - CONSUMER EDUCATION AND ACCESS PRODUCTS

10.1 Financial inclusion serves as a critical component in promoting economic growth and sustainability of the financial sector, as the majority of previously disadvantaged individuals are still involuntarily excluded from accessing some of the products and services within the financial sector, negatively impacting the quality of life of an average South African.

10.2 Financial inclusion can be achieved through participating in Consumer Education initiatives, which promote consumer knowledge of the financial sector and its products; and developing appropriate access products for the low-income consumer market segment.

10.3 Members are therefore encouraged to promote and participate in Consumer Education initiatives and in line with the requirements of the FSC by:

10.3.1 Annually contributing a minimum of 50% of 0.4% of the Net Profit after Tax Consumer Education FSC target, to the SAIA Consumer Education Fund.

10.3.2 Carrying out Member initiatives with the balance of Member Consumer Education contributions to the FSC targets, and in line with the industry Financial Inclusion objectives where possible.

10.3.3 Collaborate within the industry or the sector in support of increased reach and / or impact by Consumer Education initiatives where appropriate.

10.3.4 Consumer Education Guidance Notes are available from the FSTC website (https://fstc.org.za/guidance-notes.php).

10.4 Members are also encouraged to promote Financial Inclusion by developing appropriate access products for the targeted consumer market segment and in line with the FSC requirements, where appropriate. Access Standards Guidance Notes are available on the FSTC website (https://fstc.org.za/guidance-notes.php).

11. COMMUNICATION WITH CURRENT AND POTENTIAL POLICYHOLDERS

Principle

Members must communicate effectively with current and potential Policyholders throughout the insurance contract lifecycle, as effective communication enables Policyholders to make informed decisions relating to their insurance policies and the subject matter insured.

Standards

11.1 Members must adopt best-practice communication strategies, which may include the provision of fact sheets, worked examples and infographics to supplement communications.

11.2 Communication to Policyholders must be channelled via the Policyholder's nominated contact method.

11.3 Where a contact method has not been nominated by a Policyholder, communication with the Policyholder must be channelled via the most effective method / s of communication.

11.4 The terminology and language that are used in communications must be clear and unambiguous.

11.5 Disclosures must be user-tested to ensure a minimum level of comprehension by Policyholders.

12. ADVERTISING, MARKETING AND SOLICITING BUSINESS

General Principle

Advertising plays an important role in the non-life insurance industry as potential Policyholders are influenced thereby. Advertisements must fairly and accurately represent the product and its key features and risks, or the nature and scope of the service advertised.

Standards

12.1 Advertising must

12.1.1 Be clear, fair and not misleading.

12.1.2 Not create unrealistic expectations that can lead to poor financial decisions.

12.1.3 Conform to the standards set by the ARB.

12.1.4 Consider the best interests of consumers.

12.1.5 Not bring the insurance industry into disrepute or cause potential reputational damage to the non-life insurance industry or any part thereof.

12.1.6 Be capable of being clearly understood by the audience that might reasonably be expected to see the advertisement.

13. DEALING WITH POTENTIAL POLICYHOLDERS AT UNDERWRITING STAGE

Principle

Underwriting is a critical stage in the insurance lifecycle. Members must treat current and potential Policyholders fairly throughout this stage.

Standards

13.1 Only material information required for assessing an application for an insurance policy must be requested.

13.2 All material information must be obtained at the time of underwriting and not at claims stage. The practice of verifying information provided subsequent to the initial underwriting will, however, be an acceptable practice, provided this is not done at claims stage and in order to reject a claim.

13.3 Potential Policyholders must be informed of the legal duty to disclose all material information as well as the potential consequences of material non-disclosure and / or misrepresentation.

13.4 The following disclosures must be made by Members at underwriting stage

13.4.1 The Member's contact details.

13.4.2 Important information, such as due dates for premium payments, the consequences of non-payment, and the costs and processes involved in re-submission of debit orders, if applicable.

13.5 Potential Policyholders must receive assistance when insuring their assets, including their motor vehicles, for an appropriate value in terms of the policy wording (i.e. replacement / market value etc).

13.6 A reasonable attempt must be made to assist the potential Policyholder to understand the insurance policy including, but not limited to, the extent of cover, the key factors that affect the premium charged, the exclusions, special terms and conditions, and all relevant aspects of the policy, including excesses, the relevance of regular, nominated drivers and “no claims bonuses”, if applicable.

13.7 Copies of any relevant documentation (e.g. reports on structures of buildings, the condition of vehicles) related to an insured asset received at underwriting stage should be provided to the Policyholder if it is reasonable and appropriate to do so and if the Policyholder has requested such documentation. The Policyholder should be invited to respond and / or comment on the documentation provided if it is necessary to do so.

13.8 Where the potential Policyholder is denied insurance cover, reasons for the decision must be provided to the Policyholder.

13.9 When a full book of business is accepted by a Member without evaluating each individual risk, all insurance risks associated with the entire book of business at the time of taking over the business are deemed to have been accepted.

Principle and Standards specific to motor insurance

In addition to the clauses above, the following principle and standards apply to motor insurance specifically:

Principle

Members offering motor insurance must reassess the basis value of all motor vehicles insured regularly without any prompting from the Policyholder.

Standards

13.10 Members must reassess the basis value of motor vehicles at least annually, at renewal or at anniversary date.

13.11 The limits of indemnity or sums insured of such motor vehicles must be readjusted according to the revised values of the motor vehicles insured, where appropriate.

13.12 This revised value must be considered when recalculating the premium.

13.13 Members must take the necessary action in terms of their own specific operational models to ensure that this requirement is met, whether it is by way of an automatic adjustment on their systems or a contractual obligation placed on their Authorised Agents (including intermediaries, administration agents, or any other relevant third party service provider).

13.14 Members and / or their Authorised Agents may use any appropriate method to determine the value of the vehicle but must disclose the method used to Policyholders at underwriting stage.

13.15 Where the value of a motor vehicle is not readily available (for example in the case of older and / or imported vehicles), the agreed value or valuation method must be disclosed to the Policyholder on a regular basis, i.e. at least annually at renewal or anniversary date.

13.16 This requirement applies to motor vehicles insured in terms of personal lines polices, as well as motor vehicles insured in terms of commercial policies, where vehicles are specified with their own sums insured noted, and where this is practically possible.

13.17 For the purposes of this provision, motor vehicles include motor cars and light delivery vehicles but exclude other items such as boats, trailers, caravans, etc.

13.18 Members are encouraged to include an explanation of the relevant factors used in the premium calculation in general, in order to ensure that the Policyholder understands why the premium may not have decreased if the total value of the motor vehicle insured has decreased.

13.19 Policyholders should be advised / requested in this process to inform the Member should they wish to obtain additional cover for any additional extras that may have an impact on the total value of the motor vehicle.

13.20 Members are encouraged to communicate regularly with Policyholders in order to remind them of the importance of communicating any material changes to the Member in order to ensure that they are appropriately insured in exchange for an appropriate premium.

14. DEALING WITH POLICYHOLDERS AT CLAIMS STAGE

General Principle

The claims management process must be accessible, transparent, expeditious, efficient and designed to accommodate all activities necessary for the proper handling of an insurance claim.

General Standards

14.1 Members must honour promises arising from valid insurance claims. Accordingly, insurance claims should only be rejected in circumstances permitted by legislation and fairly within the terms of the insurance contract.

14.2 Policyholders must be adequately advised of the Member's insurance claim handling processes.

14.3 All reasonable steps to investigate the merits of a potential claim must be taken.

14.4 Any person dealing with claims must have the necessary training and competence, with a working knowledge of insurance legislation and practice relating to claims management.

14.5 Persons dealing with claims must be empowered to make impartial decisions or recommendations.

14.6 Members must promptly correct errors or mistakes that may take place when dealing with claims, and advise the Policyholder, if appropriate.

14.7 The claims management framework must accommodate the analysis of trends, risks and remedial actions in order to review the product design and disclosures in line with Treating Customers Fairly (TCF) principles.

14.8 Appropriate procedures must be in place for the identification and assistance of vulnerable Policyholders who may need assistance throughout the insurance claims process.

Claims Reporting Standards

14.9 Members must advise Policyholders of the claims reporting process at underwriting stage and when a claim is lodged.

14.10 To ensure that the claims reporting process proceeds as smoothly as possible, the Member must provide the Policyholder with all the information necessary to help them to lodge a claim. Information provided must address the following:

14.10.1 How to minimise loss.

14.10.2 The importance of cooperating in the investigation by providing the Member with all the facts, information and official documents, regarding the loss.

14.10.3 Reporting of the claim in a timely manner as provided for in the policy.

14.10.4 The need to allow the Member to handle inspection and assessment of damage prior to settlement.

14.10.5 The need to understand that Policyholders may be required to cede their rights to the insurer for recovery from the third party (if applicable) after settlement of the claim under the principle of subrogation.

14.11 Where it is necessary for the Policyholder to provide specific documents when lodging a claim, the Member must provide the Policyholder with the full list of these documents as soon as possible.

Claims Assessment and Processing Standards

14.12 Claims must be assessed based on information or documentation that is material to the assessment of the claim, in terms of the insurance policy and the law.

14.13 Claims assessment methods used must be reasonable and coherent.

14.14 The Policyholder must be notified where the Member has opted to appoint a loss assessor, loss adjuster, investigator and/or other service provider to investigate the loss or assess the damage.

14.15 Loss adjusters, loss assessors and other service providers used to assess the claim must be competent and qualified to do so.

14.16 The Policyholder must regularly be kept informed of the progress of the claim and the Member must respond timeously to routine requests made about the claim, (Guideline: 7 days) to respond.

Standards when Making Decisions regarding Claims

14.17 Once all relevant information has been collected and all enquiries have been completed, the Member must decide whether to accept or reject the claim and notify the Policyholder of its decision with reasons where the claim is rejected.

Claims Rejection Standards

14.18 If the claim is rejected, the Member must advise the Policyholder explicitly of the policy provisions, conditions or exclusions on which the rejection is based.

14.19 If the amount offered is different from the amount claimed, the Member must explain the reason for this to the Policyholder.

14.20 Where the Member is not responsible (by virtue of policy clauses) for meeting all or any part of the claim, it must notify the Policyholder of this fact and explain why.

Claims Settlement Standards

14.21 When a final payment or offer of settlement is made, the Member must explain to the Policyholder what the payment or settlement is for and the basis used for arriving at the payment/settlement.

14.22 In cases where the interest of any other party, apart from the Policyholder, is noted in the claim, the claim may be settled by payment to the other party however the Policyholder must be notified of the Member's intention to do so and the basis for doing so. The Policyholder must be afforded an opportunity to make a representation on the issue.

14.23 In the case of a claim settlement involving several insurers, indemnification of the Policyholder should be the priority: the claim should be settled in an appropriate time period while potential disputes between the insurers are resolved at a later stage. For the most common insurance claims, related to motor insurance for instance, specific agreements are concluded between insurers to accelerate and simplify claims settlement procedures involving several insured parties.

14.24 The Member must not attempt to settle a claim for less than the amount which the Policyholder would be entitled to receive.

Standard in the case of dual/multiple insurance

14.25 In the case of dual insurance or multiple insurance for the same risk, and subject to the principle that insurance is not intended to place a person in a better position than before the claim, when a Member becomes aware of the fact that a Policyholder is also insured by another insurer, the Member must:

14.25.1 Pay the full claim and arrange with the other insurer to be reimbursed for its rateable proportion of the loss or arrange with the other insurer for each of them to pay their rateable proportion due to the Policyholder within an agreed time.

14.25.2 OR Refund premiums in accordance with the respective rateable proportion of the risk, where appropriate.

Claims processing timelines and communication standards

14.26 Members must keep Policyholders informed of progress during the claims process.

14.27 Members must provide information on when payments, repairs or replacements are expected to be made, and, if necessary, explain why additional time is required.

14.28 Policyholders must be informed of the acceptance or rejection of a claim within a reasonable period (Guideline: 14 days).

14.29 Members must contact any other company that is involved in the claim within a reasonable period (Guideline: 14 days) and resolve any inter-company claim disputes as quickly as possible.

14.30 Where a Policyholder reasonably demonstrates that they are in urgent financial need of the benefits they are entitled to under an insurance policy as a result of the event causing the claim, Members must

14.30.1 fast-track the assessment and decision-making process in respect of the Policyholder’s claim.

14.30.2 make an advance payment under the settlement, where the claim has been accepted, to assist in alleviating the Policyholder’s immediate hardship.

14.31 Where the timeframes initially communicated to the Policyholder are not practically workable for the Policyholder, Members must reconsider the timelines provided and, where possible, accommodate and agree alternative timelines.

15. DEALING WITH THIRD-PARTY CLAIMS

Principle

Third parties and Policyholders must be made aware of their rights and obligations where third-party claims are concerned.

General Standards

15.1 The Member must act in good faith and must deal with third-party claims fairly, promptly and in a transparent manner.

15.2 Members must adopt a clear and informative communication process which explains to the Policyholder the procedures and processes in respect of third-party claims and recoveries.

15.3 When a Member is informed that a third party wishes to claim in relation to a matter for which the Member is the underwriter, such Member must give the third- party reasonable guidance as to the proper procedure for making a claim.

15.4 Where a Member becomes aware of an insurance event that may result in a third-party claim, the Member must handle such event as a claim made by its Policyholder, notwithstanding that such Policyholder has failed to give notice of such claim.

15.5 A Member must not reject or refuse to handle a claim made by a third party based on the failure / refusal of the Policyholder to pay the excess. However, the Member is entitled to charge the excess to its Policyholder separately.

15.6 If the Member is of the opinion that the third-party liability should be accepted, whether in full or in part, then it must give notice to its Policyholder of its intention to pay the claim and the proposed amount of settlement and the payment of the excess.

15.7 Such notice should also include an explanation of the consequences for the Policyholder who objects to such payment.

15.8 When a Member settles the claim by paying the third party, the Member should aim to make payment within a reasonable time (Guideline: 14 days) after the Member and the third party have agreed settlement terms, subject to the submission of the relevant receipts and any other requirements specified by the Member or in law, being met by the third party. This does not prevent the Member from paying a claim before the third party has finally agreed settlement terms.

15.9 A Member may not delay payment of a claim to a third party on the grounds that premiums are outstanding by its Policyholder.

Standards that apply between the Member and the Policyholder in respect of third-party claims

15.10 Members must adopt clear and informative communication processes, explaining to Policyholders the procedures and processes in respect of third-party claims and recoveries.

15.11 After the sale of the insurance policy, the Member must advise the Policyholder that in the event of an insured event involving a third party, the Policyholder must:

15.11.1 not admit liability for any fault or damage

15.11.2 inform the Member as soon as he or she becomes aware of any action against him / her, including summons. The consequences of not doing so should be communicated to the Policyholder

15.11.3 understand that the Member will act on behalf of the Policyholder and that the Policyholder need not refer the matter to other parties to handle, such as their own legal representatives.

15.12 Where a third-party claim is lodged against a Member's Policyholder, the Member must inform the Policyholder of its subrogation rights, all the actions that the Member will take, the nature of the third-party claim and the length of time it could take to finalise the claim. When the Member is informed that a third party wishes to claim in relation to a motor vehicle which is involved in an accident and which may be covered under a motor liability policy issued by such Member, it must give the third party reasonable guidance as to the proper procedure for making a claim.

15.13 Where a Member becomes aware of an insurance event that may result in a claim, the Member must handle such an event as a claim made by its Policyholder, notwithstanding that such Policyholder has failed to give notice of such claim.

15.14 The Member must also keep the Policyholder regularly informed of developments in respect of the third-party claim.

Standards that apply between the Member and the Policyholder in respect of third-party recoveries

15.15 The Member must advise the Policyholder as follows:

15.15.1 The approximate length of time it will take to complete the recovery process.

15.15.2 That in terms of the principle of subrogation, if applicable, the Member assumes the rights and responsibilities of the Policyholder once the Member has indemnified the Policyholder by paying or settling a claim and that any decisions regarding recovery and liability will be taken solely at the discretion of the Member.

15.15.3 That the Member will endeavour to recover the Policyholder's excess as well as the Member's own damage in respect of the claim.

15.15.4 Reasons for an unsuccessful or partially successful recovery (including the full or partial recovery of the Policyholder's excess).

Standards that apply between the Member and another Member in respect of third-party recoveries

15.16 The Member must communicate the intention to take legal action to the other Member in order to grant the other Member an opportunity to communicate same to its Policyholder to whom the legal action refers.

Standards that apply between the Member and uninsured third parties in respect of third-party recoveries

15.17 Each third-party claim involving an uninsured third party must be dealt with in terms of its own merits and the quantum of such a claim will be determined fairly.

15.18 The Member must advise the uninsured third party as follows:

15.18.1 That the claim will be dealt with in terms of its own merits and the quantum of such claim will be determined fairly.

15.18.2 of the complete list of all material or relevant information required from the uninsured third party for the Member to deal with the claim, as well as the consequences of not submitting such requested information.

15.19 When a decision has been made regarding the claim, the Member must advise the uninsured third party of the reasons for the decision and provide an explanation for the apportionment where there is contributory negligence on the part of the third party, as provided for in the Apportionment of Damages Act, 1956 (Act No 34 of 1956).

15.20 In the event that the uninsured third party is not satisfied with the outcome where the Member has followed the standards as set out above and where a dispute arises, such dispute must be dealt with by the Member in terms of its own internal dispute resolution process.

15.21 The uninsured third party may complain under this Code where the complaint relates to the procedures followed and the service provided by the Member.

15.22 The uninsured third party may approach the relevant Ombudsman where a complaint relates to a claim and is within a certain amount.

16. DEALING WITH REPAIRS AND WORKMANSHIP

Principle

Members must take accountability for the work of the Service Provider that they appoint and must exercise adequate oversight over the work provided by duly authorised Service Providers.

Standards

16.1 Members must appoint appropriately skilled, certified or professionally qualified Service Providers. Where recognised professional bodies exist, the appointment of members of these bodies is preferred.

16.2 An assessor and/or service provider must be dispatched to address the Policyholder's claim within a reasonable time period, taking into consideration the circumstances of the claim.

16.3 A decision regarding the repair and / or any other action must be made within a reasonable period (Guideline: 14 days) after receiving the relevant information from the assessor and/or other service provider, in relation to the type and urgency of the event.

16.4 Should a Member instruct a Service Provider to authorise a repair or other such action, the Member must honour the authorisation.

16.5 The Member may prefer a specific Service Provider, but should the Policyholder request a specific Service Provider, the Member should reasonably consider the request.

16.6 Where a Service Provider has been selected and directly authorised by the Member, the Member must:

16.6.1 accept responsibility for the quality of the workmanship and materials

16.6.2 handle any complaint about the quality or timeliness of the work or conduct of the Service Provider accordingly.

17. FRAUD AND DISHONEST CONDUCT

Principle

SAIA is opposed to fraud and dishonest conduct, and encourages Members to identify, verify, investigate and prevent such conduct.

Standards

In order to curb the growth of fraudulent claims, Members must take the following steps in terms of fraud and dishonest conduct:

17.1 Participate in combating fraud and dishonest conduct.

17.2 Establish systems and controls for detecting and identifying fraud appropriate to Members' exposures and vulnerability.

17.3 Discourage fraudulent claims by making Policyholders aware of the consequences of submitting false statements when lodging a claim.

17.4 Train employees and Authorised Agents who deal with claims to scrutinize claim documents in order detect dishonesty and possible fraud.

17.5 Should a Member cancel an insurance policy due to the Policyholder being found to have acted fraudulently or in a dishonest manner, the following procedure will apply: Members must:

17.5.1 Apply and exhaust their internal mechanisms for detecting, identifying and verifying the fraud.

17.5.2 Inform the affected Policyholder about the cancellation and the options available to the Policyholder;

17.5.3 Inform the Insurance Crime Bureau (ICB) of the cancellation of the contract and the reason for it;

17.5.4 Inform the ICB of employees dismissed as a result of fraud or a financial related crime;

17.5.5 Not disclose or perform anything that is likely to prejudice the criminal investigation and prosecution of any suspects.

17.6 Should a Member be approached by an intermediary with a book of business, the Member should establish with the ICB whether another insurer has notified it about the cancellation of a contract with that particular intermediary due to the intermediary having been found to have acted fraudulently or in an improper manner. Should the Member establish that that intermediary had in fact been referred to the ICB, the Member should not accept business through that intermediary.

Standards relating to Members, their employees and Authorised Agents and Service Providers

17.7 In dealing with Policyholders, Members, their employees, Authorised Agents and Service Providers must:

17.7.1 Treat Policyholders with respect and ensure that Policyholders are not harassed, intimidated, misled or threatened at any time. Members must include this provision in their agreements.

17.7.2 There is a presumption of innocence until the established facts indicate otherwise.

17.7.3 Only relevant information must be requested when investigating potential dishonesty and fraud, and any personal information will be dealt with in terms of the relevant privacy laws.

17.7.4 Information regarding established insurance fraud must only be shared for the purpose of combating crime.

18. MEMBERS' EMPLOYEES AND AUTHORISED AGENTS

Principle

Members must exercise appropriate governance and oversight with their employees and Authorised Agents.

Standards

18.1 Members' employees and Authorised Agents must:

18.1.1 At all times act fairly, professionally, honestly, transparently and with due skill, care and diligence.

18.1.2 Not harass, intimidate, mislead or threaten Policyholders and / or potential Policyholders.

18.1.3 Be competent and provide services which match their expertise.

18.1.4 Be trained on this Code.

18.2 Members must:

18.2.1 Ensure that contractual arrangements with employees and Authorised Agents address the matters stipulated above.

18.2.2 Provide their employees and Authorised Agents with the requisite training in respect of services they perform on behalf of the Member. Such training must include training on this Code to correct identified performance shortcomings.

18.2.3 Request their Authorised Agents to notify them of any complaints received against them while acting on the Member's behalf.

18.2.4 Have appropriate controls in place to ensure the robust identification, assessment, measurement and management of any risks associated with the outsourcing of activities to Authorised Agents.

19. COMPLAINTS

Principle

Members must have an effective complaints management framework.

For purposes of this section:

A complainant is a person who lodges a complaint in respect of the service and / or products of a Member. Such complaint could be made directly to the Member or to the Member's employees and / or Authorised Agents.

Standards for Internal Complaints Handling

19.1 The complaints management process must be accessible to complainants.

19.2 The complaints management process must be conducted fairly and in a timely manner.

19.3 Members must inform the complainant of all the relevant or material information required from the complainant, for the Member to deal effectively with the complaint.

19.4 The Member must provide the complainant with an opportunity to rectify any incorrect information provided.

19.5 The complainant must be informed of the time it will take to decide on the complaint. Should the Member not respond to the complainant within the time frames previously communicated to the complainant, the Member must inform the complainant of the causes of the delay as well as the revised timeframes.

19.6 The complainant must be kept adequately and regularly informed of the progress of the complaint.

19.7 When a decision has been made, the Member must convey it to the complainant in writing, giving:

19.7.1 The reasons for the decision.

19.7.2 Information about how the complainant can access external dispute resolution or other recourse mechanisms.

19.7.3 Timeframes within which the complainant can lodge internal dispute against the decision.

19.8 Where the complaint is upheld, the Member must implement remedial action within a reasonable period (Guideline: without delay).

19.9 Members must, in contractual agreements with authorised representatives, require such authorised representatives to inform them of any complaints received against the authorised representatives in the course of acting on behalf of the Member.

19.10 The Member must keep a record of all complaints in order to monitor and analyse the complaints and any trends.

Internal Escalation and Review Process Standards

The following standards apply where a complainant wishes to have a decision regarding a complaint reviewed:

19.11 The Member must follow an internal escalation and review process. Such process must be balanced and impartial.

19.12 The complaint must be reviewed by a person with the appropriate experience, knowledge and authority. The Member must inform the complainant of the contact details of the person to whom the complaint has been escalated for review.

19.13 When a decision has been made, the Member must convey it to the complainant in writing, giving:

19.13.1 Reasons for the decision

19.13.2 Information about how the complainant can access external dispute resolution or other recourse mechanisms

External Dispute Resolution Standards

19.14 All Members are required to subscribe to the Insurance Ombud scheme.

19.14.1 Members must provide complainants with information on how to access the Insurance Ombud scheme and the FAIS Ombud. Such information must be included in Disclosures documentation and documentation related to the rejection of claims.

Standards in respect of complaints lodged with SAIA

Complaints in respect of this Code shall be in writing and addressed to:

SAIA

PO Box 5098

Weltevreden Park

1715

info@saia.co.za (email)

011 726 5381 (phone)

086 647 2275 (fax)

Complaints lodged with SAIA under this Code against a Member will be dealt with in two stages, in general.

Standards for stage one

19.15 SAIA will deal with complaints against a Member where such complaints:

19.15.1 Have not been resolved by the Member's internal processes; and

19.15.2 Do not fall under the jurisdiction of the Insurance Ombud scheme.

19.15.3 Have been lodged with SAIA within 180 days of the date on which the event or action giving rise to the complaint occurred;

19.15.4 Relate to non-compliance with this Code;

19.16 SAIA will follow a facilitation and mediation process to resolve the complaint.

19.17 SAIA will deal with the complaint fairly, timeously, transparently and in accordance with its internal processes.

19.18 If the facilitation and mediation process followed by SAIA to resolve the complaint fails, SAIA has the right to take the complaint to the SAIA Code of Conduct Complaints Committee, as provided in stage two.

Standards for stage two

19.19 The Complaints Committee shall comprise of a senior representative from the Insurance Ombud scheme, a person nominated by the Board of the relevant Insurance Ombud scheme, a senior representative of the Financial Sector Conduct Authority ("FSCA"), a consumer representative and a person nominated by the SAIA Board, in order to avoid any potential conflicts of interest.

19.20 The Complaints Committee may co-opt a specialist in the appropriate field onto the Committee, if it deems this necessary.

19.21 The Complaints Committee must:

19.21.1 Elect a chairperson, who shall have a casting vote in the event of a deadlock.

19.21.2 Make decisions by way of a majority vote.

19.21.3 Address the complaint timeously, especially where the complainant may continue to suffer prejudice while the complaint is being dealt with.

19.21.4 Notify the Chief Executive Officer of SAIA or his / her appointed representative in writing of its decision and the reasons therefor within 90 days after receiving the complaint.

19.22 The Complaints Committee has the following powers:

19.22.1 To receive complaints regarding alleged non-compliance with this Code, and investigate such allegations;

19.22.2 To decide on its own rules and procedures for dealing with any complaint, including whether the parties may have legal representation and the terms on which the parties may be represented.

19.22.3 To conduct investigations into alleged breaches using information requested from the Member in question and supplied by the complainant, as well as any other relevant information.

19.22.4 To consider any information submitted by the Member and other relevant parties, before making its decision.

19.22.5 To dismiss complaints where the complaint is found to have no merit.

19.22.6 To make determinations where a Member has been found to have breached this Code.

19.22.7 To impose sanctions should this be deemed appropriate after considering all relevant and material factors and the guidelines set out below.

19.22.8 To receive any requests for leave to appeal against determinations made by the Complaints Committee and to consider whether an appeal will be permitted.

19.23 When dealing with complaints, the Complaints Committee will consider the following:

19.23.1 The objectives of this Code.

19.23.2 The severity of the non-compliance with this Code and its effect.

19.23.3 The potential impact of the non-compliance on the image and reputation of the non-life insurance industry.

19.23.4 The appropriate sanction to be imposed should the Committee deem it necessary to impose a sanction.

19.24 The decision of the Complaints Committee is binding on all Members.

Standards for Investigations

19.25 SAIA may:

19.25.1 Identify and investigate potential non-compliance with this Code in the absence of a formal complaint, including any liaison with any recognised Ombud Schemes.

19.25.2 Assist the Complaints Committee in its investigations where necessary.

19.25.3 Convey decisions of the Complaints Committee to Members and/or the complainants.

19.25.4 Monitor any required corrective measures.

19.25.5 Report any failure to correct non-compliance as decided by the Complaints Committee to the Complaints Committee within 21 days after the required period allowed for corrective measures has expired.

19.25.6 SAIA must acknowledge receipt of the complaint to both the complainant and the Member in writing within 7 days of receipt of the complaint and keep the complainant and the Member informed as to the progress of the complaint's consideration.

Guidelines for the imposition of sanctions

The guidelines below are neither exhaustive nor prescriptive.

19.26 Sanctions imposed should act as a deterrent to such behaviour or actions in the future, and should be appropriate, fit the contravention and consider the following factors:

19.26.1 The nature and severity of the contravention, including whether it was a repeat contravention.

19.26.2 The impact of the contravention on the complainant and any other affected person and any restorative measures that may be appropriate.

19.26.3 The mitigating or corrective actions taken by the offending Member after receipt of the complaint.

19.26.4 The quantum of any benefit or gain to the Member arising out of the contravention.

19.26.5 Whether the contravention may be a contravention of legislation or regulation and whether the referral of the outcome to an appropriate regulatory Authority is warranted.

19.26.6 Whether the sanction imposed should be restricted to the contravention or be applied to the contravening Member's business in general.

19.26.7 The reputational impact of the offending conduct on the industry.

19.26.8 The financial impact of a fine on the Member.

19.26.9 The appropriateness of imposing a suspended sanction/s.

19.26.10 The timeframe within which to effect corrective measures.

19.26.11 The impact and/or effect on the contravening Member of publishing the findings.

19.27 The Complaints Committee may impose one or more of the following sanctions on Members and must stipulate the timeframe within which any sanction imposed is to be implemented:

19.27.1 A written reprimand or warning.

19.27.2 Rectifying measures to be undertaken.

19.27.3 A requirement that a compliance audit be undertaken by an appropriate service provider, with the costs thereof to be borne by the affected Member.

19.27.4 In the case of a complaint relating to advertising, that corrective advertising be implemented utilising specified media types. The Complaints Committee may recommend that a complaint relating to advertising standards be referred to the Advertising Regulatory Board.

19.27.5 A requirement for publication of the contravention in specified media.

19.27.6 A monetary fine not exceeding an amount of R 500,000 (five hundred thousand Rand).

19.27.7 An order relating to the payment of costs incurred by SAIA in respect of the hearing.

19.27.8 A recommendation to SAIA regarding the suspension or expulsion of the Member from SAIA.

19.27.9 Referral of the matter to the appropriate regulatory Authority (including a regulator or Ombud scheme).

19.28 Fines imposed by the Complaints Committee must be paid within 30 days of finalisation of the complaint and, in line with the principle of consumer

restitution, will be contributed to SAIA's Consumer Education programme funds.

Standards for Appeals

19.29 Any request for leave to appeal against a decision of the Complaints Committee must be lodged in writing with SAIA within 21 days after the Complaints Committee's decision has been communicated to the parties. SAIA shall then immediately notify the Complaints Committee of the request for leave to appeal.

19.30 The Complaints Committee must notify SAIA in writing within 7 days of the outcome of the request for leave to appeal, and SAIA shall then notify the parties to the complaint within a reasonable period not exceeding 14 days thereafter of the Complaints Committee's decision if the Complaints Committee has not communicated the decision to the parties directly. The Complaints Committee should copy SAIA on its decision.

19.31 The appeal must be lodged with SAIA in writing within 21 days after the decision by the Complaints Committee has been communicated to the parties.

19.32 The implementation of any sanctions imposed by the Complaints Committee shall be suspended pending finalisation of the outcome of the appeal.

19.33 The appellant and the Complaints Committee (the respondent) must within 7 days of the granting of leave to appeal, agree on the identity of the person or persons to deal with the appeal from a list of candidates provided by the Complaints Committee. Where the parties are unable to reach such agreement, by default the Complaints Committee shall decide on and appoint an appropriate person or persons to deal with the appeal.

19.34 Any appeal should, wherever possible, be disposed of within 90 days of the leave to appeal being granted.

19.35 The person(s) hearing the appeal may:

19.35.1 Decide on the rules and procedures for dealing with any complaint, including the question of legal representation for the parties.

19.35.2 Choose to hear the matter *de novo* if they believe that this is in the best interests of the parties;

19.35.3 Confirm, vary or reverse any sanction(s) imposed by the Complaints Committee, subject to the provisions of 19.25 and 19.26.

19.35.4 Make any order as to the costs of the appeal and who should bear such costs as they deem fit.

20. MONITORING COMPLIANCE WITH THIS CODE

Standards

20.1 On a periodic basis, SAIA will:

20.1.1 Create awareness of this Code.

20.1.2 Monitor compliance with this Code.

20.1.3 Request Members to attest their compliance with this Code. Members will be required to submit evidence which clearly demonstrates compliance with this Code.

20.1.4 Members who satisfy compliance with this Code will receive a compliance certificate.

20.2 Where a Member's compliance with this Code is unsatisfactory or requires improvement, such Member will be requested by SAIA to implement measures to realise / improve compliance with the Code. Such measures will be monitored by SAIA.

20.3 As part of its monitoring, SAIA may provide recommendations to Members in respect of controls to adopt in order to realise / improve compliance with this Code.

21. REVIEW OF THIS CODE

21.1 This Code will be reviewed by SAIA regularly, and at least every three years, or on an *ad hoc* basis when and if deemed necessary.

21.2 The review process will take account of any changes in the Code's objectives, having regard to changes in the non-life insurance environment and legislation at the time of review.

21.3 SAIA will consult its Members, consumer and industry representatives, relevant Regulators and other stakeholders in the ongoing periodic review of this Code.

21.4 Any material amendments to this Code or any revised or new Code will be approved and adopted by the SAIA Board.

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