保險業監管局
Insurance Authority

Treating Customers Fairly

CONDUCT IN FOCUS

Insurance Authority
December 2023 • 8th Issue

CONDUCT IN FOCUS

Welcome to a statistically packed edition number 8 of Conduct in Focus.

We present the complaints statistics for 1st January 2023 to 30th September 2023.

Has the insurance market shown a statistical improvement on its Continuing Professional Development ("CPD") performance compared to last year? Who is named in the CPD Non-Compliance League Table this time around? Answers can be found in our article on CPD attainment statistics for the assessment period 1st August 2022 to 31 July 2023.

How old is the insurance market? We present the latest age statistics across licensed individual insurance intermediaries and ask what this means for the market.

In between all these numbers, we take time out to explain the "treating customers fairly" principle, being a core objective of the insurance regulatory framework, how it applies to virtually every conduct matter we consider, and give examples how we look to see this principle being applied in our inspection work.

We also include a series of gentle reminders on key regulatory issues such as the Mandatory Provident Fund Schemes Authority's Guidance Note on Conducting Sales by Unsolicited Calls, the Insurance Authority ("IA")'s Mystery Shopping Programme on Selling Practices of Qualifying Deferred Annuity Policies in Hong Kong, and some best practices for licensed insurance broker companies to adopt to enhance compliance with the obligation to notify the IA regarding relevant changes of its directors and controllers.

Peter Gregoire
General Counsel
Head of Market Conduct
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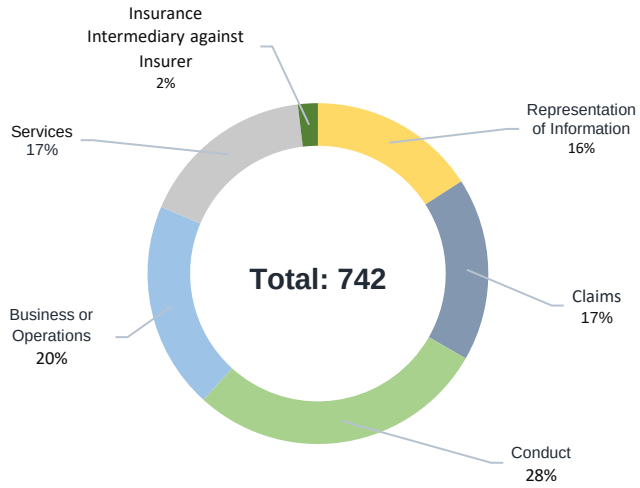
Complaint Statistics

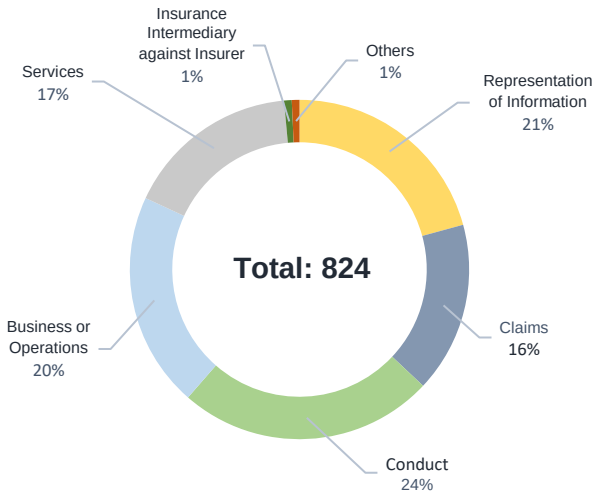
In this edition we present the complaints statistics for the first three quarters of 2023.

1 January to 30 September 2023 vs prior year

From 1st January to 30th September 2023



From 1st January to 30th September 2022



The IA received **742[1] complaints during the period from 1st January to 30th September 2023,** a reduction of 10.0% as compared to the same period last year. In terms of category, the most significant number of complaints were received in the category of "Conduct", albeit a reduction in the number of complaints on "representation of information" is observed.

Explanation of Complaint Categories

Conduct – refers to complaints arising from the process in which insurance is sold, the handling of client's premiums or monies, cross-border selling, unlicensed selling, allegations of fraud, allegations of forgery of insurance related documents, commission rebates and "twisting" (i.e. insurance agents inducing their clients to replace their existing policies with those issued by another insurer by misrepresentation, fraudulent or unethical means).

Representation of Information – refers to complaints relating to the presentation of an insurance product's features, policy terms and conditions, premium payment terms or returns on investment, dividend or bonus shown on benefit illustrations, etc.

Claims – refers to complaints in relation to insurance claims. The IA cannot adjudicate insurance claims or order payment of compensation. It can, however, handle complaints related to the process by which claims are handled (e.g. delays in processing, lack of controls or weaknesses in governance, areas of inefficiency in the claims handling process).

Business or Operations – refers to complaints related to business or operations of an insurer or insurance intermediary (e.g. cancellation or renewal of policy, adjustment of premium, underwriting decision, or matters related to the management of the insurer, etc.).

Services – refers to complaints regarding insurance related servicing by insurers or intermediaries, such as complaints related to the delivery of premium notice or annual statement, dissatisfaction with services standards etc.

[1] The IA also received 48 self-reported cases from insurers / intermediary firms during the reporting period versus 45 in the last year, both figures are excluded from the above complaint statistics.

Practice

CPD – twelve months later!

"On the first day of Christmas, the IA sent to me,
The results of the market's CPD"

Ah December! The season of good will and good cheer as we approach Christmas. And what a difference a year makes!

This time last year we were looking at disappointing results which showed that only approximately 90% of Individual Licensees in the market had met their Continuing Professional Development ("CPD") requirements for the assessment period from 1 August 2021 to 31 July 2022 ("2021/22 Assessment Period"). Individual Licensees are required to attain 15 CPD hours every assessment period to keep their professional knowledge and expertise – the very elements on which members of the public place reliance – up to date. A 90% compliance rate, therefore, meant potential policyholders stood a 1 in 10 chance of dealing with an Individual Licensee who had failed in satisfying this most basic of requirements. In no way was this an acceptable state of affairs.

Something needed to be done and since appointing principals bear a significant responsibility for ensuring their appointed Individual Licensees comply with the CPD requirements, this was where improvement needed to be targeted. So twelve months ago, we published our first CPD Non-Compliance League Table listing out the 10 principals in the insurance market with the highest percentage rates of CPD non-compliance across their appointed Individual Licensees for the 2021/22 Assessment Period.

The aim of this disclosure approach was to galvanize the insurance market into action, to do better, to be better and to demonstrate that it is better to the public it serves.

We complemented this with CPD thematic inspections in the first half of 2023, identifying areas for improvement and offering tailored recommendations for the companies in questions.

Together these actions aimed at encouraging and supporting the industry towards achieving significantly improved CPD compliance.

The question is: did it work?

CPD assessment period 1 August 2022 to 31 July 2023 ("Assessment Period 2022/23")

For the Assessment Period 2022/23, a total of 102,208 Individual Licensees were required to complete and report their completion of CPD hours. A total of 98,258 Individual Licensees complied with these requirements on time.

This means the overall compliance rate has improved from 90% in the Assessment Period 2021/22 to **96.1%** in the Assessment Period 2022/23. But this improvement only tells part of the story.

Firstly, whereas last year (i.e. Assessment Period 2021/22) Individual Licensees were required to attain only 12 CPD hours, this year (Assessment Period 2022/23) the number of CPD hours increased to 15 hours.

Secondly, the vast majority of the 3.9% non-compliant Individual Licensees, by the date of this publication have either already had their licences revoked or their licences are under automatic suspension as they have ceased to have any appointing principal. Either way, they are not carrying on regulated activities in the market any more.

Thirdly, only 0.3% of Individual Licencees with licences that are currently active were non-compliant in the Assessment Period 2022/23. This means that at the time of writing, potential policyholders can be **99.7%** confident that the Individual Licensees providing them with services through regulated activities have met their CPD requirements and that their knowledge and expertise is up to date.

Last year (Assessment Period 2021/22), the top 10 principals in the Non-Compliance CPD League Table had non-compliance rates ranging from 23.8% to 7.1% amongst their appointed Individual Licensees. This year (Assessment Period 2022/23), every one of those same 10 principals[2] have achieved 100% compliance across their Individual Licensees. This proves that with the right culture nurtured and robust controls established through its intermediary management function (as indicated in the December 2022 edition of Conduct in Focus), a principal can achieve a perfect result! Indeed it was particularly reassuring to see several insurers exceeding the practices we had articulated (with one insurer, for example, setting a 3-month advance date for targeted completion), in order to yield their 100% compliance.

To continue to reinforce this direction of improvement for the market (and at 96.1% there is still room for improvement), we publish again the CPD Non-Compliance League Table for the Assessment Period 2022/23, being the top 5 insurers with the highest percentage rates of CPD non-compliance across their appointed Individual Licensees in the Assessment Period 2022/2023, each with a total number of ≥15 non-compliant Individual Licensees:

CPD Non-Compliance League Table 2022/23

Name of Principal	CPD Non-compliance rate
FWD Life Insurance Company (Bermuda) Limited	**2.3%**
Bupa (Asia) Limited	**1.5%**
Sun Life Hong Kong Limited	**1.2%**
Bolttech Insurance (Hong Kong) Company Limited[3]	**1.1%**
Zurich Insurance Company Ltd	**0.6%**

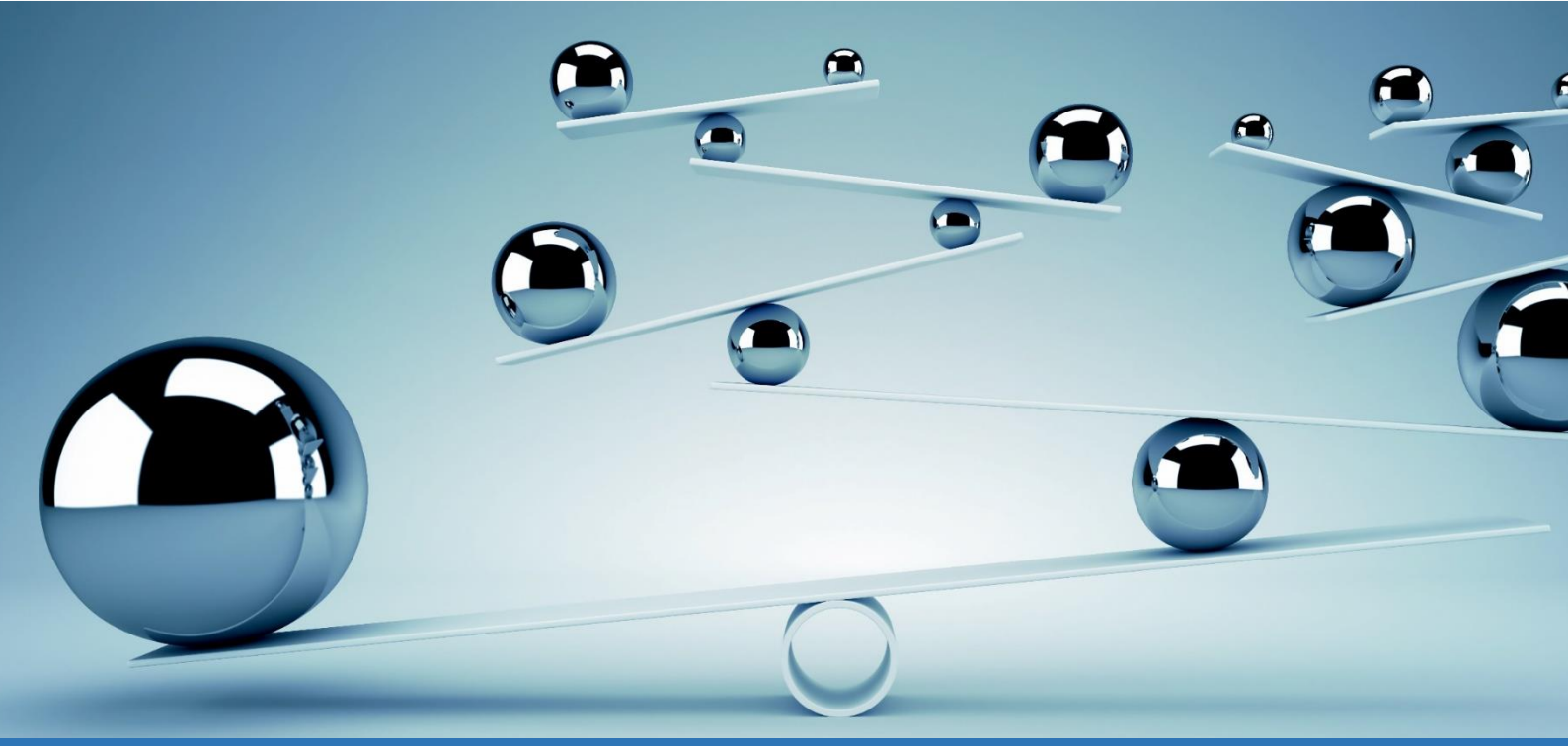
The fact that only 5 insurers are named and the percentages are significantly lower than last year is indicative of a general positive shift that has occurred in the market. However, the insurers named last year have proven that 100% compliance is possible. So the insurers named in the above table must strive for this new market standard.

There is no room for complacency on this and the IA will continue to work with the market to maintain (and demonstrate that it maintains) high levels of compliance on this and other areas. Going forward we shall also be focusing on the non-bank insurance agency and insurance broker sectors where we have identified individual principals which need to improve (in order to avoid them appearing on next year's non-compliance table).

But we do, this year, recognize the significant efforts of the market in achieving the improvement it has demonstrated. We also challenge it to make this the new and expected normal. And so it is with good cheer and hope that we wish you a Merry Christmas and look forward to a happy (and CPD compliant) New Year.

[2] The 10 principals were: Convoy Financial Services Ltd, Chubb Life Insurance Company Ltd, China Life Insurance (Overseas) Company Limited, YF Life Insurance International Ltd, Manulife (International) Limited, FT Life Insurance Company Limited, AIA International Limited, China Taiping Life Insurance (Hong Kong) Company Limited, AXA China Region Insurance Company (Bermuda) Limited, BOC Group Life Assurance Company Limited.

[3] Bolttech Insurance (Hong Kong) Company Limited was known as FWD General Insurance Company Limited before 19 June 2023.



The "Treating Customers Fairly" Principle in the insurance regulatory framework

The "treating customers fairly" principle runs like a golden thread through the tapestry of the insurance regulatory framework.

Section 90 of the Insurance Ordinance and the Codes of Conduct expressly require licensed insurance intermediaries to treat customers fairly. Guideline on the Corporate Governance of Authorized Insurers (Guideline 10) provides that ***"fair treatment of customers is an important concept and should form an integral part of an authorized insurer's business culture, business strategies and internal controls."*** Since directors, controllers and key persons in control functions of insurers are responsible for the business culture and internal controls of the insurer, it is part of their responsibility to ensure the companies they work for treat customers fairly. The same goes for responsible officers of insurance agencies and insurance broker companies.

This is all well and good, but what exactly does "treating customers fairly" mean?

Search the Insurance Ordinance, the IA's Guidelines and Codes and you will find no definition. But "treating customers fairly" is not just a soundbite or hyperbolic slogan. It is the very core objective of insurance regulation and the lens through which the IA considers virtually every conduct matter.

The "invisible hand" of the market

Insurance practitioners always talk about the "market". Listen in to their discussions and you will catch snatches of conversation about where the market sits on premium rates ("hard" or "soft"), how it will respond to loss events, whether levels of capacity are expanding or shrinking and news and rumours about major new appointments and potential movements. This is the soundtrack of the Hong Kong insurance market, which is exactly that: a market in which sellers of insurance (insurers, insurance brokers and insurance agents) are matched with buyers of insurance (potential policyholders), through supply and demand.

The market mechanism of supply and demand sees price points responding and terms and conditions adjusting to the infinite insurance buying decisions constantly ongoing. Adam Smith, the 18th century philosopher who founded the "market" concept, called this the "invisible hand" allocating resources in the most optimal manner, driving competition and stimulating innovation.

The market dynamic also spontaneously incentivizes suppliers to display good conduct to generate trust from buyers to purchase the services on offer, and to renew their purchases the following year.

No market is perfect

Why then is regulation needed, if the market already operates to allocate resources efficiently, stimulate innovation and spontaneously generate good conduct?

Because no market is perfect. Like the human beings who are the actors in it, a market is replete with imperfections and imbalances that if left unchecked could result in unfair outcomes for buyers. Regulation is needed to set parameters, standards and guardrails for suppliers to counteract these imperfections and imbalances and ensure fairness for customers. No one understood this more than Adam Smith himself who, as well as being a professor of moral philosophy served as the Commissioner of Customs for Edinburgh and was thereby, himself, a regulator.

Like all markets, the insurance market comes with inherent imperfections and imbalances.

Imbalance of knowledge and expertise

Insurance is a complex product dependent on actuarial risk evaluation, a subject within an insurer's knowledge, but beyond that of an average customer.

Asymmetries of information

Whilst insurers may draw on vast pools of data and expertise, customers do not have this luxury or resource. This gives rise to asymmetries of information between sellers and buyers.

Imbalances in bargaining power

On the retail side, large insurers have more bargaining power than the consumers they serve.

Conflicts of interest

Commission levels can create economic conflicts of interest that may skew selling in favour of certain products that may not be optimal for a particular customer's needs.

Imbalances in timing

The very nature of insurance means there is a significant time gap between the customer paying premium and the insurer having to perform its obligations (sometimes many years later) under the policy. This exposes customers to changes in strategy and management at the insurer over time, which can affect the quality of servicing of their policies.

If left unchecked, these imbalances and imperfections could result in an unlevel playing field resulting in unfair outcomes for policyholders. So there is a need to subject suppliers of insurance to regulation, to restore balance, ameliorate these market imperfections and ensure customers are treated fairly. That, in a nutshell, is the objective of regulation and the meaning of the "treating customers fairly" principle.

How "treating customers fairly" applies in practice

So wide-ranging and embedded is the "treating customers fairly" principle in the insurance regulatory framework – it is referenced over 80 times in the Insurance Ordinance, Guidelines and Codes of Conduct - it is impossible in the scope of a single article to identify all its applications. For the purposes of explaining it, and how the IA takes account of it in its conduct supervision work, however, we provide the following selected examples.

Evaluating an insurer's corporate culture

Many of the specific rules prescribed in the insurance regulatory framework aim to implement the "treating customer's fairly" principle in given situations. For example, the requirement for intermediaries to carry out a financial needs analysis to fairly identify the customer's needs for life insurance before making any recommendation. As an overriding principle, however, "treating customers fairly" also serves as a behavioral ethic that must be constantly displayed by every individual practitioner across all dealings with customers (even if there is no specific rule that applies in a given situation). The principle must also be embedded in the culture of every insurer, broker company and agency and the market as a whole.

When the IA carries out a conduct inspection of an insurer, a key aspect it evaluates is the insurer's corporate culture and the extent to which this is imbued with a "treating customers fairly" mindset.

Culture refers to the collective values, attitudes, and norms shared by the people working for and representing the insurer, including its licensed insurance agents. In assessing culture, the types of questions we consider are:

- Does the insurer have a code of conduct or values statement setting out the values it expects all its employees and agents to display when dealing with customers and does this demand that customers be treated fairly?
- Are these values set by the board of directors and senior management and cascaded down through regular communications?
- Are the values reflected in the strategic decisions made by the board so it is setting the right "tone from the top" and not saying one thing but doing another? Is there evidence of the culture and customer fair treatment being discussed in the board minutes? Is there any board committee assigned specifically to consider, drive and monitor the corporate culture of the company?
- Is culture monitored through conduct indicators such as complaints, persistency/renewal rates, claims rejection rates, post-sales call statistics, CPD attainment, turnover and disciplinary statistics? Are staff surveys or agency surveys carried out to assess culture?
- Are the values reflected in the insurer's remuneration structure and performance evaluation metrics?
- How are values cascaded down through the agency hierarchy? Are there regular meetings between senior management of the insurer and senior agency leaders to assess culture within the agency districts and teams?
- Does the insurer have in place an effective whistleblowing policy?

These items offer hard evidence of the state of an insurer's culture. But perhaps more valuable in assessing culture are the open discussions we have with management, staff and selected agents from all different levels and also by being present on-site during the inspection for a period of time, so a full "feel" for the insurer's culture can be obtained.

Product Development

Whilst major commercial customers will often play a full part in the negotiation of terms and conditions in their insurance policies (which will be bespoked for their needs), for retail customers (individuals and SMEs) the situation is different. Volume breeds standardization, such that customers at this end of the market are offered insurance products on set terms and conditions on a "take it or leave it" basis. These retail insurance products are formulated unilaterally by insurers through their product design processes with no direct customer participation. As a consequence, a potential imbalance in bargaining position exists.

The "treating customer fairly" principle addresses this by requiring the insurer to take full account of the customer's viewpoint and reasonable expectations in its product design process. There are specific requirements for product design in Guideline on Underwriting Class C Business (GL15) and Guideline on Underwriting Long Term Insurance Business (other than Class C Business) (GL16) on long term products and Guideline on Medical Insurance Business (GL31) on medical insurance products, but many of these provisions are common sense requirements that should apply to the design of all retail insurance products.

During our conduct inspections, when reviewing the product design process, we look for the presence of robust challenge from the customer viewpoint in the process itself. Insurers are expected to take full account of policyholder reasonable expectations, which involves asking and answering the question: **"What realistic expectations should a retail policyholder have with regards to the coverage and benefits provided by this insurance policy"?**

After answering this, the insurer can (and should) ensure that its product brochures, marketing materials, illustrations, and training of its agents, are calibrated to communicate clearly and manage expectations with its customers from the outset. Insurers and their agents must be honest about the limits of the product, not overpromise, convey risks in an understandable manner, and place customers in a position where they can make informed decisions.

Clear, simple, non-technical wording of brochures, policies and all communications with customers is crucial in this respect. Knowledge and expertise is vital in the insurance industry, but viewing matters from the customer's perspective involves putting this knowledge and expertise aside (and being careful not to subconsciously assume knowledge on the part of the customer). Insurers must look at the wording of the materials and illustrations from the perspective of a lay person and ask: Would this be understood and how would it be understood?

Practices such as collating lessons from complaints and customer feedback or taking soundings from customer focus groups can assist in guarding against assuming too much or too little knowledge on the part of customers and help the insurer calibrating "policy holder reasonable expectations" in the product design process. When asked: **what are "policyholder reasonable expectations" with this product?** The insurer should be able to articulate the answer.

The IA's complaints statistics indicate that insurers should pay particular attention to their **participating insurance policies** when it comes to **policyholder reasonable expectations**. These policies combine elements of protection and wealth accumulation. They have minimum guaranteed benefits that are supplemented by non-guaranteed benefits that enable policyholders to participate in the investment returns of the insurer. The value of the non-guaranteed benefits is dependent on (and can fluctuate based on) the insurer's investment mix, application of expense and decisions on how to share these across its various participating policies. These are not simple policies to be understood and insurers should resist assuming knowledge on the part of the customer and using jargon in their communications. They must work out how best to convey how these policies work in an understandable manner, so that customers are positioned to make fully informed decisions, reasonable expectations are aligned, satisfaction is achieved and trust is built.

Claims

When it comes to claims, the "treating customers fairly" principle is reflected in the insurance regulatory framework through the requirement that insurers handle claims "fairly and promptly", provide transparency to policyholders on how to make a claim, and keep claimants updated on the progress of their claims.

The IA's expectations on these matters have been articulated in our Special Supplement on Claims Handling published with Conduct in Focus in May 2023. These expectations aim at addressing the inherent imbalance created by the time gap between premium being paid and the insurer fulfilling its obligations under the policy, by holding insurers accountable for treating policyholders fairly at the claims stage.

Insurers should always challenge their claims procedures from the policyholder perspective and consider what is convenient for the claimant, not just efficient for the company. Fairness must also be reflected in the insurer's approach to handling the claim by striking a fair balance between the need to investigate to ascertain coverage and ensuring valid claims are promptly paid. When interpreting terms and conditions in insurance policies, insurers should benchmark their interpretation against the question: **Is this what a reasonable policyholder would have expected this clause to mean based on the words used?**

All these issues can be reflected upon when considering the insurer's claims payment/rejection rates, an important barometer we look at when considering the "treating customers fairly" principle in operation in the claims process.

Commission structures

Insurance intermediaries owe duties to policyholders but are remunerated through commission paid by insurers which, depending on the circumstances, can give rise to potential conflicting economic pressures. The most suitable insurance policy to meet a policyholder's interests may not be the one with the highest commission level. The temptation to focus time on generating new sales of policies may conflict with the duty to service existing ones. Since commission itself is "all or nothing" (you get paid it if you sell, but nothing if you don't), the more sizable the commission, the higher the inherent stress to push a sale. Economic reality means that commission structures – if wrongly calibrated – can overly incentivize the intermediary (even subconsciously) to put his own interests above that of the customer, risking poor customer outcomes.

How does the regulatory framework and the "treating customers fairly" principle address this?

Primarily by imposing specific duties on intermediaries to act in the best interests of the customers and for this to override any personal interest. This is then underpinned by requiring the intermediary management control function of an insurer (and responsible officers of intermediaries) to implement controls that ensure compliance with this duty. Licensed insurance broker companies must also make certain standard disclosures on their commissions and there are more detailed commission disclosure requirements for both brokers and agents for ILAS policies. For long term policies, prohibitions on indemnity commission and requiring

commission only to be paid on an earned basis, must be strictly complied with, as these serve as a basic minimum starting point towards fair customer treatment.

Beyond this, in our conduct inspections we also look at how insurers, when calibrating their commission structures, seek to align remuneration and commission levels with the objectives of long-term customer satisfaction and treating customers fairly. Focus on long term insurance products draws particular attention in this respect. Examples of the types of questions insurers can and should consider in the commission setting and structuring process are:

- Is a reasonable balance between upfront and tail commission achieved, so as to incentivize continued quality servicing after the policy is purchased?
- Does the upfront commission reflect the work done for producing and advising on the arrangement of the policy?
- Does the remuneration structure incentivize policy persistency, ethical behavior and positive customer feedback as well as achievement of sales targets?
- Are their mechanisms to discourage aggressive selling e.g. clawback or deferred commission structures tied to persistency and ethical standards of conduct?
- Would a reasonable policyholder, being informed of the amount of commission consider it representative of the value of the service provided (assuming the reasonable policyholder is apprised of the full scope of work performed by the intermediary)?

By considering these issues, an insurer can seek to ensure alignment between its remuneration structures and the “treating customers fairly” principle so as to cultivate good standards and practices in the market, build trust and mitigate against the prospect of poor policyholder outcomes.

Concluding remarks

Treating customers fairly, therefore, is an ethical principle elevated to the status of a regulatory requirement to ensure the insurance market is founded on trust. By treating customers fairly and embedding this into the culture of each company and the mindset of each insurance practitioner, insurers and intermediaries can enhance policyholder satisfaction, manage expectations, build trust and maintain long-term and lasting relationships with their customers. In doing this, the insurance market can continue to serve its vital social purpose of ensuring the losses of the few are borne by the many and that the risks we face every day are properly managed and addressed.

Regulatory Reminders

Guidance Note on Conducting Sales by Unsolicited Calls issued by the Mandatory Provident Fund Schemes Authority

To provide guidance to registered intermediaries in making unsolicited calls for marketing activities (Telemarketing), the Mandatory Provident Fund Schemes Authority ("MPFA") has issued the Guidance Note on Conducting Sales by Unsolicited Calls ("Guidance Note"), which has taken effect on 1 September 2023.

The Guidance Note aims at setting out the requirements and applicable measures relating to Telemarketing. There are a total of 13 measures in the Guidance Note, each accompanied by detailed explanations to provide further guidance to registered intermediaries. For instance, a principal intermediary is required to provide a designated telephone number for public's enquiry and verification of the callers' identities. Furthermore, to facilitate the public in verifying the callers' identities, the caller should, at the beginning of the call, accurately and sufficiently provide the following information to the called party:

(i) Full name of the caller;

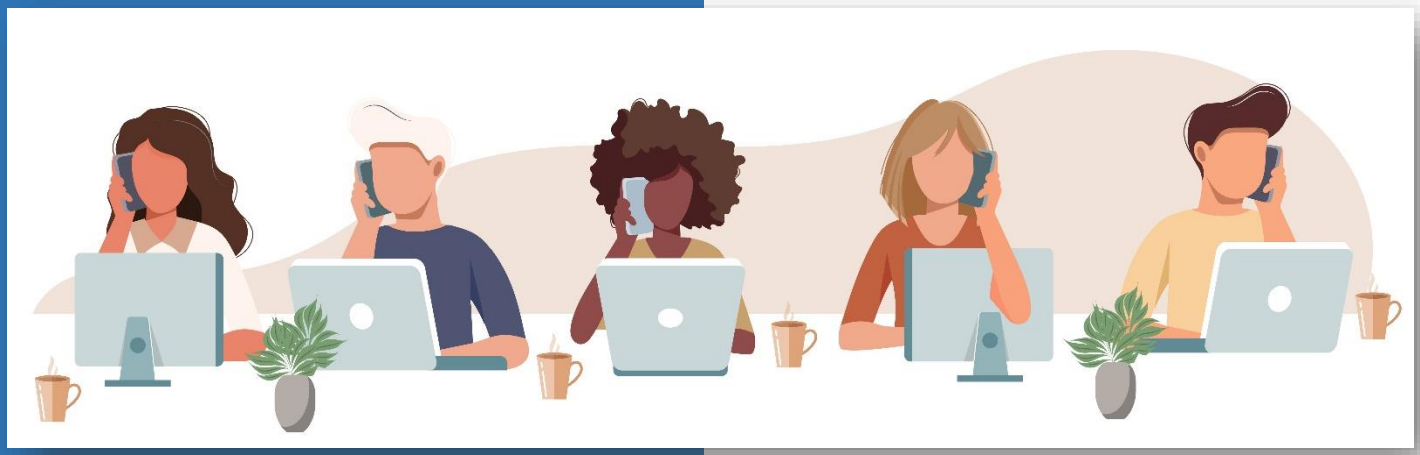
(ii) If the caller is a subsidiary intermediary, the MPF registration number of the caller;

(iii) Name of the principal intermediary that authorized the making of the call;

(iv) Purpose of the call; and

(v) Designated telephone number of the principal intermediary for verifying the identity of the caller

The Guidance Note could be found on MPFA's website (https://www.mpfa.org.hk).



Mystery Shopping Programme on Selling Practices of Qualifying Deferred Annuity Policies in Hong Kong

In 2022, a joint Mystery Shopping Programme ("MSP") was conducted by the IA, the MPFA and the Hong Kong Monetary Authority on over 20 authorized insurers and licensed broker companies to gain insights into how Qualifying Deferred Annuity Policies ("QDAP") and Tax-Deductible Voluntary Contributions are being marketed in Hong Kong and identify areas for improvement and good practices. The MSP covered a number of areas assessing the degree of fair treatment to customers, including know-your-customer procedures, financial needs analysis, suitability of recommendations and explanation of product features and risk disclosure.

The key findings from the MSP exercise were set out in a joint circular issued to the industry on 23 December 2022. The IA has since, during the course of 2023, held meetings with the concerned insurers and broker companies to go through the findings and recommendations specific to them. These insurers and broker companies and, indeed, all those offering QDAP are expected to take into account the MSP findings to promote a sound culture relating to the sale and marketing of QDAP and adhere to the principle of treating customers fairly and acting in customers' best interests, and demonstrate improvement in inspections carried out by the IA going forward.

Licensed insurance broker companies - Good practices on notifications in relation to changes in directors and controllers

Under section 64ZZD of the Insurance Ordinance, a licensed insurance broker company is required to notify the IA regarding relevant changes of its directors and controllers[4], as follows:

Section 64ZZD of the Insurance Ordinance (Cap. 41)

Duty to notify the Insurance Authority of change of directors or controllers for licensed insurance broker company

- Within 1 month after the date on which a person becomes, or ceases to be, a director or controller of a licensed insurance broker company, the company must notify the IA in writing of that fact.
- A licensed insurance broker company which, without reasonable excuse, fails to notify within the time specified, commits an offence and is liable to a fine at level 5.

Changes in controller and directors can be infrequent and infrequency can lead to forgetfulness, so it is important a broker company has the right process or checklist in place to which reference can be made when a change occurs, so the notification requirement is complied with.

[4] Section 64F of the IO defines a "controller" of a company to be a person who (i) owns or controls, directly or indirectly, including through a trust or bearer share holding, not less than 15% of the issued share capital of the company; (ii) is, directly or indirectly, entitled to exercise or control the exercise of not less than 15% of the voting rights at general meetings of the company; or (iii) exercises ultimate control over the management of the company.

The following are examples of practices broker companies can implement to ensure timely notification to the IA:

Controls and Procedures

The personnel/department in a broker company who is responsible for the onboarding/appointment procedures of the director to the company, should be sensitive to the need to notify the regulator of the change and should include in that process a checklist, that includes a reminder to notify the IA.

If the broker company is within a group of companies, it should implement procedures with its holding company(ies) so that its holding company(ies) can provide information of any changes of control which amount to the broker company having a new controller or ceasing to have a controller. An internal documented process requiring the holding company to notify such changes within 2 weeks of the change, can give the broker company a further 2 weeks to make the requisite notification to the IA.

Notify the IA and the Companies Registry at the same time

Given that broker companies are required to make statutory filings to the Companies Registry under the Companies Ordinance (Cap. 622) for appointment or cessation of directors and controllers, it would be a good practice for companies to make relevant notification to the IA and the Companies Registry simultaneously. Again, both requirements can be included in a convenient checklist that can serve as a reference for when changes happen.

Keep Proper Notification Records

A broker company should properly keep past notification records for all of its directors and controllers. The internal record should be stored in a way that the record will be easy to retrieve e.g. filed in a centralized folder. By doing this, a broker company can always check and locate relevant notifications record when needed.

To notify the IA of any changes in directors and controllers, a broker company should submit Form N5 "Notification of Change in Partners, Directors or Controllers of a Licensed Insurance Agency or Licensed Insurance Broker Company" (https://www.ia.org.hk/en/infocenter/forms/files/Form_N5_Notification_of_change_in_partners_directors_or_controllers_Eng.pdf) together with the supporting documents as stated in the Form.

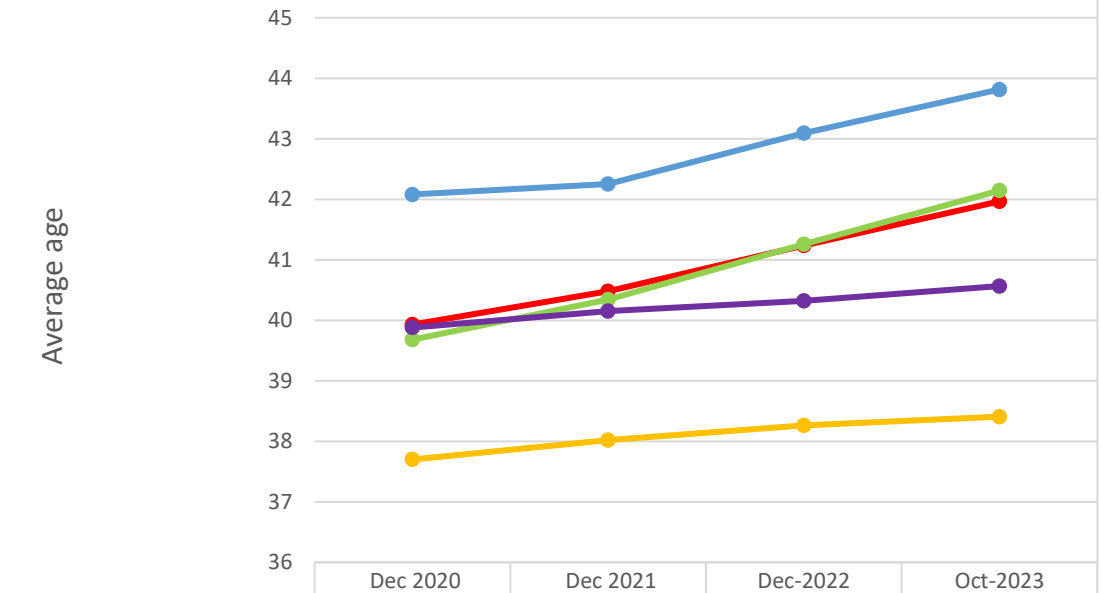
Age Statistics

Hong Kong's "Maturing" Insurance Market?

The age statistics of licensed individual insurance intermediaries show that a key threshold has been crossed in the last few years.

As we see in Chart 1, in December 2020, the average age of a licensed individual insurance intermediary was 39.9 years old. By October 2023, that average had risen above the four-decade threshold to 42 years old.

Average age of licensed insurance intermediaries by licence types (Chart 1)

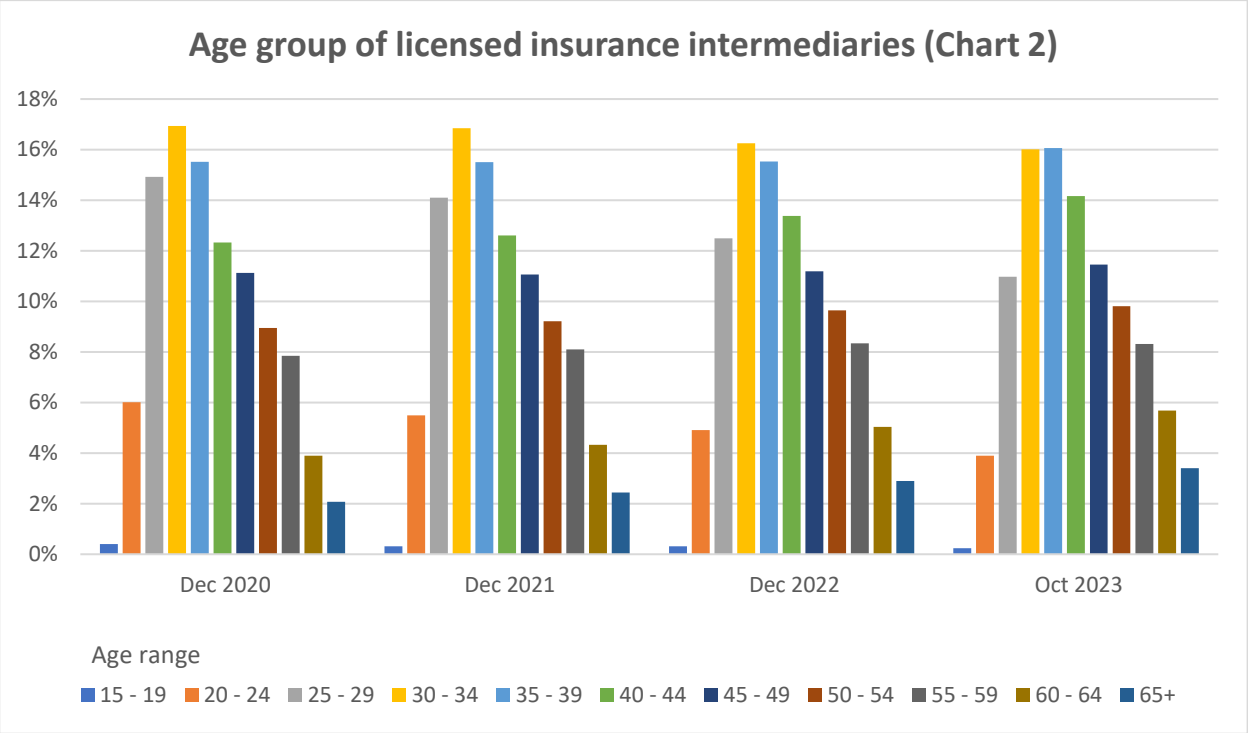


	Dec 2020	Dec 2021	Dec-2022	Oct-2023
All types	39.9	40.5	41.2	42.0
IIA	39.7	40.3	41.3	42.1
TRA	39.9	40.2	40.3	40.6
TRA appointed by banks	37.7	38.0	38.3	38.4
TRB	42.1	42.3	43.1	43.8

Chart 1 also tells us that the average age of technical representatives (broker) (43.8 years as at October 2023) was slightly higher than that of insurance individual (agents) (42.1 as at October 2023). Both exceeded the average age for technical representatives (agent) (40.6 as at October 2023), which is even lower if one just focuses of the average age of technical representatives (agents) in banks (lower than 40). The relatively youthful bancassurance channel is probably also responsible for technical representatives (agents) having the lowest rise in average from 39.9 as at December 2020 to 40.6 as at October 2023.

In Chart 2, the age statistics of licensed insurance intermediaries are broken down by age-range. Thirty-year olds make up the largest age group. By comparison to the overall labour force in Hong Kong it is forty and fifty year olds which made up the largest segment in the third quarter of 2023[5].

Chart 2 does, however, show a downward trend for the age group of 25 – 29. This age group accounted for around 15% of insurance intermediaries as at the end of 2020, but has dropped to around 11% as at October 2023.



Without data, you're just another person with an opinion

Hong Kong's insurance market is often described as a mature one. But is this particular maturing trend one that raises concerns? Or does life really begin at (an average age of) 40? Is the lowering number of twenty-somethings indicative of difficulties in sourcing talent? And why is the bancassurance channel so much younger?

We'll just present the statistics, and let you form your own opinion. And by presenting these statistics, we hope it can help generate some answers and solutions.

[5] Source: https://www.censtatd.gov.hk/en/web_table.html?id=210-06201A

Enforcement Update

The IA took its first disciplinary action in May 2021. In the 30-month period since then, the IA has taken 33 disciplinary actions for misconduct and culpable behaviour impugning fitness and properness (not including CPD related non-compliance cases). Our largest fine to date is HK$7 million (for a breach of the Anti-Money Laundering and Counter-Terrorist Financing Ordinance). The longest ban imposed is 6-years.

Our enforcement work is vital to underpin the Hong Kong insurance market with trust.

Enforcement actions demonstrate that insurance companies and insurance practitioners are held accountable for maintaining standards of conduct and business processes that serve to treat customers fairly and ensure policyholder interests are protected.

Underpinning the insurance market with the appropriate deterrence of enforcement also upholds the requirements in the insurance and anti-money laundering regulatory framework.

This, in turn, inspires confidence in the Hong Kong insurance market from the insurance buying public, both residents of Hong Kong and those who come to Hong Kong to source insurance to meet their needs.

The vast majority of disciplinary cases handled to date have related to matters emanating from the self-regulatory period, prior to 23 September 2019. This includes the run-off of cases involving the discovery of false academic certificates submitted under the previous regime. The IA has continued vigorously to discipline these cases so as to reinforce the collective intolerance of the insurance market and the public towards such unethical behaviour. It is imperative that these matters are confined to the past, and it is made clear that even an isolated attempt to try and repeat this under the current licensing regime will be met with swift criminal prosecution.

A particular focus for the IA in its enforcement work is to address any cases of mishandling or misappropriation of client premium payments, with the severest of disciplinary penalties. These cases are isolated, but given the potential deleterious effect they can have on market confidence, they must be met with the toughest appropriate deterrent penalties to demonstrate complete intolerance for such behaviour. Similarly, it is imperative that insurers implement strong governance, controls and processes to prevent such occurrences from happening in the first place, detect them if they do arise and swiftly remediate with the impacted policyholder on discovery.

Whilst the IA has been confined to following the prior regime's approach in not making names public in its press releases on disciplinary actions emanating from matters from the self-regulatory period, for matters under the current regime the IA can and does (under section 41P(3) and section 81(5) of the Insurance Ordinance (Cap.41)) disclose to the public details of its decisions, the reasons for which the decision was made and the material facts of the case. In respect of a misappropriation of premium case this may include the name of the person guilty of misconduct, the insurer issuing the relevant insurance policy and the actions taken to remediate with the impacted policyholders (along with the controls which operated to swiftly detect and remediate the matter).

Going forward, it is expected that the balance of our cases will shift to matters arising under the current regulatory regime (as opposed to the previous self-regulatory regime). In this respect the IA has expanded its Disciplinary Panel Pool to ensure that it is well resourced with experts to decide such cases in a fair, swift and impartial manner.

As our experience of taking over 1,900 disciplinary actions on CPD non-compliance cases has shown, enforcement has an important part to play not only in raising standards and confidence in the insurance market, but also in supporting the majority of insurance intermediaries and practitioners who act ethically and uphold regulatory standards. Even for the 2021/22 CPD Assessment Year, this majority was at 90%. Now this has been raised to 96.1% for the 2022/23 CPD Assessment Year. Further, the residual 3.9% minority are either no longer able to carry on regulated activities or have already been compelled by the prospect of disciplinary action to make good their CPD shortfall. This means the insurance buying public, right now, can be 100% confident that when they are dealing with Hong Kong licensed insurance intermediaries, they are dealing with practitioners who have kept their knowledge and expertise up to date through CPD. That is the effect that enforcement can play in raising the image of (and confidence in) the insurance market, positioning it for growth going forward. And that is the approach we will continue to take across all our enforcement work.

Summary of disciplinary actions taken by the IA since May 2021

Type of Misconduct	Number of insurers or licensed insurance intermediaries disciplined		Type of disciplinary action imposed by the IA
	Conduct (or underlying conduct) occurred before 23 Sept 2019	Conduct occurred on or after 23 Sept 2019	
Non-compliance with the CPD requirements	93	1,900+	• Disciplined in accordance with the CPD Penalty Framework
Use of false academic certificate	9		• Revocation of licence • Prohibition from applying for a licence for 2 to 3 years
Mishandle or misappropriate client's premium payments	4		• Revocation of licence • Prohibition from applying for a licence for 5 months to 6 years
Failure to keep separate client accounts and maintain proper books and records	2		• Public Reprimand • Fine HK$95,000
Failure to submit Financial Documents within six months following the end of the financial year	3		• Suspension of license • Fine from HK$15,000 to HK$57,500
Fabricate client's instructions and forge client's signature		2	• Prohibition from applying for a licence for 6 to 18 months
Contravene Anti-Money Laundering and Counter-Terrorist Financing Ordinance	2		• Public Reprimand • Fine HK$7 million
Misrepresentation		1	• Public Reprimand • Prohibition from applying for a licence for 5 months
Lack of fitness and properness by having been disciplined by another regulator		1	• Disciplined in accordance with the disciplinary action imposed by the other Regulator which the person is licensed with
Misconduct that are minor in nature that warranted disciplinary action	5	4	• Private Reprimand

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