Insurance Intermediaries Qualifying Examination

Long Term Insurance Examination

Study Notes

2022 Edition

PREFACE

These Study Notes have been prepared to correspond with the various Chapters in the Syllabus for the Long Term Insurance Examination. The Examination will be based upon these Notes. A few representative examination questions are included at the end of each Chapter to provide you with further guidance.

Immediately following the descriptions of some aspects of the practice of long term insurance, you will find actual cases of long term insurance claims, which are there mainly to facilitate your understanding of the subject and to make your learning more interesting. The decisions you will find in those cases were based on their particular facts, including the actual wording used in the insurance policies in question. Some of these cases are decided cases of the then Insurance Claims Complaints Bureau (ICCB) which is now The Insurance Complaints Bureau ("ICB"), and the rest concern claims disputes that were ultimately settled between the claimants and the insurers concerned without being referred to the then ICCB for adjudication. It is worth noting that the Insurance Claims Complaints Panel (Complaints Panel) of the ICB is empowered by its Articles of Association to look beyond the strict interpretation of policy terms in making a ruling.

It should be noted, however, that these Study Notes will not make you a fully qualified practitioners or other insurance specialist. It is intended to give a preliminary introduction to the subject of Long Term Insurance, as a ***Quality Assurance*** *exercise for Insurance Intermediaries.*

We hope that the Study Notes can serve as reliable reference materials for candidates preparing for the Examination. While every care has been taken in the preparation of the Study Notes, errors or omissions may still be inevitable. You may therefore wish to make reference to the relevant legislation or seek professional advice if necessary. As further editions will be published from time to time to update and improve the contents of these Study Notes, we would appreciate your feedback, which will be taken into consideration when we prepare the next edition of the Study Notes.

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NOTE

*If you are taking this Subject in the Insurance Intermediaries Qualifying Examination, you will also be required, unless exempted, to take the Subject "**Principles and Practice of Insurance**". Whilst the examination regulations do not require you to take that Subject first, it obviously makes sense to do so. That Subject lays a foundation for further studies and many of the terms and concepts found in that Subject will be assumed knowledge with this Subject.*

For your study purposes, it is important to be aware of the relative "Weight" of the various Chapters in relation to the Examination. All Chapters should be studied carefully, but the following table indicates areas of particular importance:

Chapter	Relative Weight
1	10%
2	20%
3	24%
4	24%
5	22%
Total	**100%**

1 INTRODUCTION TO LIFE INSURANCE

1.1 DEFINITION OF LIFE INSURANCE

In the first of an excellent series of textbooks produced by the U.S. Life Office Management Association Inc. (**LOMA**), life insurance (or 'life assurance' in British terminology) is defined as follows:

> "*Life insurance provides a sum of money if the person who is insured dies whilst the policy is in effect.*"

Anybody who has some knowledge about life insurance will be tempted to say "Yes, **BUT**.....". In other words, surely this is too brief an explanation for a financial service that provides a very sophisticated range of savings and investment products, as well as mere compensation for death. Nevertheless, this is apt for the first chapter on life insurance for beginners.

The definition captures the original, basic intention of life insurance: i.e. to provide for one's family and perhaps others in the event of death, especially premature death (i.e. death occurring at such a time that financial hardship will likely be caused to the dependants). Originally, policies were for short periods of time, covering *temporary* risk situations, such as sea voyages. As life insurance became more established, it was realised what a useful tool it was for a number of situations, which would include:

(a) *Temporary needs/threats*: the original purpose of life insurance remains an important element in life insurance and estate planning, as things like children's education, etc. occupy responsible people's thoughts.

(b) *Savings*: providing for one's family and oneself, as a long-term exercise, becomes more and more relevant as society evolves from a tribal, clan, family orientated community to relatively affluent individual independence.

(c) *Investment*: can be defined as a process of purchasing an asset, with an expectation that it will in the future provide an income or appreciate. The accumulation of wealth and safeguarding it from the ravages of inflation become realistic goals as living standards rise.

(d) *Retirement*: provision for one's own later years becomes increasingly necessary, especially in a changing cultural and social environment.

So our purpose, as we begin this study, is not so much to remember certain facts, but rather to *understand* something of the fundamentals of long term insurance, and to appreciate its role in modern society.

1.1.1 Needs for Life Insurance

Whilst **1.1** above outlines the developing appreciation of the many uses of life insurance, the modern scene tends to look upon available life insurance products from the perspective of meeting various needs. These we may think of as:

(a) *Personal needs*:

(i) dependants' living expenses;

(ii) final (end of life) expenses;

(iii) educational funds;

(iv) retirement income;

(v) mortgage repayment fund;

(vi) emergencies fund (usually needed to meet unexpected expenses);

(vii) disability income.

(b) *Business needs*:

(i) key persons;

(ii) business owners;

(iii) partnerships;

(iv) employee benefits.

1.2 PRINCIPLES OF LIFE INSURANCE

In the Core Subject for this Insurance Intermediaries Quality Assurance Scheme, "**Principles and Practice of Insurance**", the principles of insurance were studied in detail. By way of reminder, but not detailed comment at this stage, these principles are:

(a) *Insurable Interest*: the legal right to insure;

(b) *Utmost Good Faith*: a duty to reveal material information actively;

(c) *Proximate Cause*: determining the effective cause of a loss in the context of insurance claims;

(d) *Indemnity*: the insurer providing an exact financial compensation;

(e) *Contribution*: insurers sharing an indemnity payment;

(f) *Subrogation*: the indemnifying insurer taking over and then exercising the insured's rights of recovery against third parties.

1.2.1 Insurable Interest

In simple terms, insurable interest is such relationship with the subject matter of insurance (a person's life, in the case of life insurance) that is recognised at law or in equity as giving rise to a right to insure that person's life. This is a concept that has applied for two and a half centuries in England and is obviously based on common sense. If you have no relationship with a given person, why should you have the right to insure his life and thus *gain* from his death? Some particular points to be noted with this principle are:

(a) **Statutory requirement:** in life insurance, the requirement for an insurable interest is *derived* from section 64B of the *Insurance Ordinance*.

(b) **Effect of lack of insurable interest:** Section 64B renders a contract of life insurance void where the person for whose use or benefit or on whose account it is made has no interest.

(c) **Insurable interest in oneself and in spouse:** it is judicially presumed that we all have an insurable interest in *our own lives* for an unlimited amount, and that any one person has an insurable interest for an unlimited amount in the life of his or her spouse, so that no proof of such an interest is required.

(d) **Insurable interest in others:** with the exceptions of insurable interests founded on judicial presumptions (see (c) above) or statute (see (f) below), as case law reveals, there must be an interest which is capable of valuation in money. Some examples which may be reasonably common are:

(i) *debtors*: if a person owes you money, you may insure his life for the amount of the loan, plus accrued interests;

(ii) *business partners*: especially where personal services are involved, such as performers and musicians;

(iii) *contractual relationships*: if another person's services have been engaged under contract (booking a singer for a concert, a professional sportsperson, etc.), that person's death may cause the other contracting party to suffer financially. That potential loss is insurable.

Note: This heading would include a type of life insurance known as *Key Person Life Insurance* (or *Key Employee Life Insurance*), where an employer insures the life of an important employee, in case of loss to the business from the employee's death.

(e) **Blood relationships and family members:** in some countries (e.g. in most jurisdictions of the U.S.), a family relationship prescribed by the relevant law (brother, sister, parent, child, grandparent, grandchild, etc.) is sufficient to constitute an insurable interest.

(f) **Statutory extension of insurable interest:** in Hong Kong, by virtue of Section 64A of the Insurance Ordinance, a *parent or guardian* of a minor (i.e. a person aged under 18) is given an insurable interest in that young person. It means that, apart from one's spouse, only the relationships just mentioned constitute an insurable interest arising from blood or family connection. An insurance effected on the basis of any other blood or family relationship is technically void (see (b) above).

(g) **Sections 64C and 64D of the Insurance Ordinance:** these Sections have two other important provisions:

(i) the person interested in the life insured, or for whose use or *benefit* or on whose account the contract is entered into, must be *named* in the contract;

(In practice, this provision is not construed so widely as to include all those who the policyowner intends to benefit by receiving the policy proceeds. Therefore, where a life insurance policy is payable to the executors of the policyowner, no one cares whether the names of the executors and of the persons who are intended to benefit under the will appear in the policy.)

(ii) no more than the amount of the interest the insured (i.e. policyowner) has in the life insured is recoverable under the contract [this provision is significant only where the life insurance concerned is effected on an indemnity basis, credit life insurance being an example (see **2.1.1**a(b)(i))].

(h) **When is the interest needed?:** this is a key question, and very important consequences flow from its answer. The answer is that an insurable interest is **only** needed when the contract **begins**, and becomes irrelevant thereafter. What could be the (quite legal) consequences of this? Some examples are:

(i) *Divorce*: a spouse, who insures his/her spouse and then becomes divorced, can keep the policy in force and be perfectly entitled to collect the benefit in due time.

(ii) *Debts*: it is legally possible to insure your debtor's life, have the debt repaid, keep the policy in force, and be "paid again" in due time by the insurer.

(iii) *Assignment*: a policyowner is capable of assigning a properly arranged life insurance contract to a third party even though the latter has no insurable interest in the life insured, *provided* that this is not a premeditated act of getting round the requirement for an insurable interest. The latter act will be ineffective on the grounds that it is done for the purpose of defeating the object of a statute, and the contract is indeed void as from inception because the de facto insured (i.e. the intended assignee) has not the required insurable interest. Therefore, what matters is the intention of the policyowner when he is effecting a life policy. Taking out a life policy with the general intention of assigning it is legitimate, but doing so with the intention of assigning it to a specific person who has no insurable interest in the life insured is another matter.

1.2.2 Duty of Disclosure

This concerns another important insurance principle, that of **utmost good faith**. Put simply, utmost good faith requires the applicant to disclose all *material facts*, whether the insurer requests them or not. A **material fact** is legally defined as 'every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will accept the risk'. Some points to note:

(a) **What to disclose:** clearly, the insurer wishes to know all important facts, but you **cannot** be expected to disclose what you *reasonably* cannot be expected to know. Some conditions, for example, may be easily recognisable to qualified doctors, but the average layman cannot be expected to self-diagnose and reveal such things.

Case 1 At law insurance applicants are required to disclose material facts to the insurers

Operating a trading firm in the Guangdong Province, the policyowner effected a life insurance policy. He suffered from recurrent fever three months later for over two months, and finally died of cancer. From the medical report of a hospital on the Mainland, the insurer noted that the deceased had complained of tiredness and lack of strength the year before. On the other hand, it also noted that when he was asked in the application form if he had in the past three months experienced or sustained symptoms of tiredness for more than a week, he replied "no". The insurer therefore rejected the claim on account of a material non-disclosure.

The Insurance Claims Complaints Panel (or the "Complaints Panel") of the then Insurance Claims Complaints Bureau (ICCB) (now renamed as the Insurance Complaints Bureau (ICB)) felt that it was uncommon for an insurer to ask in an application form whether the applicant had in the past three months experienced or sustained symptoms of tiredness for more than a week. It considered that the policyowner's non-disclosure of his symptoms of "tiredness and lack of strength over a year" was not material enough for the insurer to reject the claim.

Remarks : *Apparently the Complaints Panel's decision was based on the rules that (1) an insurance applicant is only required to disclose material facts, rather than any facts he is being asked about, and that (2) the scope of "material facts" is restricted by an objective test so that those facts which only a particular insurer deems to be material are not actually material enough to enable this insurer to rely on the principle of utmost good faith.*

Case 2 At law insurance applicants are required to actively disclose to the insurers material facts he knows or should know

The policyowner was diagnosed as suffering from carcinoma of colon nine months after he had taken out a policy. His claims for critical illness benefit and waiver of premium benefit were rejected by the insurer on the grounds that he had not disclosed on the application form the medical history of his obstructive sleep apnoea.

It was noted from the medical report that the policyowner had consulted a doctor for heavy snoring and was first diagnosed as having obstructive sleep apnoea in a sleep study 12 years before his insurance application. He had five follow-up consultations in the following year. Continuous positive airway pressure therapy was recommended which he declined. Since then he defaulted follow-up consultation. He was referred to have sleep study assessment again, one year before the insurance application. It was revealed that the symptoms of snoring and excessive daytime sleepiness had not gone away. Further sleep study was arranged but he did not return for follow up.

The policyowner admitted that he had suffered from obstructive sleep apnoea for a long time, but pointed out that such symptoms were in no way related to his colon cancer. He also emphasised that the symptoms had not affected his work as a bus driver for 20 years and he had passed the annual body check provided by the bus company.

The Complaints Panel learnt from the insurer's underwriting manual that the severity of an applicant's obstructive sleep apnoea and the co-existence of associated diseases would affect the underwriting decisions for the benefits of critical illness and waiver of premium.

As no detailed sleep study had been done to assess the severity of the policyowner's obstructive sleep apnoea, the insurer had no access to information for risk assessment. The Complaints Panel believed that had the insurer been informed of his condition at the time of the insurance application, it would have asked for more related information or arranged further medical examination of the policyowner before accepting the risk. Since the non-disclosed condition was so material as would have affected the underwriting decision of the insurer, the Complaints Panel upheld the insurer's decision to reject the claims.

Remarks: *In face of insurers' declinature of claims on grounds of non-disclosure, the claimants rather frequently argue that the losses in question had no connection with the (alleged) non-disclosures, without being aware that such a connection is not among the criteria for relying on the principle of utmost good faith.*

Case 3 At law insurance applicants are required to disclose material facts to the insurers

The life insured died of tongue carcinoma. Finding out that the deceased was a chronic drinker who consumed 10 cans of beer every day, the insurer declined the death claim on the basis of non-disclosure – to the insurer's question "Have you ever smoked tobacco or taken drugs or narcotics or alcohol as a habit?" on the application form, the deceased replied in the negative.

The deceased's son insisted that his father did not have a drinking habit and would only drink on special occasions. More importantly, there was no direct relationship between alcoholic consumption and tongue carcinoma.

The Complaints Panel's attention was drawn to the medical reports of two different hospitals indicating that the deceased had a habit of taking several cans of beer daily for 30 years and was convinced that the deceased was a chronic drinker. Since this piece of non-disclosed information would be material enough to have affected the underwriting decision of the insurer, the Complaints Panel supported the insurer's decision to reject the claim.

Remarks: *As stated before, in face of insurers' declinature of claims on grounds of non-disclosure, the claimants rather frequently argue that the losses in question had no connection with the (alleged) non-disclosures, without being aware that such a connection is not among the criteria for relying on the principle of utmost good faith.*

(b) **Non-medical application:** if the insurance is arranged without a physical examination of the applicant, the insurer will normally have great difficulty alleging non-disclosure of a material fact not covered by questions on the application or the personal physician's form.

(c) **Medical application:** if the insurance is arranged with a physical examination of the applicant, the insurer cannot hold against the applicant negligent omissions or mis-diagnosing by the medically qualified person concerned.

Case 4 At law insurance applicants are required to actively disclose material facts to the insurers

The policyowner applied for a life policy and undertook a medical examination at the insurer's appointed clinic. The application was accepted by the insurer at an increased premium. Later, the policyowner passed away due to a ruptured aortic aneurysm and pneumonia. The insurer rescinded the policy from inception as an echocardiogram revealed that the policyowner had suffered from a tachycardia attack, ectopic heart beat and ischaemic change two years before the insurance application.

The Complaints Panel felt that the policyowner had an onus to disclose all his medical history, even though a medical examination had been provided by the insurer, and therefore upheld the insurer's repudiation of the claim.

Remarks: *Submitting himself to a medical examination as required by the insurer may not constitute full disclosure of the applicant's medical history and condition to the insurer, unless the nature of such medical examination is such that it will fully reveal such information.*

(d) **Medical tests:** the insurer's requests to supplement information supplied verbally with reasonable medical examinations or tests are normally met, but great care must be taken not to breach the *Personal Data (Privacy) Ordinance*, which has the effect of requiring insurers to explain the need for gathering information before any testing takes place. The subject of the tests also has the right under that Ordinance to be told their results.

(e) **Breach of the duty on the part of the policyowner:** at law, a breach of utmost good faith renders the contract *voidable* by the insurer. But with most life policies in Hong Kong, regard has to be taken of a policy condition known as an **Incontestability Provision**, which states that the insurer will not contest the policy after it has been in force for a specified period (**contestable period**), unless there is proof of fraud on the part of the policyowner (see **4.2** for more details).

1.2.3 Other Insurance Principles

(a) **Proximate cause:** this principle is concerned with the identification of the dominant, effective cause of the loss being claimed for under the insurance. The principle **does** apply to every class of business, but it is very likely to have rather less significance with life insurance partly because of the minimal use of exclusions. The application of proximate cause is very much concerned with different kinds of **perils** (i.e. causes of loss):

(i) *Insured Perils*: are those which **are** covered by the policy. Non-life policies may *specify* the perils which are covered, and one of those must be the **proximate cause** of the loss or it is irrecoverable. In life insurance, the cause of death is not critical, unless a suicide exclusion clause operates or an accidental death benefit rider applies.

(ii) *Excepted* (or *Excluded*) *Perils*: in non-life insurance, all policies carry some *exclusions*. If one of these operates with a claim, the insurer is not liable for the whole of or part of the loss, depending on the specifics of the exclusion. Life insurance policies seldom have exclusions (but see **Note** 1 below).

(iii) *Uninsured Perils*: these are causes of loss which are neither *included* nor *excluded*, for example water damage with fire insurance. If property is damaged by water (e.g. by rain) with no other cause involved, the damage is **not** covered. But if the water damage is **proximately** caused by an insured peril (say fireman fighting a fire with water hoses), the water damage **is** covered. Such complexities are unlikely to arise with life insurance claims.

Note: 1 *Suicide* is a life policy *exclusion*, and the principle of proximate cause will be an important tool to determine whether death arose from suicide or not. **However**, even here the principle does not have full impact, because suicide is only excluded for a limited time period (suicide exclusion period) (see **4.12**).

2 We may conclude that the principles of insurance, **especially** those concerned with **claims**, have less application in life insurance than in non-life insurance.

(b) **Indemnity:** this means an exact financial compensation for the loss sustained and is very important in most types of General Insurance. As far as life insurance is concerned, however,

(i) it is immediately obvious that the policy proceeds (or 'insurance proceeds') in no way pretend to (or can) represent an *exact* financial compensation. That is why life policies are called *benefit policies*, not indemnity policies;

(ii) it is impossible to *over indemnify*. It is because the insurable interests (closely linked with indemnity) in the majority of cases is *unlimited* (see **1.2.1**(c)).

(c) **Indemnity corollaries:** a corollary is a sub-principle and indemnity has two corollaries, *Contribution* and *Subrogation*.

(i) **Contribution:** in most General Insurance classes, if by some chance a person has more than one policy covering a loss, he does not get paid twice. Each policy *contributes to* (shares) the loss rateably. On the other hand, if the insured has effected more than one policy purposely, a vigilant claims handler might well take that as an *indication* of fraud!

Life insurance policies are normally not subject to the principle of indemnity, so it is quite normal for a person to have more than one life policy and each must pay in full upon the insured event happening.

(ii) **Subrogation:** this relates to the legal right of the insurer who has provided an indemnity to take over any remedies the "policyholder" (the UK equivalent of the American term "policyowner") possesses against third parties, to seek to recover his payment to the policyholder. This does not apply to life insurance.

If, for example, a third party negligently damages a person's car (which has a comprehensive cover), the person's motor insurer must pay but can attempt to recover its payment from the third party. In that same accident if an innocent victim in the car is killed, his life insurer must pay without an ensuing right of recovery from the third party.

1.3 CALCULATION OF LIFE INSURANCE PREMIUM

The premium required for insuring a given life may have to take into account *individual* features which make the risk better or worse than the average for a person of that age and sex. That, however, is essentially a matter of *underwriting*, which we shall consider in more detail in **5.3**. Life insurance (premium) **rates**, which may be thought of as the normal or standard premiums applicable according to age and sex, are subject to certain common features considered below.

1.3.1 Rating Factors

The classic criteria usually applied to life insurance premiums are that they should be:

(a) *adequate*: so that the insurer will have money to pay the benefit and meet other obligations under the contract; and

(b) *equitable* (fair): so that each policyowner is paying an amount in line with the risk and contracted benefits.

To achieve these criteria, a number of factors must be taken into account in the course of rating.

1.3.1a Mortality, Interest and Expenses

(a) **Mortality:** perhaps more accurately phrased as the *Rate of Mortality*, this indicates the rate at which insured lives are expected to die. Whilst this sounds very morbid, it will be immediately obvious that this is absolutely at the heart of life insurance premium calculation. To know, on average, when the life to be insured may be expected to die is a crucial factor in determining the correct premium to charge.

Of course, individual lives may live much longer or shorter than the average, but following the "*law of averages*" (which is sometimes called the "law of large numbers") reasonable predictions and calculations can be made. These are greatly facilitated by the use of **mortality tables**, which are published tables showing the expected rate of mortality at any given age.

As mentioned above, individual risks may call for special terms and consideration, but that is an *underwriting* matter. Premium rating using mortality tables merely deals with *normal* risks and normal expectations.

(b) **Interest:** in very simple terms, life insurance involves collecting money *now* and at specified intervals, to provide for a benefit at some time or upon some event in the *future*. This, by definition, means we have some **time**, and as the old saying goes "time is money"!

How much time we have, on average, largely concerns (a) above. The fact that we have some time means that we have an opportunity for **investment**. The interest to be earned on invested premiums is another crucial factor in determining premium rates. If a particular insurer is anticipating above average returns of investment, it can charge lower premium rates than a fair number of its competitors, and/or make more profit for its shareholders.

Note: The above two factors combined will produce what is called the *net premium* (sometimes called the **pure premium**), i.e. the money required to be collected from the policyowners just to meet death claims arising in the future under normal statistical expectations. But there is more to consider.

(c) **Expenses:** the **net premium** has to be subject to a *loading* (surcharge or additional sum) to take care of all expected and probable expenses. These will include all internal operating costs, commissions, tax and overheads to which any business is subject. With life insurance, there is also the possibility (however remote) of unusual mortality rates from some new disease or other disaster - and existing premiums **cannot** be increased later to deal with changed circumstances. Loading the net premium will include an amount to cover that kind of contingency.

Note: The **loading** added to the **net premium** produces the *gross premium*, which takes into account all three basic factors mentioned above.

1.3.1b Other Factors

As mentioned, premiums for existing policies cannot be changed. Life insurance belongs to **long term business**, and this implies that the contract not only is very likely to last several years, but also it cannot be cancelled or amended by the insurer without the consent of the policyowner. Therefore, other factors which may arise from time to time can only affect premiums for new policies. Some of the influences which might have an effect on life premium rating are mentioned below:

(a) **PAR or NON-PAR:** this is extremely important. One unique feature of life insurance is that a policy is either a "*participating*" (**PAR**) policy or a "*non-participating*" policy (**NON-PAR**). The owner of a participating policy is entitled to receive a varying share of (or to "participate" in) the divisible surplus, if any, of the insurer, normally on the policy anniversary dates. Such proceeds are termed *policy dividends* or *dividends*. Though no policy dividends are guaranteed, participating policies are subject to higher premium rates than equivalent Non-Participating policies.

Note: 1 While U.S. insurers talk of par and non-par policies and dividends, U.K. insurers issue policies which are either **With-Profit** or **Without-Profit**, and declare bonuses. The concept is the same, although there are differences between the U.S and U.K. practices. *Bonuses* are usually *reversionary* (i.e. payable only when the policy benefit is payable), whereas dividends are payable upon annual declarations. Having said that, reversionary bonuses can be surrendered without terminating the policy (see **1.3.2b**(c)(i) for surrender values). Suppose a whole life policy has earned an accumulated reversionary bonus of £5,000. The policyowner is entitled to an *immediate* payment out of such value, but only at a discount. Further suppose that according to the insurer's calculation based on factors such as the current age of the life insured and the expected rates of interest, the *future* bonus value of £5,000 is equivalent to an *immediate* surrender value of £1,000. Then by surrendering, say, half of the accumulated bonus value, the policyowner will be paid £500 immediately.

2 Not all life insurance policies can be **par** or **non-par**. *Term* insurance plans (see **2.1.1**) are normally not on a participating basis.

3 For discussions on distribution of policy dividends, please see **5.2.7**.

(b) **Competition:** no insurer enjoys a monopoly position. What the market is charging cannot be ignored.

(c) **Economic changes:** extended times of affluence or recession will doubtlessly have an impact on all product prices, including insurance.

(d) **Public health:** abnormal developments in this area (e.g. the AIDS epidemic) cannot be ignored in rating.

(e) **Fiscal changes:** a lasting increase in tax levels must be reflected in higher premium rates.

(f) **Company objectives and marketing strategies:** if a company is determined to increase its market share, competitive premium rating is surely one of the possible marketing strategies.

1.3.2 Pricing Systems

The natural and level premium systems for life insurance premium calculations might well be described as "*ancient*" and "*modern*" respectively, for reasons that will be clear shortly.

1.3.2a Natural Premium (Pricing) System

The natural premium system (or the natural premium pricing system) was used by some life insurers in the early days of the business. It was very logical, but it was doomed to failure because of its built-in features which virtually guaranteed that it could not work long-term in practice. Such features were:

(a) **Premiums:** these were not to be constant throughout the policy term, but individually calculated each year so that they reflected the *natural risk* position (age, etc.) of the life insured at each policy anniversary.

(b) **Short-term consequences:** with increasing age, there is increased mortality risk. Premiums for existing policies therefore increased every year.

(c) **Longer-term consequences:** these, in hindsight, were very predictable and included:

(i) increasing premiums with increasing age and, in later years, decreasing disposable resources or earning power of the policyowner, often presented real problems with continuation of insurance;

(ii) the system was vulnerable to *anti-selection* (also known as **selection against the insurer**), whereby the better risks - those in good health and with real prospects of a long life - dropped out of the scheme as it became more expensive, and the bad risks would normally decide to continue, for obvious reasons. This creates an *imbalance* of risks, or a failure to satisfy a criterion of the law of large numbers, i.e. the existence of a large, if not infinite, number of homogeneous exposure units in the pool.

(d) **Present day:** the Natural Premium System is no longer practised, at least not for policies which are truly "long-term".

Note: We may be tempted to be scornful of a scheme which we can now see to have such obvious defects. But it is easy to live life in retrospect. Problems and shortcomings usually only appear through experience.

1.3.2b Level Premium (Pricing) System

The level premium system (or the level premium pricing system) is now the norm and its features are described below:

(a) **Basic concept:** by the judicious use of **mortality tables** and actuarial calculations, it was realised that it was possible to quote an annual premium that would remain *level* (unchanged) for the duration of the contract, based upon the age, sex and individual underwriting features of the life to be insured. This, of course, assumes that the **death benefit level** also remains unchanged.

Compared with the cumbersome and unsatisfactory features of the **natural premium system**, the advantages and attractiveness of such a system are obvious. Therefore, it quickly superseded the old system.

(b) **Short-term consequences:** clearly, the level premium system envisages a long-term contract, where an unchanging annual premium will effectively "*average out*" over the years. It implies that the annual premium is "too much" for the risk involved in early years, and may be "too little" for the risk involved in later years.

Of course this is a simplification, but it is not inaccurate. From this concept, it may be seen that once the initial expenses and costs of setting up a policy have been absorbed, the early years' "excess" premiums plus the interest earnings thereon start to create a fund or *reserve* against the future liability.

In the usual practice of non-life insurance, the premium is calculated each year and at the end of the year the premium is considered **fully earned** by the insurer. The life policy, under the **level premium system**, soon begins to build up a cash value for the policyowner.

(c) **Longer-term consequences:** some of the implications and products of (b) above will be examined in more detail in **Chapter 4**, but we may briefly mention the features that developed from the early years' "surplus" premiums found with the level premium system:

(i) **Cash value** and **surrender value:** When a policy has been in force long enough to "clear" the set-up costs, part of the premiums received – after the risk premium for the past period has been deducted – can be considered to be "not yet earned" by the insurer; it is referred to as a "cash value". Therefore, when a policyowner cancels a policy that is carrying a cash value, there should be a sum of money payable to him, representing a refund of premiums "unearned" by the insurer. This sum is known as "**surrender value**". Surrender value equals cash value minus surrender charge, a charge that is applicable when a policy is surrendered for its cash value or when a policy, under some plans, is adjusted to provide a lower amount of death benefit.

Note: This is not true for *Term Insurance* (see **2.1.1**), where the premium is geared only to the risk of death during a specified period of cover. Such policies have no **cash value**.

(ii) **Policy loan:** the **cash value** is an acceptable *collateral* security for a loan. Borrowing money from the insurer using the cash value as security is now a *right* under modern policy terms.

(iii) **Nonforfeiture:** without specific policy provisions to the contrary, a life insurance policy will *lapse* (i.e. discontinue) if renewal premiums are not paid when due. However, its **cash value**, if sufficient, may be used voluntarily by the policyowner or sometimes automatically under policy terms, to keep the insurance in force (see **4.5**).

(iv) **Paid-up insurance:** should the policyowner decide that he cannot or does not wish to pay any further premiums, he may, as an alternative to policy surrender, pay up the policy. This means that he is not paying any more premiums and yet the policy stays in force exactly as before (so that a participating policy will continue to yield dividends), except

that he is now insured for a lower amount of insurance called the “paid-up value”, in line with the net cash value and the premiums saved as a result of his choice. A paid up policy is sometimes referred to as a reduced paid up policy, to reflect the normal fact that the paid up value is smaller than the face amount. This alternative arrangement is largely possible because the premiums paid in the early years of the policy have yet to be "fully earned" by the insurer.

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Representative Examination Questions

Type "A" Questions

1 *"Life insurance provides a sum of money if the person who is insured dies whilst the policy is in effect."* This quotation:

(a) is completely inaccurate; .....
(b) completely describes all life insurance contracts; .....
(c) does not completely describe all life insurance contracts; .....
(d) is totally misleading and contains no element of truth in it. .....

[Answer may be found in **1.1**]

2 Which of the following represents a legitimate insurable interest for life insurance?

(a) insurance of oneself; .....
(b) insurance of one's spouse; .....
(c) insurance of one's 10-year-old child; .....
(d) all the above. .....

[Answer may be found in **1.2.1**]

Type "B" Questions

3 Which **two** of the following statements are **true**?

(i) A benefit policy is the same as an indemnity policy.
(ii) Most life policies are subject to indemnity, but some are not.
(iii) Life insurance contracts are not normally subject to indemnity.
(iv) Indemnity does not normally apply to life insurance, where benefit policies are prevalent.

(a) (i) and (ii); .....
(b) (i) and (iii); .....
(c) (ii) and (iii); .....
(d) (iii) and (iv). .....

[Answer may be found in **1.2.3**]

4 Which **three** of the following are features in calculating life insurance premiums?

(i) Interest
(ii) Expenses
(iii) Mortality
(iv) Morbidity

(a) (i), (ii) ad (iii); .....
(b) (i), (ii) and (iv); .....
(c) (i), (iii) and (iv); .....
(d) (ii), (iii) and (iv). .....

[Answer may be found in **1.3.1a**]

Note: *The answers to the above questions are for you to discover. This should be easy, from a quick reference to the relative part of the Notes. If still required, however, you can find the answers at the end of the Study Notes.*

2 TYPES OF LIFE INSURANCE AND ANNUITY

To the public and perhaps inexperienced insurance intermediaries, there must seem to be a bewildering variety of life insurance contracts. Certainly, it is a sophisticated and well-developed market, but a few basic guide rules should prove helpful:

(a) **Basic functions:** it is good to distinguish the various products offered by life insurers by what the products seek to *do*. Another way of thinking about that is to ask the question: "Under what circumstances is/are the death benefit(s) payable?" Some basic formats are:

(i) payment on death *only if* it occurs during a specified period;

(ii) payment on death *at any time*;

(iii) payment on a *specified date* **or** on *earlier death*.

(b) **Basic variables:** some additions/modifications to the above are:

(i) the type of policy (called the *plan*) may be *convertible*, i.e. able to be **changed** into a different **plan**, at the policyowner's option;

(ii) *renewable*, if originally for a limited time period (e.g. five years);

(iii) **Par or Non-par:** see **1.3.1b**(a);

(iv) various *Riders*, i.e. endorsements, are often added to the basic policy to provide *additional cover*.

(c) **Basic questions:** much heartache and misunderstanding in the whole business of life insurance selling would be avoided if insurers and insurance intermediaries clearly put the following two questions to potential policyowners (and of course acted in accordance with the answers):

(i) "What do you want the insurance to do for you?", i.e. *what is it for?*

(ii) "How much premium are you able and willing to pay?", i.e. *what can you afford?*

Note: The other basic question "How much life insurance do you need?" is of course important, but this is usually answered by the insurance intermediary rather than the applicant.

Given these important preliminaries, we may now think about specific policy types. We should just say, however, that we shall only be considering an outline of the various covers, so that you may be in a position to identify and broadly distinguish the various types of **plan** available. Professional skill and discrimination can only be obtained through experience.

2.1 TRADITIONAL TYPES OF LIFE INSURANCE

These will consist of the three basic formats mentioned in (a) above, although there are many possible variations and combinations of the different types of cover. The major traditional types we shall consider are as follows:

2.1.1 Term Insurance

Such kind of insurance provides cover for a specified period or *term* only, and may also be described as **temporary life insurance**. The policy benefit is *only* payable if:

(a) the life insured **dies** during the specified period, or term; and

(b) the policy is **valid** (in force) at the time of death.

In the great majority of cases, term insurance plans run their course without a claim. For these reasons, it is the *cheapest* form of cover available (but, of course, its limitations must be understood).

In theory, the **term** could be for any period of time, even a few hours to cover an aircraft flight, for example. In practice, it is rare to find a term insurance for a period of less than *one year*.

2.1.1a Level/Decreasing/Increasing Term Insurance

(a) **Level term insurance:** this policy plan is perhaps the most popular term insurance. It involves a *level* **death benefit** throughout the policy period. In the event of death during the term, the **face amount** (also known as **face value**) of the policy is payable. The level of annual premium usually remains the same throughout the policy term.

Popular largely because of its simplicity, this is a useful answer to a temporary need which neither increases nor decreases to any significant extent over the period of time involved (perhaps a **loan** which is not being repaid by instalments).

(b) **Decreasing term insurance:** under this plan, the **death benefit** *decreases* annually, or at other specified times. The level of annual premium usually remains the same throughout the policy term. Because the benefit is continually decreasing and is payable only on death during the term, this is the **cheapest** form of life insurance available. It is particularly suited for a temporary need which is *reducing*. Some typical examples are:

(i) **Credit life insurance:** designed to pay the balance of a loan *direct to the lender* should the borrower die before a full repayment of loan has been made. This plan is usually sold to lending institutions on a *group basis* to cover the lives of their borrowers.

(ii) **Family income insurance:** perhaps linked with another policy plan which provides a **lump sum** payment on death, a family income plan will pay a stated *monthly* death benefit to the beneficiaries for the remainder of a specified period (the total amount payable (i.e. monthly benefit x number of payments) is therefore **decreasing** as time goes by). Suppose a life insured under a 5-year family income plan for a monthly benefit of $1,000 dies at the end of year 4. The plan will pay the beneficiary 12 monthly payments of $1,000 each, totalling $12,000. On the other hand, a death at the end of the 50^{th} month will mean 10 monthly payments of $1,000 each, totalling $10,000.

(iii) **Mortgage redemption (**or **'mortgage protection'**) **insurance:** a typical mortgage loan is reduced by monthly or other periodic payments. Mortgage redemption insurance is a decreasing term insurance designed to provide an amount of death benefit which *corresponds* to the decreasing balance of a mortgage loan. At any rate, the initial face amount and the subsequent reduced amounts are set at the time of purchase on the basis of the plan of repayments. Such a plan may be on a *joint-life basis* (e.g. husband and wife), the benefit being payable when the first life dies. A joint-life plan may in addition pay upon the second life's death, to help pay funeral costs and expenses. (The major differences between mortgage redemption insurance and credit life insurance are that (a) the former insures the interests of the mortgagors (who may sometimes be required by the mortgagees to name the mortgagees as beneficiaries) whereas the latter insures the lenders' interests, and (b) the former is a benefit insurance so that claims will still be payable even if at the time of death the debt has already been paid off whereas the latter is normally an indemnity insurance.)

Note: The above form of cover must not be confused with **Mortgage Indemnity Insurance**. This is quite different, being an insurance for mortgagees. It covers the risk of non-repayment of mortgage loans for any reason.

(c) **Increasing term insurance:** this plan, as the name suggests, insures a death benefit which *increases* annually or at other intervals. The increases may be at a *fixed percentage*, or in line with an agreed *index* (e.g. the Composite Consumer Price Index). The basic idea is to maintain the purchasing power of the benefit, which is especially important where severe inflation is anticipated. The premium generally increases in line with the increases in the level of benefit insured.

2.1.1b Renewable/Convertible Term Insurance

(a) **Renewable term insurance:** at first sight, this seems to be a contradiction, because a **term insurance** is for a fixed period, and this extends the period. The key point, however, is that the right to *renew* the policy is exercisable *without submitting evidence* of **insurability** (health) and the **premium** for the further period is *increased* to reflect the increased age of the life insured. (The new premium is said to be based on the **attained age**.)

Because such a plan can lead to **anti-selection** (see **1.3.2a**(c)(ii)), some limitations such as the following may be put in place:

(i) renewals may only be for the original face amount or *smaller* face amounts;

(ii) the *number* of renewals permitted may be restricted (e.g. three times);

(iii) the premium rate for a renewable term policy is usually *higher* than that for a comparable non-renewable term policy.

Frequently, one-year term policies are made renewable, either by a basic policy provision or a **rider**. These have the obvious name *Yearly Renewable Term* (**YRT**) or *Annually Renewable Term* (**ART**) insurance.

(b) **Convertible term insurance:** such a plan gives the policyowner a *conversion privilege*, i.e. the right to convert (change) the policy to a *permanent* plan without providing evidence of **insurability** (health). If this privilege is exercised, the premium for the permanent plan must be calculated on the basis of the standard rate for such a plan based on the **attained age** of the life insured.

Because **anti-selection** is again a possibility with such a plan, restrictions are usually put in place:

(i) conversion may **not** be permitted beyond a certain age (say 55 or 65);

(ii) conversion may **not** be permitted after the policy has been in force for say 50% of its specified term (or a specified number of years);

(iii) the face amount of the permanent plan will be limited to that of the term insurance (probably less after the term policy has been in force for some specified time).

2.1.2 Endowment Insurance

An endowment plan will pay the **face amount** when the life insured survives a specified **term** but upon death in case he dies within the term. When the life insured survives the insurance period, the policy is said to **mature**. As with term insurance, the description of the policy must include reference to the number of years of insurance, e.g. a 20-year endowment. Features to be noted with this plan are:

(a) **Premiums:** are not cheap, since under normal circumstances the face amount **must** become payable *not later than* the specified term in the future; premiums are **level**, normally paid annually, although *single premium* endowments are possible;

(b) **Technically:** the plan is a **combination** of a *term insurance* and a *pure endowment* for equal amounts. (A **pure endowment** is a contract under which the death benefit is *only* payable if the life insured **survives** the term);

(c) **Par or non-par:** such a plan may be on a participating (**with-profit**) or non-participating (**without-profit**) basis, at an appropriate premium;

(d) **Popularity:** because in principle such a plan provides the best of both worlds (premature death protection and personal savings for the policyowner if the policy matures), these have an apparent attraction. However, probably because of the relatively high premium rates, such plans do not have great popularity here, or in many other markets at present.

2.1.3 Whole Life Insurance

Such a plan, quite literally, provides cover that will last *the whole of one's life* (sometimes it is called **whole of life insurance**). The fundamental feature is that the face amount is paid on *death*, whenever that occurs, and **not** before. Having said that, when the life insured reaches the age at the end of the mortality table that has been used to calculate premiums for that policy, usually 99 or 100, the insurer will pay the face amount, putting an end to the contract. The relevant policy features to note are:

(a) **Premiums:** are **level**, but may be subject to different provisions, including:

  (i) *payable throughout life*: in which event the policy may be called a **straight life** insurance policy, or a **continuous premium** whole life policy;

  (ii) *payable for a limited period*: the policy may specify a number of years during the lifetime of the life insured for premium payments;

(iii) *premium subject to an age-related limitation*: instead of specifying a number of years, the policy may stipulate an age (say 65) after which no more premiums are required. As with (ii) above, premiums are only payable up to the date of death if it occurs before the specified years/age;

(b) **Par or non-par:** either plan is permissible;

(c) **Variations:** many variations are possible, such as *premiums* which **increase**, or *face amounts* which **change**, at specified times during the policy's life, to cater for different needs as time goes by. One such variation is called a *graded-premium policy*, where the premium increases (against a level **face amount**) on a regular basis, say every three years, until it equals the level premium that has been prescribed for the rest of the life of the policy.

2.2 NON-TRADITIONAL TYPES OF LIFE INSURANCE

Life insurance, more or less in its present form, has been practised for approximately 400 years. During that time, the basic policy formats have become very established and they still form a practical and useful role in providing this important form of cover. However, the pattern of economic and social life does not stand still and new products have been developed, often providing a more flexible approach to life insurance cover and associated investment. We look at two such examples.

2.2.1 Universal Life Insurance

In an attempt to provide greater consumer choice and flexibility, this product has been developed, in the form of a variation of the whole life insurance. It has been well described as a life insurance contract which:

(a) is subject to flexible premiums*;*

(b) has an adjustable death benefit;

(c) has an "unbundled" pricing structure; and

(d) accumulates a cash value.

We examine these and other features of this innovative product:

(a) **Flexible premiums:** subject to a minimum level of first-year premium payment(s), the policyowner is allowed to enjoy the feature of flexible premiums. After the first policy year, he can even skip premium payments. Of course, the amounts of cover and cash value depend on how much premium has been paid and when the cash value is inadequate to cover the next, say 60 days of expense and mortality charges, the policy will lapse.

(b) **Adjustable death benefit:** subject to certain limits, the death benefit purchased may be *increased* or *decreased*, although proof of **insurability** may be required for an increase in benefit.

(c) **"Unbundled" pricing:** the insurer separates and individually discloses, both in the policy and in an *annual report* (see (f) below) to the policyowner, the three basic pricing factors, i.e.:

(i) the **pure cost** of protection (covering the death risk);

(ii) **interest**; and

(iii) **expenses**. (The calculation of life insurance premiums includes an item for **expenses**, called *loading* (see **1.3.1a**(c)). Normally this is not disclosed to the policyowner, but with universal life insurance the expenses and other charges element is specifically disclosed to a purchaser.)

(d) **Cash value:** the intention is that the policy should acquire an increasing *cash value*. This of course is heavily influenced by the amount of premiums paid by the policyowner. After the first premium payment, additional premiums (subject to an individual limit) can be paid at any time. These, with interest earnings, are added to the cash value after the deduction of:

(i) a specified percentage *expense charge*; and

(ii) the *pure cost* of protection (deducted monthly).

(e) **Death benefit:** according to the plan the policyowner chooses, this may be a *face amount* plus the **cash value**, or the face amount only. For a given face amount and given premium amounts, the former option will mean a *lower* rate of accumulation of cash value because the insurer needs to be compensated for running a risk of paying out a *higher* amount of death benefit.

(f) **Annual report:** each year the policyowner receives a report which shows the *status* of the policy. The information given includes:

(i) the *death benefit option* selected (see (e) above);

(ii) the specified *amount* of insurance in force;

(iii) the *premiums paid* during the year;

(iv) the *expenses deducted* during the year;

(v) the **guaranteed** and *excess interests earned on* the cash value;

(vi) the *pure costs* of insurance deducted;

(vii) policy loan outstanding;

(viii) cash value withdrawals; and

(ix) the **cash value** *balance*.

It will be seen that this is a sophisticated product, allowing great choice to the policyowner to adjust his insurance according to his needs and financial resources as time goes by. Insurance intermediaries are advised to consult the insurers on local forms of this modern insurance plan.

2.2.2 Unit-Linked Long Term Insurance

Also known as a "linked long term policy" and "investment-linked long term policy", the unit-linked long term policy is one whose value is *directly* linked to, or *directly* reflects, the performance of the investments that have been purchased with the premiums paid. This may be achieved by formally linking the policy value to **units** in a special *unitised fund* run by the insurer, or to **units** in a *unit trust*. The value of the units is directly related to the value of the underlying assets of the fund or unit trust. Because of such linkage, the policy value naturally *fluctuates* according to the overall movements of those assets.

A detailed study of this sophisticated financial product is beyond the needs of this study and is instead within the scope of the Paper 'Investment-linked Long Term Insurance'. The following features of the product suffice for your study here:

(a) **Common principle:** unit-linked policies may come in a variety of forms, but there is a common factor. All or part of the premiums will be used to purchase *units* in a fund at the price applicable at the time of purchase. The value of the policy will then fluctuate according to the value of the units allocated to it.

(b) **Types of funds:** a variety of funds may be used for linking purposes, including *equities* (ordinary shares), *fixed interest* investments and a whole range of cash and other asset funds.

(c) **Types of policy:** in theory, any kind of life insurance product may be unit-linked. The most common in practice are *whole life* and *endowments*, sometimes with a **guaranteed** minimum value, however unit prices may move.

Special care must be taken with products which are essentially investments, so that the consumer is aware that values may go up or down. This aspect is considered more in **5.2.6**.

2.3 ANNUITIES AND PENSIONS

Each refers to income or other financial provision (usually) for retirement or old age. A definition of each term is:

(a) **Annuity:** a contract whereby an insurer promises to make a series of periodic payments (called "annuity benefit payments") to a designated individual (called the "payee") throughout the lifetime of a person (called the "annuitant") or for an agreed period, in return for a single payment or series of payments made in advance (called "annuity considerations") by the other party to the contract called the "contractholder" (or "annuity purchaser"). Very often, the payee, annuitant and contractholder are the same person.

(b) **Pension:** a plan to provide for a monthly (or other periodic) income benefit to a person in retirement, until his death. It may consist of an annuity.

2.3.1 Annuities

Under a simple annuity plan, the balance of the annuity considerations paid is "lost" if the **annuitant** dies before their exhaustion. This has very little public appeal, especially in Hong Kong, so annuities are not commonly found in practice. They have their uses, particularly with elderly people with a reasonable to considerable amount of capital and no living dependants or close family. In such circumstances, a guaranteed income for life may have its attractions, especially in view of the consequent removal of the temptation to spend the capital at an excessive rate.

Some features to be noted with annuities are:

(a) **Immediate annuity:** usually purchased with a single payment, it starts making annuity benefit payments one annuity period (time span between one scheduled payment and the next in the series; say, one month) immediately thereafter.

(b) **Deferred annuity:** can be purchased with a single premium or with premiums paid in instalments. The annuity benefit payments begin at some specified time or specified age of the annuitant, rather than immediately. A deferred annuity policy has an accumulation phase and an annuitization phase. During the **accumulation phase**, the policyholder pays premiums regularly over a period of time which is usually followed by a **deferral period** to allow the paid up sum to grow through investment by the insurers. At the completion of the accumulation phase, the deferred annuity insurance policy will annuitize, the **annuitization phase** will begin and the annuitant will receive regular payments during the **annuity period**.

(c) **Variations:** a number of possible variations exist. The **annuity certain** provides for annuity benefit payments to be made for a *fixed number of years* only, whether death occurs in the meantime or not. The **life annuity**

is one that provides for periodic benefit payments for the lifetime of the annuitant, and it is also referred to as a **whole life annuity** to distinguish it from a **temporary life annuity**, under which benefits payments are made during a specified period but only as long as the annuitant is alive. The **life income annuity with period certain** (or known as a **guaranteed annuity**) provides for benefit payments to be made for *at least* a specified number of years, even where death occurs within the period, and for the duration of the life of the annuitant if he survives the period.

(d) **Underwriting:** the underlying philosophy of **annuities** is completely *opposite* to that with **life insurance**. With the latter, the **premium rate** increases with age at inception and is **higher** for men than women of the same age. With annuities, the amount of each annuity benefit payment increases with age at payment commencement, and men receive a higher annuity benefit payment than women of the same age do. Put briefly, **life insurance** is based upon the chances of *dying* while **annuities** are based upon the chances of *living*!

2.3.1a HKMC Annuity Plan – a public immediate life annuity scheme

(a) **Overview**

On 5 July 2018, the HKMC Annuity Limited ("HKMCA"), wholly-owned by the Hong Kong Mortgage Corporation Limited, officially launched an immediate whole of life annuity scheme named the "HKMC Annuity Plan", for subscription by Hong Kong Permanent Residents aged 65 or above. By providing the annuitant with a steady stream of guaranteed monthly annuity payments (which are fixed amounts) after receiving a single premium, the HKMC Annuity Plan enables the annuitant to better plan his retirement life.

Interested persons can make sales appointments with the HKMCA directly.

(b) **Product Features**

Below is a summary of the product features of the HKMC Annuity Plan:

(i) **Minimum and maximum premium amounts per person**: Depending on the monthly annuity payment amount needed, applicants may subscribe a single premium within the range of HK$50,000 - HK$3,000,000.

(ii) **Guarantees:** Taking into account annuitants' possible fear of being disadvantaged for premature death, the HKMC Annuity Plan offers a **guarantee of minimum total annuity payment.** In the event that the annuitant dies within the Guaranteed Period (i.e. the period that commences from the premium start date and lasts until the guaranteed monthly

annuity payments made by the HKMCA reach a sum equal to 105% of the premium paid), the designated beneficiary will receive the **Monthly Death Benefit Payments** (i.e. the remaining unpaid guaranteed monthly annuity payments) until the cumulative payments made (to the annuitant and the beneficiary combined) reach the guaranteed minimum total payment (i.e. 105% of the premium paid). Alternatively, the beneficiary may choose to receive a **Lump-sum Death Benefit Payment** equivalent to the higher of (i) the **guaranteed cash value** of the policy as at the date on which the death claim application is received by the HKMCA (which may result in a financial loss); and (ii) 100 % of the premium paid less the cumulative guaranteed monthly annuity payments made by the HKMCA as at the date on which the death claim application is received by the HKMCA, without extra discount (thus avoiding the financial loss in the case of (i) immediately above).

(iii) **Policy surrender:** The policyowner may surrender the policy within the Guaranteed Period in return for a surrender value. It is important for potential policyowners to note that early surrender may result in a financial loss, which could be significant at times.

(iv) **Special withdrawal:** The policyowner may apply for a special withdrawal for paying medical or dental expenses incurred in Hong Kong within the Guaranteed Period. The amount withdrawn may be used for medically/dentally necessary medical/dental treatment or examination, without being restricted to specified critical illnesses. Subject to an upper limit of HK$300,000, the amount withdrawn would be the lower of (i) 50% of the premium paid, and (ii) the premium paid less the cumulative guaranteed monthly annuity payments made. Special withdrawal may only be made once, and will result in a proportional reduction of the guaranteed monthly annuity payments, without extra discount.

2.3.1b Tax Deductions for Deferred Annuity Premiums

(a) **Overview**

It is a 2018-19 Financial Budget initiative to provide tax deductions for deferred annuity premiums and Mandatory Provident Fund tax deductible voluntary contributions ("TVCs") to encourage the working population to make early retirement savings in order to cope with the financial risk arising from longevity. To implement this initiative, the Inland Revenue and MPF Schemes Legislation (Tax Deductions for Annuity Premiums and MPF Voluntary Contributions) (Amendment) Bill 2018 was passed so that from the

year of assessment 2019/20 onwards the premiums that a taxpayer pays for a qualifying deferred annuity for himself and/or his spouse on or after 1 April 2019 are tax deductible under salaries tax and tax under personal assessment. Apart from deferred annuity premiums, such tax concession also applies to a taxpayer's TVCs made on or after that date.

The new Ordinance imposes a maximum tax deductible limit of HK$60,000 per person per year. It is an aggregate limit for qualifying deferred annuity premiums and TVCs, so that whether a taxpayer makes TVCs of HK$60,000 or pays HK$60,000 of qualifying deferred annuity premiums, or makes TVCs and purchases a qualifying deferred annuity as well, the taxpayer may still claim tax deductions up to HK$60,000 a year. Given the prevailing highest tax rate of 17%, the maximum tax savings can reach HK$10,200 a year.

Based on the consideration that an annuity covering the taxpayer's spouse as a joint annuitant is a convenient retirement planning tool for a married couple, a taxpaying couple are allowed to allocate tax deductions for deferred annuity premiums amongst themselves in order to claim the total deductions of HK$120,000 a year, provided that the deduction claimed by any one of them does not exceed the individual limit.

To be tax deductible, deferred annuity premiums must be premiums paid for a qualifying deferred annuity policy ("QDAP"), which is one that satisfies the criteria specified in a Guideline issued by the Insurance Authority ("IA") and has been certified by the IA for this purpose. A list of all QDAPs is maintained on the IA's website (www.ia.org.hk).

(b) **Guideline on Qualifying Deferred Annuity Policy (GL19)**

Taking effect on 1 April 2019, the Guideline on Qualifying Deferred Annuity Policy (GL19) issued by the Insurance Authority sets out the criteria which a deferred annuity policy has to satisfy in order to obtain the necessary certification from the IA to become a QDAP, the process for obtaining such certification and the ongoing requirements which authorized insurers have to meet in respect of the promotion, arrangement and administration of QDAPs. GL19 applies to all insurers authorized to carry on long term business and involved in developing, designing, underwriting and/or selling QDAPs.

The following is a summary of the criteria for QDAPs set out in GL19:

(i) **Policy Features**

(1) **Minimum total premiums paid and minimum premium payment period**: With a minimum total amount of HK$180,000, qualifying annuity premiums must be payable for a minimum period of 5 years.

(2) **Minimum annuity period:** The annuity period is at least 10 years.

(3) **Minimum frequency of annuity payments:** The annuity payments are made regularly and at least as frequently as annually.

(4) E**arliest annuitization:** The annuity period starts when the annuitant reaches age 50 at the earliest.

(5) **Policy currency:** While there is no restriction on policy currency, the relevant risks (e.g. exchange rate risk) should be clearly disclosed to potential policyholders in the Product Brochure ("PB"). Exchange rates should be adopted in a consistent manner, by following the rates published on the website of the Inland Revenue Department ("IRD").

(6) **No lapse gain:** As far as possible, surrender values should be so set as to prevent insurers from profiting from an early termination of the policy.

(ii) **Disclosure Requirements**

(1) **Disclosure of internal rate of return:**

- The **internal rate of return** ("IRR") is a useful financial tool for appraising an investment plan that involves a stream of incomes or outlays happening at different points in time. The further a given amount of income is from the start date of the plan, the lower the IRR will be. On the contrary, the further a given amount of outlay is from the start date of the plan, the higher the IRR will be. By comparing the IRR of an investment plan to its **opportunity cost** (see **Glossary**) or other financial metrics, a decision is made on whether or not to participate in the investment plan.

- Although annuity should not be viewed as an investment tool for pursuing a high return, with this in mind the IRR may be taken as an

evaluation tool, perhaps alongside others, for comparing different annuity policies or comparing an annuity product with another type of financial product.

- GL19 requires that the IRR of the annuity policy should be disclosed in the PB both in the form of minimum to maximum IRRs for the guaranteed portion (i.e. guaranteed IRRs) and total projected benefit (i.e. total IRRs) respectively, and in the form of an example of a non-smoking male aged 45 for illustration.

- Personalized IRRs for the guaranteed IRR and total IRR should be disclosed in the Benefit Illustration ("BI") at the point of sale. Disclosure of personalized IRRs in the BI is currently optional, and will be mandatory from 31 March 2020 onwards.

- GL19 specifies the formula that should be used to calculate the IRR for the stream of monthly premium contributions and monthly annuity payments.

- Some policies may allow the policyholders or annuitants to leave the entire or part of the annuity payments with the insurers so as to generate future interest. GL19 requires that insurers should, in calculating the IRR, assume that the policyholders or annuitants will choose to receive the annuity payments in full as soon as they fall due. Any reinvestment returns of the annuity payments payable to the annuitant should be excluded from the calculation of the IRR.

- For policies without a fixed policy term (e.g. a lifetime policy), insurers should adopt 30 years as the annuity period in calculating the IRR, and clearly disclose the relevant assumption to potential policyholders.

(2) **Guaranteed annuity payments subject to minimum percentages of total projected annuity payment:** Insurers should include a clear presentation in the BI of the guaranteed annuity payments and non-guaranteed annuity payments, if applicable. The guaranteed annuity portion is subject to minimum percentages of the total projected annuity payment according to a prescribed table or scale.

(3) **Clear separation of premiums of riders:** Premiums paid for riders do not constitute qualified annuity premiums paid. Therefore they are not tax deductible and should be deducted from the Annual Summaries of QDAPs issued to policyholders. Where premiums for embedded features (e.g. death benefits) are negligible in amount and the cost of unbundling such premiums would outweigh the benefit of disclosing them, insurers may apply to the IA for a waiver of the requirement of separation of premiums of riders.

(4) **Risk disclosure – QDAPs:** Insurers and licensed insurance intermediaries should ensure that policyholders or potential policyholders are fully apprised of the policy features and risks associated with QDAPs, and the relevant risks (e.g. the risk of significant financial loss upon an early surrender of the policy) are clearly and prominently disclosed in the PB.

(5) **Additional risk disclosure - tax implications of certification:** In addition to the usual risk disclosure applicable to all annuity policies, insurers and licensed insurance intermediaries should remind policyholders or potential policyholders that, even where a deferred annuity policy is certified by the IA, it does not follow that the premiums paid under that policy will automatically be tax deductible. The reason for this is that there may be other tax related criteria (relating to the personal circumstances of the policyholder, for example) which need to be satisfied. Accordingly, certification by the IA only indicates that the policy complies with the criteria set out in GL19. The policyholder should be reminded to refer to the website of the IRD or to contact the IRD directly for any tax related enquiries.

(iii) **Others**

(1) **Issuance of Annual Summary of QDAP:** Insurers should issue a separate Annual Summary of QDAP in respect of each policy to the policyholder within 40 days after the end of the year of assessment (i.e. 31 March), or within a reasonable time after receiving a request from the policyholder.

(2) **Training of insurance intermediaries:** Insurers are reminded to provide insurance intermediaries with sufficient training and ensure appropriate internal controls are in place to prevent any mis-representation and mis-selling of QDAPs.

(3) **Record keeping:** Authorized insurers should maintain complete documentation and records to prove compliance with the requirements of GL19, and make them available to the IA upon request.

(4) **Names of QDAPs:** The name of a QDAP must clearly indicate that it is a deferred annuity insurance policy. It must also be clearly indicated in the PB of the QDAP that the policy is certified by the IA as such.

(c) **Guide for Using The Qualifying Deferred Annuity Policy Logo**

According to the Guide for Using The Qualifying Deferred Annuity Policy Logo issued by the IA, the logo for Qualifying Deferred Annuity Policy - designed for easy identification of a QDAP by members of the public - should be prominently displayed on the product brochures of all QDAPs. Authorized insurers may display the logo in marketing, promotion and advertising items of their QDAPs, where appropriate. Use of the logo in relation to any other insurance products (whether for marketing, promotion, advertising or otherwise) or corporate brand marketing in general is strictly prohibited.

2.3.2 Pensions

In Hong Kong pensions are often considered to be more in the Government realm (for example for most Civil Servants). More common in the non-Government sector are **Provident Fund Schemes**, which provide for a *lump sum* benefit on retirement or other specified time, rather than an income. The Mandatory Provident Fund System, implemented since December 2000, is having a profound effect in this area.

2.4 GROUP AND INDIVIDUAL INSURANCE PLANS

The majority of the plans we have considered so far have been with applications for the insurance of *individuals*, either insuring themselves or another person. This remains a key element in the field of life insurance, but *group insurance* is playing an increasing role. This is especially so with **employee benefit plans**, where an employer provides a form of life insurance, often as an additional benefit supplementing salaries and wages. Again, this is a complex area, but there are certain features that we may note:

(a) **Basic difference:** the most obvious difference between individual and group insurance plans is that the latter covers a number of people under a single policy. Sometimes this is called a *master group insurance contract.*

(b) **Contracting parties:** these are the insurer and the *group policyholder*, usually an employer, but possibly a club or other organisation insuring its members. The persons within the group who are covered may be referred to as *group insured* or sometimes *group lives insured* or *persons insured*.

(c) **Different plans:** plans may either be *contributory* (where the employees or other persons insured pay a share of the premium) or *non-contributory* (where individual members do not contribute towards the premium).

(d) **Eligible groups:** usually group insurance concerns a *single employer*, covering his staff members (collectively called a 'group'), but the members of association groups (i.e. members of clubs, trade unions, sports associations, etc.) formed for a purpose other than purchase of insurance could equally be considered eligible. Besides, *multiple-employer groups* (consisting of the staff members of different companies) may participate in a single plan.

(e) **Underwriting:** doing business "in bulk" means that the high degree of underwriting attention applicable to individual insurance is neither possible nor necessary. Detailed individual information is usually not required with group plans.

(f) **Individual eligibility:** eligibility is usually decided by the **employer**, and the criterion for admission to group coverage is usually stated in an *actively-at-work provision*. This requires that the individual was not only employed, but also at work (not ill or on leave) when coverage became effective.

(g) **Cover declined:** an eligible person (particularly with **contributory** schemes) may initially decline coverage. Should that person change his mind later, evidence of *insurability* may be required (to counteract **anti-selection**).

(h) **Termination of cover:** for individual persons insured, their cover may terminate upon ceasing to be eligible (leaving the employer or group) or failing to pay any required premium. Some plans allow individuals to *convert* their previous group cover into **individual** cover, often without proof of insurability but normally within a specified time period.

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Representative Examination Questions

Type "A" Questions

1 There are two common questions which can very usefully be asked by the honourable insurance intermediary with any enquiry about life insurance. One of these questions is "What do you want the insurance to do for you?" The other is:

(a) "How much money do you have?" .....
(b) "What is the commission rate for me?" .....
(c) "Do you really think you need this insurance?" .....
(d) "How much premium are you able and willing to pay?" .....

[Answer may be found in **2**]

2 Decreasing term insurance means that:

(a) the death benefit goes down each year; .....
(b) the premium goes down each year; .....
(c) the death benefit and the premium go down each year; .....
(d) the commission to the agent goes down each year. .....

[Answer may be found in **2.1.1a**]

Type "B" Questions

3 Anti-selection is a possibility with convertible term insurance. Which of the following are intended to discourage or counteract anti-selection?

(i) Conversion not allowed after say age 55.
(ii) The permanent insurance face amount must be for more than this policy.
(iii) Conversion not possible after the policy has been in force for some years.
(iv) The permanent insurance face amount must not be for more than this policy.

(a) (i) and (ii); .....
(b) (i), (iii) and (iv); .....
(c) (ii), (iii) and (iv); .....
(d) (i), (ii) and (iv). .....

[Answer may be found in **2.1.1b**]

4 Which **three** of the following are **not true** in relation to whole life insurance?

(i) The death benefit payable decreases each year.
(ii) The death benefit is only paid when the life insured dies.
(iii) The death benefit is only payable after a fixed number of years.
(iv) The death benefit is payable after a fixed number of years or on earlier death.

(a) (i), (ii) and (iii); .....
(b) (i), (ii) and (iv); .....
(c) (i), (iii) and (iv); .....
(d) (ii), (iii) and (iv). .....

[Answer may be found in **2.1.3**]

[If still required, the answers may be found at the end of the Study Notes.]

3 BENEFIT RIDERS AND OTHER PRODUCTS

Note: The term "policyowner-insured", as readers will come across in this chapter, refers to cases in which the life insured and the policyowner are the same person. Most life insurance policies are issued to policyowners who are also the lives insured (or 'lives assured' in British terminology). However, readers should also be aware that when one person purchases insurance on the life of another person (the policy being referred to as a 'third party policy') the purchaser is the policyowner and the person whose life is insured is the life insured.

3.1 DISABILITY BENEFITS

Also known as an endorsement, a **r**ider (or policy rider) is such an amendment to a policy that becomes part of the insurance contract and that either expands or limits the benefits payable under the contract. A rider that excludes coverage is known as an exclusionary rider. We shall consider two common riders applicable to situations where the policyowner-insured becomes subject to some form of *physical disability*.

3.1.1 Disability Waiver of Premium (known as a **WP Benefit Rider**)

A *waiver* is an act of voluntarily giving up a right or removing the conditions of a rule. Under a Disability Waiver of Premium Rider, which may be added to virtually all types of life insurance policies, the insurer agrees to **waive** his right to *renewal premiums* otherwise payable whilst the policyowner-insured is *totally disabled*. This does not mean that the policy is **suspended**. Instead it remains in force, so that a policy that builds a cash value will continue to do so, and a participating policy will continue to yield dividends, as if the policyowner had paid the premiums.

For the purposes of a WP Benefit Rider, "total disability" may mean that, because of disease or bodily injury, the life insured cannot do any of the essential acts and duties of his or her job, or of any other job for which he or she is suited based on schooling, training or experience. Another form of "total disability" is also covered, i.e. the life insured's total loss, starting while the rider is in effect, of the sight in both eyes or the use of both hands, both feet, or one hand and one foot.

Case 5 Definition of "total and permanent disability" for purposes of "waiver of premium" rider

The insured, who was a fireman, had been suffering from chronic low back pain and bilateral knee pain since early 1998. An x-ray photo of the lumbosacral spine revealed degenerative changes. His employment contract with the Fire Services Department was terminated in July 1999 because the Medical Board had assessed him to be unfit to continue working as a fireman. The insured believed that his condition had met the policy definition of Total and Permanent Disability and submitted a claim for waiver of premiums.

According to the policy definition, Total and Permanent Disability means "the life insured is unable to engage in any gainful occupation as a result of sickness or injury". The insurer declined his claim on the basis that a medical report had confirmed that the insured could work and walk unaided without functional limitation. Moreover, the Fire Services Department had confirmed that the insured's particulars had been circulated to other government departments in search of alternative employment.

Having noted the above, the Complaints Panel was of the view that whilst the disability had resulted in the life insured being unable to continue his old occupation as a fireman, it did not prevent him from engaging in another gainful occupation. As such, it supported the insurer's decision to decline the claim for waiver of premium.

Remarks: *the policy concerned has adopted a rather restrictive definition for "total and permanent disability" for the purposes of its "waiver of premium" rider, while more liberal definitions are available.*

There are normally some limitations, as follows:

(a) **Waiting period:** where the policyowner-insured has been totally disabled as defined in the policy for a minimum period (usually three or six months), renewal premiums will be waived. Once started, waivers will continue throughout the life of the policy until the disability ends. The original thinking behind Waiting Period probably was that most people continue to receive salaries and wages for at least short periods of disablement and so can still afford to pay premiums. But in fact some WP benefit riders will *refund* premiums which have been paid during the waiting period if the disablement extends beyond the waiting period, in which case the waiting period is a kind of "*time franchise*". (For illustrations of franchise, please read Chapter 3 of the Principles and Practice of Insurance Examination Study Notes.)

(b) **Age limitation:** usually waivers are only available to cover disabilities which begin during a specified age range, such as the age range of 15 - 65.

(c) **Premium frequency:** differing practices exist as to what mode of premium payment is assumed when premiums are being waived. For example, if premiums are being waived on a monthly basis, the insured person who recovers, say, 25 days after a premium has been waived would have to resume premium payments the following month. On the other hand, if premiums are being waived on an annual basis, his recovery after, say, 2 months would result in a waiver of premiums for an additional 10 months while he is no longer disabled, unless some adjustments are made. In view of such an undesirable situation, some policies provide that an annual premium-paying mode will automatically switch to a monthly mode for the purposes of premium waivers. Alternatively changes to the frequency of premium payments during disability periods are expressly disallowed.

(d) **Exclusions:** the cover given by this rider is similar to personal accident or medical insurance, so it normally carries some similar **exclusions**, such as:

(i) *intentional* self-inflicted injuries;

(ii) injuries sustained whilst engaging in *criminal activities*;

(iii) *pre-existing* conditions;

(iv) injuries resulting from *war* while the policyowner-insured is in military service.

3.1.2 Disability Income

Whereas a WP rider gives relief from *expenditure* during total disability, a Disability Income rider (as the name suggests) provides an *income* during periods of total disability. Again, a Disability Income rider may be added to virtually all types of life insurance.

The usual provisions of this rider include:

(a) **Definition:** "Total Disability" is defined in the manner as does a WP Benefit Rider (see **3.1.1** above).

(b) **Amount payable:** two alternative methods are used to establish the amount of disability income to be paid: an income formula and a flat benefit amount. A typical group disability income policy adopts an income formula, which expresses the income amount as a percentage of the insured member's pre-disability earnings, less the amount of any disability income benefit he receives from another source. Where a flat benefit amount is payable, no regard is to be paid to any other income benefits the insured member receives.

(c) **Waiting period:** similar in concept to that applicable with the WP rider, but the period varies from one to six months.

(d) **Not a loan or an advance payment:** the basic policy remains in full force during total disability so that if death occurs during a period of total disability the face amount of the basic policy is payable in addition to any income benefits paid or payable.)

3.2 ACCIDENT BENEFITS

Accident benefits that are commonly added to any kind of life insurance policy relate to *accidental death* and *dismemberment*. Frequently they are combined in a single rider, known as an **Accidental Death and Dismemberment (AD&D) Rider**.

3.2.1 Accidental Death and Dismemberment

To consider these separately, although they are frequently combined:

(a) **Accidental death benefit (ADB):** this normally undertakes to pay a benefit *equal to the face amount* of the basic policy as an **additional** sum should death be caused by an *accident*. The customary provisions are:

(i) death must have been caused **directly and independently** of all other causes, by an *accidental bodily injury*, and have occurred within one year after that injury;

(ii) customary personal accident insurance *exclusions* apply, including:

(1) intentional *self-inflicted* injuries (e.g. as a result of **suicide**);

(2) *war-related* injuries;

(3) injuries whilst engaging in *illegal activities*;

(4) *aviation* injuries (except as a fare-paying passenger);

Note: 1 This benefit is often called a **Double Indemnity Benefit**. We know from earlier studies (see **1.2.3**(b)) that the use of the term 'Indemnity' here is **technically inaccurate**, since life insurance is normally **not** subject to the principle of indemnity.

2 Also referring to previous studies (see **1.2.3**(a)), **proximate cause** becomes important with this rider. By contrast, the cause of death is in most cases irrelevant in relation to claims under the basic life insurance plan.

(b) **Dismemberment:** literally "dismemberment" means losing one or more *members* (limbs), but the term within the **AD&D rider** relates to both the loss of limbs and the loss of *sight*. The usual provisions are:

(i) **Basic cover:** normally, a sum equal to the accidental death benefit is payable if the life insured loses any *two limbs* or the sight in *both eyes* as a result of an accident.

(ii) **Lower benefit:** often policies provide for payment equal to a stated proportion of the accidental death benefit if an accident results in the loss of **one** limb, the loss of sight in **one** eye, or another specified lesser injury.

(iii) **Definition:** the loss of a limb may be described as the *actual* loss of limb (by physical severance at or above the wrist or ankle) or the *loss of the use* of the limb.

(iv) **Combination:** normally, the policy provides that where the same accident has resulted in both dismemberment and death, it will pay either the dismemberment benefit or the death benefit, but not both.

3.2.2 Other Accident Benefits

Different insurers may provide various forms of cover, but a typical rider giving other accident benefits has the following features:

(a) **Benefit schedule:** *accidental bodily injuries* being covered, a schedule (or list) of specified injuries is given, with a corresponding benefit against each. The list usually includes:

(i)	*Death*	100% of sum insured;
(ii)	*Loss of Two Limbs*	a specified percentage;
(iii)	*Total Loss of Sight*	a specified percentage;
(iv)	*1 Limb & Sight in 1 Eye*	a specified percentage;
(v)	*Either 1 Limb or Sight in 1 Eye*	a specified percentage;
(vi)	*Various specified lesser injuries*	see below

Lesser injuries: comprise a detailed list of possible injuries, ranging from serious impairments (e.g. loss of a thumb or index finger) to relatively minor ones (e.g. loss of a single finger joint).

(b) **Other benefits:** cover may include one or more of the following:

(i) *Serious Burns* - at least third degree burns: a specified amount **$**;

(ii) *Weekly Benefits* - during disability: a specified amount **$** (for no more than 52 weeks);

(iii) *Hospital Benefit* - a specified daily benefit (for no more than 1,000 days);

(iv) "*Double Indemnity*" - all benefits (**except** hospital stay) doubled, if the injury arose whilst travelling on regular public transport or in the burning of certain public places (cinemas, etc.).

(c) **Exclusions:** the normally applicable exclusions, which are commonly found with personal accident covers, include:

(i) *Self-inflicted injuries* (including **suicide**, at any time);

(ii) *War-related injuries*;

(iii) *Injuries whilst involved in illegal activities*;

(iv) *Disease or illness* (unless caused by an accident);

(v) *Childbirth & pregnancy*;

(vi) *Injuries resulting from hazardous sports* (as defined).

3.3 ACCELERATED DEATH BENEFITS

The meaning of this is that when a policyowner-insured in a prescribed serious situation, all or part of the death benefit under the policy may be payable to him, although death has not yet occurred. Provisions for this are contained in an *accelerated death benefit rider* (ADB rider), also known as a living benefit rider. Common features with the different riders concerned are:

(a) **Basic reasons:** the benefits are released at times of great personal stress, under grave and life-threatening circumstances. They are to assist with related expenditure and to provide at least partial relief from the extra burden of financial worry at times which are already grief-laden.

(b) **Eligible plans:** the riders are only likely to be permitted with policies having a significant **face amount** for the sake of keeping administrative costs down.

(c) **Beneficiaries:** since pre-death payments to the policyowner-insured will have an impact upon the expectations of the beneficiaries, some insurers will, in the event of a claim under the rider, require the latter to sign a *release* (or *release form*), acknowledging that the death benefit stands reduced by the amount of the ADB payment.

(d) **Assignees:** if the policy has been assigned, the assignee must sign such a release form, before an ADB is paid.

(e) **Types of benefits:** we shall consider two such accelerated death benefits, namely the *critical* illness and the *long-term care* benefits.

3.3.1 Critical Illness Benefit

The basic features of this rider are:

(a) **Meaning:** a stated portion of the death benefit is paid to the policyowner-insured when:

(i) he is diagnosed with a *specified disease*;

(ii) he is diagnosed with a *terminal illness* and has a *life expectancy* of 12 months or less; or

(iii) it is necessary for him to undergo a specified *medical procedure*.

(b) **Specified diseases:** the list of insured diseases is not identical with all insurers, but they all can be categorised into the following:

(i) cancer;

(ii) illnesses related to the heart;

(iii) disability;

(iv) illnesses related to a major organ;

(v) illnesses related to the nervous system;

(vi) illnesses related to the immune system;

(vii) others.

(c) **Medical evidence:** a statement from an attending physician is necessary, confirming the condition and, in the case of a terminal illness, the assessed *life expectancy* as well.

(d) **Amount of benefit:** this will vary between companies and depend on the type of disease contracted, payment of the *full death benefit* being a possibility. Critical illness benefit is invariably paid as a *lump sum*.

(e) **Restrictions:** again, these are not universal, but typically they may include:

(i) critical illness cover is only available up to a specified age, say, age 80;

(ii) critical illness cover is only available to standard risks;

(iii) payments may not be made for multiple/recurring events, perhaps subject to exceptions with a couple of diseases;

(iv) waiting period: the diagnosis mentioned in (a) above has to be one done when the rider has been in effect for a specified number of days, say, 90 days.

(f) **Premium waiver:** some riders offer to *waive* all renewal premiums due after say three months of meeting the incapacity definition.

Note: A critical illness package policy comprising a death cover and a critical illness cover is now widely available in Hong Kong, with both sharing the same face amount. Yet critical illness benefit plans offering no death benefit and critical illness benefit riders with death benefit are also available.

3.3.2 Long-Term Care (LTC) Benefit

This is not a very common product in Hong Kong at present, but the basic features of this rider are:

(a) **Meaning:** a stated portion of the death benefit is payable to a policyowner-insured who requires *constant care* for a condition.

(b) **Types of care:** these will be specified in the rider, e.g. to be cared for either in an *approved nursing home* or in the policyowner-insured's home by a duly *authorised* carer.

(c) **Medical evidence:** often the rider specifies that the care needs to be *medically necessary*. Confirmation of this is not always easy. Sometimes, the approval of the *policyowner-insured's physician* is acceptable, but many insurers require that the policyowner-insured be unable to perform a specified number of *activities of daily living* (**ADLs**) before the need is established. (ADLs will include basic human needs and functions, such as washing and dressing oneself, and mobility.)

(d) **Amount of benefit:** typically, this may be **2%** of the death benefit **per month** for *nursing home* care and **1%** for *home health care*. The maximum total payments may range between **50%** and **100%**.

(e) **Waiting period:** usually there is a **90-day** waiting period before **LTC** benefits are payable. Also, some insurers require the policy to have been in force for **one year** or more before LTC benefits are payable.

(f) **Premium waiver:** it is common for premiums to be waived, both for the rider benefit and the basic insurance plan, during the period that LTC benefits are being paid to the policyowner-insured.

3.4 MEDICAL BENEFITS

In earlier days, medical benefits would not be provided under life insurance policies. Such cover was considered to be part of the **"Accident"** (Personal Accident) portfolio. In more recent times, the boundary lines between various classes of business have become less clearly marked. It is therefore quite common for life insurers to consider medical benefits insurance part of their "insurances of the **person**" range of products. Cover may be given as a **rider** to a life insurance policy, or separately as a general insurance policy (for which type of insurance the insurer must of course be duly authorised by the Insurance Authority (IA)).

A typical form of cover found in Hong Kong at present is very likely to include most of the following features:

(a) **Basic plan:** Intended to cover the expenses related to *medical treatment* and *hospitalisation*, the Basic Plan has a number of headings under which cover is given, typically as follows:

(i) **Hospital charges:** these are very likely to have three different categories, according to choice and premium paid, the usual descriptions being *Private Room*, *Semi-Private Room* and *Ward Bed*. Cover includes Room and Board, Miscellaneous Hospital Services and an available supplement for Intensive Care treatment.

(ii) **Private nursing:** again with three categories, this includes nursing treatment at home, in hospital by a qualified nurse or as recommended by the attending medical practitioner.

(iii) **Surgeon's, anaesthetist's** and **operating theatre fees:** maximum benefit / cover is specified according to the three categories and the seriousness of the operation involved.

(iv) **In-patient physician's fees:** for non-surgical cases.

(v) **In-patient specialist's fees:** for treatment, consultations, etc.

(vi) **Out-patient follow-up care:** within 6 weeks of hospital discharge.

(vii) **Free worldwide assistance:** a number of benefits and covers to help in the event of emergency needs whilst abroad. These range from instant telephone assistance to the return of mortal remains.

(b) **Optional medical plan:** various titles may be given to this option, available at extra premium. The basic intention is to provide coverage for much increased limits under the various headings and categories of the Basic Plan.

(c) **Major exclusions:** there are limits to the time during which various benefits under the Basic and Other Plans may be paid, but these are part of the description of cover. Specific *exclusions* are very likely to include the following:

(i) **Pre-existing conditions**;

(ii) **Pregnancy and childbirth** related expenses;

(iii) **Drug or other substance abuse**, self-inflicted injury and sexually transmitted diseases;

(iv) **AIDS** or **HIV** related conditions (sometimes only excluded for say the first five years of the insurance);

(v) **Congenital abnormalities** treatment.

3.4.1 VOLUNTARY HEALTH INSURANCE SCHEME ('VHIS')

(a) **Background**

Fully launched, i.e. offered to consumers, on 1 April 2019, the Voluntary Health Insurance Scheme ("VHIS") is a policy initiative implemented by the Food and Health Bureau ("FHB") of the Government to regulate individual indemnity hospital insurance products, with voluntary participation by insurance companies and consumers. Under the VHIS, the participating insurance companies can offer **indemnity hospital insurance plans** ("IHIP") that have been certified by the FHB ("Certified Plans") for individual consumers to purchase voluntarily.

The VHIS is designed to bring certain benefits to consumers. By enhancing the accessibility, quality and transparency of individual hospital insurance, the VHIS provides an additional option for consumers who are willing and can afford to pay more to use private healthcare services.

(b) **Tax Deduction under the VHIS**

With the passage of the Inland Revenue (Amendment) (No. 4) Bill 2018 on 31 October 2018, taxpayers are now entitled to tax deductions under salaries tax and personal assessment for qualifying premiums they pay on or after 1 April 2019 for Certified Plans for themselves or any of their "specified relatives" – defined to cover the taxpayer's spouse and children and the taxpayer's or his/her spouse's grandparents, parents and siblings. The deduction ceiling is HK$8,000 per insured person per year, irrespective of the number of policies that cover the insured person. However, there is no cap on the number of specified relatives who are eligible for tax deductions. For instance, if the taxpayer purchases a total of four policies for four insured persons (e.g. the taxpayer himself and three "specified relatives") and the taxpayer is the policyholder of these policies, then the annual deduction ceiling would be HK$32,000 (i.e. HK $8,000 x 4) for the qualifying premiums paid.

(c) **Administration of the VHIS**

The VHIS is administered by the Voluntary Health Insurance Scheme Office ("VHIS Office") of the FHB. Insurance companies seeking to offer VHIS-compliant products must first register as VHIS Providers and, before their **Standard Plans** and **Flexi Plans** (if offered) are marketed, each plan must have been successfully certified as a **Certified Plan** (see (c)(iii) below for these three terms) by the FHB. The FHB has set out the scheme rules in a set of scheme documents for compliance by VHIS Providers:

(i) **Registration Rules for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** ("Registration Rules"): Insurance companies must be successfully registered with the FHB as VHIS Providers according to the Registration Rules before they are allowed to sell Certified Plans.

(ii) **Voluntary Health Insurance Scheme Certified Plan Policy Template** ("Policy Template"): The Policy Template illustrates the minimum requirements on the policy structure, terms and benefits of Certified Plans, including **Standard Plans** and **Flexi Plans**. Where a Certified Plan provides terms and benefits that exceed the minimum requirements, the insurance policy concerned may require additional, amended or supplementary terms that the Policy Template does not stipulate. Where an insurance policy covers not only a Certified Plan but also another insurance plan (e.g. where a Certified Plan forms a rider to a life insurance policy), the policy will contain terms and benefits that the Policy Template does not stipulate, and these terms and benefits will not be subject to the requirements of the VHIS.

(iii) **Product Compliance Rules under the Ambit of the Voluntary Health Insurance Scheme** ("Product Compliance Rules"): The Product Compliance Rules sets out the minimum product design requirements for an insurance plan to be certified as VHIS-compliant and the relevant product certification procedure. The basic principles are set out below:

(1) An individual IHIP must be certified by the FHB before it can be marketed as a Certified Plan.

(2) All **Certified Plans** must be individual IHIP. The following are some examples that are not deemed to be individual IHIP: group insurance plans with master policy for employees; outpatient insurance plans; non-indemnity insurance plans including hospital cash plans and critical illness cash plans; and indemnity insurance plans that cover specific illnesses (e.g. cancer) only.

(3) An individual IHIP can qualify as either type of Certified Plans, namely a **Standard Plan** or a **Flexi Plan**, subject to product compliance and prior certification by the FHB.

(4) The product design of a **Standard Plan** is basically fixed, save for minor allowable variations. It must offer terms and benefits equivalent to the minimum requirements of Certified Plans under the VHIS, namely **Basic Benefits**, as prescribed in the Policy Template (see (c)(ii) above).

(5) A **Flexi Plan** must provide **Enhanced Benefits** in addition to the **Basic Benefits**. The design of **Flexi Plans** must adhere to the "better-off principle" entailing terms and benefits which will bring more protection to customers when compared with a **Standard Plan** while policyholders' entitlement to the **Basic Benefits** would not be adversely affected, save for specified exceptions.

(6) Both **Standard Plan** and **Flexi Plan** may encompass a minor element of benefits other than **Basic Benefits** and **Enhanced Benefits**, namely **Other Benefits**. **Other Benefits** are allowed to form part of a Certified Plan to cater for the licensing requirement for long-term insurers to provide long-term insurance benefits (e.g. life insurance) in the individual IHIP they offer.

(7) The table below illustrates the principles in defining **Standard Plan** and **Flexi Plans**:

	Standard Plan	**Flexi Plan**
Basic Benefits	Must include	Must include
Enhanced Benefits	Must not include	Must include
Other Benefits	Optional	Optional

(8) An insurance policy issued under a Certified Plan may attach or be attached to other insurance plans (e.g. a Certified Plan serves as a rider attached to a life insurance policy). However, such other insurance plan(s) will not be considered as part of the Certified Plan, and the policy terms and conditions must not contradict with the objectives of the VHIS and must not reduce the protection of the Certified Plan to the policyholders under the same policy.

(iv) **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** ("Code of Practice"): The Code of Practice sets out the required conduct and practices covering product offering, migration arrangement, sales and marketing, handling of application, cooling-off period, after-sales

services, etc. for VHIS Providers to comply with so as to supplement the Policy Template. It is particularly important for insurance intermediaries to get familiar with the requirements of the Code of Practice on "**sales and marketing**", which are summarised below:

(1) In conducting sales and marketing activities, VHIS Providers should provide clear, accurate, non-misleading and easily accessible **information of the VHIS and Certified Plans** to consumers for them to make informed choices.

(2) VHIS Providers should ensure that all **sales and marketing materials** are accurate and in a non-misleading manner, in Chinese and English (except for social media and advertisements), in plain language and complete.

(3) VHIS Providers should ensure consumers, policyholders and insured persons can easily **distinguish terms and benefits** under Certified Plans from non-VHIS products across all sales and marketing materials.

(4) In the course of marketing Certified Plans, VHIS Providers and their sales representatives should disclose and exercise due diligence in explaining the **key product and premium information** of Certified Plans to consumers.

(5) VHIS Providers should provide an **easy access to essential information** (such as company website, communications with sales/service representatives, enquiry hotline, etc.) so that consumers can easily enquire about the information on the VHIS and the Certified Plans, e.g. their registration status as a VHIS Provider; product and premium information of the Certified Plans on offer; underwriting factors, material facts and information of consumers for underwriting purposes; eligibility for tax deduction; complaint handling procedures.

(6) VHIS Providers should inform applicants of their obligations to disclose **personal information and material facts** for underwriting, and the possible consequences of material non-disclosure, misrepresentation and fraud.

(7) Where VHIS Providers stipulate in the VHIS Certified Plan Policy Template that they may withhold part of premium refund for **reasonable administration charges**, they should explain the relevant practices and calculation to the applicants upfront.

(8) VHIS Providers should explain to applicants for Certified Plans the **cooling-off right** (see (d)(vii)(4) below) that policyholders will have during the cooling-off periods prescribed in the policies.

(9) In the case of a **Standard Plan**, VHIS Providers should explain to consumers during the selling process and upon enquiry that all benefits described in the **Standard Plan** are applicable **worldwide** except for psychiatric treatments. With **Flexi Plans** subject to restrictions in territorial scope of cover, they should instead explain the definition of regions with restrictions and the benefit adjustment rules, and that the reduction is inapplicable to the **Basic Benefits** of the **Flexi Plans**, i.e. the coverage equivalent to the **Standard Plan**.

(10) In the case of a **Standard Plan**, VHIS Providers should explain to consumers during the selling process and upon enquiry that all benefits described in the **Standard Plan** are not subject to any restriction in the **choice of healthcare services providers**. With **Flexi Plans** subject to restrictions in the choice of healthcare services providers, they should instead explain the list of selected healthcare services providers, and that the restrictions are inapplicable to the **Basic Benefits** of the **Flexi Plans**, i.e. the coverage equivalent to the **Standard Plan**.

(11) In the case of a **Standard Plan**, VHIS Providers should explain to consumers during the selling process and upon enquiry that all benefits described in the **Standard Plan** are not subject to any restriction in the **choice of ward class**. With **Flexi Plans** subject to restrictions in the choice of ward class, they should instead explain the targeted ward class and the details of benefit adjustment upon voluntary choice of higher ward classes, and that the insurance company will guarantee that such benefit adjustment will not apply in the event of involuntary ward upgrade, or to the **Basic Benefits** of the **Flexi Plans** (i.e. the coverage equivalent to the **Standard Plan**) in the event of voluntary ward upgrade.

(12) VHIS Providers should explain to consumers during the selling process and upon enquiry the **coinsurance** arrangement of prescribed diagnostic imaging tests under the **Standard Plan**, and the coinsurance and deductible arrangements approved by the FHB for eligible **Flexi Plans**, if any.

(13) Subject to the rules on tax deductions promulgated by the Government, VHIS Providers should, in the selling process and upon enquiry, inform consumers of the eligibility of Certified Plans for claiming **tax deductions**.

It is worth noting that the IA will issue a **guideline on medical insurance business (GL31) (see 3.4.2 for more details of this guideline)** to be applicable to all medical insurance business, including the VHIS. The guideline will provide guidance on the expected standard and practices to ensure fair treatment of customers.

(d) **Fundamental Features of the VHIS**

The VHIS is equipped with the following features in order for it to function effectively:

(i) Insured Persons under the VHIS must be **Hong Kong residents** (including holders of Hong Kong Identity Card) aged between 15 days and 80 years.

(ii) There are **two types of Certified Plans**: **Standard Plan** and **Flexi Plan**. The **Standard Plan** provides standardised basic coverage according to the minimum requirements of the VHIS, whereas the **Flexi Plan** provides enhanced coverage while generally preserving all the coverage provided by the **Standard Plan**. Examples of **Flexi Plan** enhanced coverage include higher benefit amounts and a choice of products that suit different consumers' needs.

(iii) **Setting of premiums** is virtually unfettered. In line with the free market principle, VHIS Providers are free to set their own premium levels. By common market practice, Certified Plans may charge **standard premiums** that differ by age and gender, and adjust the overall premium level annually according to factors like medical inflation and revisions of benefit amounts. In order to enhance market transparency and promote price competition, it is a requirement that VHIS Providers publish age-banded premium schedules for their Certified Plans.

(iv) It is **not mandatory** for VHIS Providers to accept any applications. They may underwrite the insured persons to assess their risks, and decide whether to accept the applications unconditionally, accept the applications with premium loading and/or **case-based exclusions**, or reject the applications. They are required to explain their underwriting decisions and application results to the applicants concerned and, upon the applicants' request, provide written notice for such explanations.

(v) Certified Plans' coverage is not restricted to charges of private hospitals. Insured Persons may claim reimbursement of healthcare expenses incurred in **healthcare institutions, whether public or private**. Besides, purchases of Certified Plans will not affect Insured Persons' entitlement to use public healthcare services.

(vi) Upon successful registration as VHIS Providers, insurance companies must provide their existing policyholders of individual hospital insurance with an opportunity to switch (or "**migrate**") to Certified Plans.

(vii) Compared with many existing indemnity hospital insurance products, Certified Plans are more attractive in a number of ways, as reflected by the following **product features** of both the **Standard Plan** and the basic coverage of the **Flexi Plan**:

(1) The policy terms and conditions, benefit coverage and benefit amounts are standardized.

(2) Premium transparency is enhanced by easy access to the standard premium schedule by age, gender and other factors of each Certified Plan on the VHIS website and the websites of VHIS providers. Upon policy renewal, a VHIS Provider may adjust the standard premium for a VHIS policy according to the prevailing standard premium schedule adopted by it on an overall portfolio basis. During each policy year and upon renewal, no additional rate or amount of premium loading or **case-based exclusion(s)** on the insured person may be imposed by reason of any change in the insured person's health condition.

(3) The insured is guaranteed a right of renewal up to the age of 100. Moreover, there is no "**lifetime benefit limit**" - the maximum amount of benefits that a medical insurance policy says it will pay cumulatively during the lifetime of the insured person.

(4) The policyholder has the right ("**cooling-off right**") to cancel a newly effected policy during the 21-day period (or a longer period offered by the VHIS providers) after the delivery of the policy to the policyholder or to the policyholder's representative or the issuance of notice of policy availability to the policyholder or to the policyholder's representative, whichever is the earlier, with full refund of the premiums paid provided no benefit payment has been made or is to be made or impending.

(5) Coverage is extended to include:

- **Unknown pre-existing conditions** - Pre-existing conditions not known at the time of joining are partially covered during a waiting period of 3 years upon policy inception (i.e. no coverage in the 1st policy year, 25% reimbursement in the 2nd policy year and 50% in the 3rd policy year) and fully covered from the 4th policy year onwards.

- **Treatment of congenital conditions** – Investigation and treatment of congenital conditions which have manifested or been diagnosed after the age of 8 is covered, subject to the same reimbursement arrangement that applies to unknown pre-existing conditions.

- **Day case procedures** – Surgical procedures (including endoscopy) not conducted in hospital are covered, subject to such provisos as "medical necessity".

- **Prescribed advanced diagnostic imaging tests** – Computed Tomography ("CT scan"), Magnetic Resonance Imaging ("MRI scan") and Positron Emission Tomography ("PET scan") not conducted in hospital are covered, subject to 30% coinsurance.

- **Prescribed non-surgical cancer treatments** – Chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatments are covered.

- **Psychiatric treatments** – Psychiatric treatments during confinement in Hong Kong as recommended by a specialist are covered.

3.4.2 Guideline on Medical Insurance Business (GL31)

In order to make sure that fair treatment is applied to customers when selling the medical insurance products, IA has prepared GL 31 which is regarded as minimum standards for authorized insurers, licenced insurance intermediaries, and licensed insurance brokers. In fact, IA has considered the feedback from various stakeholders, insurance industry as well as the Insurance Core Principles, Standards, Guidance and Assessment Methodology ("ICP"). Generally speaking, ICP were circulated by the International Association of Insurance Supervisors on relevant aspects and practical application of supervisory concepts.

(a) **Purpose, Application and Status**

(i) Fair treatment of customers is a crucial principle which reinforces public trust and confidence in the insurance sector. In accordance with Insurance Core Principles (ICP) 19, fair treatment of customers includes achieving outcomes such as

(1) developing, marketing and selling products in a way that concerns for the interests and needs of customers;

(2) providing customers with information before, during and after the point of sale that is accurate, clear, and not misleading;

(3) minimising the risks of sales which are not appropriate to customers' interests and needs;

(4) ensuring that any advice given is of a professional standard;

(5) dealing with customer claims, complaints and disagreements in a fair and timely manner; and

(6) protecting the privacy of information obtained from customers.

ICP 19 also shows that fair treatment of customers involves concepts such as ethical behaviour, acting in good faith and the prohibition of abusive practices.

(ii) GL31 applies to all authorized insurers underwriting medical insurance business, and all licensed insurance intermediaries carrying on regulated activities in respect of medical insurance business. GL31 applies in respect of all medical insurance business, including individual and group business, Certified Plans under the VHIS and any other types of medical insurance business. Besides, GL31 provides guidance on the standards and practices which are expected to be met in order to ensure fair treatment of customers across all aspects of medical insurance business.

(iii) GL31 does not have the force of law because it is not subsidiary legislation. Thus, it should not be interpreted in a way that would override the provision of any law. A non-compliance with the provisions in GL31 would not by itself make an authorized insurer or a licensed insurance intermediary liable to judicial or other proceedings. A non-compliance may, however, for example reflect on the IA's view of the continued fitness and properness of (1) the directors, controllers or key persons in relevant control functions of the insurers to which GL31 applies and (2) the licensed insurance intermediaries to which GL31 applies and (in the case of licensed insurance agencies and licensed insurance broker companies) their directors, controllers or responsible officers. The IA may also take guidance from GL31 in considering whether there has been an act or omission likely to be prejudicial to the interests of policy holders or potential policy holders. In addition, the IA will always take account of the full context, facts and impact of any matter before it in this respect.

(b) **Product Design**

Authorized insurers should take into account the interests and needs of different types of customers when developing medical insurance products. Before launching a medical insurance product to the market, insurers should carry out a careful review of the product by making reference to their business models; the applicable law, regulations and rules (including but not limited to the Product Compliance Rules under the Ambit of the VHIS published by the FHB); and their risk management approach. In particular, insurers should put in place appropriate policies, procedures and controls to enable them to:

(i) design a medical insurance product that seeks to meet the identified needs and the expectation of the target customer base;

(ii) price a medical insurance product reasonably taking into account the sustainability of the product; and

(iii) adopt channels of distribution which are aimed at targeting the identified target customers.

(c) **Sales Process**

After launching any medical insurance product, an authorized insurer, licensed insurance agencies and licensed insurance broker companies should monitor the processes by which the product is distributed against the requirements set out in the section 6 (Sales Process) of GL31, with a view to ensuring customers are treated fairly during the selling process. If the insurer, licensed insurance agency or licensed insurance broker company identifies any shortfall from the requirements, they should take appropriate remedial action(s).

3.5 INSURABILITY BENEFITS

Insurability means that by normal underwriting and business standards a particular risk is acceptable for insurance. The usual feature that affects this is, of course, the **health** of the person who is to be the *life insured*. Checking whether a person is insurable is a basic element in **underwriting** (see **5.3**). Sometimes the question of insurability, however, arises for an existing client (perhaps with policy **reinstatement** - see **4.7** or on other occasions). This question, however, may be avoided if the policy is made subject to the **Guaranteed Insurability (GI) Benefit**.

3.5.1 Guaranteed Insurability Option

The **GI** benefit is also referred to as a *Guaranteed Purchase Option*. The basic features of this rider are:

(a) **Meaning:** the policyowner has the right to purchase additional insurance (of course for an additional premium) on specified option dates, at specified ages, or when a specified event happens, **without** having to supply evidence of insurability.

(b) **Limitations:** the *amount* of additional cover may be limited (to the existing policy's face amount, or less). Also the right must be exercised before the life insured reaches a certain *age* (typically aged **40**).

(c) **Not automatic:** if the policyowner does not effect the extra cover when the right is triggered, that particular right is **lost**. He may, however, exercise the right when the next turn comes, if any.

(d) **Specified event:** the rider may specify the insured events as marriage, the birth of a child, etc.

(e) **Temporary cover:** some insurers grant *term insurance* cover automatically to cover the policyowner-insured during the period allowed for exercising his purchase option, so that if he dies before completing the option he will still have extra term insurance cover.

(f) **Policy with WP:** if the insurance also has a **Disability Waiver of Premium** rider (see **3.1.1**) and the policyowner-insured is disabled at the time he is entitled to exercise an option for additional cover, the additional cover will granted *automatically*. The **WP** rider also provides for **all** premiums to be *waived*, until the recovery or death of the policyowner-insured.

3.6 INFLATIONARY ADJUSTMENT

Inflation, which reduces the purchasing power of money, is an important element to be considered with any **long-term** insurance linked to a specified **face amount**. Bearing in mind that long-term policies may continue for many years, perhaps a few decades, before they become payable, it will be realised that what was once a significant amount may in real terms have been reduced to a small or even trivial sum, because of inflation.

Clearly, this is a problem needing serious attention to the whole of one's life insurance programme, but in the context of this Chapter on **Benefit Riders**, provision has been made in relation to disability income benefits being paid, as follows:

3.6.1 Cost of Living Adjustment (COLA) Benefit

This rider or policy provision provides for periodic increases in the disability income benefits being paid to disabled policyowner-insured. As the name suggests, the increases are linked to increases in a recognised independent index, such as the *Composite Consumer Price Index*.

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Representative Examination Questions

Type "A" Questions

1 The "waiting period" with a Disability Waiver of Premium rider means:

(a) a time period during which premiums are waived; .....
(b) the time allowed to a policyowner for payment of premium; .....
(c) the time period before a policy can be subject to this rider; .....
(d) a time period during disablement before premiums are waived. .....

[Answer may be found in **3.1.1**]

2 A "Double Indemnity" provision under a life policy is incorrectly named because:

(a) life policies are normally not subject to indemnity; .....
(b) the amount paid is not always double the face amount; .....
(c) it is only paid in the event of death through an accident; .....
(d) it is illegal for the beneficiary to be paid twice for the same event. .....

[Answer may be found in **3.2.1**]

Type "B" Questions

3 Which of the following remarks are **true** concerning the AD&D rider?

(i) Loss of a limb may mean the actual loss of a limb, or loss of its use.
(ii) A sum equal to the death benefit is paid for the loss of one limb.
(iii) A sum equal to the death benefit is paid for the loss of two limbs.
(iv) Dismemberment benefits can also be for the loss of sight in an accident.

(a) (i) and (ii) only; .....
(b) (i) and (iii) only; .....
(c) (i), (iii) and (iv); .....
(d) (ii), (iii) and (iv). .....

[Answer may be found in **3.2.1**]

4 Which **three** of the following are usually included within the insured events of the Critical Illness Benefit?

(i) Disability
(ii) Illness related to the immune system
(iii) Influenza
(iv) Cancer

(a) (i), (ii) and (iii); .....
(b) (i), (ii) and (iv); .....
(c) (i), (iii) and (iv); .....
(d) (ii), (iii) and (iv). .....

[Answer may be found in **3.3.1**]

[If still required, the answers may be found at the end of the Study Notes.]

4 EXPLAINING THE LIFE INSURANCE POLICY

It should be mentioned at the outset of this Chapter that the Hong Kong Life Insurance market tends to use policy wording commonly found in the United States and North America. The General Insurance market, on the other hand, mostly uses policy styles originating in the U.K. For the purposes of this study (the Life Insurance Policy), we shall follow the more common "U.S. style" policy provisions, making appropriate comments relating to possible variations should a local insurer be using U.K. style life insurance policy wording.

4.1 ENTIRE CONTRACT PROVISION

A Life Insurance Policy is a most important document. The contract is *Long Term*, i.e. lasting many years, perhaps decades. Unlike with most other classes of business, it is essential that the original policy document be presented when a claim is made. The "**entire contract**" provisions are therefore very important. They provide that:

(a) the entire contract consists of the policy, any attached riders and the attached copy of the application (such an insurance contract being termed a closed contract);

(b) only certain specified senior officials of the company are authorised to make changes to the contract;

(c) no change to the contract will be effective unless made in writing; and

(d) no change to the contract can be made unless the policyowner agrees to it in writing.

4.2 INCONTESTABILITY PROVISION

This means that within the terms of these provisions the *validity* of the contract **cannot** be contested (challenged) by the insurer. Disputes over the validity of an insurance contract may arise with an alleged breach of **utmost good faith**, i.e. certain **material facts** have been omitted or misrepresented.

(a) The typical **Incontestability Provision** (or **Incontestable Clause**) states that the insurer will not (normally - see below) contest the contract after it has been in force during the lifetime of the life insured for *two years* from the date of issue. (If the phrase ‘during the lifetime of the life insured’ was omitted and the life insured died during the contestable period, the beneficiary might possibly delay making a claim until the end of this period and seek protection of the provision);

(b) Under Hong Kong law, an Incontestable Clause cannot be relied upon in the event of *fraud* on the part of the claimant or the insured. Hong Kong law will not support fraud, whatever a contract may say.

[**Example:** suppose a life insurance policy is arranged solely on the basis of the health and other information declared by the policyowner-insured. He fails to reveal certain **material** information such that a prudent underwriter would not have insured him. The man dies after three years. Under the normal rules of **Utmost Good Faith,** the insurer could avoid the contract. Nevertheless, it cannot do that because of the overriding effect of the incontestability provision. However, if the policyowner's failure constitutes a fraudulent breach of the duty of utmost good faith, the insurer may disregard the provision and avoid the contract if the applicable law is that of Hong Kong.]

Case 6 The Incontestability Provision often serves as an effective shield against an insurer's attempt to repudiate liability on the basis of breach of the duty of utmost good faith

The policyowner died of nasopharyngeal carcinoma three years after he had effected a life policy. It was revealed that he attended a medical examination by the insurer's medical officer in the morning four days after he had signed an insurance application. In the afternoon of the same day, the insured consulted a private doctor, complaining of swelling of right neck gland and blood in post-nasal drip sputum for one month. The diagnosis of nasopharyngeal carcinoma was suggested. However, the insured failed to disclose any of the above symptoms on the application form or during the medical examination. The insurer therefore refused to pay the death benefit on grounds of material non-disclosure.

The wife of the policyowner stressed that her husband consulted the private doctor just because he did not feel well that afternoon. The consultation was not a pre-scheduled appointment. As the insured often contracted flu and cold in the previous months and his symptoms were very similar to those of flu and cold, he, not being a medical expert, believed himself to be suffering from flu and cold again. Moreover, he disclosed on the application form that he had previously suffered from flu and cold and had recovered after taking medicine. This served to prove that he had fully disclosed all his medical information to the best of his knowledge at the time of the insurance application.

The Complaints Panel noted that the questions on the application form that related to the alleged non-disclosure specifically asked about "disease" suffered or treated for. Although the policyowner presented himself as a result of certain symptoms, there was no evidence suggesting that he had failed to disclose on the application form a known or diagnosed disease. Therefore the Complaints Panel was convinced that the insured had honestly completed the application.

Further, the Complaints Panel found no warning clause on the application form that had imposed on the policyowner an obligation to notify the insurer of changes in his health condition occurring after signing the application form and before issuance of the policy, which condition in this instance deteriorated soon after the application was signed.

More importantly, there is a two-year contestable period applicable to life insurance policies, beyond which a policy cannot be rescinded unless fraud is proven. The policyowner passed away more than two years after his insurance policy came in force. As no evidence had been put forward to the Complaints Panel to suggest the presence of fraud, the Complaints Panel concluded that the incontestability provision should be invoked.

Based on the above, the Complaints Panel ruled in favour of the claimant and awarded her the death benefit.

Remarks: *The claimant won her case on two alternative major grounds. Firstly, the Complaints Panel decided that the policyowner had not been in breach of the duty of utmost good faith. At law, the proposer is only required to disclose such material facts that he actually knows or ought to know. Apparently the Complaints Panel considered that the symptoms that the policyowner had at the time when he was signing the application form or undergoing the medical examination would not constitute material facts that he actually knew or ought to know. In addition, unless varied by private agreement, the duty of disclosure extinguishes as soon as the insurance contract is concluded. The Complaints Panel was apparently of the view that the subject insurance contract was concluded when the application was signed – not when the policy was issued, so that the diagnosis shortly after that critical moment, even though being material facts, would not be required to be disclosed to the insurer. Second, even if breach of the duty of utmost good faith on the part of the policyowner had been established, he should be allowed to take advantage of the Incontestability Provision unless fraud could be proved against him.*

(c) Such a clause would not have the effect of preventing the insurer from raising the question of illegality, e.g. for lack of insurable interest.

(d) An **Indisputable Clause** (the UK equivalent of the **Incontestability Provision**) has been held by the English courts to be incapable of preventing an insurer from avoiding liability on grounds of negligent misrepresentation on the part of the insured unless the clause expressly mentions negligence or the clause does not otherwise make sense.

4.3 GRACE PERIOD

Under U.K. style policies, this is also called **"Days of Grace"**. Essentially, this relates to a period of time after the date on which a premium is due, when cover is kept operative. But for this grace period provision, the policy would **lapse** if the premium is not paid by the due date. So it allows for a *late payment* of premium without penalty. The features of these provisions are:

(a) the grace period is usually a minimum of **30** or **31 days**;

(b) the grace period does not apply to the initial premium for the policy;

(c) payment of premium within the grace period is deemed to be payment *on time*;

(d) this is **not** a period of *free insurance*; for example:

(i) if the life insured dies within the grace period before payment of the premium, the premium due will be deducted from the death benefit payable;

(ii) if the life insured survives the grace period without paying the premium due (and subject to any other policy provisions, such as nonforfeiture, see **4.5** below), a U.K. style policy will lapse from the date the premium was due, whereas a U.S. style policy will lapse at the end of the grace period (giving rise to "free insurance" for one month).

(e) special provisions may arise with non-traditional types of policy, e.g. *universal life policy*.

4.4 BENEFICIARY DESIGNATION

A **beneficiary** is a person to whom the policyowner of a life policy instructs the insurer to pay the death benefit when it is due. A fundamental condition for the payment is that the beneficiary must survive the life insured. In practice, there are various types of designations and beneficiaries:

(a) The beneficiary is usually *named* in the policy. But *class designations* (i.e. identification of a certain group of people as beneficiaries instead of naming each of the persons) can alternatively be done. Examples of class designation include "my children", and "my brothers and sisters".

(b) The *primary* (or *first*) beneficiary receives the death benefit, when payable (if more than one is designated, shares will be equal unless otherwise specified in the policy). One or more Contingent Beneficiaries may be designated in addition to primary beneficiaries, in case all the primary beneficiaries do not survive the life insured.

(c) A life policy usually allows the policyowner to change the beneficiary designation whilst the policy is in force, in which case the designated beneficiary is called a "**revocable beneficiary**". Alternatively, he may have a provision included in the policy making the designation irrevocable so that a change of beneficiary will require the written consent of the current beneficiary. Turning back to the usual policy wording, which allows a beneficiary designation to be revoked, equity will not allow the act of naming a substitute beneficiary in such a policy to prejudice any vested, beneficial interest of the original beneficiary, even if such an act is strictly within the terms of the contract. For instance, effecting a life insurance policy for the benefit of the policyholder's spouse and/or any of his or her children will have the effect of creating a (statutory) trust under the Married Persons' Status Ordinance, so that the spouse and/or the children will become beneficial owners of the policy, with the policyowner as the trustee. Under the strong protection of equity, these beneficial interests can simply be

viewed as gifts (or "gifts inter vivos", to be more precise, with "inter vivos" meaning "among living people") that even the donor (policyowner) himself cannot take back! This is because these interests are now parts of the respective estate of the beneficiaries, whether or not the beneficiaries will survive the life insured being irrelevant.

(d) The wording of the typical beneficiary designation provision is apparently simple, giving rise to a general belief that any payable death benefit will certainly be paid to the beneficiary. In fact, a situation of conflicting claims may arise, possibly from policy beneficiaries, assignees, trustees of the policy, trust beneficiaries, trustees-in-bankruptcy, and personal representatives. An insurer in such a situation will face the risk of having to pay claims twice by taking it for granted that the beneficiary designation provision is paramount.

4.5 NONFORFEITURE BENEFITS

Most conventional life insurance plans (other than **term** insurance plans) acquire a **cash value** after an initial period in force. That cash value is important for a number of reasons, discussed elsewhere in these Study Notes, and has special relevance to the question of **nonforfeiture**. If something is "forfeited", it means that it is lost or rights to it are taken away. "Nonforfeiture" therefore means that rights are not lost under certain circumstances, in this instance the *discontinuance of premium payments*.

Without specific provisions to the contrary, the policy will **lapse** if the premium is not paid within the **grace period**. The customary nonforfeiture provision is that:

(a) the policy does **not** lapse because of non-payment of premium. Unless instructions are received to the contrary, the **cash value** of the policy is used to pay due premiums for as long as the cash value lasts, keeping the policy in force for the full amount;

Note: Some insurers do not regard this as a nonforfeiture benefit, but treat it as a quite separate policy provision known as an *automatic premium loan* (**APL**) provision.

(b) the owner of a policy which has a cash value or dividend value, who decides not to pay any more premiums, may exercise any one of the following *options*:

(i) *cash surrender value* (also known as *surrender value*): the cash surrender value is paid when the policyowner terminates the policy;

(ii) *reduced paid-up insurance*: the net cash value is used as a single premium to purchase life insurance of the same plan as the original policy for a lower amount of cover;

(iii) *extended term insurance*: the net cash value is used as a single premium to purchase term insurance for the same amount as the original face amount, for such period as the net cash value can provide.

Note: These options arise when the insurer receives notice of a decision to discontinue premium payments. If premium payments merely stop, with no notice of selection from the policyowner, the automatic provision in (a) above, if any, will be triggered. Those policies that have no such clause often provide that option (b)(iii) above should apply automatically if the policyowner has failed to choose one of the options.

4.6 POLICY LOAN

Another feature directly arising from the existence of a policy **cash value**, is the facility of borrowing money from the insurer, using the cash value as security. The concept arises with the **APL** feature mentioned in **4.5**(a) above, but the customary **Policy Loan** provisions are:

(a) the policyowner has a *right* to borrow money from the insurer;

(b) the loan may be for *any purpose*;

(c) the loan may be up to the policy *cash value* (less one year's loan interest);

(d) the only *security* required for the loan is the policy cash value;

(e) the applicable interest rate may be subject to a prescribed maximum;

(f) the amount and timing of any repayments are at the discretion of the policyowner, and any unpaid interests will become part of the policy loan;

(g) the amount of any outstanding loan (including any unpaid interests) will be deducted from the death benefit or surrender value that is payable.

4.7 REINSTATEMENT

Under U.K. life insurance practice, this is also known as **"Policy Revival"**. The concept is that a policy which has *lapsed* ("died") can be brought back to "life" under certain circumstances. Of course, this can always happen by the *mutual consent* of the insurer and the policyowner. The term "reinstatement", however, in this context concerns the *right* of the policyowner to have a lapsed policy brought back into force. The usual policy provisions which apply to this are:

(a) there is a time limit within which this may be demanded;

(b) that period during which the right can be exercised may vary between insurers, but **5 years** is quite representative;

(c) the right normally applies only to **lapsed** (not **surrendered**) policies;

(d) the reinstatement may be subject to any of the following *conditions*:

  (i) evidence of continued *insurability* (good health);

(ii) *repayment* of any outstanding loan (inclusive of interests);

(iii) payment of *back premiums*, plus interests thereon to be charged at a prescribed rate;

(iv) payment of a reinstatement *fee*;

(v) a further *contestable period* (see **4.2**) from the reinstatement date;

(vi) a further *suicide exclusion period* (see **4.12**) from the reinstatement date.

4.8 MISSTATEMENT OF AGE OR SEX

Please note that this is a *misstatement* of age or sex. In the event of a voluntary sex change operation to an existing life insured, the advice of the insurer concerned should be obtained.

Obviously, a different age or sex from that indicated when the insurance was arranged can have a significant impact on the policy premium and/or benefit. The customary provisions in these circumstances are:

(a) *If the error is discovered after a claim has arisen*: the amount of the benefit payable is adjusted (up or down) to reflect the amount payable had the correct age/sex been given and the same premium paid.

Note: If the insurer follows the commonest practice in the U.K. on this issue, any benefit adjustment could only be *downward*. If the age/sex mistake indicates that too much premium has been paid, the overpaid premium will be *refunded* (without interest) without an upward adjustment to the benefit payable. Again, this might be a point to check with any insurer using U.K. policy forms, etc.

(b) *If the error is discovered before a claim arises*: the policyowner is usually given the choice of:

(i) leaving the face amount unchanged and either receiving a refund premium or paying an extra premium after calculating the correct premium that should have been paid; or

(ii) adjusting the face amount of the policy to the amount which the premium paid would have purchased at the correct age or sex.

Note: The U.K. practice on this point will be the same.

4.9 ASSIGNMENT

Section 9 of the Law Amendment and Reform (Consolidation) Ordinance allows the assignment of a legal chose in action (see **Glossary**) by following a prescribed formality, with interests in an insurance contract constituting choses in action. Among the criteria for a valid legal assignment is one that the chose in action to be assigned must be present, not future; and it has been held that interests in a life insurance contract are present and are capable of assignment. As an alternative to the 'present' description, it is said that interests in a life insurance contract are reversionary, that is to say, even though the policyowner's rights under the contract are unquestionably recognised, the actual enjoyment of the insurance is deferred until some date or event in the future. When an assignment happens or is attempted, the policyowner is termed the '*assignor*' and the person on the other side of the deal the '*assignee*'. Assignment can be performed so as to execute a contract or a gift.

Certain features of assignment that we should note, arising from policy provisions and otherwise, are as follows:

(a) **Notice of assignment:** an assignment is valid from the date of notice given to the insurer. A typical life insurance policy contains an assignment provision, which, without intending to prevent an assignment, says that the insurer is not bound to act in accordance with an assignment until it receives a written notice of it.

(b) **Validity of an assignment:** the said assignment provision disclaims insurer's responsibility for this; this implicitly is saying that the assignor should seek independent legal advice on the formalities required for a valid assignment.

(c) **Rights of the assignee:** the assignee inherits from the assignor all his rights and remedies upon a valid assignment. However, the assignee cannot recover more than the assignor, so that where an assignor has purchased insurance by fraud or misrepresentation, the insurer can set up a defence against the assignee. Besides, the insurer can enforce against the assignee any of its right to set off against the assignor, so that when any policy benefit is payable to the assignee any overdue premiums from the assignor and outstanding policy loans to the assignor together with interests thereon will be deducted from the benefit, in which case the assignee is said to receive the *net policy proceeds*.

(d) **Assignment is of benefit, not burden:** the laws do not allow a person to assign to another person an obligation that he owes to a third person (e.g. an obligation to pay insurance premiums) without the third person's consent.

(e) **Limitations on assignment:** an assignment

  (i) must not violate any *vested right* of any **beneficiary** (especially of any **irrevocable beneficiary** - one that cannot be changed without his consent). It is important to note that through a revocable beneficiary designation, what the designated beneficiary will acquire is a mere expectation to receive benefit, as opposed to a vested right or interest;

  (ii) must not be for *illegal* purposes (e.g. money laundering);

(iii) may be restricted to involve *only* a **lump sum** payment of policy benefit to the assignee, i.e. no other settlement options.

(f) **Types of assignment:** life insurers categorise assignment into two types:

(i) **absolute assignment:** where all ownership rights under a life insurance contract are irrevocably assigned, such an assignment is termed an absolute assignment;

(ii) **collateral assignment:** the arrangement is *temporary*, usually where the policy is used as **collateral security** for a loan (**not** from the insurer). The terms of such an assignment limit the assignee's interest to the *loan plus interests* thereon, and give the assignor a right of reversion once the loan is repaid in full. The assignor is not entitled to acquire a **policy loan** or **surrender** the policy whilst a notified collateral assignment is in force.

4.10 DIVIDEND OPTIONS

Participating policies (known in the U.K. as *"with-profit"* policies), in due time, should qualify for dividends, which are distributed in three ways: cash dividend, reversionary bonus and terminal bonus (see **5.2.7**). **Cash dividends** become payable to the participating policyowner immediately. However, the policy normally presents some options in respect of cash dividends, so that they may be:

(a) paid in *cash* at once;

(b) applied towards *future premiums* of the policy;

(c) left with the insurer to earn *interest* (**note**: dividend deposit (inclusive of the interests thereon) is distinct from cash value);

(d) used to buy *paid-up* additional insurance, which will generate dividends as well;

(e) used to purchase *one-year* term insurance.

Note: If the policyowner makes no selection from the available options, most policies make provision for what is known as an *automatic dividend option* to apply. In Hong Kong, practice seems to vary, but the likely alternative applications are:

(i) option (c) above, leaving the dividends with the insurer to earn interest; or

(ii) option (d) above, the purchase of paid-up additional insurance.

Insurance intermediaries should check with the insurers.

4.11 SETTLEMENT OPTIONS

When the policy benefit becomes payable, the beneficiary and/or policyowner may choose between several alternative methods of receiving the proceeds ("**settlement options**" or "**optional modes of settlement**"). These are:

(a) a *lump-sum settlement*: a single payment, to complete the whole contract;

(b) an *interest option*: the policy proceeds are left with the insurer, who pays interest annually or at agreed more frequent intervals;

(c) a *fixed period option*: the policy proceeds (and interests) are paid in instalments of equal amounts over an agreed period of time - effectively this is an option of purchasing an *annuity certain* with the policy proceeds as a single premium;

(d) a *fixed amount option*: the insurer pays equal instalments of a stated amount for as long as the policy proceeds (and interests) last;

(e) a *life income option*: the policy proceeds (and interests) are paid in agreed instalments over the payee's lifetime - effectively this is an option of purchasing a *life annuity* (see **2.3.1**(c)) with the policy proceeds as a single premium. Under this method, the payee should expect smaller instalment payments than would be available under the fixed period or fixed amount option.

4.12 SUICIDE EXCLUSION

One of the features of life insurance is that the benefit may be payable even if the cause of the claim was the *deliberate act* of the life insured. This arises from the underlying reason for life insurance, which originally was primarily to make provision for dependants, rather than to benefit the life insured personally.

With a long term contract and under those circumstances, it would be unfair to penalise the family in the tragic event of the life insured taking his own life. On the other hand, certain safeguards against the effecting of life insurance with suicide in mind are perfectly reasonable. The usual provisions are:

(a) suicide is *excluded* for an initial period of the policy;

(b) that period may vary with insurers, but *1 year* after the date the policy is issued is very representative;

(c) should suicide occur *after* that period, the death benefit is payable as normal;

(d) should suicide occur *during* that period, the death benefit is not payable, but it is normal for the policy to state that premiums paid (less any outstanding loan and interests) are *refunded*.

Note: 1 Being a policy exclusion, it is for the insurer to *prove* that death was by suicide - not always an easy thing to do.

2 Bearing in mind the overall intention of the exclusion (to defeat arranging a policy when suicide was contemplated), it is not unknown for an insurer to pay for a proved suicide which can reasonably be assumed to be attributable to events arising *after* the policy commenced, and which will otherwise be caught by the exclusion. Of course, this would be *ex gratia payment* (i.e. not legally required) and the circumstances would have to be quite unusual.

3 Suicide was but is no longer criminal.

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Representative Examination Questions

Type "A" Questions

1 Under "The Entire Contract" provision, changes to the contract:

(a) cannot be made at all; .....
(b) can be done only if the policyowner agrees; .....
(c) can be done if the policyowner requests it; .....
(d) can be made if senior officials of the insurer say so. .....

[Answer may be found in **4.1**]

2 A "Grace Period" is also known as:

(a) days of grace; .....
(b) the cooling-off period; .....
(c) the nonforfeiture clause; .....
(d) the payment of benefit period. .....

[Answer may be found in **4.3**]

Type "B" Questions

3 Which of the following are nonforfeiture options?

(i) Cash surrender value
(ii) A lump-sum settlement
(iii) Extended term insurance
(iv) Reduced paid-up insurance

(a) (i) and (ii) only; .....
(b) (i), (ii) and (iii) only; .....
(c) (i), (iii) and (iv) only; .....
(d) (i), (ii), (iii) and (iv). .....

[Answer may be found in **4.5**]

4 Which of the following are dividend options?

(i) Cash payment
(ii) Left with insurer to earn interest
(iii) Used to buy paid-up additional insurance
(iv) Used to purchase one-year term insurance cover

(a) (i), (ii) and (iii) only; .....
(b) (i), (iii) and (iv) only; .....
(c) (ii), (iii) and (iv) only; .....
(d) (i), (ii), (iii) and (iv). .....

[Answer may be found in **4.10**]

[If still required, the answers may be found at the end of the Study Notes.]

5 LIFE INSURANCE PROCEDURES

5.1 COMPANY OPERATION

The way a company operates is determined by the company itself and there is no set pattern or formal structure that must be adopted. Therefore, the following comments are only *representative* of a company's operations. Before looking at the internal organisation of a typical life insurer, however, we should just mention two important types of company, according to their *constitutional* basis:

(a) **Mutual insurance companies:** a *mutual* insurance company has no **shareholders**. Legally, it is owned by its *participating policyholders* (i.e. owners of participating policies (see **1.3.1b**(a))), and controlled by its Board of Directors and senior management. Being a mutual has certain advantages, especially for policyholders, who do not have to share company profits with shareholders. It has certain disadvantages as well, particularly with regard to the raising of new equity capital, should this be required.

Note: The fact that a company has the word "Mutual" in its title is not conclusive evidence that it **is** a "mutual", as defined above. Whilst this may well be the case, and all companies having "Mutual" in their title undoubtedly began as such a business unit, some "mutuals" world-wide have *de-mutualised*, changing their constitutional status, to become as below.

(b) **Proprietary** or **stock companies:** these companies are much more common business structures, consisting of a limited liability company owned by its shareholders. "Limited liability" means that the shareholders cannot be compelled to contribute anything further towards company losses or capital requirements once their shares are *"fully paid-up"*.

5.1.1 Typical Company Operational Structure

Since company structures cover a great number of inter-related activities and there is no set pattern to follow, we shall briefly mention various departments or functions, in alphabetical order only:

(a) **Accounts department:** according to company policy and structures, an Accounts department may represent the relatively routine (but **important**) role of *bookkeeping* and *financial record* maintenance, or (more likely) it will include **Management Accounting**, with responsibilities in the key areas of *budgeting* and *investment*, etc. Standard functions of the Accounts Department include:

(i) *Receipts*: monitoring and recording all payments due to the company, by way of premiums, reinsurance recoveries, loan repayments, etc.

(ii) *Payments*: monitoring and recording all payments to be made by the company, including claims, salaries, agency commissions, purchases, etc.

(iii) *Financial returns*: every insurer must submit audited accounts each year, as required by the Insurance Ordinance. This is a major function and responsibility of the Accounts department.

(b) **Actuarial department:** as mentioned before, life insurance is profoundly involved with mathematical calculations and projections. The actuarial department therefore has a key role in company operations, its involvement including:

(i) *Product pricing*: probably sub-divided between the various major types of product offered, e.g. Individual Life, Group Life, Health, Personal Accident and Retirement Benefits.

(ii) *Valuation*: a **core function**, required by statute, valuation consists of the calculation of the values of **assets** and **liabilities**. The way this is done is critical to the *solvency margin* of the company and the determination of the divisible surplus, from which **dividends** or **bonuses** can be declared. (It is the Board of Directors that makes the actual decisions on declaration of dividends or bonuses.)

(iii) *Claims and reinsurance*: calculations and projections of reserves and needs in these areas are obviously of great importance.

(iv) *Management reporting*: this could be within the area of the company accounting staff, but whoever performs the function, it is a critical one. Unless top management are supplied with reliable data on reserves, surpluses and other key matters, effectively the company cannot operate (at least not efficiently, and that probably means "not for long"!).

(c) **Agency training and control:** the majority of individual life insurance plans are sold through insurance agents. They at one and the same time represent almost the "lifeblood" of the company, and a major responsibility regarding their appointment, training and discipline. Details of requirements are given elsewhere in these and other Study Notes, but very important matters in this area include:

(i) *Training programmes*: arranging, organising and administering, with all the logistics and personnel details involved.

(ii) *Examinations*: both with regard to their being accepted as insurance intermediaries (this Insurance Intermediaries Quality Assurance Scheme, for example) and other professional qualifications.

(iii) Resources and facilities: the provision of suitable materials, premises and opportunities for training and career development has obvious applications.

(d) **Claims:** without claims we have no business! Perhaps a slight oversimplification, but there is truth in the remark. This important area includes:

(i) *Routine administration*: all the required enquiries, checking and general supervision to confirm all is in order.

(ii) *Various types of claim*: such as death claims, maturities and surrenders, which may require different kinds of expertise.

(iii) *Investigative work*: sometimes detailed forensic or other enquiries need to be made in verifying the validity of a claim.

(e) **Client service** (also known as **policyowner service**: see **5.5**): This involves a variety of functions, including:

(i) *Changes to policies*: these may relate to **financial** or **non-financial** changes, all of which are important to efficiency.

(ii) *Communication*: this will involve both correspondence and telephone/personal enquiries, and **complaints**.

(iii) *Documentation*: policy duplicates (with all attendant checks and enquiries) and other document requests.

(iv) *Policy renewals*: the important process relating to the **retention** of business.

(f) **Marketing**: This is a general term that can signify many things. It usually includes:

(i) *Product research*: and development of new products.

(ii) *Promotions/publicity*: producing the materials and physically attending to all logistic and other details involved.

(iii) *Advertising*: closely related to (ii) but with special features such as media involvement and sponsoring.

(iv) *Public relations*: news conferences, media interviews, public talks and seminars, for example.

(v) *Market research*: examining needs, demands and results.

(g) **Underwriting:** this is considered as a technical exercise in **5.3** below, but as an element in company operations this department includes:

(i) *Risk assessment*: the technical matter of risk selection, rating and imposing terms, as necessary.

(ii) *Medical requirements*: arranging and monitoring such medical examinations and related documentation as may be required.

(iii) *Reinsurance*: the extent to which reinsurance may be required or arranged with individual risks.

Note: The above departments are representative, as previously mentioned. They do not form a comprehensive list and are not intended to represent the operational structure of any particular insurer.

5.2 APPLICATION

Some insurers might refer to an application as a *proposal*. Either term may be found in the Hong Kong market, although "application" is perhaps more widely used. Both refer to the request for insurance cover from an intending policyowner. A number of significant issues and considerations are involved with this important matter, made more important by the fact that a life insurance contract cannot be **cancelled** by the insurer once it becomes operative.

5.2.1 Application Procedure

Competition and the desire for efficiency have led to questions on the application being kept to the minimum. Often, questions are phrased so that a **"No"** answer means that no further enquiry needs to be made in that topic, whereas a **"Yes"** answer may need further details or enquiry.

(a) **General rules for application procedures:** the application/proposal is the main, and sometimes virtually the *only*, source of information for underwriting purposes. The insurance intermediary should therefore take great care in his advice and general assistance to the client when the form is being completed, noting the following:

(i) All **material facts** should be given. "Yes" answers in response to enquiries on health and other matters must be accompanied by full explanations, including any relevant dates (see: **1.2.2**).

(ii) Normally the applicant should complete the form **personally**. Sometimes the insurance intermediary is asked to assist by writing things at the client's dictation. Great care must be taken with this, to ensure that the client realises that the form is **his** statement and the answers are **his**.

(iii) **Alterations** and amendments should be avoided, if possible. If not, they must be very clear. Anything incorrect must be clearly crossed through or deleted and the alteration should be **signed and dated** by the applicant. (A replacement form may be advisable in many cases.)

(iv) **All** questions should be answered, as fully as required. Failure to observe this rule can only result in delay. Information with life insurance is too important to be waived.

(b) **Key points to be considered:** Some areas requiring special attention include:

(i) The **desired commencement date** should be clearly indicated. It is normal for insurers to allow a policy to be back-dated for a certain period (which may vary with the insurer concerned).

(ii) The **identity** of the applicant and life to be insured is important to establish. Any available **Identity Card** (or equivalent document of identification) should be inspected by the agent (some insurers require a copy to be attached to the application).

(iii) **Age next** (or sometimes **last**) **birthday** is an important element affecting the premium. Sometimes in Hong Kong this may not be easy to establish. It is not uncommon to find that only the year of birth is known. In that event, cautious insurers are very likely to regard the birthday as being the 1st January that year.

(iv) **Other personal details**, including occupation, residential address and family medical history all have a significance which is self-explanatory.

(v) **Signature** of both the applicant and the life to be insured (if different) must be obtained. If an intended signatory cannot write, an appropriate mark or chop is acceptable, but this must be witnessed by two persons (one of whom may be the insurance intermediary).

(c) **Supplementary requirements:** these may involve a number of issues, detailed instructions about which will be supplied by the insurer. Some areas likely to be involved, however, include such matters as:

(i) **Life underwriter's report:** signed by the insurance intermediary, and including the reason for the purchase and the length of his acquaintance with the client.

(ii) **Mode of premium payment:** whether autopay facilities apply.

(iii) **Proof of insurability:** establishment of an **insurable interest**.

(iv) **Underwriting forms:** additional questionnaires for "Yes" replies relating to certain conditions, or other matters (e.g. hazardous sports).

5.2.2 Receipts and Policy Effectiveness

The fact that a life insurance policy cannot be cancelled by the insurer once it has commenced is a matter of recurring importance. In connection with **receipts** issued by insurers, for example, in Non-Life insurance a receipt is merely an acknowledgement that some money has been received. This is not inevitably connected with the *inception date* of the insurance, which could have **already** commenced some time ago, or could be intended to commence in the future. Moreover, even if the (Non-Life) policy has commenced, there is usually a policy condition allowing **cancellation** if need be. Not so with **Life Insurance**.

In life insurance, a *premium receipt* is a written acknowledgment that an insurer has received the initial premium submitted with an **application** for insurance. There are **two** types of premium receipt which are in common use:

(a) **Conditional premium receipt:** with this type of receipt, the insurer agrees that the insurance will commence *at the time of application*. **BUT** this is true only **provided** that the applicant is subsequently found to have been insurable on *standard terms* at the time of application. Two things follow from this:

(i) if the applicant is found to be insurable, but **only** for a *different* plan, premium or amount of cover, then the insurance is **not** effective from the *date of application*. Technically, we may say that the **offer** has not been **accepted** on its exact terms, so the contract does not commence until any *revised terms* have been agreed;

(ii) if the applicant, **subsequent** to the application becomes *uninsurable* or even *dies* he **is** covered provided he is found to have been insurable *at the time of application*.

(b) **Binding premium receipt:** this may be known by other names, such as a *Temporary Insurance Agreement* (TIA) or an *Unconditional Premium Receipt*. Whatever the title used, the basic features surrounding such a receipt are:

(i) this represents a **contract**, *separate from any subsequent insurance policy* that may be issued;

(ii) cover **begins** from the date the *application* was signed and the date that the *premium* was paid;

(iii) cover is **not conditional** upon the applicant subsequently proving to be, or to have been, *insurable*; **but**

(iv) cover is **limited** to a maximum specified *number of days* (say **60** or **90** days);

(v) the cover may terminate **earlier** than the final day of the period specified:

(1) from the date the insurer *returns the premium*;

(2) a specified number of days after *mailing* a notice of termination to the applicant;

(3) from the date when coverage begins under the *issued policy*.

Note: In Non-Life insurance a similar document is used to give **temporary**, unconditional but **cancellable** cover. There it is called a **Cover Note**, although it is usually only for 30 days cover and may or may not be conditional upon any premium payment.

5.2.3 Client Service - Policies and Standards

Client service has been described as the range of activities a company engages in to keep its customers satisfied.

5.2.3a The Importance of Client Service

This may have a number of considerations, including the following:

(a) *Customer loyalty*: the customer who is happy with you tends to stay with you. Continuity and the **conservation** of business are very important in life insurance, where the most of the costs and expenses are "up front" (when the policy is first arranged).

(b) *Customer "prospecting"*: "prospecting" may be described as the search for new customers. If existing customers are happy with you, they immediately become your "unpaid prospectors" with their friends and families.

(c) *Productivity/Profitability*: quality service leads to fewer mistakes and fewer complaints. That in itself means that effort can be directed to more productive activity, with its consequent impact on profitability.

5.2.3b How to Achieve Quality Client Service

There is no simple answer to this, but certainly the following will greatly assist in achieving desired goals in this area:

(a) *Corporate culture*: this should always be **customer-orientated**.

(b) *Delegation*: of adequate and appropriate **authority** and **accountability** to front-line employees.

(c) *Systems*: should be created to monitor **customer satisfaction**.

(d) *Training*: and technology appropriate to these goals should be available.

Note: The above recommendations apply primarily to the insurer, but the underlying principles are easily adapted and applicable to insurance intermediaries.

5.2.4 Cooling-Off Period

One of the popular conceptions, and certainly a popular fear in the general public, is that life insurance salesmen may be too assertive, even aggressive, in their selling. The perceived result from this could be that a person might be pressurised into purchasing a life insurance that he does not really want, or cannot really afford.

To counteract this perceived possibility, the Insurance Authority ("IA") issues the Guideline on Cooling-off Period (GL29) pursuant to section 133 of the Insurance Ordinance (Cap. 41) ("Ordinance") and its principal function to regulate and supervise the insurance industry for the protection of policy holders.

The following are the major provisions of GL29:

(a) Scope of Application

(i) GL29 applies to all authorized insurers carrying on long term business, and all licensed insurance intermediaries carrying on regulated activities in respect of long term business.

(ii) GL29 applies to all new life insurance policies, except for the following types of insurance policies:

a. group policies; and

b. any policies of the nature specified in Class G, Class H and Class I in Part 2 of Schedule 1 to the Ordinance.

(iii) Further, GL29 does not apply to the following life insurance policy related transactions:

a. a premium increase for an increase in sum assured in respect of an existing policy;

b. an increase in sum assured by way of indexation under the terms and conditions of an existing life policy;

c. a new rider being added to an existing life insurance policy; and

d. a policy holder exercising his/her conversion rights under the terms and conditions of an existing life insurance policy (e.g. a right to convert a term basic or term rider into a whole of life policy).

(b) Cooling-off Period

(i) For the purpose of GL29, the Cooling-off Period is a mechanism in relation to a life insurance policy to which GL29 applies which allows the policy holder to cancel the policy within the 21 calendar day period and obtain a refund of premium.

(ii) The Cooling-off Period is to be drawn to the attention of the policy holder, by means of:

a. a statement in relation to the Cooling-off Period to be included in the application form for the life insurance policy, in accordance with paragraph (e);

b. a reminder to be included with the life insurance policy, in accordance with paragraph (f), when the policy is delivered; and

c. the delivery to the policy holder (or the nominated representative of the policy holder) of the Cooling-off Notice by the authorized insurer.

(iii) The Cooling-off Period should commence by the delivery to the policy holder or nominated representative of the policy holder, of:

a. the life insurance policy (together with the reminder of the Cooling-off Period as stated in paragraph (f)); or

b. the Cooling-off Notice,

whichever is the earlier.

(iv) The Cooling-off Period is the period of 21 calendar days immediately following the day of the delivery to the policy holder or the nominated representative of the policy holder, of:

a. the life insurance policy; or

b the Cooling-off Notice,

whichever is the earlier. For the avoidance of doubt, the day of delivery of the life insurance policy or the Cooling-off Notice is not included for the calculation of the 21 calendar day period. However, if the last day of the 21calendar day period is not a working day, the period shall include the next working day.

(v) In order for the Cooling-off Period to commence within an appropriate time-frame of the date of issue of the life insurance policy:

a. where the life insurance policy is to be delivered by the authorized insurer directly to the policy holder (or the nominated representative of the policy holder), the authorized insurer should deliver the policy within 9 calendar days of the date of issue of the policy (the "**9 calendar day period**");

b. where the life insurance policy is to be delivered to the policy holder (or the nominated representative of the policy holder) via a licensed insurance intermediary,

(1) the authorized insurer should provide the policy to the licensed insurance intermediary sufficiently in advance of the end of the 9 calendar day period, to enable the licensed insurance intermediary to deliver the policy to the policy holder (or the nominated representative of the policy holder) within the 9 calendar day period; and

(2) on receipt of the policy, the licensed insurance intermediary should use all reasonable endeavours to deliver the policy to the policy holder (or the nominated representative of the policy holder) within the 9 calendar day period;

c. the authorized insurer should deliver the Cooling-off Notice directly to the policy holder (or the nominated representative of the policy holder) within the 9 calendar day period; and

d. if the last day of the 9 calendar day period is not a working day, the period shall include the next working day.

(c) Right to Cancel during the Cooling-off Period

(i) A policy holder has the right to cancel the life insurance policy at any time within the Cooling-off Period and obtain a refund of premium. To exercise this right of cancellation, the policy holder would need to provide written notice directly to the authorized insurer requesting cancellation of the policy and return the policy, if applicable.

(ii) For all life insurance policies to which GL29 applies (except policies of the nature specified in Class C in Part 2 of Schedule 1 to the Ordinance and single premium policies), the refund should be 100% of the premium which the policy holder has paid.

(iii) For all life insurance policies specified in Class C in Part 2 of Schedule 1 to the Ordinance and all single premium policies to which GL29 applies, authorized insurers have the right to apply a Market Value Adjustment ("MVA") to the premium to determine the amount that is to be refunded, subject to all of the following requirements being satisfied:

a. Any such MVA must be calculated solely with reference to the loss that the authorized insurer might make in realizing the value of any assets acquired through investment of the premiums under the policy. The MVA calculation must not include any allowance for expenses or commissions in connection with the issuance of the policy.

b. Prior to the completion of the policy application form, the authorized insurer's right to apply an MVA and its basis of calculation must have been disclosed in the relevant product brochure.

c. The prospective policy holder must have been informed of the authorized insurer's right to apply an MVA and its basis of calculation before the prospective policy holder signs his/her policy application form.

(d) Obligations specific to Authorized Insurers and Licensed Insurance Intermediaries

(i) An authorized insurer is required to deliver the Cooling-off Notice to the policy holder or nominated representative of the policy holder. The authorized insurer should include the following information in the Cooling-off Notice:

a. the availability of his/her life insurance policy and the expiry date of the Cooling-off Period;

b. the right to re-consider his/her decision to purchase the life insurance product within the Cooling-off Period;

c. the right to obtain a refund of premium paid if the policy is cancelled within the Cooling-off Period;

d. the contact information of the customer service department of the authorized insurer (including the address, service hotline number and email address); and

e. a reminder that if the policy holder or the nominated representative of the policy holder does not receive the policy within 9 calendar days after delivery of the Cooling-off Notice, he/she should contact the authorized insurer.

(ii) An authorized insurer is also required to:

a. comply with paragraph (b) (v) a, if the life insurance policy is to be delivered by the authorized insurer directly to the policy holder (or the nominated representative of the policy holder);

b. comply with paragraph (b) (v) b (1), if the policy is to be delivered to the policy holder (or the nominated representative of the policy holder) via a licensed insurance intermediary;

c. specify in its licensed insurance intermediaries' training materials and internal guidelines that its insurance intermediaries must comply with the requirements set out in paragraphs (b) (v) b (2), (c) (iii) c and (d) (iii);

d. comply with the requirements set out in paragraph (d) (iii) a, if the policy is not entered into through a licensed insurance intermediary;

e. devise internal control measures to ensure and provide proof that:

(1) policies are delivered to policy holders (or the nominated representatives of policy holders) within the 9 calendar day period; and

(2) Cooling-off Notices are delivered to the policy holders (or the nominated representatives of the policy holders) within the 9 calendar day period;

f. keep records of proof such as copies of the acknowledgements of receipt of policy delivery. In case of a complaint or dispute, the authorized insurer may be required to produce evidence to show that the policy or the Cooling-off Notice was delivered (and when the delivery took place);

g. maintain records in respect of any cases of complaints or disputes where policy holders have sought to cancel their policies and obtain refund of premiums after the Cooling-off Period has expired, but such requests have been refused; and

h. provide records referred to in paragraphs (d) (ii) e, f and g to the IA as soon as is practicable upon request.

(iii) A licensed insurance intermediary should:

a. before a prospective policy holder signs the policy application form, inform the prospective policy holder of the right to cancel the policy within the Cooling-off Period, the expiry date of the Cooling-off Period and the authorized insurer’s right to apply an MVA together with its basis of calculation (if applicable);

b. comply with the requirements in paragraph (b) (v) b (2), if applicable; and

c. comply with any other requirements about the Cooling-off Period as set out in other codes and guidelines which apply to the licensed insurance intermediary.

(e) Statement in relation to Cooling-off Period in Policy Application Form

(i) A statement in line with the "Guideline on Statement in relation to Cooling-off Period in Policy Application Form" (See **Appendix A**) should be included by the authorized insurer in the policy application form immediately above the space for the prospective policy holder's signature.

(ii) The statement should be prominently displayed using a legible font size which is no smaller than the font size used for any other declaration on the policy application form. This requirement applies irrespective of whether the policy application form is paper, electronic or in some other format.

(iii) The statement should be communicated in the same language(s) as are used for all other sections of the policy application form.

(f) Reminder of Cooling-off Period at Policy Issuance

(i) The authorized insurer should include a reminder to the policy holder of the Cooling-off Period with the life insurance policy when the policy is delivered.

(ii) The reminder may be provided by way of a letter from the authorized insurer delivered directly to the policy holder with the delivery of the policy, or a statement included by the authorized insurer on the policy jacket or policy cover, taking into account the specificities of the medium used.

(iii) The reminder must be communicated in the same language(s) as the policy and other communications/documents which are (or have been) provided or sent to the policy holder in relation to the policy.

(iv) The reminder must be prominently displayed using a legible font size.

(v) For further details regarding the required reminder, see the "Guideline on Reminder of Cooling-off Period at Policy Issuance" (See **Appendix B**).

5.2.5 Policy Replacement

Life insurance policies which are long-term contracts of insurance are designed to be valid for a number of years during a person's life. The terms and conditions of a life insurance policy reflects this intention. A policy holder, having purchased a life insurance policy, may later consider purchasing another life insurance policy to replace whole or part of the life insurance policy initially purchased. In these circumstances, the policy holder should be mindful of the disadvantages of making changes to the life insurance policy initially purchased such as the surrender or withdrawal charges. Accordingly, if a policy holder applies to purchase a new life insurance policy and combines this with replacing or making changes to a life insurance policy previously purchased, authorized insurers and licensed insurance intermediaries should ensure the policy holder is fully informed of the consequences of such replacement of changes to facilitate he/she can make a fully informed decision. To address this issue, the Insurance Authority ("IA") issues the Guideline on Long Term Insurance Policy Replacement (GL27) pursuant to section 133 of the Insurance Ordinance (Cap. 41) ("Ordinance") and its principal function to regulate and supervise the insurance industry for the protection of existing and potential policy holders.

The following are the major provisions of GL27:

(a) Scope of Application

(i) GL27 applies to all authorized insurers carrying on long term business, and all licensed insurance intermediaries carrying on regulated activities in respect of long term business.

(ii) GL27 applies in respect of any life insurance policy which a customer applies to purchase after the Effective Date of this Guideline unless any of the exceptions in paragraphs (a) (iii) or (a) (iv) apply.

(iii) GL27 does not apply to:

a. the purchase of any life insurance policy which is a group policy;

b. a life insurance policy which is sold in a manner which meets all of the conditions in paragraph (a) (iv) below; or

c. any life insurance policies which an authorized insurer or a licensed insurance intermediary, as the case may be, has obtained the IA's prior written consent to exempt from the requirements of GL27 (e.g. through the InsurTech Sandbox).

(iv) The conditions for the purposes are:

a. the life insurance policy is sold to a customer directly by an authorized insurer, or by an authorized institution in its capacity as a licensed insurance agency of an authorized insurer;

b. the life insurance policy is sold through a digital distribution channel like webpage or mobile app;

c. the authorized insurer or authorized institution does not provide a recommendation to the customer before or during the point of sale; and

d. in addition to complying with all existing product disclosure requirements, the authorized insurer or the authorized institution displays a prominent statement at the point of sale of the life insurance policy, warning the customer that if the customer is purchasing the life insurance policy to replace an existing life insurance policy, the customer should seek professional advice to understand the associated risks and detrimental consequences of policy replacement.

(b) Policy Replacement

(i) Regarding the purchase of any life insurance policies to which GL27 applies, the authorized insurer of the policy and the licensed insurance intermediary should take all reasonable steps to ascertain whether the customer is purchasing the life insurance policy as a policy replacement.

(ii) For the purposes of paragraph (b) (i) above, the purchase of a life insurance policy to which GL27 applies, is a policy replacement if at the time of the application date for the new life insurance policy,

a. the customer has or had another life insurance policy (or other life insurance policies) (collectively "existing life insurance policy");

b. the policy holder(s) of the existing life insurance policy and the life insurance policy being purchased is (are) the same; and

c. in order to fund the purchase of the new life insurance policy, the customer is using some or all of the total cash value of the existing life insurance policy or any savings made as a result of reducing the premium payable under the existing life insurance policy, by means of the following:

(1) reducing the total cash value or sum insured of the existing life insurance policy, by the customer exercising (or having exercised) a right under the policy (e.g. withdrawal, surrender) or by automatic operation of the terms and conditions under the policy (e.g. lapse, reduced paid-up insurance, extended term insurance); or

(2) by the customer taking out (or having taken out) a policy loan from the existing life insurance policy (whether at the customer's request or by automatic operation of the policy terms and conditions); or

(3) by the customer suspending premium payment or ceasing to pay premium under the existing life insurance policy.

(iii) The following transactions are not considered to be policy replacements:

a. where the new life insurance policy is being effected solely by reason of the existing life insurance policy being converted into the new life insurance policy under the provisions of the existing life insurance policy;

b. where the existing life insurance policy and the new life insurance policy are with the same authorized insurer and the new life insurance policy is being effected solely by reason of the existing life insurance policy being converted or migrated into the new life insurance policy under a conversion or migration program offered by the insurer, in which re-underwriting is not required;

c. where the only change made to the existing life insurance policy, relates to the coverage under a rider on the existing life insurance policy and no change is made to the life coverage of the basic plan of such policy; and

d. where the life insurance policy is purchased in place of an existing life insurance policy cancelled during its cooling-off period (as defined under the Guideline on Cooling-Off Period (GL29)).

(iv) The reasonable steps an authorized insurer or licensed insurance intermediary should include ensuring that sufficient enquiries are made of the customer to find out whether the customer is funding the purchase of the new life insurance policy using the total cash value of the existing life insurance policy, or using savings from reducing the premium payable under the existing life insurance policy. At minimum the enquiries to be made of the customer should include the questions set out in the template (See **Appendix C**). These enquiries should be made during the sale process for new life insurance policies and may be incorporated as a separate section of a policy application form. Authorized insurers and licensed insurance intermediaries can modify the questions in the template (See **Appendix C**), use the information collected during the Financial Needs Analysis process and vary the questions to be asked regarding policy replacement depending on the particular circumstances of the customer.

(v) A licensed insurance intermediary should assess and provide advice to the customer on whether the proposed purchase of the new life insurance policy is in the customer's best interests taking account of the reduction in the total cash value or sum insured under the existing life insurance policy and any other adverse consequences to the customer arising from the policy replacement. A licensed insurance intermediary should ask the customer to provide information on his/her existing life insurance policy(ies) so that such assessment may be provided. A licensed insurance intermediary must properly document the information provided by the customer during this assessment process. The factors considered, evaluation, the recommendation(s) made by the licensed insurance intermediary, and reason(s) for such recommendation(s) should also be documented as appropriate.

(c) Important Facts Statement - Policy Replacement

(i) When a new life insurance policy which has been identified as a policy replacement, the authorized insurer or licensed insurance intermediary should require an "**Important Facts Statement - Policy Replacement**" ("IFS-PR") (See **Appendix D**) to be signed by the customer. The purpose of this is to make the customer aware of the disadvantages which may arise from the policy replacement, so that the customer can consider these disadvantages together with the information and advice given by the licensed insurance intermediary and make an informed decision as to whether or not to proceed with purchasing the new life insurance policy.

(ii) The licensed insurance intermediary dealing with the application for the new life insurance policy which has been identified as a policy replacement should explain to the customer the implications of and risks associated with the policy replacement as identified in the IFS-PR and ask the customer to read the IFS-PR and consider the information contained in it.

(iii) The originals of the signed IFS-PR should be kept by the authorized insurer of the new life insurance policy which is the subject of the application. The authorized insurer must provide a copy of the IFS-PR to the customer on or before the date of issue of the new life insurance policy.

(iv) Authorized insurers should maintain complete records of the signed IFS-PRs dispatched to customers applying for new life insurance policies which have been identified as policy replacements. Such records should include the signed IFS-PRs, the dispatch date and mode of dispatch of the copies of the signed IFS-PRs to customers. Such records should be made available to the IA for inspection as soon as practicable upon request.

(d) Internal Policy Replacements

(i) An "internal policy replacement" means the purchase of a new life insurance policy which is considered to be a policy replacement (per paragraph (b) (ii) above), where the authorized insurer of the new life insurance policy is also the insurer of the customer's existing life insurance policy.

(ii) Authorized insurers should implement processes for checking their internal records and databases to identify internal policy replacements by reference to the criteria listed in paragraph (b) (ii) above, as follows. Whenever an application is received for a new life insurance policy, an authorized insurer should check:

a. whether as at the application date, the customer has, or had at any time during the 12 months immediately prior to the application date, an existing life insurance policy with the authorized insurer; and

b. if so, whether any of the matters in paragraph (b) (ii) c (1), (2) or (3) above has taken place in respect of the existing life insurance policy during the 12 months immediately prior to the application date.

If the matters in paragraph (d)(ii)b above are identified, the authorized insurer shall determine if it is necessary to contact the customer for the purpose of reaffirming his/her intention to fund the purchase of the new life insurance policy by making changes on the existing life insurance policy and informing him/her of the corresponding disadvantages.

(iii) Where a new life insurance policy is applied for by a customer who is identified by the authorized insurer as having an existing life insurance policy with the insurer (by reason of the checks carried out in paragraph (d) (ii) above), but this is not considered to be a policy replacement at the time of such application, the insurer should have processes in place to continue to monitor the existing life insurance policy for any changes during the 12 months immediately following the application date for the new life insurance policy, which may indicate a policy replacement (per paragraphs (b) (ii) c (1), (2) and (3)). If, as a result of such monitoring any of the matters in paragraphs (b) (ii) c (1), (2) or (3) is identified, the authorized insurer shall determine if it is necessary to contact the customer for the purpose of reaffirming his/her intention to fund the purchase of the new life insurance policy by making changes on the existing life insurance policy and informing him/her of the corresponding disadvantages.

(e) Complaints Monitoring

(i) Authorized insurers should keep track of complaints in relation to policy replacement cases (and keep records of such complaints), and perform on-going monitoring on the complaint trends. If any abnormality is found, proper management action shall be taken to identify the root causes of the complaints and remedial action should be taken.

(f) Effective controls and procedures to be established by authorized insurers, licensed insurance broker companies and licensed insurance agencies

(i) Authorized insurers should develop internal controls to ensure their appointed licensed insurance individual agents and licensed insurance agencies comply with the requirements under GL27 and that the applications for life insurance policies made through licensed insurance brokers also comply with the requirements of GL27. Such controls should cover:

a. controls to ensure reasonable steps are taken to ascertain whether a customer is purchasing a life insurance policy as a policy replacement, with appropriate records being maintained to evidence these steps;

b. controls to ensure that, where a policy replacement is identified, the customer is provided with an IFS-PR, signs the IFS-PR and is made aware of the disadvantages which may arise from the policy replacement, with appropriate records being maintained to evidence these;

c. controls to ensure there is an effective mechanism to identify and handle internal policy replacement cases;

d. controls to identify possible cases where licensed insurance intermediaries have evaded the control measures or assisted or abetted customers to do so (e.g. the customer signs an IFS-PR form before being provided with the opportunity to read and understand the form), take remedial action if necessary including in respect of the licensed insurance intermediary concerned; and

e. controls to identify policy replacement cases which are suspicious (e.g. licensed insurance intermediaries who have solicited a significant number of new life insurance policies for the insurer which are policy replacements), identify the root cause and take remedial action if necessary.

(ii) Licensed insurance broker companies and licensed insurance agencies are also required to develop and implement internal controls to ensure that they and their licensed technical representatives (broker) and licensed technical representatives (agent), as the case may be, comply with the requirements of GL27.

(g) Record Keeping

(i) Proper records should be maintained by authorized insurers, licensed insurance broker companies and licensed insurance agencies in respect of policy replacement matters including but not limited to the required documentation set out in GL27 for inspection and review by the IA.

5.2.6 Benefit Illustrations for Long Term Insurance Policies

The Insurance Authority ("IA") issues the Guideline on Benefit Illustrations for Long Term Insurance Policies (GL28) pursuant to section 133 of the Insurance Ordinance (Cap. 41) ("Ordinance"), its principal function to regulate and supervise the insurance industry for the protection of existing and potential policy holders and its function to promote and encourage the adoption of proper standards of conduct, and sound and prudent business practices by authorized insurers.

GL28 aims to set out the standard requirements for benefit illustration documents to be provided to potential policy holders or existing policy holders to allow them to have adequate and clear information on the benefits of a life insurance policy.

(a) **Scope**

(i) GL28 applies to all authorized insurers carrying on long term business and sets out the minimum requirements for point-of-sale benefit illustrations, supplementary illustrations and inforce re-projection illustrations which are required to be provided by authorized insurers in respect of the life insurance policies to which GL28 applies.

(ii) The requirements laid down in GL28 must be followed for all life insurance policies with cash value (except group policies). Individual policies with refundable features are regarded as life insurance policies with cash value for the purposes of GL28.

(ii) The issuance of inforce re-projection illustrations is optional for the following types of life insurance policies:

a. reduced paid-up insurance policies and extended term insurance policies, where future dividends and coupons from those policies are forfeited and the deposit account is accumulated at a guaranteed interest rate;

b. non-participating policies; and

c. Investment-linked Assurance Schemes ("ILAS") policies (i.e. contracts of insurance in Class C (Linked long term) of Part 2 of Schedule 1 to the Ordinance).

(b) **General Principles**

(i) In respect of life insurance policies to which GL28 applies, authorized insurers should provide benefit illustrations at the point-of-sale containing, at minimum, the information in the Standard Illustrations set out in the Appendices to GL28 ("Standard Illustrations"). Authorized insurers are responsible for ensuring that the information provided in their benefit illustration documents is adequate, accurate, clear and not misleading.

(ii) Unless otherwise stated in GL28, any supplementary illustrations and inforce re-projection illustrations should also follow the minimum requirements under the Standard Illustrations.

(iii) An authorized insurer should prepare an inforce re-projection illustration based on the current policy option chosen by the policy holder (e.g. withdrawal, premium offset, top-up, etc.), and the updated actuarial assumptions and the authorized insurer's current view of the market outlook. The re-projection should start from the policy year in which the re-projection is performed, taking into account the policy's updated inforce policy status (e.g. attained age, current sum assured, etc.). Relevant warnings of associated risks and explanatory notes should be suitably modified and presented.

(iv) The specific requirements for particular product types are covered in the relevant Appendices of GL28.

(v) Authorized insurers should require customers to sign a declaration on the benefit illustration documents provided at the point-of-sale. It is optional for insurers to require customers to sign supplementary illustrations. Digital signatures or other similar signature verification technology may be accepted. For the avoidance of doubt, authorized insurers are not required to obtain the customer's signature for inforce re-projection illustrations.

(vi) When life insurance policies are sold through non-face-to-face distribution channels, such as the internet or through telemarketing, customers are deemed to have signed the benefit illustration documents provided that:

a. an explanation of the key product features of the relevant policy is provided to the customer during the selling process;

b. in the case of internet sales, as part of the online purchase path, the customer is required to confirm that he/she has reviewed the benefit illustration documents; and

c. the benefit illustration documents are sent to the customer together with the delivery of the policy to the customer.

(c) **Supplementary Illustration**

(i) Authorized insurers may provide supplementary illustrations in relation to optional product features, which the policy holder may elect from time to time (such as premium holiday, partial surrender, top-up, etc.). Certain column(s) of the supplementary illustration can be omitted if the same information is shown in the Standard Illustration.

(ii) When a premium offset option is illustrated in a supplementary illustration, the requirements under paragraph 4.1(c) of Appendix 1 to the Guideline on Underwriting Long Term Insurance Business (Other Than Class C Business) (GL16) (**see 5.2.8 and Appendix K** for more details of this Guideline) issued by the IA must be met.

(iii) With regards to policy loans, an authorized insurer should provide a notice to the policy holder alerting the policy holder of lapsation risk arising as a result of the amount of the policy loan exceeding the account/surrender value, and (save in the case of ILAS policies) the expected timeline (in years) leading to policy lapsation based on the current assumptions for the policy loan ("Alert Notice"). The Alert Notice should be provided in the following situations:

a. when a supplementary illustration on a basic plan with a policy loan is provided to the policy holder at the point-of-sale;

b. when the policy holder applies for a policy loan;

c. as soon as possible, after an automatic policy loan is first drawn down; and

d. when issuing regular anniversary statements in relation to a policy in respect of which a policy loan has been drawn down.

In addition, an authorized insurer should provide a re-projection of the policy loan amount upon request with a clear indication that the interest rate on the policy loan will be amended from time to time depending upon market conditions. A policy holder should be informed of his/her right to request for such re-projection when the Alert Notice is provided.

(iv) While the provision of benefit illustrations for riders is optional, where authorized insurers opt to provide benefit illustrations for riders at the point-of-sale or as inforce re-projection illustrations, at a minimum an illustration on the basic plan must be provided to the policy holder with a separate supplementary illustration combining the basic plan and the rider.

(d) **Customization**

(i) Authorized insurers may customize their benefit illustration documents to exclude information not applicable to the product or not relevant to customers and may include additional information provided that such additional information is not misleading and does not distract customers from the information disclosed in the Standard Illustration.

(ii) Any additional information provided in addition to the minimum requirements of the Standard Illustration must be relevant and of value to customers.

(iii) Authorized insurers must follow the format of the Standard Illustration so that, and without limitation, the "total premiums paid" column is shown before the benefit payment columns, and the surrender values are shown before the death benefits.

(iv) Authorized insurers should not highlight any figures (e.g. in bold, underlined or in any colour or font size which is different from the general text in the benefit illustration documents) which are not guaranteed.

(e) **Preparation and Timing of Provision of Benefit Illustration Documents**

(i) The timing of the provision of benefit illustration documents is as follows:

a. in relation to benefit illustration documents provided at the point-of-sale, these should be provided to the potential policy holder for review and signature prior to the potential policy holder signing the application form (save where paragraph (b) (vi) above applies); and

b. inforce re-projection illustrations should be provided to the policy holder at least on an annual basis after policy issuance (this does not apply in relation to policies where the provision of re-projection illustrations is optional – see paragraph (a) (iii) above).

(ii) Authorized insurers are required to provide illustrations reflecting the particulars of customers rather than using a specimen illustration for all customers. The particulars of customers should include (but are not limited to) age, gender, or smoking habit.

(iii) Benefit illustration documents should be in the same language(s) as used by authorized insurers in other pre-sale literatures. English or Chinese versions of the benefit illustration documents should be made available to customers upon request. Authorized insurers are responsible for the consistency of contents among all sales materials. Benefit illustration documents must be legible in the context of font size, format and layout.

5.2.6a Specific Requirements for Benefit Illustration Documents for Investment-linked Assurance Schemes (ILAS) Policies (GL28 – Appendix I)

a) **Assumed Net Rates of Return**

(i) Authorized insurers may choose one of the two options below to illustrate the assumed net rates of return:

a. Four assumed net annual rates of return for illustration, 0%, 3%, 6% and 9% with separate tables showing the corresponding surrender value and death benefit respectively; and

b. Three assumed net annual rates of return for illustration, 0%, 3% and 6% in the same table showing the corresponding surrender value and death benefit.

(ii) For both of the above options, aside the illustration of 0% assumed net annual rate of return, all other rates of return (i.e. 3%, 6% and 9%) are maximum rates that authorized insurers can adopt. Authorized insurers may choose to illustrate assumed net annual rates of return using lowers rates of return, e.g. 0%, 2%, 5% and 7%.

(b) **Fees and Charges**

(i) The illustration is prepared to reflect all policy level fees and charges but not fund management charges. Fund management charges are defined as solely the fees and charges levied by fund managers.

(ii) Any fees and charges applied by authorized insurers in the form of fund management charges should be reflected through the numerical illustration regardless of whether those fund management charges are deducted through unit deduction or are reflected through their unit price calculation (e.g. "mirror fund" is involved). For example, if there is a 1% fund management charge accruing to the authorized insurer and a 1.5% fund management charge accruing to the fund house, the numerical illustration will reflect the 1% charge mentioned above while the 1.5% fund management charge accruing to the fund house will be mentioned in the notes to the illustration.

(c) **Disclosure**

(i) Authorized insurers may choose to show account value under each scenario before the benefit payment columns. If there is insufficient space, authorized insurers may take away the column with assumed net rate of return at 9% p.a., but not the others.

(ii) The projected surrender values and death benefits should be shown as at the end of each of the first five years of the policy, and at least for every five-year interval thereafter until maturity or the end of policy whichever is applicable, after deducting all relevant fees and charges as described in paragraph (b) of 5.2.6a to this Guideline. The number of policy years should not be illustrated higher than the customer's age at one-hundred (100) or the maturity of the policy, whichever is applicable. Besides, the last few rows should be illustrated by "at age 90", "at age 95" and "at age 100" to make it easier for customers to understand.

(iii) The notes to illustration should include reference to the fact that the fund management charges levied by the fund houses are not included in the illustration and, hence, a higher rate of return will be required to pay the fund management charges levied and achieve the rate of return shown in the illustration (which is net of the fund management charges levied).

(iii) A clear statement should be shown prominently in the benefit illustration documents to remind the customer of the situation where the policy may be terminated due to zero account value in a low investment yield scenario. This situation is only applicable to the scenarios that the projected account value will become zero before the end of the illustration period.

(v) A warning statement should be shown prominently in the benefit illustration documents to alert the customers that early surrender or early premium discontinuance may result in significant loss.

Note：the Standard Illustration for ILAS Policies can be found in **Appendix E**.

5.2.6b Specific Requirements for Benefit Illustration Documents for Participating Policies (GL28 – Appendix II)

(a) **Assumed Setting**

(i) In setting the best estimate assumptions for the base scenario, the Appointed Actuary should have regard to Actuarial Guidance Notes 9 (AGN 9) on Best Estimate Assumptions issued by the Actuarial Society of Hong Kong (ASHK), in particular Appendix A, which provides guidance and consideration covering benefit illustration assumptions.

(ii) Authorized insurers are allowed to illustrate benefit values with investment return not higher than the rate determined under best estimation.

(b) **Pessimistic and Optimistic Scenarios**

(i) As required under GL16 issued by the IA, additional high and low return scenarios must be provided in the benefit illustration to show the variability of the ultimate results. A wider range of scenarios is expected for investment strategy with higher volatility. For consistency purposes, the terms "Pessimistic Scenario" and "Optimistic Scenario" must be used. The underlying change in investment returns and accumulation interest rate in these scenarios are required to be disclosed in the explanation notes underneath.

(ii) Authorized insurers are required to adopt the twenty-fifth (25th) and seventy-fifth (75th) percentiles of the investment returns in the projections as pessimistic and optimistic scenarios (except otherwise with the written consent of the IA after an authorized insurer has demonstrated to the satisfaction of the IA that it has practical difficulties for so doing) while keeping other assumptions (except dividend/coupon accumulation interest rates, if applicable) unchanged. Authorized insurers could adopt a return rate lower than 25th percentile as the pessimistic scenario but cannot adopt a return rate higher than 75th percentile as the optimistic scenario.

(c) **Disclosure**

(i) The insurance terminology in the benefit illustration documents should be consistent with other product documents (e.g. product brochure, policy provisions, etc.) using the admissible insurance terminology stated in Part I of the Annex on GL28 (see Appendix I). In case where an authorized insurer has a need to use its own terminology, the IA will consider granting written consent on an individual case basis depending on the justifications and whether

the terminology is considered to be or likely to be misleading or not. For the avoidance of doubt, a list of inadmissible terminology which is considered to be misleading has shown in Part II of the Annex on GL28 (see **Appendix J**) for attention.

(ii) For inforce re-projection illustration where the insurance terminologies differ to those in other documents for policies issued prior to the adoption of GL16 issued by the IA, a glossary with mapping of existing terminologies to admissible terminologies should be provided to policy holders.

(iii) Authorized insurers may choose to present the figures in separate tables showing surrender values before death benefits. The "total premiums paid" column must be shown in each table. For the requirements, pessimistic and optimistic scenarios are required to be shown on the same page. In case where an authorized insurer has a need to present on separate pages for pessimistic and optimistic scenarios, the IA will consider granting written consent on an individual case basis depending on the justifications and whether the presentation is considered to be or likely to be misleading or not.

(iv) Illustration of pessimistic and optimistic scenarios for supplementary illustration and inforce re-projection illustration is optional. If authorized insurers choose to show variation of illustration against baseline scenario, at a minimum, pessimistic scenario has to be shown.

(v) Only the figures calculated as at the "end of policy year" should be shown. Illustrations of benefits are to be provided for the years:

a. Stated for not less than 30 years (with at least a 5-year interval after policy year 5), or the benefit term if shorter; and

b. At age 65, or on the maturity of the policy if earlier; and

c. At age 100, or on the maturity of the policy if earlier; and

d. On the maturity of the policy.

Note： the Standard Illustration of Participating Policies can be found in **Appendix F.**

5.2.6c Specific Requirements for Benefit Illustration Documents for Universal Life (Non-Linked) Policies (GL28 – Appendix III)

(a) **Rate of Return**

(i) Authorized insurers should project the benefit values using two different assumptions:

a. Based on the minimum guaranteed crediting interest rates prescribed under the policy, excluding any non-guaranteed bonus. If the policy does not offer any guaranteed crediting interest rate, a conservative crediting interest rate of 0% per annum should be used ("Guaranteed Basis" or "Conservative Basis").

b. Based on the current assumed crediting interest rate (i.e. the current crediting interest rate assumption based on best estimate) forecasted by the authorized insurers ("Current Assumed Basis"), which may not be the same as the current crediting interest rate where declaration could be changed from time to time.

(ii) The crediting interest rates before any relevant policy fees and charges should be adopted.

(iii) In setting the best estimate assumptions under the Current Assumed Basis, the Appointed Actuary should have regard to AGN 9 issued by ASHK, in particular Appendix A, which provides guidance and consideration covering benefit illustration assumptions.

(iv) Authorized insurers are allowed to illustrate benefit values with crediting interest rate not higher than the rate determined under best estimation.

(b) **Fees and Charges**

(i) Under the Guaranteed Basis or Conservative Basis, the maximum scale of fees and charges should be adopted in the projection. If the maximum scale of fees and charges is not applicable, the current scale of fees and charges should be adopted.

(ii) Under the Current Assumed Basis, the current scale of fees and charges should be adopted.

(iii) Authorized insurers are required to provide Summary of Fees and Charges specified in the Standard Illustration of Universal Life (Non-Linked) Policies at the point-of-sale and for inforce re-projection. Among other fees and charges, the following should be disclosed:

a. Surrender charge rates/surrender charge amount (if applicable) should be disclosed. For surrender charge rates shown, the basis to which the rates apply should be clearly stated.

b. Cost of insurance rates in each of the first 10-policy-year should be disclosed. For charges in later years, authorized insurers can show the rates with a 5-year interval until policy maturity.

c. In addition to the current rates of charges, the maximum rates of charges should be shown. In case there is no maximum charge, "N.A." should be marked in the column to represent 'not applicable'.

(c) **Pessimistic and Optimistic Scenarios**

(i) The illustration based on an assumed crediting interest rate under pessimistic and optimistic scenarios is optional and can be shown only if:

a. The plan has significant (which is 20% or more) target equity investment; and

b. In the opinion of the authorized insurer's Appointed Actuary, the optional illustration is not misleading to the applicants.

(ii) This illustration is allowed mainly for the demonstration of the variability of crediting interest rates due to exposure of equities. It should not be used as benchmark for future crediting interest rates, which would be considered to be misleading to applicants.

(iii) Authorized insurers are required to adopt the 25th and 75th percentiles of the investment returns in the projections as pessimistic and optimistic scenarios (except otherwise with the written consent of the IA after an authorized insurer has demonstrated to the satisfaction of the IA that it has practical difficulties for so doing) while keeping other assumptions (except dividend/coupon accumulation interest rates) unchanged.

(d) **Disclosure**

(i) The insurance terminology in the benefit illustration documents should be consistent with other product documents (e.g. product brochure and policy provisions, etc.) using the admissible insurance terminology stated in Part I of the Annex on GL28 (See **Appendix I**). In case where an authorized insurer has a need to use its own terminology, the IA will consider granting written consent on an individual case basis depending on the justifications and whether the terminology is considered to be or likely to be misleading or not. A list of inadmissible terminology

which is considered to be misleading has shown in Part II of the Annex on GL28 (See **Appendix J**) for attention.

(ii) For inforce re-projection illustration where the insurance terminologies differ to those in other documents for policies issued prior to the adoption of GL16 issued by the IA, a glossary with mapping of existing terminologies to admissible terminologies should be provided to policy holders.

(iii) Authorized insurers may choose to present the figures in separate tables showing surrender values before death benefits. The "total premiums paid" column and "account value" column under the Guarantee Basis / Conservative Basis and the Current Assumed Basis must be shown in each table. For the requirements, pessimistic and optimistic scenarios are required to be shown on the same page. In case where an authorized insurer has a need to present on separate pages for pessimistic and optimistic scenarios, the IA will consider granting written consent on an individual case basis depending on the justifications and whether the presentation is considered to be or likely to be misleading or not.

(iv) The term "Guaranteed Basis" can be used if and only if all values under the projection are guaranteed; otherwise, the term "Conservative Basis" should be used.

(v) It is not allowed to include a projection other than the Guaranteed Basis / Conservative Basis or the Current Assumed Basis or pessimistic and optimistic scenarios.

(vii) Illustration of pessimistic and optimistic scenarios for supplementary illustration and inforce re-projection illustration is optional. If authorized insurers choose to show variation of illustration against baseline scenario, both pessimistic and optimistic scenarios will have to be shown.

(vii) Only the figures calculated as at the "end of policy year" should be shown. Illustrations of benefits are to be provided for the years:

a. Stated for not less than 30 years (with at least a 5-year interval after policy year 5), or the benefit term if shorter; and

b. At age 65, or on the maturity of the policy if earlier; and

c. At age 100, or on the maturity of the policy if earlier; and

d. On the maturity of the policy.

Note：the Standard Illustration for Universal Life (Non-Linked) Policies can be found in **Appendix G**.

5.2.6d Specific Requirements for Benefit Illustration Documents for Non-Participating Policies (GL28 – Appendix IV)

(a) **Principle**

(i) Non-participating policies offer only guaranteed benefit values throughout the whole policy term.

(ii) Any products involving non-guaranteed element(s), such as declared guaranteed benefits to be maintained in a deposit account for accumulation with non-guaranteed interest rate, should follow the Standard Illustration for Participating Policies.

(b) **Disclosure**

(i) The insurance terminology in the benefit illustration documents should be consistent with other product documents (e.g. product brochure and policy provisions, etc.), using the admissible insurance terminology stated in Part I of the Annex (See **Appendix I**) on GL28. In case where an authorized insurer has a need to use its own terminology, the IA will consider granting written consent on an individual case basis depending on the justifications and whether the terminology is considered to be or likely to be misleading or not. For the avoidance of doubt, a list of inadmissible terminology which is considered to be misleading has shown in Part II of the Annex (See **Appendix J**) on GL28 for attention.

(ii) While the provision of inforce re-projection illustration is optional, if the insurance terminologies therein differ to those in other documents for policies issued prior to the adoption of GL16 issued by the IA, a glossary with mapping of existing terminologies to admissible terminologies should be provided to policy holders.

(iii) Only the figures calculated as at the "end of policy year" should be shown. Illustrations of benefits are to be provided for the years:

a. Stated for not less than 30 years (with at least a 5-year interval after policy year 5), or the benefit term if shorter; and

b. At age 65, or on the maturity of the policy if earlier; and

c. At age 100, or on the maturity of the policy if earlier; and

d. On the maturity of the policy.

Note：the Standard Illustration for Non-Participating Policies can be found in **Appendix H**.

5.2.7 Distributions of Policy Dividends

5.2.7a Basic Principles of Dividend Distributions

Participating policies, which are discussed in other parts of the Study Notes (see **1.3.1b**(a) and **4.10**), are bought with expectations of returns in the form of policy dividends, and they normally grant guaranteed cash values as well. Generally, the amounts of dividend to be declared and distributed are directly linked to the experience of the pooled fund of the relevant participating policies. (By "pooled fund", it means the whole of the assets which the relevant insurer has created on its balance sheet as a result of granting the participating policies and which it then manages on behalf of such policies.) The experience of the pooled fund over a given period is a function of the fund's investment yields, expenses, claims, etc. for that period. In general, dividend amounts feel the largest impact from the pooled fund's investment returns, which may or may not be consistent with the overall business performance of the insurer. As a matter of prudence, only when the actual experience is found to be more favourable than the actuarial and financial assumptions that the insurer has made should it declare policy dividends.

As said above, dividend amounts depend on the experience of the pooled fund. It is also worth noting that insurers normally reserve the right to determine dividend amounts. In practice, decisions on dividend amounts are based on the advice of the respective appointed actuaries and subject to the approval of the respective boards of directors. The actuaries, in making recommendations, will consider the experience of the pooled funds, the economic outlook and the equity between different classes and generations of policyholders within a single pooled fund. Besides, dividends are normally smoothed out in order to reduce large short-term fluctuations. Smoothing takes various forms and varies from one insurer to another, depending on the terms of the insurance contracts and the company policies.

The Insurance Authority ("IA") has issued a Guideline on Underwriting Long Term Insurance Business (Other Than Class C Business) (GL16) (see **5.2.8** and **Appendix K**) to impose requirements applicable to participating policies on relevant insurers, the actuaries they have appointed and their boards of directors. Below is an overview of such requirements.

An insurer should have a corporate policy that covers allocation of surplus/profits between shareholders and the participating pool, as well as declaration of policyholder dividends/bonuses and other discretionary benefits. This policy should be clearly documented, approved by the board of directors and made available to the IA on request.

When designing products with non-guaranteed benefits, the appointed actuary is obligated to ensure that there is a fair chance of achieving the non-guaranteed returns. The appointed actuary should submit a report to the board of directors, recommending policy dividends/bonuses and other non-guaranteed benefits annually or more frequently, and the report should be made available

to the IA upon request. The dividends/bonuses declaration mechanism will be subject to the IA's regulatory review, who may require the insurer to appoint an independent party to assess whether the corporate policy has been applied completely, consistently and fairly.

It is the board of directors who are ultimately responsible for interpreting the policyholders' reasonable expectation and deciding on dividends/bonuses declaration, taking into account the principle of fair treatment of customers and the issue of equity between the shareholders and the policyholders.

5.2.7b Methods of Dividend Distributions

In Hong Kong, policy dividends are generally distributed in three ways:

(a) As a cash dividend: many policyholders choose to leave cash dividends on deposit with their insurers.

(b) As a reversionary bonus, where policy benefits are permanently increased by the declared amounts (see **1.3.1b**(a)).

(c) As a terminal bonus, such that the payout value is usually targeted to be close to the asset share of the fund (the policyholders' notional share of the participating fund), taking into account the total return of the underlying assets.

Cash dividends and reversionary bonuses are usually declared on an annual basis while terminal bonuses are usually declared at policy maturity or when the policy has been in force for a given number of years.

In Hong Kong, the majority of life insurers use method (a), with a few using method (b). Method (c) is an optional supplement to methods (a) and (b). Whilst the above is a description of the typical dividend philosophy, it is important to note that variations are possible.

5.2.7c Advantages of Participating Policies

The main advantage of participating policies is that apart from availability of cash values and death benefits guarantees, the policyholder can participate in any favourable experience of the pooled fund in the form of dividends. A second advantage is that the risk of return to the policyholder is lower than with investment-linked policies, owing to the said guarantees. With investment-linked policies, the policyholder selects the underlying investments and will have the full upside if they perform well but also the full downside if they perform badly because such policies generally make no guarantees. The fact that returns on participating policies are generally smoothed is another advantage.

5.2.7d Transparency of Life Insurers with regard to Dividends

The practices commonly adopted by insurers in helping policyholders better understand dividend distributions under participating policies are as follows:

(a) **Benefit Illustrations**: At the point of sale (and later on at the request of customers on policy anniversaries), insurers provide them with an illustration of policy benefits, which separately shows benefits that are guaranteed and those that are not.

The Actuarial Society of Hong Kong, with the encouragement and support of the Insurance Authority, has issued a Guidance Note on illustrations, "AGN5: Principles of Life Insurance Policy Illustrations", which aims to provide standards and principles in preparing illustration documents.

Most insurers provide benefit illustrations that assume that declared cash dividends will be left on deposit with them to earn interest at rates that are not guaranteed and that fluctuate with the market interest level. Such assumptions are explicitly mentioned in the illustrations. Furthermore, applicants are requested to sign illustrations in order to ensure that they have read the illustrations and that the illustrations have been explained to them.

To assist potential policyholders in better understanding and assessing the impact of changing rates of investment return, insurers are required by Guideline On Underwriting Long Term Insurance Business (Other Than Class C Business) (GL16) to provide additional high and low return scenarios in benefit illustrations. A wider range of scenarios is expected where an investment strategy that will likely lead to higher volatility of return is adopted.

(b) **Annual Statements**: In annual statements to customers, some insurers highlight any changes to policy dividends and give broad reasons for them. As a requirement of GL16, insurers should at least on an annual basis provide policyholders with a refreshed up-to-date inforce benefit illustration reflecting the latest condition and outlook.

(c) **Premium Offset**: Insurance plan proposals sometimes project that once premiums have been paid for a stated number of years, assuming that all projected cash dividends are left on deposit with the insurers, such dividends plus the projected interests on them will be capable of funding all future premiums so that the policyholders may then choose to stop paying premiums without affecting the validity and continuity of the policies, which practice is known as "premium offset". While this option may sound attractive to some customers, it is important to note that at any time after such an option has ever been exercised by a customer, it is possible to see unfavourable interest rate levels so that he will have to pay premiums with cash in hand again or risk policy lapse or reduced benefit amounts.

As a requirement of GL16, the customer should be provided with a projection of the premium offset option based on different scenarios, especially the adverse situation (where the premiums are not offset due to a reduced dividend level). The illustration may not use 'vanish', 'vanishing premium' or similar terms that suggest that the policy has been fully paid up, to describe a plan that allows using non-guaranteed elements to pay a portion of future premiums. The customer should also be warned that the sustainability of premium offset depends on future dividend declarations, which are not guaranteed.

(d) **General Information on Dividends**: According to GL 16, authorized insurers should adopt a prudent process in disclosing non-guaranteed (e.g. dividend/ bonus) benefits at the point of sale. This is in line with the purposes of providing customers with adequate and clear information and managing their reasonable expectations on dividends. Factors that could significantly affect the determination of policyholders' dividends, including but not limited to, claim factors, interest income factors, market risk factors, expense factors, and persistency factors should also be disclosed to the customers at the point of sale. Non-guaranteed rate (e.g. dividend/ bonus) philosophy, being the key driver leading to volatility of non-guaranteed benefits in most circumstances, should include investment policies and objectives, as well as investment strategy. As such, the authorized insurer should provide information on its philosophy in deciding dividends in the product brochure and disclose on its company website the non-guaranteed dividends fulfillment ratios for each product series which has new policies recently issued.

5.2.8 Guideline on Underwriting Long Term Insurance Business (Other Than Class C Business) (GL16)

This Guideline (see **Appendix K**) is issued by the Insurance Authority pursuant to the Insurance Ordinance taking into account the Insurance Core Principles, Standards, Guidance and Assessment Methodology promulgated by the International Association of Insurance Supervisors. GL16 sets out requirements for authorized insurers underwriting long term insurance business (other than Class C business). Where appropriate, this Guideline should be read in conjunction with other relevant codes/circulars/guidelines/guidance notes issued by the IA or other regulatory bodies.

The major areas covered by GL16 are:

- Product design;
- Provision of adequate and clear information;
- Suitability assessment;
- Advice to customers;
- Appropriate remuneration structure;

- Ongoing monitoring; and
- Post-sale control.

According to GL16, an insurer who is selling participating (or with-profit) policies or universal life policies should disclose on its company website the non-guaranteed dividends/bonuses fulfilment ratios (for participating (or with-profit) policies) or historical crediting interest rates (for universal life policies) of each product series where new policies belonging to that series have recently been issued. The "fulfilment ratio" of a product is calculated as the average ratio of "non-guaranteed dividends/bonuses actually declared" against "the illustrated amounts at the points of sale". Customers should be alerted to the fact that dividend history is not an indicator of the future performance of the participating products.

In this connection, the Insurance Authority has issued a guide to prescribe a clear and uniform methodology to calculate and disclose fulfillment ratios of the non-guaranteed dividends for participating products, and historical crediting interest rates for universal life products.

5.2.9 Guideline on Financial Needs Analysis (GL30)

Due to the long term nature of life insurance policies, policyowners may have their liquidity locked up. It is therefore important for authorized insurers and licensed insurance intermediaries to ensure that a proper assessment of each customer's circumstances including needs, financial situation, ability and willingness to pay premiums, etc., is undertaken before any recommendation is made in respect of a suitable life insurance policy for the customer, and that the recommendation is based on that assessment. For the assessment purpose, the Insurance Authority ("IA") has issued the Guideline on Financial Needs Analysis (GL30).

GL30 applies to all authorized insurers carrying on or advising on long term business, and all licensed insurance intermediaries carrying on regulated activities in respect of long term business.

The following are the detailed requirements for the Financial Needs Analysis (FNA):

(a) Types of life insurance policies for which and FNA must be carried out

(i) Save in the case of exempted products (see paragraph (a) (ii) below), and regardless of the channel of distribution, an FNA must be performed for every application for a new life insurance policy[1], where the policy which is the subject of the application is one of the following types:

a. policies of the nature specified in Class A in Part 2 of the Schedule 1 to the Insurance Ordinance except:

(1) term insurance policies;

[1] Treatment of a new rider or additional top-up to an existing policy should follow the FNA requirements as if the rider or top-up is a new life insurance policy.

(2) refundable insurance policies without substantial savings component, or renewable insurance policies without cash value, that provide insurance protection (e.g. hospital cash, medical, critical illness, personal accident, disability or long-term care cover); or

(3) group policies;

b. policies of the nature specified in Class C in Part 2 of the Schedule 1 to the Ordinance.

(ii) A policy is an exempted product (and hence an FNA would not be required in respect of an application for such policy), if the product meets all the requirements in (a) to (d) below:

a. the policy is:

(1) a non-participating endowment product with guaranteed payment of not less than the total premium paid upon maturity; or

(2) a universal life product providing a surrender value which is not less than the total premium paid at all times;

b. the policy is sold to customers directly by an authorized insurer or by a licensed insurance agency of an authorized insurer through a digital distribution channel (e.g. webpage or mobile app);

c. the authorized insurer or licensed insurance agency does not provide a recommendation to the customer before or during the point-of-sale; and

d. in addition to complying with the existing product disclosure requirements, the authorized insurer or licensed insurance agency makes the following disclosures in relation to the policy before a customer is able to purchase it:

(1) state the objective(s) of the policy;

(2) state the type and nature of the policy (e.g. “The product is a long term insurance plan underwritten by [name of authorized insurer] and is neither a bank deposit nor a bank savings plan”);

(3) highlight the target premium amount, payment period and benefit periods;

(4) include a prominent warning to the customer concerning affordability of the policy during the entire premium payment period; and

(5) include relevant information highlighting the liquidity risk associated with the product.

(b) Information to be collected

(i) Save for the life insurance policies within the scope of paragraphs (a) (i) a. (1) to (3) and (a) (ii) above, an authorized insurer or a licensed insurance intermediary cannot opt out (and cannot accept an application from a customer who wishes to opt out) of the FNA process unless it obtains the IA's prior consent (e.g. through the InsurTech Sandbox).

(ii) The extent and granularity of the information to be collected can be varied depending on the particular circumstances of the target customers and the mode of operation of the distribution channel. Authorized insurers and licensed insurance intermediaries have an obligation to collect adequate information to place themselves in a position whereby they can perform reasonable assessments before making any insurance recommendation.

(iii) A template is set out at Appendix (See **Appendix L**) to illustrate the information that should normally be collected during the FNA process. Authorized insurers and licensed insurance intermediaries can add questions or modify the exact wording of the questions for the purposes of a proper assessment of the customer's particular circumstances, having due regard to the products available under the relevant distribution channel and technology adopted. However, any such changes must be justifiable on the basis that, (i) the substantive meaning of the questions (in the Appendix (See **Appendix L**)) are retained in spite of the changes made; (ii) in spite of the changes made, the principle of "fair customer treatment" continues to be satisfied; and (iii) the reason(s) for such changes must be documented.

(iv) If a customer refuses to disclose information during the FNA process, the licensed insurance intermediary should clearly explain to the customer that without such information the authorized insurer and licensed insurance intermediary would be unable to comply with the requirements contained in GL30, and consequently this would likely result in the authorized insurer rejecting the application. In these circumstances, the licensed insurance intermediary cannot recommend any insurance product to the customer.

(c) Documentation and signatures

(i) A licensed insurance intermediary must properly document the information provided by the customer during the FNA process. The factors considered, evaluation, the recommendation(s) made by the licensed insurance intermediary, and reason(s) for such recommendation(s) should also be documented as appropriate. When conducting the FNA, care should be taken to determine from whom, and in relation to whom, the relevant information should be collected (e.g. where the policy is to be held on trust, the assessment should be made based on the circumstances of the potential policyowner and/or the insured (e.g. settlor, beneficiary, protector or enforcer of the trust) rather than the trustee) and proper documentation should be maintained.

(ii) Before the issuance of a life insurance policy which requires an FNA to be conducted, an authorized insurer has the obligation to ensure that a proper and complete FNA has been conducted. In the case of business referred from a licensed insurance broker company, the authorized insurer is required to ensure that an FNA has been properly conducted by the licensed insurance broker company before accepting the application.

(iii) A completed FNA form must be signed and dated by the customer and the licensed insurance intermediary. Digital signatures or other similar signature verification technology are permitted. A completed and signed FNA form shall be valid for 12 months from the date the customer signs it. Customers should be reminded to inform the relevant authorized insurer or the licensed insurance intermediary of any material changes to the information provided during the FNA process. In the event that a customer purchases an additional insurance policy(ies) or coverage from the same authorized insurer or via the same licensed insurance intermediary within 12 months after an FNA form is completed, it is not necessary to conduct another FNA unless there are material changes in the circumstances of the customer or the purchase of the additional insurance policy or the additional coverage would result in a mismatch (see paragraphs (f) (i) to (f) (iv) for further details).

(d) Matters to consider before making the recommendation

(i) Licensed insurance intermediaries must have due regard to the relevant information provided by customers in an FNA before making any recommendation. Where a customer has other policy(ies) in force, whether with the same authorized insurer or with other authorized insurers as disclosed by the customer, the assessment should be carried out based on an aggregate of all the in force policies of the customer, rather than just the policy which

is the subject of the application. An authorized insurer should have internal controls for identifying the accumulation of multiple policies it has in force for the same individual customer.

(ii) When assessing a customer's ability and willingness to pay insurance premium, the source of funds of the customer must be duly considered to ensure that the customer can afford the recommended product(s) throughout the entire duration of the premium payment term. For instance, where the premium payment term of the recommended policy will last beyond the target retirement age of the customer, the licensed insurance intermediary should assess whether the customer can afford the premium payment after his/her retirement.

Where the customer has indicated that **premium financing** is intended to be used, the licensed insurance intermediary must take that into account when assessing a customer's ability and willingness to pay insurance premium. According to the **Circular on the supervisory standards and key requirements on the use of premium financing to take out long term insurance policies** issued by the IA, this affordability assessment in respect of premium financing, which should be explained to the customer, must at a minimum, ascertain whether the customer has sufficient financial resources to (1) pay at the outset the portion of the premium not financed by the premium financing facility; (2) meet all scheduled repayments (including principal and interest repayments) over the entire tenure of premium financing facility; and (3) repay the sum owed under the premium financing facility if demanded by the lender before maturity of the policy. To comply with the above requirement, insurance intermediaries without access to the information regarding the premium financing facility should ask for and obtain such information from the customer. If the customer refuses to disclose such information, the insurance intermediary should perform the affordability assessment as if the customer is not acquiring the proposed policy using premium financing (i.e. the total premium is to be funded entirely by the customer's own funds). The insurance intermediary must also explain to the customer that, without the information, it would not be able to assess the customer's suitability and affordability of acquiring the proposed policy using premium financing, pursuant to the Standard and Practice 6.1(b)(iv) of the Code of Conduct for Licensed Insurance Agents or Code of Conduct for Licensed Insurance Brokers.

(iii) Where an ILAS product may be the subject of a recommendation to a customer, information must be collected during the FNA process about whether the customer is able and willing to make his/her own decision to choose and manage different investment choices available under the ILAS product. If the customer has

indicated that he/she does not want or is unwilling to choose or manage different investment choices, no ILAS product should be introduced or recommended to the customer. If the customer has indicated that he/she wants or is willing to choose or manage different investment choices with professional advice to be provided by the authorized insurer or licensed insurance intermediary, no ILAS product should be introduced or recommended to the customer unless such a service will be provided to the customer by the authorized insurer or the licensed insurance intermediary.

(e) Provision of insurance options

(i) For the purposes of the Guideline on Underwriting Class C Business (GL15), whenever an ILAS policy is recommended to a customer, a participating policy that meets the customer's investment objective should also be provided to the customer as an option in accordance with the relevant requirement under GL15.

(ii) For the purposes of the Guideline on Underwriting Long Term Insurance Business (other than Class C Business) (GL16), where, following an FNA process as required by GL30, a licensed insurance broker recommends an insurance product to a customer, the licensed insurance broker should also provide the customer with at least another insurance option from a different authorized insurer that meets the customer's needs and circumstances. The only exception to this would be where the licensed insurance broker concludes that there is no other insurance option available to the customer. In this exceptional situation, the licensed insurance broker should document its justification for reaching the conclusion that no such other insurance option is available.

(f) Handling of mismatch cases

(i) When a licensed insurance intermediary recommends an insurance product which does not meet the needs and circumstances of the customer based on the information collected during the FNA process, this is regarded as a "mismatch". Authorized insurers, licensed insurance agencies and licensed insurance broker companies must put in place appropriate control measures to handle mismatch cases based on the principle of "fair customer treatment". Where a mismatch exists and the licensed insurance intermediary makes a recommendation despite the mismatch, the licensed insurance intermediary is required to clearly explain the mismatch to the customer and why (despite the mismatch) the product is recommended to the customer. The licensed insurance intermediary must also document the details of the explanation.

(ii) In the case a recommendation of mismatch has been made, the authorized insurer should, during the underwriting process, review and assess the reasonableness of such recommendation and satisfy itself that the mismatch case has been handled in accordance with the control measures it has put in place, before accepting the application.

(iii) A deviation between the recommended level of insurance protection and the level of insurance protection identified during the FNA process (i.e. where the recommended level is higher or lower than the level of protection identified in the FNA) is not considered a mismatch if the deviation has a justified, sound and reasonable basis (e.g. the deviation is because of the underwriting limit set by the authorized insurer, or is based on the health status of the customer, etc.). In such a case, the licensed insurance intermediary is required to clearly explain to the customer, and properly document, how the recommended level of insurance protection is determined. This requirement also applies where the recommended benefit/protection period deviates from the customer's choice. Special care should be taken when the customer indicates a wealth accumulation-related objective, e.g. "saving up for the future". In such a case, if the recommended product(s) is not able to achieve the target savings amount within the timeframe indicated by the customer, this should be considered as a mismatch unless the deviation from the target savings amount has a justified, sound and reasonable basis.

(iv) Authorized insurers should normally not accept an application with a mismatch in affordability (e.g. the customer has indicated a target premium term of 10 years but is recommended a product with a whole-of-life payment term). In rare cases where there are valid reasons for such a recommendation, the licensed insurance intermediary is required to clearly explain the mismatch to the customer and why the product is recommended to the customer despite the mismatch (and properly document such explanation). It is not considered a mismatch when the recommended insurance policy has a shorter premium payment term than the target premium term indicated by the customer.

5.2.10 Important Facts Statement for Mainland Policyholder

The Insurance Authority (IA) has issued the **Important Facts Statement for Mainland Policyholder** ("IFS-MP") (see **Appendix M**) for compliance by authorized insurers carrying on long term business starting from 1 September 2016. The IFS-MP aims to remind Mainland customers of the factors and risks to be considered when they are taking out long term insurance policies in Hong Kong to enable them to make an informed decision. The requirements in respect of the IFS-MP are as follows:

(a) The IFS-MP is required for all new applications through any distribution channels for long term insurance individual policies under Class A, B, C, D, E, and F of "long term business" as defined in the Insurance Ordinance made by customers being holders of Resident Identity Card (PRC). They shall not opt-out of this requirement. For the avoidance of doubt, in case of change of policy ownership or policy assignment where the new policyholders/assignees are holders of Resident Identity Card (PRC), the IFS-MP is required for the new policyholders/assignees.

(b) The IFS-MP needs only be conducted once for one policy. There is no need for Mainland customers to sign the IFS-MP for top-up or rider addition if the basic plan was taken out after the implementation of the IFS-MP. On the other hand, if the basic plan was taken out before the implementation of the IFS-MP, the insurer concerned should endeavour to ask the Mainland customers to sign the IFS-MP for top-up or rider addition. In case it is not possible to do so (e.g. the insurer concerned is unable to contact the customer or the customer refuses to sign the IFS-MP), the insurer may send the IFS-MP to the Mainland customer for information together with the other document(s) to be issued for the top-up or rider addition. The insurer must retain record of dispatch as proof of compliance with the requirement. For the avoidance of doubt, if an existing Mainland customer subsequently purchases a second life insurance policy, he/she has to sign another IFS-MP. That said, if the Mainland customer takes out more than one policy from an insurer at the same time, the insurer has the option to require the customer to sign on one single IFS-MP with all those product names listed at the top of the IFS-MP; or individual IFS-MP for each product taken out.

(c) It should be presented as a separate form. In case the insurer intends to include it as a separate section within another point-of-sale document (e.g. application form), prior consultation with the IA is required.

(d) Intermediaries are required to go through the IFS-MP on a point-by-point basis with the Mainland customers at the point-of-sale.

(e) Insurers must adopt the IFS-MP in full, although individual insurers may add additional disclosure to accurately reflect the risks associated with their specific products. All the questions must be presented in a single form/section with the heading clearly stated as IFS-MP.

(f) The IFS-MP follows the practice of the IFS for Investment-linked Assurance Scheme ("ILAS") where the customer will need to sign on every page of the form.

(g) Insurers may also prepare English and Traditional Chinese versions of the IFS-MP. However, the one signed by the Mainland customers must be in Simplified Chinese.

(h) A copy of the signed IFS-MP must be provided to the Mainland policyholders. Insurers have the discretion as to when the copy is delivered but in no case should it be delivered later than policy delivery (i.e. it may be delivered together with the policy). For the avoidance of doubt, this does not affect the requirement for the return of policy applications from Mainland customers to insurers within 7 working days of the signing of policy application (including the declaration signed by the policyholder confirming that the selling process is conducted in Hong Kong) where the insurers concerned do not have an independent process for authenticating the identification and entry proofs documents of the Mainlander customers.

(i) There will be no impact on the existing post-sale confirmation call arrangement for ILAS and vulnerable customers.

(j) For ILAS products, Mainland customers have to sign both IFS-MP and IFS-ILAS.

(k) The font size of the IFS-MP must not be smaller than 12.

(l) The IFS-MP is a document required by the IA. For the avoidance of doubt, it is not a marketing document (i.e. for ILAS) and does not require the approval of the Securities and Futures Commission.

5.2.11 Guideline on Offering of Gifts (GL25)

The offering of Gifts or other similar gratuities in the marketing, promotion or distribution of insurance products may unduly influence or otherwise distract customers when it comes to making informed decisions in relation to insurance products and the suitability of such products to meet their insurance needs and other circumstances. In view of this, Guideline on Offering of Gifts (GL25) provides guidance on certain restrictions on the use of gifts and rebates which authorized insurers and licensed insurance intermediaries should follow when marketing, promoting or distributing insurance products classed as long term business.

In general, according to GL25, authorized insurers and licensed insurance intermediaries are restricted to directly or indirectly offer Gifts to customers when marketing, promoting or distributing long term Products (Class C (Investment-linked) Products; Class A (Life and annuity) Products and Class D (Permanent health) Products).

However, when offering Class A Products or Class D Products, a gift may be offered to a customer only if, according to a reasonable assessment made by the authorized insurer or licensed insurance intermediary, the Gift would not distract the customer from making an informed decision on whether or not to purchase the product. the responsibility lies with an authorized insurer and licensed insurance intermediary to make an assessment.

One exception to the above is that authorized insurers and licensed insurance intermediaries which offer Class A Products, Class C Products or Class D Products may offer **Permitted Gifts** as specified in GL25, such as allocation of bonus fund units, gifts offered for relationship building purposes or can be redeemed at a later date under a customer loyalty programme, provision of sponsorship and support for customers, brand building campaigns and ancillary services, provided that the criteria referenced in the Annex to GL25 is strictly adhered to.

5.3 UNDERWRITING

Underwriting may be simply described as the *assessment of risks* for the purposes of insuring them or deciding what insurance terms should apply. Another way of describing the term is to say that it is determining the *insurability* of proposed risks. Since life insurance involves a **long-term** contract that **cannot** be cancelled by the insurer, we may say that normally life insurance underwriting for an individual risk can only be done **once**. It is therefore important to get it right first time.

5.3.1 Underwriting Factors

Underwriting is said to consist of two main stages:

(a) **Identifying the degree of risk:** from experience life insurance underwriters can identify degrees of risk with applications, usually under two headings:

(i) **Physical hazard:** this concerns largely objective factors that are likely to increase the risk of the *insured event* (death) happening. These will include obvious features such as known health dangers, including:

(1) significantly *overweight*;

(2) heavy *smoker*;

(3) *substance abuse* (alcohol, drugs etc.);

(4) very dangerous *occupation* or *leisure pursuits*;

(5) adverse inheritable family or personal *medical history*.

(ii) **Moral hazard:** this concerns rather more subjective factors surrounding the basic *honesty* or honourable intentions of the applicant/proposer. Whilst **suicide** is not a common potential problem (and is in any event covered to a large extent by policy provisions - see **4.12**), there are other considerations. For example, the person may deliberately hide important information or submit false information to obtain cover. It is, of course, less easy to determine moral hazard than physical hazard.

(b) **Classifying the proposed risk:** classifying proposed risks into appropriate *categories* enables the insurer to determine an *equitable premium*. Insurers tend to have four categories of risks, as follows:

(i) **Standard risks:** these present no abnormal features, and are perfectly acceptable at the appropriate premium according to the age and sex of the applicant.

(ii) **Sub-standard risks:** sometimes called **special class risks**, they are expected to produce a higher mortality rate than a group of normal lives. They are *insurable*, but only subject to certain considerations to be discussed in **5.3.3** below.

(iii) **Declined risks:** as the name indicates, these are risks that a particular insurer has found to be unacceptable. Insurers generally try to give cover if they reasonably can, but obviously there are some applications where health or other factors make it impossible to accept.

(iv) **Preferred risks:** not all insurers use this category, which implies an *above average* risk application that merits a discount or other favourable terms. This may include confirmed non-smokers or individuals who otherwise represent better prospects of long years before a claim is likely to arise.

Note: The above may be said to represent **technical underwriting**, involving an assessment of the intrinsic and perceived hazards presented by individual risks. We should also note what is called **Financial Underwriting**. This term relates to an assessment of the sum to be insured in relation to various matters, including:

1 the perceived ability of the policyowner to meet premium obligations;

2 the degree of risk presented (and therefore whether **reinsurance** might be advisable/available);

3 accumulation of policy plans for the same person;

4 whether it is in excess of usual levels for persons corresponding to the age and general circumstances of the applicant/proposer. We cannot say that any life insurance is *too much*, but if it is very high by customary standards this may put the insurer on enquiry.

5.3.2 Medical Reports

5.3.2a Non-medically Examined Business

Many life insurance plans are arranged on a *non-medically examined* basis. That is, the information supplied on the application and other circumstances surrounding the proposal (age, apparent health, sum to be insured, etc.) allow the underwriter to proceed without further enquiry.

5.3.2b Medically Examined Business

Sometimes, however, further information is required from qualified medical practitioners. The source of such enquiry may be an *attending physician* (by which is meant a doctor or other qualified medical person who usually supplies or has previously supplied medical care to the applicant) or an *examining physician* (by which is meant a physician who conducts a medical examination (the U.S. term commonly used is a **physical**) at the request of the insurer, who pays for this). A number of factors need to be considered with this subject:

(a) **A sensitive subject:** it is human nature to become anxious at the thought of a medical examination. This is quite illogical, as it must be for one's good to know the truth, but that is not how most of us think. Insurers are quite aware of this and only request medical information if it is deemed really necessary. In addition, great care has to be taken not to infringe any statutory provisions regarding the *protection of personal data*.

(b) **Attending Physician's Statement** (APS)**:** this is the most frequently required medical report and the usual reasons for requesting it are:

(i) specific medical disclosures on the application need further enquiry;

(ii) the amount of insurance requested is high;

(iii) the applicant is at a fairly advanced age (say, over 50).

(c) **Specialised medical questionnaire:** the examining (or attending) physician may be supplied with a separate questionnaire specifically designed to obtain information on a particular illness or condition that needs to be considered with the applicant concerned. This may relate to any of a number of conditions, ranging from blood pressure to cancer, being conditions that previously disclosed information suggests a need for further inquiry.

(d) **Confidentiality:** obviously, medical information is very private and the information obtained must be treated with the utmost confidence. However, if and when medical tests are suggested, the applicant has the right to know what tests are to be done, what the information is needed for, and (if he wants to know) the results of any tests.

5.3.3 Sub-Standard Life and Underwriting Measures

Usually for medical, but sometimes for other reasons, a particular applicant may prove to be below the required standard for acceptance at normal rates. There are a number of possible underwriting reactions to this situation, including:

(a) **Refuse to insure:** sometimes called *declinature*. This is a drastic measure that insurers prefer to avoid if at all possible. Most life applications can be accommodated, although sometimes the terms of the insurance may have to be more severe.

(b) **Load the premium:** increasing the premium is a standard way of dealing with sub-standard risks. The extra premium, which may be quite modest or quite substantial according to circumstances, can turn the abnormal into insurable risks. A common form of such a method is a method of Extra Percentage Tables, which is to classify sub-standard risks into groups based on the expected percentages of standard mortality and then to impose extra premiums on individual risks that reflect the excess mortality (see (c) below) of these risks.

(c) **Other options:** the above two reactions are the most common, but there is a wide range of possibilities, which might include one or more of the following:

(i) to create a **"debt"** on the policy (or a lien against the policy), which normally will reduce year by year so that it disappears on a specified date. This method is suitable where the excess or extra mortality is of a distinctly decreasing and temporary nature.

A 'debt on policy' is one of the underwriting measures which are associated with the 'numerical system of rating'. Under this system, the underwriter applies a mortality rating of 100 to the normal average healthy life, and then adds to it for adverse features (e.g. overweight) and subtracts from it favourable features (e.g. non-smoking). The excess of the final mortality rating over 100 is termed an 'extra mortality'. This extra mortality will be converted into an additional premium or a debt against the sum assured.

The decreasing debt is the most commonly used type of debt. Suppose the debt is set at $190,000 at the inception of a 20-year endowment policy for a sum assured of $400,000. Should death occur in the first year of cover, the policy proceeds will be $210,000 (i.e. $400,000 minus $190,000). The debt will reduce, and so the *actual* cover will increase, at the end of each of the first 19 years of cover, by $10,000. So in the last year of the policy, the cover is $400,000.

Note: allocation of bonuses will be done on the basis of the full sum assured (i.e. the nominal cover).

(ii) specific **exclusions**, perhaps of death from a particularly dangerous pastime or leisure pursuit (this would be very rare, since it tends to defeat the object of the cover);

(iii) offering a **limited plan:** short term cover may be possible, where the medical evidence indicates that very long-term insurance is doubtful;

(iv) decline to accept **at present**, i.e. to **defer** a decision, if the applicant is severely injured or otherwise has a (hopefully) temporary adverse condition.

5.4 POLICY ISSUANCE

Once the underwriting process is complete and cover has been approved, the policy can be prepared and then delivered to the policyowner. The important fact that a policy cannot be **cancelled or amended** after its issue without the agreement of the policyowner once more needs to be mentioned. Issuing and delivering the policy in some respects may be looked upon as the "point of no return" for the insurer. Careful policy checking and confirmation is therefore needed before this happens.

5.4.1 Policy Delivery

This may be considered with policy issuance as the two are very closely connected. Using modern technology, policy documents can be produced with great speed and accuracy. The in-house system should create the client's record and verify that the first premium has been received. Policies are mostly in standard format within the class and plan concerned. Therefore, only *variations* affecting the particular client alter the routine format. All of this can be dealt with by an automated system. Some slight differences in procedure should be noted as follows:

(a) **Individual policy covers** (including *annuities*)**:** the production and delivery is straightforward, delivery normally usually being made by the **marketer**.

(b) **Group policy covers:** here the process involves enrolling individual *employees* (or other group persons). The technology system must therefore produce not only the master policy, but also a *certificate* and perhaps an *enrolment card* for each insured person. Each such person receives a certificate and completes an enrolment card, the process normally being overseen by the **insurance intermediary** or **group representative**.

5.5 AFTER SALES SERVICE

The **conservation** of existing business has been mentioned before (see **5.2.3a**(a)). This, for reasons given, is very important and the quality of after-sales service is a vital element in this area. Such service is within the responsibilities of Client Service personnel (see **5.1.1**(e)), whose department might well now be called *Policyowner Service*, or **POS**. By way of reminder, the duties of POS may include:

(a) *Correspondence*: and other communication with customers.

(b) *Documentation*: duplicate policies, surrenders, plan conversion, etc.

(c) *Premium payments*: handling all aspects of this.

(d) *Benefit administration*: cash values, policy loans and dividends.

(e) *Policy changes*: see below.

5.5.1 Policy Changes

These changes may be relatively trivial, amending some administrative detail, or may have a significant effect upon contract terms. The changes usually requested include **changing** the

(a) *type of insurance cover*: obviously of considerable significance;

(b) *address*: of the policyowner or beneficiary, for example;

(c) *beneficiary*: clearly this must be a permissible change, under contract terms;

(d) *amount of cover*: after any due underwriting consideration;

(e) *owner of the policy*: another obviously important change.

Note: All changes must be carefully processed. The change requested may seem very straightforward, but there is always the possibility that it will have legal or other implications, ranging from underwriting or reinsurance matters even to potential attempted fraud (**money laundering,** etc.).

5.6 CLAIMS

With Non-Life insurance, claims are only expected under a small proportion of policies. There the cover is "in case" there is need and generally speaking neither party wishes to experience a claim situation. The latter may be true in some respects for Life insurance, but there a claim (except for **term insurance**) is inevitable if the policy is kept in force. Indeed, with many contracts having a **savings** element, the policyowner often looks forward to making a claim. Claims may be considered under three headings, as follows:

5.6.1 Maturity Claims

Mostly concerning **endowment insurance**, these involve situations where the life insured is still living and (if also beneficiary) able to collect the proceeds personally. With these, as with all procedures dealt with under this Chapter, each insurer may have its own system, but typically the following considerations arise with maturity claims:

(a) **Near the date:** a month or so in advance of the date the insurer writes to the policyowner, in order to:

  (i) *remind* him of the maturity date;

  (ii) state the *amount* payable;

  (iii) list any *requirements* for payment;

  (iv) enclose a relevant form of *release*.

(b) **Claim entitlement:** the insurer can only deal with the person having a right to the policy proceeds, who could be the policyowner himself, an assignee (where the policy has been assigned), or a trustee (where the policy has been placed in

trust). Also, the policy will be required and, in practice, only assignments duly recorded are recognised. Regarding loss of a life policy, this is only inconvenient but not crucial, because the policy is only evidence of the insurance contract, rather than the contract itself. However, as failure to produce a policy may constitute constructive notice to the insurer (i.e. knowledge that the insurer would have acquired had it made the investigations that are usual in the circumstances) of another person's interest in it, a prudent insurer will require that a proper search for it be made. If it is still unfound, the insurer may ask the claimant to make a statutory declaration in respect of the loss, and to provide a written promise to indemnify the insurer against any losses due to its settling the claim without production of the policy.

(c) **Adjustments:** the payment may have to be subject to deductions for any outstanding items, such as policy loans, unpaid premiums and interests owing. Of course, any *third party interest* has to be respected and processed in an appropriate manner.

(d) **Proof of age:** if the policy is marked "*age not admitted*", this means that formal proof of age was not given at policy inception. Some insurers may not require confirmation of age if the policy has matured, but it should be requested because **misstatements of age** could have an impact on the policy benefit (see **4.8**).

(e) **Unpaid maturities:** a suitable monitoring and follow-up procedure must be in existence for any maturity claims where the policyowner does not respond to (a) above.

5.6.2 Death Claims

Maturity claims, for obvious reasons, are normally processed in a "happy" atmosphere. Death claims on the other hand inevitably have a serious and sometimes tragic background. Whilst this must not intrude unduly into the professional way in which the claim is processed, insurers and insurance intermediaries should be sensitive to the situation. The specific points needing attention with such claims are:

(a) **Claim entitlement:** people who are possibly entitled to a policy's death benefits include the surviving policyowner in the case of a third party policy (see **Glossary**), the personal representative of the policyowner-insured, an assignee and a trustee. Where a policy is expressed to be payable to a third party, named or unnamed, without creating a trust or effecting an assignment, he will normally have no right to sue under the contract and it is the policyowner's successors in title who can enforce the contract. That said, where paying the third party has been made an essential term of the contract, payment to him will discharge the insurer of policy liability so that whether or not the paid third party may, in certain circumstances, have to account to the policyowner's personal representative will not concern him.

For "**loss of policy**" procedure, please see **5.6.1**(b) above.

(b) **Date of death:** this must be established, as it can affect the *amount* payable, e.g. with **decreasing term** insurance, and with any **dividend/bonus** calculations. Indeed, with **term** insurance, the policy could have expired.

(c) **Proof of death:** normally, this is fairly easy to obtain, with the *death certificate* (the **original** document must be produced). Problems may arise over death certificates, however, where death arises or is alleged to have arisen overseas. This has on occasions been a particular area for *fraud*.

(d) **Cause of death:** this will be shown on the death certificate and it may be important for a number of reasons, including:

(i) *suicide*: happening within the suicide exclusion period (see **4.12**);

(ii) *accident*: the policy may be subject to an **ADB rider** (see **3.2.1**(a));

(iii) *suspicious or surprising*: death shortly after the policy was issued, or where the cause would normally develop over a longer period than that for which the policy has been in existence, will put the insurer on enquiry. **Fraud** must always be a possibility in such circumstances. Even if fraud does not apply, the policy may still be within a **contestable** period (see **4.2**);

(iv) *murder*: in most cases, this will not affect the validity of the claim, but if the murderer is proved to have been the **beneficiary**, the law (**"public policy"**) will not allow the murderer to benefit personally.

(e) **Presumption of death:** where no death certificate can be issued and it is assumed the life insured has died, this may have to be resolved by the **court**.

(f) **Proof of age:** see comments in **5.6.1**(d). Normally, proof of age is easily obtained by producing the deceased's **birth certificate**, **identity card** or **passport**.

5.6.3 Surrenders

Many of the considerations arising with **maturity claims** have relevance here, as the claimant is still living. Specifically, areas needing attention are:

(a) **Proof of title:** those who are possibly entitled to the cash value include the policyowner, an assignee and a trustee (or a trustee-in-bankruptcy). For "**loss of policy**" procedure, please see **5.6.1**(b) above.

(b) **Adjustments:** unpaid premiums, policy charges, policy loans and interests must be taken into account;

(c) **Discharge:** an appropriate release is obtained. Care must be taken to protect any **assignee** or **third party** interest in an appropriate manner;

(d) **Other enquiries:** the insurer or insurance intermediary should take special care with applications for surrender of the policy. Obviously, the policyowner has

every right to discontinue cover, but it may be helpful and productive to make discreet and courteous enquiries so as to detect potential attempted fraud, e.g. money laundering.

Sometimes, the insurance meets a real need for the client, but he meets unexpected life situations and his first thought is to cancel his insurance. That may not be in his best interests and other more suitable alternatives may be available (**policy loan**, use of **nonforfeiture** provisions, etc.).

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Representative Examination Questions

Type "A" Questions

1 A mutual life insurance company means that:

(a) each shareholder has limited liability; .....
(b) the company is owned by shareholders; .....
(c) all policyholders share equally in profits and dividends; .....
(d) the company is legally owned by its participating policyholders. .....

[Answer may be found in **5.1**]

2 Which of the following is **not** likely to be the responsibility of the marketing department of a life insurance company?

(a) market research; .....
(b) product research; .....
(c) settlement of claims; .....
(d) promotions and publicity work. .....

[Answer may be found in **5.1.1**(f)]

Type "B" Questions

3 Which **two** of the following statements concerning the "Cooling-off Period" are **true**?

(i) The period is for 14 days only.
(ii) It concerns all authorized insurers carrying on long term business, and all licensed insurance intermediaries carrying on regulated activities in respect of long term business.
(iii) If properly exercised, the new policy is cancelled and the premiums are returned.
(iv) The period relates to the time during which the insurer may cancel the policy.

(a) (i) and (ii); .....
(b) (i) and (iii); .....
(c) (ii) and (iii); .....
(d) (iii) and (iv). .....

[Answer may be found in **5.2.4**]

4 Which **three** of the following are matters likely to affect **physical hazard** when underwriting a life insurance application?

(i) Significantly overweight
(ii) Adverse inheritable family medical history
(iii) Dishonesty of the applicant in providing information
(iv) The applicant's heavy dependency on drugs, alcohol or tobacco

(a) (i), (ii) and (iii); .....
(b) (i), (ii) and (iv); .....
(c) (i), (iii) and (iv); .....
(d) (ii), (iii) and (iv). .....

[Answers may be found in **5.3.1**]

[If still required, the answers may be found at the end of the Study Notes.]

Appendix 1

Guideline on Statement in relation to Cooling-off Period in Policy Application Form

An explanation of a policy holder's right to cancel the life insurance policy within the Cooling-off Period must be prominently displayed in the application form for the policy and (depending on the distribution channel utilized) must be clearly explained to him/her by the insurer or licensed insurance intermediary (as the case may be) during application process. Guidance on the appropriate wording which may be used for this statement is given below:

1. For all life insurance policies to which this Guideline applies (except policies of the nature specified in Class C in Part 2 of Schedule 1 to the Ordinance and single premium policies)

"Cancellation Rights and Refund of Premium(s) within Cooling-off Period

I understand that I have the right to cancel the policy and obtain a refund of any premium(s) paid by giving a written notice to [the name of authorized insurer]. I understand that to exercise this right, the notice of cancellation must be [signed by me and] received directly by [name of authorized insurer] at [address of the authorized insurer's Hong Kong Main Office] [see Notes (a) and (b) below] within the Cooling-off Period. I understand that the Cooling-off Period is the period of **21 calendar days** immediately following either the day of delivery of the policy or the Cooling-off Notice to me or my nominated representative (whichever is the earlier). I understand that the Cooling-off Notice is a notice that will be sent to me or my nominated representative by [name of authorized insurer] to notify me of the Cooling-off Period around the time the policy is delivered."

Notes

(a) Authorized insurers may adjust the above wording and specify the manner in which the written notice to cancel the policy is to be given by a policy holder. For example, a written notice may be sent by the policy holder to the authorized insurer by email.

(b) The address must be a Hong Kong address.

Guideline on Statement in relation to Cooling-off Period in Policy Application Form (GL29 – Appendix 1) (2/2)

(Source: Insurance Authority (IA) GL29)

Appendix 1

2. For all policies of the nature specified in Class C in Part 2 of Schedule 1 to the Ordinance and all single premium policies to which this Guideline applies

"Cancellation Rights and Refund of Premium(s) within Cooling-off Period

I understand that I have the right to cancel the policy and obtain a refund of any premium(s) paid less any market value adjustment, by giving a written notice to [the name of authorized insurer]. I understand that to exercise this right, the notice of cancellation must be [signed by me and] received directly by [name of authorized insurer] at [address of the authorized insurer's Hong Kong Main Office] [see Notes (a) and (d) below] within the Cooling-off Period. I understand that the Cooling-off Period is the period of **21 calendar days** immediately following either the day of delivery of the policy or the Cooling-off Notice to me or my nominated representative (whichever is the earlier). I understand that the Cooling-off Notice is a notice that will be sent to me or my nominated representative to notify me of the Cooling-off Period around the time the policy is delivered."

Notes

(a) Authorized insurers may adjust the above wording and specify the manner in which the written notice to cancel the policy is to be given by a policy holder. For example, a written notice may be sent by the policy holder to the authorized insurer by email.

(b) As part of the sales process, authorized insurers will be required to disclose, before the application is signed, their rights to apply an MVA and the details of the basis of calculation of the MVA.

(c) An authorized insurer's right to apply an MVA (together with its basis of calculation) must be included in the relevant product brochure.

(d) The address must be a Hong Kong address.

Appendix 2

Guideline on Reminder of Cooling-off Period at Policy Issuance

A clear reminder of the Cooling-off Period must be given to the policy holder together with the life insurance policy at the time the policy is delivered. The policy holder must also be advised of the right to call the authorized insurer direct if he/she wishes to further understand the Cooling-off Period. Guidance on the appropriate wording which may be used for this reminder is given below:

"Your Right to Change Your Mind

If you are not fully satisfied with this policy, you have the right to change your mind.

We trust that this policy will satisfy your financial needs. However, if you are not completely satisfied then you should:

(a) return the policy, if applicable, and

(b) provide us with written notice, [signed by you], requesting cancellation.

The policy will then be cancelled and the premium(s) paid * will be refunded.

*[*For all policies of the nature specified in Class C in Part 2 of Schedule 1 to the Insurance Ordinance (Cap. 41) and all single premium policies, add "less a deduction of the amount (if any) by which the value of your investment has fallen at the time when your cancellation notice is received by us".*]

These cancellation rights are subject to the following conditions:

(a) Your request to cancel the policy must be [signed by you and] received directly by our office at [address of the authorized insurer's Hong Kong Main Office] [see Note (a) below] within **21 calendar days** immediately following the day of delivery of this policy or the Cooling-off Notice to you or your nominated representative (whichever is the earlier). (The Cooling-off Notice is the notice sent to you or your

nominated representative (separate from the policy) notifying you of your right to cancel within the stated 21 calendar day period).

(b) No refund can be made if a claim payment under the policy has been made prior to your request for cancellation.

Should you have any further queries, you may contact [contact information of the authorized insurer (including the address, service hotline number and email address)] and we will be happy to explain your cancellation rights further."

Note

(a) Authorized insurers may adjust the above wording and specify the manner in which the written notice to cancel the policy is to be given by a policy holder. For example, a written notice may be sent by the policy holder to the authorized insurer by email.

Question Template – Policy Replacement (GL27 – Appendix A) (1/1)

(Source: Insurance Authority (IA) GL27)

Appendix A

Question Template – Policy Replacement

Name of Insurer of this application : _____

Application/Proposal Number : _____

Name of Applicant/Proposer : _____

In order to fund the purchase of your new life insurance policy, are you using, or do you intend to use some or all of the funds arising from your existing life insurance policy, or any savings made by reducing the premium payable under your existing life insurance policy? For example, such funds or savings may arise from:

a) surrendering / partially surrendering your existing life insurance policy to obtain its surrender value
b) taking out a policy loan (including automatic premium loan) from your existing life insurance policy
c) withdrawing policy values from your existing life insurance policy (e.g. cash out dividends or redeem fund units etc.)
d) lapsation of your existing life insurance policy (e.g. by non-payment of premium)
e) exercising the right to a premium holiday under your existing life insurance policy

□ Yes □ Not yet decided □ No

Please check one appropriate box only

Warning: Please answer the above question carefully. Making changes on your existing life insurance policy may not be in your best interest. Your licensed insurance intermediary must explain to you the financial implications, insurability implications and claims eligibility implications of such changes. For this purpose, your licensed insurance intermediary may require certain information on your existing life insurance policy. You may need to approach the insurer of your existing life insurance policy to obtain accurate and up to date information on your existing policy.

If your answer is "Yes" or "Not yet decided", your licensed insurance intermediary must explain the "Important Facts Statement – Policy Replacement" to you.

Signature of the Applicant/Proposer	Date (DD / MM / YYYY)
Signature of Licensed Insurance Intermediary	Date (DD / MM / YYYY)
Full name of Licensed Insurance Intermediary	Type of License and License No.

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Important Facts Statement – Policy Replacement (GL27 – Appendix B) (1/2)

(Source: Insurance Authority (IA) GL27)

Appendix B

Important Facts Statement - Policy Replacement

This "Important Facts Statement – Policy Replacement" ("IFS-PR") aims to help you understand the factors to be considered and the risks involved in replacing your existing life insurance policy with a new life insurance policy. Your licensed insurance intermediary should explain to you the implications and associated risks involved in replacing your existing life insurance policy.

If you do not understand any of the following paragraphs or the advice or information provided to you by your licensed insurance intermediary is different from the information in this IFS-PR, please **do not sign** this IFS-PR and **do not proceed** with replacing your existing Life Policy.

SOME IMPORTANT FACTS YOU SHOULD KNOW
Please read carefully before signing.
Your insurance intermediary shall explain the content to you.

Financial Implications

1. **Informed Decision:** Life insurance policies usually lasts for a long period of time. If you surrender / take out policy loan from / withdraw policy values from / suspend or stop paying premium / reduce the premium payable on your existing life insurance policy, particularly during the early years of the policy period, you will usually suffer loss, including by way of having to pay charges. You should carefully compare your existing life insurance policy against the new life insurance policy you intend to purchase, and assess whether replacing your existing life insurance policy is in your best interests before you make a final decision.

2. **Difference between cash value from Surrender/ Lapse and total premium paid under your existing Life Policy** - The cash value that you may receive from surrendering your existing life insurance policy or allowing your existing life insurance policy to lapse, may be less than your total premium paid. This means that you may suffer a loss. Further, you may incur surrender charges if you surrender your existing life insurance policy or allow it to lapse.

3. **Policy Loan Interest -** The issuing insurer of your existing life insurance policy may charge you interest starting from the loan drawdown date. You should carefully review your regular statements to understand the opening and ending loan balance as well as the interest amount charged in the relevant period. Your existing life insurance policy may be terminated if the accumulated loan amount (and interest) exceeds a specified level of the account value / cash value of your existing life insurance policy.

4. **Withdrawal/ Partial Surrender Charges -** You may be subject to withdrawal charges or partial surrender charges within a prescribed period before the end of the policy term of your existing life insurance policy. For the new life insurance policy you intended to purchase, you may be subject to other early surrender / withdrawal charges within a prescribed period before the end of the term of the new life insurance policy.

5. **Policy Set-up Cost and Remuneration for licensed insurance intermediaries –** If you purchase a new life insurance policy, a substantial part of the initial premium may be used to pay for policy administration costs incurred by insurers and remuneration for the licensed insurance intermediaries. As a result, you may incur additional cost for replacing your existing life insurance policy.

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Important Facts Statement – Policy Replacement (GL27 – Appendix B) (2/2)

(Source: Insurance Authority (IA) GL27)

6. **Higher Premium -** You may have to pay higher premium under the new life insurance policy in view of the difference in age, changes of health conditions, occupation, lifestyle / habit, and recreational activities (as compared with when you purchased your existing life insurance policy).

7. **Loss of Financial Benefit under the existing life insurance policy -** You may lose the financial benefit accumulated over the years (e.g. loyalty bonus or dividends) or to which you may be entitled (e.g. terminal bonus or dividends) under the existing life insurance policy.

8. **Financial Benefits under the New Life Insurance Policy Not Guaranteed -** The illustrated benefits of a new life insurance policy may NOT be guaranteed and whether they can be achieved depend on the performance of the issuing insurer of the new life insurance policy. If the new life insurance policy is an investment-linked assurance scheme policy, the illustrated benefits are based on assumed rates of return only.

Insurability Implications

9. **Changes in Coverage -** If you purchase a new life insurance policy and use it to replace an existing life insurance policy, some benefits, which are the policy features of the existing life insurance policy, may not be covered under the new life insurance policy due to changes in age, health conditions, occupation, lifestyle / habit or recreational activities. Also, riders / supplementary benefits under your existing life insurance policy may not be available under the new life insurance policy.

Claims Eligibility Implications

10 Benefits under the existing life insurance policy will no longer be payable to you if you surrender the policy or allow it to lapse. Besides, you may need to start a new waiting period in respect of certain benefits (e.g. medical, critical illness, suicide or incontestability) under the terms and conditions of the new life insurance policy.

Declaration

By the Insurance Intermediary

I declare that I have discussed and explained the implications and associated risks (including the above listed items) to the Applicant/Proposer regarding his/her decision to replace his/her existing life insurance policy with a new life insurance policy. I further declare that I have not made any inaccurate or misleading statements or comparisons, or withheld any information which may affect the decision of the Applicant/Proposer.

Signature of the Licensed Insurance Intermediary	Full Name of the Licensed Insurance Intermediary
Type of Licensed and Licensed No.	Date (DD/MM/YY)

By the Applicant/Proposer:

I understand the content of the above listed items.

Warning: you must read all items carefully and check that the licensed insurance intermediary has explained all the information on this IFS-PR before you sign this IFS-PR.

Signature of the Applicant/Proposer	Full Name of the Applicant/Proposer	Date (DD/MM/YYYY)

Standard Illustration for ILAS Policies (GL28 – Appendix I) (1/3)

(Source: Insurance Authority (IA) GL28)

Standard Illustration for ILAS Policies

X Y Z LIFE ASSURANCE COMPANY LIMITED

IMPORTANT:
THIS IS A SUMMARY ILLUSTRATION OF THE SURRENDER VALUES AND DEATH BENEFITS OF [NAME OF PRODUCT]. IT IS INTENDED TO SHOW THE IMPACT OF FEES AND CHARGES ON SURRENDER VALUES AND DEATH BENEFITS BASED ON THE ASSUMPTIONS STATED BELOW AND IN NO WAY AFFECTS THE TERMS OF CONDITIONS STATED IN THE POLICY DOCUMENT.

THE ASSUMED RATES OF RETURN USED BELOW ARE FOR ILLUSTRATIVE PURPOSES. THEY ARE NEITHER GUARANTEED NOR BASED ON PAST PERFORMANCE. THE ACTUAL RATES OF RETURN MAY BE DIFFERENT!

Proposal Summary for ABC product

1.	Name of Life Insured:	Age :	Sex :	Smoker / Non Smoker

2. Benefit Summary

Policy Currency:

Benefit Description	[Initial] Sum Assured [1]	[Initial] [M/Q/SA/A] Premium [2]	Premium Payment Term [3]	Benefit Term
Basic Plan				

Total [Initial] [M/Q/SA/A] Premium:

========

[Notes for insurers:
[1] Where the sum assured varies, the initial sum assured at the policy commencement has to be stated. "N.A." could be stated if sum assured is not applicable.

[2] Where the premium varies over the premium payment term, the initial premium at the policy commencement has to be stated. The monthly, quarterly, semi-annually or annually premium actually paid by the policy holder is to be stated.

[3] In case of single premium, this column should state 'Single Premium' or '1' (to denote the premium payment term has only 1 premium payment).]

Standard Illustration for ILAS Policies (GL28 – Appendix I) (2/3)

(Source: Insurance Authority (IA) GL28)

First Option: with assumed net rate of return of 0%, 3%, 6% and 9% p.a.

3a. Basic Plan – Illustration Summary of Surrender Values

Projected Surrender Values					
End of Policy Year	Total Premiums Paid	Assuming Net Rate of Return of 0% p.a.*	Assuming Net Rate of Return of [3%] p.a.*	Assuming Net Rate of Return of [6%] p.a.*	Assuming Net Rate of Return of [9%] p.a.*
1 2 3 4 5	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
10 15 .... At age 90 At age 95 At age 100					

3b. Basic Plan – Illustration Summary of Death Benefits

Projected Death Benefits					
End of Policy Year	Total Premiums Paid	Assuming Net Rate of Return of 0% p.a.*	Assuming Net Rate of Return of [3%] p.a.*	Assuming Net Rate of Return of [6%] p.a.*	Assuming Net Rate of Return of [9%] p.a.*
1 2 3 4 5	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
10 15 .... At age 90 At age 95 At age 100					

Standard Illustration for ILAS Policies (GL28 – Appendix I) (3/3)

(Source: Insurance Authority (IA) GL28)

Second Option: with assumed net rate of return of 0%, 3% and 6% p.a.

3. Basic Plan – Illustration Summary

Projected Surrender Values and Death Benefits							
End of Policy Year	Total Premiums Paid	Assuming Net Rate of Return of 0% p.a.*		Assuming Net Rate of Return of [3%] p.a.*		Assuming Net Rate of Return of [6%] p.a.*	
		Surrender Value	Death Benefit	Surrender Value	Death Benefit	Surrender Value	Death Benefit
1 2 3 4 5	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
10 15 … At age 90 At age 95 At age 100							

4. Explanatory Notes

* The Surrender Values and Death Benefits shown in the above illustration are calculated based on the net rates of return. However, the net rates of return are net of any underlying/ reference fund charges levied by fund houses which vary with different underlying/ reference funds. Assuming the underlying/ reference fund charges are [1.50%] p.a., the gross rates of return on the underlying assets of the underlying/ reference funds used in this illustration are therefore *[First Option: [1.50%] p.a., [4.50%] p.a., [7.50%] p.a. and [10.50%] p.a. / Second Option: [1.50%] p.a., [4.50%] p.a. and [7.50%] p.a.]* respectively. For details of underlying/ reference fund charges, please refer to the offering documents of the underlying/ reference funds. Please note that this illustration might not be relevant to the actual rates of return, which depend on your choice of investment options. Please consult your advisor for further details. If you select any investment options linked to a money market fund or a fixed income fund, the above returns in the growth scenarios would be considered higher in many cases and unlikely to be achieved should low interest rate environment persists. You are strongly encouraged to consult your financial advisor who could provide further information on these underlying/ reference funds - both for your initial and subsequent investment option selections.

[Under the assumed net rate of return at 0% [and b%] p.a., your policy will remain in force up to an attained age of x [and y] of the individual insured respectively. The policy will be terminated afterwards. Your policy may also be terminated under other adverse investment scenarios. If the actual investment return is below the above assumed net rate of return, the policy may be terminated earlier than above attained age(s). You could lose all your premiums paid and benefits accrued if any condition of automatic early termination is triggered.]

Warning

- ***You should only invest in this product if you intend to pay the premium for the whole of your chosen premium payment term.***
- ***Should you terminate this policy early or cease paying premiums early, you may suffer a significant loss.***
- ***Your policy may be terminated if the account value is insufficient to pay the fees and charges.***

Declaration

I confirm having read and understood the information provided in this illustration and received the principal brochure.

Name of Applicant: _____ ***Signature:*** _____ ***Date:*** _____

Standard Illustration for Participating Policies (GL28 – Appendix II) (1/5)

(Source: Insurance Authority (IA) GL28)

Standard Illustration of Participating Policies

X Y Z LIFE ASSURANCE COMPANY LIMITED

IMPORTANT:
THIS IS A SUMMARY ILLUSTRATION OF THE PROJECTED SURRENDER VALUES AND DEATH BENEFITS OF YOUR POLICY. IT IS INTENDED TO SHOW THE PROPORTION OF ANY NON-GUARANTEED ELEMENTS AND THE IMPACT OF CHANGE OF SUCH ELEMENTS UNDER SPECIFIED SCENARIOS. IN NO WAY SHOULD IT AFFECT THE TERMS AND CONDITIONS STATED IN THE POLICY DOCUMENT.

Proposal Summary for ABC product

1.	Name of Life Insured:	Age :	Sex :	Smoker / Non Smoker

2. Benefit Summary

Policy Currency:

Benefit Description	[Initial] Sum Assured / Protection Amount [1]	[Initial] [M/Q/SA/A] Premium [2]	Premium Payment Term [3]	Benefit Term
Basic Plan Supplementary Benefits e.g. Accidental Death Benefit Double Indemnity Hospital Income				

Total [Initial] [M/Q/SA/A] Premium:

========

[Notes for insurers:

[1] The protection amount could be a sum assured or the value of a regular payment as in the case of hospital income riders attaching to the policy. Where the sum assured varies, the initial sum assured at the policy commencement has to be stated. "N.A." could be stated if sum assured is not applicable.

[2] Where the premium varies over the premium payment term, the initial premium at the policy commencement has to be stated. The monthly, quarterly, semi-annual or annual premium actually paid by the policy holder is to be stated.

[3] In case of single premium, this column should state 'Single Premium' or '1' (to denote the premium payment term has only 1 premium payment).]

Standard Illustration for Participating Policies (GL28 – Appendix II) (2/5)

(Source: Insurance Authority (IA) GL28)

3. Basic Plan – Illustration Summary

End of Policy Year	**Total Premiums Paid**	SURRENDER VALUE				DEATH BENEFIT			
		Guaranteed	Non-Guaranteed		Total	**Guaranteed**	Non-Guaranteed		Total
			Accumulated Dividends and Interest	Terminal Dividend			Accumulated Dividends and Interest	Terminal Dividend	
1 2 3 4 5	**9,999,999**	**9,999,999**	9,999,999	9,999,999	9,999,999	**9,999,999**	9,999,999	9,999,999	9,999,999
10 15 20 25 30 At age 65 (5-year interval) At Age 100									

Explanation on above illustration:

Please refer to the Explanation Notes Section.

PRINT DATE: DD/MM/YYYY

Standard Illustration for Participating Policies (GL28 – Appendix II) (3/5)

(Source: Insurance Authority (IA) GL28)

X Y Z LIFE ASSURANCE COMPANY LIMITED

The table below illustrates the impact on Surrender Values under Pessimistic and Optimistic Scenarios. The projected benefits under the two scenarios are calculated assuming the investment returns are lower and higher than the company's current assumed investment return respectively; while other factors, such as claims experience, expense factors and persistency factors, affecting these values are assumed to remain unchanged. The two scenarios do not represent lower and upper bounds for the actual investment return; the actual amount of non-guaranteed benefits payable may be higher or lower than those illustrated. They only illustrate, for reference purposes, the projected variation of return of the company based on the investment policies and objectives adopted for this policy.

4. Basic Plan – Surrender Values – Illustration Under Different Investment Return

End of Policy Year	**Total Premiums Paid**	SURRENDER VALUE							
		Guaranteed	Pessimistic Scenario			Optimistic Scenario			
			Non-Guaranteed		Total	Non-Guaranteed		Total
			Accumulated Dividends and Interest	Terminal Dividend		Accumulated Dividends and Interest	Terminal Dividend	
1 2 3 4 5	**9,999,999**	**9,999,999**	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
10 15 20 25 30 At age 65 (5-year interval) At age 100								

Explanation on above illustration:
Please refer to the Explanation Notes Section.

Standard Illustration for Participating Policies (GL28 – Appendix II) (4/5)

(Source: Insurance Authority (IA) GL28)

X Y Z LIFE ASSURANCE COMPANY LIMITED

The table below illustrates the impact on Death Benefits under Pessimistic and Optimistic Scenarios. The projected benefits under the two scenarios are calculated assuming the investment returns are lower and higher than the company's current assumed investment return respectively; while other factors, such as claims experience, expense factors and persistency factors, affecting these values are assumed to remain unchanged. The two scenarios do not represent lower and upper bounds for the actual investment return; the actual amount of non-guaranteed benefits payable may be higher or lower than those illustrated. They only illustrate, for reference purposes, the projected variation of return of the company based on the investment policies and objectives adopted for this policy.

5. Basic Plan – Death Benefits – Illustration Under Different Investment Return

End of Policy Year	**Total Premiums Paid**	DEATH BENEFIT							
		Guaranteed	Pessimistic Scenario			Optimistic Scenario			
			Non-Guaranteed		Total	Non-Guaranteed		Total
			Accumulated Dividends and Interest	Terminal Dividend		Accumulated Dividends and Interest	Terminal Dividend	
1 2 3 4 5	**9,999,999**	**9,999,999**	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
10 15 20 25 30 At age 65 (5-year interval) At age 100								

Explanation on above illustration:
Please refer to the Explanation Notes Section.

Standard Illustration for Participating Policies (GL28 – Appendix II) (5/5)

(Source: Insurance Authority (IA) GL28)

6. Explanation Notes

(i) Sections 3, 4 and 5 are only summary illustrations of the major benefits of your basic plan excluding any supplementary benefits as shown in Section 2 (if applicable) and assume that all premiums are paid in full when due. You should refer to your licensed insurance intermediary or the company for more information or, if appropriate, a more detailed proposal.

[if applicable]

(ii) The amount of total premium(s) may differ slightly from the total of the premiums payable in the policy due to rounding differences.

[only applicable to reversionary bonus plans]

(iii) The face value of any reversionary bonus and terminal bonus will be paid when the company is paying the Death Benefit, whereas the cash value of these bonuses will be paid when the policy is surrendered in whole or in part or terminated (other than due to the death of the Insured). The cash value of these bonuses may not be equal to the face value of the bonuses.

[only applicable to reversionary bonus plans]

(iv) The face value of reversionary bonus is guaranteed once declared while the cash value of reversionary bonus is not guaranteed / [The face value and cash value of reversionary bonus are guaranteed once declared.]

(v) The projected non-guaranteed benefits included in Section 3 are based on the company's dividend/bonus scales determined under current assumed investment return and are not guaranteed. The actual amount payable may change from time to time with the values being higher or lower than those illustrated. As another example, the possible potential impact of a change in the company's current assumed investment return on the Total Surrender Value and the Total Death Benefit are illustrated in Sections 4 and 5. Under certain circumstances, the non-guaranteed benefits may be **zero**.

(vi) In Sections 4 and 5, benefits under Pessimistic Scenario are based on a decrease of about x% p.a. whereas benefits under Optimistic Scenario are based on an increase of about y% p.a. in comparing with the current assumed investment return.

(vii) As illustrated in Sections 3, 4 and 5, you can leave the projected dividends and other cash payments with the company for interest accumulation at an interest rate which is not guaranteed. The interest rate used by the Company for interest accumulation in Section 3 is A % pa. The actual interest rate may change from time to time with rate higher or lower than A %. In accordance with the change in the investment return under Pessimistic and Optimistic Scenarios in Sections 4 and 5 as mentioned in note (v), the accumulation interest rate of B % and C % is used respectively. These rates are also not guaranteed. You may cash all or part of the amount of projected dividends and other cash payments without affecting the protection amount of Section 2 but the total values shown above will be reduced accordingly.

(viii) When reviewing the values shown in the illustrations in Sections 3, 4 and 5, please note that the cost of living in the future is likely to be higher than it is today due to inflation.

7. Dividend / Bonus History

[Website address that shows dividend / bonus history]

You may browse the above website to understand the company's dividend / bonus history for reference purposes.

Warning

- You should only apply for this product if you intend to pay the premium for the whole of the premium payment term.
- Should you terminate this policy early or cease paying premiums early, you may suffer a significant loss.

Declaration

I confirm having read and understood the information contained in this summary of illustrated benefits, and received the product brochure and the information regarding the relevant dividend/bonus history (if applicable).

Name of Applicant : _____ Signature : _____ Date : _____

Standard Illustration for Universal Life (Non-Linked) Policies (GL28 – Appendix III) (1/6)

(Source: Insurance Authority (IA) GL28)

Standard Illustration for Universal Life (Non-Linked) Policies

X Y Z LIFE ASSURANCE COMPANY LIMITED

IMPORTANT:
THIS IS A SUMMARY ILLUSTRATION OF THE PROJECTED SURRENDER VALUES AND DEATH BENEFITS OF YOUR POLICY. IN NO WAY SHOULD IT AFFECT THE TERMS AND CONDITIONS STATED IN THE POLICY DOCUMENT.

THE ASSUMED CREDITING INTEREST RATES USED ARE FOR ILLUSTRATIVE PURPOSES ONLY. UNLESS OTHERWISE STATED, THEY ARE NEITHER GUARANTEED NOR BASED ON PAST PERFORMANCE. THE ACTUAL CREDITING INTEREST RATES MAY BE DIFFERENT!

Proposal Summary for ABC product

1.	Name of Life Insured:	Age :	Sex :	Smoker / Non Smoker

2. Benefit Summary

Policy Currency:

Benefit Description	[Initial] Sum Assured / Protection Amount [1]	[Initial] [M/Q/SA/A] Premium [2]	Premium Payment Term [3]	Benefit Term
Basic Plan Supplementary Benefits e.g. Accidental Death Benefit Double Indemnity Hospital Income				

Total [Initial] [M/Q/SA/A] Premium:

========

[Notes for insurers:

[1] The protection amount could be a sum assured or the value of a regular payment as in the case of hospital income riders attaching to the policy. Where the sum assured varies, the initial sum assured at the policy commencement has to be stated. "N.A." could be stated if not applicable.

[2] Where the premium varies over the premium payment term, the initial premium at the policy commencement has to be stated. The monthly, quarterly, semi-annual or annual premium actually paid by the policy holder is to be stated.

[3] In case of single premium, this column should state 'Single Premium' or '1' (to denote the premium payment term has only 1 premium payment).]

Standard Illustration for Universal Life (Non-Linked) Policies (GL28 – Appendix III) (2/6)

(Source: Insurance Authority (IA) GL28)

3a. Basic Plan – Illustration Summary

The table below illustrates projected Account Values, Surrender Values and Death Benefits under Guaranteed Basis / Conservative Basis and Current Assumed Basis. Figures under Guaranteed Basis are calculated based on minimum guaranteed crediting interest rate, maximum scale of fees and charges and exclude non-guaranteed bonus (if any). / [Figures under Conservative Basis are not guaranteed and are calculated based on minimum guaranteed crediting interest rate / crediting interest rate of 0% p.a., maximum fees and charges / current fees and charges (which may be subject to changes), and exclude non-guaranteed bonus (if any).] Figures under Current Assumed Basis are calculated using current forecast crediting interest rate, current fees and charges (which may be subject to changes), and include non-guaranteed bonus (if any), and are not guaranteed. The actual amount payable may be lower or higher than those illustrated. Under certain circumstances, the non-guaranteed bonus may be zero (if applicable). The current assumed crediting interest rate illustrated by the company shall in no way be interpreted as a projection or estimation of the future returns. The future crediting interest rate may be lower or higher. Details of the maximum and current scale of fees and charges are presented in Summary of Fees and Charges.

End of Policy Year	**Total Premiums Paid**	**Guaranteed Basis** / Conservative Basis			Current Assumed Basis		
		[Description of Minimum Guaranteed Crediting Interest Rate / 0% p.a.**]**			[Description of Current Assumed Crediting Interest Rate]		
		Maximum / Current fees and charges are applied			Current fees and charges are applied		
		Account Value	**Surrender Value**	**Death Benefit**	Account Value	Surrender Value	Death Benefit
1 2 3 4 5	**9,999,999**	**9,999,999**	**9,999,999**	**9,999,999**	9,999,999	9,999,999	9,999,999
10 15 20 25 30 At age 65 (5-year interval) At Age 100							

Explanation on above illustration:
Please refer to the Explanation Notes Section.

Standard Illustration for Universal Life (Non-Linked) Policies (GL28 – Appendix III) (3/6)

(Source: Insurance Authority (IA) GL28)

3b. Basic Plan – Illustration Summary (Optional subject to paragraph 3 of Appendix III)

The table below illustrates the impact on Account Values, Surrender Values and Death Benefits under Pessimistic and Optimistic Scenarios. All figures illustrated are not guaranteed and are calculated based on pessimistic and optimistic views of future crediting interest rates, current scale of fees and charges and include non-guaranteed bonus (if any). The two scenarios do not represent lower and upper bounds for the actual crediting interest rate. They only illustrate, for reference purposes, the projected variation of Account Values, Surrender Values and Death Benefits of this policy based on the investment policies and objectives adopted by the company. The actual amount payable may change from time to time with the values being lower or higher than those illustrated. Under certain circumstances, the non-guaranteed bonus may be zero (if applicable). The crediting interest rates illustrated by the company shall in no way be interpreted as a projection or estimation of the future returns. The future crediting interest rate may be lower or higher. Details of the current scale of fees and charges are presented in Summary of Fees and Charges.

End of Policy Year	**Total Premiums Paid**	Pessimistic Scenario			Optimistic Scenario		
		Crediting Interest Rate: X% p.a.			Crediting Interest Rate: Y% p.a.		
		Current fees and charges are applied			Current fees and charges are applied		
		Account Value	Surrender Value	Death Benefit	Account Value	Surrender Value	Death Benefit
1 2 3 4 5	**9,999,999**	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
10 15 20 25 30 At age 65 (5-year interval) At Age 100							

Explanation on above illustration:
Please refer to the Explanation Notes Section.

PRINT DATE: DD/MM/YYYY

Standard Illustration for Universal Life (Non-Linked) Policies (GL28 – Appendix III) (4/6)

(Source: Insurance Authority (IA) GL28)

4. Explanation Notes

(i) Section 3 is *[Sections 3a and 3b (optional) are]* only a summary illustration of the major benefits of your basic plan excluding any supplementary benefits as shown in Section 2 (if applicable) and assume that all premiums are paid in full as planned without exercising the premium holiday option. You should refer to your licensed insurance intermediary or the company for more information or, if appropriate, a more detailed proposal.

[if applicable]

(ii) The amount of total premium(s) may differ slightly from the total of the premiums payable in the policy due to rounding differences.

(iii) When reviewing the values shown in the above illustration in Section 3, please note that the cost of living in the future is likely to be higher than it is today due to inflation.

5. Crediting Interest Rate History

[Website address that shows historical crediting interest rate]

You may browse the above website to understand the company's crediting interest rate history for reference purposes. Please be reminded that the crediting interest rates shown on the website are before any relevant policy fees and charges are applied (e.g. cost of insurance, policy administration fees, etc.).

Standard Illustration for Universal Life (Non-Linked) Policies (GL28 – Appendix III) (5/6)

(Source: Insurance Authority (IA) GL28)

Summary of Fees and Charges

The scales of fees and charges used in the basic plan illustration in Section 3 are set out below. The current scale of fees and charges, unless otherwise specified, is not guaranteed and is subject to the company's sole discretion to change with prior written notice to policy holders [x] months before effective (note: the [x] cannot be less than 1).

1) Premium Charge
[y]% of each premium paid will be deducted upfront.

2) Surrender Charge
You will be subject to a surrender charge if policy termination occurs before [N]th policy year [or policy maturity if applicable] based on the following table.

Policy year	Surrender charge rate on [Account Value] / Surrender charge amount
1	
2	
3	
etc.	

3) Cost of Insurance
Amount of cost of insurance depends on Insured's attained age, sex, smoking habit, sum assured and cost of insurance rates in the following table. The cost of insurance rates is applied to [sum at risk, which is the higher of sum assured less account value and zero]. The company retains the right to increase the cost of insurance rates up to the maximum rates as specified [if maximum rate is applicable] / The company retains the right to increase the cost of insurance rates above the current rates without limit [if maximum rate is not applicable].

Policy year	Attained age	Cost of insurance rate (Current rates)	Cost of insurance rate (Maximum rates)
1			(Mark "N.A." if not applicable)
2			
3			
…			
10			
15			
etc.			
(end of policy year)	(age at maturity)		

4) Policy Administration Fee
The policy administration fee will be charged from your policy account according to a percentage of your [account value] varied with policy year based on the following table. The company retains the right to increase the policy

administration fee up to the maximum rates as specified [if maximum rate is applicable] / The company retains the right to increase the policy administration fee above the current rates without limit [if maximum rate is not applicable].

Policy year	% of [Account Value] (Current rates)	% of [Account Value] (Maximum rates)
1		(Mark "N.A." if not applicable)
2		
3		
etc.		

5) All other current and maximum (if available) fees and charges (e.g. policy fee, etc.) should also be included and disclosed as appropriate.

Warning

- You should only apply for this product if you intend to pay the premium for the whole of the premium payment term.
- Should you terminate this policy early or cease paying premiums early, you may suffer a significant loss.
- Your policy may be terminated if the Account Value is insufficient to pay the fees and charges.

Declaration

I confirm having read and understood the information contained in this summary of illustrated benefits together with the Summary of Fees and Charges of this illustration document, and received the product brochure and the information regarding the relevant crediting interest rate history (if applicable).

Name of Applicant : _____ Signature : _____ Date : _____

Standard Illustration for Non-Participating Policies (GL28 – Appendix IV) (1/2)

(Source: Insurance Authority (IA) GL28)

Standard Illustration for Non-Participating Policies

X Y Z LIFE ASSURANCE COMPANY LIMITED

Proposal Summary for ABC product

1.	Name of Life Insured:	Age :	Sex :	Smoker / Non Smoker

2. Benefit Summary

Policy Currency:

Benefit Description	[Initial] Sum Assured / Protection Amount [1]	[Initial] [M/Q/SA/A] Premium [2]	Premium Payment Term [3]	Benefit Term
Basic Plan Supplementary Benefits e.g. Accidental Death Benefit Double Indemnity Hospital Income				

Total [Initial] [M/Q/SA/A] Premium:

========

[Notes for insurers:

[1] The protection amount could be a sum assured or the value of a regular payment as in the case of hospital income riders attaching to the policy. Where the sum assured varies, the initial sum assured at the policy commencement has to be stated. "N.A." could be stated if not applicable.

[2] Where the premium varies over the premium payment term, the initial premium at the policy commencement has to be stated. The monthly, quarterly, semi-annual or annual premium actually paid by the policy holder is to be stated.

[3] In case of single premium, this column should state 'Single Premium' or '1' (to denote the premium payment term has only 1 premium payment).]

Standard Illustration for Non-Participating Policies (GL28 – Appendix IV) (2/2)

(Source: Insurance Authority (IA) GL28)

3. Basic Plan – Illustration Summary

End of Policy Year	**Total Premiums Paid**	**Guaranteed Surrender Value**	**Guaranteed Death Benefit**
1 2 3 4 5	**9,999,999**	**9,999,999**	**9,999,999**
10 15 20 25 30 At age 65 (5-year interval) At Age 100			

4. Explanation Notes

(i) Section 3 is only a summary illustration of the major benefits of your basic plan excluding any supplementary benefits as shown in Section 2 (if applicable) and assumes that all premiums are paid in full when due. You should refer to your licensed insurance intermediary or the company for more information or, if appropriate, a more detailed proposal.

[if applicable]

(ii) The amount of total premium(s) may differ slightly from the total of the premiums payable in the policy due to rounding differences.

(iii) When reviewing the values shown in the above illustration in Section 3, please note that the cost of living in the future is likely to be higher than it is today due to inflation.

Warning

- You should only apply for this product if you intend to pay the premium for the whole of the premium payment term.
- Should you terminate this policy early or cease paying premiums early, you may suffer a significant loss.

Declaration

I confirm having read and understood the information contained in this summary of illustrated benefits, and received the product brochure/leaflet.

Name of Applicant : _____ Signature : _____ Date : _____

Annex: List of Admissible and Inadmissible Insurance Terminologies (GL28 – Annex)
Part I – List of ADMISSIBLE alternative insurance terminology (1/2)
(Source: Insurance Authority (IA) GL28)

Annex: List of Admissible and Inadmissible Insurance Terminologies

Part I – List of ADMISSIBLE alternative insurance terminology

Insurance terminology in the templates (English)	Admissible alternative insurance terminology (English)	Insurance terminology in the templates (Chinese)	Admissible alternative insurance terminology (Chinese)
Non-Participating, Participating and Universal life products			
Benefit Term	Policy Term / Protection up to age	保障年期	保單年期 / 保單期 / 保險單期 / 保障至年齡 / 保障期至(歲)
--	--	身故賠償額	身故保障 / 身故賠償 / 身故權益 / 身故保障賠償 / 死亡賠償
--	Cash coupons	--	現金 / 可支取現金
--	Guaranteed monthly income / Monthly guaranteed annuity payment **(Note A)**	--	保證每月入息 / 每月保證年金金額
--	Paid up addition	--	紅利繳清保險
--	--	保費	供款
Premium Payment Term	Premium Term / Premium Payment Period / Premium Payment up to age	保費供款年期	保費繳費年期 / 保費繳款年期 / 保費繳付年期 / 保費繳付期 / 繳付保費年期 / 保費年期 / 保費繳費至年齡 / 保費繳付期至(歲)
--	Maturity Dividend / Maturity Bonus	--	期末紅利 / 期滿紅利
--	Special Dividend / Special Bonus	--	特別紅利
Reversionary Bonus	--	復歸紅利	歸原紅利 / 保額增值紅利
Surrender Value	Surrender Benefit / Cash Value	退保發還金額	退保保障 / 退保價值 / 現金價值 / 現金值 / 淨現金價值

Annex-1

Annex: List of Admissible and Inadmissible Insurance Terminologies (GL28 – Annex)

Part I – List of ADMISSIBLE alternative insurance terminology (2/2)

(Source: Insurance Authority (IA) GL28)

Insurance terminology in the templates (English)	Admissible alternative insurance terminology (English)	Insurance terminology in the templates (Chinese)	Admissible alternative insurance terminology (Chinese)
Sum Assured	Sum Insured	保險金額 / 保障金額	保額 / 保障額 / 投保額
Supplementary Benefits	Supplementary Contract / Rider	--	--
Terminal Dividend / Terminal Bonus	--	終期紅利	--
--	--	戶口價值	賬戶價值
--	--	保險成本	保險費用 / 人壽保險費
--	--	保險成本費率	保險費用率
Premium Charge	Policy Premium Charge / Premium Expense Charge	保費費用	保單保費費用 / 保費行政費用
Sum At Risk	Net Amount At Risk	淨保額	風險額 / 淨承擔風險總值
--	--	萬用壽險	萬用人壽保險

Annex: List of Admissible and Inadmissible Insurance Terminologies (GL28 – Annex)

Part II – List of INADMISSIBLE alternative insurance terminology (1/2)

(Source: Insurance Authority (IA) GL28)

Part II – List of INADMISSIBLE alternative insurance terminology

Insurance terminology in the templates (English)	INADMISSIBLE insurance terminology (English)	Insurance terminology in the templates (Chinese)	INADMISSIBLE insurance terminology (Chinese)
Non-Participating, Participating and Universal Life Products			
Benefit Term	Coverage up to age	--	--
Sum Assured	Face Amount / Coverage / Benefit Amount **(Note B)**	保險金額	面值
Accumulated Dividends & Interest	Step up protection cash value / Step up protection face amount / Accumulated dividends / Balance of accumulated dividends	累積紅利及利息	積存紅利 / 積存的保單紅利 / 累積紅利 / 積存紅利餘額
Terminal Dividend/ Terminal Bonus	Maturity Dividend / Maturity Bonus / Special Dividend / Partner Bonus **(Note C)**	終期紅利	期滿紅利 / 期滿花紅 / 期末獎賞 / 期末紅利 / 特別紅利 / 特別獎賞 / 終期獎賞 / 終期花紅 / 期終額外紅利
Account Value	Accumulation Value / Accumulated Value / Policy Value	戶口價值	累積價值 / 保單價值 / 帳戶價值
Crediting Interest Rate	Crediting Rate / Interest Rate / Projected Crediting Rate	派息率	利率 / 給付利率 / 息率 / 存入利率 / 存入年利率
Current Assumed Basis	Current Basis / Projected (Non-Guaranteed) Basis	現時假設基礎	現行基礎 / 現時(非保證)基礎 / 預計(非保證)基礎
--	--	現時假設派息率	現時息率
Premium Charge	Administrative Charges / Management Charge	保費費用	行政管理費
Surrender Charge	Withdrawal Charge	退保費用	提早贖回費 / 提款手續費

Notes:

A. For products offering monthly income, the guaranteed monthly income cannot be used to mean

sum assured (or initial sum assured). This feature can be included as additional information on top of the sum assured (or initial sum assured).

B. Authorized insurers can include additional information in the Standard Illustrations only if it is relevant to illustrate the product features and of value to customers. For example, the term "Face Amount" defined as the unit measure for premium should not be used in the illustration.

C. Terminal Dividend refers to dividend payable upon death, surrender or maturity. If the dividend is only payable upon maturity, it should be named as Maturity Dividend / Maturity Bonus. For dividend / bonus to be issued under other situation, it could be labeled as Special Dividend / Bonus or other appropriate terms, provided that such label is not misleading with detail explanation presented in the illustration.

GL16

GUIDELINE ON UNDERWRITING LONG TERM INSURANCE BUSINESS (OTHER THAN CLASS C BUSINESS)

Insurance Authority

Guideline on Underwriting Long Term Insurance Business (Other Than Class C Business) (GL16) (2/26)

(Source: Insurance Authority (IA) GL16)

Contents

Guideline on Underwriting Long Term Insurance Business (Other Than Class C Business) (GL16) (3/26)

(Source: Insurance Authority (IA) GL16)

1. Introduction

1.1 This Guideline is issued pursuant to section 133 of the Insurance Ordinance (Cap. 41) ("the Ordinance") taking into account the Insurance Core Principles, Standards, Guidance and Assessment Methodology ("ICP") promulgated by the International Association of Insurance Supervisors ("IAIS"). Specific references are:

(a) Section 4A of the Ordinance stipulates that the Insurance Authority ("IA")'s function is to protect existing and potential policyholders. Section 4A(2)(c) states that the IA shall promote and encourage the adoption of proper standards of conduct, and sound and prudent business practices by authorized insurers.

(b) ICP 19 stipulates that the conduct of the business of insurance should ensure that customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied. ICP 19.0.1 further stipulates that the conduct of insurance business should help to strengthen public trust and consumer confidence in the insurance sector.

1.2 This Guideline applies to all authorized insurers underwriting long term business (other than Class C business).

2. Relevant Regulatory Documents

2.1 Where appropriate, this Guideline should be read in conjunction with other relevant codes/circulars/guidelines issued by the IA or other regulatory bodies, including the following[1]:

(a) Standard Illustration for Participating Policies issued by the Hong Kong Federation of Insurers ("HKFI")

(b) Standard Illustration for Universal Life (Non-linked) Policies issued by HKFI

(c) AGN 5 Principles of Life Insurance Policy Illustrations issued by the Actuarial Society of Hong Kong ("ASHK")

[1] The list is not exhaustive and may be subject to changes from time to time. Authorized insurers have the responsibility to ensure compliance with all the relevant requirements with due regard to their own circumstances.

(d) AGN on Best Estimate Assumptions issued by the ASHK

(e) Selling of Non-linked Long Term Insurance ("NLTI") Products issued by Hong Kong Monetary Authority

3. Purpose

3.1 Both IAIS and the global insurance industry have placed increasing emphasis on fair treatment of customers. ICP 19.2.4 stipulates that fair treatment of customers encompasses:

(a) developing and marketing products in a way that pays due regard to the interests of customers;

(b) providing customers with clear information before, during and after the point of sale;

(c) reducing the risk of sales which are not appropriate to customers' needs;

(d) ensuring that any advice given is of a high quality; and

(e) managing the reasonable expectations of customers.

3.2 This Guideline sets out the requirements for authorized insurers underwriting long term insurance business (other than Class C business). In assessing whether the requirements have been duly followed by authorized insurers, the IA will consider the substance and nature of the matters involved. The name or form of the arrangements adopted by individual authorized insurers would be irrelevant.

4. Duties of the Board, the Controller and the Appointed Actuary

4.1 It is the duty of the Controller, as specified under section 13A(12) of the Ordinance, to ensure that requirements set out in this Guideline and the relevant ICPs are observed throughout the life cycle of all long term (except Class C) insurance policies. It is also the duty of the Board to maintain general oversight over the implementation of measures in compliance with this Guideline and is ultimately responsible for ensuring fair treatment of customers.

4.2 It is a reasonable expectation for policyholders to expect to receive at least a fair proportion, if not all, of the non-guaranteed part of the illustrated

benefits. It is the duty of the Controller, the Appointed Actuary and the Board to ensure that such policyholders' reasonable expectation is met.

4.3 It is a continuing duty of the Appointed Actuary to advise the Board of his or her interpretation of policyholders' reasonable expectations. For instance, in the context of the provision of standard illustration, it is the duty of the Appointed Actuary to adopt reasonable assumptions, as well as to provide regular and up-to-date assessment of such assumptions to the Board for making suitable amendments. When a significant change of the underlying assumptions is likely to take place, the Appointed Actuary should take all reasonable steps to ensure that the Board appreciates the implications for the reasonable expectations of the policyholders.

4.4 Any attempt to circumvent the requirements prescribed in this Guideline would be regarded as acting in bad faith. In the case of Controllers, this may affect the "fit and proper" assessment under sections 8(2) and 13A(4) of the Ordinance. In the case of Appointed Actuaries, this may constitute non-compliance with professional standards under section 15C of the Ordinance, and may render the incumbent not acceptable to the IA under section 15(1)(b) of the Ordinance.

5. Product Design

5.1 ICP 19.2.4 stipulates that insurers should develop and market products with due regard to the interests of customers. During the product design stage, the insurer should carry out a diligent review to ensure that the product meets the "fair treatment of customers" principle, including:

(a) sustainability of the product;

(b) needs and affordability of the target customers;

(c) risks of the product; and

(d) distribution channels for the product.

5.2 When performing the diligent review mentioned above during the product design stage, authorized insurers are required to take a holistic view of all the relevant factors. For example, a product with complex features may not be suitable for distribution through the online channel, where advice to customer cannot be given during the sale process.

5.3 Authorized insurers are required to monitor the products after launch to ensure that they continue to meet the needs of the target customers, assess the performance of the various distribution channels with respect to sound commercial practices, and take the necessary remedial actions where appropriate.

5.4 In considering whether the design of a product meets the requirements of this Guideline and the "fair treatment of customers" principle, authorized insurers are required to look at all relevant factors in their totality, including the product features, insurance elements, added value/services to customers, fees/charges, surrender penalties (where applicable), remuneration structure etc.

5.5 Fees and charges (including charging basis, level of charges, applicable period etc.), where applicable, to be paid by the customers should be fair, commensurate with the insurance protection offered by the product concerned, and reflect the services/added value of the authorized insurer.

5.6 During product design, the determination of pricing assumptions should be based on the best estimate assumptions. For the guidance and considerations in setting best estimate assumptions, the Appointed Actuary should follow AGN on Best Estimate Assumptions issued by the ASHK.

6. Provision of Adequate and Clear Information

6.1 ICP 19.2.4 stipulates that insurers should provide customers with clear information before, during and after the point of sale.

6.2 ICP 19.3.4 stipulates that the product development and marketing process should include the use of adequate information on customer needs.

6.3 ICP 19.2.4 further stipulates that insurers should manage the reasonable expectations of customers.

6.4 ICP 19.5.1 stipulates that an insurer should take reasonable steps to ensure that a customer is given appropriate information about a policy in good

time and in a comprehensible form so that the customer can make an informed decision about the arrangements proposed.

6.5 Product information (e.g. product brochure, standard illustration) should be bilingual[2], clear and succinct, with the use of plain language and legible font size, and should be easily understandable by average customers. To facilitate understanding by customers, authorized insurers should avoid using technical or industry terminology.

6.6 Key product risks should be included in the product brochure and marketing materials and authorized insurers should communicate the relevant product risks to their potential customers. The risks are different for different products and it is the insurer's duty to identify the key product risks in the interest of customers, including the areas (where applicable) below:

(a) Key exclusion – The insurers should disclose key exclusion of the policy in the product brochure and marketing materials alongside description of policy coverage.

(b) Premium adjustment – If the insurer has the right to adjust the policy premium, it should disclose the factors leading to such adjustment and also the frequency and timing of adjustment. For insurance products with premium adjustment features within premium payment term, they cannot be labeled as "level premium".

(c) Premium term – The insurers should disclose the minimum premium term of the policy and the consequence of non-payment of premium within the premium term, including loss of coverage, surrender penalty, and financial loss incurred by the policyholder.

(d) Termination conditions – If the insurer has the right to terminate the policy before the maturity date, it should disclose the conditions of making such a decision.

(e) Market value adjustment – If the insurer has the right to apply market value adjustment on premium paid within cooling-off

[2] For the avoidance of doubt, the English and Chinese versions of the product documents can be separated, but BOTH must be available to the customers. Authorized insurers should ensure consistency between English and Chinese versions of all the product documents (including product brochure, standard illustration, policy contract, etc.).

period, the insurer should disclose the factors for the determination of such adjustment.

(f) Inflation risk – The insurers should alert customers, where appropriate, the adverse impact of inflation (i.e. where the actual rate of inflation is higher than expected, and the policyholder might receive less in real terms even if the insurer meets all of its contractual obligations).

6.7 For products with policy loan facility, authorized insurers should provide policyholders with information about the terms of the loan (including interest rate to be charged) before the loan is drawn down. For products with automatic policy loan facility, policyholders should be immediately notified that a loan has been first drawn down in accordance with the policy provisions and the interest rate being charged. Whenever there are changes to the policy loan interest rate, policyholder should be notified within a reasonable period before the new interest rate is effective. For ongoing disclosure, regular account statements to be sent to policyholders should contain information about the interest rate being charged, opening and ending loan balance as well as the interest amount charged in the period, with the relevant information highlighted to draw policyholders' attention.

6.8 For policies to be used as collateral assignment (e.g. for premium financing), authorized insurers should ensure that the policyholder fully understands the relevant risks and limitations (e.g. interest rate risk, rights that the assignee may exercise on the policy on behalf of the policyholder, risk of release of information to the assignee, etc.).

6.9 Authorized insurers have the sole responsibility of ensuring accuracy of the proposal vis-a-vis the policy provisions, with warning statements and other tools (e.g. FAQs) where appropriate to increase customers' awareness.

7. Suitability Assessment

7.1 ICP 19.6.2 specifies that insurers should seek the information from their customers that is appropriate for assessing their insurance needs, before giving advice or concluding a contract. This information may vary, but should at least include information on the customer's:

(a) knowledge and experience;

(b) needs, priorities and circumstances; and

(c) ability to afford the product.

7.2 Customers' needs should be properly assessed through the use of Financial Needs Analysis ("FNA") form where appropriate. Insurance policies should not be marketed to customers before their needs are properly analyzed.

7.3 Customers that have indicated their insurance needs should be presented with different insurance options that are available to meet their specific needs and financial circumstances.

7.4 For insurance products with long term contribution commitment or investment elements, suitability assessment should include assessing the premium payment horizon of the potential policyholder, with due regard to the financial circumstances, planned retirement age etc.

7.5 The suitability assessment should be carried out whenever there are relevant changes to the circumstances of the customer.

7.6 Authorized insurers have the duty to verify all available information and assess whether a particular product is suitable for their needs during the underwriting process.

7.7 Authorized insurers should endeavour to reduce the risk of sales that do not meet the needs of customers by:

(a) strengthening training to intermediaries;

(b) assessing the affordability and suitability of products for policyholders during the underwriting process based on available information; and

(c) providing tools for intermediaries to facilitate the recommendation of suitable products to customers.

8. Advice to Customers

8.1 ICP 19.1.1 stipulates that insurers and intermediaries should discharge their duties in a way that can reasonably be expected from a prudent person in a like position and under similar circumstances. Authorized insurers have the duty to put in place appropriate measures to ensure that their employees and agents are adequately trained to act with due skill, care and diligence.

8.2 ICP 19.6.1 further stipulates that where advice is given to a customer, such advice goes beyond the provision of product information and relates specifically to the provision of a recommendation on the appropriateness of a product to the disclosed needs of the customer.

8.3 After a customer has considered the insurance options, and is beginning to consider an insurance policy, he/she should also be properly apprised of all the product features, including the fees and charges (where applicable), surrender penalties (if any) as well as the product risks, key exclusions, 21-day cooling-off period etc.

8.4 The proper sales process flow is set out in the flowchart at the **Annex**. It involves completion of the FNA (if applicable), confirmation of needs, comparison of different insurance options (where FNA has been performed), and explanation of the key product features/exclusions.

9. Appropriate Remuneration Structure

9.1 Authorized insurers have the duty to ensure that the remuneration structure for their intermediaries do not create misaligned incentives for the intermediaries to engage in mis-selling, aggressive selling, fraudulent acts or money laundering activities. The insurers are therefore required to put in place an appropriate remuneration structure to address such risks.

9.2 Indemnity commission, or any standing arrangement that offers advance payment of commission, is strictly prohibited. Authorized insurers should only pay commission on an earned basis.

9.3 Cases of mis-selling, aggressive selling, fraud and money-laundering often surface after the expiry of the clawback period. To deter such activities, authorized insurers should put in place a clawback mechanism to fully recover all commission paid in proven fraud / money laundering / mis-selling cases.

10. Ongoing Monitoring

10.1 ICP 19.7 requires insurers and intermediaries to ensure that, where customers receive advice before concluding an insurance contract, any potential conflicts of interest are properly managed.

10.2 ICP 19.7.5 further stipulates that conflicts of interest may be managed in different ways as relevant to the circumstances, for example, through appropriate disclosure and informed consent from customers.

10.3 Authorized insurers should put in place a proper mechanism to monitor on an ongoing basis any such potential conflict of interests.

10.4 ICP 19.8 stipulates that insurers are required to:

(a) service a policy appropriately through to the point at which all obligations under the policy have been satisfied;

(b) disclose to the policyholder information on any contractual changes during the life of the contract; and

(c) disclose to the policyholder further relevant information depending on the type of insurance product.

10.5 On-going communication with policyholders should be maintained at least annually as an integral part of expectation management (e.g. projections for non-guaranteed benefits in anniversary statements).

10.6 Authorized insurers should also put in place a proper mechanism to monitor the products (e.g. complaints, design flaw etc.) after launch.

11. Post-sale Control

11.1 ICP 19.2 stipulates that insurers and intermediaries should establish and implement policies and procedures on fair treatment of customers. Authorized insurers should have proper control systems in place to achieve fair treatment of customers and monitor that such policies and procedures are adhered to.

11.2 For the protection of vulnerable customers[3], authorized insurers are required to make audio-recorded post-sale confirmation calls to all vulnerable customers procuring life insurance products (except term insurance) or products involving investment risks to ensure customers' understanding on the products and their associated risks. The post-sale confirmation calls are required to be conducted within 5 working days of the date of policy issue to reaffirm customers' understanding of the policy that they have procured, and that they are fully aware of their rights and obligations under the policy.

(a) The insurers should appoint a separate quality assurance team to make the post-sale calls.

(b) The insurers should use their best endeavours to make the post-sale calls, attempting different times of the day and different days of the week.

(c) The insurers are encouraged to adopt additional measures such as on-site recording at the service centre or immediate "dial-in" to or from the call centre for customers who are visitors or who may be difficult to reach.

(d) In the event of unsuccessful calls, a confirmation letter should be sent to the customers, alongside an email/SMS alert that draws the attention of the customers to the importance of the confirmation letter.

11.3 Authorized insurers should collect sufficient information of the policyholder for the purpose of identification of vulnerable customers.

[3] A vulnerable customer is a person (i) over 65 years of age, (ii) whose education level is "primary level" or below, or (iii) who has no regular source of income.

11.4 Authorized insurers are required to put in place an effective mechanism to identify possible cases of intermediaries abetting customers to evade the control measures, such as having high rate of unsuccessful post-sale calls.

11.5 Authorized insurers should have in place proper documentation systems for quality control and future monitoring. Apart from the policy documents, records of the post-sale calls, confirmation letters and the email/SMS alerts, as well as control reports in respect of above measures, should also be kept properly.

12. Commencement

12.1 This Guideline shall take effect from 26 June 2017.

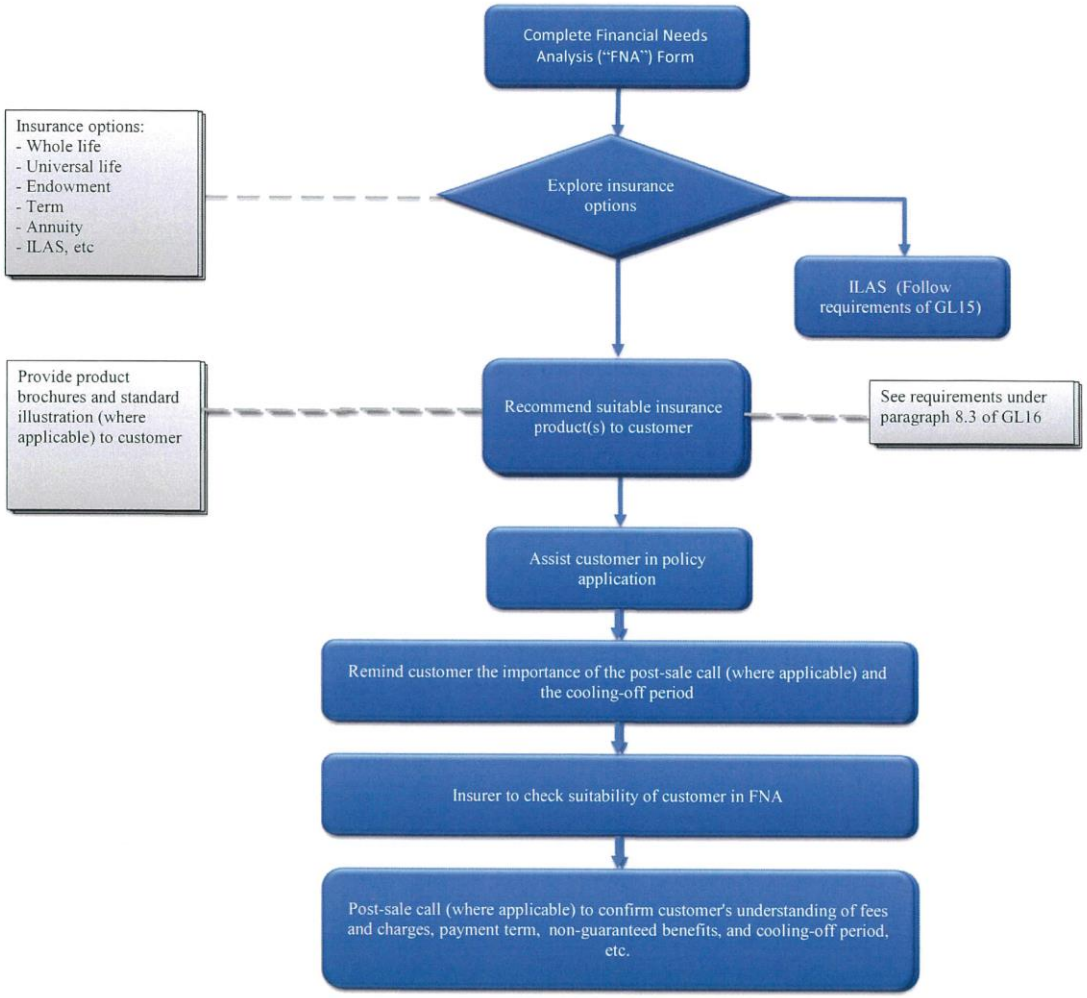
June 2017

Guideline on Underwriting Long Term Insurance Business (Other Than Class C Business) (GL16) (14/26)

(Source: Insurance Authority (IA) GL16)

Annex

Selling Process of Non-linked Insurance Products



Annex-i

Appendix 1

Requirements Applicable to Participating Policies

1. Introduction

1.1 For the purpose of this Guideline, a participating (or with-profit) policy is a policy that pays non-guaranteed dividends or bonuses (including cash bonus and reversionary bonus) to the policyholder. Dividends/bonuses are generated from profits of the authorized insurer that sold the policy and are typically paid out on an annual basis over the life of the policy. Some policies also include final or terminal payments that are paid out to the policyholders upon maturity or termination of contract.

2. Governance of Participating Policy Business

2.1 To ensure appropriate governance of participating policies, an authorized insurer should have a corporate policy covering allocation of surplus/profits between shareholders and the participating pool, as well as declaration of policyholder dividends/bonuses and other discretionary benefits. This should be clearly documented, approved by the Board and made available to the Insurance Authority ("IA") on request.

2.2 As a minimum, the policy should cover:

(a) The overall philosophy in setting non-guaranteed policyholder benefits, including sharing surplus or experience, smoothing and guarantees.

(b) The approach to sharing surplus or experience, including the items to be shared and any quantifications for these.

(c) The charges for guarantees and/or capital if appropriate, including justifications and reasonableness etc.

(d) The investment strategy, including ongoing management of the asset mix.

(e) Maintenance of fairness between different products and generations.

(f) Smoothing of payouts should be explained and justified, including whether it is expected to be on average cost-neutral to the shareholder.

(g) How the assets are held and managed, including the segregation mechanism in case of pooling of funds for investment purpose.

(h) The principles and practices in determining the projected non-guaranteed benefits of standard illustration at point of sales and annual inforce illustration.

(i) Measures to manage potential conflict between its duty to policyholders and its duty to shareholders, particularly in relation to the declaration of dividends/bonuses for policyholders. The authorized insurer should provide information about the above measures either in the product brochure or in a separate leaflet to be provided to customers at the point of sale; or on its website (should also provide the relevant link to the website address in the product brochure). These may include:

(i) The profit sharing ratio between shareholders and participating fund;

(ii) Establishment of Dividend/Profit Sharing/With Profits Committee to provide independent advice on the management of participating business; or

(iii) Written declaration by the Chairman of the Board, an Independent Non-Executive Director and Appointed Actuary.

2.3 When designing products with non-guaranteed benefits, it is the Appointed Actuary's duty to ensure that there is a fair chance in achieving the non-guaranteed returns. It is thus essential for the Appointed Actuary to define the philosophy and assumptions for the determination of non-guaranteed benefits, as well as to advise the Board.

2.4 The Appointed Actuary should submit a report to the Board recommending policyholder dividends/bonuses and other non-guaranteed benefits annually and more frequently, if such is required. The authorized insurer's dividends/bonuses declaration mechanism will be subject to IA's regulatory review. The IA may require the authorized insurer to appoint an independent party to assess whether the policy has been applied completely, consistently and fairly. The report should also cover:

(a) Any changes to the policy since the last report, including an explanation of why this is consistent with policyholders' reasonable expectation.

(b) Explanation where decisions are contractual and related to policy documents or other customer communications, and where decisions are at the discretion of the authorized insurer, taking into account the issue of equity between shareholders and policyholders.

(c) Consistency in the dividends/bonuses declaration mechanism needs to be maintained for the product design stage and throughout the policy life.

2.5 The Appointed Actuary's report should be made available to the IA upon request.

2.6 The Board, on the advice of the Appointed Actuary, is ultimately responsible for interpretation of the policyholders' reasonable expectation, and deciding the dividends/bonuses declaration, taking into account the principle of fair treatment of customers, and the issue of equity between shareholders and policyholders.

3. Provision of Standard Illustration

3.1 The objective of a standard illustration is to provide a potential customer with the projected performance of a life insurance policy showing the total benefits with a breakdown for guaranteed and non-guaranteed benefits, which may reasonably be payable at each policy year should certain conditions be met. Hence, it is important for an authorized insurer to identify clearly what assumptions are made in producing the projected non-guaranteed benefits.

3.2 It is important for the potential customer to understand the projected benefits of the life insurance policy where he or she intends to purchase. The potential customer must sign the standard illustration to confirm his/her understanding (including understanding of the worst and extreme scenario where dividends/bonuses may be zero).

3.3 In the provision of standard illustrations, the authorized insurer must follow the guiding principles as laid out by the Actuarial Society of Hong Kong ("ASHK") in AGN 5 Principles of Life Insurance Policy Illustrations, namely:

(a) the standard illustration must not be misleading;

(b) where premiums and benefits are illustrated, the conditions upon which these are payable must be clearly set out;

(c) the use of such standard illustration in different distribution channels; and

(d) the standard illustration must be consistent with the regulatory requirements.

3.4 Additional high and low return scenarios must be provided in the standard illustration to show the variability of the ultimate results. A wider range of scenarios is expected for investment strategy with higher volatility.

3.5 The Appointed Actuary should have regard to Appendix A of AGN on Best Estimate Assumptions issued by the ASHK, which provides guidance and considerations for setting the standard illustration assumptions.

3.6 In the standard illustration, guaranteed and non-guaranteed dividends/bonuses should be separately presented with an explicit message that non-guaranteed dividends/bonuses may be zero.

3.7 The illustration should show the annual dividend (or reversionary bonus) and terminal dividend (or terminal bonus) separately. The policyholders need to understand the different implications on annual and terminal dividends/bonus if there are changes in, say, the assumptions (e.g. the terminal dividends/bonuses may be more volatile than annual dividends/bonuses).

4. Disclosure of Non-Guaranteed Benefits

4.1 In addition to the provision of standard illustration, an authorized insurer should adopt the following process in disclosing non-guaranteed benefits:

(a) Disclosure at the point of sale:

(i) Customers should be apprised of factors that will significantly affect the determination of policyholders' dividends/bonuses, including but not limited to the following factors:

(aa) Claims factors – The claims factors represent the experience of mortality and morbidity of the business.

(bb) Interest income factors – This may include not only interest earnings, but also outlook of interest rates, and the effects of capital gains and losses.

(cc) Market risk factors – Authorized insurers should disclose the types of market risk that would significantly affect the determination of dividends.

(dd) Expense factors – This may include direct expenses

which are specifically related to the group of policies, such as commission, underwriting and issue expenses and other maintenance expenses, such as premium collection expense. This may also include indirect expenses such as general overhead costs, which will be allocated to such group of policies.

(ee) Persistency factors – This includes policy lapse and partial surrender experience; and the corresponding impact on investments.

(ii) Non-guaranteed rate (e.g. dividend/bonus) philosophy should include investment policies and objectives and investment strategy, which will very likely result in the variation of investment returns against the long term expectation. In most circumstances, it is the key driver leading to volatility of non-guaranteed benefits.

(iii) The authorized insurer should highlight the investment strategy (e.g. target asset mix / geographical allocation / currency mix, use of derivative instruments and securities lending etc.) of the underlying investment in its product brochure. The asset classes (e.g. equities, bonds, deposits) and security concentration (e.g. US Treasury, corporate bonds, high yield bonds) should also be mentioned in the investment strategy. The additional information can help customers understand the risk and volatility of returns of the underlying assets and the non-guaranteed returns.

(iv) The authorized insurer should provide information on its philosophy in deciding dividends/bonuses in the product brochure (with updated information published on its website as well).

(v) The authorized insurer should disclose on its company website the non-guaranteed dividends/bonuses fulfillment ratios for each product series which has new policies recently issued. Customers should be informed the website address that shows these fulfillment ratios. It

is required to disclose at least the product type and fulfillment ratios for each product series. The fulfillment ratio is calculated as the average ratio of non-guaranteed dividends/bonuses actually declared against the illustrated amounts at the point of sale. Non-guaranteed benefits may vary from product type to product type. The authorized insurer should therefore disclose:

(aa) For dividend type traditional participating products – fulfillment ratios of the accumulated dividends (including accumulation interest and terminal/maturity dividend, if applicable).

(bb) For reversionary bonus type traditional participating products – fulfillment ratios of accumulated reversionary bonus and terminal bonus.

(vi) Customers must be alerted to the fact that dividend history is not an indicator of future performance of the participating products.

(b) Disclosure during policy life (process to ensure timely and accurate communication especially when changes to customer benefits are anticipated):

(i) Ongoing communication must be provided to policyholders at least on an annual basis on both actual non-guaranteed benefits declared for the year and a refreshed up-to-date inforce standard illustration reflecting the latest conditions and outlook. Such communication will help manage policyholders' reasonable expectation at least once a year and minimize the gap between the original standard illustration and the actual performance.

(ii) Monitor the non-guaranteed benefits regularly (at least annually) and check the sustainability of the non-guaranteed benefits based on the actual experience and investment outlook.

(iii) If there is any change to dividends/bonuses (or their philosophy), the authorized insurer should inform relevant policyholders of the change of dividend/bonus by writing separately or include the information in the annual statements with explicit reasons for the change.

(c) In illustrating premium offset option, the authorized insurer should follow the requirements below:

(i) Projection of the premium offset option based on different scenarios, especially the adverse situation (where the premiums are not offset due to a reduced dividend level), is required to be provided to the customer.

(ii) The illustration should not use the term "vanish" or "vanishing premium" or similar terminologies that suggest that the policy has been fully paid up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums. The customer should be reminded that he/she has the obligation to pay premiums for the entire term. Otherwise, the benefit will be affected.

(iii) Clear disclosure should be made to ensure that the customers fully understand the risk involved, in particular under the scenario where the level of dividend is persistently low. In cases where future dividends are to be used to pay premiums for medical riders, the authorized insurer is required to alert customers the additional risk brought about by possible future medical cost inflation and/or reduced dividends. The authorized insurers should provide policyholders with regular update through annual statements.

(iv) If the product offers a range of premium payment terms, the authorized insurer should mention the shorter premium term options only as an alternative. Customers should be warned that the sustainability of premium offset depends on future dividend declaration, which is

not guaranteed. Policyholders may be obliged to resume future premiums, even if the premium offset option has been activated, in case declaration of policyholder dividends is lower than the illustrated scale. While policyholder dividends play an important part in determining the future premium offset point, customers should be reminded there are a number of other factors that should be taken into consideration. These factors include dividend withdrawals, change in dividend options and addition of optional benefits to the policy.

(d) For the withdrawal illustration option, disclosure should be made to ensure that the customers fully understand the risk involved. For example, illustrated withdrawal amounts, which depend on non-guaranteed dividends, might not be sustainable. If withdrawal or partial surrender is used, a warning message that withdrawal or partial surrender will affect future benefits should be in place.

Appendix 2

Requirements Applicable to Universal Life Policies

1. Introduction

1.1 For the purpose of this Guideline, a universal life policy is a type of life insurance with a savings element that may provide a cash value buildup. The cash value is credited with declared interest (i.e. at the declared crediting interest rate), and debited by cost of insurance charges, as well as any other policy charges and fees. The declared interest rate will vary from time to time and will be subject to a minimum if the product offers a guaranteed interest rate. It provides flexibility to policyholders in respect of premium payment and withdrawal from policy accounts (with applicable fees and charges). The death benefit, savings element and premiums can be reviewed and altered as policyholders' circumstances change.

2. Governance of Universal Life Policy Business

2.1 To ensure appropriate governance of universal life policies, authorized insurers should have internal policies covering the mechanism to determine the crediting interest rate, cost of insurance charge, other policy fees and charges, as well as other discretionary benefits. This should be clearly documented, approved by the Board and made available to the Insurance Authority upon request.

2.2 Authorized insurers should follow paragraphs 2.2 to 2.6 of the Appendix 1 for the purpose of this section.

3. Provision of Standard Illustration

3.1 Authorized insurers should follow paragraphs 3.1 to 3.3 of Appendix 1 for the purpose of this section.

3.2 Projections of policy benefits should be provided on at least two bases: (a) guaranteed or conservative basis; and (b) current assumed basis.

3.3 If a policy provides a minimum guaranteed interest rate and maximum policy charges, one of the projections has to be prepared based on such

guaranteed interest rate and maximum policy charges. The projection could be labeled as guaranteed basis. Otherwise, projected crediting interest rate at 0% p.a. (if minimum guaranteed interest rate is not available) or current charges (if maximum charges are not available) should be used, and this projection can only be labeled as conservative basis. The other projection has to be prepared based on a set of best estimate assumptions whereby current best estimate crediting interest rate and current charges are to be used for this purpose. Policyholders should be alerted with an explicit message that the crediting interest rate may be zero (or the minimum guaranteed interest rate where applicable).

3.4 It is optional for authorized insurers to provide additional high and low return scenarios in the standard illustration to show the variability of projected benefits provided that the projections are not misleading. The optional standard illustration is only applicable for products having substantial variable investment exposure.

3.5 The Appointed Actuary should have regard to Appendix A of AGN on Best Estimate Assumptions issued by the Actuarial Society of Hong Kong, which provides guidance and considerations on setting the standard illustration assumptions.

3.6 In the standard illustration, all fees and charges (current and maximum scales, if applicable) should be shown clearly, with an explicit message that the current fees and charges could be subject to change (if applicable).

4. Disclosure of Non-Guaranteed Benefits

4.1 Authorized insurers should follow paragraphs 4.1(a) and 4.1(b) of Appendix 1 for disclosure of non-guaranteed benefits where applicable for universal life policies, with the exception of paragraph 4.1(a)(v). For example, terminology may be modified from "dividend/bonus" to "crediting interest rate".

4.2 The authorized insurer should disclose on its company website the historical crediting interest rates for each product series which has new policies recently issued. Customers should be informed the website address that shows these historical crediting interest rates. It is required to disclose at least the historical crediting interest rates for each product series.

4.3 In addition, key risks applicable to universal life policies (including fees and charges, lapsation risk due to zero account value etc.), and different types of crediting interest rates for different cohort of universal life product (if applicable), etc. should be disclosed.

Financial Needs Analysis ("FNA") Template (GL30 – Appendix) (1/2)

(Source: Insurance Authority (IA) GL30)

Appendix

Financial Needs Analysis ("FNA") Template

The following questions form the basic content of the FNA form, authorized insurers or licensed insurance intermediaries shall, in accordance with the particular circumstances of the customers, add questions or modify the exact wording of the questions in compliance with requirements under paragraph 6.5 of this Guideline.

Notes to customer: This FNA form is to facilitate the identification of suitable insurance product(s) to meet your needs and circumstances. Please answer all questions in this form. Do NOT sign on this form if any questions are unanswered or have been crossed out. Do NOT sign on blank form. You need to inform us (the insurance company) if there is any substantial change of information provided in this form.

1. What are your objectives for seeking to purchase an insurance product? (tick one or more)
   - ☐ Financial protection against adversities (e.g. death, accident, disability etc.)
   - ☐ Preparation for health care needs (e.g. critical illness, hospitalization etc.)
   - ☐ Providing regular income in the future (e.g. retirement income etc.)
   - ☐ Saving up for the future (e.g. child education, retirement etc.)
   - ☐ Investment
   - ☐ Others (Please specify_____)

(The supplementary question to Q1 below is applicable only if "Investment" is chosen as one of the objectives in Q1 above)

To meet your "Investment" objective indicated above, how would you prefer to manage different investment options/investment choices, if available, under the insurance product? (tick one)

- ☐ I want to make my own decisions (without any professional advice to be provided by the authorized insurer and/or licensed insurance intermediaries) to choose and manage different investment options/investment choices, if available, under an insurance product, and I am willing to do it throughout the entire duration of the target benefit/protection period of an insurance product
- ☐ I want to make my own decisions (with professional advice to be provided by the authorized insurer and/or licensed insurance intermediaries) to choose and manage different investment options/investment choices, if available, under an insurance product, and I am willing to do it throughout the entire duration of the target benefit/protection period of an insurance product
- ☐ I do not want to choose or manage different investment options/investment choices, if available, under an insurance product

(For Q2 and Q3, a specific period/amount can be stated instead of ticking one of the boxes)

2. What is your target benefit/protection period/expected timeframe for meeting the target amount for insurance policy? (tick one)
   - ☐ Less than 1 year
   - ☐ 1-5 years
   - ☐ 6-10 years
   - ☐ 11-15 years
   - ☐ 16-20 years
   - ☐ More than 20 Years
   - ☐ Whole of life

Financial Needs Analysis ("FNA") Template (GL30 – Appendix) (2/2)

(Source: Insurance Authority (IA) GL30)

3. Your ability and willingness to pay insurance premiums:
   a. What is your average monthly disposable income (i.e. after deducting the expenditure) from all sources (including income from liquid assets) in the past 2 years?
      ☐ Not less than HK$ _____ ; or
      ☐ In the following range:
         ☐ less than HK$10,000
         ☐ HK$10,000 - HK$19,999
         ☐ HK$20,000 - HK$49,999
         ☐ HK$50,000 - HK$100,000
         ☐ over HK$100,000

   b. What percentage of your monthly disposable income (i.e. after deducting the expenditure) from all sources (including income from liquid assets) would you be able and willing to use to pay for the insurance premium (including your existing insurance policy(ies)) throughout the entire term of the insurance policy? (tick one)
      ☐ Less than 10%
      ☐ 10% - 20%
      ☐ 21% - 30%
      ☐ 31% - 40%
      ☐ 41% - 50%
      ☐ More than 50%

   c. For how long are you able and willing to pay for an insurance policy? (tick one)
      ☐ 2-5 years ☐ 6-10 years ☐ 11-15 years ☐ 16-20 years
      ☐ More than 20 Years (until target retirement age of ____)
      ☐ Whole of life (including period after target retirement age of ____)
      ☐ A single payment of not more than HK$ _____

Appendix M

Important Facts Statement for Mainland Policyholder ("IFS-MP") (Only Chinese version available (1/4)

(Source: Insurance Authority (IA) Circulars on Regulatory Matters issued on 8 July 2016)

[保险公司标志]

重要资料声明书—
内地人士在港投购人身/寿险保单

[保险公司名称]
人身/寿险产品名称:

阁下应细阅本声明书及保险产品文件(包括推销刊物、产品资料概要及销售/利益/退保说明文件(如适用))。**若阁下不明白或不同意以下声明的任何一段、或此声明内容与中介人的讲述有异,请勿签署确认或投购本保单**。

此乃香港保险监管机构要求保险公司对内地人士[注]在港投购人身/寿险保单所需披露之重要资料。阁下签署前必须细阅。中介人亦有责任向阁下详细解释内容。

(1) **销售过程:本保单的整个销售过程必须在香港境内进行,且所有投保文件亦必须在香港境内签署**。任何在内地进行有关本保单的销售行为,不受香港法规监管。如阁下日后发现有关本保单销售的陈述或文件具误导性,又或有关中介人曾向阁下作出不正确或误导性的陈述或保证,以诱使阁下购买本保单,而有关销售行为并非在香港进行**(例如在内地举办的香港产品说明会或以即时通讯或社交媒体应用程式向内地人士推广香港保险产品等行为)**,香港的监管机构未必能就相关投诉作出调查,**而此等行为亦可能违反内地法规**。阁下**必须**备存相关文件,包括香港入境纪录及销售时所获取的资料,以保障阁下的利益。此外,请确保投保申请书上填报的通讯地址、电子邮件地址(如有)及联系电话能直接联络阁下,否则阁下可能不会收到保险公司所发出与本保单有关的文件。

(2) **销售人员**:向阁下**直接销售**本保单的人士必须是在香港登记的保险中介人。**如阁下经其他人士推介本保单,须注意当中可能存在误导销售的风险。**

(3) **保险回报率及红利**:产品资料及退保说明文件(如适用)中的回报率及红利,除非已注明外,否则**并非保证**,将来实际取得的金额可能**较预期为低或高**。

本人现确认已阅读及明白以上第(1)至(3)段内容。

投保人姓名	投保人签署	日期

注:内地人士指持有中华人民共和国居民身份证人士

[Updated on 8-7-2016]

Important Facts Statement for Mainland Policyholder ("IFS-MP") (Only Chinese version available (2/4)

(Source: IA Circulars on Regulatory Matters issued on 8 July 2016)

(4) **提前退保/提取保单款项：**若阁下在保单期满前的指定时限内终止保单、退保、提取部份保单款项，均须支付**提前退保或提取保单款项的收费**（如适用），**而阁下可取回的金额可能远低于已缴的保费，甚至为零。**亦可能因此丧失获得红利的权利。若阁下暂停缴交或调低供款额，保险公司往后可能会按照保单原先应缴保费水平继续收取相关的保单费用。

(5) **保单合约条款：** 保单是阁下与保险公司共同订立的合约，阁下的权益（包括申索权益）均须依据保单的条款处理。如阁下收到保单后发现合约条款内容与中介人的讲述有异，请立即直接联络保险公司以作澄清。

(6) **汇率风险：**如本保单(或投资相连人寿保险计划的投资选择或其相连基金的资产)并非以人民币结算(例如以港元、美元或其他保费及保额所指定的货币)，阁下将承担汇率升跌或相关货币之外汇政策改变所带来的风险。

(7) **法规及政策改变风险：**本保单在香港承保，如内地相关法规及政策日后改变，可能为阁下带来不可预见的风险(例如外汇政策改变令阁下无法缴付保费以至保单失效等)。

(8) **回佣/返佣协议：**中介人不应直接或透过第三方向阁下以任何回佣/返佣诱使阁下购买本保单，**这可能会被视为违规行为**。保险公司亦不会确认任何回佣/返佣协议。

(9) **资金来源核实：**因应香港法律及保险公司的核保等要求，保险公司有责任及需要对保单的资金来源进行核实，包括在需要时或较高风险的情况下要求投保人提供合法资金来源证明，以及与保单保额相匹配的合法收入证明。**就可疑个案或因应香港执法机构的要求，保险公司可在毋须取得保单持有人的同意下，向有关机构转交相关资料**。

本人现确认已阅读及明白以上第（4）至（9）段内容。

投保人姓名	投保人签署	日期

Important Facts Statement for Mainland Policyholder ("IFS-MP") (Only Chinese version available (3/4)

(Source: Insurance Authority (IA) Circulars on Regulatory Matters issued on 8 July 2016)

(10) **投诉及诉讼：** 如阁下日后需办理理赔，又或不满意保险公司的理赔而要提出投诉或法律诉讼时，可能需亲临香港办理。处理有关保险的申诉、聆讯、或审理亦可能要求保单持有人及或受益人亲临香港法院方可进行。

本人现确认已阅读及明白以上第（10）段内容。

投保人姓名	投保人签署	日期
保险经纪/代理姓名 (登记编号)	保险经纪/代理签署	日期
保险经纪/代理公司名称及盖章(如适用) (登记编号)		

Appendix M

Important Facts Statement for Mainland Policyholder ("IFS-MP") (Only Chinese version available (4/4)

(Source: Insurance Authority (IA) Circulars on Regulatory Matters issued on 8 July 2016)

Requirements in respect of the Important Facts Statement for Mainland Policyholder ("IFS-MP")

(1) The IFS-MP is required for all new applications through any distribution channels for long term insurance individual policies under Class A, B, C, D, E, and F of "long term business" as defined in the Insurance Companies Ordinance (Cap 41) made by customers being holders of Resident Identity Card (PRC). They cannot opt-out of this requirement. For the avoidance of doubt, in case of change of policy ownership or policy assignment where the new policyholders/assignees are holders of Resident Identity Card (PRC), the IFS-MP is required for the new policyholders/assignees.

(2) The IFS-MP needs only be conducted once for one policy. There is no need for Mainland customers to sign the IFS-MP for top-up or rider addition if the basic plan was taken out after implementation of the IFS-MP. On the other hand, if the basic plan was taken out before implementation of the IFS-MP, the insurer concerned should endeavour to ask the Mainland customers to sign the IFS-MP for top-up or rider addition. In case it is not possible to do so (e.g. unable to contact the customer or the customer refuses to sign the IFS-MP), the insurer concerned can send the IFS-MP to the Mainland customer for information together with the other document(s) to be issued for the top-up or rider addition. The insurer must retain record of dispatch as proof of compliance with the requirement. For the avoidance of doubt, if an existing Mainland customer subsequently purchases a second life insurance policy, he/she has to sign another IFS-MP. That said, if the Mainland customer takes out more than one policy from an insurer at the same time, the insurer concerned has the option to require the customer to sign on one single IFS-MP with all those product names listed at the top of the IFS-MP; or individual IFS-MP for each product taken out.

(3) It should be presented as a separate form. In case insurer intends to include it as a separate section within another point-of-sale document (e.g. application form), prior consultation with the IA is required.

(4) Intermediaries are required to go through the IFS-MP on a point-by-point basis with the Mainland customers at the point-of-sale.

(5) Insurers must adopt the IFS-MP in full, although individual insurers can add additional disclosure to accurately reflect the risks associated with their specific products. All the questions must be presented in a single form/section with the heading clearly stated as IFS-MP.

(6) The IFS-MP follows the practice of the IFS for Investment-linked Assurance Scheme ("ILAS") where the customer will need to sign on every page of the form.

(7) Insurers can also prepare English and Traditional Chinese versions of the IFS-MP. However, the one signed by the Mainland customers must be in Simplified Chinese.

(8) A copy of the signed IFS-MP must be provided to the Mainland policyholders. Insurers have the discretion as to when the copy is delivered but in no case should it be delivered later than policy delivery (i.e. it can be delivered together with the policy). For the avoidance of doubt, this does not affect the requirement for the return of policy applications from Mainland customers to insurers within 7 working days of the signing of policy application (including the declaration signed by policyholder confirming that the selling process is conducted in Hong Kong) where the insurers concerned do not have an independent authentication process for authenticating the identification and entry proofs documents of the Mainlander customers.

(9) There will be no impact on the existing post-sale confirmation call arrangement for ILAS and vulnerable customers.

(10) For ILAS products, Mainland customers have to sign both IFS-MP and IFS-ILAS.

(11) The font size of the IFS-MP must not be smaller than 12.

(12) The IFS-MP is a document required by the IA. For the avoidance of doubt, it is not a marketing document (i.e. for ILAS) and does not require the approval of the Securities and Futures Commission.

Guideline on Offering of Gifts (GL25) (1/10)
(Source: Insurance Authority (IA) GL25)

GL 25

GUIDELINE
ON
OFFERING OF GIFTS

Insurance Authority

Guideline on Offering of Gifts (GL25) (2/10)

(Source: Insurance Authority (IA) GL25)

Contents **Page**

1. Introduction

1.1 The Insurance Authority ("IA") issues this Guideline pursuant to section 133 of the Insurance Ordinance (Cap. 41) (the "Ordinance"), its principal function to regulate and supervise the insurance industry for the protection of existing and potential policy holders and its function to promote and encourage the adoption of proper standards of conduct and sound and prudent business practices by authorized insurers and licensed insurance intermediaries. This Guideline also takes into account the Insurance Core Principles, Standards, Guidance and Assessment Methodology ("ICP") promulgated by the International Association of Insurance Supervisors, in particular ICP 19 which stipulates that the conduct of the business of insurance should ensure that customers are treated fairly.

1.2 The offering of Gifts (as defined in Section 2 of this Guideline) or other similar gratuities in the marketing, promotion or distribution of insurance products may unduly influence or otherwise distract customers when it comes to making informed decisions in relation to insurance products and the suitability of such products to meet their insurance needs and other circumstances. In view of this, this Guideline provides guidance on certain restrictions on the use of gifts and rebates which authorized insurers and licensed insurance intermediaries should follow when marketing, promoting or distributing insurance products classed as long term business.

2. Interpretation

2.1 In this Guideline, unless the context otherwise specifies:

(a) "Class A Product" means any contract of insurance in Class A (Life and annuity) of Part 2 of Schedule 1 to the Ordinance.

(b) "Class C Product" means any contract of insurance in Class C (Linked long term) of Part 2 of Schedule 1 to the Ordinance. These are usually known as Investment-linked Assurance Scheme products.

(c) "Class D Product" means any contract of insurance in Class D (Permanent health) of Part 2 of Schedule 1 to the Ordinance.

(d) "Customer" bears the same meaning as policy holder or potential policy holder, as those terms are used in the Ordinance.

(e) "Gift" may include any kind of gift, incentive, enticement or inducement, whether financial or non-financial, but does not include:

(i) the payment of fees or commissions to licensed insurance intermediaries; or

(ii) any discount of premiums, fees or charges payable under a contract of insurance (i.e. insurance policy), provided that the discount is expressly stated in the quotation, offer letter, promotional materials, insurance policy or the policy schedule, thereby reducing the amount of premium, fee or charge the policy holder is obliged to pay under the terms of the insurance policy.

(f) "Permitted Gift" means a gift listed in the Annex to this Guideline.

(g) "Rebate" means:

(i) in relation to premiums, any repayment made as a gratuity directly or indirectly to a customer of an amount of premium previously paid by a customer; or

(ii) in relation to commissions, any payment made as a gratuity directly or indirectly to a customer by a licensed insurance intermediary of part of the commission received by the licensed insurance intermediary.

2.2 Unless otherwise specified, words and expressions used in this Guideline shall have the same meanings as given to them in the Ordinance.

3. Relevant Regulatory Documents and Status of this Guideline

3.1 This Guideline should be read, where appropriate, in conjunction with the relevant provisions of the Ordinance and all other relevant rules, codes, circulars and guidelines issued by the IA or other regulatory bodies, including but not limited to the following:

(a) Guideline on Underwriting Class C Business (GL15) issued by the IA;

(b) Guideline on Underwriting Long Term Insurance Business (other than Class C Business) (GL16) issued by the IA;

(c) Code of Conduct for Licensed Insurance Agents issued by the IA;

(d) Code of Conduct for Licensed Insurance Brokers issued by the IA;

(e) Code of Conduct for Persons Licensed by or Registered with the Securities and Futures Commission; and

(f) All relevant rules, codes, circulars and guidelines administered or issued by the Hong Kong Monetary Authority in relation to gifts.

3.2 This Guideline does not have the force of law, in that it is not subsidiary legislation, and should not be interpreted in a way that would override the provision of any law. A non-compliance with the provisions in this Guideline would not by itself render an authorized insurer or licensed insurance intermediary liable to judicial or other proceedings. A non-compliance may, however, for example reflect on the IA's view of the continued fitness and properness of (i) the directors, controllers and key persons in relevant control functions of the authorized insurers to which this Guideline applies and (ii) the licensed insurance intermediaries to which this Guideline applies and (in the case of licensed insurance agencies and licensed insurance broker companies) their directors, controllers and responsible officers. The IA may also take guidance from this Guideline in considering whether there has been an act or omission likely to be prejudicial to the interests of policy holders or potential policy holders (albeit the IA will always take account of the full context, facts and impact of any matter before it in this respect).

4. Scope of Application

4.1 This Guideline applies to all authorized insurers carrying on long term business and all licensed insurance intermediaries carrying on regulated activities in relation to long term business.

Guideline on Offering of Gifts (GL25) (6/10)
(Source: Insurance Authority (IA) GL25)

5. Restrictions on offering Gifts

Class C Products

5.1 Authorized insurers and licensed insurance intermediaries should not directly or indirectly offer Gifts to customers when marketing, promoting or distributing Class C Products.

Class A Products and Class D Products

5.2 Authorized insurers and licensed insurance intermediaries should not directly or indirectly offer Gifts to customers when marketing, promoting or distributing Class A Products or Class D Products, unless the requirements in paragraph 5.3 are satisfied.

5.3 A Gift for the purposes of paragraph 5.2 may be offered or made to a customer only if, according to a reasonable assessment made by the authorized insurer or licensed insurance intermediary, the Gift would not distract the customer from making an informed decision on whether or not to purchase the product. Accordingly, the responsibility lies with an authorized insurer and licensed insurance intermediary to make an assessment as to whether, in their reasonable opinion, the proposed Gift would distract a customer in making such informed decision. In making such assessment, the authorized insurer or licensed insurance intermediary should take account of all the circumstances in which the Gift is proposed to be offered or made (including the value of the Gift relative to the amount of premium payable by the customer in relation to the product and the manner in which the Gift is to be marketed or offered). This assessment may be made either on a case-by-case basis or, if Gifts are to be offered or made as part of a marketing campaign or programme, at the time the marketing campaign or programme is formulated.

Permitted Gifts

5.4 As an exception to paragraphs 5.1 to 5.3 above, authorized insurers and licensed insurance intermediaries which offer Class A Products, Class C Products or Class D Products may offer Permitted Gifts as shown in the Annex, provided that the criteria referenced in the Annex in relation to each Permitted Gift is strictly adhered to.

Miscellaneous

5.5 The restrictions in paragraphs 5.1 to 5.3 also apply:

(a) in relation to the marketing, promotion or distribution of a range, group or collection of insurance products, where one or more of those insurance products is a Class A Product, Class C Product or Class D Product; or

(b) in relation to the offering or provision of any Gift by an authorized insurer to a licensed insurance broker representing a customer.

6. Premium Rebates and Commission Rebates

6.1 Rebates of premiums or commissions should not be offered or paid to customers in relation to long term insurance products.

6.2 Paragraph 6.1 does not apply in relation to any rebates which are recorded in the contract of insurance, whether in the insurance policy, the policy schedule, the quotation or offer letter, or in any promotional material (the terms of which are incorporated by reference into the contract of insurance).

7. Procedures and Controls

7.1 Authorized insurers, licensed insurance agencies and licensed insurance broker companies should maintain robust internal procedures and controls, including adequate record keeping (with such records to be made available to the IA upon request), to ensure that they and their staff, including but not limited to their licensed individual insurance agents, licensed technical representatives (agent) or licensed technical representatives (broker), where applicable, comply with this Guideline. Authorized insurers should also give due consideration to the requirements of this Guideline when considering their sales practices and their dealings with their licensed insurance agents and the licensed insurance broker companies with which they do business (as the case may be).

8. Commencement

8.1 This Guideline shall take effect from 23 September 2019 ("Effective Date").

9. Transitional Provision

9.1 The IA recognizes that the authorized insurers and licensed insurance intermediaries to which this Guideline applies may require time to update their documentation, controls and processes to align with the requirements in this Guideline. A transitional period of 12 months from the Effective Date (i.e. from 23 September 2019 to 22 September 2020) will therefore apply in respect of certain requirements of this Guideline ("Transitional Period"). During this Transitional Period, authorized insurers, licensed insurance agents or licensed insurance brokers shall comply with the provisions in this Guideline unless an alternative requirement is identified in the table below. If an alternative requirement is identified in the table below, during the Transitional Period, the alternative requirement may be followed in place of the identified provision in this Guideline by the authorized insurer or licensed insurance intermediary as referenced in the table below.

Guideline on Offering of Gifts (GL25) (9/10)

(Source: Insurance Authority (IA) GL25)

Topics	Provisions in this Guideline	Alternative Requirements
Restrictions on offering Gifts	Section 5	During the Transitional Period, as an alternative to the sections of this Guideline referenced in the column headed "Provision in this Guideline", a) Authorized insurers which were carrying on long term business immediately prior the Effective Date and their licensed insurance agents (including, in the case of licensed insurance agencies, the licensed technical representatives (agent) of the agencies) may continue to comply with the "Guidance Note on Gifts, Promotions and Incentives for Class A and Class C Products" and also, in the case of licensed insurance agents, paragraph 80(l) of the Code of Practice for the Administration of Insurance Agents (7th version dated 1 March 2010); b) Licensed insurance broker companies registered immediately prior to the Effective Date with the Hong Kong Confederation of Insurance Brokers ("CIB") and their licensed technical representatives (broker) may continue to comply with Rule 7.13 of the Membership Regulations of the CIB (version dated 15 July 2015); and c) Licensed insurance broker companies registered immediately prior to the Effective Date with the Professional Insurance Brokers Association ("PIBA") and their licensed insurance technical representatives (broker) may continue to comply with Rule 5(d) of the Membership Regulations of PIBA (version dated 1 February 2015), and the referenced documents are adopted for the purposes of the Transitional Period.
Procedures and Controls	Section 7	

September 2019

Annex

Permitted Gifts

For the purposes of this Annex, "Relevant Products" means a Class A Product, Class C Product or Class D Product.

(a) Allocation of bonus fund units and other similar product specific bonuses in respect of any Relevant Products (where applicable).

(b) Gifts that are offered for "relationship building" purposes and are not tied to the marketing, promotion or distribution of any Relevant Products.

(c) Gifts that can be redeemed at a later date under a customer loyalty programme through the accumulation of points provided that the number of points earned is not directly or indirectly linked to the volume or value of sales (or both) of any Relevant Products or, in the case of a licensed insurance broker, are not directly or indirectly linked to the distribution volume or a pre-determined level of sales of any Relevant Products.

(d) Provision of sponsorship and support for customer information seminars, compliance support and financial planning software. The level of sponsorship and support should not be in the form of subsidy or cash equivalents and should not be directly or indirectly linked to the distribution volume or a pre-determined level of sales of any Relevant Products.

(e) Brand building campaigns such as lucky draws that are open to all policy holders and potential policy holders and are not tied to the marketing, promotion or distribution of any Relevant Products.

(f) Ancillary services that are relevant and reasonably found in any Relevant Products at no extra charge, such as medical check-ups, medical consultancy services or emergency SOS services.

***

GLOSSARY

Absolute Assignment（絕對轉讓） In life insurance terminology, an Absolute Assignment is an irrevocable assignment of all policy ownership rights to a third party to the contract. **4.9**(f)(i)

Accelerated Death Benefits（提前支付死亡保險利益） These are life insurance death benefits which may, in prescribed circumstances (e.g. life threatening health situations), be payable in part or in full in advance of death of the policyowner-insured. **3.3**

Accident Benefits（意外保險利益） Additional benefits that may be added to a life policy by means of an Accidental Death Benefit (ADB) Rider（意外死亡保險利益附約） or Accidental Death and Dismemberment (AD&D) Rider（意外死亡及喪失肢體附約）. **3.2**

Accidental Death and Dismemberment (AD&D) Rider（意外死亡及喪失肢體附約） Under this rider, an accidental death benefit is payable in a sum equal to the face amount of the basic plan, providing what is termed a "double indemnity"（雙倍賠償）, and a dismemberment benefit is payable in the event of, say, loss of any two limbs or loss of sight in both eyes. **3.2**

Accidental Death Benefit (ADB) Rider（意外死亡保險利益附約） An addition to a basic life plan, providing a double benefit should the life insured die from an accident. **3.2.1**(a)

Actively-at-Work Provision（在職工作條款） A group life insurance policy provision that to be admitted to the plan, a prospective member (employee) must have been present at work on the day when coverage became effective. **2.4**(f)

Activities of Daily Living (ADLs)（日常起居活動） A list of basic human needs and functions (washing and dressing oneself, etc.); inability to perform these will satisfy a criterion for payments under a **Long Term Care Benefit** rider（長期護理附約）. **3.3.2**(c)

Annually Renewable Term (ART) Insurance（每年可續保定期保險） An alternative title for Yearly Renewable Term (YRT) Insurance. **2.1.1b**(a)

Annuitant（年金標的人） The annuitant of an annuity is the person whose life is the subject matter of that annuity. **2.3**(a)

Annuity（年金） A contract whereby an insurer promises to make a series of periodic payments (called "annuity benefit payments") to a designated individual (called the "payee") throughout the lifetime of a person (called the "annuitant") or for an agreed period, in return for a single payment or series of payments made in advance (called "annuity considerations") by the other party to the contract called the "contractholder" (or "annuity purchaser"). Very often, the payee, the annuitant and the contractholder are the same person. **2.3**

Annuity Certain（確定年金） A variation of an annuity which pays benefits for a fixed number of years, whether the annuitant survives or dies during that period. **2.3.1**(c)

Anti-Selection（逆選擇） A situation where "bad" risks (lives insured) tend to continue with their insurers, whilst "good" risks tend not to. This is a real danger with the natural premium system. Also known as **Selection Against the Insurer**（不利於保險人的選擇）. **1.3.2a**(c)(ii)

Applicant（投保人） A person who is applying for life insurance. **1.2.2**

Application（投保單） The more usual term in Hong Kong life insurance for a proposal form, by means of which underwriters obtain preliminary information from applicants. **5.2.1**(a)

Assignee（承讓人） In relation to a life insurance contract, it is a third party to whom the policyowner's interests in the contract have been assigned. **4.9**

Assignment（轉讓） In relation to a life insurance contract, it is the transfer of interests in the contract to a third party, with or without consideration. **4.9**

Assignor（轉讓人） In relation to a life insurance contract, it is a person who has assigned his interests in the contract to a third party to the contract. **4.9**

Attained Age（到達年齡） The current age of a life insured. **2.1.1b**(a)

Attending Physician's Statement (APS)（主診醫生報告） In relation to a death claim, an APS might be required from the physician who treated the life insured prior to his death, in support of the claim. **5.3.2b**(b)

Automatic Dividend Option（自動紅利選擇） If a policyowner expresses no preference regarding dividend options, this policy provision provides for a particular option to be applied automatically. Often an automatic option means that paid-up additional insurance will be purchased with any declared dividends. An alternative will be to leave the dividends with the insurer to earn interests. **4.10 Note**

Automatic Premium Loan (APL) Provision（自動保費貸款條文） **4.5**(a)**Note**
A policy provision to the effect that in the event of non-payment of a due premium, and in the absence of an instruction from the policyowner, the cash value of the policy, if any, will be automatically used to pay the premium so as to keep the policy in force.

Beneficial Interest（實益權益） Where a person has an interest of value or use in property which he does not legally own, he is said to have a beneficial interest in that property. **4.4**

Beneficiary（受益人） The Beneficiary of a life insurance policy is the person whom a policyowner has nominated to receive benefits under the policy. **4.4**

Benefit Policies（利益保單） Policies which do not pay claims on an indemnity basis, but on a stipulated benefit basis (e.g. in life insurance policies). **1.2.3**(b)(i)

Benefit Riders（保險利益附約） Endorsements to a life insurance policy, granting additional benefits, e.g. **Accidental Death Benefit (ADB)** rider（意外死亡附約）. **3**

Binding Premium Receipt（立約保費收據） A premium receipt which confirms a temporary life insurance cover. It therefore fulfils some of the features found with cover notes in general insurance. Being temporary, the life insurance cover can be terminated by the insurer earlier than the end of the specified maximum period of cover. Also known as an **Unconditional Premium Receipt**（不附條件保費收據） and **Temporary Insurance Agreement (TIA)**（臨時保險協議）. **5.2.2**(b)

Bonuses（英式紅利） The approximate equivalent of dividends with participating policies, bonuses are normally reversionary amounts added to the ultimate benefit payable under a with-profit policy. They are usually declared as a percentage, to be applied to either the sum insured or the sum of the sum insured and the accumulated bonus in arriving at the amount of bonus. **1.3.1b**(a) **Note** 1

Case-based Exclusion(s)（個別不保項目） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "The exclusion of a particular sickness or disease from the coverage of Certified Plan that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person." **3.4a**(d)(iv)

Cash Value（現金價值） It is a savings element that results when the premiums received during the early years of level premium life policies have been found to exceed the total payment of death claims occurring in those years. The excess amounts are set aside and collectively referred to as a cash value. The cash value that has been allocated to a policy can be used by the policyowner in a number of ways, e.g. to be withdrawn in the form of surrender value, or used as a pledge for policy loans. **1.3.2b**(c)(i)

Certified Plans（認可產品） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "Individual IHIP [indemnity hospital insurance plans] certified by FHB [the Food and Health Bureau] as VHIS[Voluntary Health Insurance Scheme]-compliant, including the **Standard Plan** and **Flexi Plans**." **3.4a**(a)

Chose in Action（據法權產） A personal right which can only be enforced or claimed by action, and not by taking physical possession. Examples include a debt, a cheque and a patent. **4.9**

Class Designation（概括式指定） A description of policy beneficiaries by group association rather than by name, e.g. "my children", and "my brothers and sisters". **4.4**(a)

Coinsurance (Medical Insurance Policy)（共同保險（醫療保險單）） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "A percentage of eligible expenses the Policy Holder must contribute after paying the Deductible (if any) in a Policy Year. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policyholder is required to pay if the actual expenses exceed the benefit limits of the Certified Plan." **3.4a**(c)(iv)(12)

Collateral Assignment（抵押轉讓） In life insurance terminology, a Collateral Assignment is a temporary assignment of a policy as collateral security for a loan. The assignee's interest with such an assignment is limited to the amount of the loan plus interests. **4.9**(f)(ii)

Comprehensive Cover（綜合保障） In motor insurance, it is the widest form of cover, combining third party liability and "own damage" cover. A Comprehensive private car policy may also give other benefits, such as personal accident and/or medical expenses insurance. **1.2.3**(c)(ii)

Conditional Premium Receipt（附條件保費收據） A receipt for premium which confirms that insurance will begin from the time of the application, provided the life insured is subsequently found to have been insurable on standard terms at that time. **5.2.2**(a)

Conservation（保留） The retention of existing business, i.e. avoiding policy lapses and surrenders. **5.2.3a**(a)

Contestable Period（可異議期） The period of time specified in an **Incontestability Provision**（不可異議條款）beyond which the insurer will not contest the contract. **4.2**(b)

Contingent Beneficiary（次順位受益人） A beneficiary who has been designated to receive the death benefit payable under a life insurance policy if it is he, rather than the primary beneficiary, who survives the life insured. **4.4**(b)

Continuous Premium Whole Life Policy（連續繳費終身壽險單） **2.1.3**(a)(i)
A whole life insurance policy where the premiums continue to be payable throughout the lifetime of the life insured.

Contribution（分擔） An insurance principle which means that two or more insurers covering the same insured for the same loss share that loss rateably. However, this is in providing an indemnity, to which life insurance is not normally subject. Therefore the existence of more than one life insurance policy will not affect the amounts payable by the individual insurers. **1.2**(e)

Contributory (Plans)（供款（計劃）） Group life, or employee benefit, schemes where the premium is paid in part by the members of the plans. **2.4**(c)

Convert (Conversion)（轉換） A policyowner's exercise of the right to choose a substitute insurance plan in accordance with a conversion provision, or by mutual consent. **2.1.1b**(b)

Convertible Term Insurance（可轉換定期壽險） A term insurance which provides the policyowner with the right to convert the insurance plan into a permanent plan, without evidence of insurability. **2.1.1b**(b)

Cooling-off Period（冷靜期） Among the standardised provisions of Certified Plans under the Voluntary Health Insurance Scheme ("VHIS") is one that grants policyholders the right to cancel their newly effected policies within the relevant cooling-off periods with full refund of the premiums paid provided no benefit payment has been made or is to be made or impending. The cooling-off period lasts for 21 days (or a longer period offered by the VHIS providers) after the delivery of policy or the issuance of notice to the policyholder or the policyholder's representative stating that the policy is available and when the cooling-off period would expire, whichever is the earlier **3.4a**(d)(vii)(4)

Cost of Living Adjustment (COLA) Benefit Rider（生活指數調整附約） **3.6.1**
A rider providing for periodic increases in the disability income benefits being paid to a disabled insured, which increases are linked to a prescribed index.

Cover Note（暫保單） A term from general insurance, referring to a document issued to prove the temporary existence of insurance, the approximate equivalent in life insurance being the **Binding Premium Receipt**（立約保費收據）. **5.2.2**(b) **Note**

Credit Life Insurance（信用壽險） A form of decreasing term insurance normally on a group basis arranged by a lending institution to cover the outstanding balances of loans should the borrowers die without full repayments. The benefit is payable direct to the lending institution. **2.1.1a**(b)(i)

Critical Illness Benefit（危疾保險利益） Critical illness insurance, covering a range of specified diseases, is provided either in the form of a rider or a standalone insurance plan. In the former case, the insurer offers to make a lump-sum advance payment from the sum insured of the basic life insurance plan. In the latter case, the lump-sum benefit payment offered will be an advance payment only where the critical illness insurance plan offers death benefit as well as critical illness benefit. **3.3.1**

Customer Protection Declaration (CPD) Form《客戶保障聲明書》 An important document that must be completed and signed before a customer agrees or makes a decision in relation to the purchase of a new life insurance policy. It is part of the concern of the insurance industry to preserve high ethical and professional standards, and to control inappropriate replacement of insurance policies instigated by insurance intermediaries. **5.2.5**(c)

Days of Grace（寬限日期） See **Grace Period**（寬限期）. **4.3**

Death Benefit（死亡保險金） The basic amount payable under an insurance policy upon the death of the life insured. This may be subject to additional factors, e.g. accidental death benefits. **2.2.1**(e)

"Debt" on Policy（保單負債） An underwriting measure with a sub-standard risk, whereby a "debt" is placed against the face amount, possibly reducing to extinguishment as the policy years go by without a claim. **5.3.3**(c)(i)

Declinature（拒保） An insurer's refusal to insure a given risk. **5.3.3**(a)

Declined Risk（拒保風險） A given risk which is impaired to such an extent that a particular insurer is refusing to insure it. **5.3.1**(b)(iii)

Decreasing Term Insurance（遞減定期壽險） Term insurance whose face amount reduces each year or at specified times. It is the cheapest form of life cover, useful to meet a diminishing temporary need, e.g. a mortgage loan scheduled for repayments over a period of years. **2.1.1a**(b)

Defer Decision（延遲決定） An option for the life underwriter where a proposed risk is uninsurable owing to a temporary condition (e.g. accident injuries). The risk is not permanently refused, but it will need reassessment at a later date. **5.3.3**(c)(iv)

Deferred Annuity（延期年金） An annuity where annuity benefit payments begin at some specified future time or specified age of the annuitant. **2.3.1**(b)

De-mutualised（股份化） A description of a life insurance company which has changed its mutual status, to become a proprietary company, i.e. a limited company owned by its shareholders. **5.1**(a) **Note**

Disability Income rider（殘疾收入附約） A policy rider providing an income during the insured person's period of disability. **3.1.2**

Disability Waiver of Premium Rider（殘疾豁免保費附約） An endorsement to a life policy, offering to waive premiums otherwise payable whilst the insured person is totally disabled, keeping the life insurance in full force. **3.1.1**

Dismemberment（喪失肢體） The loss of one or more limbs, but within the AD&D Rider provisions the term also applies to loss of sight. **3.2.1**(b)

Dividend Options（紅利選擇） The choices available to the policyowner of a participating policy with declared dividends. These choices include: receiving the dividends in cash, applying them towards future premium payments, leaving them to earn interests with the insurer, etc. **4.10**

Dividends（紅利） Amounts declared to holders of participating policies on the basis of the experience of the pooled fund to which those policies are connected and which the insurer concerned manages. Usually expressed as a percentage of the premium paid. **4.10**

Divisible Surplus（可分配盈餘） That amount of an insurance company's surplus (i.e. that portion of the owners' equity which represents the excess of its assets over its liabilities and capital) which is available for distribution to the holders of its participating policies (or with-profit policies) in the form of dividends (or bonuses). **1.3.1b**(a)

Double Indemnity Benefit（雙倍賠償利益） An additional benefit to be paid, equal to the policy face amount, should death occur as a result of an accident. An alternative name for **Accidental Death Benefit**（意外死亡保險利益）. **3.2.1**(a)**Note** 1

Duty of Disclosure（披露責任） It requires the parties to a proposed insurance contract to reveal to the other, before contract conclusion, all material facts whether these are requested or not. **1.2.2**

Employee Benefit Plans（僱員福利計劃） Group life insurance for employees within the same organisation or industry. **2.4**

Endowment Insurance（儲蓄壽險） Life insurance that will pay the face amount when the life insured survives a fixed period of years (at maturity) but upon death in case he dies within the period. **2.1.2**

Enrolment Card (and **Certificate)**（成員登記卡、保險憑證） Documents used with group life insurance, providing evidence of cover to individual insured persons. Separate from the **Master Policy**（總保單）. **5.4.1**(b)

Entire Contract Provision（完整合約條款） A life policy provision that defines the whole set of documents constituting the insurance contract. **4.1**

Equities（股票） Ordinary shares in a proprietary company. As an investment vehicle, they carry a higher risk than some types of investment, but usually offer long-term growth prospects. **2.2.2**(b)

Equity（衡平法） Equity is a set of rules originally established by the Chancery Court of England to mitigate the rigour of common law so as to achieve enhanced fairness. Equity prevails over common law. **1.2.1**

Estate（財產） All the property which is owned by an individual, especially someone who has died recently. **4.4**(c)

Estate Planning（財產策劃） The making of a plan when one is alive, for the disposal of one's estate after one's death or upon his becoming incapacitated. **1.1**(a)

Ex Gratia Payment（通融賠付） A payment, usually of a claim, which is made "out of grace or favour", i.e. where there is no legal liability to make such a payment. **4.12 Note** 2

Examining Physician（體檢醫生） A qualified medical professional conducting a medical examination on behalf of an insurer. **5.3.2b**

Excepted/Excluded Perils（除外危險） A cause of loss excluded from an insurance cover. **1.2.3**(a)(ii)

Excess Interest（額外利息） Interest earned over and above the guaranteed interest. Must be notified in the Annual Report with universal life insurance. **2.2.1**(f)(v)

Exclusions（除外責任） Risks or losses removed from an insurance cover. These are relatively rare with life insurance, but may more commonly be found with rider benefits, e.g. suicide with accidental death benefits. **5.3.3**(c)(ii)

Extended Term Insurance（展期保險） An option under a non-forfeiture benefits provision of a permanent life insurance policy, whereby the net cash value is used as a single premium to purchase a substitute term insurance cover for the same amount as the original face amount, and for such period as the amount of cash value can provide. **4.5**(b)(iii)

Face Amount（保額） Specified on the first page of a life insurance policy, it is the amount the policy promises to pay upon death of the life insured. Equivalent to "sum insured" and "sum assured". **5.2.5**(b)

Family Income Insurance（家庭收入壽險） A variation of decreasing term insurance which pays the life insured's surviving spouse or dependant a stated monthly benefit in the event of death, for the remainder of a specified period of time. **2.1.1a**(b)(ii)

Financial Underwriting（財務性核保） Underwriting concentrating more on the implications arising from the amount of insurance requested, e.g. whether the policyowner can meet premium obligations, whether reinsurance may be required, and whether the amount seems excessive by normal criteria with such class of risks. **5.3.1Note**

First Beneficiary（第一受益人） See **Primary Beneficiary**（第一順位受益人）. **4.4**(b)

Flexi Plan（靈活計劃） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "Any individual IHIP [indemnity hospital insurance plans] under the VHIS [Voluntary Health Insurance Scheme] framework with enhancement(s) to any or all of the protections or terms and benefits that the **Standard Plan** provides to the Policy Holder and the Insured Person, subject to the certification by FHB [the Food and Health Bureau]. Such plan shall not contain terms and benefits which are less favourable than those in the **Standard Plan**, save for the exception as may be approved by FHB from time to time." **3.4a**(c)(iii)(5)

Fulfilment Ratio（實現率） When a participating (or with-profit) policy that offers non-guaranteed dividends/bonuses is being recommended to a prospective customer, projected values are normally presented to him for reference purposes. He may, before making a purchase decision, want to know how likely these values or amounts will come true. It will help to be shown Fulfilment Ratios that are relevant to the recommended insurance product. Relating to a particular insurance product and to a definite period of its existence in the past, the Fulfilment Ratio is substantially the average proportion that the non-guaranteed dividends/bonuses actually declared bear to the amounts projected at the points of sale. **5.2.8**

Fully Earned（已完全賺取的） When an amount of premium for a particular period in the past is said to be fully earned, that amount is taken as corresponding to the risk run by the insurer during that period, so it (the earned or fully earned premium) contains no "surplus" to provide for a cash value or other benefit common with the level premium system in many types of life insurance. **1.3.2b**(b)

Fully Paid Up（完全清繳） Once a policy has been fully paid up, no more premiums have to be paid but it will continue to provide cover. It is one of the non-forfeiture options (see **Reduced Paid-Up Insurance**（減額清繳保險）). **5.2.7d**(c)

Fully Paid-Up Shares（完全清繳的股票） Shares in a proprietary company (or stock company), for which the subscription price has been wholly paid by the shareholders. **5.1**(b)

Grace Period（寬限期） A period of time after a premium is due, during which the premium may be paid and cover kept continuous, without penalty. Also known as **Days of Grace**（寬限日期）. **4.3**

Graded-Premium Policy（等級保費保險單） A variation of whole life policy, where the premium increases on a regular basis, e.g. every three years, but the face amount remains unchanged. **2.1.3**(c)

Gross Premium（毛保費） The premium for a life insurance policy after taking into account the three rating factors of mortality, interest and expenses. **1.3.1a Note**

Group Insurance（團體保險） Life insurance of a number of persons forming a recognisable group, e.g. employees of a particular employer. **2.4**

Guaranteed Annuity（保證年金） An annuity which guarantees that annuity benefits will be paid until the annuitant dies and will be paid for at least a certain period, even if he does not survive that period. Also known as a **Life Income With Period Certain**. **2.3.1**(c)

Guaranteed Insurability Option (GIO)（保證可保選擇） Under this rider, the policyowner has the right to purchase additional insurance of the same type as the basic life insurance plan either on specified option dates, at specified ages, or when a specified event happens, without having to supply evidence of insurability. **3.5.1**

Immediate Annuity（即期年金） An annuity where the annuity benefit payments commence one annuity period (i.e. the time span between one scheduled payment and the next in the series) immediately following the purchase of the annuity. **2.3.1**(a)

Incontestability Provision（不可異議條款） A provision in a life insurance or annuity policy whereby after an initial period the insurer may not contest the policy. **4.2**

Increasing Term Insurance（遞增定期壽險） Term insurance that provides a death benefit that increases automatically at specified intervals over the period of insurance. The increases may be linked to an agreed index (e.g. the Composite Consumer Price Index). **2.1.1a**(c)

Indemnity（彌償） Restricting insurance payment to an exact financial compensation, the principle of indemnity is not normally applicable to life and personal accident insurance. **1.2**(d)

Indemnity Corollaries（彌償引伸） Sub-principles of the parent principle of indemnity, i.e. contribution and subrogation. As with indemnity, neither is likely to have any application with life insurance. **1.2.3**(c)

Insurability Benefits（可保權利益） Two types of insurability benefits are offered as riders to life insurance policies, i.e. **Paid-up Additional Insurance**（清繳增額保險）and **Guaranteed Insurability Option**（保證可保選擇）. **3.5**

Insurable Interest（可保權益） In the context of life insurance, it is the legal right to insure an individual's life, which is required at the commencement of insurance, although it is not needed when the insured event happens. **1.2.1**

Insured Perils（受保危險） Causes of loss covered by a particular policy. **1.2.3**(a)(i)

Internal Rate of Return (IRR)（內部回報率） A useful financial tool for appraising investment plans. An investment plan is often appraised by comparing its expected return to its **Opportunity Cost**. But the calculation of the expected return would become complicated if the investment plan involves a stream of incomes or outlays happening at different points in time as opposed to a single income and outlay. In such circumstances, it makes sense to calculate the investment plan's **IRR** by taking into account the different amounts of cash involved and the time they are paid or received, and then compare the IRR to the opportunity cost or other financial metrics. **2.3.1b**(b)(ii)(1)

Irrevocable Beneficiary（不可撤換受益人） A beneficiary who cannot be changed without his/her consent. **4.9**(e)(i)

Joint-Life Basis（聯合壽險方式） A life insurance policy that grants cover on a joint-life basis insures the lives of two (or more) persons. Such a policy will pay either on the first or last death, as specified. **2.1.1a**(b)(iii)

Key Person Life Insurance（關鍵人物人壽保險） A type of insurance that a business may purchase for insuring the life of an individual whose death might cause a significant financial loss to the business. **1.2.1**(d)(iii) **Note**

Lapse（失效） It is the kind of termination of a life insurance policy that will result from the non-payment of a due premium within the permitted time period (including the **Grace Period**（寬限期）). **1.3.2b**(c)(iii)

Level Premium System（均衡保費制度） The normal method of life insurance pricing, whereby (for the same face amount) the annual premium is established at inception and does not vary throughout the term of the policy. **1.3.2b**

Level Term Insurance（定額定期壽險） Term insurance that offers a death benefit that does not change during the term of the policy. **2.1.1a**(a)

Life Income Annuity With Period Certain（確定期間終身年金） See **Guaranteed Annuity**（保證年金）. **2.3.1**(c)

Living Benefit Rider （生前支付保險利益附約） Another name for **Accelerated Death Benefit Rider**（提前支付死亡保險利益附約）. **3.3**

Loading（附加保費） A sum added to a life insurance policy's net premium to cover all of the insurer's costs of doing business (commissions, etc.). **1.3.1a**(c)

Long Term Care (**LTC**)（長期護理） A rider allowing a stated portion of the death benefit to be advanced to the policyowner-insured when he requires constant care for a medical condition. **3.3.2**

Market Value Adjustment (**MVA**)（市值調整） A permitted right of insurers under the cooling-off initiative to make an adjustment with the refund of premiums, in relation to linked policies and non-linked single premium life policies. **5.2.4** (g)(ii)

Master Policy （總保單） The primary insurance document with a group life insurance plan. **5.4.1**(b)

Material Fact（重要事實） A fact that would influence the judgment of a prudent insurer in determining whether to accept a risk or at what premium to accept it. **1.2.2**

Mature (**Maturity**)（期滿） In relation to an endowment insurance policy, it means the policy becomes payable upon the life insured's survival of the period of insurance. **2.1.2**

Maturity Claims（期滿索償） Claims under endowment type insurance, where the full number of years specified have been completed and the life insured is still living. **5.6.1**

Medical Application（要體檢投保） A proposal for life insurance where a physical medical examination of the life to be insured is required. **1.2.2**(c)

Money Laundering（洗黑錢） The illegal practice of "cleansing" money obtained illegally (e.g. through drug trafficking) by the use of business or financial instruments such as life insurance. Insurers and insurance intermediaries must take great care in trying to detect and eliminate such practices. **5.5.1Note**

Moral Hazards（道德危險） Rather more subjective features concerning human attitudes, behaviour and conduct which may have a bearing on the risk. **5.3.1**(a)(ii)

Mortality（死亡率） An important consideration in determining life insurance premium rates. It refers to the rate at which insured lives may be expected to die at a given age. The term, therefore, may more accurately be described as **Rate of Mortality**（死亡比率）. **1.3.1a**(a)

Mortality Tables（死亡表／生命表） Published statistics on mortality, indicating the expected rates of mortality at given ages. **1.3.1a**(a)

Mortgage Indemnity Insurance（按揭彌償保險） A type of insurance that protects a mortgagee against the risk of the value of the mortgaged property falling beneath, say, 75% of the original valuation for any reason. **2.1.1a**(b)(iii) **Note**

Mortgage Redemption Insurance（抵押贖回保險） A form of decreasing term insurance, with the benefit linked to the outstanding balance of a mortgage loan that the policyowner has raised. It often grants cover on a joint-life basis, paying on the first death. **2.1.1a**(b)(iii)

Multiple-Employer Groups (Insurance)（多個僱主的團體（保險）） Group life insurance where different employers participate in a single plan covering their respective employees. **2.4**(d)

Mutual Insurance Company（相互保險公司） An insurance company with no shareholders, technically owned by its participating policyholders (i.e. owners of participating policies). **5.1**(a)

Natural Premium System（自然保費制度） A system of life insurance premium pricing, whereby the premium for any one policy changes each year according to the prevailing age of the life insured and other features. This is unworkable from a practical point of view and may be considered an academic concept. **1.3.2a**

Natural Risk（自然風險） The intrinsic risk presented by the life insured at a particular point in time, related to the person's age, health and other factors. **1.3.2a**(a)

Net Cash Value（淨現金價值） Although a policy with cash value may allow the policyowner to cancel the policy in return for a surrender value, or to buy a substitute insurance cover using the cash value as a single premium, the amount actually available for any one of these purposes (i.e. the Net Cash Value) may not equal the cash value for a couple of reasons. The Net Cash Value is calculated by making adjustments for amounts such as paid-up additions, outstanding policy loans and interests, and advance premium payments. **1.3.2b**(c)(iv)

Net Policy Proceeds（淨保單收益） The entitlement of an assignee under a life insurance policy, his interests being subordinate to those of the insurer regarding overdue premiums, outstanding policy loans and accrued interests. **4.9**(c)

Net Premium（淨保費） Sometimes called the **Pure Premium**（純保費）, this, in the context of life insurance pricing, may be described as the basic premium to be charged exactly to cover the cost of death claims arising under normal statistical expectations, with no allowances for expenses and profit. **1.3.1a Note**

Non-Contributory (Plans)（非供款（計劃）） Group life, or employee benefit, plans where the members do not contribute premiums. **2.4**(c)

Nonforfeiture（不能作廢） A consequence of the level premium system and policies having a cash value. In the event that future premiums are not paid, the policy does not lapse (become forfeit), because the cash value may be used to keep the policy in force. **4.5**

Nonforfeiture (Options)（不能作廢（選擇權）） These are the choices available to the policyowner who does not wish to continue payment of premiums under a policy with a cash value, that will prevent the policy from lapsing. These options include: taking a surrender value in cash, accepting reduced paid-up insurance and accepting extended term insurance in substitution of the original plan. **4.5**(b)

Nonforfeiture Provisions（不能作廢條款） Policy provisions that provide **Nonforfeiture Options**. **4.5**

Non-Medical Application（免體檢投保） A request for life insurance which (subject to certain stipulations) does not have to be accompanied by a physical medical examination of the life to be insured. **1.2.2**(b)

Opportunity Cost（機會成本） The **Opportunity Cost** of an investment plan is the value of the most valuable of all alternatives to that investment plan. **2.3.1b**(b)(ii)(1)

Option Dates（備擇日期／行權日期） Dates specified under a **Guaranteed Insurability Option**（保證可保選擇） on which additional insurance may be purchased without evidence of insurability. **3.5.1**(a)

Package Policy（一籃子保單） Put simply, it is a single policy containing different types of cover (e.g. a personal accident and sickness policy). **3.3.1 Note**

Paid-Up Additional Insurance（清繳增額保險） A participating policy normally allows the policyowner to use any declared dividend as a net single premium to purchase Paid-Up Additional Insurance for the same plan and in whatever face amount the dividend can provide at the attained age of the life insured. **4.10**(d)

Paid-Up Insurance（清繳保險） Insurance that a policyowner opts in substitution of the original insurance, with a reduced amount of insurance, without liability to pay further premiums, but otherwise on the same terms as the original insurance. **1.3.2b**(c)(iv)

PAR/NON-PAR（分紅／不分紅） The customary abbreviation for policies that are participating or non-participating. **1.3.1b**(a)

Participating/Non-Participating（分紅／不分紅） Also known as **With-Profit**（有利潤） or **Without-Profit**（無利潤）, the terms indicate whether the policyowners can expect to share in the divisible surplus of the insurer or not. **1.3.1b**(a)

Participating Policyholders（分紅保單持有人） Those policyholders whose policies are participating (or with-profit). **5.1**(a)

Pension（退休金） A monthly or other periodic payment to a person in retirement, until death. **2.3**

Permanent Plan（永久計劃） A life insurance plan which is effective throughout the life insured's lifetime provided premiums continue to be paid, and which contains a savings element. **2.1.1b**(b)(iii)

Personal Data (Privacy) Ordinance（《個人資料（私隱）條例》） This is a piece of legislation that is to safeguard the privacy of personal data. When seeking sensitive information about health condition in the course of processing life insurance applications, practitioners should take great care not to breach the Ordinance. **1.2.2**(d)

Personal Needs（個人需要） Life insurance fulfils a vital function of satisfying an individual's various needs in everyday life, such as the needs to make provision for the education of one's children, for one's own retirement and for dependents' living expenses in case of one's premature death. **1.1.1**(a)

Personal Representative（遺產代理人） The executor of a will or the administrator of the estate of a deceased person. **5.6.2**(a)

Physical Hazards（實質危險） The objective measurable factors that are very likely to increase the risk of the insured event happening, such as obviously known health dangers (e.g. heavy smoking and serious overweight). **5.3.1**(a)(i)

Policy Loan（保單抵押貸款） A policy that generates a cash value usually allows the policyowner to borrow money (Policy Loan) from the insurer against the security of the cash value. **1.3.2b**(c)(ii), **4.6**

Policy Revival（保單復效）**)** See **Reinstatement**. **4.7**

Policyowner-insured（受保保單所有人） Where the life insured and the policyowner are the same person, this person can be referred to as a policyowner-insured. **3 Note**

POS (Policyowner Service)（保單所有人服務部） The Client Service Department, responsible for such matters as documentation, correspondence, premium payments, etc. **5.1.1**(e), **5.5**

Pre-Existing Conditions（保險生效前已患的疾病） It is common for medical benefit policies to exclude expenses relating to medical problems that existed before the insurance commenced. **3.4**(c)(i)

Preferred Risks（優良風險） Above average risks, constituting highly desirable types of business for the insurer (e.g. confirmed non-smokers in excellent health). **5.3.1**(b)(iv)

Premium Holiday（保費免繳期） A facility which allows a policyholder of a regular premium plan to skip premium payments for a period of time provided that the policy value is sufficient to cover the mortality charges and fees. No penalty or debit interest will be incurred. **5.2.6b**

Premium Waiver（保費豁免） A policy provision whereby premiums otherwise payable are not required by the insurer under prescribed circumstances, e.g. when the life insured has become disabled. **3.3.1**(f)

Presumption of Death（推定死亡） Where a person has not been seen for several years, an application can be made to the court to presume him to be legally dead. **5.6.2**(e)

Primary Beneficiary (or **First Beneficiary**)（第一順位受益人／第一受益人） Where a policy has two or more policy beneficiaries, the one who is stated as having priority in receiving the policy proceeds is called the Primary Beneficiary. There could be more than one Primary Beneficiary. **4.4**(b)

Principal Brochure（主要推銷刊物） A document required with all investment-linked assurance schemes, containing the information necessary for prospective scheme participants to make an informed judgment of the investment proposed to them. **5.2.4**(g)

Proprietary (or Stock) Company（營利（或股份）公司） A company having shareholders, who have their liability towards the company's debts limited to the extent of any amounts unpaid in respect of their company shares. **5.1**(b)

Provident Fund Scheme（公積金計劃） A retirement provision, but unlike with a pension, the benefit is in the form of a lump-sum amount payable at retirement or other specified time. **2.3.2**

Proximate Cause（近因） It is the principle which seeks to establish the dominant or effective reason for a loss occurring. The cause of death may sometimes be important in life insurance, for example, if the policy provides additional benefits for accidental death (or if death happens within the contestable period or suicide exclusion period). **1.2**(c)

Public Policy（公共政策） It is a principle of law that enables the court to set aside, or deny effect to, acts or transactions that tend to injure the public good or public order. **5.6.2**(d)(iv)

Pure Endowment（純生存保險） A rare form of life insurance where the benefit is only payable if death does **not** occur during the period (term) specified. **2.1.2**(b)

Pure Premium or **Pure Cost of Protection**（純保費／保障的純成本） See **Net Premium**（淨保費）. **1.3.1a Note**

Qualifying Deferred Annuity Policy (QDAP)（合資格延期年金保單） **2.3.1b**(a)
Premiums paid under a deferred annuity policy are tax deductible, provided that the policy constitutes a **Qualifying Deferred Annuity Policy**, which is one that satisfies the criteria specified in the **Guideline on Qualifying Deferred Annuity Policy** (GL19) issued by the Insurance Authority ("IA") and has been certified by the IA for this purpose.

Reduced Paid-Up Insurance（減額清繳保險） A non-forfeiture option that allows the policyowner to use the net cash value as a single premium to purchase substitute insurance with a lower sum insured than the original one. **4.5**(b)(ii)

Reinstatement（復效） The restoration of a lapsed policy into full force. Also known, with UK style policies, as **Policy Revival**（保單復效）. This is provided for under policy conditions, but is subject to certain limitations, e.g. a specified time period (perhaps five years for exercising the option), repayment of back premiums and interest, and perhaps other measures. **4.7**

Reinsurance（再保險） Insurance that transfers all or part of the risk assumed by an insurer under one or more insurance contracts to another insurer. **5.1.1**(g)(iii)

Release (or Release Form)（棄權聲明／解除責任憑證） Documentary confirmation from a beneficiary that the policy's death benefit stands reduced by the amount of any accelerated death benefit payment. Alternatively, a discharge given by a benefit recipient, e.g. with a policy surrender and death claim. **3.3**(c), **5.6.3**(c)

Renewable Term Insurance（可續保定期壽險） Term insurance that offers the right of renewal for further period(s) without evidence of insurability. **2.1.1b**(a)

Renewal Premiums（續保費） Premiums paid or payable for life insurance after payment of the initial premium. **1.3.2b**(c)(iii)

Reserve（儲備金） That part of the premium collected which is considered to be unearned will be used to build policy reserve for the purposes of paying policy benefits in the future. **1.3.2b**(b)

Reversionary (Interest/Bonus)（復歸（權益／紅利）） A financial interest which exists now, but where full enjoyment and privileges of ownership is deferred until some future time or event, e.g. reversionary bonuses under with-profits policies. **4.9**, **4.10**

Rider（附約） Such an amendment to a policy that becomes part of the insurance contract and that either expands or limits the benefits payable under the contract. **3.1**

Settlement Options（賠付選擇） The choices available to the policyowner when the policy proceeds become available. These options include: lump sum single payment, proceeds left to earn interest with the insurer and proceeds paid in instalments over a fixed period, etc. **4.11**

Single-Employer Plans（單一僱主計劃） Group life insurance where all insured persons are employees of the same employer. **2.4**(d)

Special Class Risks（特殊風險） See **Sub-Standard Risks**（次標準風險）. **5.3.1**(b)(ii)

Standard Plan（標準計劃） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "The insurance plan with terms and benefits equivalent to the minimum compliant product requirements of the VHIS [Voluntary Health Insurance Scheme], which are from time to time published and subject to regular review by the Government." **3.4a**(c)(iii)(4)

Standard Risks（標準風險） Risks presenting no abnormal features and insurable on normal terms. **5.3.1**(b)(i)

Straight Life Insurance（純粹壽險） Whole life insurance for which premiums are payable for as long as the life insured lives. **2.1.3**(a)(i)

Subrogation（代位權） A legal principle which allows an insurer who has provided an indemnity to take over for his own benefit rights the policyholder has against third parties. As indemnity does not apply to life insurance, so this corollary of indemnity – subrogation - does not apply to it either. **1.2**(f)

Sub-Standard Risks（次標準風險） Proposed risks which are more likely to result in a loss that the average, so that they are either rejected or insurable with special terms. Sometimes called **Special Class Risks.** **5.3.1(**b)(ii)

Sum Assured（保額） See **Face Amount**. **5.3.3**(c)(i)

Sum Insured（保額） See **Face Amount**. **5.2.5**(b)

Surrender（退保） Termination of an insurance policy by the policyowner for a **Surrender Value**. **5.6.3**

Surrender Value（退保價值） Payable in cash, a policy's surrender value equals the cash value minus a surrender charge, a charge that is applicable when a policy is surrendered for its cash value or when a policy, under some plans, is adjusted to provide a lower level of death benefit. Also see **Cash Value**（現金價值）. **1.3.2b**(c)(i)

Switching (Policy Switching)（轉保） Changing an existing life insurance policy for a replacement one. The term, however, has an undesirable implication whereby policyholders are persuaded to make the change which may be more for the benefit of the insurance intermediary or the new insurer than the policyholder. The latter practice is known as **Twisting**（誘導轉保）(i.e. an inappropriate replacement of a life insurance policy). **5.2.5**

Technical Underwriting（技術性核保） Assessment of the intrinsic and perceived hazards of given risks, as to their insurability and terms. **5.3.1 Note**

Temporary Insurance Agreement (TIA)（臨時保險協議） See **Binding Premium Receipt**（立約保費收據）. **5.2.2**(b)

Term Insurance（定期壽險） Life insurance which will pay benefit only if the life insured dies during the period (term) specified. Also known as **Temporary Life Insurance**（短期人壽保險）. **2.1.1**

Third Degree Burns（三級燒傷或燙傷） Can be defined as full thickness skin destruction due to burns. **3.2.2**(b)(i)

Third Party Policy（第三者保單） A policy where the insurance is on the life of a person other than the applicant. **3**

Title（所有權） It is a legal term meaning the right to hold goods or property (e.g. policy proceeds). **5.6.3**(a)

Total Disability（完全殘疾） As defined under the Disability Income Rider, this means that the insured person is unable to perform the essential acts of his own occupation, or any occupation for which he is reasonably fitted by education, training or experience. **3.1.2**(a)

Twisting（誘導轉保） See **Switching**（轉保）. **5.2.5**(a)

"Unbundled" Pricing Structure（「分別列示各定價因素」定價結構） A feature of universal life insurance, whereby the insurer separately discloses the three pricing factors: mortality (or pure cost of protection), interest and expenses. **2.2.1**(c)

Unconditional Premium Receipt（不附條件保費收據） See **Binding Premium Receipt**（立約保費收據）. **5.2.2**(b)

Underwriting（核保） The process of identifying and classifying the degree of risk represented by an application, and of determining its insurability and the contract terms to be adopted. **1.3.1a**(a), **5.1.1**(g), **5.3**

Uninsured Perils（不保危險） These are causes of loss neither specifically covered nor specifically excluded by a policy. An important consideration with non-life insurance and the principle of proximate cause, but unlikely to have any significant application to life insurance. **1.2.3**(a)(iii)

Unit-Linked Long Term Policy（單位相連長期保單） Also known as an '**Investment-Linked Long Term Policy**'（投資相連長期保單）, it is an insurance policy with its policy value generally linked to the performance of its underlying investments. **2.2.2**

Universal Life Insurance（萬用壽險） Life insurance which is subject to a flexible premium, has an adjustable benefit and an 'unbundled' pricing structure, and accumulates a cash value. **2.2.1**

Utmost Good Faith（最高誠信） A common law principle whereby each party to an insurance contract must, prior to contract conclusion, reveal to the other all **Material Facts** whether these are requested or not. At law, a breach of this principle makes the contract voidable, subject to such contract terms as the **Incontestability Provision**. **1.2**(b)

Waiting Period – in relation to Critical Illness Rider（等候期—與危疾附約有關的） Where diagnosis is a defining element of an insured event of the Critical Illness Rider, the diagnosis has to be one done when the rider has already been in effect for a specified number of days. **3.3.1**(e)(iv)

Waiting Period – in relation to Disability Waiver of Premium Rider（等候期—與殘疾豁免保費附約有關的） A qualification to the Disability Waiver of Premium Rider, whereby premiums are not waived until the insured person has been disabled for a specified number of months. Some insurers refund premiums paid during the waiting period if the disability lasts longer, so that premiums begin to be waived. **3.1.1**(a)

Whole (of) Life Insurance（終身壽險） Life insurance where the benefit is payable only on death, whenever that occurs. **2.1.3**

With-Profit Policy)（有利潤保單） The equivalent term in U.K. insurance terminology of a participating policy. **1.3.1b**(a) **Note** 1

Without-Profit (Policy)（無利潤保單） The equivalent term in U.K. insurance terminology of a non-participating policy. **1.3.1b**(a) **Note** 1

Yearly Renewable Term (YRT) Insurance（每年可續保定期壽險） One year term insurance with guaranteed insurability renewal provisions. Also known as **Annually Renewable Term (ART) Insurance**. **2.1.1b**(a)

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Representative Examination Questions

Answers

	QUESTIONS			
CHAPTER	**1**	**2**	**3**	**4**
1	(c)	(d)	(d)	(a)
2	(d)	(a)	(b)	(c)
3	(d)	(a)	(c)	(b)
4	(b)	(a)	(c)	(d)
5	(d)	(c)	(c)	(b)

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