

GOVERNMENT NOTICE

MINISTRY OF FINANCE

No.2

2021

REGULATION ISSUED IN TERMS OF THE FINANCIAL INSTITUTIONS AND  
MARKETS ACT, 2021

The Minister of Finance has, under section 465(5) (d), (e), (f), and (m) of the Financial Institutions and Markets Act, 2021 (Act No 2 of 2021), issued the regulations set out in the Schedule.

MINISTER OF FINANCE

WINDHOEK

2021

SCHEDULE

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INSURANCE TERMS DEFINED FOR THE PURPOSES OF SECTION 8 OF THE ACT

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NAMIBIA FINANCIAL INSTITUTIONS SUPERVISORY AUTHORITY

**Regulation No: INS.R.2.2**

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**FINANCIAL INSTITUTIONS AND MARKETS ACT, 2021 [Act No. 2 of 2021]**

**Insurance terms defined for the purposes of section 8 of the Act**

**Regulation No. INS.R.2.2**

## **Definitions**

1. (1) In this Regulation, unless the context indicates otherwise—
  - (a) “Act” means the Financial Institutions and Markets Act, 2021 [Act No. 2 of 2021], and includes the regulations prescribed under the Act and the standards and other subordinate measures issued by NAMFISA under the Act; and
  - (b) “a member of medical aid fund” includes—
    - (i) a member of a medical aid fund registered under the Act; and
    - (ii) a member of a fund, scheme or entity, other than a registered medical aid fund, created by law to provide its members with medical aid benefits.
- (2) Words and phrases defined in the Act have the same meaning in this Regulation, unless the context indicates otherwise, including, without limitation, the following—
  - (a) as defined in section 4 of the Act—
    - (i) insurer;
    - (ii) insurance;
    - (iii) long-term insurance;
    - (iv) policy;
    - (v) policy benefits;
    - (vi) premium;
    - (vii) registered insurer;
    - (viii) reinsurer;
    - (ix) short-term insurance;

- (b) as defined in section 8 of the Act—
  - (i) health event;
  - (ii) long-term insurance business;
  - (iii) short-term insurance business; and
- (c) as defined in section 321 of the Act—
  - (i) business of a medical aid fund;
  - (ii) health service;
  - (iii) fund or medical aid fund; and
  - (iv) member.

**Applicability**

2. This Regulation applies to all registered insurers and registered reinsurers.

**The meaning of certain terms for the purposes of short-term insurance business**

- 3. (1) For the purpose of short-term insurance business, “gap insurance” means—
  - (a) motor vehicle finance gap insurance that is purchased by a person for protection against losses that can arise when the amount of compensation received from a total loss does not fully cover the amount the insured owes on the vehicle's financing or lease agreement; or
  - (b) insurance that is purchased by a person for protection against losses that can arise when the amount of compensation received from an insurance claim does not fully cover the replacement value of the insured asset or the amount the insured owes on the insured asset(s).
- (2) For purposes of sub-Regulation (1), “gap insurance” does not include payments to cover—
  - (a) overdue lease or loan payments;
  - (b) costs for extended warranties, credit life insurance, or other insurance purchased with the loan or lease;
  - (c) carry-over balances from previous loans or leases;
  - (d) financial penalties imposed under a specific lease agreement, for example for excessive use, abnormal use or higher mileage, etcetera;
  - (e) security deposits not refunded by a lessor;

- (f) amounts deducted by the primary insurer for wear and tear, prior damage, towing, or storage;
  - (g) costs of equipment added to the motor vehicle by the insured, meaning that only factory-installed equipment is covered; or
  - (h) mechanical issues, such as engine or transmission failures, or any other vehicle problems that are not losses covered by the vehicle insurance policy.
4. (1) For the purpose of short-term insurance business, a “health policy” includes—
- (a) emergency evacuation or transportation: expenses to cover guaranteed access to and utilisation of specialised medical transportation and guaranteed hospital admission to ensure that the insured is admitted to an emergency health facility and stabilised, but only to the extent that such expenses are not covered by a medical aid fund registered under the Act;
  - (b) medical expense shortfall: lump sum payment to cover the costs or expenses of a relevant health service that, in respect of benefits provided by a medical aid fund registered under the Act, does not constitute a benefit, a benefit not paid in full by such medical aid fund or a member’s benefit being depleted in a specific benefit year;
  - (c) third party liability: lump sum payment to cover an insured for the expenses of relevant health service following the injury of a third party (other than the insured) —
    - (i) as a result of a motor vehicle accident; or
    - (ii) while at the property of the insured;
  - (d) international travel insurance: lump sum payment covering expenses associated with a relevant health service incurred as a result of a sickness, disability or death event that occurs while travelling outside of the Republic of Namibia; and
  - (e) domestic travel insurance: lump sum payment covering expenses associated with a relevant health service incurred as a result of a sickness, disability or death event that occurs while travelling in the Republic of Namibia.
- (2) A health policy must—
- (a) be priced fairly for all policyholders; and
  - (b) have a maximum waiting period of 6 months.
- (3) A registered insurer or reinsurer must not—

- (a) refuse a claim because of pre-existing conditions which were fully disclosed by the policyholder at policy inception stage; and
- (b) cancel a policy because of poor claims experience.

**The meaning of certain terms for the purposes of long-term insurance business**

5. For the purposes of long-term insurance business, “gap insurance” means insurance that—

- (a) is purchased by a member of a medical aid fund or a member of a fund, scheme or entity, other than a registered medical aid fund, created by law to provide its members with medical aid benefits to supplement an existing benefit of a type that is available only to members of medical aid funds; and
- (b) is designed to make up the difference between the amount that the medical aid fund or a fund, scheme or entity, other than a registered medical aid fund, created by law to provide its members with medical aid benefits is liable to pay to cover treatments and the amount that any specialist or other healthcare service provider charges the member for a health service.

6. (1) For the purposes of long-term insurance business, “health policy” means a contract in terms of which a registered insurer, in return for a premium, undertakes to provide policy benefits on the occurrence of a health event.

(2) For the purpose of sub-Regulation (1), a health policy includes—

- (a) lump sum or income replacement benefits payable on the occurrence of a health event to cover—
  - (i) contingency expenses incurred by the policyholder on experiencing a specified health event; and
  - (ii) if applicable, loss of income as a result of the health event, provided the policyholder provides proof of the loss of income;
- (b) expenses for frail care for policyholders over the age of 60 years to cover custodial care (assistance with activities of daily living); and
- (c) expenses related to HIV testing and HIV and Aids treatment on an employee group basis for employees and their dependants, to the extent that such expenses are not covered by a medical aid fund.

(3) For greater certainty, a health policy does not include a contract for benefits that are included in the business of a medical aid fund.

(4) A health policy must—

- (a) be priced fairly for all policyholders; and

- (b) have a maximum waiting period of 6 months.
- (5) A registered insurer or reinsurer must not—
  - (a) refuse a claim because of pre-existing conditions which were fully disclosed by the policyholder at policy inception stage; and
  - (b) cancel a policy because of poor health or high claims.

**The meaning of sickness**

- 7. For the purposes of—
  - (a) paragraph (e) of the definition of “fund” in section 8(1) of the Act;
  - (b) sections 8(5) and 465(5)(f) of the Act; and
  - (c) Regulation 4(d) and (e) of this Regulation,

“sickness” means a malady, affliction, dysfunction, debility or infirmity of body or mind, including, without limitation, a weakened, unhealthy or unsound condition, resulting from a specific type of illness or disease.