Prepare for your family's sake before death comes knocking

Life with Cameron

Bruce Cameron

Among other things, I am a trustee on the boards of two defined contribution retirement funds. One of the tasks of a retirement fund trustee is to approve distributions to dependants and beneficiaries on the death of a member before retirement.

Recently, I unfortunately had to sign a number of distributions. Of these, the oldest fund member who died was 52 years of age, most of the others were in their forties and at least one was still in his thirties.

The distribution for each deceased member is divided into two parts. The first part is the accumulated savings, which is made up of the contributions of the member and the employer plus investment growth.

The second part is the group life assurance, which, in the case of these funds, is a three-times multiple of current pensionable income (this means basic salary and not allowances such as car allowances).

What worried me about most of the distributions was that the total amount provided to the dependants was often less than R500 000. And this was often the total amount that would be left to an unemployed mother and children on which to live. In other words, the member of the fund had made no other provision, such as taking out life assurance, to ensure that his or her dependants could maintain the lifestyles they had enjoyed before the member's death.

One of the great advantages of a defined benefit scheme is that when a fund member dies, the pension (benefit) received by the dependants is calculated as if the member of the fund had continued to work until retirement age.

With a defined contribution fund, the dependants only receive a pension benefit to the extent of the money accumulated in the fund up to the time of the member's death plus any group life assurance.

So, for example, let's say we have two fund members of a defined contribution fund who died recently:

◆ Jack A (aged 28) was a member of five years' standing, married with two children aged two and six; he earned a pensionable salary of R15 000 a month (R180 000 a year); had accumulated retirement savings of R140 000; and his dependants were entitled to a group life benefit of three times annual salary. The result is that Jack A's dependants would receive R140 000 plus R540 000, totalling R680 000.

Let's assume a return on the amount of a generous 10 percent a year. That is R68 000 a year, or R5 666 a month. So Jack A's family now has to take a cut in income of almost 60 percent.

It was absolutely imperative that Jack A make up the shortfall with life assurance cover against death as well as disability.

◆ Jill B (aged 47) was a member of 25 years' standing, married with two children aged 16 and 18; she was earning a pensionable salary of R30 000 a month (R360 000 a year); she had accumulated retirement savings of R1.2 million; and her dependants were entitled to a group life benefit of three times annual salary.

The result is that Jill B's dependants will receive R1.2 million, plus R1 080 000, totalling R2 280 000.

Let's again assume a return on the amount of a generous 10 percent a year. That is R228 000 a year, or R19 000 a month. So, Jill B's family now has to take a cut in income of almost 40 percent.

So, although Jill B's dependants are far better off than Jack B's, it was still absolutely imperative that Jill B had made up the shortfall with life assurance cover against death as well as disability.

I have simplified these calculations by ignoring any tax consequences and the debilitating effect of inflation. It is essential that all members of defined contribution funds should do these simple calculations for themselves.

Even defined benefit members will probably also find a shortfall.

If you find a shortfall (as you surely will), I would suggest you immediately get hold of a financial intermediary to do a financial needs analysis to establish exactly how much life assurance against death and disability you require to ensure your family will be financially secure in the event of the unexpected happening to you.

You should not delay. That proverbial bus could be just around the corner.

Even if you already have risk life assurance against death and disability, you should check regularly whether it is sufficient.

Gerhard Joubert, the chief executive of the Life Offices' Association, tells me that the LOA has no actual figures on what percentage of the population has life assurance, but there is sufficient data for the industry to know that there are too many people without risk assurance and even when people do have risk assurance, they have too little or no disability assurance.

He says while many people take out life assurance against dying, they avoid taking out equally important disability assurance against being sick and/or injured and unable to earn a living.

Joubert points out that many funds and employers are reducing the amount of group life assurance because the Aids pandemic is pushing up the costs of premiums. So, rather than pay less to retirement savings, group risk assurance benefits are being reduced.

It is in the area of risk provision that life assurance companies come into their own.

They may not provide the best investment products, but every one of us, except the very wealthy, needs life assurance to ensure the future welfare of our dependants.

Financial adviser gathers 'forces' to take on Discovery

Wynand Venter is calling on members to join in a court action against Discovery Health and recoup money the administrator had drawn from them as ancillary service fees over a number of years. **Laura du Preez** reports

An independent financial adviser plans to sue Discovery Health medical scheme administrator, and/or Discovery Health Medical Scheme in an attempt to recover some of the millions of rands that members of the scheme were "illegally" charged for ancillary services in the past.

Wynand Venter, of Wynsam Wealth in Pietermaritzburg, is offering about 240 000 Discovery members the opportunity to join the suit to claim back the R39 a month, or R468 annually, they paid to Discovery over a number of years before 2005.

GATHERING FOR CLASS ACTION

No court papers have been filed yet, as Venter hopes to get a number of members to join the suit first. The first 25 members have already signed up.

He says members can join the suit without having to pay the legal fees, because Wynsam Wealth "will take care of all costs".

Venter says he has senior counsel's advice that Discovery contravened the Medical Schemes Act when it billed individual members and groups of less than 35 members the extra fee, called the ancillary service fee.

This fee was paid to the administrator for extra services, such as access to the DiscoveryWorld website, daily SMS or email notification of claims payments, and an emergency response service.

"The fee was made to appear compulsory; even Discovery employees were under this impression and advised brokers and members that it was compulsory. Discovery Health marketing material of the time period also made it appear compulsory. This fee and the way it was collected is illegal in terms of the Medical Schemes Act, Section 21(a)," Venter says.

He says members who joined Discovery Medical Scheme in groups of more than 35 , such as employer groups, were not charged the ancillary fee.

Discovery stopped charging all its members the fee in 2005 after the issue was highlighted by Venter and Personal Finance.

NEW LEGISLATION

Alan Pollard, Discovery's head of research and Vitality, says Discovery does not believe there is any basis to the claim being made by Venter and will oppose it if papers are filed.

Previously, Pollard told Personal Finance it had not been Discovery's intention to mislead members.

He said that before the Medical Schemes Act became effective, the ancillary services were provided as part of the administration agreement between the scheme and Discovery Health, the administrator of the scheme.

When the Act made it illegal for a scheme to do anything other than the business of a medical scheme in 2000, Discovery decided to provide the services to members on a voluntary basis.

However, members were not asked whether or not they wanted to continue receiving the services and paying for them once they became voluntary. Instead, Discovery assumed members would want to continue enjoying these services.

WEBSITE SIGNING

Venter says Discovery collected R110 million in ancillary fees each year for a number of years before it stopped the practice.

Most members are not aware of the charges or the "illicitness of their nature", he says.

Discovery members who want to join the suit can sign a "power of attorney" for Wynsam Wealth (www.wynsam.co.za) to act on their behalf to attempt to get their money back from Discovery.

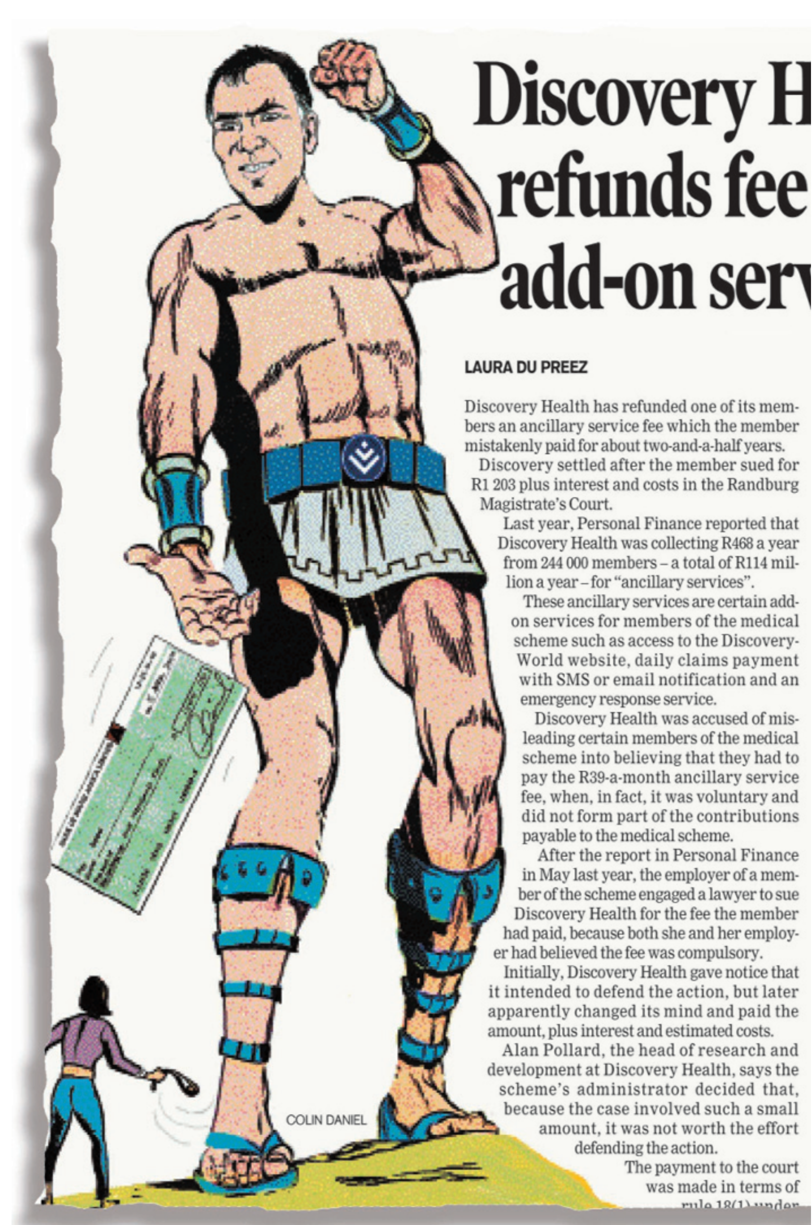
There is no charge for members who want Venter to act on their behalf, and members do not need to become a client of Wynsam Wealth.

Venter says he just wants to see justice done.

In July 2005, Discovery Health refunded the ancillary service fees paid for two and a half years by one of its members.

This was after the member sued Discovery in the Randburg Magistrate's Court for R1 203 plus interest and costs.

The settlement was reached with the member without Discovery admitting any liability.



Discovery H
refunds fee
add-on serv

LAURA DU PREEZ

Discovery Health has refunded one of its members an ancillary service fee which the member mistakenly paid for about two-and-a-half years.

Discovery settled after the member sued for R1 203 plus interest and costs in the Randburg Magistrate's Court.

Last year, Personal Finance reported that Discovery Health was collecting R468 a year from 244 000 members – a total of R114 million a year – for "ancillary services".

These ancillary services are certain add-on services for members of the medical scheme such as access to the DiscoveryWorld website, daily claims payment with SMS or email notification and an emergency response service.

Discovery Health was accused of misleading certain members of the medical scheme into believing that they had to pay the R39-a-month ancillary service fee, when, in fact, it was voluntary and did not form part of the contributions payable to the medical scheme.

After the report in Personal Finance in May last year, the employer of a member of the scheme engaged a lawyer to sue Discovery Health for the fee the member had paid, because both she and her employer had believed the fee was compulsory.

Initially, Discovery Health gave notice that it intended to defend the action, but later apparently changed its mind and paid the amount, plus interest and estimated costs.

Alan Pollard, the head of research and development at Discovery Health, says the scheme's administrator decided that, because the case involved such a small amount, it was not worth the effort defending the action.

The payment to the court was made in terms of

The Personal Finance article on how Discovery Health repaid the ancillary fees it charged a member appeared in the issue of July 2, 2005.

Growing state scheme attracts 800 members each day

LAURA DU PREEZ

The Government Employees Medical Scheme (Gems) has signed up its 100 000th principal member, making it one of the five largest medical schemes in the country.

This restricted medical scheme for government employees now provides health cover to almost 300 000 people, 40 percent of whom were not members of any medical scheme previously.

This means that other schemes have lost about 60 000 members to Gems since January last year.

Gems has grown its membership from 0 to 100 000 in just 14 months by giving government employees incentives to join the scheme.

As of July last year, the government has been paying 75 percent of the contributions, to a maximum of R1 900 a month, for employees earning more than R60 000 a year who join Gems.

Employees earning less than R60 000 can receive a 100 percent subsidy if they join Gems's lowest-cost option.

The government is paying only two-thirds of the contributions up to a maximum of R1 014 a month in 2006 for employees who remain on their existing medical schemes.

The government has chosen to offer incentives rather than force its existing employees to join Gems, but new government employees can access the government subsidy only if they join Gems. As a result of this, more than 800 members are signing up every day.

Dr Eugene Watson, the principal officer of the medical scheme, says the process to elect Gems's first boardof trustees has begun.

In line with the Medical Schemes Act, members will elect 50 percent of the trustees on the board of trustees, at an annual general meeting which will be held later this year.

Gems is currently governed by Watson and an interim board of trustees (also known as the steering committee) of 11 government employees who were appointed by Geraldine Fraser-Moleketi, the Minister of Public Service and Administration.

These trustees will remain on the board as the employer-elected trustees, and the members will elect a further 11 trustees.

"Providing more South Africans with quality, yet affordable, health care is still a challenge for both Gems and the entire healthcare industry. The sector needs to attract new lives, increasing both the size of the risk pool, as well as the inherent clinical risk profile," Watson says.

"Enlarging the risk pool will also increase the total revenue generated, which, in turn, will create additional opportunities for all service providers. This will then create business and employment opportunities," he says.

When Gems launched late in 2005 existing medical schemes had about 550 000 government employee members and as many as 488 000 of these members (according to membership data for 2005 from Global Credit Ratings) were in open schemes (those that admit anyone and are not restricted to employer groups).

Government employees then made up more than 26 percent of the membership of open schemes.

Brokers warned against selling gap cover policies

LAURA DU PREEZ

While the short-term insurance industry is holding its breath over the outcome of an appeal by Guardrisk against a ruling to shut down its gap cover products, the Council for Medical Schemes has warned short-term insurance brokers that Guardrisk's appeal does not give them an "umbrella" under which they can continue to sell gap cover policies.

Guardrisk, the short-term insurance subsidiary of Alexander Forbes, has been granted leave to appeal against a ruling by the Witwatersrand High Court in December last year that it had to shut down its gap cover policies within three months of the ruling.

Many other insurers, which could be forced to close down their gap cover and other health insurance policies, are on tenterhooks, awaiting the outcome of the appeal.

Herman Schoeman, Guardrisk's managing director, says Guardrisk's legal advisers have advised that, as a result of the appeal, the court order is suspended.

This means the company will not have to close down its 130 000 policies by Monday in line with the court order, Schoeman says.

ACCREDITATIONS UNDER THREAT

In spite of this, Alex van den Heever, an adviser to Patrick Masobe, the Registrar of Medical Schemes, says brokers should not continue selling these products.

He says the registrar's office is aware that the country's largest broker houses are selling gap cover policies and warned that they could lose their accreditation as medical scheme brokers if they persist in doing so.

If the Council for Medical Schemes revokes a broker's accreditation, that broker automatically loses his, her or its licence to operate as a financial services provider in terms of the Financial Advisory and Intermediary Services (FAIS) Act, Van den Heever says.

He says this is what was agreed between the Financial Services Board, which regulates the FAIS licences, and the council.

Guardrisk and other short-term insurers have been selling gap cover policies to fund the difference between your medical scheme cover and the amount you are charged for health care.

Guardrisk's AdmedGap and AdmedPulse policies pay the insured the difference between the tariff amount listed in the National Health Reference Price List (NHRPL) and the amount charged by a healthcare provider (up to a maximum of 3.5 times the NHRPL) for procedures in hospital.

Many schemes reimburse their members for healthcare services they have obtained at NHRPL rates or some factor of these rates.

Many healthcare providers charge rates higher than the NHRPL, and this can result in big out-of-pocket expenses for members.

But the registrar's office is of the view that these products are doing the business of a medical scheme and therefore need to register as medical schemes and provide the same minimum benefits that schemes do.

If they do not, they undermine medical schemes by cherry picking the young and healthy members, who find that it is cheaper to reduce their medical scheme cover and take out a gap cover policy to cover the shortfalls.

WORK OF MEDICAL SCHEMES

Guardrisk, echoing the arguments of the Short Term Insurance Association (SAIA), argued in court it is entitled in terms of the Short Term Insurance Act to sell these policies.

However, Judge Lewis Goldblatt did not accept Guardrisk's interpretation of the Short Term Insurance Act, saying that it would lead to unintended consequences. Rather, he agreed with the registrar's office that products that defray actual medical expenses are doing the business of a medical scheme.

Schoeman says no date has been set for Guardrisk's appeal and it is likely it will be heard only next year.

He also denied rumours that Guardrisk has developed another product that it is planning to launch if the appeal is unsuccessful and the AdmedGap and AdmedPulse policies are closed down.

He says marketing these policies aggressively now would send the wrong message to the market.

Peter Edwards, the divisional head of health care at Alexander Forbes, says Alexander Forbes's consultants are not selling AdmedGap or AdmedPulse policies to any new groups because of the legal uncertainty created by the court case.

However, Edwards says, new employees taken on by companies that have already taken out AdmedGap or AdmedPulse policies for the benefit of their employees are, in some cases, still being added to these policies.

Alexander Forbes is not selling any other gap policies, he says.

Constantia Insurance Company sells gap cover policies that are underwritten by Ambledown. Tiago de Carvalho, the managing director of Ambledown, says his company believes that its products are legal and will now continue to market these products until there is certainty about the Guardrisk judgment.

De Carvalho says Constantia has 70 000 policyholders who have bought gap cover products.

De Carvalho says he does not believe the products are causing medical scheme members to buy down and he does not believe they are undermining cross-subsidisation in medical schemes.

GREY AREA

Rob Taylor, the managing director of health care at NMG Consultants and Actuaries, says because gap cover is considered a "grey area" NMG has not sold these policies and has advised clients only that this cover is available.

He says NMG agrees with the line taken by the registrar's office and hopes that the brokers responsible will be made accountable and brought to book.

NMG has lost clients over the past couple of years to competing brokerages because it has not sold gap cover, Taylor says.

Jannie Kotze, a director of the holding company of the company that administers Resolution Health Medical Scheme denied that Resolution had ever sold gap cover together with membership of its scheme.

Kotze says brokers selling membership of the scheme had been "assisted" by being put in touch with Safcam, an underwriter of gap cover products.

In the past, he says, Resolution's application form provided for members to elect to have gap cover.

PSG Konsult and Advance Wealth Management are in the process of phasing out gap cover products and replacing them with legally compliant products, Wallie Krumm of PSG Konsult says.

He says that this process is time consuming and affects policyholders. PSG Konsult itself committed to adhere to any ruling from the registrar and the Court of Appeal, Krumm says.

Meanwhile, the SAIA, which represents short-term insurers, has asked for a meeting with the National Treasury to discuss the Guardrisk judgment.

Refilwe Moletsane, the deputy chief executive of the SAIA, says the association wants to point out to the treasury the shortcomings that have created a need for products such as the gap cover policies sold by Guardrisk and the wide-ranging impact the judgment will have on the short-term insurance industry.

New credit act comes at right time to protect consumer, says regulator

NEESA MOODLEY

More than 4 200 credit providers have sent in registration applications in an industry "ripe for regulation", National Credit Regulator Gabriel Davel said at a Consumer Rights Day conference hosted by Absa this week.

There are about 14 million credit-active consumers in an industry where the total volume of consumer credit is estimated to be worth R680 billion a year, Davel says.

He was speaking about the National Credit Act (NCA) which takes full effect in June this year and which his office has been tasked with monitoring and enforcing.

The NCA places more responsibility on credit providers, such as banks and department stores, and is intended to protect consumers from unscrupulous moneylenders.

If you want to apply for credit in the year ahead but are not sure of your credit rating, the NCA entitles you to access your credit record with a credit bureau once a year, at no cost to yourself. However, if you require access to your credit records again during that year, you will have to pay a fee of R20 a request.

The onus will now lie with the credit bureaux to take all reasonable steps to ensure that all records are up to date.

Davel says if you have to personally spend any money to correct information at a credit bureau, the NCA empowers you to claim that money back from the credit bureau concerned.

The reckless lending clause in the NCA requires companies to prove that at the point of extending credit to you, they took steps to ascertain whether you could afford the repayments.

If they cannot prove this, companies will not be able to secure judgments against you.

"We have had numerous instances of companies granting credit willy-nilly and then simply obtaining a judgment against the consumer for an amount to be deducted from their salary, with no regard as to the consumer's ability to pay," Davel says.

His office already employs just under 60 staff members but intends to increase this to 80 to enhance its ability to properly monitor and enforce the NCA.

"We know that the major banks take the law seriously and will take steps to ensure they comply, particularly as the NCA provides for a maximum fine of up to 10 percent of a company's revenue if it is found guilty of transgressing the law," Davel says.

Absa, the biggest bank in the country, posted a total revenue of R30.4 billion last year.