Annex

Common Findings from Onsite Conduct Inspections on Insurers

&

Recommended Best Practices

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Corporate Governance and Corporate Culture

Relevant rules, guidelines and/or practices

1. The Guideline on the Corporate Governance of Authorized Insurers ("GL10") and the Guideline on Enterprise Risk Management ("ERM") ("GL21") set out the minimum requirements and standards of corporate governance expected of an authorized insurer and general guiding principles. These are adopted by the Insurance Authority ("IA") in assessing the effectiveness of the insurer's corporate governance framework in a conduct inspection. The relevant requirements include:
    - Paragraphs 1.2(c) and (f) of GL10: the corporate governance framework of an authorized insurer should set out requirements relating to how decisions and actions are taken, and provide for corrective action for non-compliance or weak oversight, management and control.
    - Paragraph 7.3 of GL10: an authorized insurer should manage and control a system of "checks and balances". Establishing a clear framework, policies and guidelines is one of the essential elements of this process as they provide expectations for performance within the organization.
    - Paragraph 7.15 of GL10: an authorized insurer should have formal procedures to identify potential suspicious transactions and establish lines of communication for reporting any suspicious transactions or activities to the Board, the senior management and/or the law enforcement authorities.
    - Paragraphs 3.3(a) and 3.3(d) of GL21: an insurer should have an appropriate governance structure with well-defined roles and responsibilities and reporting lines in order to maintain a sound system of checks and balances, and a feedback loop mechanism that ensures continued effectiveness of ERM framework.
    - Paragraph 10.1 of GL10: fair treatment of customers is an important concept and should form an integral part of an authorized insurer's business culture, business strategies as well as internal controls.

2. Conduct in Focus (5th Issue) published in August 2022 highlighted that self-reporting of material breaches and incidents to the IA, should be a core part of the corporate governance and control framework of every authorized insurer. Self-reporting on material matters forms an important part of the regular engagement between the IA and the regulated entities which are subject to its supervision, ensuring their problems are being identified, addressed and rectified in a timely manner and policyholder interests are being upheld. Self-reporting also serves as a demonstration that an insurer's controls and processes are operating to detect and remediate issues when they arise.

Observations

3. Corporate governance is broadly the collection of systems, mechanisms, internal controls, checks and balances, and decision-making and other processes implemented within a company to ensure it is well-managed, well run and compliant with all laws and regulatory requirements. It is the adequacy and effectiveness of an insurer's corporate governance, as it relates to the insurer's conduct of business, that the IA assesses during a conduct inspection.

4. Vital to adequate and effective corporate governance is corporate culture – the shared values, beliefs, attitudes and behaviors that define how the insurer operates and its employees and those representing the company (including its insurance agents) interact with each other and treat customers. Corporate culture sets the tone for everything the insurer does in acting through its board, management, employees and insurance agents. It is, in essence, the personality of the insurer.

5. A key part of any conduct inspection is the assessment of the insurer's corporate culture and the extent this is embedded within its corporate governance. Corporate governance that is not embedded with the right corporate culture, becomes mere tick-box compliance – a cosmetic process that, at best, fails to achieve the substance of the insurer's conduct objectives and, at worst, masks inherent shortcomings in the fair treatment of customers. Every IA conduct inspection report, therefore, starts with an overall assessment of the insurer's corporate culture and the degree to which this is threaded into its corporate governance.

6. Our broad observation is that insurers who had strong corporate culture – and generally strong corporate governance as a result - were those that recognized the importance of cultivating the right culture. Evidence of this was observed in:

   - culture being discussed and considered at board and committee meetings (reflecting the right tone from the top);
   - qualitative and quantitative measures and indicators of culture being examined regularly at various levels of management and up to board level;
   - a set of defined cultural and ethical values, alignment with which is included in all key processes such as remuneration structures, performance management, recruitment and onboarding, and disciplinary processes; and
   - measures to seek to ensure culture was imbued across an insurer's agency force, at every layer of the agency hierarchy.

7. Weaknesses in culture were observed where evidence was missing in the aforesaid areas. One key indicator of weak culture is where members of management and those working in control functions demonstrate, during an inspection, an attitude of "not my sink, not my dishes" or "not my lane, not my lookout". Such an attitude reflected a siloed mindset, a fragmented approach to responsibilities and a misappreciation of how their function was a part of the whole corporate governance framework which needed to function effectively as a whole to achieve

its objectives. This attitude of clear-cut separation and atomization was more commonly observed than expected, particularly (a) between functions in the first and second lines of defence, (b) in interactions between the insurer and its appointed insurance intermediaries, and (c) within an agency force. Such a culture lends itself less to fair customer treatment and more to an internal blame game when customers are treated unfairly. It also creates gaps in communication and delays in addressing issues. Management in insurers which face this cultural issue should focus every effort on eliminating it, by improving corporate culture in line with the areas highlighted in paragraph 6 above.

8. The controls, processes and mechanisms that make up a sound corporate governance system need to be documented in internal terms of reference and operating manuals, with clear metrics to be used for oversight purposes and discussed in regular meetings. A sound documented terms of reference or manual will (a) set out the principles and objectives which the process seeks to achieve; and (b) detail the processes that need to be followed for these purposes. This will be supported by minutes of meetings that take place in line with the terms of reference/manual to evidence that the process is followed, and the measures are being assessed. A common issue identified was that a documented governance process often lacked these elements, but only providing high-level principles without detailed procedural steps. In some cases, documentation was entirely absent, for example the lack of meeting minutes (or any records that the meeting had taken place) to evidence management discussions in line with the steps stated in the process.

9. As a general observation, certain insurers, through their intermediary management function, tended to focus oversight efforts solely on problematic insurance intermediaries on a case-by-case basis, rather than overseeing the entire insurance intermediary force as a whole. Such an approach resembles reactive "fire fighting" (remediating problems after they have arisen) as opposed to proactive corporate governance designed to prevent problems from arising in the first place through identification of emerging issues which can be addressed before they manifest into problems. Robust oversight across all licensed insurance intermediaries is essential and should be a standing agenda item in regular management meetings, discussions and reports.

10. No insurer – or any business – is problem free. When material incidents do arise, self-reporting is essential. This enables early identification and resolution of problems and is a key indicator of sound corporate governance in action. By contrast, the absence of self-reports is not indicative of perfection, but raises suspicions that either problems are not being identified, or are being downplayed and swept under the carpet. In a number of our conduct inspections, we identified material matters that should have been the subject of self-reporting but were not. Examples included instances of misappropriation of premiums by insurance agents. In many cases, disciplinary actions were delegated to upline managers rather than being handled by senior management, thereby undermining accountability.

Moreover, the lack of a structured framework linking categories of misconduct to corresponding disciplinary actions has led to inconsistency and ineffectiveness in the disciplinary process.

Recommended best practices

11. Cultivating a culture of shared accountability and proactive engagement is essential to mitigate these risks and uphold governance standards. Senior management and board members must actively model and reinforce a culture of ownership, transparency and ethical conduct. Clear tone-from-the-top messaging should be regularly communicated, emphasizing, amongst others, that governance is a shared responsibility across all levels and functions. Management should regularly assess its corporate culture against the areas listed in paragraph 6 above which serve as best practice.

12. Best practice would also include promoting structured collaboration between the first and second lines of defence through joint risk assessments, shared dashboards and regular cross-functional meetings. Collaboration should be a core value of an insurer's corporate culture and failure to adhere to this value should be treated as failure to perform. Clarifying roles and fostering mutual engagement in risk and control matters are essential to break down silos within and across the organization.

13. Insurers who demonstrated best practice have often introduced a "1.5 line of defence", being specialized risk or compliance functions embedded within business units. This hybrid layer provides focused expertise and proactive guidance, supporting the first line in managing risks effectively while maintaining clear accountability boundaries with the second line. Acting as a bridge, the 1.5 line enables early intervention, timely advice and stronger alignment on risk objectives, ensuring business units are equipped with the necessary tools and oversight.

14. Best practice also includes sound documented terms of reference or manual that (a) set out the principles and objectives which the process seeks to achieve; and (b) detail the processes that need to be followed for these purposes. Reliance solely on general principles and an absence of detailed processes is insufficient to achieve effective corporate governance. Documentation needs to be specific, actionable, and supported by proper records, including meeting minutes and decision logs, to demonstrate the effectiveness of governance practices and facilitate regulatory review.

15. Oversight activities should apply to the full spectrum of licensed insurance intermediaries, not only those with problematic issues. To achieve this, insurers should embed regular performance reviews, conduct monitoring, and risk assessments into management discussions and reporting cycles. One of the effective best practices observed is the development and use of systematic analytical tools to monitor the sales activities of all insurance agents. These tools,

typically in the form of dashboards, track key indicators such as case size, product commission levels, and policy persistency. Each indicator is clearly defined and assessed across multiple agency hierarchy levels based on historical data and experience. Examples of how these analytics are used by insurers, include the following:

- Detecting unusual sales activities that warrant management attention. Insurers may use dashboard-based matrices to identify atypical sales patterns that require follow-up, as these may indicate potential misconduct or fraudulent activity. Apart from policy persistency rates, other common variables reviewed include a high concentration of high-commission products, sudden spikes in production over a short period, and an unusually high number of special policy arrangements (e.g. policy loans or premium holidays) in the early policy years within an agent's portfolio.

- Cross-checking of contact details during customer onboarding to identify potential matches with the insurer's appointed insurance agents (as a means of identifying potential misconduct or future problems in contacting the policyholder directly). If a match is identified, a request is raised to Agency Management to initiate follow-up actions — such as enquiring with the concerned agent about the reason for the shared contact details and collecting supporting documents. If the suspicion is substantiated, the case is escalated to the management committee to determine whether disciplinary action(s) is warranted.

16. Insurers should establish clear, company-wide protocols for the self-reporting of material incidents. These protocols must define severity thresholds, reporting channels, and escalation timelines to ensure consistency and accountability. To be effective, these procedures should be actively communicated across the organization and reinforced through regular training and internal communications. This enables timely and transparent reporting aligned with regulatory expectations. A well-defined internal protocol should also outline reporting responsibilities, escalation procedures, and disciplinary pathways. By embedding these elements into the governance framework, insurers reinforce a culture of integrity, transparency, and proactive compliance.

Recruitment & Onboarding of Licensed Insurance Agents

Relevant rules, guidelines and/or practices

17. Section 13AE(12)(f) of the Insurance Ordinance (Cap. 41) (the "Ordinance") defines the intermediary management control function of an insurer as a function to establish and maintain internal controls for, among other matters, administering the licensed individual insurance agents appointed by the insurer in relation to the regulated activities carried on by them, monitoring their compliance with the Ordinance, and ensuring that the arrangements for their referring insurance business to the insurer comply with the requirements of the Ordinance and applicable Guidelines and Code of Conduct for Licensed Insurance Agents. Per sections 64W and 64ZV of the Ordinance, a pre-requisite for an individual to be a licensed individual insurance agent, is for that individual to be a fit and proper person to carry on regulated activities. A further pre-requisite is, at the time the licence application is made, for the individual to have been appointed as agent by at least one insurer.

18. Paragraph 7.10.3(a) of GL21 states that the conduct risk policy of an authorized insurer should address the approaches and controls which the insurer has in place for dealing with potential policyholders and existing policyholders with due skill, care and diligence.

19. To help Key Persons in Control Function for Intermediary Management ("KPIMs") understand their roles and duties, the IA published a handbook in February 2026 (the "KPIM Handbook"). The KPIM Handbook outlines the internal controls and measures that are expected to be established by the intermediary management function, for instance, to conduct due diligence on licensed insurance agents, to have written agreements in place in respect of business dealings with licensed insurance intermediaries to clarify their respective roles and obligations, and to ensure that selected licensed insurance intermediaries continue to remain suitable to promote the insurance products of the insurer.

Observations

20. The internal controls an intermediary management function of an insurer must establish should include controls on the recruitment, onboarding, licensing and renewal processes of its individual insurance agents. The objective of these controls is to ensure that only individuals who meet the minimum "fit and proper" criteria are recruited and appointed as insurance agents, that the terms and conditions of such individuals' appointment (and their authority) are clearly set and understood, and that such individuals receive adequate training before they deal with customers on behalf of the insurer. Inadequacies in such processes

would increase the risk of unfair customer treatment and expose insurers to heightened regulatory and operational risks.

21. Insurers operate in a competitive market. Those insurers that rely on individual insurance agents to distribute their policies often face business pressure to grow their agency forces (on the assumption that more insurance agents mean more selling) and to get agents selling as quickly as possible. Adequate control processes at the recruitment, contractual appointment and onboarding stages – to ensure these processes are performed properly – can operate as reasonable restraints against the pressure for speed. These controls are necessary and they must be adequate to ensure those selling and providing advice on insurance to customers, are fit and proper, properly appointed with clear authority, and know what they are doing.

22. The well-performing internal control functions in insurers that we inspected were ones which stood firm on their controls in spite of business pressure, recognizing the necessity of such controls to ensure quality customer service and fair treatment of customers. The controls these insurers established were best in class.

23. By contrast, control functions which had weaker controls on these areas were those that had succumbed to the short term business pressures. Indeed, this was the underlying cause of most of the weaknesses in the controls and processes identified in the recruitment, contracting and onboarding of insurance agents, during our inspections. We outline these weaknesses below:

Recruitment and onboarding

24. Certain intermediary management functions of insurers had weaknesses in their due diligence and reference checking processes in the recruitment and onboarding stages for candidates to be appointed insurance agents.

25. Examples of the adverse consequences of very aggressive recruitment strategies were observed, particularly within those insurers targeting industry recruits without proper adequate controls and safeguards in the process. Upfront incentives were paid without sufficient control measures to control the conduct risk these engendered. Persistency ratios of agents' policies were not factored into their performance evaluation to ensure business quality, nor were there effective clawback mechanisms for the incentive payments in case of conduct irregularities. In addition, insufficient consideration was given, at the time of recruitment, to candidates' prior conduct history and recent financial soundness (e.g. outstanding debts) prior to offering incentive programs. As a result, some insurers risked positioning themselves as a magnet for problematic candidates, attracting individuals with poor track records or questionable integrity in what turned out to be colossal acts of self-harm.

26. Some insurers did not perform direct validation checks against the public registers of relevant local financial regulators, conduct academic certificate validation, or carry out debt and criminal record searches as part of their due diligence on candidates being recruited as potential new insurance agents.

27. There were instances of inconsistencies in candidates' declarations highlighting potential fit and proper concerns being ignored. Approval authorities for appointment decisions were also applied inconsistently, and formal sign-off protocols were absent.

28. For certain cases where due diligence raised potential fit and proper concerns about candidates (e.g. previous bankruptcy, criminal records, or perceived conflicts of interest arising from external engagement), but the insurer wished to proceed with considering the appointment in any event, there were no clear guidelines or documented assessments, nor evidence of approval obtained from appropriate seniority levels. Moreover, some applications were submitted to the IA without proper consideration of whether the candidate met the fit and proper criteria as prescribed in the Guideline on "Fit and Proper" Criteria for Licensed Insurance Intermediaries under the Ordinance. This raised doubts as to whether the relevant insurers undertook any assessment at all, or simply sought approval for a licence without proper scrutiny.

Agency contracts

29. One pre-requisite for an individual to be granted a licence as an individual insurance agent is the need to be appointed as an agent by at least one insurer. This means the candidate needs to have entered into an agency contract with the appointing insurer (to evidence the appointment) prior to the licensing application being made, but on terms where he only starts performing regulated activities after (if) the licence is granted. A benefit of doing it this way (which the Ordinance implicitly requires) is that it gives candidates time to familiarise themselves with their rights and obligations (and authority) under their agency contract. This understanding is vital to their conduct when they eventually start dealing with customers. Whilst a number of insurers had adequate and timely controls on agency contracting in place, weaknesses were found with other insurers' controls in this area.

30. Certain insurers inspected, put speed of appointment ahead of carrying out the appointment properly, deferring the signing of agency contracts until after the IA had granted the licence. They did this based on the mistaken belief that formalizing the appointment would only be necessary if the candidate successfully obtained a licence. However, as stated, the appointment by (at least one) insurer is a pre-requisite to the licence being granted (so by deferring this the insurers concerned unwittingly risked the basis on which their insurance agents' licences were being granted). Further, failing to set the terms and conditions of appointment early, meant insurance agents had insufficient time to understand the parameters of their authority before dealing with customers on

behalf of the insurer. From a conduct risk perspective, this was problematic.

31. In another instance, some individuals were recorded by the IA as being appointed directly by an insurer, while in reality they had entered into agreements with an insurance agency that assumed full responsibility for recruitment, administration and oversight. In other words, although the insurer was listed as the principal, it had no direct control over the activities of the individuals concerned. This inaccurate appointment structure failed to reflect the true nature of the relationship and undermined the legitimacy of the licensing arrangement. It also created regulatory blind spots - specifically, the insurance agency, which is effectively acting as the principal of the individuals concerned, falling outside the scope of regulatory scrutiny in the event of misconduct.

32. Separately, concerns have been raised by some insurance agents regarding delays and lack of transparency in the handling of agent contracts. Common issues include insufficient time or guidance provided prior to signing, and failure to provide insurance agents with a copy of the signed contract within a reasonable timeframe for their own reference. In some cases, insurance agents who lost their original copy reported that insurers were reluctant or unwilling to provide a replacement, making it difficult for them to understand and fulfill the agreed contractual terms and conditions.

Specific matter regarding renewals of licences

33. Under section 64ZV of the Ordinance, renewal applications must be submitted to the IA no later than 45 days before the licence is due to expire. However, many insurers did not place sufficient emphasis on this requirement or adequately monitor their insurance agents' compliance with it, leading to frequent late submissions.

Recommended best practices

34. Intermediary management functions of insurers should implement a comprehensive governance framework that embeds clarity, accountability, and consistency across the processes for recruitment, contracting and onboarding of licensed individual insurance agents and the related licensing and licence renewal processes.

35. **As regards recruitment best practice controls**:

- These should include a documented recruitment policy, covering standards for how recruitment should be carried out for new insurance agents (requiring transparency of information in any recruitment advertisements, explanations to candidates of the role and work of an agent, communication of the fit and proper and other requirements demanded) and existing intermediaries (i.e. industry recruitment).

- Common sense dictates that where industry recruits are recruited with upfront incentive payments that then need to be supported by meeting business volume production targets to avoid the payment being clawed back, heightened conduct risk of aggressive selling and possible switching and churning may exist. Levels of incentives must be justified for achievability without aggressive selling (with such justification being documented). Insurance agents receiving such incentives should be subject to additional controls with their persistency ratios, complaints records and other conduct data being monitored more regularly during the clawback period. Further, basic due diligence on the previous track record of such industry recruits, must be subject to critical review (rather than easily by-passed through documentation that on its face is obviously less than genuine). Currently, the IA does not prescribe specific requirements/prohibitions for incentives schemes for industry recruits. With the new reference checking scheme for insurance intermediaries still in its infancy – and its implementation in part driven by the adverse consequences of these incentive schemes - we are monitoring how this may assist in mitigating the risks identified. However, insurers need to appreciate that incentive schemes must meet the principle of fair customer treatment to which all aspects of an insurer's conduct must adhere (and which brings such incentive schemes within the regulatory remit). Insurers need to demonstrate that this principle is met with documented evidence, when their schemes are inspected.

36. **As regards onboarding**:

Academic certificates

- The prescribed requirements for the enhanced vetting requirements of Mainland academic certificates set out in the Hong Kong Federation of Insurers' ("HKFI") circular of 13 April 2017 need to be embedded as part of the onboarding process for new insurance agents. For the most part, our inspections observed that they are.
- Best practices observed were where insurers also included processes for checking the genuineness of non-Mainland academic certificates as well. Certain insurers used third parties to do this, and examples were given where problems were unearthed by this process (which is commended).
- It is also imperative – where insurers seek to recruit candidates whose academic qualifications fall within the "catch-all" of being equivalent to a prescribed qualification – that they have a governance process which assesses and justifies that equivalency with explanations being put forward as part of the licensing process. Simply "testing the IA's bottom line" by submitting the application with a so-called "equivalent" but unjustified certificate, speaks volumes about the poor state of an insurer's conduct culture. By contrast, those insurers who show they have done the due diligence, demonstrate that "fair customer treatment" is front and centre of their control processes.

Other fitness and properness issues

- More broadly, the due diligence process should cover checks on other fit and proper requirements (e.g. previous bankruptcy, criminal records, or perceived conflicts of interest arising from external engagement). Where these processes identify potential fit and proper issues, but the insurer considers the candidate fit and proper in any event because the issues have been mitigated or eradicated, then it must have a process in place for considering and justifying this with the appropriate levels of senior management signing off on the appointment (usually the KPIM him or herself).

37. **As regards agency contracting**:

- Intermediary management functions need to be aware that the Ordinance requires an application for a new individual insurance agent's licence to have been appointed by at least one insurer as a pre-requisite for the IA to grant the licence, albeit the individual must not carry out regulated activities until the licence is granted.
- This means, in their processes for onboarding new agent candidates, an insurer should contract with the candidate before the licence application is made to demonstrate the appointment. Under the terms of this contract, the individual is appointed as an insurance agent, but must not commence regulated activities until the licence is granted.
- It is important that the insurer ensure these contracts are entered into and signed before the licensing application is made.
- Best practice would also be to supplement the execution of the contract, with a process whereby the terms and conditions are explained to the insurance agents so that they understand their role, expectations and limits of their authority.
- Insurance agents should also be provided with a copy of their agency contract (in their preferred language or in a bilingual version), so they understand their rights and obligations – a matter which is important to conduct practice.
- Insurers should also have transparent processes for insurance agents to access a copy of their contracts, so they can keep the obligations in their contracts at the top of mind in their conduct.

38. **As regards licensing – and particularly renewals**:

- It needs to be understood that if an application is made more than 45 days before the renewal date, even if the IA has not decided on the renewal application by the renewal date, the licence will continue until such decision is made. By corollary, any application made within the 45 day period will not have the same protection – if the application has not been decided by the renewal date, the licence will expire.

- Given this, it is in the interests of individual insurance agents and the insurers appointing them, for renewals to be submitted before the 45 day period begins. The attitude of "the IA is so efficient in dealing with renewals, so we can ignore this 45 day deadline" is unacceptable. After all, can an insurer or intermediary who cannot deal with the renewal of their own licence in a timely manner, be trusted to deal with the renewal of their customer's insurance policies in a timely manner? This is a conduct issue. It speaks to the conduct culture of the insurer and fair customer treatment and is a conduct indicator the IA employs. So best practice (and there are insurers that do this) is for the intermediary management function to have in place standard processes for informing and reminding insurance agents to get their renewal applications in before the 45 day period begins (and chasing up on this).

39. For all of the controls identified, best practice would be for these to be documented clearly in written procedural manuals which are regularly updated to incorporate all current statutory requirements and internal standards. These should set out the end-to-end processes to be followed and clearly define objectives, roles and responsibilities, approval authorities, maker-checker protocols, automated reminders and escalation mechanisms. These need to serve as practical operational guides for frontline staff, enabling them to execute processes accurately, maintain compliance, and reduce reliance on ad hoc decision-making. It is also important to maintain records of meetings and other evidence that shows the steps are being followed substantively (so the manuals and processes are not just there to impress the IA on inspection, and ignored after the inspection ends). Both operational staff and insurance agents should be clearly briefed on the process to enhance transparency, accountability, and operational efficiency.

Recruitment & Onboarding of Licensed Insurance Broker Companies

Relevant rules, guidelines and/or practices

40. Section 13AE(12)(f) of the Ordinance defines the intermediary management control function of an insurer as a function to establish and maintain internal controls for, among other matters, ensuring that the arrangements by licensed insurance broker companies for referring insurance business to the insurer comply with the requirements of the Ordinance and applicable Guidelines and Code of Conduct for Licensed Insurance Brokers. The KPIM Handbook outlines the areas on which an intermediary management control function should establish internal controls on licensed insurance broker companies in order to meet these requirements. These include due diligence on the broker company at the outset of any relationship and properly documenting (e.g. by way of written agreement) the relationship with the broker company to provide

clarity of respective roles and obligations. Thereafter periodic ongoing due diligence and monitoring should be carried out on the broker companies to assess that their regulated activities in referring business to the insurer remain compliant.

41. The IA's circular on 22 May 2024 and accompanying Annex, reminded insurers that the scope of controls its intermediary management function needed to establish, extended to licensed broker companies and their arrangements for placing business with the insurer, to ensure these arrangements complied with the requirements under the Ordinance, Guidelines and Code of Conduct for Licensed Insurance Brokers for referring business to the insurer. That circular was written in the context of non-compliant broker business models that relied on using unlicensed selling via referrals from unlicensed persons to source long term business applications from Mainland customers. These applications were then being placed with insurers in suspected contravention of the licensing requirements for regulated activities in section 64G of the Ordinance (the licensing requirements). The Annex to the circular set out the IA's expectations for the enhanced due diligence and monitoring controls an intermediary management function needed to establish for licensed insurance broker companies' arrangements, where the broker company focused on using referrals from unlicensed persons to source long term business opportunities from Mainland customers, to ensure the arrangements were not breaching requirements under the Ordinance.

42. Paragraph 7.1 of GL10 highlights that sound risk management and internal control systems are vital to effective corporate governance as they oversee the proper conduct of an authorized insurer's business and affairs. They help ensure the completeness of accounting records, the accuracy of financial information, the prevention of fraud and the prudent management of risks, etc. The Board should ensure that sound risk management and internal control systems are in place and the relevant procedures are properly followed.

Observations

43. Our inspections show variations in the standards of controls established by insurers' intermediary management functions on licensed insurance broker companies placing business with them. Some insurers have strong practical controls on the following areas:

    a) **Initial due diligence** – Substantive initial due diligence is performed at the outset of the relationship. This involves a member of the intermediary

management function gathering information on the broker company – both quantitative data and qualitative information gleaned through meeting the responsible officer – and preparing a documented evaluation report. This report, based on the information gathered, sets out a comprehensive understanding of the broker company's licensing status, types and volume of business (based on financial information obtained), number of technical representatives, the business model it operates (how it sources and services customers) and its compliance arrangements and how these are an embedded part of its operation (including training capacity and level of controls over technical representatives). Where the business model is identified as having higher conduct risk (e.g. reliance on unlicensed referrals to generate applications for long term insurance from Mainland customers), further enhanced due diligence is conducted to understand how the broker company ensures referrals are performed without unlicensed selling/regulated activities being carried on and that licensed technical representatives carry on substantive regulated activities. The level of referral fees is factored into this analysis. If the conduct risk assessed is not within the insurer's appetite, no relationship is formed with the broker company.

b) **Clarity of roles and obligations** – A best practice insurer will ensure there is clarity on the roles and obligations of the licensed insurance broker company and insurer in doing business with each other from the outset of the relationship, through either an agreement or documented terms and conditions, so that mutual expectations are clear. This covers key issues such as policy delivery during cooling-off period, the role of the broker company in the claims process, how renewal notices are to be delivered (preferably directly from the insurer to the policyholder with a copy to the broker) and information that will be exchanged for periodic reviews (by both the insurer and the broker company).

c) **Training** – If in the due diligence evaluation, it is identified the broker company may need assistance in providing training to its technical representatives, as best practice the insurer provides that training support. This can include making certain critical regulatory and new product training compulsory for the responsible officer as part of the insurer's ongoing controls on the broker company, with some insurers making completion a pre-requisite for continued access to submissions systems.

d) **Ongoing monitoring** – As best practice, an insurer will calibrate the level of its ongoing monitoring of a broker company to its evaluation of the level of conduct risk at the outset of the relationship (i.e. proportionate and risk based), with tighter and more frequent monitoring on broker companies with high risk business models (e.g. reliance on unlicensed referrals for Mainland customer business). As part of its ongoing monitoring, an insurer will utilize internal data across all partnered licensed broker companies (e.g. persistency rates, complaints and business performance) and external intelligence (e.g. social

media monitoring and whistleblower reports) to identify irregularities with processes in place to follow up on potential conduct red-flags indicated by this data.

e) **Periodic and documented reviews** – as best practice, an insurer will carry out substantive periodic and documented reviews of licensed insurance broker companies (where the initial due diligence is updated) with the frequency tied to the level of conduct risk initially assessed as well as business performance. Beyond engagement with the broker company's responsible officer, best practice for these reviews include regular onsite visits to the broker company's registered business address and meeting with the broker company's technical representatives to assess their competency (e.g. their knowledge of the insurer's products) and business practice (e.g. whether their business was generated through referrals from unlicensed persons). Periodic reviews also include regular identification of dormant broker companies (those which have not placed business throughout an identified time period), with system access being restricted to reflect this.

44. Our inspections also found certain insurers having weaknesses in each of these control areas. Some of these insurers had due diligence and monitoring controls in place, but the nature of these lent themselves more to a tick-box exercise, rather than a substantive assessment of the broker companies' conduct risk posed to the insurer. There was little by way of engagement between the insurer and the responsible officers of the broker companies in this process, to seek to understand how the broker company did business and the nature of their compliance arrangements. Examples of this "tick-box" approach include questionnaires which broker companies need to complete (many questions literally are just tick-box) with the submission of the completed questionnaires seeming to be the end of the process, with little done by way of evaluations of the answers given.

45. A few insurers still appear to misunderstand that, as broker companies represent policyholders, not insurers, compliance by broker companies with the insurance regulatory requirements is not a core responsibility for the intermediary management functions of insurers. These insurers stood out by the absence of supporting documents to demonstrate controls on licensed insurance broker companies, or that such controls as they did have were being applied consistently.

46. Weak controls on licensed insurance broker companies were identified by:

- a lack of systematic process for regularly verifying the licensing status of the partnered broker companies.
- processes for managing dormant partner accounts, as well as suspension and termination of distribution partners, either being missing or poorly defined, and key elements, such as suspension criteria, timelines, communication protocols, and appeal mechanisms lacking or inadequately documented.
- ongoing periodic reviews of broker companies not being rigorously conducted

and heavily reliant on the same due diligence questionnaires used at onboarding. Periodic review schedules were not consistently adhered to, with limited evaluation being made of conduct risk arising from broker company business models that heavily relied on referrals from unlicensed parties. In some cases, delays in follow-up by the insurers were due to insufficient resources allocated.

- Weak access controls within sales systems, enabling broker companies to create sub-accounts without verification of the account holder's identity or intermediary status. In certain cases, suspended brokers were still able to access the insurer's system, retrieve sales materials, and potentially engage in unauthorized customer interactions and conduct regulated activities without the required licence.

47. In carrying out our inspections, the IA recognized that context was important. Much improvement has been driven by the issuance of our 22 May 2024 circular, specific to high conduct risk broker models reliant on unlicensed referrals to generate long-term business applications from Mainland customers. It was evident that certain weaknesses identified in our inspections were due to enhancements being in progress rather than completed, in response to that circular. As of now, however, insurers have had abundant time to bring themselves up to compliance with that circular.

Recommended best practices

48. Paragraph 43 above identifies the general areas in which an intermediary management function of an insurer should establish controls on a licensed insurance broker company and the best practices to follow in this respect. We emphasize again that these controls should be substantive, not tick-box. Due diligence evaluations should aim to achieve a comprehensive understanding of the broker company's business model and compliance arrangements embedded within its operational practices. This then enables the insurer to calibrate its ongoing monitoring, level of training support and periodic review frequency, to its evaluation of the conduct risk assessed in the due diligence. In other words, it lends itself to a risk-based, proportionate approach that can be holistic, covering not only compliance matters but business performance.

49. If the broker company's business model heavily relies on unlicensed referrers to source customers, the insurer's due diligence must be enhanced to ascertain that the business model aligns with the three principles stated in the IA's circular on 22 May 2024.

50. As regards ongoing monitoring, another good practice observed is the gathering of intelligence and implementation of social media monitoring using targeted keyword and hashtag searches relevant to insurance in Hong Kong and the insurer's brand. This helps detect unauthorized use of insurer's logo, misleading promotional materials and improper referral activities etc., across different social

media platforms.

51. A positive practice also noted, is certain insurers exploring the use of mystery shopping on broker companies, not only to assess their conduct from a compliance perspective (thereby rooting out any misuse of rebates via unlicensed referrers being made), but also from a broader servicing perspective.

Training

Relevant rules, guidelines and/or practices

52. Licensed insurance intermediaries can only advise on matters on which they are competent to advise (section 90(a) of the Ordinance) and, for these purposes, must possess appropriate levels of professional knowledge and have a good understanding of the different types of insurance policies in respect of which they may carry on regulated activities (General Principle 4 in the Codes of Conduct). Individual insurance intermediaries are also required to comply with the continuing professional development requirements in Guideline on Continuing Professional Development for Licensed Insurance Intermediaries (GL24) to keep their technical and regulatory knowledge up to date and refresh themselves on the ethical standards demanded in carrying on regulated activities.

Observations

53. Training is a core control measure for insurance intermediary management functions to establish for the appointed licensed individual insurance agents and the appointed insurance agencies. It can also serve as an important control measure to support licensed insurance broker companies which are business partners in keeping their knowledge up to date and competent to arrange the insurer's products. Most insurers appreciate this and offer training (i) to assist candidates to obtain their licence, (ii) as part of their onboarding to train them on specific products offered by the insurer and (iii) as part of keeping their knowledge up to date on regulatory requirements new or changes to existing products.

54. Insurers with strong training controls, recognized that training is a substantive means of improving their insurance intermediaries' professional knowledge, performance, compliance and career development. They have engaging training courses which develop knowledge. They put on sufficient training sessions or mechanisms for intermediaries to be trained. They incentivize training to be completed and penalize those who miss training. They keep training records and courses up to date. Feedback from insurance agents in inspection interviews who

received this kind of level of training support was positive and they generally demonstrated practical knowledge.

55. By contrast, weaker training controls were apparent from insurers who approached training as a box to be ticked to show cosmetic compliance, with training focused on how to answer multi-choice questions (with evident answer-sharing amongst peers to enable them to just "get it done"). There was also evidence of weak enforcement if training was missed, gaps in training records and sometimes failure to appreciate that training course recognition had expired (despite continuing with delivery). Feedback from insurance agents in inspection interviews, subject to this type of training protocol, suggested that they viewed training as less about knowledge enhancement and more about ticking the compliance box.

Recommended best practices

56. Training is a vital control and insurers who focus on the cosmetic over the substantive, are wasting time and resources. Those who just teach how to answer multiple-choice questions, belong to a past era. The present and future belong to those insurers that take training seriously, aim to convey knowledge through training and help intermediaries make a career in insurance by arming them with the skillset to serve customers over the long term. Their training courses are engaging, use practical case scenarios and ethical dilemmas for discussion and test knowledge attained with quizzes that make intermediaries think. These quizzes are a mix of:

- single-answer multiple choice questions, where the options are not obvious to choose between;
- questions where a series of relevant options have to be chosen (and have to be discerned from irrelevant options); and
- questions which are not multiple choice but where the intermediary has to calculate the answer (e.g. a scenario to work out affordability of a customer).

Insurers following best practice have a wide range of questions in their question bank and continually refresh these to keep them up to date, so as to provide intermediaries with a different experience each time the course is taken.

57. These courses (delivered in person, virtually or through e-learning as part of both onboarding and annually thereafter) are supported with comprehensive maintenance of training records which are checked (with missing records identified and penalized) and incentives given for intermediaries to do training and penalties imposed if they miss it. Intermediaries who have not done training in line with the insurers' expected schedule are flagged up, with follow-up to ensure training is kept up to date.

58. As best practice (and indicated in the broker controls above) insurers also offer their training to the broker companies which are their business partners, so the

responsible officers (and even technical representatives) have the opportunity of keeping their knowledge up to date (especially those broker companies who do not have their own training support). Attendance at the training offered by the insurer can also be part of the periodic evaluation of its broker companies.

59. A "no train, no sell" policy on new products offered by the insurer and also for its onboarding training, is also a best practice identified, with agent codes only activated upon full completion of mandatory onboarding training, access restriction to sales tools until product training is completed, and actively monitoring training completion status.

60. Training schedules, attendance expectations, and the importance of compliance should be consistently and proactively communicated to all licensed insurance intermediaries. As stated, to enhance engagement, insurers should consider introducing interactive e-learning modules and offering virtual classes tailored to agent preferences, rather than simply distributing PDF or PowerPoint materials for self-study followed by basic multiple-choice questions as a superficial form of assessment.

61. Strengthening monitoring controls is equally critical. This includes issuing timely reminders, applying meaningful disciplinary actions for non-compliance, and establishing clear accountability to ensure compliance training is completed as required.

Remuneration for Licensed Insurance Intermediaries

Relevant rules, guidelines and/or practices

62. According to paragraph 9.1 of the Guideline on Underwriting Long Term Insurance Business (other than Class C Business) ("GL16"), authorized insurers have a duty to ensure that the remuneration structures they set for their intermediaries do not create misaligned incentives for intermediaries to engage in mis-selling, aggressive selling, fraudulent acts or money laundering activities, but are aligned with the "treating customers fairly" principle. The insurers are therefore required to put in place an appropriate remuneration structure to address such risks.

63. Paragraph 9.2 of the GL16 (for long term business) stipulates that indemnity commission, or any standing arrangement that offers advance payment of commission, is strictly prohibited. Also, it is clarified under the Questions and Answers of GL16, that any commission payable should be paid on an earned basis (i.e., at the time of payment, the cumulative commission paid cannot be higher than the cumulative premiums received). For the avoidance of doubt, overrides directly attributable to the sale of the relevant policy are deemed as part of the

commission paid.

64. The "Practice Note on Remuneration Structures of Authorized Insurers for Licensed Insurance Intermediaries for Participating Policies" issued on 30 July 2025 ("Practice Note") supplements the requirements under GL16 and sets out the IA's minimum expectations on how authorized insurers should structure remuneration for licensed insurance intermediaries in relation to participating policies with regular premium payment terms.

65. On 10 April 2006, the then Office of the Commissioner of Insurance issued a circular on "Insurance Fraud"[1], highlighting aggressive commission schemes offered by insurers and conflicts of interest of insurance brokers. These commission structures set by insurers often required minimum production requirements and provided incentives based on business volume, exposing insurance brokers to unmanageable conflicts of interest. The circular emphasized that any incentive or inducement provided by an insurer to influence an insurance broker to place more business with it jeopardizes the broker's independence and constitutes a serious market conduct issue. Prohibited practices include, but are not limited to, insurers entering into contracts or agreements (exclusive or otherwise) to induce brokers by offering commission levels based on volume or requiring brokers to meet certain annual business targets. This has been carried forward into the Practice Note issued by the IA supplementing Standard and Practice 7.1 of the Code of Conduct for Licensed Insurance Brokers.

Observations

66. As an overall comment on our inspection of remuneration structures on long term business, whilst we found evidence that the principle of not creating misaligned incentives and upholding fair customer treatment was broadly recognized, this was not consistently reflected in the remuneration structures on long term policies with savings and investment elements (a matter which had to be addressed by the Practice Note). There was also little evidence of consideration being given to these issues in the setting of performance bonuses for insurance agents. Our findings show that it is not uncommon for insurers to offer periodic performance bonuses based on the aggregated first year commission ("FYC") or first year premium generated by insurance agents. While such arrangements may be designed to drive performance within a specific period of time, they effectively act as an uplift on FYC and thereby an uplift on the incentive to sell in order to generate more FYC. In setting these bonuses, we saw little in the way of assessment of how this might incentivise conduct that crosses over into aggressive selling and the risk of misconduct, and what appropriate safeguards and monitoring could be set (or were in place) to mitigate this risk, to ensure customers were treated fairly notwithstanding the incentive.

[1] https://www.ia.org.hk/en/legislative_framework/circulars/reg_matters/files/cir_20060410.pdf

67. In certain cases, the design of remuneration mechanisms appeared not to take proper account of the regulatory prohibition on indemnity commissions on long term policies. This prohibition already applies a very narrow and strained interpretation to the requirement that commission is paid on an "earned basis" (i.e. at the time of payment, the cumulative commission paid cannot be higher than the cumulative premiums received). It was therefore surprising to see arrangements that appeared to disregard even this narrow interpretation. Examples included the use of financial allowances, or other forms of performance bonuses that were solely tied to business volume to pay out more in commission than had been received in premium. The absence of effective monitoring mechanisms – such as systems to flag when total commission exceeds 100% of the first-year premium, assessed both at the individual agent level and at the aggregate team level to which the agent belonged – was a further enabler for these suspected (whether intentional or otherwise) circumventions.

68. Insurers structure their agency forces into teams with a defined hierarchy, such that more senior insurance agents are given management responsibility over more junior insurance agents. Intermediary management functions often have to rely on agents with management responsibility to set the right conduct culture for the agency force and also to demand compliant conduct from the insurance agents under their management. A good practice noted was where insurers had mechanisms in their remuneration structures for insurance agents with management responsibility to hold them accountable for managing the compliance and conduct culture of the insurance agents reporting up to them. A basic control on this is the clawback mechanism for remuneration from insurance agents with management responsibility, where their downline agents repeatedly or systematically commit misconduct. Those insurers who did not have such a mechanism were at an obvious disadvantage to those who did, in holding upline insurance agents accountable for their management responsibilities.

69. Within the broker channel, it was noted that a number of remuneration structures designed by insurers aimed to drive business volume beyond just a standard commission payment (i.e. for the broker company to place more business with the insurer and to be rewarded with higher benefits if volume targets were met). These were often dressed up cosmetically not to look like breaching the volume commission prohibition (stated in the longstanding 10 April 2006 circular) but appeared substantively to have the same effect. Remuneration structures that link eligibility for higher overrides and special incentives to the achievement of a minimum production threshold, may unduly influence broker independence and compromise product suitability assessments to customers. Similarly, marketing sponsorships or other allowances paid upon achieving volume thresholds, might in substance, constitute volume-based commission by a different name.

Recommended best practices

70. As a general observation, when it comes to commission structures on long term

insurance policies with savings and investment elements, there needs to be greater consideration (and evidence of consideration) of factoring in the fair customer treatment principle in their design. Even though it is customers ultimately paying for the service provided by the intermediaries, where that payment is in the form of remuneration to insurance intermediaries, it is set by the insurer – and since the customer (the ultimate paying party) is not present in considering the amount that should be paid for the service, regulation demands that insurers consider the customer's point of view by factoring in fair customer treatment into remuneration design. Further, this should not only be done at the product design and premium setting stage, but also reviewed thereafter at regular intervals with any indicators showing a linkage between remuneration structure and poor conduct outcomes for customers (through low persistency, misunderstanding at the claims stage, a high level of complaints) being addressed through adjustments to the structure. Insurers are challenged to consider this and demonstrate how they have done this on future inspections.

71. As stated, the narrow and strained interpretation of paying commission on an "earned" basis, as a means of not breaching the indemnity commission ban, already gives insurers wide leeway on commission payment. On participating policies the IA has brought in its Practice Note outlining how commission should be spread. Insurers must stick to this. And whether it is on participating policies or other long term insurance policies, they must ensure that the indemnity commission prohibition is not breached. They should put processes in place to monitor total commission payout ratios and implement system logic to ensure that the total commission does not exceed premium collected at any point of time (not only at the individual agent level, but also at the aggregate team level since up-line managers may receive overriding commission). Any entitlement above this threshold should be deferred, and a designated report should be developed to support ongoing monitoring, which may include extending the monitoring of policy lapse ratios beyond the initial policy years to better capture longer-term sustainability.

72. To promote accountability within the agency force, insurers should consider how their remuneration structures for upline managers reflect their accountability not just business performance in their team, but also ethical and compliance conduct by their downline insurance agents. In some insurers, accountability was evident (reflecting positive conduct culture), but in others there was a "not my sink, not my dishes" mindset coming across from some agency leaders in their interviews (being reflective of poor conduct culture). This accountability mechanism should be clearly documented in internal manuals and rigorously enforced in practice. The clawback mechanism referenced above would be an example of good practice on this issue.

73. For broker companies, in addition to the standard commission that applies to all partnering broker companies, compensation packages may sometimes include non-standard components (e.g. overrides and other incentives). Any such non-

standard components must be grounded in a reasonable and transparent framework that safeguards broker impartiality. Insurers should also maintain comprehensive documentation outlining the rationale behind each element of the compensation structure, the criteria used for determining payments, the calculation methods employed, and approval processes for all components of broker remuneration. Insurers need to take note that the "fair customer treatment" principle should be factored into the design of intermediary remuneration, and the IA needs to see evidence of this in its inspections.

74. Regarding sponsorship arrangements with brokers that are stated not to be tied to any sales-volume threshold (and therefore are claimed not to be subject to volume-based commission restrictions), insurers should still define acceptable and prohibited items, supported by transparent criteria to guide approval decisions. Regular reviews should be conducted to ensure there is no undue favoritism toward a single broker, and that sponsored events are not disproportionately reliant on a single insurer for funding. Where sponsorship amounts exceed reasonable parameters (or where patterns suggest elevated risk), independent functions such as compliance and finance should be involved in the approval process. Again, factoring the "fair customer treatment" principle into these arrangements and justifying them by applying a substance-over-form approach is something the IA wants to see evidence of in its inspections.

75. Insurers often have business development teams (or partnership distribution teams) to manage broker relationships and recommend remuneration levels. To manage potential conflicts of interest where business development teams may inherently be inclined to recommend more generous remuneration to support sales growth, the IA observes best practice whereby some insurers involve their compliance and/or risk management functions as independent reviewers. This independent review helps ensure that remuneration levels set for major broker partners appropriately take into account the conduct and regulatory risks presented by the broker company.

Financial Needs Analysis for Long Term Policies

Relevant rules, guidelines and/or practices

Applicable to section "Generating benefit illustration document before conducting Financial Needs Analysis ("FNA")"

76. In accordance with Standard and Practice 6.1(a) of the Code of Conduct for Licensed Insurance Agents, before giving regulated advice, a licensed insurance agent should carry out an appropriate suitability assessment in relation to the customer's circumstances. In relation to long-term insurance policies, the FNA forms a crucial part of this suitability assessment. The core purpose of the FNA

is to ascertain the financial needs of the customer so that, based on this information, the agent can determine what type of insurance policy would be suitable for the customer and then provide his/her recommendation to the customer.

Applicable to sections "Information about existing policies and concurrent applications" and "Information about target benefit/protection amount and target benefit/protection period/expected timeframe for meeting the target amount"

77. Paragraph 6.4 of the Guideline on Financial Needs Analysis ("GL30") states that 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.

78. Furthermore, paragraph 6.10 of GL30 requires that 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. Similarly, when assessing the customer's ability and willingness to pay insurance premiums, a licensed insurance intermediary should take into account any insurance premiums payable under insurance policies which are the subject of concurrent applications being made by the customer, as well as applications already made but not yet accepted.

79. Pursuant to paragraph 6.19 of GL30, authorized insurers should develop and implement effective policies, controls and procedures to ensure compliance with the requirements in this Guideline, including compliance by authorized insurers' appointed licensed individual insurance agents and licensed insurance agencies. Proper training must also be provided by authorized insurers to ensure that these policies, controls and procedures are effectively communicated to their appointed licensed individual insurance agents and licensed insurance agencies. An authorized insurer should also set up a robust monitoring program to ensure ongoing compliance with GL30.

Applicable to section "Verification of information"

80. Pursuant to paragraph 7.6 of GL16, authorized insurers have a duty to verify all available information, and assess whether a particular product is suitable for the customer's needs during the underwriting process.

Applicable to section "Provision of insurance options and suitability of advice"

81. Pursuant to paragraph 7.3 of GL16, 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.

Applicable to section "Deviation between level of insurance protection/saving amount offered by the recommended policy and that needed/indicated by the customers"

82. According to paragraph 6.17 of GL30, a deviation between the level of insurance protection/saving amount offered by the recommended insurance policy and that needed/indicated by the customer is considered a mismatch unless the deviation has a justified, sound and reasonable basis.

Observations

83. As can be seen from the above referenced provisions, the FNA requirements for long term policies are prescriptive and detailed. Long term insurers inspected generally had controls and processes in place to ensure the majority of these requirements were met. With that said, our inspectors did observe certain specific areas where improvement in such controls was needed, or certain practices needed to be avoided, to bring the insurer better into line with the FNA requirements. These are identified below:

Generating benefit illustration document before conducting FNA

84. The FNA should be conducted with the customer at the outset, enabling the licensed insurance agent to provide regulated advice based on the customer's circumstances and identified needs. In other words, any recommendation of a specific insurance policy to purchase should emerge from (and be based on) the information obtained in the FNA. In the normal course, therefore, after an FNA is carried out, if (based on the information gathered) the intermediary intends to recommend particular insurance products, he/she would at that point prepare the requisite benefit illustration documents for the recommended products to support the customer's decision-making.

85. In our inspections, however, we found several examples of benefit illustration documents for specific insurance policies having been prepared before the completion of the FNA. This practice raised concerns as to whether recommendations were being made prior to the circumstances of the customer being ascertained through the FNA, such that instead of the recommendation being based on the FNA, the FNA was being completed post-recommendation and crafted to fit the pre-recommended product – a practice which might constitute misconduct in making a recommendation that has not in substance taken account of the customer's circumstances.

86. To assist a customer in making an informed decision, the customer should not be steered in a particular direction before the circumstances on which an insurance recommendation should be based are established. While some insurers rely on the FNA signing date being earlier than the illustration signing date (rather than the illustration generation date) as a procedural safeguard, this control does not fully eliminate the risk of product preselection before a proper FNA is conducted, where the illustration has been generated before the FNA. Stronger control is required to ensure that product recommendations are genuinely driven by the customer's assessed needs from the FNA.

Information about existing policies and concurrent applications

87. Our inspection unearthed examples of insurers' FNA forms not including targeted questions about customers' existing in-force policies and concurrent applications being made. This information goes to relevant issues such as affordability and identification of insurance needs (which needs to take into account other insurances the customer would have). The absence of such information limits the insurers' ability to demonstrate that these critical factors were properly considered during the FNA process, potentially affecting the robustness and suitability of the advice provided.

Information about target benefit/protection amount and target benefit/protection period/expected timeframe for meeting the target amount

88. In certain samples inspected, key information such as the customer's target benefit or protection amount, the intended benefit or protection period, and the expected timeframe for achieving the target, was not collected for certain insurance objectives indicated by customers, such as financial protection against adversities, preparation for health care needs, or investment purposes. The absence of this information can undermine the reliability of the recommendation and hinder the ability to assess whether the proposed product appropriately meets the customer's objectives.

Verification of information

89. Another common issue we observed was the absence of follow-up when inconsistent information was provided for different FNA forms and insurance application forms completed by the same customer. Not addressing such obvious discrepancies might compromise the integrity of the fact-finding process and the reliability of the suitability assessment.

90. In certain samples, we found inadequate insurer verification of applications where significant differences in the monthly disposable income and/or net liquid assets were declared by the same customer within a short timeframe. There were also instances where the average monthly expenses (including insurance premium expenses), reported by customers in the FNA form, were equal to or even lower

than the aggregate monthly premiums of the customer's in-force policies, with no documented justifications for these obvious irregularities.

Provision of insurance options and suitability of advice

91. Inspections also revealed instances where only a *single* insurance product was recommended to customers following the FNA process, despite multiple products being available from the same insurer to meet the customer's stated objective. This raised concerns about whether a sufficient range of product options has been presented to enable the customer to make an informed decision.

92. Samples were also found that even where, based on the FNA information, a single product from the insurer could address all of the customer's stated objectives, insurance agents instead recommended a combination of different policies that collectively met customer's needs (and not even putting forward the single product as an alternative). Some insurers allowed this even where there was no explanation as to why the combination better met the circumstances of the customer than the single product and why the customer had not even been given the option of the single policy to consider. As a consequence, customers were paying for several policies (each generating commission for the agent) and not appreciating they could buy just one policy. On the face of it, this raised questions as to whether insurance agents might be putting their own interests ahead of their customers (and the relevant insurers were enabling this).

93. Certain samples showed instances of intermediaries recommending insurance products that did not fully align with the objectives indicated by customers in the FNA. For example, customers who wished to manage their own investment choices were recommended participating policies, which did not allow such control. Conversely, customers who preferred not to manage investment choices were recommended an Investment-Linked Assurance Scheme ("ILAS") product.

94. When introducing an ILAS product, some insurers permitted their insurance agents to recommend a universal life plan or other endowment products as alternatives, instead of a participating policy as required under GL30.

Deviation between level of insurance protection/saving amount offered by the recommended policy and that needed/indicated by the customers

95. Samples inspected included cases where the level of insurance protection offered by the recommended policies was significantly lower than the customer's stated needs, or the projected surrender value (including non-guaranteed amount) could not meet the customer's savings target. In a number of these cases, there was insufficient documentation to justify how the recommended level of insurance protection was determined and whether review and assessment of the reasonableness of such recommendation had been conducted during underwriting.

Recommended best practices

Generating benefit illustration document before conducting FNA

96. Before recommending any insurance product to customers, insurance agents should conduct an appropriate suitability assessment based on the customer's circumstances, including the customer's insurance needs and affordability. Generating benefit illustrations prior to completing the FNA may suggest product bias and compromise the objectivity of the FNA process. Insurers should enhance system controls to enforce the correct sequence of steps and prevent premature benefit illustration generation.

Information about existing policies and concurrent applications

97. Insurers should ensure that the FNA form incorporates dedicated sections or targeted questions to capture information on customers' existing policies and any concurrent applications. This enables a more accurate assessment of insurance needs, helps identify potential overlap between existing and proposed coverage, assists in the affordability check, supports the recommendation of appropriate supplementary solutions, and ensures the overall level of insurance protection is suitable for the customer.

Information about target benefit/protection amount and target benefit/protection period/expected timeframe for meeting the target amount

98. Without knowledge of the customers' target benefit or protection amount and the intended protection period or expected timeframe for achieving the target, it would be difficult for insurance agents to determine whether the recommended product could adequately meet the customers' needs. Insurers should review their FNA forms and consider whether capturing such information is essential for accurately understanding customers' needs and circumstances. If so, insurers should establish controls and procedures to ensure that such information is collected before any regulated advice is provided to customers.

99. Sufficient training should be provided for insurance agents to ensure a solid understanding of the suitability and affordability assessments, including the method for determining the recommended level of insurance protection.

Verification of information

100. Insurers should implement effective controls to identify customers' in-force policies and any concurrent applications. This includes cross-checking declarations made on the application form against the insurer's internal database of in-force policies and pending applications. Premium commitments under all existing in-force policies should be duly considered when evaluating affordability and suitability for the new application. For example, the total premiums of all in-

force policies should be assessed against the customer's reported monthly expenses in FNA forms. Significant fluctuations in financial data (e.g. income, expenses, premium commitments) within a short period of time must be followed up. Intermediaries should be reminded of their obligations to act with due care, skill, and diligence, particularly in ensuring that all information completed on behalf of customers is accurate and complete.

Provision of insurance options and suitability of advice

101. Attention is drawn to paragraph 7.3 of GL16 which provides that customers who have indicated their insurance needs should be presented with different insurance options that are available to meet their specific needs and financial circumstances. Presenting customers with only one single insurance option (without justification) may not be in line with this requirement, unless the insurance agent reasonably concludes that only one insurance product among those offered by his/her appointing insurer is suitable to meet the customer's needs and circumstances.

102. The expectation for licensed insurance agents to explore multiple insurance options with customers is further reinforced by Standard and Practice 2.2(b)(ii) of the Code of Conduct for Licensed Insurance Agents, which requires a licensed insurance agent to consider what available insurance products can reasonably meet the customer's circumstances, based on the product range offered by its appointing insurer, when the licensed insurance agent makes a recommendation on an insurance product.

103. Where multiple products are recommended in place of a single product that could meet all of the customer's stated objectives, insurers should ensure that (a) either the single product is also put forward as an option for the customer to consider or (b) the rationale for not putting forward the single product, but only the suite of policies – is clearly documented and justifiable (such that it is shown the suite of policies substantively better meets the customer's circumstances than the single policy). In particular, insurers should establish controls to prevent product bias, ensure transparency in the recommendation process, and avoid practices that could incentivize the submission of multiple applications for the benefit of intermediaries.

104. In cases where product recommendations do not fully align with the customer's stated objectives or preferences, intermediaries must clearly explain the differences, justify the recommendation, and document customer acknowledgement. Underwriting or compliance functions should review such cases to ensure the recommendations are reasonable and supported by the customer's informed consent.

105. Insurers should implement adequate controls to ensure that product recommendations are fully aligned with the objectives and preferences indicated by customers in the FNA form. For example, an ILAS product should be

presented as an option to customers who wish to manage their own investment choices. Where an ILAS product is recommended, customers must also be presented with a participating policy as an alternative option, in accordance with GL30. Where other products, such as universal life or endowment products, may be presented as additional alternatives, the inclusion of a participating policy alongside an ILAS recommendation remains mandatory under GL30.

Deviation between level of insurance protection/saving amount offered by the recommended policy and that needed/indicated by the customers

106. Insurers are reminded that in case of a deviation between the level of insurance protection/savings amount offered by the recommended insurance policy and that needed/indicated by the customer, intermediaries should clearly explain the deviation to the customer, and properly document why the level of protection/savings is suitable in view of the customer's circumstances.

Premium Collection – Long Term Insurance

Relevant rules, guidelines and/or practices

107. General Principle 8 of the Code of Conduct for Licensed Insurance Agents sets out the fundamental principles of professional conduct which a licensed insurance agent should demonstrate in handling client assets. In particular, an agent should only receive payment of premiums, where it is within the scope of the agent's authority as granted by its appointing insurer.

108. Conduct in Focus (1st Issue) published in October 2020, highlighted conduct issues arising from collection of premiums by insurance agents, and identified the necessity (to align with General Principle 8 of the Code of Conduct for Licensed Insurance Agents and section 90(h) of the Ordinance) of insurers making it clear to policyholders what authority they give insurance agents to collect premiums and the limits of that authority. If no such authority was given, the insurer should make it clear in a prominent way in its customer communications that payment of premiums should be made directly to the insurer and must not be made to the agent.

Observations

109. Since our issue of Conduct in Focus in October 2020, and as is evident from our inspections, long term insurers have taken seriously the problems that can arise from individual insurance agents collecting premiums and have evidently improved clarity on their agent collection authority and controls and processes on

this. Several insurers (commendably) strictly prohibit their individual insurance agents from collecting premiums.

110. In our inspections, we did identify specific areas where certain insurers could further improve in this area, particularly in communicating the position on authority of insurance agents to collect premiums. Where no authority existed, it was important that this message was consistently communicated and reinforced in internal and external communications, procedural manuals, training materials and company-wide communications. Inconsistencies in messaging had led to confusion among staff and insurance agents (and sometimes customers) as to whether or not insurance agents had any authority. It is imperative to eliminate such confusion, given the extent of the conduct problems that collection of premiums through individual insurance agents could give rise to.

111. For those insurers that did grant some authority to their insurance agents to collect premiums on their behalf, including accepting cash and issuing temporary or interim receipts to policyholders, the strength of controls in place, ongoing monitoring and clarity of communication were even more important to consider. Again, we observed areas where such controls needed to be further tightened. While this practice might offer operational flexibility, it poses inherent high conduct risk so must be carefully managed and tightly controlled. These risks include the potential mixing of personal and client funds, delayed remittance of premiums, and, in more serious cases, misappropriation of premiums. It may also be confusing to customers (and indeed insurance agents themselves) regarding what circumstances they do have authority to collect monies and the limits of that authority.

Recommended best practices

112. The obvious best practice from inspections we observed, is for long term insurers not to give their individual insurance agents authority to collect premiums. This is then backed up with clear training and communication to insurance agents to reinforce the message not to collect premiums even if asked by the customer. This message is reinforced from onboarding and throughout the agent's career. The absence of authority is clearly stated in agency contracts and in operations manuals. Further, it is stated clearly to customers on websites, mobile applications, premium notices, notice and letter of premium due and letter of change of payment mode, that they must not pay premiums to insurance agents but instead to clearly state on official payment channels (there should be no ambiguity in this).

113. Where any long term insurers take the risk of giving some authority to insurance agents to collect premiums (not a best practice), the controls must be stringent and tight. Such measures may include clearly communicating the scope of insurance agents' authority to policyholders, setting specified limits on the amount of premiums that insurance agents are permitted to collect, monitoring

the return of interim receipts to ensure timely reconciliation and detection of any irregularities, establishing clear protocols for the issuance, usage and return of temporary receipt booklets, and verifying that all collected funds are properly remitted to the insurer. The prohibition on mixing must be maintained. Further, agent collection, even within their authority should be emphasized as being a last resort where (for whatever reason) direct payment is not possible (not just inconvenient). Again, this message must be communicated to customers. Direct payment offers the highest level of protection to customers, particularly in view of the widespread availability and convenience of secure e-payment methods in Hong Kong.

Cooling-Off and Delivery of Policy – Long Term Insurance

Relevant rules, guidelines and/or practices

114. According to paragraph 5.5 of the Guideline on Cooling-off Period ("GL29"), the insurer should deliver the policy to the policyholder within 9 calendar days from the date of issue of the policy ("9 calendar day period"). If the policy is to be delivered to the policyholder through a licensed insurance intermediary, the insurer should provide the policy to the intermediary sufficiently in advance of the end of the 9 calendar day period to enable the intermediary to deliver the policy to the policyholder within the 9 calendar day period. Also, the insurer should deliver the Cooling-off Notice directly to the policyholder (or the nominated representative of the policyholder) within the 9 calendar day period.

115. Paragraph 7.2(e) of GL29 further requires an insurer to devise internal control measures to ensure and provide proof that policies are delivered to policyholders (or the nominated representatives of policyholders) within the 9 calendar day period. As supplemented in the answer to question 1 of the Interpretation Notes of GL29, the following records, by way of example, contain the timing of the delivery which are considered to be sufficient proof of delivery:
    - Where a delivery is made by hand, an acknowledgement of receipt signed and dated by the policyholder or his/her nominated representative;
    - Where a delivery is made by registered post or couriers, a delivery confirmation note or slip; and
    - Where a delivery is made via electronic means (e.g. email), an electronic acknowledgement of receipt issued from the intended recipient's email account or a written (electronic) reply from the intended recipient confirming safe receipt of the delivery.

116. The answer to question 4 of the Interpretation Notes of GL29 states that, if a

licensed insurance broker (who acts as the agent of the policyholder) is expressly nominated and authorized by the policyholder to receive or handle the life insurance policy or policy related documents for and on behalf of the policyholder, he/she shall be a "nominated representative of the policyholder".

Observations

117. GL29 stipulates the cooling-off period to be a 21-calendar-day period, starting from the earlier of (i) the delivery of the policy, or (ii) the delivery of the Cooling-off Notice to the policyholder or the nominated representative of the policyholder. During this period, policyholders can reflect on their purchasing decision and, if they change their minds, cancel the policy and obtain a refund of premiums. This serves as an important policyholder protection reinforcing the importance of policyholders being positioned to make informed decisions. Insurers recognized this and in our inspections we observed – had processes in place to achieve the cooling-off period. There were, however, some weaknesses in certain processes observed.

118. A few insurers were observed to be using the policy issue date as the starting date for the cooling-off period and voluntarily offering a slightly longer duration (e.g. 29 to 32 calendar days) as compensation. Whilst this could normally result in the policyholder still having 21 calendar days from the delivery date (of the policy or cooling-off notice), there may be occasions where this would not be the case. For example, delays in policy printing and internal administrative processes before mailing, especially during longer public holidays, could result in the actual cooling-off period experienced by policyholders being shorter than the required 21 calendar days.

119. More seriously, some issues were observed in policy delivery timeliness and acknowledgements of receipt. Certain insurers failed to deliver policies within the requisite 9 calendar day period, with some policies only reaching policyholders after the cooling-off period had expired. Delays were particularly common when delivery was handled by insurance intermediaries. In several cases where insurers relied on insurance intermediaries to deliver policies, the policies were dispatched to the intermediaries 10 to 19 days after issuance, causing further delays in reaching policyholders.

120. For some insurers, the acknowledgement of receipt did not align with the IA's expectations as set out in the Interpretation Notes of GL29. For example, in cases where policies were delivered electronically via email or uploaded to an e-portal, insurers did not implement adequate monitoring measures to confirm whether delivery was successful or whether the customer had accessed the e-portal. Similarly, for hand deliveries made through insurance agents, acknowledgements of receipt were often not collected by insurers. As a result, these requirements appeared to be largely cosmetic, with little evidence that

they were taken seriously or effectively enforced in practice.

Recommended best practices

121. To safeguard cooling-off rights, insurers are expected to make every reasonable effort to deliver policies to the policyholders within 9 calendar days of issuance, so policyholders can reflect on their purchase decisions with the requisite information at hand. Delays or failures in delivery risk undermining policyholders' ability to exercise their cooling-off rights.

122. Insurers should reassess their methods for calculating the cooling-off period to ensure fair treatment for all policyholders. In accordance with GL29, the period must be at least 21 calendar days, counted from the earlier of the delivery of the policy or the Cooling-off Notice. Any deviation from this standard may result in non-compliance and compromise policyholder protection.

123. To strengthen delivery oversight, insurers should implement robust monitoring mechanisms, particularly for policies delivered via intermediaries. A best practice is to arrange for policies to be delivered directly to policyholders by registered post (rather than through intermediaries), which provides secure and traceable mailing records to support proof of delivery. On the other hand, if insurers choose to allow insurance agents to handle policy delivery, stricter controls should be in place. This may include requiring prior approval, ensuring the timely submission of customer acknowledgement receipts, and applying appropriate disciplinary penalties in cases of non-compliance to reinforce accountability.

124. Effective tracking of policy acknowledgements is essential for ensuring delivery compliance. Insurers should implement structured monitoring processes to follow up on outstanding acknowledgements. For example, issuing regular reports to insurance agents and their uplines to highlight pending acknowledgements, enabling them to take timely follow-up actions with customers. Additionally, adopting a multi-channel notification strategy — such as sending reminders via SMS, e-portal push notifications, and mail — can also help prompt timely responses from policyholders and support consistent tracking of delivery and receipt records.

Claims Handling

Relevant rules, guidelines and/or practices

125. Sections 7 and 10 of GL10 stipulate that an authorized insurer should have in place proper policies and procedures regarding settlement of insurance claims to ensure its claimants are treated fairly in the claims handling process. In setting out these policies and procedures, the board has the ultimate responsibility to discharge its obligations to ensure that policyholders are treated fairly in the claims handling process.

126. Guideline on Medical Insurance Business (GL31) also sets out minimum standards for claims handling. An authorized insurer is required to handle and settle claims fairly and promptly and must provide policyholders with sufficient information and timely advice on the claims handling process and clear explanations in plain language regarding claim results. These principles are ones which align with the "treating customers fairly" principle and may therefore be considered applicable across all lines of business.

127. To facilitate insurers to discharge their responsibility to handle and settle insurance claims fairly and promptly, and using the context of medical claims, best practices and expectations have been indicated in the Conduct in Focus (7th Issue) published by the IA in May 2023.

Observations

128. The standards for claims handling in the insurance regulatory framework are principle-based, founded on the "treating customers fairly" principle and thereby give insurers latitude on how to design their claims authorities and operational processes and controls to meet that principle. In our inspections, different processes were observed and it was gratifying to see those insurers that gave prominence to claims handling as a vital service – using it as a "selling" point to convince customers to insure with them. The insurers that put claims handling as "front and centre" service, invested resources in it (rather than just seeing it as a cost to be minimized) and a number of best practice controls and processes were observed with these insurers.

129. As a customer-centric practice, some insurers also adopted an approach whereby, if part of a claim was undisputed but the remaining part was subject to a dispute or pending further information, they made a partial settlement for the undisputed portion first. They then continued to assess the outstanding portion once the additional information was received (e.g. further documentation from the medical service provider), rather than delaying settlement of the entire claim. This is a commendable practice.

130. However, there were also across the spectrum, several areas identified where improvement was needed (particularly with insurers that placed more prominence on front end selling of insurance, and less on claims servicing).

131. Certain areas that needed improvement were identified in communication practices and governance oversight. Most notably, some insurers, upon receipt of a claim, provided updates only to servicing intermediaries, expecting them to relay the information or request outstanding documents from claimants. However, there was no assurance that such communication was effectively conveyed, raising the possibility that claimants were left unaware of the progress of their claims or the additional information required for assessment particularly if the intermediaries did not act promptly or diligently. Furthermore, some procedural manuals put in place by insurers lacked clear timelines for issuing claim acknowledgements, pending memos, reminder letters and notifications, which resulted in inconsistent and delayed communications.

132. Communication and coordination with reinsurers were found to be insufficient in several instances. Insurers did not consistently follow up on pending approvals, even after response deadlines (if fixed) had passed. In certain cases, no formal response timeframe had been established between the insurer and reinsurer, which is particularly problematic when insurers opt to wait for instructions from the reinsurer before making a claims decision. This practice can place policyholders at a disadvantage, resulting in unnecessary delays in the resolution of their claims.

133. Certain senior management reviews of the claims process were found to be limited in scope. In some instances, there was a lack of regular and structured assessment of the overall efficiency, accuracy and robustness of the claims adjudication process. In particular, there was insufficient analysis of the root causes behind recurring issues, emerging trends such as an increase in reversed decisions, and potential gaps in staff training. This lack of in-depth review limited the organization's ability to identify systemic weaknesses and implement timely improvements.

134. Fraudulent claims erode the principle of risk pooling and divert resources intended for genuine policyholders. Insurers must maintain effective fraud detection controls that balance investigative rigor with the obligations to handle legitimate claims fairly and promptly. The Insurance Fraud Prevention Claims Database ("IFPCD") launched by the HKFI helps insurers identify suspicious claims early while ensuring genuine claims are settled without delay. However, a few insurers have not joined the IFPCD and, at the same time, have not implemented equally robust internal controls to compensate for their non-participation.

Recommended best practices

135. A well-structured and transparent claims handling process is a cornerstone of trust between insurers and policyholders. It represents the most direct and impactful interaction customers have with their insurer, often during times of stress or financial uncertainty. In short, it is the reason why customers buy insurance. Therefore, insurers are expected to uphold the highest standards of fairness, efficiency, and clarity throughout the claims journey.

136. Insurers should establish clear arrangements with their insurance intermediaries explicitly defining their respective roles and responsibilities in the claims process and hold them accountable for these.

137. Indicative timeframes should be developed for each stage of the claims process, such as claim acknowledgement, issuance of pending memos, and reminder letters of additional documents or information. Certain insurers set these timeframes and communicate these to claimants, helping enhance customer experience and safeguard policyholder interests. This is certainly a best practice. Further, they include these details in clearly documented internal operations manuals. The indicative timelines are clearly communicated to the relevant parties as appropriate. Where claims processing exceeds the published timeframes, the insurer then provides periodic updates to claimants, explaining the reasons for delay and, where possible, giving an estimated timeframe for a decision. Claims ongoing past the timeline are escalated and have increased focus placed on them at regular intervals until the claims process is complete. The overall position on claims is reviewed to spot potential indicators where problems might arise.

138. Insurers rely on reinsurers – that is part and parcel of the insurance business. And, yes, sometimes contractually, prior consent from a reinsurer may be required for the insurer to pay the claim in order to be certain of recovery from the reinsurer. However, this process is no excuse for delays in claims decisions for claimant customers. Claimant customers are not a party to the reinsurance contract and liability of the insurer for the claim under the insurance policy is not contingent on consent from the reinsurer being obtained. Reinsurers need to get on with their decision (and recognized insurers need to make claims decisions promptly for customers) and insurers must not hide behind reinsurers to delay claims decisions for customers. To avoid this, a best practice is for insurers and reinsurers to agree upfront on specific binding timelines for insurers to report specified information to reinsurers and for reinsurers to come back with their consent (or otherwise) so there is no delay in claims decisions to customers.

139. The IA by its circular of 27 February 2023 has stated its position on insurers' participation in the IFPCD launched by HKFI. Participation is demonstrative of effective controls against fraudulent claims (as demanded by GL10). Non-participation will require demonstration that alternative controls are in place in inspection, such that the insurer has got the balance right between investigating

suspected fraudulent claims properly, and the need to settle legitimate claims fairly and promptly. Those insurers not able to provide such demonstration may wish to join the IFPCD or face continued dialogue with the IA (thereby keeping the inspection open).

140. As part of sound corporate governance, the claims handling process should go beyond statistical reporting. Insurers should conduct regular reviews to identify emerging trends, respond to evolving issues such as regulatory changes, and pursue continuous internal process enhancements. Senior management should actively monitor these developments to ensure claims are handled appropriately and that no cases remain pending for a prolonged or unreasonable period of time. This oversight is essential to uphold the principles of handling claims in a fair, prompt and transparent manner.

Offering of Gifts – Long Term Insurance

Relevant rules, guidelines and/or practices

141. According to paragraphs 5.2 and 5.3 of the Guideline on Offering of Gifts ("GL25"), authorized insurers have to make a reasonable assessment to determine if the gift offered to customers when marketing, promoting or distributing Class A Products or Class D Products, would distract the customer from making an informed decision. 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 program, at the time the marketing campaign or program is formulated.

142. Paragraph 7.1 of GL25 states that authorized insurers should maintain robust internal procedures and controls, including adequate record keeping, to ensure that they and their staff, including but not limited to their licensed individual insurance agents, comply with GL25.

Observations

143. This is an area that needs to be improved in order for the IA not to extend the regulatory requirement to a simple prohibition on gifts being used in the offering and promotion of long term products. The fact that it is still allowed for Class A and D Products subject to a proper suitability assessment being carried out, means that insurers must carry out that assessment and not treat it as just a cosmetic tick-box exercise. In certain gift offerings we inspected, however, the assessments were not comprehensive enough to capture all relevant factors, such as the gift's value in relation to the premium payable by the customer. In some cases, insurers relied solely on acquisition cost or face value as the basis for gift valuation, which

may not accurately reflect their fair market value. Inconsistencies in valuation approach (such as alternating between cost, face value, and market value) without adequate justifications further heightened the risk of inaccurate or unjustified assessments. Additionally, the absence of reviews and proper documentation on the relevance and justification of assessments raised governance concerns. These issues were compounded by missing records of required senior management approvals and compliance reviews.

144. Procedural manuals governing the initiation of marketing and/or gift campaigns were found to be inadequate, or in some cases, entirely absent. Furthermore, while some insurers did not prohibit their insurance agents from self-initiating gift campaigns with proper prior approval, internal guidelines and communications did not adequately outline the procedures for obtaining the necessary authorization. As a result, many insurance agents remained unaware of the proper protocols, increasing the risk of inconsistent or non-compliant practices.

Recommended best practices

145. The use of gifts, incentives, or inducements in marketing, promoting, or distributing long term insurance products must be subject to rigorous monitoring and governance if it is going to continue to be allowed. The objective must be to ensure that customers make purchasing decisions based on their genuine needs rather than being unduly influenced by gifts, which could lead to unsuitable or unaffordable policies and increase the risk of future lapsation. Controls must safeguard fair treatment and uphold policyholder interests over the long term.

146. Assessment processes should not be limited to a binary yes/no checklist, especially in complex scenarios where detailed explanations and justifications are necessary. Evaluations should consider key factors such as the timing of the gift offering, the perceived attractiveness of the gifts to the targeted customers, their market value and whether such value is significant relative to the premium payable by the customer. Clear and consistent valuation methodologies (e.g. preferably aligned with fair market value) should be adopted unless other reasonable justifications are provided. Where potential compliance risks are identified, an independent review by an additional function (e.g. Compliance) should be incorporated to strengthen oversight.

147. Procedural manuals should be standardized across all levels to eliminate inconsistencies. These manuals must clearly define the types of gift campaign subject to assessment, establish a uniform approval workflow and embed governance controls to ensure consistent application of policies. Internal communications with relevant staff and insurance agents should be clear, consistent, and sufficiently detailed to support full understanding and effective compliance with the established procedures.

Handling of Orphan Policies

Relevant rules, guidelines and/or practices

148. To facilitate insurers (especially life insurers engaged in issuing insurance policies with long-term commitments) to handle orphan policies, best practices have been indicated in the Conduct in Focus (3rd Issue) published by the IA in October 2021 (and in the KPIM Handbook). This edition of Conduct in Focus sets out expectations for handling orphan policies, including but not limited to the seven key areas under the section "Controls and Processes for Policies". Among other recommendations, the IA recommended two means of notification to ensure that policyholders are notified of the departure of the original insurance agents and the contact information of the new servicing insurance agents for any insurance-related issues.

Observations

149. It is encouraging to see that some insurers have taken this matter seriously, with several good practices being included in the controls to aim to avoid policies becoming orphaned – a matter that has been a root cause of different types of poor conduct. Other insurers, by contrast, need improvement in this area and the inspection findings mentioned below come from them.

150. Inspections revealed recurring weaknesses in the handling of orphan policies and the assignment of new servicing insurance agents. Key issues included delays in both the assignment process and the notification of affected policyholders regarding the termination of previous insurance agents and the appointment of replacements. Additionally, there was a lack of effective system monitoring mechanisms. These shortcomings allowed orphan policies to remain undetected for extended periods, creating opportunities for departed insurance agents to exploit the situation, potentially harming policyholder interests and giving rise to conduct risks.

151. Communication deficiencies were also common, with insurers failing to notify policyholders through multiple channels, as recommended in the Conduct in Focus. Additionally, the content of these notifications often lacked essential details, such as the licence number of the new servicing agent and the insurer's customer service hotline, reducing transparency and customer confidence.

152. Another common finding identified was the presence of procedural and governance gaps. These included inconsistent or missing operational manuals, unclear or inadequate eligibility criteria for agent assignments, and over-reliance on agency leaders' discretion without the support of standardized benchmarks. In some cases, newly joined insurance agents were assigned to handle hundreds of

orphan policyholders despite being unfamiliar with the company's products or procedures.

153. Incentive mechanisms often failed to properly account for the service obligations associated with orphan policies. As a result, there was little motivation for new servicing insurance agents to deliver quality service to orphan policyholders. While some insurers had procedures requiring insurance agents to initiate contact with policyholders for an introduction, there were no effective monitoring measures to ensure timely follow-up.

Recommended best practices

154. Servicing insurance agents are critical to delivering a seamless experience for policyholders, making it essential to appoint a qualified replacement promptly when an existing servicing agent leaves to avoid service gaps. A swift reassignment process not only ensures continuity but also helps identify and resolve any issues stemming from the previous agent's actions. To address these deficiencies, insurers should implement comprehensive and standardized procedures for managing orphan policies. These procedures should ensure that insurance agents and all relevant staff are familiar with the requirements and protocols for policy assignment.

155. Assignment of orphan policies should be initiated within a reasonable time prior to the departure of the original servicing agent. The selection of a new servicing agent must be guided by clearly defined quality benchmarks, such as years of service, complaint or disciplinary records, business persistency ratios, and the number of orphan policies currently assigned, etc. Assignments should not rely on subjective discretion (e.g. district directors) but should follow objective and transparent criteria to ensure consistency and fairness.

156. Policyholders should be notified of any changes in servicing insurance agents within a reasonable timeframe through at least two means of notification. These channels should be selected to maximize the likelihood of successful contact, taking into account policyholders' preferences, the efficiency of each method, and their complementarity. Notifications must include essential details such as the full name, licence number and contact details of the new insurance servicing agent. In cases where a policy is served by multiple servicing insurance agents simultaneously, the policyholder should still be informed of the departure of any original servicing agent to ensure transparency.

157. Insurers should review their incentive frameworks for orphan policies to ensure that mechanisms are suitably calibrated to reflect the associated service obligations. By aligning incentives with the successful delivery of quality service to orphan policyholders, insurers can better motivate newly assigned servicing insurance agents and appropriately recognize their efforts. This alignment supports a customer-centric culture and helps maintain high service standards.

158. Training programs should be developed for insurance agents and their managers, supported by detailed procedural manuals and workflows. In parallel, oversight mechanisms must be strengthened through robust tracking systems, effective record-keeping protocols, and regular reporting to senior management. Once procedures and requirements are established, it is essential to implement proper monitoring mechanisms to ensure they are consistently and efficiently followed. This ensures that the intended objectives (such as timely policyholder engagement and the delivery of continuous quality service) are effectively achieved.

Policy Replacement

Relevant rules, guidelines and/or practices

159. Paragraph 5.2 of Guideline on Long Term Insurance Policy Replacement ("GL27") states that the purchase of a life insurance policy 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;
(b) the policyholder of the existing life insurance policy and the life insurance policy being purchased is the same; and
(c) in order to fund the purchase of the new life insurance policy, the customer is using, or intends to use, *some* or all of the total cash value of the existing life insurance policy or any savings made or to be made as a result of reducing the premium payable under the existing life insurance policy.

160. Paragraph 7.2 of GL27 requires authorized insurers to implement processes for checking their internal records and databases to identify internal policy replacements. When potential policy replacements are identified, the authorized insurers 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 to the existing life insurance policy and informing him/her of the corresponding disadvantages.

161. Q&A12 in the Interpretation Notes to GL27 reminds authorized insurers to observe the principle of "fair customer treatment" to exercise appropriate judgement and apply a reasonable threshold taking into account relevant factors, such as the reduced premium payable under the existing life insurance policy as a percentage of the premium of that policy before the reduction / the premium of the new life insurance policy, the reduced cash value / sum insured of the existing life insurance policy as a percentage of the total cash value / sum insured of that policy before the reduction, and other relevant factors.

Observations

162. Our inspection identified a deficiency in an insurer's internal policy replacement procedures for checking internal records and databases to identify internal policy replacements. For instance, reviewed samples revealed that one policyholder had lapsed 6 existing insurance policies (within a year from their applications) and purchased 4 new insurance policies via the same individual agent during the review period. Notably, all products involved were medical-related insurance. Although internal policy replacement checking was performed by the insurer in respect of the above policies, the relevant lapsation transactions were not regarded as potential internal policy replacements as the reduction in premium payment for each medical-related policy lapsation individually did not exceed the internal threshold established by the insurer.

163. Approximately 80% of medical-related policies would be excluded from internal policy replacement monitoring under the threshold set by the insurer. Apparently, reliance on that absolute limit threshold for determining the necessity of any follow-up action (as per paragraph 7.2 of GL27) creates a gap in reaffirming policyholders' intentions and informing them of potential disadvantages associated with replacing their policies. Specifically, known pre-existing conditions (identified after the lapsation of the existing policy) may not be covered under the new policy, and policyholders will need to start a new waiting period in respect of certain benefits (e.g. coverage for unknown pre-existing conditions, suicide or incontestability) under the terms and conditions of the new plan.

Recommended best practices

164. It is recommended to reassess the internal threshold for potential policy replacements, and to develop a robust communication strategy (e.g. applying a percentage-based threshold in addition to an absolute limit threshold, and reviewing the customer's policy portfolio on an aggregated basis over a reasonable period rather than solely on an individual-transaction basis) to inform policyholders of the implications of policy replacement arising from their existing life insurance policy(ies).

End