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ASSOCIATION OF KENYA INSURERS

THE INSURER

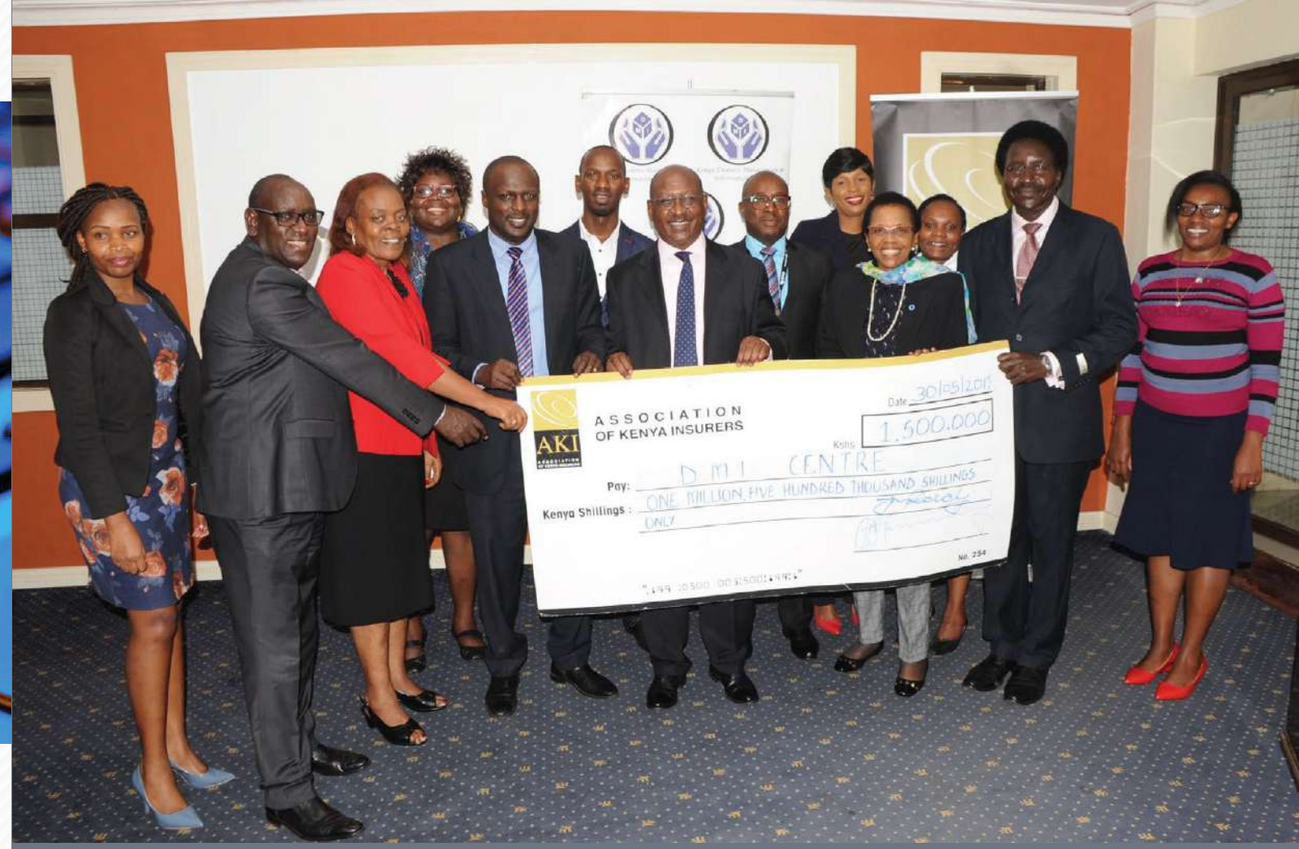
JOURNAL OF THE ASSOCIATION OF KENYA INSURERS

VOL 20 JUNE 2019

INSURANCE AND SECURITY

C O N T E N T

I N S E U C R U A R N I C T E Y &



We would like to appreciate members for their support towards 9th edition of the medical camp held on Saturday 8th June at Isinya, Kajiado County.

Special thanks to

APA Insurance, Britam General Insurance,
CIC General Insurance Co.,
Fidelity Shield Insurance Co.,
Heritage Insurance Co., ICEA Lion Group,
Intra Africa Assurance Co., Liberty Insurance,
Madison Insurance Co., Occidental Insurance Co.
and UAP-Old Mutual Group.

EDITOR'S NOTE

Over the Easter weekend this year, one of our banks lost over Ksh.10 million through sophisticated ATM attacks: The four 'hit 'machines were not vandalised, rather they were 'manipulated' through state-of-the-art cyber commands to empty their cassettes into the perpetrators' gunny bags. This malpractice—known as ATM Jackpotting—is a recent phenomenal having emerged in the US less than two years ago and is as sophisticated as they come: It is time our security organs 'upped' their game and 'hit' back in equal intensity.

Violent robberies are a thing of the past, thanks to advances nay innovations in technology. As Moses Wetsusa discerns in Risk Transference, businesses of all sizes are struggling to identify, assess and respond to an explosion of digital threats and targeted cyber-attacks that could paralyse their operations at any moment. Consequently, any forward-looking company has to rethink its security wellbeing. And on this front, insurance companies are the most vulnerable as they transact large amounts of money on their day-to-day operations in claims and premiums.

One of the biggest risks to any commercial entity is its most treasured asset; staff. Gone rogue, members of staff can in a flash bring an employer to his knees: An insider is more dangerous that an 'alien' to a business. Insider threats are not pedestrian but they emanate from the way a company treats its staff that in return may impact their social lives leading to the drive to 'rebel'. The buck in this scenario stops—as we learn from Checking Insider Threats—with security/HR minders as people generally do not get a job to become an insider: It is a result of something happening. In similar breath, Jacob Ochola notes that insurance against terrorism is vital in ensuring our individual and general security since a standard terrorism and sabotage policy offers insurance for life and assets that are exposed to war, terrorism and political violence attacks.

Disputes date back to the onset of human civilisation; what matters is how they are resolved. Legal suites always leave a bitter after-taste hence the need for more amicable resolutions. Mediation comes in handy here as it is—as Shafiq Taibjee maintains—the gentleman's justice system. Mediation is one the first steps a business takes not only to deal with internal work place disputes between staff and internal customers as they are known but external customers as well

Know-your-customer is a vital component of any business transaction. At times, scanty customer data impedes business growth and innovation, this could be solved by the recently launched Huduma Namba. As Morris Aron avers, data guides strategy and operations. Huduma Namba database provides a vital source of data that if used by those in the finance and insurance sectors will lead to better ways of making sales, serving customers better, innovating products and so on.

Most of the illnesses taking people to the hospital today are triggered by a mental health issue: Depression is all over, especially among the youth; so observes Grace Kariuki-Nderitu. If medical cover for depression was easily accessible and symptoms of mental health conditions were widely known, some of these cases would have been averted: What say you industry?

MEDIATION;

The gentleman's justice system

The whole process depends on whether the parties are willing to find common ground and to subsequently enforce the agreement reached

By Shafiq Taibjee

The arbitrator controls the entire process and like a trial, both sides are given the opportunity to present their case after which the arbitrator makes a decision: There are very limited chances of appeal.

In Kenya's Alternative Dispute Resolution (ADR) most popular forms are Arbitration, Mediation and Adjudication. For the purpose of understanding the difference we will touch on arbitration and adjudication superficially.

Arbitration is the submission of a disputed matter to an impartial third party for decision making. The third party is known as the arbitrator and his decision is known as an award. It is an out-of-court method for resolving a dispute.

Adjudication is a procedure under which an independent third party called an adjudicator—within a fixed period (28 days) and in accordance with agreed procedures—will give an interim decision on a dispute, which must be implemented. If either party is not satisfied with the decision, then the dispute can be referred to a final procedure such as arbitration or litigation.

Mediation is the most lenient form of ADR. It is a voluntary, consensual and non-binding process, whereby the parties to a dispute agree to involve a third party neutral to help them resolve their differences. Much emphasis is placed on the mediator's role usually one person, however it can even be a panel at times.

Mediators are independent and impartial; they rely on their pervasive power, communication skills and facilitation skills to assist the parties to reach a mutually agreeable outcome. A mediator does not make decisions; it is the parties who agree to a negotiated settlement. The focus of the parties to a dispute is on the future and the possibilities of a workable solution. A mediator must be sensitive, alert and have the ability to perceive, appreciate and respect the needs, interests, aspirations, emotions, sentiments, frame of mind and mind-set of the parties to mediation. They must have the highest standards of honesty and integrity in conduct and behaviour.

Mediation above all is a human process which entirely rests on the parties' goodwill. It is a forum where the parties can freely discuss the matters, express their disagreements and assess whether a settlement is conceivable. The mediator helps along in terms of encouraging the parties and being creative enough to offer solutions. The parties receive external assistance from the mediator to instil a dialogue, identify areas of contention and maximise consensus. The process is less adversarial than arbitration or litigation. Important to note is the parties are free to halt the discussion and walk away: This is why it is a gentlemen's method of settlement as the whole process depends on whether the parties are willing to find common ground and to subsequently enforce the agreement reached.

Alternative Dispute Resolution in general is a very private and not like court trials which are open to the public. In mediation, whatever the parties agree to remains confidential and cannot be used even in the court. This is a process which is in control of the parties unlike arbitration or a court trial. In this process, there is no judge who decides the outcome. There are a myriad of cases in today's business environment that mediation is a preferred method. For example, in family matters, art related disputes, disputes between states, insurance matters and so on. Mediation is usually conducted in shuttle diplomacy and allows parties to be heard in separate meetings called caucuses. The Insurance (Third Parties Risks) (Amendment) Act 2014 Section 4 (1) (b) specifically mentions arbitration or mediation.

Any business—insurance included—works on how well the customer is treated and whether they would be willing to deal with you as repeat customers. On daily basis, we read about various complaints against businesses where claims have been delayed or not paid, deals that did not end well due to individuals involved in the transaction and so on. Mediation is one the first steps a business takes not only to deal with internal work place disputes between staff and internal customers as they are known but external customers as well.

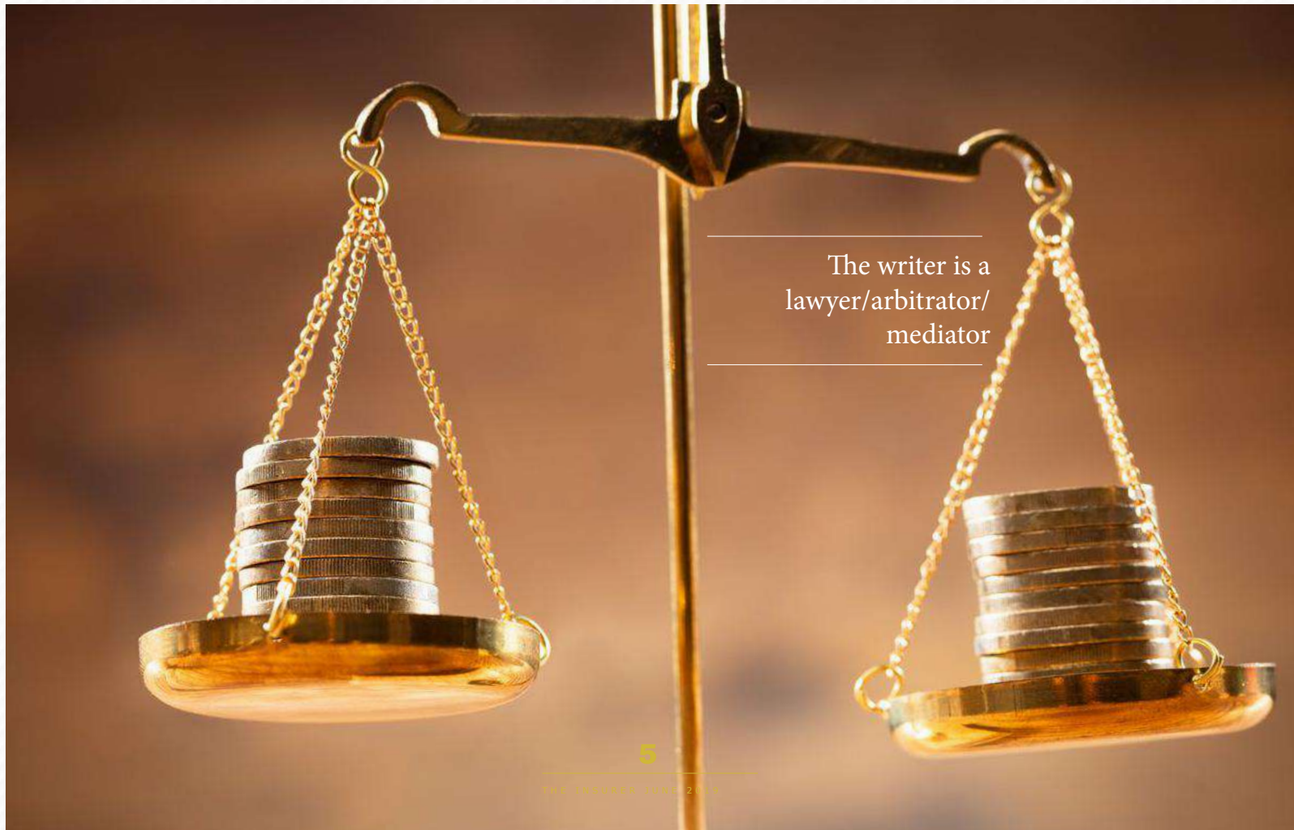
Workplace conflict is managed by professionals who the company can outsource as consultants and it makes a huge difference in the smooth operations of the workplace. This is an area that must be dealt with on its own and would be a subject of another article.

Examples of commercial (non-tort) third-party claims include inter alia – commercial liability, professional liability or "errors and omissions", Directors, Officers and employment practices liability. Mediation of third-party claims is advantageous for several reasons. First, it allows claimants, often times aggrieved individuals, to air their grievances in a controlled, civil and courteous environment. This is particularly constructive in the employment practices setting. Furthermore, it allows the claimant to speak to the mediator privately to develop creative non-monetary solutions, for example, relocating the disgruntled employee to a different department.

Second, in the case of multiple defendants with indemnification and subrogation claims, a unique opportunity is afforded for the defendants to collectively work together in order to resolve the matter with the help of a skilled mediator rather than as finger pointing adversaries.

Third, and perhaps most obvious, is mediation allows both sides to avoid the cost of litigation and risk of trial. Mediating at an early stage is advantageous to both parties in that it avoids the "sunk cost" phenomenon where litigants feel obligated to "stay the course" of litigation because their clients have already invested so much time, effort and money into the litigation.

Cases involving third party claims are among the most frequently seen by the commercial litigator. A typical insurance liability agreement imposes a duty on the insurer to defend and indemnify the insured against claims made by a person who is not a party to the liability agreement or "third party" within the scope of the agreement.



The writer is a lawyer/arbitrator/mediator

TECHNOLOGY IN INSURANCE;

The benefits

Moving transactions onto a secured shared ledger, significantly transforms and streamlines business processes and systems

By Peter Wanjohi

As implementation of smart technologies continues, connected machines will interact, visualise entire production chains, verify the authenticity and make decisions autonomously. It is imperative that the insurance industry continues to embrace these new technologies to remain competitive.

In relation to the foregoing trend, adoption of blockchain accords the insurance industry numerous opportunities.

Blockchain technology is part of the fourth industrial revolution that will bring exponential changes to the way we live, work and relate to one another mainly due to the adoption of cyber-physical systems and Internet of Things. It is a decentralised, distributed ledger technology that can store immutable complete transaction histories enabling peer-to-peer transaction in one of the safest environments.

The Key Characteristics

Decentralised: Blockchain technology does not rely on a central point of control, verification comes from the consensus of multiple users.
Distributed: shared with peers (computers in the blockchain network) where each user has a full copy of the ledger and participates in confirming transactions independently, making the process highly transparent
Immutable (Secure): Blockchain is designed to store information in a way that makes it virtually impossible to add, remove or change data without being detected by other users i.e. Recorded transactions cannot be altered without having the consensus of the entire blockchain network participants. Since all participants have a copy of the entire blockchain, they can detect any tampering and thus, all parties know that they can trust their records.

How Blockchain Works

A blockchain is a continuously growing list of records. Blockchain collects and orders data into blocks, and then chains them together securely using cryptography. Each block contains a cryptographic hash of the previous block, a timestamp, and transaction data.

The Steps

- A business transaction first is recorded
- A block representing the transaction is created
- The block is shared with peers in the blockchain network
- The block and the transaction is validated by all the participants in the network.

Moving transactions onto a secured shared ledger, significantly transforms and streamlines business processes and systems and have a huge impact on a transparency, stability and efficiency and is a huge step forward for the industry.

- Once validated the block is complete and it is time-stamped

- Other peers may also be sending their blocks simultaneously, the timestamps ensures the data is added in the right order, avoiding duplicate entries and all participants have the latest version

- A new block of data joins the existing block to form a chain and it is secured using a hash, a cryptograph that makes an unbreakable link between blocks, it becomes permanent and unalterable.

Data can be freely exchanged without compromising privacy and data security; by ensuring sensitive data is only shared with parties that have a need to see it in each instance. This provides a faster, safer way to verify key information and establish trust.

Smart Contract

A smart contract (intelligent contract software) is a contract written in computer code describing a transaction step by step. The block is linked to a smart contract that automatically triggers transactions when a specific predefined condition on a blockchain are met. A smart contract is a self-executing agreement where the terms between buyer and seller are directly written into the code itself, these mechanisms are unalterable, almost impossible to hack, and helps guarantee that both sides to an agreement aren't ripped off. Smart contracts also allow for more complex transactions to be carried out between two anonymous parties without the need for a central authority, enforcement system, or legal guidance.

Essentially, this means that smart contracts can be programmed to enable a wide variety of actions.Smart Contract Application in Insurance Blockchain (digital ledgers and transactions) and smart contract concepts can be applied to insurance policies.

An insurer can use smart contracts to facilitate the terms of a Policy. Every aspect of the policy will be recorded in the smart contract. The policy holder will review the terms and agree to the contract. As long as the policy holder continues to meet the terms, such as paying their

Why Blockchain?

Distributed Ledger technologies have the potential to be a key game changer in the insurance industry. Moving transactions onto a secured shared ledger, significantly transforms and streamlines business processes and systems and have a huge impact on a transparency, stability and efficiency and is a huge step forward for the industry.

Each customer data is increasing exponentially from multiple policies per customer and also fuelled by Internet of Things. Blockchain technology assists with combining and sharing data obtained from different sources and make it easy to access and control also ensuring sensitive data is only shared with parties that have a need to see it. Blockchain technology enables data to be captured from various sources and updated/ validated by multiple participants at the same time without altering existing data. The up-to-date and secured data is also accessible seamlessly by all the users in the blockchain network.

Enables Fraud Detection and Prevention

A blockchain process is transparent, maintains a centralised database and takes consensus from all the parties. When each transaction has been logged in a blockchain network within or across organisations, instantly, an insurance company is able to verify the authenticity of a customer, policy or claim and identify fraudulent cases such as multiple claims from a single incident.

Boosts Operational Efficiency across the Insurance Value Chain

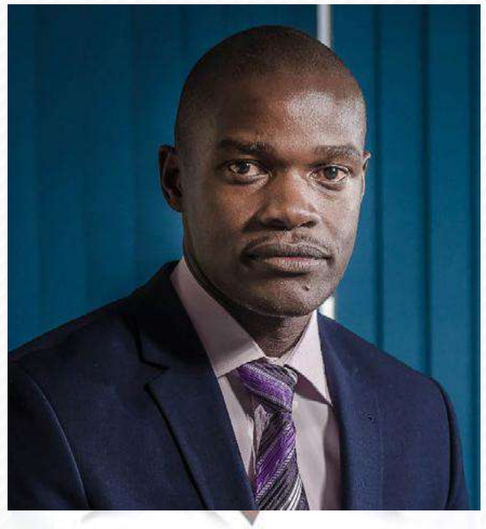
Quick data access in a shared ledger enables automatic policy execution, since there is less burden on gathering, reconciling and submitting documents. Consider, for example, a re-insurer, insurer and broker consolidating their policy data and storing it on a distributed ledger cryptographically.
The underwriting and application process could have significant efficiency gains for the insured and the insurer, reducing the processing time to near real-time. Real-time data processing enables automatic initiation of claims by smart contracts reduce cost and increase operational efficiency by eliminating the role of third-parties and enhances customer experience due to faster claims processing during customer distress.

Blockchain has numerous use cases in a wide variety of industries, including finance, energy, supply chain management, health, data storage and more. Despite this, adoption will not happen overnight, however, trends are already emerging. While the time factor must be kept in mind, lack of knowledge, setup costs, scalability, absence of regulation, resistance to change are some of the challenges that need to be solved before we can see blockchain adopted at a mainstream level. Given the current technological advancements, the revolution will entail a convergence of technologies; blockchain, artificial intelligence and the internet-of-things.

The core benefits of blockchain technology are being explored across the global insurance industry, with example collaborative initiatives from the Blockchain Insurance Industry Initiative - B3i; RiskBlock Alliance; Blockchain advisory council (formed by LIMRA). Insurance stakeholders need to collaborate and position themselves to take advantage of the numerous opportunities and further efficiencies that blockchain and its convergence with other new technologies will deliver over the coming years.

RISK TRANSFERENCE; Enables Seamless Data Sharing
The function of cyber insurance

Cyber risk is now much more than a data breach and the nature/sophistication of potentially catastrophic cyber-attacks keeps evolving.



By Musa Wetsusa

Digital technology in today's increasingly interconnected world is forging perilous new threats to businesses everywhere. Rapidly emerging innovations unleash not only exciting new levels of communication, automation, mobility and convenience but also unprecedented potential for cyber-related disaster.

Businesses of all sizes are struggling to identify, assess and respond to an explosion of digital threats and targeted cyber-attacks that could paralyse their operations at any moment. From tangible assets such as property to intangible assets that include intellectual property (IP), customer data and reputation, organisations in every sector are becoming dangerously exposed to an array of emerging cyber risks. Financial services and retail businesses, for example, are already a focus of organised cybercrime, while ransomware and distributed denial-of-service attacks are increasingly being used against organisations in industries such as healthcare, media and entertainment. Public sector and telecommunications businesses, meanwhile, are considered highly susceptible to espionage or terrorism-related cyber-attacks.

Digital technology has also opened the door to business system failures that can inflict massive physical damage, accidents and theft. As organisations are quickly learning—sometimes at high costs—cyber risk is now much more than a data breach and the nature and sophistication of potentially catastrophic cyber-attacks keeps evolving.

As a region, we are quite exposed and early adopters of cyber security mitigation measures will do well in the face of inherent risks of attack. The insurance industry, for example, is a data-driven industry that relies heavily on data analytics for business efficiency. This makes it a very lucrative target for cyber criminals since data is even more valuable now in the underworld than it was previously. This is compounded by the fact that insurance companies transact large amounts of money on their day-to-day operations in insurance claims and premiums.

Previously, these companies were not so much awake to the fact that they could be indeed, targets by cybercriminals. As such, insurance companies had not implemented controls to prevent against cyber-attacks and even if they were implemented, they were not measured for effectiveness in a bid to combat cyber-crime. However, this has changed drastically in the past few years with more insurance companies' top management acknowledging cyber risks and allocating budgets for implementation of corrective actions for information security risks. Among key measures adopted by insurance companies to curb cyber threats include:

Outsourcing of Managed Security Services:
In cases where the companies had not budgeted for information security, you can be sure that the same roles were not filled as well. Therefore, it only makes sense to outsource the full function of information security to a company with the skills and resources to provide the required visibility of cyber threats.

Implementation of SIEM (security information and event management) : 24/7 monitoring of logs from the key jewels of the organisation such as databases, perimeter and internal network devices, critical core banking systems and ERP, just to mention a few, is paramount in ensuring protection of information systems against fraud.

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Strengthening of the Information Management System: Insurance companies have sought out the expertise of both internal and external auditors to help assess the validity, effectiveness and efficiency of their Information Security Management System. This has seen an improvement in controls such as password policies, acceptable use of assets, segregation of duties and logical access controls, among others.

But still, with all these controls in place, there is still probability that cyber-attacks may occur that could lead to data loss, financial losses and fines from regulators among others.

So what is the next frontier in cyber risk mitigation?

Cyber risk insurance, commonly referred to as cyber liability insurance coverage (CLIC), is a product aimed at helping organisations recover from a cyber-attack by offsetting the cost involved in the process. Emerging in 2005, the errors and omissions (E&O) insurance slowly gave birth to cyber insurance which targets omissions in companies operating automated business models via information technology. It covers expenses that are related to first parties as well as claims by third parties and the common reimbursable expenses are:

- Forensics investigations following a breach.
- Business losses incurred from an event such as repairing reputation damage, monetary losses, data loss recovery and costs incurred in managing a crisis.
- Privacy and notification whereby the company has to inform customers of a data breach, and monitoring of accounts that may have been compromised.
- Lawsuits and extortion. These could emerge from legal expenses associated with data loss and also blackmail from cyber attackers from such situations as ransomware attacks.
- This product is applicable to any organisation that has the probability to suffer a cyber-attack as well as third parties that have been contracted to offer managed security services. It is a great opportunity for insurance companies to venture into since it will be inevitable sooner or later.

The product is being offered by several reinsurers in the country and this is expected to rise in the coming months since its relevance is being noticed the world over. The risk remains very much top-of-mind and the need for vigilance remains high. Cyber insurance is an important way for CEOs to protect their organisations. The insurance industry is at the threshold of a major shift that poses real challenges, but the payoff promises to be significant for insurers willing to rethink strategies and offerings for the digital age.

Public sector and telecommunications businesses, meanwhile, are considered highly susceptible to espionage or terrorism-related cyber-attacks.

The Writer is the Managing Director, Sentinel Africa Consulting

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DIGITAL TRANSFORMATION;
A survey findings

Modernising applications and infrastructure can be a long and expensive process, but moving to the cloud can enable that to happen quickly

By Stanley M. Chege

When considering expectations for return on investment (ROI) the results were a bit surprising.

Business owners and IT leaders are pursuing digital transformation to drive business performance. A new survey from Webtorials highlights how businesses understand the importance of digital transformation, but several barriers are hindering adoption (CIO, 2019). Digital transformation is a hot topic among chief information officers (CIOs) and business leaders, as those companies that become digital organisations will become market leaders. And those that don't make the shift, will struggle to survive.

The study confirms how important digital transformation is today, with 78 per cent of the respondents agreeing that if their industry is changing, digital transformation is needed for survival. The important message is, "needed for survival". Managers should not view digital transformation as something to help a business keep up with the Joneses; it is now life or death for many companies. Here are the findings:

Long-term value preferred over short-term gains.

- When considering expectations for return on investment (ROI) the results were a bit surprising. The lion's share of the respondents (61 per cent) said the ROI is long-term and strategic rather than based on short-term results. That leaves only 39 per cent trying to get a quick payback on their digital transformation investments.

- Those wanting a quick payback are looking at digital transformation the wrong way. It is not about a quick-hit project here and there. Instead, digital transformation is a cultural shift based on sustained long-term market leadership, so it was good to see the bulk of respondents sharing that opinion.

Improving customer experience the top digital initiative

The study also touched on what benefits respondents are looking for. The top response: Enhanced customer experience, which should not be a surprise because improving customer experience is top of mind with most executives.

Businesses need to focus on customer experience now or fall behind the competition. An interesting proof point to this comes from ZK Research, which found that in 2018, two-thirds of millennials switched away from a brand because of a bad experience.

Digital initiatives should revolve around customer experience, and the survey certainly supported that.

The next three benefits to digital transformation were close enough in percentage terms. They are: Remaining competitive, streamlining business process and enabling new business models. The response "remaining competitive" seems a bit vague. It is about using digital technology to catch up to peers, whereas new processes would refer to getting a step up on the

It is good to see business and IT leaders focusing on improving the business instead of stagnating the business by trying to suck cost out of it.

- Top areas of technology investment; cloud, security, and analytics

An interesting aspect of the survey results is what businesses would invest in to support digital transformation. Below are the top five projected areas of IT spend:

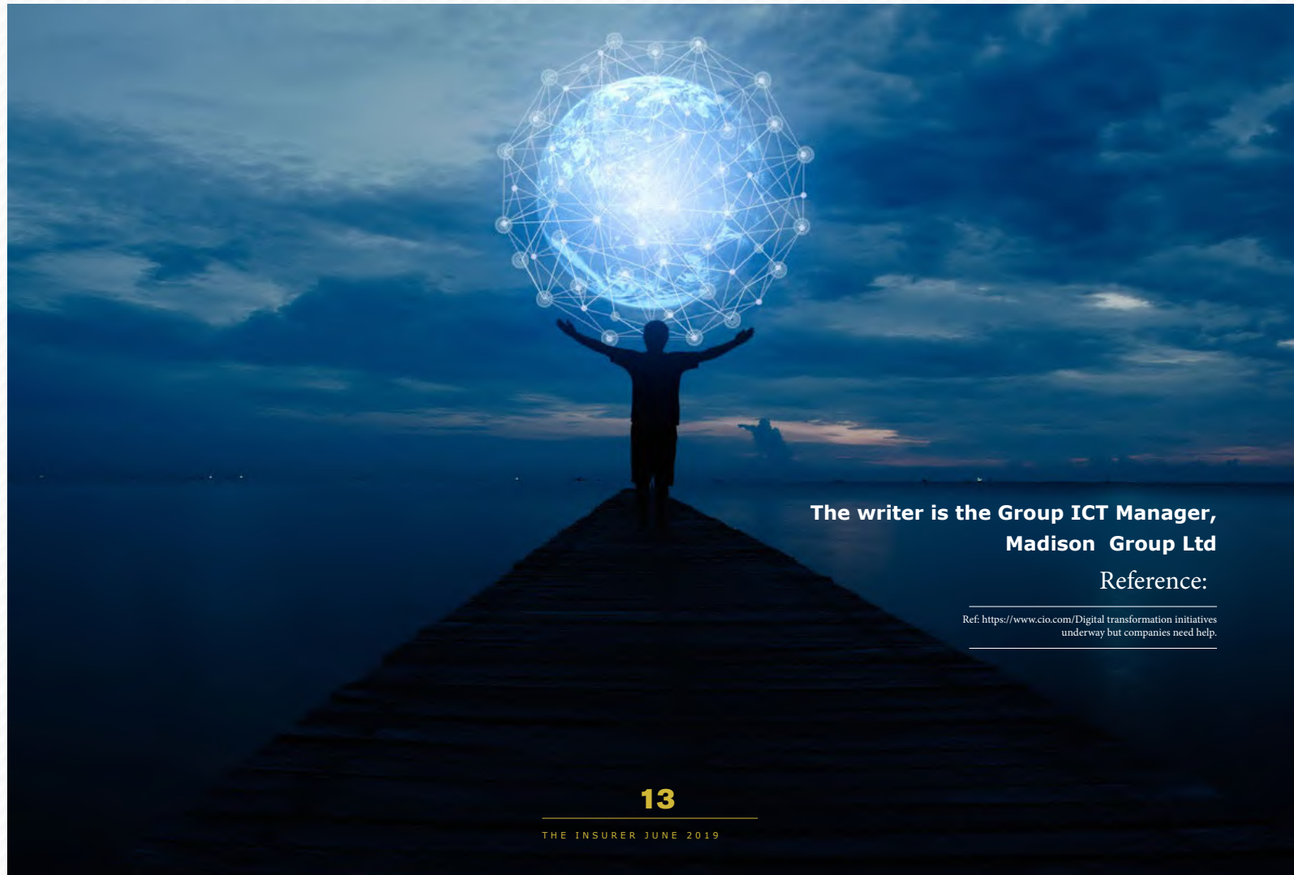
- 37% Cloud migration
- 35% Security
- 33% Data analytics/artificial intelligence (AI)
- 26% Mobility and unified communications
- 22% Emerging technologies such as IoT, virtual reality

The areas of spend are prioritised around where respondents are feeling the most pain. For example, modernising applications and infrastructure can be a long and expensive process, but moving to the cloud can enable that to happen quickly.

Security has been, and continues to be a top care-about for business and IT leaders, as every breach can cause serious legal and customer problems. Also, data analytics and AI enables companies to find insights in the massive amount of information being created today. People cannot connect the dots using manual methods, making AI-based analytics mandatory.

- Businesses need better budget commitment and executive buy-in
  The survey also looked at the challenges that hold companies back from a successful transition to digital. The top response was budget commitment followed by executive support. This is an interesting set of data points because in the early part of the survey, most respondents said digital transformation is core to survival, but this data shows it is tough to get budget and executive buy-in.

- Skills gap exists, and respondents are leaning towards smaller, agile service providers for help.
  Complicating things is the skills gap. The survey revealed that only 39 per cent of respondents feel they have the necessary in-house talent, so building the "leap of faith" plan requires a skill set that most companies do not have. An obvious choice is to seek help from an outside service provider, but attitudes are changing as to who businesses prefer to partner with. The survey found, however, that 57 per cent prefer smaller, agile service providers compared to only 43 per cent that prefer the larger incumbent carriers.
  That is because people understand that agility and speed matter, and typically big, established service providers do not move fast enough, which holds customers back.



The writer is the Group ICT Manager, Madison Group Ltd

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FINANCIAL LITERACY IN PHASES;
How insurance enhances financial security

Savings and investments on assets should have adequate all-risk insurance to ensure continuity through uninterrupted benefits

By Patrick Wameyo

A life-phase based approach to financial planning introduces key choices that an individual will need to take along the natural path or course of life, which can both be dramatic and unpredictable.

Recently, I attended a financial literacy breakfast session facilitated by Sharon Letcher, the co-author of the financial literacy hand book Rich Dad Poor Dad and founder of Pay Your Family First. One of the key messages that she explored was that money is a very powerful tool. She demonstrated to us how money when used well could make you rich, and when not used well, it could make you very poor.

The lady also offered a six-step wealth generation formula that assures financial security. She advised us that by; "…combining our passion with our talent and then seeking the right association and taking the right action are the key steps to success. When you combine all these components with a strong faith and a mission that you will truly have personal success."

I spent my early career years in banking, where I encountered many owners of large, small and medium size businesses looking for funding to grow or expand their businesses. I also met a few—a rare breed of such business owners—who had no need for a banks' money. Today, I meet many budding entrepreneurs looking for cash to turn their brilliant ideas into thriving enterprises: A common denominator among all these three groups of business owners, and employees is to improve the quality of their lives. They have a common interest to generate income that is eventually invested to generate other income.

I can confirm that during the course of both my banking and financial planning careers I have encountered many examples of people who have made and kept real money, and as well as those who lost it all. Why would one know how to make and not know how to keep money?

The life phases planning approach is fashioned around the phases a typical path of a person's course of life from birth to post-retirement. Each phase covers approximately seven years, starting at zero (birth year) to seven years, and subsequently every seven years. The years before, at and after the end of each phase are characterised by psychological transition underpinned by a biological clock related hormonal change and response through behaviour change. The social choices of the individual at each of these stages have long term implications on the economic stability and by extension their financial security, whether they know it or not. As is with all matters of the clock, time is a key determinant of the economic value of the choices. The first three phases of life covering ages between zero to 21 years (0-7, 8-15 and 16 – 21) is predominantly the sum of parent influence as the young person has not become economically responsible especially in Kenya. In modern societies, parents take on education insurance for children's education and life policy-based investments for their retirement period. These parental choices for the benefit of the child impact their future choices where they were involved.

Usually the parents also acquire property through mortgages and other options and require credit life insurance to cover them for various insurable risks to safeguard the assets and associated income lines. Failure on the part of parents to engage in savings, investment and associated insurance schemes during this phase would typically expose the children to economic difficulties when parents either lose their sources of income or pass away without handing down substantial endowment. A few parents take on investments that produce regular stable incomes such as rent, dividends and or interest from income funds to cater for education needs. Such investments require large capital outlay and would typically be backed by strong savings culture and access to credit for leverage.

As the young adult enters into fourth life phase, between ages 22 and 29 years and subsequently mid-career ages between 30 and 49 years, they begin to take on increasing levels of social and economic choices. Whether they leverage on the parental actions taken in the earlier phases, or start from a zero base, developing an authentic long-term financial plan with timed milestones is the first critical step to financial security. The plan should outline milestones for savings and investment over a ten to twenty years period, as well as a risk management plan for reducing risk of loss by insurable events. It should also mitigate the effects of damage caused by acts of God. Choices made, postponed or ignored altogether in this life phase have long term impact on financial security. Savings and investments on assets should have adequate all-risk insurance to ensure continuity through uninterrupted benefits of compound returns necessary for wealth accumulation.

Crossing into senior citizenship, the last three phases starting at age 50 to 56 and ending with 71 years introduce new set of issues. Initial phases are characterized by wealth consolidation, where upon the now mature adult reorganises resources freed up by declining school fees and children maintenance costs. The investor risk profile now reduces significantly as retirement age approaches. A focus for asset safety, stability of rates of return and cash flow replace aggressive growth of earlier phases.

Old age diseases spike medical and other age-based expenses. Upon retirement 'de-accumulation' starts. Assets producing income must be maintained under all-risk insurance to sustain the stability of income and curtail any form of avoidable disruption. Throughout all the phases, medical insurance is necessary and helps to improve the length of useful life.

I will attempt to respond to this puzzle by following a life phase-based approach to financial planning. I must however begin with a warning note, a necessary basis for mutual understanding. A life-phase based approach to financial planning introduces key choices that an individual will need to take along the natural path or course of life, which can both be dramatic and unpredictable. I will limit myself to social-economic choices with economic impact and time period between the first birthday and the seventieth birthday.

Whether you are in business or employment, every shilling you make requires protection: Insure it.

The writer is a Financial Literacy coach, the founding director of Financial Academy & Technologies and The Entrepreneurship Centre (EA).

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GLOBAL TRENDS;
In the insurance market

With time always a scarce resource, the insurance industry is transitioning into the more virtual and flexible workforce of the future.

By Christine Gitachu-Mungai

Regardless of firm size, insurance companies are increasing their research and development budgets to design insurance packages that come with minimal premiums yet provide maximum returns.

The insurance industry has experienced rapid changes in recent years as a result of evolving trends: The current and new entrants into the industry are striving to provide innovative products, technological changes as well as influence of consumer behaviour to secure their position. More than ever before, it is emergent that the insurance industry has transitioned from being a service into a commodity. There are reasons for this conceptual paradigm shift.

Amongst the leading causes for this—and which continues to influence the global trending parameters within the same—is the aspect that the provision of low pricing is increasingly perceived as a crucial component, with risk optimisation being more of an obsession. Efficient service delivery—which ensures that the customer is kept happy at all times—has become a key focus in the insurance market and huge investments are being made by insurers so as to keep up pace with the changing needs and behaviour of customers.

There is no doubt that the global insurance industry has been undergoing massive changes in the last couple of years. With the increased emphasis on aspects such as customised insurance plans and heightened levels of competition, then it is times such as these that warrant the investment into insurance products that meet the needs of customers. Regardless of firm size, insurance companies are increasing their research and development budgets to design insurance packages that come with minimal premiums yet provide maximum returns. As at 2018, the automobile insurance industry for example had well reached the $200 billion threshold globally, bringing around a game changer which highlighted the fact that only insurance organisations that are truly customer-centric would survive the onslaught of any trend changes—especially amongst tech-savvy automobile owners.

With a trend into usage-based insurance (UBI), the insurance industry will ultimately see many players change their product offering to meet this changed customer behaviour. A key feature of UBI is that insurance providers will be able to keep tabs on behaviours of customers and evaluate the inherent risks policy holders pose while also being able to accurately calculate premium rates in accordance with this data. One key feature of UBI is that insurance plans will be able to track usage patterns of components that have been insured via the use of mobile applications and sensors towards the enablement of discounts provision to users who manage their risks well. It is therefore anticipated that UBI will be able to attract the attention of not only the established insurance firms, but of smaller and start-up insurance firms.

The rise of artificial intelligence (AI) for behavioural premium pricing has also gradually found its way as an emerging trend in the insurance industry. AI is seen as a game changer not only in the insurance sector, but across every other service industry. Improving customer experiences as well as expediting claims processes remain key service delivery points for insurance firms especially with the heightened popularity of messaging platforms, AI and machine learning (ML). All these have brought about the rise of chatbots development for a wide range of insurance and general business needs.

Chatbots have today become an integral component of many business initiatives that have at their core digital customer experiences and business modernisation. If global estimates are anything to go by, chatbots are predicted to generate global savings that are in excess of $8 billion by 2022, while being able to provide for insurance firms decreased processing timelines, round the clock customer service, straight through processing and expedited resolution times that are all geared towards increased client satisfaction.

The growing trend in the use of chatbots however needs to be treated with some caution because when chatbot interactions become non-conversational, inferior to interpersonal interactions or become too mechanical, the very essence of the initiative could potentially lead to business losses. Insurance firms therefore would need to vigilantly plan and execute such systems if they are to overcome the tactical and strategic challenges.

Ultimately, the last decade has seen an internet of things (IOT) trend that has greatly influenced the global insurance industry. For example, in the last couple of years, about seven per cent of the total auto manufacturing industry has joined the bandwagon of the IOT technology trend in the formulation of seamless connectivity and in-built safety features in vehicles. Professionals in the auto insurance industry anticipate that there will be an increase in auto manufacturers who will desire to fall in line with this trend and manufacture vehicles with the capability of communicating with each other and with the ultimate hope that accidents and road fatalities would be reduced or altogether eradicated in the future. Vehicles fitted with the IOT technology will also additionally be deemed to assist auto insurance providers in the collation of driving habits as well as other car owner details, and in effect simplifying the process of calculating auto insurance premiums and in the evaluation of risks.

Finally, beyond technology, the global insurance industry is also in stride in putting in place processes aimed at responding to fundamental shifts in employment as more insurance professionals join the abundant talent economy.

With time always a scarce resource, the insurance industry is transitioning into the more virtual and flexible workforce of the future. The goal herein will be the creation of exponential insurance professionals who are augmented by emergent technological trends and better poised to depart from traditional tasks and lay more focus on strategic roles that provide higher value.

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HOW INSURANCE WORKS; The basics

Insurance Companies also need insurance to be able to cover the risks they have insured; this is called Re-Insurance

By Hazel King'ori

When you buy any type of insurance, you pay a premium. This premium joins a pool of premiums from other policy holders. The money from this pool is what is used to pay your claim if the insured event occurs. The risk of an insured event is therefore spread among a large group of people. Remember: Insurance cannot prevent something bad from happening. But it helps us recover financially if something does happen to something we value.

Additional fact: Insurance Companies also need insurance to be able to cover the risks they have insured, this is called Re-Insurance and it works the same way insurance does.

What is an Insurance Policy Document?

An insurance policy document is a contract between the customer and an insurance company. It is evidence of insurance.

What is in a policy document?
It sets out the terms and conditions of the insurance. It also sets out the roles and responsibilities of the customer and the insurance company especially for when a claim arises.

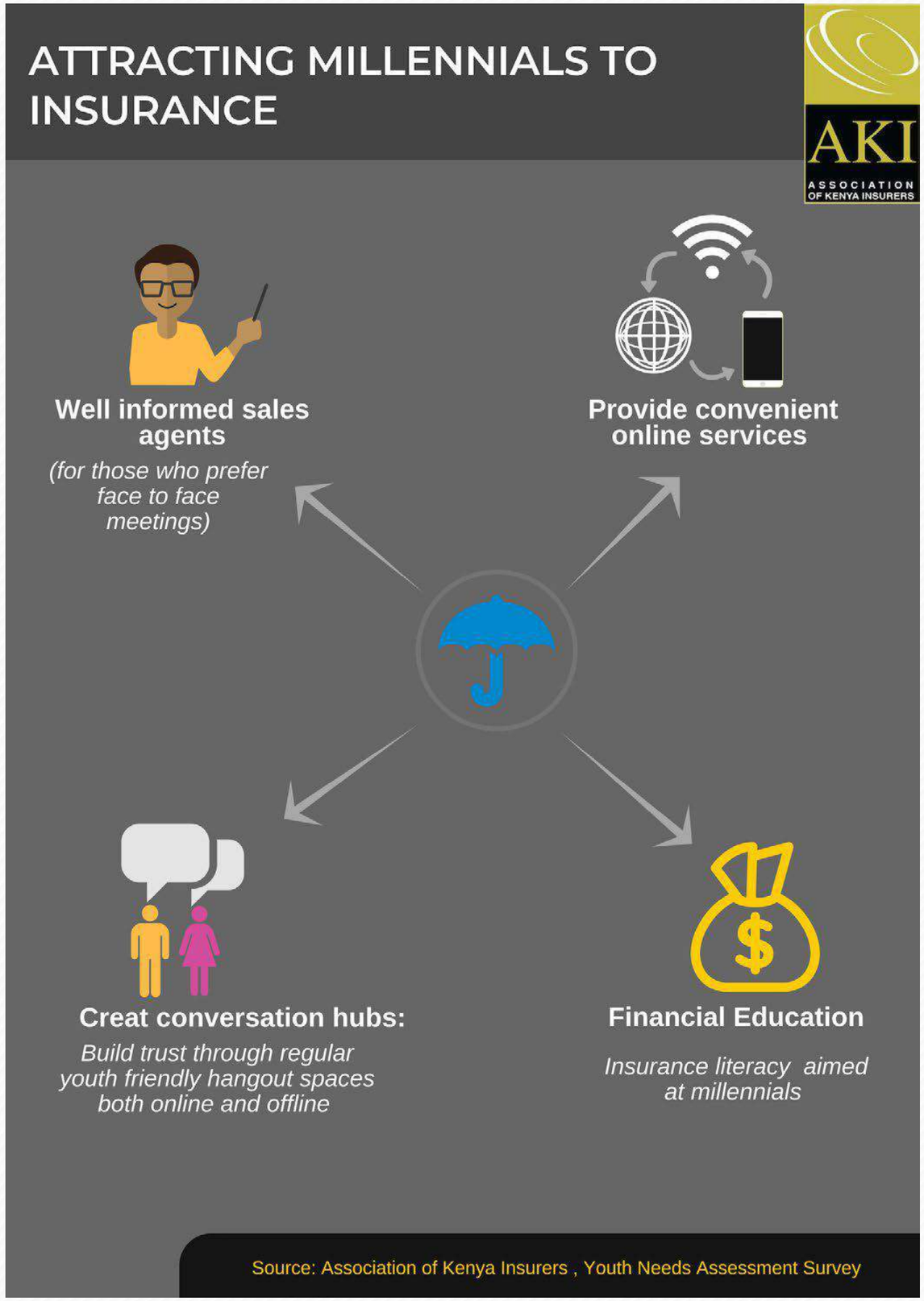
What is contained in a policy document?
The policy document is structured in various sections. It is important to understand what each section covers.
Generally, the sections address the following;

- The type of insurance; health insurance, life insurance, motor insurance
- Name and address of the insured customer and the insurance company
- Length of cover including the start date and expiry date
- Amount of premium to be paid
- The sum assured if it's life insurance
- Definitions of terms used within the policy document
- Details of what is insured; if its car insurance what exactly is covered
- What is not insured (Exclusions)
- Extensions; these are additional benefits
- Conditions of the policy; these include the responsibilities of the customer, claims process and dispute resolution among others

What especially should you read and understand?
It is important to read the exclusions and inclusions of the policy. Exclusions in an insurance policy describe conditions or types of loss that will not be covered by the policy. Knowing the exclusions of an insurance policy can help you purchase the right policy based on your insurance needs.

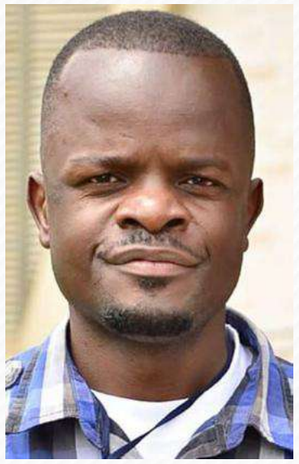
> ***The risk of an insured event is therefore spread among a large group of people.***
> ***Remember: Insurance cannot prevent something bad from happening.***

Hazel Kingóri is the Manager, PR, Research & Education at Association of Kenya Insurers



HUDUMA NAMBA; Its impact on insurance and finance

The number will combat impersonation which is the entry point of most of the fraud that inhibits banking and insurance sectors



By Morris Aron

Huduma Namba is the trending talk in town. There are diverse opinions on what the number portends, some bordering on evil scheming and others purporting it is intended to influence the 2022 polls. But when all is said and done; what is Huduma Namba and how will it impact insurance and the wider financial sector of Kenya's economy?

Huduma Namba is a centralised database for everyone living within the boundaries of Kenya. The unique number is generated by the National Integrated Identity Management System (NIIMS) and is used to save biometric, demographic and physical details of all Kenyan residents with one key agenda—for efficient Government services delivery. Essentially, the number will be the last point of verification on the authenticity of an identity; the ultimate source of truth on identity.

The 'noise' around the number stems from the fear of the general populace that having such a detailed database containing sensitive information on people is a potential serious risk if such information is not adequately protected. The government has not explained well enough how the safe keeping of the database will be carried out as there is no data protection policy in place.

Benefits of the number

To the government, the number has several advantages: A properly functioning Huduma Namba means easy access to Government services, coordinated registration of people, proper planning for Government services to allow for maximum resource utilisation, reduction in population handling operation costs and detection and prevention of fraud including terrorism among other things.

To insurance and the finance sector, the number brings efficiency of service delivery in the public service as all private entities must at one time or another deal with the government. It is easy to see why the immediate benefit of Huduma Namba will be elimination or significant reduction in fraud and crime.
This is because the number will eliminate cases of identity theft and forgeries which form the foundation of most fraud and crime.

For an insurance firm and the same for a financial establishment, a reduction in claims or any other form of fraud as a result of impersonation will mean significant savings on compensation and a boost in earnings. For banks and other establishments—which have been grappling with sophisticated forms of theft and losing millions of shillings due to impersonation—a Huduma Namba will be a significant step in addressing the issue. This is because cases of identity duplication or impersonation will have been dealt a significant blow. The number will combat impersonation and most if not all the ills that come with it.

The government has not explained well enough how the safe keeping of the database will be carried out as there is no data protection policy in place.

Huduma NAMBA
Kwa Huduma Bora

Impersonation is the entry point of most of the fraud that happens in banking and insurance sectors since the advent of mobile banking and smart cards.

Efficiency in service delivery

Once Hunduma Namba is operational, personal details stored at NIIMS will be linked and relayed in real time to other Government agencies including the Lands Registry, National Social Security Fund, law enforcement agencies, National Hospital Insurance Fund, Kenya Revenue Authority, financial agencies, immigrations, National Transport and Safety Authority, Independent Electoral and Electoral and Boundaries Commission and universities among other databases. This will significantly reduce the time period for verification and processing of requests.

A good portion of day-to-day operations in insurance and banking sectors involve verification of identity and authenticity. With Huduma Namba as the ultimate truth, the process of verification and authentication will have been made easier and faster. Processes such as opening an account, verifying a claim or authenticating a document will take shorter than they do today once the number is operational.

Innovation

Like any new technology, Huduma Namba presents a new frontier of possibilities. Given the identity assurance that it brings, insurance and finance firms can innovate on new products and services based on the surety. The innovations can include new insurance policies and new savings schemes among others. Already, an international smartcard operator has taken the advantage of the platform—although they say they are not related to the Huduma Namba initiative—by launching a Card in collaboration with a number of leading banks: The card enables an individual to make and receive social payments safely, conveniently and without cash in store, online, by phone anywhere the card is accepted worldwide.

Big Data

In the present world, big data is everything. Big data guides strategy and operations. Huduma Namba database provides a vital source of data that if used by those in the finance and insurance sectors will lead to better ways of making sales, serving customers better, innovating products and so on.

All in all, the key to any success of Huduma Namba in the finance and insurance sectors lies in the ability to have a proper functioning portal and a working data protection policy.

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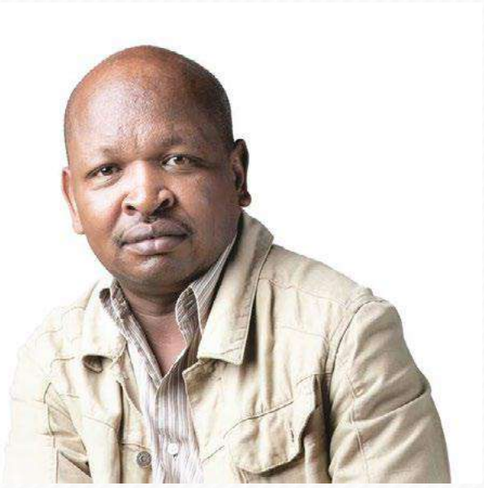
CHECKING INSIDER THREATS;
The need for inclusivity

Insiders can do serious harm to an enterprise, including suspension of operations, loss of intellectual property, reputational harm, plummeting investor/customer confidence



By Aram Kaboro

Whenever an employee shows signs of "going rogue," advanced analytic tools can be collected and shared with an analyst to determine what is driving his/her behaviour; when an employee starts downloading a lot of information, and their performance deteriorates besides getting to work late, it is time for an investigation.

At 6:05 p.m. on December 23, 2013, Lennon Ray Brown scanned his employee identification badge to exit his place of work. Earlier that evening, at about 6:03 p.m. Brown—after having a 'discussion' with his supervisor about his performance at work—had knowingly transmitted a code and command to 10 core Citibank Global Control Center routers that erased the running configuration files in nine of the routers, resulting in a loss of connectivity to approximately 90 per cent of all Citibank networks across North America.

On July 25, 2016, Brown—who worked at Citibank Regents Campus in Irving, Texas, and was responsible for the bank's IT systems—was sentenced to 21 months in federal prison and ordered to pay $77,200 in restitution. During his trial, a text that he had sent to a co-worker shortly after he shut down the bank's system was read in court, "They was firing me. I just beat them to it. Nothing personal, the upper management need to see what they guys on the floor is capable of doing when they keep getting mistreated. I took one for the team. Sorry if I made my peers look bad, but sometimes it take something like what I did to wake the upper management up."(sic)

The above anecdote is a modern-day illustration of insider threat to corporate modus operandi. Locally, and specifically in this industry, cases abound of data/information misappropriation that have cost insurers dearly. Clients' confidential information has been known to find its way from corporate data bases into the wrong hands courtesy of insiders entrusted with it leading into macabre self-enrichment 'stunts'—including faking death in pursuit of Life Insurance settlements.
Insiders can do serious harm to an enterprise, including suspension of operations, loss of intellectual property, reputational harm, plummeting investor and customer confidence, and leaks of sensitive information to third parties, including the media.

The Perpetrators

Negligent Employees: Employees that may accidentally delete or modify critical information or unwittingly share sensitive information. Unintended disclosure comes in the form of posting information on public-facing websites or social media sites, sending information to the wrong party or posting proprietary data to unapproved cloud providers and applications.

Exploited Employees: These insider threats are the least frequent: But they have the potential to cause the most damage due to their insider access. Employees are exploited when an external adversary finds their way into the network with compromised user credentials. User credentials can be stolen in many ways, including phishing, malware and web-based attacks.

Malicious Insiders: These are employees with the wilful intent to deliberately steal critical company information typically for selling or profiting from the information. Cases also include sabotage of facilities, equipment and IT systems. These cases are the most challenging to identify and can cause some of the greatest harm to an organisation.

Developing an Insider Threat Program

An insider threat program should first start with a risk analysis that asks what needs protection, what a chief security officer CSO is willing to do and what he/she won't do in terms of policies, procedures and technology. Also, what groups in the organisation have access to what is deemed most vulnerable? Insurance is a customer-centric industry. An insurer's chief security officer (CSO) would thus be compelled to advise the company's customer service team that they cannot use their laptops to access personal email, use a cloud application or browse a website outside the system.
Nevertheless, this should be done with latitude: Too much security is going to impact business growth and revenue. Defined policies that are clear and easily adoptable should be created and members of staff regularly trained.

A holistic approach should be inculcated; one that includes alignment and support of all key executive stakeholders, policies and defined business processes that are aligned to establish baseline job behaviours for personnel, linkage between the enterprise's cyber security strategy and technology. The stakeholder aspect should be a collaborative effort across the C-suite and key executive stakeholders. Those stakeholders often include executives from risk, IT, HR, legal, ethics and physical security who can impact change in policy, processes, employee lifecycle events, physical and IT security controls. They are owners in protecting, preserving and enhancing an organisation's reputation. With regards to technology, there must be analytics tools to analyse items such as expense compliance, downloads, access control logs, time and attendance and more. And that is where the key stakeholders come in. CSOs must closely partner with HR because both will have access to some of the data needed.

Email software can also be employed to proactively identify anomalous behaviour/communications within the workforce. While privacy advocates may disagree, most companies monitoring their workforce are monitoring them in an anonymised fashion, meaning that there are no names associated with the alerts that come up, only an alphanumeric is generated. So how you position and communicate the monitoring is key: Be transparent about it.

People generally do not get a job to become an insider: It is a result of something happening; such as a crisis in their personal life but the bottom line in an insider threat programme is protecting the enterprise. Whenever an employee shows signs of "going rogue," advanced analytic tools can be collected and shared with an analyst to determine what is driving his/her behaviour; when an employee starts downloading a lot of information, and their performance deteriorates besides getting to work late, it is time for an investigation.
By and large insider threats focus on an employee destroying or stealing an enterprise's security practices, data and computer systems. Nevertheless, not all insider threat actors are malicious insiders. The complacent insider can include an employee who simply clicks on a phishing scam to someone who is just engaged in very poor cyber hygiene. That individual is simply engaging in the behaviour in the execution of their job that violates policy security controls and is thus opening all sorts of potential windows to external attacks. Insider threat is a people problem: They should be sensitised.

The writer is the consulting editor of this journal

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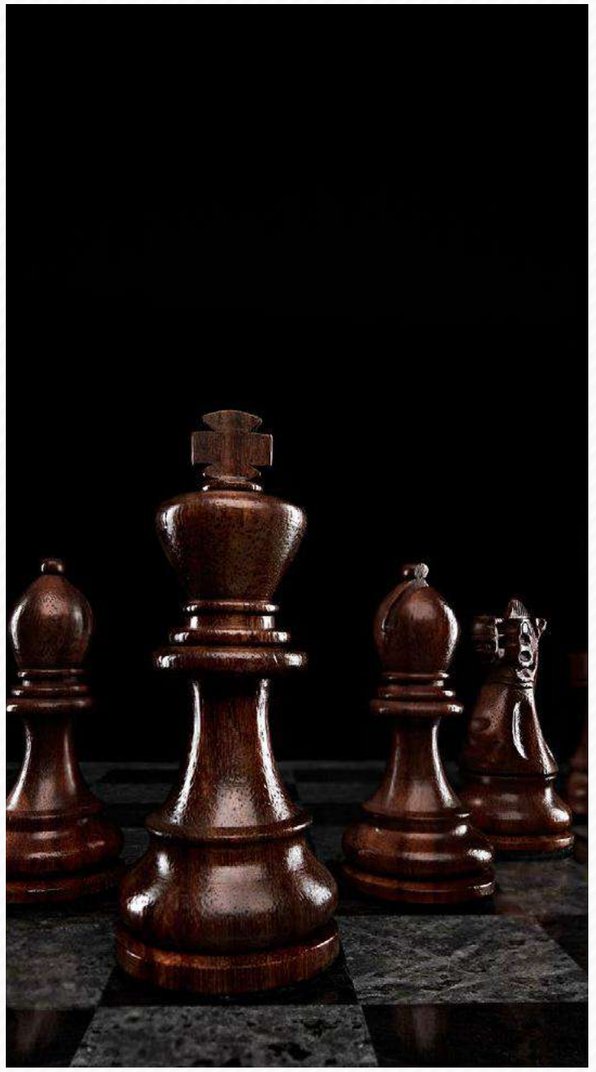

ABOUT MENTAL HEALTH;
The case for insurance

If individuals know their medical insurance covers mental and emotional health, they would seek help early enough to avert chronic states

When one suffers from depression, for instance, their ability to be productive in their work place is lowered.

By Grace Kariuki-Nderitu

Irene (not her real name) came in to see me after a friend convinced her to seek mental health counselling. During our first session, I quickly realised that she had been battling symptoms of depression for several years but had not known how to seek for help. It was not until she opened up to her friend that she had been slashing parts of her body in an attempt to cope with the emotional pain she was feeling inside. The friend, being aware of depression and its devastating effects, convinced her to seek professional help.

So, what is mental illness? Mental illness is a health condition that causes changes in thinking, emotion, and behaviour. These changes then lead to inability to function well at work, in the society as well as within one's family. Some of the severe mental illnesses include mood disorders, anxiety disorders and personality disorders.

What is depression?

Depression is a severe mental illness that negatively affects the way one feels, thinks and behaves. It is characterised by intense feelings of sadness, loss of interest, feelings of helplessness and hopelessness and in some cases suicidal ideation, attempts, and completion. Depression can be triggered by many things including genetics but it is mainly triggered by a life transition or experience that poses difficulty in coping with day-to-day living.

For many years, mental illness was seen as a moral failure or psychological/emotional weakness. Over time, the medical and psychological model of viewing mental illness have provided many advances not only to comprehensively treat but also reduce the stigma surrounding the illnesses. The medical model argues that the symptoms have a physical cause that affects the physical structure and functioning of the brain. Therefore, depression and other mental illnesses can be treated with medications. The psychological model argues that mental illnesses are triggered by biological, social and a person's inner and social experience. Both these models help to advocate for a comprehensive treatment plan that would help individuals live and cope with mental illnesses. With proper diagnosis and treatment plans, an individual with mental illness can live a productive life.

The World Health Organization champions that there is no health without mental health.

This means that mental health must be given a high priority if the goals of a healthy population will be reached. Untreated mental illness causes great losses both in revenue and socially within our communities. When one suffers from depression, for instance, their ability to be productive in their work place is lowered.

The employer losses revenue and work hours while the family and society lose income and social support from that individual. If it is a mother who is suffering from depression, she is unable to go to work, nurture her children or support her husband: When the family loses her income, the financial burden then creates a crisis for that family that could end up in a break-up. However, if insurance companies would increasingly and aggressively offer mental health cover, such a mother would quickly get help before things get to crisis levels and much would be saved in terms of revenue and social support. It is important then for insurance companies to embrace the medical model of mental health and offer the coverage that is needed so their members can get help before their lives get into crisis mode.

Irene needed at least 12 sessions to treat the depression and self-harming behaviours through talk therapy. It was expensive to pay for these sessions from her pocket. An insurance policy that covered depression and mental health would have come in real handy to help her get the treatment she so desperately needed. Many times clients with mental health illnesses are unable to complete treatment because they cannot it or are unaware that an insurance policy with this provision can pay for the treatment. Additionally, finding psychologists and therapists already panelled with Insurance companies is a challenge.

In the recent past, cases of suicide among young people—especially young men in their prime—have been on the rise. If medical cover for depression was easily accessible and symptoms of mental health conditions were widely known, some of these cases would have been averted. There is therefore a need to prioritise awareness not only of the cover but also of the symptoms within the insurance providers. It will add much more value to covered members if they knew that the same way diabetes and cancer is covered is the same way mental health conditions are covered.

Another consideration is that most of the illnesses taking people to the hospital are triggered by a mental health issue. After her husband died, Mary (not her real name) suffered many physical symptoms like gastrointestinal challenges, migraine headaches, muscle weakness, backaches and other psychosomatic symptoms. The family spent a lot of money running tests and treating these physical conditions with no relief. One day, a nurse suggested the family seek the services of a professional counsellor who was able to diagnose her with a mental health condition that had been triggered by the trauma caused by the death of her husband. If mental health awareness was more prevalent, the family would have saved much money and not to mention the emotional struggle to deal with Mary's unexplained illnesses. Her insurance cover would have provided the provision to be assessed for mental/psychological condition the moment physical symptoms were ruled out.

Insurance companies can aid in this awareness if they embrace mental health cover. They can let their members know of these mental health conditions that they cover and encourage them to use the cover to treat these conditions before they reach crisis levels. If individuals know their medical insurance covers mental and emotional health, then they will be more inclined to seek help early enough to avert chronic states of mental illness.

Insurance companies can also help to panel credentialed mental health specialists, therapists and counsellors in addition to the psychiatrists already on their panels. This would help their members find mental and emotional health treatment easily and in a timely manner.

Though the stigma of going to a counsellor still exists, once a person attends a productive session with a qualified counsellor/therapist, they find much value and are inclined to seek treatment more readily than before. Probably insurers need to train their financial advisors on mental and emotional health matters so that they can adequately share this information with potential and existing members.

The writer is Marriage and Family Therapist

SANDBOX REGULATION;

Balancing innovation and prudence

The regulatory guidelines are intended to enable innovations that are capital-market-related to be tested before being launched in the market

By Lynn Obwanda

There is a need for regulators to support innovators in the financial space to encourage economic growth.

The stringent regulations put in place after the crisis plus the increase in the development space has led to regulators having to strike a balance to accommodate the development of technology, financial stability and the protection of the consumer; the end result has been coming up with new ways to regulate the technological developments. There is a need for regulators to support innovators in the financial space to encourage economic growth. The need to strike a balance where there is a structured method of regulating innovations brought about the sandbox regulation.

A regulatory sandbox is a regulatory approach where rules and regulations are enacted by regulators which allows for the testing of innovations in a live environment: it means new products, business models or technologies can be tested against the rules provided. This creates an environment where a regulator is able to supervise an innovation up to the point it is launched out in the market.

There are principals that regulatory sandbox adhere to;

Entry test: This determines

whether a firm/ applicant is qualified to participate in the sandbox. This would include; whether the proposed innovation creates a solution to the financial industry, whether it would benefit the consumer, whether it has reached the mature development stage, whether the participants understand the laws and regulations governing their conduct and the risk management they have in place.

Scope:

- Sectorial restrictions; these differ in various countries. There are countries that restrict authorisations of institutions that would work with applicants/ firms, while other countries allow for all regulators in the financial space to be able to have applicants for the sandbox regulation.
- Target customers; the customers targeted by the applicants/participants are limited and the numbers depends on the regulations.
- Time and Size; the participants have a limited time to be in the sandbox. This creates clarity and minimises risks.

Mandatory provisions: There are minimum compliance levels for the participants in the sandbox that they have to adhere to.

Removing the privilege The regulators may remove the privilege from the participants if

- The risks to the market exceed the benefits.
- Where the participants are not complying with the regulations in place
- Where the purpose of participating in the sandbox is not being achieved.

There are certain advantages to a regulatory sandbox;

- The regulators are able to understand the innovations before they are launched and there is in-depth discussions on the same
- Increases innovations and thereafter competition which if achieves success it leads to growth of the industry.
- Regulators are able to curtail risks before they have a major effect in the market.

Disadvantages
- The risks are very high and may potentially cause instability in the market.
- Lack of standardisation
- Lack of transparency
- The level playing field is not uniform

In 2015, the United Kingdom (UK) launched its first regulatory sandbox; they realised that introducing regulatory sandbox had certain advantages for example; it reduced the time and costs of innovation, the innovators could easily be financed and a number of products, business models and services could easily be tested before introducing them to the market. By 2018 there were 20 countries that started exploring the concept.

In Kenya, regulatory sandbox is a new concept. The Capital Market Authority (CMA) is the first regulatory body to have come up with guidelines for regulatory sandbox. The regulatory sandbox guidelines are intended to enable innovations that are capital market related to be tested before they are launched in the market. In March 2019, the board of CMA approved the guidelines and the authority begun accepting applications to its regulatory sandbox.
Innovations, especially technological ones in the insurance industry have increased over time hence the term Insuretech; the term is a combination of "insurance" and "technology". Insuretechs are technology–led companies that are taking advantage of new technologies to develop innovative business models to meet the demands of the modern, digital-savvy insurance consumer.

The Insurance Regulatory Authority (IRA) is currently developing guidelines for sandbox regulations where they have relaxed certain legal and regulatory requirements for the applicants. The intention of the sandbox guidelines is to enable innovations within the insurance space to be tested in a live environment before being launched in the market. This ensures that the innovations (products, services or business models) are of quality, the consumer is protected and growth of the insurance industry. IRA has a criteria for the applicants to be able to participate in the sandbox—the innovation should have the potential to advance inclusive insurance, the applicant should have conducted legal due diligence, the innovation should be at a mature development stage, the applicant should have sufficient resources, clear business plan and exit strategy and the applicants should be fit and proper. These guidelines are in draft form and they are yet to be passed by IRA.

The regulators in the financial space need to move forward since fintech is moving from "digitisation of money" to "monetisation of data" necessitating the need for a regulatory framework. There are challenges with the sandbox regulation where the regulators are not disclosing data on the number of participants and the ones who have disclosed, the participants seemed low. This may indicate that the regulators are still very cautious in accepting participants or the participants are not meeting the threshold of the innovations. The regulators would wholly bear the risk hence they have to be cautious in allowing participants: This is because they have to seek a balance between promoting innovations, protecting consumers and market stability.

The sandbox regulatory space is still fraught with a lot of unclearness and this of course leads to uncertainty.

The regulatory sandbox guidelines are intended to enable innovations that are capital market related to be tested before they are launched in the market.

The writer is the Statutory & Legal Affairs Manager of Association of Kenya Insurers.

TREATING CUSTOMERS FAIRLY;
An update

Two years since TCF was rolled out, the industry has made good progress towards demonstrating fair treatment of customers

By Monicah Thirima

Treating Customers Fairly (TCF) is an outcome based regulatory model that seeks to ensure that specific and clearly articulated fairness outcomes for customers are delivered by regulated entities . Specifically, TCF aims to help customers fully understand the features, benefits, risks and costs of the financial products they buy, minimise the sale of unsuitable products by encouraging best practice before, during and after a sale.

TCF focuses on six fairness outcomes positioned from the perspective of customers. The outcomes are designed to provide evidence that customers are treated fairly at all stages of relationship from product design, marketing, sales and during claims and complaints handling. The fairness outcomes are summarized as follows;

Customers are confident that they are dealing with firms where TCF is central to the firm's culture.
Products and services marketed and sold are designed to meet the needs of identified customer groups.
Customers are given clear information and are kept appropriately informed before, during and after time of contracting.
Outcome 4: Where advice is given, it is suitable and takes account of the customer circumstances.
Customers are provided with products that perform as they have been led to expect and that services are of acceptable standard and in line with what they have been led to expect.
Customers do not face unreasonable post-sale barriers imposed by firms to change product, switch provider, submit a claim or make a complaint.

Delivery of the six outcomes translates to improved customer confidence, marketing of appropriate products and services including enhanced transparency and discipline.
TCF is widely practiced in the United Kingdom and South Africa. It was introduced in the insurance industry in Kenya in 2014 and anchored under section 3A of the Insurance Act. In Kenya, TCF addresses the challenges of illiteracy, information asymmetry, unfair business practices and sale of inappropriate products faced by consumers. Its adoption was a timely response to the various Consumer Rights endorsed by the Constitution of Kenya 2010 and the Consumer Protection Act 2012. The scope was informed by the TCF standards set by the International Association of Insurance Supervisors (IAIS) geared towards strengthening consumer rights.

Implementation of TCF commenced with constitution of a committee that was mandated to develop strategies for delivering on the six fairness outcomes.

The committee comprised of industry players that included,

Delivery of the six outcomes translates to improved customer confidence, marketing of appropriate products and services including enhanced transparency and discipline.

Insurers, Insurance Brokers, Reinsurers, Association of Kenya Insurers, Association of Insurance Brokers of Kenya, Association of Kenya Reinsurers, the National Treasury and College of Insurance.

The committee developed a TCF self-assessment tool, a questionnaire template, structured around each of the six fairness outcomes. The tool enabled regulated entities evaluate their TCF readiness through in-depth review of their practices and operations. Apart from self-assessment, the tool facilitated improvement on emerging TCF gaps.

Industry workshops were held to train on the six fairness outcomes with the corresponding self-assessment tool. The training targeted the Board members and Principal Officers of regulated entities, senior managers, insurance agents, insurance brokers, bancassurance and other insurance service providers. In addition, key persons responsible for TCF implementation in the regulated entities were trained. A baseline survey was conducted to determine the industry's standing on TCF before commencement of full implementation.

In January 2017, the TCF tool was rolled out for use by regulated entities. Each entity was required to continually use the tool to measure performance and set goals in order to fully deliver on the fairness outcomes. The same tool is applied by the Insurance Regulatory Authority to monitor implementation through onsite and offsite inspections.

It has been two years since the TCF was rolled out and so far, the industry has made good progress towards demonstrating fair treatment of customers. The consumer protection unit at the Authority handling complaints against insurance companies recorded decreased complaints on mis-selling of insurance products. The complaints reduced from 17per cent in 2016 to nine per cent in 2018. The reduction is attributable to the informed choices that insurance consumers make following full disclosure of information on the insurance products by the regulated entities. Products sold meet customer needs and consequently, there are less cases of cancellation of cover due to mis-selling. Customer care desks created at the insurance companies have also assisted to address customer concerns.

Insurers are keen to demonstrate fair treatment of their customers and therefore preserve evidence of representations made and advice given at the points of sale. Insurance contracts are issued within the required timelines and claims service standards are readily availed to the policyholders. Assessment and investigation reports that inform insurers decisions are shared with the insureds.

Success in implementation of TCF cannot be fully ascertained without feedback from the consumers of the insurance services. In this regard, a national TCF survey has been commissioned to assess how TCF has impacted on consumers. Outcome of the survey is expected by end of June 2019 and will inform areas of improvement.

The writer is the head, Consumer Protection at IRA

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BEATING ALL ODDS;
The determination of Karani Kinyua

At one time in his eight-month stay in the hospital bed, he was nearly operated on a wrong diagnosis

Karani atop Mount Titlis, Switzerland in a recent Top Agents Tour across various European destinations

Franklin Delano Roosevelt, often referred to by his initials FDR, was an American statesman and political leader who served as the 32nd president of the United States from 1933 until his death in 1945. A member of the Democratic Party, he won a record four presidential elections and became a central figure in world events during the first half of the 20th century. Roosevelt directed the federal government during most of the Great Depression, implementing his New Deal domestic agenda in response to the worst economic crisis in U.S. history. As a dominant leader of his party, he built the New Deal Coalition, which realigned American politics into the Fifth Party System and defined American liberalism throughout the middle third of the 20th century. His third and fourth terms were dominated by World War II.

Roosevelt is widely considered to be one of the most important figures in American history, as well as among the most influential figures of the 20th century. FDR is generally rated by scholars as one of the three greatest U.S. presidents, along with George Washington and Abraham Lincoln. FDR was a wheelchair-user the entire time he was in office: He, upon starting his political career in gusto, contracted polio while drinking water at a campground and became paralysed from the waist down. Even though it was not made public until years later that he could not walk for fear of the public doubting his competency, FDR proved paralysis was not a roadblock to being a great leader.

Closer home, and in this industry, the story of Mr. Karani Kinyua goes to prove that one can beat any odds and excel in what they set out to do.

One evening in April 2003, Karani—a top sales agent with one of the insurers in Kenya—went to bed looking forward to the next day. His career was already soaring at the age of 34, with a strong client base and enviable personal investments in various portfolios.

But his life would change forever that night; he woke up paralysed the following morning: He would spend the next eight months in hospital. He clearly remembers that fateful Monday morning when all he could lift was his right hand. He picked his phone and called a doctor friend. The doctor broke down the door and minutes later, Karani was rushed to hospital in Nairobi. All he expected to get was an injection and he would be whole again, but that was never to be.

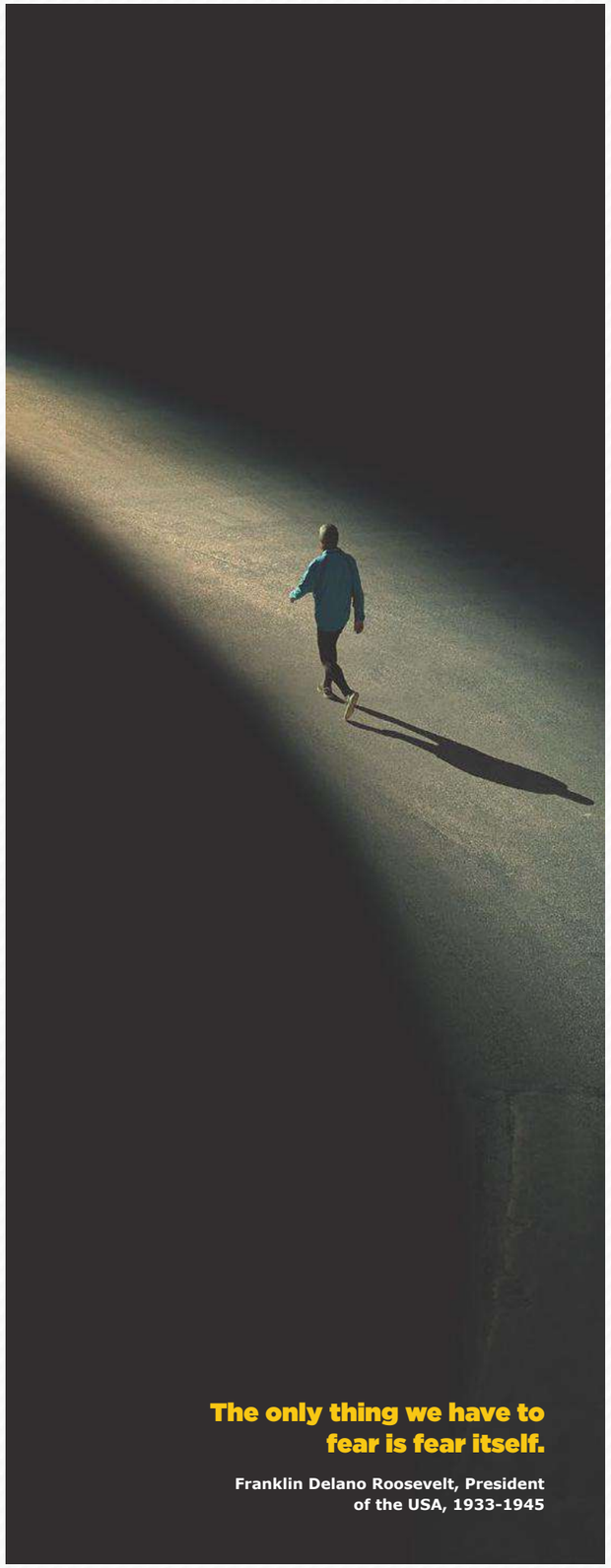
At one time in his eight-month stay in the hospital bed, he was nearly operated on a wrong diagnosis as all the numerous tests and scans to determine his ailment were in vain. A few days later, a nurse about to sign off for the day conducted tests on him and announced that he needed to be taken to the Intensive Care Unit. Karani resisted frantically, his position being that he was recuperating steadily but the nurse heard none of it. This turned out to be a life saver as his breathing was weak and he was put on support machines. He went through a series of tests with excruciating pain until the Nerve Conduction Velocity test confirmed that he had contracted the Guillain-Barre Syndrome: This is a disorder in which the body's immune system attacks part of the peripheral nervous system. He was to be confined to a wheel chair for the rest of his life. After three weeks, he was transferred to another hospital, and in unbearable pain, he relied on the nurses even for the simplest tasks like scratching an itch.

With his medical cover depleted, Karani remarkably worked from his hospital bed calling up clients and convincing them to buy insurance as his friends assisted him sign deals. Cash strapped he resolved to recuperate at home and hired two nurses, going against the doctors' directive that he remain in hospital. Karani remained bedridden for four years, surviving on commissions from the existing clients while taking medication and physiotherapy. He notes that his former employer terminated his services on his medical condition and he resigned into using his friends and associates to drop his applications in various insurance companies. This is how UAP Insurance accepted him and gave him a chance to bounce back to his status before the fateful night.

He did an annual GWP of Ksh.100 million plus in UAP Old Mutual (General, Medical & Life) in 2017 (and Year to date performance of Ksh. 60 million plus, and on course to surpass the 2017 achievement), finishing as one of the top agents, underlining his consistent performance. This has earned him various awards including several trips abroad, where he has built admirable networks.

Currently the CEO of Covernet Insurance Agency based at Kilimani in Nairobi, Karani is a role model, a living legend and inspiration to the insurance industry agents—young and old alike. "You are as disabled as you think. Nothing was going to come between me and success." he notes.

Ref: https://en.wikipedia.org/wiki/Franklin_D._Roosevelt



THE INSURER | JUNE 2019

OF SMES AND INSURANCE; the need for prioritisation

No business wants to pay for insurance that they do not need, especially when they are experiencing slow growth

A recent National Economic Survey report by the Central Bank of Kenya indicates that Small and Medium Enterprises (SMEs) contribute three per cent of the country gross development product: They constitute 98 per cent of all business in the country and create 30 per cent of the jobs annually. On the other hand, a survey by the Kenya National Bureau of Statistics indicates that approximately 400,000 micro, small and medium enterprises do not celebrate their second birthday; few reach their fifth birthday, leading to concerns of sustainability of this critical sector.

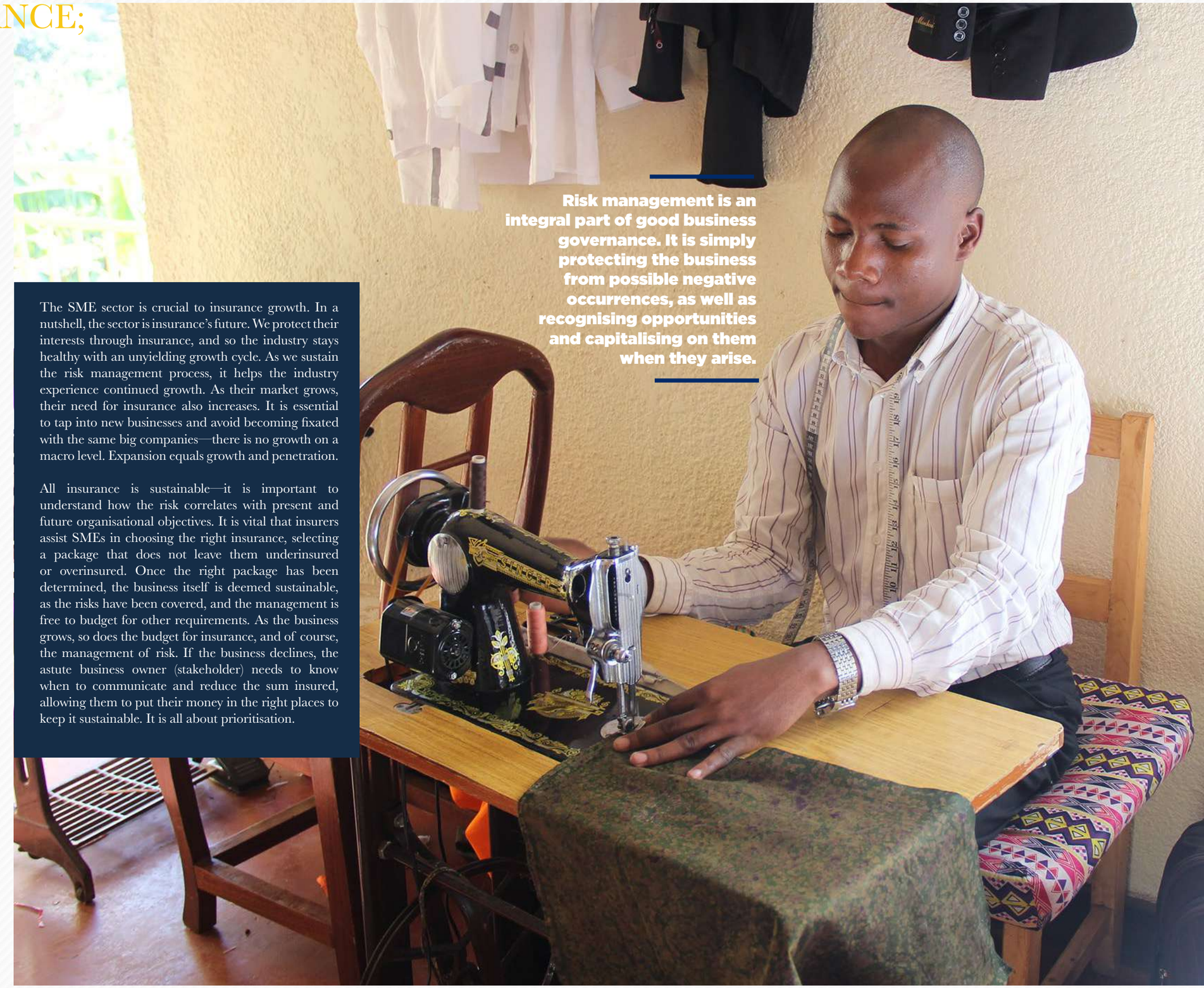
The world over, SMEs are recognised as big drivers of economic growth, innovation, regional development and job creation. A strong and vibrant SME sector provides a strong foundation to increase standards of living and to reduce poverty. Despite the internationally recognised importance of SMEs, African small businesses often have difficulties accessing financing for growth and innovation from the formal financial sector. Insurers have for long given the sector a wide berth but not anymore: In SMEs lies potential for insurance penetration and overall economic growth for emerging economies.

Insurance allows business owners to run their companies without having to worry about unexpected events that can slow them down or bring them to a complete halt. Whether it is water damage from leaking pipes, money lost in transit theft, or a fire at a warehouse, these are liabilities that cannot always be anticipated. Insurance provides the confidence to keep moving with the knowledge that assets are covered from loss and other legal liabilities.

SMEs are businesses in the private sector and they cut across all industries. The nature of risk therefore varies according to the industry in question. The onus is therefore on insurers to help the owner to identify the risk prevalent in his business and make efforts to embark on good management techniques. Risk management is an integral part of good business governance. It is simply protecting the business from possible negative occurrences, as well as recognising opportunities and capitalising on them when they arise.

The SME sector is crucial to insurance growth. In a nutshell, the sector is insurance's future. We protect their interests through insurance, and so the industry stays healthy with an unyielding growth cycle. As we sustain the risk management process, it helps the industry experience continued growth. As their market grows, their need for insurance also increases. It is essential to tap into new businesses and avoid becoming fixated with the same big companies—there is no growth on a macro level. Expansion equals growth and penetration.

All insurance is sustainable—it is important to understand how the risk correlates with present and future organisational objectives. It is vital that insurers assist SMEs in choosing the right insurance, selecting a package that does not leave them underinsured or overinsured. Once the right package has been determined, the business itself is deemed sustainable, as the risks have been covered, and the management is free to budget for other requirements. As the business grows, so does the budget for insurance, and of course, the management of risk. If the business declines, the astute business owner (stakeholder) needs to know when to communicate and reduce the sum insured, allowing them to put their money in the right places to keep it sustainable. It is all about prioritisation.



Risk management is an integral part of good business governance. It is simply protecting the business from possible negative occurrences, as well as recognising opportunities and capitalising on them when they arise.

The main challenge when dealing in SMEs is the education of insurance. This education provides the basis to differentiate between the essentials that must be covered and those items that may prove to be more luxury than necessity. As a result, penetration can increase through increased education and experience.

Customisation can also prove challenging with SMEs. These businesses come in all shapes and sizes, and there is no "one-size-fits-all" model. To accommodate this segment, we must provide packages that suit their individual needs. No business wants to pay for insurance that they do not need, especially when they are experiencing slow growth.

When it comes to penetrating the SME segment, there are many internal and external changes facing insurers as they strive to gain a competitive advantage. Among the top three are education, experience, and communication.

Education and experience are proving to be a challenge, as both are used to educate the potential client on the benefits of their coverage. Ultimately, insurance is not a luxury in business; it is a necessity. The right comprehensive plan will provide shelter during the potential storm ahead. Insurers should explain the benefits of a said plan and the risks associated with becoming underinsured: They should also customise these schemes for their client, which is imperative for the SME sector.

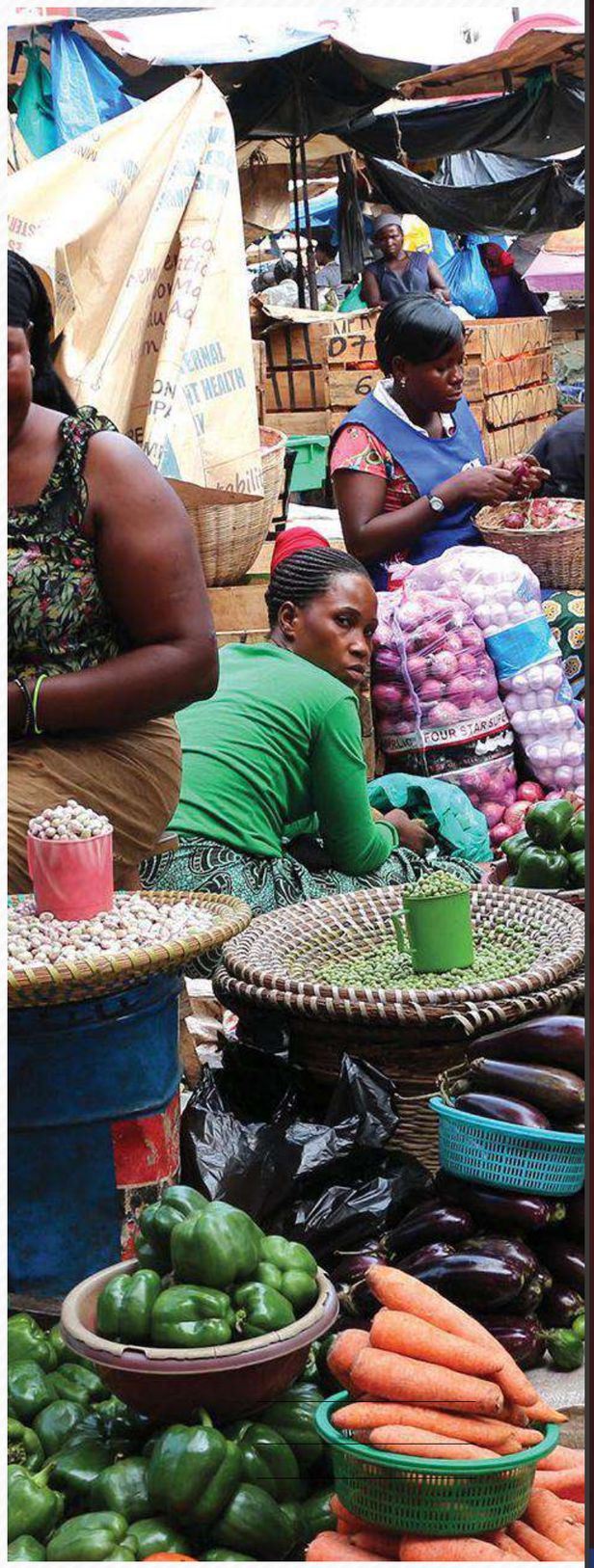
Communication is also an increasing challenge in this segment. With recent technological advances, the growing SME insurance-buying market wants to make premium payments from their phones.

Most insurance companies do not know how they want to handle mobility, and they need to determine their path forward before the client moves onto an insurer who can deliver. On the flip side of that, despite technology, insurers need to continue to communicate with their clients. If the business declines, the insurer in tandem with the client needs to know when to communicate and reduce the sum insured, allowing them to put their money in the right places to keep it sustainable.

In the beginning, money and price are unquestionably deciding factors for most SMEs. One must remember that a majority of these companies are in their infancy; they are just starting out, and every shilling counts. However, through proper advising, insurers can help them understand that the lowest price is not always in their best interest—as it may not cover their business comprehensively.

Insurers should use their industry knowledge to their advantage, educating their potential clients on the benefits of each package. In many SMEs, finance plays a critical role in formulating and implementing a sustainability strategy. The key here is value for money. You are selling an airtight policy that is a wise investment for the future of the client's business and long-term growth.

The writer is the consulting editor of this journal



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