



## ASISA GUIDELINE ON MISREPRESENTATION AND NON-DISCLOSURE

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## 1. PURPOSE OF THE GUIDELINE

- 1.1. When concluding an insurance contract, it is important in the pre-contractual stage (at the time of application and before cover is granted) to make full and honest disclosures of all material facts known to the applicant which would be relevant to the assessment of the risk, the premium to be determined and the decision to be made by the parties to conclude the contract. A statement of fact which is false or misleading, irrespective if it was deliberate, negligent or innocent amounts to misrepresentation which, if material, may affect the validity of the contract or result in certain other adverse consequences for both the customer and the insurer, such as premium loadings or exclusions. Even a non-disclosure, by way of an omission, may result in a pre-contractual misrepresentation.
- 1.2. This **Guideline on Misrepresentation and Non-Disclosure** (“**Guideline**”) has been proposed in order to provide guidance to ASISA members when dealing with misrepresentation and non-disclosure in the context of long-term insurance policies.
- 1.3. This Guideline is applicable to insurance contracts with simplified or full underwriting.
- 1.4. This Guideline is being shared with ASISA members and the public at large for their consideration and voluntary implementation and is non-binding on ASISA members. ASISA members should take their own decisions as to how they will use this Guideline.
- 1.5. Please note that the material and information contained in this Guideline is for general information use and do not constitute legal advice.

## 2. BACKGROUND

- 2.1. An insurer, especially in the case of life insurance policies, requires a disclosure of certain information and facts to enable it to appropriately assess the risk to be insured and to determine an appropriate premium against which such risk is to be insured against. Some of this information would fall within the exclusive purview of the customer (and requires disclosure). Disclosure by the customer of certain information is essential for the insurer to assess the risk and insurability of the customer. The duty of disclosure therefore requires the customer to inform the insurer, when applying for insurance cover, of any fact which the insurer would deem material to its decision to grant or decline such cover (what the insurer would deem material may be different from what the customer deems material). This duty of disclosure also enables the insurer to decide on the appropriate terms of cover, if the cover is granted, based on the customer’s individual needs and risk profile.



- 2.2. The customer's duty of disclosure operates alongside that of the insurer to obtain facts in a clear and understandable manner and ensure that the questions posed to the applicant address aspects that the insurer deems material to grant cover under the proposed terms.

## **Duty of good faith**

- 2.3. A duty of good faith is to be applied to all insurance contracts, especially in respect of pre-contractual negotiations and this attaches specific importance to the duty of disclosure. Both parties, the insurer and the customer, bear the responsibility to act in accordance with this principle and provide honest and true information in all required aspects (e.g. health, financial, lifestyle & risky hobbies, as well as occupational information). The duty to disclose extends to all facts that are material to the policy, including those facts that diminish or increase risks and impacts the premium charged. This information is vital for the issuing of the policy and to provide the best possible terms to the customer. Failure to adhere to this principle could have significant consequences, including the voidance of the policy contract, adjustment of policy terms or benefits and repudiation of claims. This duty of good faith applies at all times leading up to and throughout the duration of the contract. It is vitally important for the customer to disclose correct and adequate information in all policy applications. The customer should not rely on information disclosed on previous applications.

## **Benefits of full disclosure**

- 2.4. Full and accurate disclosure on life insurance policies benefits both the customer and the insurer. In terms of the customer, it ensures a fair underwriting process, a quicker claims experience and peace of mind, knowing that they've fulfilled their obligations.
- 2.5. Full and accurate disclosure also assists underwriters to accurately assess the risk and determine the correct premium. By providing full disclosure at application stage or where risk changes are made to the policy, the claims process is more efficient, potential delays that could arise if the customer had to provide missing information or answers questions later, can be avoided and the insurer can then focus on the merits of the claim and provide a timely decision.
- 2.6. According to the 2023 Ombudsman for Long-Term Insurance Annual Report, the Ombudsman received 110 complaints from customers regarding life insurance claims that were declined due to non-disclosure. In 2023, 14% of these complaints were resolved wholly or partially in favour of the complainant and in 2022, 21%). These figures provide an example of how important it is to inform customers about the importance of fully and truthfully disclosing their circumstances when they take out a policy.



### 3. WHAT IS MISREPRESENTATION AND NON-DISCLOSURE?

- 3.1. An insurance contract is subject to the general requirements for contractual validity, namely: consensus, legality, formalities, possibility, capacity and certainty. With specific reference to the element of consensus, parties to a contract need to reach consensus on the essential terms of the contract, failing which, the contract will be voidable. If consensus is obtained in a wrongful manner, through misrepresentation, the contract will be voidable at the discretion of the innocent party.
- 3.2. Misrepresentations made in relation to insurance can take the form of positive misrepresentations or negative misrepresentations.
  - 3.2.1. A **positive misrepresentation** occurs when the customer makes an incorrect/false statement that has to do with a material fact to the insurer. An example of this would be intentionally answering a question in the underwriting process incorrectly. To be actionable, a misrepresentation must mislead the insurer to enter into the insurance contract on the proposed terms by relying on the incorrect information.
  - 3.2.2. An omission to speak when under a legal duty to do so constitutes a misrepresentation by silence. A misrepresentation by silence is also referred to as a **non-disclosure** or **negative misrepresentation**. A negative misrepresentation occurs when the customer fails to (fully) disclose a material fact to the insurer. An example of this would be failure to disclose a medical condition known to the customer at the time of completing the proposal form for life insurance.
- 3.3. Misrepresentation can furthermore be classified as follows:

#### **Innocent misrepresentation**

- 3.3.1. This occurs when a customer makes a false statement who believes it to be true or fails to disclose a fact because the customer believes it is irrelevant or not material. Errors are made without the intent to deceive. This type of misrepresentation typically results in minimal or no prejudice to the insurer. However, an insurer who has been the victim of innocent misrepresentation can still pursue damages (monetary award as a remedy for a loss caused as a consequence of the misrepresentation), if it can be shown that the insurer suffered a loss because of the misrepresentation.
- 3.3.2. The key characteristics of innocent misrepresentation include:



- 3.3.2.1. A genuine lack of awareness or misunderstanding of the facts.
- 3.3.2.2. No intent to deceive or mislead the insurer.
- 3.3.2.3. The customer is unaware that the information provided is inaccurate.



## Examples

### Example 1:

On the application form, the customer failed to disclose the result of an abnormal test conducted many years ago. At the time, their doctor described the abnormality as minor, requiring no treatment or follow-up. The individual experienced no symptoms and was not prescribed any medication. Given the passage of time and the customer's understanding of the issue as insignificant, the customer forgot about the test and did not disclose it to the insurer.

### Example 2:

The customer disclosed a past diagnosis of a thyroid condition. When asked for the date of diagnosis, the customer provided a date that differed by one year from the medical records. The diagnosis occurred many years ago, making it difficult for the customer to recall the exact date. However, the customer accurately described the condition and had no intention to mislead the insurer.

## Negligent misrepresentation

- 3.3.3. This occurs if a customer makes a statement they believe to be true without taking reasonable care to ensure its completeness and accuracy, and the insurer relies on this incorrect information and suffers a loss as a result. Unlike innocent misrepresentation, the customer has a full understanding of the facts and should reasonably be aware of the importance of full disclosure to the insurer. Apart from denying a claim, as with deliberate misrepresentation, insurers can also pursue both damages and a rescission of the contract.
- 3.3.4. Key features of negligent misrepresentation include:
  - 3.3.4.1. The customer has knowledge of the relevant facts.
  - 3.3.4.2. The customer fails to take sufficient care in disclosing all necessary details.

- 3.3.4.3. There is no intent to deceive, but the customer's negligence results in prejudice to the insurer.
- 3.3.4.4. At the time of the misrepresentation, the customer is generally unaware that their omission may cause harm.



## Example

The life insured has been on treatment for high blood pressure for several years. During a routine visit to their general practitioner (“GP”) to collect a repeat prescription, the GP advises them to schedule an appointment with a specialist for an ECG and echocardiogram - standard tests for managing hypertension. An appointment is made, but due to scheduling constraints, it is set for six months later. In the meantime, the customer applies for insurance and discloses their hypertension. The insurer sends a hypertension questionnaire. The customer completes the questionnaire, providing details about their condition. However, in their haste, they answer “No” to the question: “*Are you awaiting any further tests or investigations?*” Based on the information provided, the underwriter assesses the hypertension as mild and well-controlled, and issues the policy, including critical illness cover. Six months later, the specialist tests (ECG + ECHO) reveal a heart valve issue and cardiac hypertrophy—both covered under the critical illness benefit. A claim is submitted. At the time of application, the life insured was unaware of these conditions and did not intend to mislead the insurer. However, their failure to disclose the pending specialist tests led the insurer to accept the risk under incorrect assumptions. Had the insurer been aware of the upcoming investigations, they would have postponed the decision until the results were available. Although the misrepresentation was not deliberate, it resulted in prejudice to the insurer due to the lack of reasonable care in completing the application.

## Deliberate/fraudulent misrepresentation

- 3.3.5. This occurs when a false representation is made verbally, in writing or by conduct, or concealment and for the purpose of deceiving, defrauding, or causing another to rely on it detrimentally, including to deliberately state information or facts in a wrongful or misleading way. Deliberate non-disclosure refers to the deliberate failure by the customer to disclose facts or information that is material to the assessment, acceptance and/or management of the risk being covered or the claim being paid out. The intent is to deceive the insurer – either to obtain a policy under terms they would not otherwise qualify for or to claim benefits under false pretences. Deliberate misrepresentation is very serious. An insurer who has been the victim of alleged deliberate misrepresentation can deny the claim and claim both rescission, which will



set the contract aside, and damages. The customer may also be subject to criminal sanctions.

3.3.6. Key features of deliberate/fraudulent misrepresentation include:

3.3.6.1. The customer has full knowledge of the facts.

3.3.6.2. The customer knowingly provides false or incomplete information that contradicts those facts.

3.3.6.3. The intent is to mislead the insurer into accepting the policy on favourable terms.

3.3.6.4. In some cases, the customer may already intend to claim against the policy based on the misrepresented facts.



## Examples

### Example 1:

Insurers ask about smoking because it significantly impacts health risks and life expectancy. Smokers face higher premiums due to increased health risks, leading some applicants to hide their smoking status to secure lower rates. If the applicant has lied about his smoking status, for example to reduce the premium, the dishonesty can result in serious consequences, including policy changes, denial of benefits, or legal repercussions.

### Example 2:

An applicant intentionally provides false information regarding his/her health status. This could include omitting to disclose pre-existing conditions, intentionally answering questions correctly or lying about a recent diagnosis, for example cancer.



## Comparison of misrepresentation

Aspect	Innocent Misrepresentation	Negligent Misrepresentation	Fraudulent Misrepresentation
<b>Definition</b>	A false statement or omission made with a genuine belief that it is true.	A false statement or omission made due to failure to exercise reasonable care.	A false statement made knowingly and with intent to deceive.
<b>Knowledge of facts</b>	Unaware that the information is incorrect or incomplete.	Knows the facts, but fails to take proper care in disclosing them.	Knows the facts and deliberately provides false information or omits information.
<b>Intent to deceive</b>	None	None	Intent to mislead the insurer.
<b>Standard of care</b>	Own belief based on own understanding.	Fails to meet the standard of reasonable care expected.	Willfully disregards the truth and ethical obligations.
<b>Awareness of misrepresentation</b>	Unaware that the information is incorrect or incomplete.	Unaware of consequences, but should reasonably have known better.	Fully aware that the information is false.
<b>Impact on insurer</b>	Usually minimal or no prejudice.	Can cause significant prejudice.	Causes serious prejudice and may result in financial loss.
<b>Legal consequences</b>	May lead to policy adjustment. Damages may be pursued.	May justify policy adjustment or cancellation of policy or claim denial. Damages may be pursued.	Claim denial, policy cancellation, and/or legal action. Damages may be pursued. Criminal sanctions may also be imposed.



## 4. POLICYHOLDER PROTECTION RULES AND THE DIDCOTT PRINCIPLE

### Policyholder Protection Rules

4.1. Misrepresentation is regulated under **Rule 21** of the **Policyholder Protection Rules** under the **Long-Term insurance Act No 52 of 1998**, as amended from time to time.

4.2. **Rules 21.1** and **21.2** provide as follows:

*“21.1 Notwithstanding anything to the contrary contained in a policy, but subject to rule 21.2 –*

- (a) the policy must not be invalidated;*
- (b) the obligation of the insurer under the policy must not be excluded or limited; and*
- (c) the obligations of the policyholder must not be increased,*

*on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless a reasonable, prudent person would consider that representation or non-disclosure as being likely to have materially affected the insurer’s ability to assess the risk under the policy concerned at the time of issue or time of any variation thereof.*

*21.2 The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view to the effect of such information on the assessment of the relevant risk.”.*

4.3. It is clear from the above that the insurer may only rely on material misrepresentation, i.e. where a reasonable, prudent person<sup>1</sup> would consider that the non-disclosed or misrepresented information should have been correctly disclosed to the insurer, in order for the insurer to correctly assess the relevant risk.

4.4. It is furthermore clear that the insurer will only be able to:

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<sup>1</sup> The Office of the Long Term Ombudsman (now part of the National Financial Ombud Scheme South Africa) has frequently stated that the “reasonable prudent person” is neither the actual applicant for insurance nor the actual insurer, but a hypothetical person standing in the shoes of the applicant, with the knowledge and appreciation that a lay person would possess of the factors an insurer would take into account in assessing the risk. The test is therefore an objective one; one is not concerned with how the particular policyholder, or insurer, regarded the medical questions and the information that should have been given in response to the questions, but with how a reasonable prudent applicant would have regarded them.



- 4.4.1. void the policy contract;
- 4.4.2. avoid/limit its contractual obligations; or
- 4.4.3. increase the policyholder's obligations

in cases of material misrepresentation.

- 4.5. **Rules 21.3 and 21.4** deal specifically with age and provides as follows:

*“21.3 If the age of a life insured under a policy has been incorrectly stated to the insurer, the policy benefits must, notwithstanding rules 21.1 and 21.2 and subject to rule 21.4, be those which would have been provided under that policy in return for the premium payable had the age been correctly stated.*

*21.4 If the nature of the policy is such as to render such arrangement as referred to in rule 21.3 inequitable, the Authority may direct the insurer to apply such different method of adjustment to the policy benefits of the policy as the Authority considers equitable in relation to the misstatement of age.”.*

- 4.6. It is a common misconception that the information misrepresented or non-disclosure by an applicant for life insurance, has to be linked to the claim event in order for the insurer to be able to rely on misrepresentation. This is not the case – the misrepresentation can relate to any questions posed to the applicant that were not answered correctly.

## **Materiality**

- 4.7. A false representation in itself is not wrongful. For the representation to be wrongful it is required to be material. The test for materiality relates to the element of wrongfulness and is objective. The criterion of the “reasonable man” is to be invoked. The duty to disclose by the customer at the time of contracting encompasses not all material facts, but only those material facts relevant to the risk. The enquiry is if the fact itself is material and based on the subjective viewpoints of the contracting parties.
- 4.8. For a misrepresentation to be deemed material, an incorrect impression is to have been created and a reasonable person in position of the insurer, against whom the misrepresentation is made, may have reacted or relied on the mistake and caused the insurer to have entered into the contract or agreed to terms thereof, which would not have occurred had the true facts / state of affairs been known.
- 4.9. If the insurer is induced to contract by the customer's misrepresentation of a fact (which is a



material fact), the insurance contract will be voidable at the instance of the insurer and a claim for damages against the customer can also be made. The insurer could additionally choose to repudiate the claim and to uphold the policy with the customer.

- 4.10. Even in the case of material misrepresentation, the assessment as to whether the material facts that were misrepresented were relevant to the risk of the insurer is important to the outcome.<sup>2</sup>
- 4.11. Proposal forms containing questionnaires are often utilised for purposes of insurance applications. The questions posed in the proposal may be indicative of the aspects and considerations which the insurer deems material to the assessment of the risk. However, there is still a duty of disclosure which vests with the customer and, in addition to answering the questions truthfully it is the customer's duty to make a full disclosure to the insurer of all material facts. It is accordingly important for insurers to assess whether the questions used comprehensively deal with the material factors.

### The Didcott principle

- 4.12. In the case of innocent or negligent misrepresentation, the policy may be reconstructed using the Didcott Principle<sup>3</sup> to what it would have been, had the insurer been properly informed. The policy terms may or may not change following the reconstruction and this is dependent on the circumstances of the case. This may translate to an additional premium that is added retrospectively. However, deliberate misrepresentation does not require reconstruction of the policy. In this instance the insurer can void the cover if the insurer can prove that the information withheld was done so knowingly and deliberately. Each insurer should have a detailed process regarding their approach to non-disclosure and misrepresentation. Each insurer should also have their own time period for verifying a customer's initial disclosures (also referred to as policy validation). However, the period should be reasonable and take into consideration the fair treatment of the customer.

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<sup>2</sup> Please see *B v Hollard Life Insurance (2014/10011) [2018] ZAGPJHC 460; [2018] 4 All SA 77(GJ) (16 April 2018)* explaining the court's view on this pre-contractual duty to disclose, which exists in respect of material facts relevant to the risk.

<sup>3</sup> The Didcott Principle is the accepted guideline in the South African market for policy reconstruction. In *Pillay v South African National Life Assurance*, Judge John Didcott applied the law (where an insurer could cancel the policy even when the withheld information would not have dissuaded the insurer from accepting the risk) but noted that the harshness of outcome will not always be fair. Didcott suggested that in certain instances of non-disclosure, it would be more equitable to 'reconstruct' the policy than to cancel it. According to what has become known as the 'Didcott principle', if the insurer would still have issued the policy, albeit at a higher premium or with an exclusion, then it would not be fair for the insurer to repudiate the claim. (Max Ebrahim, partner, Webber Wentzel)



- 4.13. Should misrepresentation be detected on a policy, the insurer should investigate this in a timely manner. The information obtained to reconstruct the policy should be factual and material and the process is to place the insurer in the position they would have been in, had the information been disclosed. Speedy resolution is essential as the outcome may have a bearing on the claim.
- 4.14. The following remedies are available in terms of the Didcott Principle:
- 4.14.1. If a higher premium would have been charged, the customer's claim is to be reduced proportionately in relation to the underpayment of the premium, alternatively the underpayment can be reclaimed with interest.
  - 4.14.2. The insurer should be able to claim from the customer an underpayment of premiums, irrespective if a claim is brought by the customer.
  - 4.14.3. If the insurer would have included an exclusion or waiting period, the customer's rights are treated as if the policy included such term.
- 4.15. In the case of innocent or negligent misrepresentation, the policy may accordingly be reconstructed using the Didcott Principle<sup>4</sup> to what it would have been, had the insurer been properly informed. The policy terms may or may not change following the reconstruction and this is dependent on the circumstances of the case. However, deliberate non-disclosure does not require reconstruction of the policy. In this instance the insurer can void the cover if the insurer can prove that the information withheld was done so knowingly and deliberately. Each insurer should have a detailed process regarding their approach to non-disclosure and misrepresentation. Each insurer should also have their own time period for verifying a customer's initial disclosures (also referred to as policy validation).
- 4.16. The information obtained to reconstruct the policy should be factual and material and the process is to place the insurer in the position they would have been in, had the information been disclosed. Speedy resolution is essential as the outcome may have a bearing on the claim.

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<sup>4</sup> The Didcott Principle is the accepted guideline in the South African market for policy reconstruction. In *Pillay v South African National Life Assurance*, Judge John Didcott applied the law (where an insurer could cancel the policy even when the withheld information would not have dissuaded the insurer from accepting the risk) but noted that the harshness of outcome will not always be fair. Didcott suggested that in certain instances of non-disclosure, it would be more equitable to 'reconstruct' the policy than to cancel it. According to what has become known as the 'Didcott principle', if the insurer would still have issued the policy, albeit at a higher premium or with an exclusion, then it would not be fair for the insurer to repudiate the claim.



## 5. FURTHER ENQUIRIES

- 5.1. An insurer cannot disregard important information which is disclosed at application stage without making further enquiries to find out what the actual position is. This is so in respect of all information, whether medical, financial or otherwise and whether the information is obtained from the applicant or other sources.



### Example

An applicant says “no” to the question whether he suffers from diabetes. He does, however, disclose that he is using the medication Glucophage (medication used for problems with blood sugar). To the question whether he has sought medical advice for any ongoing medical problems, he indicates “yes” and without giving the condition, he mentions the name of a specialist. The insurer should have followed up on the disclosed information regarding the medication and the specialist regarding the negative answer to the question whether the applicant suffers from diabetes. The Ombudsman ruled that where the insurer has been negligent in not following up on disclosed information, the Ombudsman will not uphold the insurer’s right to repudiate the policy, and cover will have to be reinstated.

*[OMBUZZ Issue Number 40 November 2018]*

## 6. CLAIMS INVESTIGATION PROCESS

- 6.1. In instances where non-disclosure or misrepresentation is suspected, insurers should conduct a thorough investigation to validate the claim, assess the accuracy of information provided at application stage, and ensure the claim aligns with the policy terms and underwriting decisions. A claims investigation process may involve several steps as outlined below:
- 6.1.1. investigating the potential misrepresentation and gathering evidence;
  - 6.1.2. determining if the claim falls within the policy terms and conditions;
  - 6.1.3. referring the claim to the underwriters to review the information received and assess whether the underwriting decision would have differed had full disclosure been made;
  - 6.1.4. assessing the policy validity and claim eligibility;
  - 6.1.5. reviewing all the information gathered and making a claims decision.
- 6.2. Despite an investigation into misrepresentation, the insurer should still ensure that it treats the customer fairly, focusing on fairness, transparency and timely resolution.



## 7. WHAT ARE THE RESPONSIBILITIES OF THE DIFFERENT PARTIES?

All parties involved play a vital role in ensuring that accurate and full disclosures are made. Some of the responsibilities of the parties are noted below:

### Insurer

- 7.1. The insurer's responsibilities include the following:
  - 7.1.1. To ask questions in a clear and understandable manner to make it easy for the customer to disclose the information accurately.
  - 7.1.2. To make it clear to the customer that he/she cannot rely on disclosures that may have been made in other applications for insurance and that he/she must answer the questions honestly and fully.
  - 7.1.3. Based on the information provided by the customer, to request further information if required, such as medical information and laboratory tests, in a clear and understandable manner.
  - 7.1.4. To act on all disclosures when they are made by the life assured
  - 7.1.5. To explain to the customer why full disclosure is important from the insurer's perspective.
  - 7.1.6. To provide the customer with information regarding the consequences of misrepresentation and non-disclosure and how this may affect the validity or agreed terms of the policy.
  - 7.1.7. To provide the policy terms and conditions to the customer in a timeous manner.
  - 7.1.8. Where required, to submit copies of the customers consent to third parties when requesting further information on which to underwrite or process a claim.
  - 7.1.9. To keep all parties concerned informed on the progress of non-disclosure investigation and the outcome of the claim.
  - 7.1.10. To inform the customer about their responsibilities as set out in this Guideline.

### Financial intermediary

- 7.2. If the customer has a financial intermediary, the responsibilities of the financial intermediary



include the following:

- 7.2.1. To assist the customer to provide correct and full disclosures and to obtain all the information required by the insurer for purposes of underwriting the policy.
- 7.2.2. To ensure that customers understand:
  - 7.2.2.1. the questions asked by the insurer so that they may answer them to the best of their ability;
  - 7.2.2.2. that questions asked should not remain unanswered as it could potentially delay the assessment of the application;
  - 7.2.2.3. the importance of honesty and the potential consequences if information is withheld or is inaccurate;
  - 7.2.2.4. that they cannot not rely on information provided in respect of other policies.
- 7.2.3. To provide the customer with information regarding the consequences of misrepresentation and non-disclosure and how this may affect the validity or agreed terms of the policy.
- 7.2.4. To facilitate the claim and ensure that all the required information is submitted to the insurer.

## **Medical practitioners**

- 7.3. Medical practitioners also have a role to play in ensuring that accurate and complete health information is provided regarding the customer. Their responsibilities include the following:
  - 7.3.1. To complete the required questionnaires or forms (with the customer's consent).
  - 7.3.2. To take care in providing accurate information as changes that are made at a later stage could be viewed with concern by the insurer and may not be accepted.
- 7.4. Forms/questionnaires should not be completed by the receptionist and merely signed by the medical practitioner.



## Customer

- 7.5. The customer's responsibilities include the following:
  - 7.5.1. To ensure they answer all questions on the application form and claim form honestly and fully, whether they deem the disclosure to be relevant/ material or not, and that they don't rely on previous information provided in respect of other policies.
  - 7.5.2. To provide contact details of their relevant healthcare providers, if requested.
  - 7.5.3. To submit the required proof (e.g. payslips, bank account details, job description, medical information and diagnostic tests).
  - 7.5.4. To read and ensure that they understand the application form and ensure that all disclosures are accurate and complete.
  - 7.5.5. To disclose status changes as required by the policy, e.g. to disclose changes in occupation and activities.
  - 7.5.6. To read and understand the policy wording (this includes any wording relating to a contractual obligation to disclose any changes in health between the policy application stage and the start date of the risk).
  - 7.5.7. To never sign a blank application form or a form completed by a third party without first checking that it is accurate.
- 7.6. It is clear that the various role players should work together to address the issue of misrepresentation and to ensure fair and equitable outcomes.



## DOCUMENT HISTORY

Date	Publication/amendment
March 2026	First published

## RESPONSIBLE SPA AND COMMITTEES

<b>Responsible Board Committee</b>	Life and Risk Board Committee
<b>Responsible Standing Committee</b>	Claims Standing Committee Medical & Underwriting Standing Committee
<b>Responsible Senior Policy Advisor</b>	ASISA Point Person to the Life and Risk Board Committee