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HKFRS 17 Insurance Contracts – Contractual service margin educational guidance

Determining coverage units and relative weighting for contracts that provide multiple services

The HKICPA, during its work on finalising HKFRS 17 *Insurance Contracts* and its amendments, noted comments from stakeholders that the identification of coverage units and determination of the amount of contractual service margin (CSM) to recognise in profit or loss is a topic involving technical complexity and judgement¹. This was notably pronounced in relation to contracts involving blends of multiple and heterogeneous services, which are present in Hong Kong.

This publication is designed to provide preparers with a summary of relevant requirements and principles in HKFRS 17², and to illustrate the potential application of those requirements to specific and simplified scenarios. In doing so, it considers two examples intended to be representative of products in the Hong Kong market that help to illustrate common challenges encountered when applying the requirements in question. The principles-based nature of the HKFRS 17 requirements means that in both examples more than one approach may be possible; in presenting the different possible approaches, commentary has been provided on certain considerations that an entity would need to take into account in order to assess whether the approach might be applicable.

Users of this guidance should note that the examples in this publication are simplified fact patterns designed for educational purposes. As such, the illustrative approaches in this publication may not necessarily be applicable to other circumstances or fact patterns. Entities should exercise judgement and carefully consider their specific contractual terms, facts, and circumstances when applying HKFRS 17. This publication does not prescribe, nor should it be interpreted as requiring, a specific approach to applying the requirements.

Scope

This publication considers the recognition of the CSM in profit or loss under HKFRS 17 for insurance contracts that provide multiple services. In particular, it focuses on the identification of coverage units and the determination of the relative weighting of the benefits provided.

¹ This feedback was noted in the Institute's response to the IASB Exposure Draft *Amendments to IFRS 17* dated 25 September 2019 (available on the Institute's website.)

² HKFRS 17 is fully aligned with IFRS 17 as issued by the IASB.

For the purposes of illustration, this publication assumes that both examples are insurance contracts without direct participation features, and that the investment services provided in Illustrative example 2 are investment-return services (and as such, that the criteria of an investment-return service in HKFRS 17 paragraph B119B are met). The provision of educational guidance on the assessment of whether an insurance contract has direct participation features or provides an investment-return service is beyond the scope of this publication. Although this publication presents examples of insurance contracts without direct participation features, the CSM recognition principles for insurance contracts with direct participation features are similar, and much of this guidance would be relevant for consideration when assessing contracts with direct participation features, which provide investment-related services (see Illustrative example 2: Fact pattern).

HKFRS 17 References

HKFRS 17 prescribes the subsequent measurement of the CSM for contracts without direct participation features in paragraph 44, which states that the carrying amount of the CSM at the start of the reporting period should be adjusted for a selection of factors to arrive at the carrying amount at the end of the reporting period. One adjusting factor is the recognition of the CSM in profit or loss as per paragraph 44(e)³:

- 44 ...
- (e) *the amount recognised as insurance revenue because of the transfer of insurance contract services in the period, determined by the allocation of the contractual service margin remaining at the end of the reporting period (before any allocation) over the current and remaining coverage period applying paragraph B119.*

The term **coverage period** is defined in Appendix A of HKFRS 17 as:

*The period during which the entity provides **insurance contract services**. This period includes the **insurance contract services** that relate to all premiums within the boundary of the insurance contract.*

The term **insurance contract services** is defined in Appendix A of HKFRS 17 as:

The following services that an entity provides to a policyholder of an insurance contract:

- (a) *coverage for an **insured event** (insurance coverage);*
- (b) *for **insurance contracts without direct participation features**, the generation of an investment return for the policyholder, if applicable (investment-return service); and*
- (c) *for **insurance contracts with direct participation features**, the management of underlying items on behalf of the **policyholder** (investment-related service).*

As directed by paragraph 44(e), paragraph B119 and its accompanying paragraph B119A provide guidance on the recognition of the CSM in profit or loss as follows:

B119 *An amount of the contractual service margin for a group of insurance contracts is recognised in profit or loss in each period to reflect the insurance contract services provided under the group of insurance contracts in that period (see paragraphs 44(e), 45(e) and 66(e)). The amount is determined by:*

³ For insurance contracts with direct participation features, equivalent guidance is located in paragraph 45(e).

- (a) *identifying the coverage units in the group. The number of coverage units in a group is the quantity of insurance contract services provided by the contracts in the group, determined by considering for each contract the quantity of the benefits provided under a contract and its expected coverage period.*
- (b) *allocating the contractual service margin at the end of the period (before recognising any amounts in profit or loss to reflect the insurance contract services provided in the period) equally to each coverage unit provided in the current period and expected to be provided in the future.*
- (c) *recognising in profit or loss the amount allocated to coverage units provided in the period.*

B119A To apply paragraph B119, the period of investment-return service or investment-related service ends at or before the date that all amounts due to current policyholders relating to those services have been paid, without considering payments to future policyholders included in the fulfilment cash flows applying paragraph B68.

As such, as noted by paragraph BC279 of the Basis of Conclusions to HKFRS 17, the CSM is recognised over the coverage period in a pattern that reflects the provision of insurance contract services as required by the contract.

Transition Resource Group for IFRS 17 observations⁴

The determination of coverage units to reflect the services provided under a group of insurance contracts was discussed in the May 2018 meeting of the Transition Resource Group for IFRS 17 (TRG). The TRG's meeting summaries are not authoritative guidance; however, they do provide an understanding of how those involved with the implementation of IFRS 17 have commented at that point in time.

The summary for that meeting explains TRG members observed that the determination of coverage units involves judgement and estimates to best achieve the principle of reflecting the services provided. The TRG also noted those judgements and estimates should be applied systematically and rationally, and the method which would best reflect the services is a matter of judgement based on facts and circumstances.

Observations made by TRG members at the May 2018 meeting in considering how to achieve the principle of reflecting the services provided are reproduced below⁵:

- (a) The period in which an entity bears insurance risk is not necessarily the same as the insurance coverage period.
- (b) Expectations of lapses of contracts are included in the determination of coverage units because they affect the expected duration of the coverage. Consistently, coverage units reflect the likelihood of insured events occurring to the extent that they affect the expected duration of coverage for contracts in the group.
- (c) Because the objective is to reflect the insurance services provided in each period, different levels of service across periods should be reflected in the determination of coverage units.

⁴ This meeting took place prior to the issuance of *Amendments to IFRS 17*, and as such, focuses on insurance coverage and not investment-return service.

⁵ From paragraph 35 of the *Summary of the Transition Resource Group for IFRS 17 Insurance Contracts meeting held on 2 May 2018* (accessible through the website of the International Accounting Standards Board).

- (d) Determining the quantity of benefits provided under a contract requires an entity to consider the benefits expected to be received by the policyholder, not the costs of providing those benefits expected to be incurred by the entity.
- (e) A policyholder benefits from the entity standing ready to meet valid claims, not just from making a claim if an insured event occurs. The quantity of benefits provided therefore relates to the amounts that can be claimed by the policyholder.
- (f) Different probabilities of an insured event occurring in different periods do not affect the benefit provided in those periods of the entity standing ready to meet valid claims for that insured event. Different probabilities of different types of insured events occurring might affect the benefit provided by the entity standing ready to meet valid claims for the different types of insured events.
- (g) IFRS 17 does not specify a particular method or methods to determine the quantity of benefits. Different methods may achieve the objective of reflecting the services provided in each period, depending on facts and circumstances.
- (h) The following methods might achieve the objective if they are reasonable proxies for the services provided under the group of insurance contracts in each period:
 - (i) A straight-line allocation over the passage of time, but reflecting the number of contracts in a group.
 - (ii) A method based on the maximum contractual cover in each period.
 - (iii) A method based on the amount the entity expects the policyholder to be able to validly claim in each period if an insured event occurs.
 - (iv) Methods based on premiums. However, premiums will not be reasonable proxies when comparing serviced across periods if they are receivable in different periods to those in which insurance services are provided, or reflect different probabilities of claims for the same type of insured event in different periods rather than different levels of service of standing ready to meet claims. Additionally, premiums will not be reasonable proxies when comparing contracts in a group if the premiums reflect different levels of profitability in contracts. The level of profitability in a contract does not affect the services provided by the contract.
 - (v) Methods based on expected cash flows. However, methods that result in no allocation of the contractual service margin to periods in which the entity is standing ready to meet valid claims do not meet the objective.

Illustrative examples

These illustrative examples assume that the group of contracts do not contain other products. If other products are included in the group, the determination of coverage units should be considered for the group of contracts as a whole by considering the services provided for each contract in the group. Also, the approaches illustrated below should not be viewed as the only possible approaches.

Illustrative example 1

Illustrative example 1: Fact pattern

Consider a medical reimbursement product with multiple insurance services where policyholders are required to choose a benefit tier (ward, semi-private or private) with the following benefit schedules:

	Item	Type of limit	Benefit limit (USD)		
			Ward	Semi-private	Private
Confinement benefits					
1	Daily room & board	Per day	100	200	400
2	Physician's visit	Per day	100	200	400
3	Specialist's fee	Per confinement	300	600	1,200
4	Miscellaneous expenses	Per confinement	1,200	2,500	4,000
5	Intensive care	Per day	600	900	1,500
Surgical benefits					
6	Surgeon's fees	Per surgery	6,000	9,000	12,000
7	Anaesthetist's fees	Per surgery	35% of surgeon's fee		
8	Operating theatre fees	Per surgery	35% of surgeon's fee		
Other benefits					
9	Emergency OP treatment	Per injury	900	1,500	2,500
10	Home nursing	Per visit	50	100	200
11	Long-term treatment	Per illness	7,500	15,000	22,500
12	Worldwide emergency assistance services	Per trip	60,000		

There is no specific annual limit or lifetime limit stated in the contract. The benefits and limits in the schedule are constant year on year. The contract is assumed to be measured under the general measurement model and all contracts are grouped into the same portfolio.

Illustrative example 1: HKFRS 17 analysis

This illustrative example raises several complexities in the application of the HKFRS 17 requirements in determining the insurance contract services provided, including:

- How to determine the amount that the policyholder benefits from when the contract does not contain one single contractual annual or lifetime limit and when the limits that do exist are based on number of occurrences?
- How to determine the relative weighting of the different benefits in the contract in determining coverage units for the contract as a whole?

Illustrative approach 1A: Voluntary disaggregation into groups of contracts which consist of homogeneous contracts

- Divide the three tiers of policyholders (ward, semi-private, private) into three different groups of contracts.
- For each group of contracts, coverage units are calculated based on the actual and projected number of contracts in-force in the group (policy count). Effectively the CSM is recognised into profit or loss based on passage of time, with adjustment for decrement (lapse or maturity of the insurance contracts) to account for the expected duration of the coverage.

Approach 1A does not explicitly calculate the quantity of benefits of contracts in each group and avoids the associated application complexities. Instead, in recognition of the constant amount of service being provided over the duration of the contract, approach 1A uses the number of policies as a proxy for the services provided in each period and will provide an allocation of the CSM to profit or loss in a straight-line over the passage of time, adjusted for the number of contracts in the group.

In taking this approach, consideration needs to be given to the time period that should be used and the level of service for the group of contracts during that time period. The appropriate time period would align with the expected coverage period coming from the full measurement of cash flows including the effect of insured events. If the benefits and limits in the contract were not constant over the duration of the contract, recognition of the CSM into profit or loss on the basis of passage of time may not be appropriate. Examples could be where the various benefits of the contract were subject to conditions that differed between benefits such as waiting periods, annual or lifetime limits and changes in the benefit level over time. Where the benefits and limits in the contract are constant over the duration of the contract, decrements in the number of policies should be allowed for to reflect expected lapses and hence a reduction in the insurance service being provided for the group of contracts as a whole.

HKFRS 17 paragraph 21 permits the further subdivision of portfolios beyond the minimum three groups described in HKFRS 17 paragraph 16 when setting the level of aggregation of insurance contracts. In dividing the insurance contracts into three separate groups of contracts based on the policyholder tier, each group will contain homogeneous insurance contracts providing the same level of service. For each category of ward, semi-private and private, the benefit levels are the same. The entity is standing ready to meet, and the policyholder can validly claim, the same level of benefits within each category. The entity is therefore providing the same level of insurance service for each contract in the group. Using a constant quantity of benefits measure for the actual and expected number of contracts in the group (e.g. policy count) will provide an allocation of the CSM into profit or loss reflecting the level of service provided in the period.

A key feature of approach 1A as a potential approach is that it requires each of the group of contracts to contain homogeneous contracts, and while voluntarily sub-dividing groups is permitted by HKFRS 17, it is not a requirement and there could be other reasons why entities may want to aggregate all these contracts into one group.

Illustrative approach 1B: Keep insurance contracts in one group, differentiate between different tiers of policyholders

Approach 1B is an extension of approach 1A. For a base tier of contracts, e.g. the ward classification, the quantity of benefits is policy count with a value of 1. The quantity of benefits for the semi-private and private insurance contracts are also policy count but scaled up relative to the difference in level of benefits compared to the base tier. For example, the quantity of benefits for each contract in the semi-private and private classification could be 1.5 and 2 respectively. Judgement would need to be applied on the scaling factor as the difference in benefits between tiers is rarely a straight multiple across all benefits. Possible approaches to determine the relative level of service between the different tiers include:

- Using total premiums as a scaling method, if the only factor affecting the premium level is the benefit level (i.e. premium is not differentiated between age groups or other risk factors), and the level of profitability is similar to all contracts and across all tiers.
- Using historical claims data to determine the distribution of claims for each tier, and inferring the relative service level between different tiers (e.g. by comparing the mean of the claims or a specific percentile of the claims).

The relative scaling factor would be applied to the calculation of coverage units in a reporting period to reflect differences in the amount of insurance service provided between contracts of differing tiers (i.e. the different "quantity of benefits" from paragraph B119(a)).

Illustrative approach 2: Calculate probable maximums of each benefit based on historical claims data

- Determine the maximum amount of claim under each benefit based on a “probable maximum” metric.
- The probable maximum could be assessed based on credible historic claims data of similar products.

TRG members observed that in determining the quantity of benefits provided under a contract, an entity should consider the benefits expected to be received by the policyholder. Given a policyholder benefits from an entity standing ready to meet valid claims, the quantity of benefits provided relates to the amounts that *can* be claimed by the policyholder. Possible methods include the use of (i) the maximum contractual cover in each period, and (ii) the amount the entity expects the policyholder to be able to validly claim in each period if an insured event occurs. The probable maximum method described in approach 2 identifies an expected maximum that a policyholder can validly claim in each period using information available to the insurer. This could be calculated as a probable maximum amount of claim for each benefit or for the contract as a whole. One possible technique to estimate the probable maximum could be to identify the tail of the claims distribution based on historical claims or pricing assumptions, and use this amount as the coverage unit of a contract in any given period. This method could reflect the different levels of cover across the benefit tiers in the group. In estimating a probable maximum based on distribution patterns, judgement would be required as to the appropriate point in the tail to be selected for use.

If the probable maximum amount is determined for each benefit, the total coverage unit can be determined by summing up these amounts. This approach would effectively be weighting the benefits in the contract in a way that excludes statistically improbable scenarios while avoiding an overall approach of incorporating probability into the determination of coverage units. Having excluded the statistically improbable scenarios, equal weighting is given to the different types of benefits (i.e. no additional weighting mechanism is incorporated). This approach of summing up all the levels of cover provided is consistent with the TRG discussions on an example of a contract with a combination of different types of cover (Example 11 in Agenda Paper 5 of the May 2018 TRG).

Proxy methods

Approaches 3 and 4 are methods which look to approximate the service patterns that would be achieved through approaches such as those above using methods which are simpler operationally. The circumstances when such proxy methods would be reasonable are discussed below.

Illustrative approach 3: Premiums as a proxy for the services provided in the contract

- Using premiums or adjusted premiums as a proxy for the quantity of benefits in the contract.

Premiums will not be a reasonable proxy for the services provided in the contract if any of the following exist:

- For an individual contract, the premiums are receivable in different periods to those in which the insurance service is being provided.
- For an individual contract, the premiums reflect different probabilities for the same type of insured event in different periods.

- For the group of contracts, the premiums reflect different levels of profitability in contracts.

If any of the above conditions exist, the premiums would need to be adjusted to remove the differentiation of premiums receivable in different periods, different probabilities for the same insured event, or different levels of profitability for the same insured event, as the case may be.

In this approach, a relative weighting of benefits within the contract is not required as the quantity of benefits is calculated for the contract as a whole.

Illustrative approach 4: Expected cash flows as a proxy for the services provided in the contract

- Using expected cash flows or adjusted expected cash flows as a proxy for the quantity of benefits in the contract.

This could be an acceptable approach if expected cash flows are a reasonable proxy for the services provided under the group of insurance contracts in each period. However, expected cash flows will not be a reasonable proxy for the services provided in the contract if any of the following exist:

- Expected cash flows reflect different probabilities of claims for the same type of insured event in different periods.
- The approach results in no allocation of the CSM to periods in which the entity is standing ready to meet valid claims.

In this approach, a relative weighting of benefits within the contract is not required as the quantity of benefits is calculated for the contract as a whole.

Illustrative example 2

Illustrative example 2: Fact pattern

Consider an investment-linked product with a blend of investment services and multiple insurance services. The base contract is a regular premium investment-linked product with flexible investment options, as well as protection from death and total permanent disability (TPD) with a fixed sum assured. The fixed sum assured depends on the amount of protection desired by the policyholder and will therefore be different between different policyholders and can take a range of values. The fixed sum assured is paid in addition to the account balance of the contract on death or TPD. The following “unit-deducting riders” (i.e. the cost of insurance of the riders are deducted from the unit balance of the contract) are attached to the base contract as optional additional insurance benefits:

1. A medical reimbursement rider – benefit schedule is the same as that in Illustrative example 1.
2. A critical illness rider that pays a fixed amount of benefit upon the diagnosis of various defined illnesses.

The base contract and the riders have the same expected coverage period.

For purposes of illustration, the contract as a whole (base and rider combined) is assumed to be measured under the general measurement model with investment-return service. Similar types of investment-linked contracts might be measured under the variable fee approach, depending on whether they meet the conditions for the scope of the variable fee approach in paragraph B101 of the standard, meaning that the contract would be considered to contain

investment-related services rather than investment-return services. While the approaches below do not address this scenario explicitly, much of the below would be relevant for consideration when assessing contracts containing investment-related services.

Illustrative example 2: HKFRS 17 analysis

This illustrative example raises several complexities in the application of the HKFRS 17 requirements in determining the insurance contract services provided:

- What is the quantity of benefits for the investment-return service?
- What is the quantity of benefits for the multiple insurance services given the large variation in maximum benefits for each contract (death benefit can vary considerably between policyholders)?
- What is the quantity of benefits for the contract as a whole, if the quantity of benefits for the investment-return service and insurance services are not comparable?

Various approaches are set out below for measuring the quantity of benefits for the investment-return service. To an extent, these are all proxies that make use of readily available data, and the considerations when these would be appropriate for use are noted for each approach.

Illustrative approach 1: Calculate quantity of benefits for the contract using maximum payment of the different contractual features

- The quantity of benefits for the insurance service and investment-return service is not separately determined. One total quantity of benefit is calculated for each contract. This approach would note that it is not a requirement or necessity to identify the quantity of benefits for different benefits and services separately in all cases and it will not be required in this illustrative example because the base contract and riders have the same expected coverage period.
- The quantity of benefits for the combined insurance service and investment-return service is based on the account balance and the maximum of the various insurance benefits included in the contract:
 - o Death benefit – based on sum assured (excludes the account balance).
 - o TPD – based on sum assured (excludes the account balance).
 - o Medical reimbursement – based on the probable maximum loss concept in approach 2 of Illustrative example 1 (note that the straight-line approach in approach 1A or 1B of Illustrative example 1 cannot be used here because contracts are not homogeneous within the same group).
 - o Critical illness – based on sum assured.
- The use of account balance here is a proxy for the benefit being provided through the investment-return service. Hence, its use here is not on grounds of principle. In using account balance, an entity would need to be satisfied that it is a reasonable reflection of the pattern of service being provided under the contract.
- In determining the relative weighting of the benefits provided by the insurance coverage and the investment-return service, the entity considers that using a measure of maximum payment for each service will already incorporate a form of weighting (e.g. weight each service by its maximum amount) and it would therefore be appropriate for the total quantity of benefits for the whole contract to be the sum of all the maximum payments calculated, without further adjustment.

Illustrative approach 2: Calculate a constant quantity of benefit for each contract and scale by a factor to reflect different sizes of contracts in the group

- Approach 2 views the services provided by each individual contract to be constant over the duration of the insurance contract.
- For the insurance benefits, the limits of the protection cover are fixed as stated in the contract and are constant over the duration of the contract.
- For the investment-return service, this is viewed by the entity as a constant service over the duration of the contract, because the key service provided by the entity to the policyholder is one that generates an investment return for the policyholder through the provision of access to investment options that are managed by third party managers. If the level of that access is considered to be provided constantly and continuously until the end of the contract, then the measure of service can be viewed as constant. On an individual policy level, the pattern is therefore considered to be constant.
- The entity therefore considers the insurance service and investment-return service to be constant throughout the duration of each contract and, in satisfaction of the weighting requirements of different services within a single contract, one constant measure of the quantity of benefits can be used for the total contract. If all contracts are of the same size, the use of policy count (number of policies in the group allowing for expected lapses and maturities) would be possible.
- To reflect the fact that contracts within the group may be of different sizes, the constant measure used for each contract should be scaled by a relevant factor. In selecting a factor, the entity should consider measures that allow for comparability of the size of a contract relative to other contracts, meaning that to the extent actual or expected policy lapses differ between contracts of different sizes, this is reflected in the pattern of coverage units of the group of contracts. Examples of relevant factors would include initial expectations on total premiums, total payments to policyholders, total sum assured or other factors that reflect the size of different contracts. The coverage units for the group of contracts over time will then be the sum of the scaled policy counts of the group.

This approach (approach 2) could be a reasonable reflection of the services provided when the insurer considers all the services in a contract are constant over the duration of the contract, as is the case for this example as the expected coverage period is the same for the base contract and the riders. At an individual contract level, if the insurance and investment-return service are both constant services, then the quantity of service for the contract is constant and therefore a relative weighting of the different benefits within the contract is not required for measurement purposes. In satisfying the requirement to disclose the basis of weighting, such an approach could be disclosed as giving equal weight to the different amount of benefits.

Illustrative approach 3: Separately calculate quantity of benefits for the investment-return service and insurance coverage, using account balance for investment-return service

- Approach 3 calculates the quantity of benefits for the insurance coverage and investment-return service separately. This approach acknowledges that the pattern of provision of insurance coverage and investment-return service may differ.
- Quantity of benefits for the insurance coverage is based on the maximum of the various insurance benefits included in the contract:
 - o Death benefit – based on sum assured (excludes the account balance).
 - o TPD – based on sum assured (excludes the account balance).

- Medical reimbursement – based on the probable maximum loss concept in approach 2 of Illustrative example 1 (note that the straight-line approach in approach 1A or 1B of the Illustrative example 1 cannot be used here because contracts are not homogeneous within the same group).
- Critical illness – based on sum assured.
- For the investment-return service, the investment account balance is considered a proxy. The entity considers the account balance to reflect the different level of investment services being provided to the policyholder over the duration of the contract. In choosing the account balance (which is similar to maximum benefit) to reflect the investment service, this approach will be similar to Illustrative approach 1 which would not be the case if a different measure had been chosen to reflect the investment service.
- In determining the relative weighting of the benefits provided by the insurance coverage and the investment-return service, the entity considers that using a measure of maximum payment for each service will already incorporate a form of weighting and it would therefore be appropriate for the total quantity of benefits for the whole contract to be the sum of all the maximum payments calculated, without further adjustment. This calculation would give a quantity of coverage units for the group of contracts as a whole, to which the end of period CSM would then be applied equally in accordance with paragraph B119(b) to determine the CSM amortisation for the period.

Illustrative approach 4: Similar to approach 3 with a weighting of all the insurance contract services in the contract

Similar to approach 3, but instead of a simple aggregation of all the quantity of benefits calculated for each benefit, a weight is calculated and applied to each benefit. Judgement is required in determining appropriate weights to reflect the different services in the contract and care should be taken to ensure the data points used are not arbitrary. Examples of non-arbitrary data points could be the use of policyholder outflows (which could be expected or maximum possible claims).

Illustrative approach 5: Separately calculate quantity of benefits for the investment-return service and insurance coverage, using a constant measure for investment-return service

This approach could be a reasonable proxy for the insurance contract services provided when the insurer considers that the investment-return service in a contract is constant over the duration of the contract, but where the level of insurance coverage varies over the duration of the contract.

- Similar to approach 3, but the insurer takes the view that the level of investment-return service provided to the policyholder is constant throughout the duration of the contract based on the same arguments mentioned in approach 2, where the investment-return service is the generation of an investment return for the policyholder through the provision of access to investment options.
- Setting aside consideration of how to aggregate with the insurance coverage, policy count (allowing for expected lapses and maturities) could be used as a proxy for the quantity of benefits for the investment return-service given it is considered to be a constant level.
- However, in determining the total quantity of benefits for both insurance coverage and investment-return service, an equal weighting of the insurance coverage and the investment-return service would not be appropriate if policy count is used as a proxy for the investment-return service (i.e. were the quantity of benefits of “1” to be simply



summed without further adjustment with the quantity of benefits for the insurance coverage measured using maximum benefit). This would distort the total quantity of benefits for the contract as a whole by unduly allocating substantially all of the quantity of benefits to the insurance coverage. In this case, a relative weighting should be applied to increase the weight of the investment-return service so as to be comparable to the quantity of benefits of the insurance coverage. Possible factors that could be used to weight the investment-return service to make it comparable with the quantum of the insurance coverage would include metrics such as expected total premiums, total payments to policyholders, total sum assured or other factors.