Welcome to the 3rd edition of the SCOR Global Life UK newsletter.

We hope this latest publication will be equally as useful and well received as the previous 2 editions.

This issue includes a range of varied topics in connection with Underwriting, Claims, Pricing and Marketing from a number of our team members as shown below:

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SCOR Global Life’s claims philosophy

SCOR Global Life is the only reinsurer to publish a full claims philosophy in the UK which we make available on our SOLEM manual. We continually review our philosophy to ensure we keep pace with industry and product developments and that it is fair and reasonable for the insurers that we serve taking into account the spirit of the contract and the pricing aspects. In many areas we seek to go beyond the policy terms and conditions to ensure we have a good outcome for all our customers and stakeholders alike and will take a more generous approach to certain claims where possible and appropriate.

The trend in recent years for many insurers has been to develop a philosophy of their own, which a reinsurer can sign up to, so that both parties understand exactly which claims will be paid and is in line with the pricing.

So why is having a claims philosophy so important?

The main reason is to ensure that insurers are making consistent claims decisions across their portfolio and are clear on the claims they want to pay.

When insurers develop a product or make changes to an existing product, they want to ensure they pay as many claims as possible but at the same time, they need to retain profitability. There are a number of factors to consider and a multi-disciplinary approach is required. This may include working with your pricing team, CMO’s, legal teams, marketing, underwriting and claims. It’s also important to involve your reinsurer early in the process.

The pricing actuaries will undertake forensic analysis of previous claims experience and general population studies with the aim of predicting how many claims insurers will pay on the new product. If insurers pay more claims than they anticipate, then the product is less likely to be profitable.

Therefore, to ensure previous and future claims experience is in line with expectations, it is essential that insurers have a robust claims philosophy in place that all assessors are aware of and work towards. It is also key that any claims that are paid which are not in line with the documented philosophy, are recorded as such and they can be clearly identified and removed from the claims experience if necessary when the analysis is undertaken.
Philosophy
reviews in action

So how do SCOR go about reviewing claims philosophy?

We’ve been carrying out an extensive review of philosophy over the last 12 months and there are a number of areas where we have determined that we are able to be more generous than the stated ABI definitions. One example of where we have been able to take a more flexible approach to claims is our philosophy for Multiple Sclerosis (MS).

Historically, we have always assessed claims for MS in line with the definition wording i.e. a definite diagnosis of MS under the McDonald criteria, followed by persisting clinical symptoms typical of MS. It was always our intention to pay claims for those that had neurological symptoms over a 6 month period, although our philosophy allowed for flexibility where the symptoms were not continuous for the full six months.

However, with many insurers now applying ABI+ definitions to their policies, the severity criteria is being reduced or even removed and many insurers had policy definitions where the need for persisting clinical symptoms was reduced from six months to three months. When pricing the newer ABI+ definitions, it gave us an opportunity to also review the basis with which historical definitions were determined and whether we could adopt the newer, more generous definitions to our back book.

The first thing we noted was that the diagnosis of MS is now more sophisticated than it has been in the past. MRI scanning is now able to distinguish between old and new lesions meaning they can be disseminated by time and space (as required in part of the MacDonald criteria). When the persisting clinical symptoms criteria was added to the MS definition, this was largely to ensure the diagnosis was correct but this is not so relevant given the advances in diagnostic techniques. So from that point of view, we felt comfortable with relaxing the persisting clinical symptoms requirement.

Turning to the pricing, we then conducted a review of historic MS claims. In some cases, we saw that some of the previously declined claims were in effect deferrals, i.e. that they were awaiting permanent symptoms. We also reviewed data suggesting that the majority of those diagnosed with MS went on to suffer from persisting symptoms 10 years post diagnosis. We determined therefore that there would be a price for relaxing the requirement for persisting symptoms, but that it would be a small/negligible cost.

As a result of our research, we developed a new policy definition where the need for persisting clinical symptoms was removed altogether and the definition is based on one attack of clinical impairment of motor or sensory functions, with current symptoms, or two or more attacks of clinical impairment of motor or sensory functions. Many insurers now have this as an ABI+ definition in their latest policies.

As our pricing actuaries did not expect this change in definition to result in a significant increase in the number of claims paid and were able to support this newer, more relaxed definition at no extra cost, we were able to adopt this as our general MS philosophy on our back book.

Other areas where we have recently applied flexibility to our claims philosophy are with regards to claims for Parkinson’s Disease and also claims where the insured event occurred outside the term of the policy. For Parkinson’s Disease, where historic definitions require “permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability” we will now accept claims where the permanent clinical impairment includes bradykinesia (slowness of movement which is part of the clinical criteria for diagnosing Parkinson’s Disease) with either tremor, muscle rigidity or postural instability, rather than requiring all three criteria.

We also recently documented our approach to claims where the claimant was symptomatic for a CI condition during the policy term but was not formally diagnosed until the plan had expired. Full details of all our philosophies can be found in the claims section on SOLEM https://solem.scor.com

These are examples of our approach of joining up the work that is done as part of product development with our claims philosophy and ensuring all areas feed into the approach we feel is reasonable to adopt.

There will be some scenarios where the expected increase in claims paid will be too great and will have too great an impact on profitability so that unfortunately, there will be some areas of philosophy that we have been unable to change, or at least not been able to change without applying an additional charge.

At SCOR, we pride ourselves on having an open and transparent philosophy and will look to be as flexible as possible. If you are looking at reviewing or indeed revising your philosophy, please let us know and we would be more than happy to work with you.

For further information regarding Claims Philosophy, please contact Paul Blyth or Gill Salton at SCOR Global Life.
Can We Learn From Good and Bad Practices? Claims Experience Analysis

The Purpose
Actuaries analyse the claims experience of a block of business to derive some useful information, which can be used for various purposes. For example, to use the past experience of the existing block as a guide for pricing new business, to check how the claims experience of the existing block is performing against what was initially assumed to price that block, to produce management information, or to update their current assumptions used in pricing/reserving.

Whatever the purpose, the underlying method of a claims experience analysis is fundamentally the same. In simple terms, the number of actual claims made during a period of time is counted and compared with the number of claims which was expected to be made during that period. Actuaries refer to this ratio as “A over E” (or A/E). The expected number of deaths is calculated as the number of policy years multiplied by mortality rates taken from a set of rate tables (usually split by age / sex / smoker) used by actuaries.

In reality, this ratio is rarely equal to 1 (ie A never equals E). This is because the actual number of claims made over a period of time will hardly ever turn out to be exactly the same as the expected number of claims. Therefore, this ratio of A/E is frequently monitored by actuaries to help them detect any deviation between the A and the E and take corrective measures. For example, let us assume that the experience analysis is performed as part of a premium review exercise on a reviewable block of business. Then an A/E ratio higher than 1 means the actual claims experience is worse than what was expected and can lead to a loss for the insurer. On the other hand, an A/E ratio lower than 1 means the actual experience is better than what was assumed in pricing. The better experience can therefore translate into profit for the insurer or to lower the premiums for future new business (ignoring all other factors of course).

Example of how total A/E is split by various factors

<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>ACTUAL</th>
<th>EXPECTED</th>
<th>A/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTA</td>
<td>4,564</td>
<td>4,051</td>
<td>113%</td>
</tr>
<tr>
<td>DTA</td>
<td>2,976</td>
<td>2,804</td>
<td>106%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7,540</td>
<td>6,855</td>
<td>110%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENDER</th>
<th>ACTUAL</th>
<th>EXPECTED</th>
<th>A/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE</td>
<td>4,870</td>
<td>4,465</td>
<td>109%</td>
</tr>
<tr>
<td>FEMALE</td>
<td>2,670</td>
<td>2,390</td>
<td>112%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7,540</td>
<td>6,855</td>
<td>110%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SMOKER STATUS</th>
<th>ACTUAL</th>
<th>EXPECTED</th>
<th>A/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-SMOKER</td>
<td>5,234</td>
<td>4,699</td>
<td>111%</td>
</tr>
<tr>
<td>SMOKER</td>
<td>2,306</td>
<td>2,155</td>
<td>107%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7,540</td>
<td>6,855</td>
<td>110%</td>
</tr>
</tbody>
</table>

For each factor, the table shows the actual number of claims, the expected number, and the ratio of A divided by E. The example is hypothetical and does not reflect the experience of any real office.
For further information regarding Claims Experience Analysis, please contact Imad Salah at SCOR Global Life.

Utilising the results

Whatever the results of the analysis, should there be a significant deviation between the A and the E, it is important to understand the reason for this deviation. To do this, it is normal for actuaries to not only look at the total actual/expected claims but also to consider the A/E split by the main rating factors (or risk cells). Examples include: splitting A/E by gender, smoker status, product and benefit type, sales channel, standard and rated cases, policy year, calendar year, and underwriting years (see example in figure 1 on the left). Splitting the A/E into various risk cells is very important when analysing the experience and could help explain the main reasons for any deviation between the actual and expected experience. For example, looking at A/E for different underwriting years could show that the experience has been improving in recent years, which could be for instance, as a result of a recent change in the underwriting practices of the insurer leading to fewer claims than initially anticipated. Alternatively, looking at A/E for various calendar years could show a certain pattern which may have resulted from changes in claims handling, and so on. One issue with breaking the total claim numbers (actual and expected) into many risk cells is that we could end up with very few claims in each cell, which would make it difficult to draw meaningful conclusions. This is what actuaries (and statisticians) commonly refer to as “credibility”. There are many theories and debates on the minimum number of claims required in each cell to give fully credible results, but the more claims there are, the more the results of the analysis are credible and can be relied upon.

As mentioned above, the results of the experience analysis could highlight changes made in various departments or practices. Therefore, it is important to communicate the results of the analysis not only with pricing or reserving actuaries but also with other departments such as claims, underwriting, marketing and management. This could help identify the sources of any issues or reinforce the improved practices across the relevant department. From a reinsurance pricing point of view, A/E analyses are key in determining reinsurance rates during a tender. Therefore, it’s important for offices to ensure that claims and underwriting practices are completed in line with those agreed in the reinsurance tender as this will impact the future claims experience and ultimately the rate paid to the reinsurer.

Plot of the above A/E’s by underwriting year – the downward shape of the graph indicates that in this example claims experience has been improving in recent years. This could be due to improvement in underwriting practices, targeting a different channel with a healthier mix of policyholders, etc.

A/E for various Underwriting years

![A/E for various Underwriting years](image-url)
The Rise of Wearable Technology – What does it mean for the insurance market?

It seems that almost daily, there is an article in the insurance news about how wearable technology and the latest gadgets might revolutionise the whole industry by giving people the opportunity to use their health data to get cheaper life insurance premiums.

What are the latest developments?

There has been a growing trend of development in the fitness and sports tracking field with devices from firms such as Jawbone and Fitbit. The very latest addition to the Apple product suite, the Apple Watch is just the latest development in a range of products that appeals to a market keen on having the very latest in technology while helping those who aspire to greater health and fitness.

Whether it’s measuring fitness, activity, sleep or even stress levels there is a growing market for fitness wearables and sports trackers that has got our industry thinking about whether the data from these devices can be used to underwrite people; effectively rewarding the fittest, healthiest lives by reducing their premiums.

Can we really underwrite lives by looking at their activity and fitness?

It is still early days with regard to knowing precisely what will be measured by wearable devices, but there is some data available from US studies to suggest that even moderate activity such as regularly walking for one mile without stopping improves an individual’s relative risk compared to someone who doesn’t.

Actuaries would clearly need to consider the implications of this and ensure that they took out some of the impaired lives from the data to have a true picture of the impact of activity on the healthy lives but the early signs are that more activity reduces risk and therefore potentially, premiums.

Are wearables the future of underwriting?

Technology to measure performance and behaviours is nothing new. Car telematics which has been around for some time can predict and reward good drivers, and in a similar way people believe they should be rewarded for healthier behaviour when it comes to buying life cover.

There is very good evidence to suggest that people believe in being rewarded for healthy behaviour. In a study conducted by Confused.com in 2013, there were some interesting attitudes:

64% of people in the UK think they should pay less for life insurance if they can show they don’t smoke

44% feel they should get cheaper life insurance if they show they are exercising regularly

43% think they should be rewarded with life insurance discounts for eating healthily.

There is also strong evidence to suggest that many people would be very willing to share their data (provided this could be done confidentially) to get cheaper life cover.
Wearable Tech Survey

SCOR Global Life recently asked a group of individuals about how much cheaper they’d like their premiums to be due to supplying data from a wearable device. They were also asked about their view of the potential advantages and disadvantages of using them to buy life cover.

Responses to the survey showed that most people would expect a reduction of 11-20% or 21-30%, and this probably simply reflects different price attitudes at different ages. The potential benefits and disadvantages were as shown in these figures.

In the first figure above, regarding potential benefits, respondents mentioned getting a free device as being important in the ‘Other’ category.

In the second figure regarding potential disadvantages, respondents were concerned about premiums increasing if they couldn’t demonstrate healthier behaviour in the ‘Other’ category.

<table>
<thead>
<tr>
<th>Potential Benefits</th>
<th>% Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>A faster process</td>
<td>20%</td>
</tr>
<tr>
<td>A more accurate decision</td>
<td>30%</td>
</tr>
<tr>
<td>Lower premiums</td>
<td>50%</td>
</tr>
<tr>
<td>Real-time health information</td>
<td>10%</td>
</tr>
<tr>
<td>None of the above</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concerns</th>
<th>% Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process could be slower</td>
<td>10%</td>
</tr>
<tr>
<td>Confidentiality issues</td>
<td>20%</td>
</tr>
<tr>
<td>Fraud concerns</td>
<td>30%</td>
</tr>
<tr>
<td>None of the above</td>
<td>5%</td>
</tr>
</tbody>
</table>

« As a customer buying life cover in this way, what do you think are the potential benefits. You can choose more than one answer »
Answered: 85  Skipped: 0

« What do you think are the potential disadvantages of buying life cover in this way? You can choose more than one answer »
Answered: 85  Skipped: 0
The Rise of Wearable Technology – What does it mean for the insurance market?

Risks for the industry and individuals

The survey is just a snapshot of current attitudes to wearables, albeit an important one and it does highlight where some of the main concerns about wearables and where their future lies. It’s no coincidence that many if not all of the articles written on this subject raise anti-selection and fraud as well as data accuracy and privacy as key concerns for the industry and individuals. It is right that we too should focus on these.

Anti-selection and fraud

• If data from wearable devices is to be made available by individuals, perhaps through an app on a smartphone or other device, can life companies be certain that they are getting not only accurate data, but data relating to the individual they are seeking to cover?
• What controls can be put in place to ensure that the data being supplied has not been provided from another (perhaps younger, fitter) individual who has used the device to provide data that will be used fraudulently to get cheaper cover?

Companies will be keen to put controls in place to ensure that the data they receive relates to the individual they are being asked to cover and has not been tampered with.

Data accuracy and privacy

• With the technology still at a relatively early developmental stage, how can individuals be confident that devices will provide data that is truly representative of their health and lifestyle?
• Can they be sure that the data they provide through their devices will be interpreted accurately and stored confidentially by life companies?

Manufacturers will need to continue to invest in developing devices that record and present accurate data. Actuaries will need to be able to price these risks accurately to allow underwriters to have the confidence that they are accepting the right risks ensuring profitability is not compromised. Unless the data can be accessed and uploaded by life companies confidentially, data privacy could be a thing of the past.

The future of wearables in insurance

Consumers will continue to drive change through technology and there is no doubt that wearables are here to stay. This will almost certainly have implications for the way insurers do business. But there is some way to go before insurers can positively use the data supplied by wearables to drive change and transform the market in the way insurance is underwritten.

For further information regarding Wearable Technology, please contact David Ferguson or Catherine Lyons at SCOR Global Life.
The Challenge
I work on a rule of thumb whereby any event containing the word ‘pre’ is usually a bit of a disappointment. A prequel at the cinema is generally an over-hyped film trying too hard to exploit money from an audience who fell in love with the main attraction – I give you Jar Jar Binks as damning proof. Pre-dinner drinks are normally the socially stifled awkward discussions with strangers before alcohol loosens the tongue and the fun starts. And don’t get me started on pre-match anthems or prefabricated furniture.

Pre-quote underwriting may be the exception however as I find it all a bit exciting. It’s a part of our market where things are happening, uncertainty abounds and opportunity exists. The logic is pretty simple – customers don’t like it when they do a quote, get a premium and then apply and get a completely different, and much higher, premium. The increase in premium comes when they are asked to reveal more personal information, including bodily measurements, lifestyle and health and we find they do not meet our definition of ‘standard healthiness’. I can understand that it’s not a great experience and it’s easy to see that we risk alienating customer and will lose a few sales on the back of it.

What’s Currently on Offer?
One of the first to the party was the quote portal Assureweb with their pre-quote tool, XRAE. They have developed their existing quote functionality with this new tool as an add-on, optional underwriting process. It set out some generic questions covering smoking habits, height/weight, alcohol consumption, family history, blood pressure and cholesterol. Upon answering the questions the applicant (led by the advisor) is able to get an indicative quote from the 5 or 6 providers who have signed up. Whilst the indicative quote isn’t binding the theory is that it at least sets expectations and starts the sales process on a more realistic basis. With those expectations set, the customer still needs to go through the traditional sales process, including answering a full underwriting question set. To date the proposition hasn’t achieved the success that would have been hoped for but it is early days.

UnderwriteMe promises much more. And at the moment it is just a promise with regard to a pre-quote comparison service – we have been talking about it for a long time now and eagerly await its launch. It will ask a full underwriting question set up-front, with drill down reflexive questioning. This question set will be agreed with all providers who are signed up such that following completion of the underwriting process a guaranteed premium will be delivered, selection of provider will be easier and the sales process will be much quicker. This seems the most comprehensive solution but potentially still has a lot of work to do to sign up both providers and distributors.

Elsewhere in the market, Lifequote is already deploying a version of its pre-quote underwriting. This is available to advisors and strikes something of a balance by asking a reduced set of approx. 16 underwriting questions. This then returns a number of options as to how to proceed. For those who are shown to be acceptable risks they will be offered the write to buy with no further underwriting through Aviva (Buy Now). Through other providers the customer will receive an indication that based on the questions that they have answered they are likely to be a standard rate but that they will still need to go through the application process with a chosen provider to confirm this. For non-standard risks, an indication of premium loading is provided for the main risks but not all risks – this mainly covers BMI and lifestyle risks but not medical risks.

... /...
The Lifequote approach seems flexible and we can see a variant of it in the direct market, on Confused.com. Within Confused.com the ‘buy now’ functionality covers Admiral as well as Aviva. In addition the outcomes differ to the advisor space as indicative loadings are not shown.

iRESS are probably the largest quote portal currently in the market. At the moment they don’t play in this space but have announced their intentions to bring height/weight into their term comparison service – a simple change but one which will pick up a significant proportion of the underwriting ratings issued. At the same time they are planning on introducing postcode and occupation into that comparison process – this is a really interesting development as it starts to extend the pricing rating factors that we could be using in the future. In doing so it raises lots of interesting questions, but that’s a different story and potentially a topic for a future SCORacle.

Webline have promoted the work they are doing on Cover Me Now. A proposition to ask a shortened underwriting question set to generate a guaranteed premium at the quote stage with the whole process being managed within Webline rather than a provider extranet. A slicker process with the aim of simplifying and speeding up the process in order to enhance conversion rates. A number of providers and reassurers are engaged in the development phase and again, we await delivery in the market.

Final Thoughts

There is no clear and obvious winner in the race to deliver a successful pre-quote underwriting proposition. This will require investment in solutions, providers to sign up to the concept and a willingness to make underwriting rules available. It will also, crucially need, the distribution community to adopt the proposition. Nobody seems to have cracked each of those challenges yet - it is definitely an interesting space to keep watching.

The big win for me however, isn’t in winning back a few lost sales because a premium has changed, as the case is often presented. Instead the big win comes from freeing up time and money. If an advisor doesn’t need to go chasing all the providers to find out their underwriting stance on a given non-standard risk then it surely frees up some of their time to go and make a few more sales. If an underwriter doesn’t need to field endless calls to try and clarify their underwriting rules or doesn’t need to manually deal with multi-propped quotes, which actually have only a small chance of going on risk with their company, then suddenly underwriting time gets freed up and our cost per case reduces. Those underwriters will then be free to underwrite the additional cases that the advisor is out getting with their freed-up time. And imagine if we also took those underwriting cost savings and actually ran some educational advertising campaign to encourage a hesitant buying population to take some action. If we could do all that then we might see some significant market growth – now that’s a really exciting main attraction.
A Positive Way Forward –
A review of Financial Underwriting

Within SCOR we are continually reviewing practices with regards financial underwriting and looking for ways to help our customers achieve the necessary balance of maintaining appropriate risk management and keeping the processes that enable business to be written as smoothly as possible.

At SCOR we believe this is a crucial area to keep contemporary and to get right from an underwriting perspective, where if practices are too conservative then it will significantly impair an insurers ability to attract “large” risks as brokers will look elsewhere to place their business. From the other perspective, without at least some sensible risk controls in place, there is the real potential for business to be accepted that could adversely impact the experience of the portfolio from increased moral hazard and early lapse.

With this in mind, SCOR are working to refresh our recommended guidelines for the UK and Irish markets and it is intended that these will be accessible through our SOLEM underwriting guide shortly. This article highlights some of the areas that we have identified through our research where there have been important developments and also makes suggestions that we hope will be useful.

In our industry we are constantly striving to improve the “Customer Journey” by making the process as slick and efficient as possible. Unfortunately, it appears that the bottle neck within the process can often be caused by financial underwriting requirements. This has led to us receiving numerous enquiries involving various aspects of financial underwriting, such as requests to increase the limits at which evidence is sought, enquiries as to what information should be asked for on the application form and what multiples to use when calculating the maximum sum assured available.

We do not feel that the way forward is to arbitrarily increase limits and multiples purely to reduce the number of cases requiring further information and instead thought it would be beneficial to reassess the process of financial underwriting and we have initiate a project to do just that.

Our philosophy as ever remains “Does it make sense?”

Should we continue to Underwrite Financially?

This is something underwriters are often challenged with and from the “ease of process” view, this might seem entirely sensible. However, it would be ignoring potential issues further down the line.

When we look at the historical reasons for underwriting these concentrated on “fraud”, “anti-selection” and ‘early lapses’ due to the subsequent unaffordability of the premiums. The challenge to underwriting is whether these considerations are still relevant enough to justify obtaining financial evidence, or is this going too far for the size of the problem?

Fraud - Whilst fraudulent activity relating to insurance cover is rare, it still exists and we all remember the high profile case of John Darwin ’The Canoe Man’. However, this was not an isolated case of fraud and there are examples of fraud seen every year that barely make any headlines. Worryingly, some of these cases are becoming increasingly clever through use of technology where the production of fraudulent documentation to support claims has never been easier.

Anti-selection – The concept that an applicant was aware of knowledge placing them at an increased risk at the time of application and has not disclosed this can be very difficult to identify and even harder to prove. There is no doubt that improvements in application forms asking better questions over the years has help to reduce this problem, particularly for life cover. However, anti-selection remains a concern for critical/serious illness benefits, where we still see a number of very early claims shortly after acceptance where anti-selection is suspected.

One recent outstanding example we have encountered involved an applicant approaching multiple companies for critical illness/serious illness cover over a 6 month period for sums assured all of which were below automatic evidence requirements. Cover was accepted for life and critical/serious illness that accumulated into millions of pounds/euros. Within 2 months of the final policy commencing a claim for cancer was submitted that from a purely medical perspective appeared to be completely meeting the criteria for payment with no history of symptoms prior the risk commencing. ... /...
Lapses - This is the area that from a cost per case perspective probably represents the highest risk for direct offices. Based on research we have carried out the average cost per case is £300/€300, substantially more for “larger” sum assured cases when costly medical evidence might also be obtained. Equally our research has shown that average lapse rates are 6% - 10% with the highest rate applying to policies below 50,000 and above 500,000 GBP or Euro sums assured.

In addition to these more traditional considerations, there is also a responsibility for companies to adhere to the Financial Conduct Authority’s “Treating Customers Fairly” (TCF) guidance that includes an expectation that policies sold are appropriate and fit for purpose, where unnecessary or excessive cover may be considered contrary to what is considered to be “good business practice.

With the above in mind our initial high level thoughts are that there is still a need to financially underwrite. However, the reasons for and value of doing so differs significantly for different products with much more care being necessary for critical illness/serious illness cover than for life cover because of the increased moral hazard and cost of the cover.

What other corroborative evidence can we obtain ourselves? There are some excellent tools available in the market such as Experian (previously Risk Disk), which hold incredibly useful data held by Companies House etc. These are particularly useful when assessing business covers and can provide not only a check against what information has been already submitted but can often supply other useful information to provide even greater insight into businesses. Rather than acting to create further issues, more often the additional information these tools provide, enables faster acceptance by reducing further evidence requests.

So what can we do to improve the customer journey and persistency?

Inclusion of some very simple questions on the application form can help considerably and reduce the requirement of a full questionnaire to be completed – salary, details of all existing, concurrent/pending cover. This as first line “financial evidence” can easily be obtained and helps to justify cover requested and helps to reduce anti-selection from the excessive cover being accumulated in the market.

Carefully consider requirements based on the type of cover being sought e.g. more relaxed guidelines relating to Life cover and tighter controls for Critical Illness, Disability, and Income Protection cover.

Carefully consider requirements based on the type of cover being sought e.g. more relaxed guidelines relating to Life cover and tighter controls for Critical Illness, Disability, and Income Protection cover.

This should include items as follows:
- ensuring that the level of cover is generated by customer needs according to affordability and circumstances. For example, clear guidelines for appropriate multiples of salary for personal cover and maximum levels of cover for house persons or those on lower incomes acknowledging the different approaches for life and critical/serious illness etc. Equally, similar guidance should exist for business related covers in respect of multiples etc., to ensure that once again the cover appropriately matches the customer/businesses needs based on their circumstances.
- Special arrangements and reduced financial criteria for business cover through specific distributors. Whilst this is not a new concept for the market, companies can build good relationships with brokers and distributors that provide a regular flow of good quality business or where there is already considerable financial assessments made other than for insurance purposes. Where this is established, it makes good sense to allow business through these connections to be allowed some preferential treatment through the underwriting process by reducing usual requirements.
Summing up

At SCOR we are very conscious that our main responsibility to our customers is to support them to write profitable business as efficiently as possible and in relation to financial underwriting we need to continue to be well informed and flexible in our approach. We also recognise the significant difference in product types whereby the approach for life cover can be very much more relaxed than for critical/serious illness for the reasons explained earlier.

We are also aware of the pressure that our customers are under from intermediaries who are in turn under pressure from their customers. Therefore, at all costs we have a responsibility to avoid any action that might unnecessarily prolong the underwriting process or limiting the cover from that requested without good reason for doing so.

When examining the root of some of the issues seen with financial underwriting, we feel there are definitely measures that companies can take to significantly help in providing a smoother process for large risk cases.

Please keep a watch out for our revised guidance and in the meantime we would be very happy to discuss these items and others further, and to help with the implementation of any of these ideas.