

Life in the Future



Term assurance price wars

Life cover is the cornerstone of the protection industry. But with premium rates having fallen so low, what lies ahead for this market: expansion or stagnation?

Rates are becoming more competitive than ever, and the term market is increasingly commoditised. Consumers today can pick up a protection policy online or at their local supermarket.

As little as £14 a month buys a 40-year-old non-smoking male (accepted at standard rates) £100,000 of life cover for 25 years. That £14 is unlikely to represent anything more than a small percentage of our 40-year-old male's monthly supermarket bill – especially if he has a growing family to feed! By the same token, a 30-year-old male paying £7.50 a month is hardly going to miss the cost of two pints in a typical London pub. Term assurance is certainly affordable. Cheap might be a better word.

As noted in the previous edition of *In Focus*, it is primarily reinsurers who are taking on the mortality risk through large quota share arrangements. At Hannover Life Re (UK) we have a great deal to offer in terms of innovation and product development for critical illness, tiered benefits and enhanced annuities. But we also have a wealth of knowledge about bread and butter term assurance products. In the following article we discuss the various factors influencing pricing and

product development in both today's and tomorrow's term assurance market.

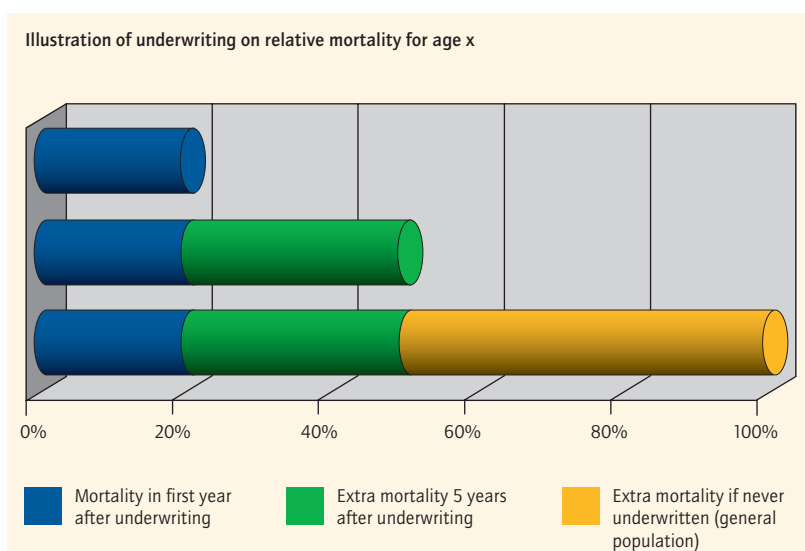
The importance of quality underwriting and claims control

It is impossible to overstate the influence of good underwriting on the profitability of a book of business. This is especially true in a competitive market like term assurance where margins have shrunk and volume is often king.

Better quality application forms have helped improve claims experience. Initiatives such as tele-underwriting have also played their part by leading to reductions in non-disclosure. An extended underwriting process is often cited as a barrier to sales. But in a price-sensitive competitive market, underwriting plays a crucial role in justifying low rates.

Underwriting effect in the early policy years

The illustration below represents the effect of underwriting on the mortality risk of the general population.



For the purposes of this illustration, we have split mortality into three segments left to right. The first of these represents the remaining mortality risk in year one after full medical underwriting. With the medically unhealthy underwritten out, or rated according to the additional risk they pose, the mortality rate is much lower than for the general population. A significant proportion of deaths in this segment would result from factors like external injuries to the body that are hard to mitigate through underwriting. This is especially true at younger ages.

The next segment represents the mortality risk that arises as the effects of initial underwriting begin to wear off over the duration of the policy.

Finally the third segment represents the remaining difference between the insured population and the general population. This is attributable both

to the longer term impact of underwriting and to other factors such as socioeconomic effects.

Whilst external causes predominate among claims in the early years of a policy, there will still be a significant number of deaths from other causes such as circulatory disorders and cancers. So there remains scope here for reducing mortality rates through underwriting improvements.

Underwriting has always been a trade off between the cost of acquiring medical evidence and its impact on claims. But failure to keep pace with the level of medical information your competitors are requesting raises the spectre of anti-selection.

Mortality trends into the longer term.

It is important to consider how long-term mortality trends will develop in future and what effects they will have. Over the years we have seen steady improvements in long-term mortality trends at all ages. The past, however, is not necessarily a reliable guide to the future. Familiar industry concerns over issues such as obesity and metabolic syndrome come to mind in this context. There is also the potential one-off shock of a serious infectious pandemic such as human transmissible avian flu.

On the other hand we need to consider the influence of positive factors such as more effective use of statins and increasing health awareness. Current changes in food labelling practices will make it easier for health-aware consumers to make informed choices about what they eat. There is growing awareness too of dietary issues such as trans-fats. Meanwhile tough new restrictions on smoking in public have helped reinforce awareness of the health risks posed by tobacco.

For critical illness and other disability contracts we must also consider factors such as rising trends in incidence rates – whether caused by improving medical diagnostics or an increasing incidence of operations. But for term assurance these factors are irrelevant. There is only one claim state with term assurance: dead. This condition is easy to verify and hard to dispute!

Reinsurers currently make allowance in their rates for some degree of future mortality improvement alongside up-to-date assumptions as to underwriting practices. This has helped drive down the market price for term assurance. Given the concerns noted above one might question whether this will continue in future. We are, however, seeing a sustained focus on developing underwriting at the point of entry into the insured pool as a means of mitigating these future risks. For this reason we would expect reinsurers to continue allowing for future mortality improvements – but it seems unlikely that more aggressive assumptions will now lead to further price reductions.

Future developments

Preferred lives

The concept of preferred lives as established in the US suggests one route forward for the UK industry if it continues to focus on price. Some would even argue that we are already moving in this direction. There is a certain logical appeal to the idea of offering preferential rates to applicants who conform to an overall profile suggesting a better than average risk. An individual who has never smoked, has no driving violations and whose older relatives have not suffered any hereditary influenced cancers before a certain age, for example, might be deemed to satisfy the relevant criteria.

But would the UK market really benefit from developing a preferred market? With rates already so low for cleanly underwritten lives, preferred rates look hard to justify in term of cost to the consumer. Bear in mind also that only a sub-set of those currently rated on standard terms would qualify as preferred lives. So moving towards a preferred market is unlikely to have any dramatic effect in narrowing the protection gap.

Evolving underwriting processes

The more you underwrite, the more you reduce your mortality risk and claims costs. But additional underwriting also adds to office costs and discourages customers. Our goal must therefore be a sophisticated and evolving underwriting process that is slick and simple for the customer, but also risk-effective and cost-efficient for the insurer.

Achieving this balance depends on a continuous process of optimisation. Simplifying the underwriting process should bring down costs and increase volumes by lowering the barriers to writing new business.

We could potentially make allowance in our standard rates for cases that might previously have attracted a small rating. But, whilst fine in theory, this approach would soon break down if it led to anti-selection.

As we have seen with the introduction of tele-underwriting, however, it is possible now to have a question set that drills down as it progresses based on the information provided by the applicant – reducing non-disclosure in the process.

Future development may well take the form of simplified underwriting based on the application of new technology and more specific criteria. If this technology includes non-invasive tests it could also help to bring about an improved customer experience. A specific example of this would be developing the use of reflex testing.

Reflex testing involves requesting additional tests on previously stored medical samples such as blood

or oral fluid. Once initial tests have been carried out (and the samples retained) the underwriter can review their results alongside the medical evidence and then, if necessary, request further tests without further inconveniencing the applicant or incurring the cost of obtaining fresh samples.

Health Track

At Hannover Life Re (UK) we think in terms of practicalities as much as concepts. We have been giving a lot of thought to the issue of how life companies can implement these new technologies in today's marketplace. One outcome of this thought process was the forum for protection providers we hosted this September at which Gemini Biomedical outlined its new screening product *Health Track*.

In a nutshell, *Health Track* is a new way of collecting medical information for life and health insurance. It works by inviting applicants to attend a local pharmacy to undergo a series of questions and screening tests – after which the results are consolidated into a report. This report is made available electronically in real time on the day of the appointment, with a signed hard copy sent by post. There is also the option of developing and implementing reflex testing protocols.

The range of results highlighted in the *Health Track* report will include:

- Height and weight (BMI)
- Waist and hip measurement/ratio
- Blood pressure and pulse
- Oral fluid cotinine test (for declared non-smokers)
- Urine test for glucose, blood, protein and other markers
- Blood cholesterol (using pinprick test)

The service provided by Gemini is as follows:

- once an applicant has been selected for screening the insurer keys their basic details into a secure browser provided by Gemini
- Gemini then sends a letter and screening pack to the applicant on the insurer's behalf
- within two days of their details being submitted, the applicant is contacted and scheduled to attend an appointment at a convenient participating pharmacy
- on arrival at the pharmacy, the applicant's identity is verified and the screening carried out
- all question responses, measurements etc are input to the *Health Track* system and the resulting report printed off and signed by the applicant before being sent to the insurer

We believe *Health Track* could represent a viable alternative, in certain situations, to paramedical screening. You may wish to explore the potential for including it in your medical evidence gathering processes.

Optimising underwriting and new technology

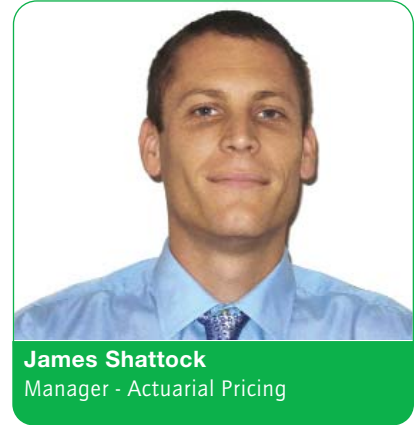
The current focus on reducing claims through improved underwriting will no doubt continue. A growing awareness of threats such as the obesity epidemic and metabolic syndrome is already leading to the inclusion of hip to waist measurements in medical examinations.

Heart attacks and sudden strokes are prevalent causes of death in the claims experience. The next article on 'skin cholesterol testing' considers an alternative method of identifying those most at risk through less invasive testing for risk factors with a high specificity. This is one more example of how we continue to optimise our underwriting processes as new technology and research becomes available.

This could have a significant effect in allowing improved classification of the risk presented by each applicant. And these changes, of course, would not only

have an impact on term assurance, but would also prove valuable for other protection products like critical illness.

We continue to realise the potential offered by new developments in medical research and technology. As ever we at Hannover Life Re (UK) will be monitoring developments closely and doing everything we can to keep our clients informed early of the most promising developments.



James Shattock
Manager - Actuarial Pricing

Live Another Day

2007 Life Convention & Exhibition, Manchester Central



Courtney Marsh, Oliver Wyman and David Brand



David Brand and Andy Hill, Swiss Re.



James Perkins, HBOS and Kirsteen Grant

This year the successful Institute of Actuaries annual Life Convention and Exhibition was held in Manchester, we supported the exhibition along with colleagues from our home office providing delegates with access to our global network.

Delegates visited the Hannover Life Re stand to test their memory for the Crossword Competition and skill against the Optix Challenge game.

The Optix Challenge required delegates to remember the changing light sequence to complete the pattern. Finalists went through to complete as much of the sequence in the fastest time possible. Our winning finalists were Courtney Marsh, Oliver Wyman who took first prize of a Luxury Hamper and Optix Game followed by Andy Hill, Swiss Re winning second prize of Champagne and an Optix Game and third place went to James Perkins, HBOS who also took home an Optix Game.

Rebecca Jonson of Deloitte tested her memory skills and won our Crossword Competition and prize of a Nintendo DS Lite including Brain Training game.

We look forward to seeing everyone at next year's Life Convention which is being held in Amsterdam from 9-11 November. If you didn't get a chance to catch up with us contact our Client Relationship Management team on 01 344 846819 to find out what makes us somewhat different.

2007 and Beyond

So another year has almost passed us by. Are we any closer to resolving the big issues confronting our industry?

Non-disclosure is more of a problem than ever. The protection gap shows no sign of narrowing. Rate cutting has become endemic in the term market as providers beat each other up for market share. Oh, and guess what: income protection is still not selling.

Is there an underlying problem here? I believe there is. Quite simply: the public don't trust us. OK, it isn't the first time I've made this observation – and I'm sure it won't be the last. But this is simply too big an issue to brush aside.

Unless we begin to improve the public's perception of this industry, I fully expect we will still be confronting a very similar set of problems for many years to come. So let's see if we can get a grip on the fundamental issues and maybe even identify some possible solutions!

The Price of Term Assurance

Can it really be less than a year since we all started gearing up for the wonderful new world of pensions term? Term assurance with tax relief, we called it, in a masterstroke of creative marketing. Sales began to increase. We may have worried slightly that some of these new sales were churning existing policies – but who could really blame advisors and policyholders if they were? Best advice, we said.

What a great marketing success it was! Until, that is, our hopes were cruelly dashed by a certain Mr Brown (remember him in his previous role under that nice Tony Blair?) Just as sales were starting to take off, and narrowing the protection gap looked like a realistic ambition, the Government went and spoiled it all.

But what had given us such high hopes in the first place? Fundamentally, of course it was our faith in those magic sales-assisting words tax relief. That price reduction would have made all the difference, we said.

Well, let's take a slightly closer look. Term rates in the UK have never been cheaper. For a non-smoking man aged 30 at his next birthday over a 25-year term, for example, one leading provider is currently quoting premiums of £7.50 per month for a £100,000 policy. Tax relief at 22% (soon to be 20%) takes that down to around £6 per month. Does that really make such a difference to the product's affordability? OK, someone paying tax at a higher rate would benefit more – but surely the real challenge is to



communicate the value of the product not to pare away forever at its price. When you are talking about a policy whose monthly cost is around that of a paperback novel, would an extra 20% really put someone off – assuming they are convinced they need it in the first place?

How have we ended up in a situation where the leading term players are reduced to trimming pennies from their premiums just to maintain new business? More importantly, how do we get off this never ending merry-go-round? I'll come back to the latter point as part of a broader argument a little later on.

Non-disclosure

This time last year I remember arguing that a 20% rate of claims declinature in the critical illness arena was unsustainable. This year the issue has broadened to take in how and why claims are turned down.

Grieving wives and ombudsmen, it seems, have equal difficulty understanding why a husband's non-disclosure of an apparently minor and unrelated condition – a bad back for example – should result in non-payment of a death claim when he dies in a car crash two years later.

If we were to step off 'planet insurance' (to borrow a phrase) for a moment, we might even question the logic ourselves! Perhaps the real test is to imagine yourself on live TV – Watchdog, let's say – defending this kind of decision.

The ABI's decision to set up a working group to address this issue is one example of a very positive development this year. Now that the importance of the problem has been recognised, I am optimistic that a workable solution can be found.

Income Protection

There is precious little progress to report on the income protection (IP) front however. We seem to be as far away as ever from convincing the public that IP is worth having. Sales have resolutely refused to take off, and, at the risk of sounding a controversial note, maybe it's time we bowed to the inevitable. Stand-alone IP may never become a big seller in the individual market, but the recent launch of various 'hybrid' products could offer a glimmer of hope. Packaging IP with a range of other benefits to provide a broader solution to clients' identified needs might just be the beginning of a new trend.

Critical Illness

I'm sure you are aware by now that Hannover Life Re (UK) favours a new kind of critical illness plan that matches benefits with needs by scaling (or tiering) benefits – and perhaps expanding the range of illnesses covered. It seems a growing number of companies are coming round to our point of view, but we still hear the question 'Why should we swap our 'standard' plan for one of these complicated new fangled products?' Why? Because we need to focus more on satisfying policyholders' needs rather than our own.

The Way Forward?

So where does all this leave us? We are falling over ourselves in the term market to reduce prices and trim our margins just to maintain sales in what has quite clearly become a commodity market. Our customers think we are hell bent on avoiding as many claims as possible – often for reasons they think are ridiculous. We have failed to convince our target market as to the value of health products we see as essential. And we struggle to implement new ideas and innovations. Not an altogether happy picture!

So where do we go from here? The imperative of Treating Customers Fairly (TCF) – is a well known concept in the insurance market. How do we treat our customers fairly? In a nutshell, by designing new worthwhile products that customers want to buy and that pay out benefits when they expect. Can we ever get away from the idea that insurance is *sold and not bought*? Maybe not, but if we can regain the customers' trust it needn't be quite such a hard sell.

We must continue our efforts to improve customers' experience of purchasing our products. Refining our underwriting processes will help enormously with this. Alleviating problems with non-disclosure is a key objective, obviously – but we also need to prioritise enhancing the whole purchasing experience. Improving our testing procedures within the underwriting process should help and this is described in another article in this issue of *In Focus*.

There are also some encouraging signs of new more comprehensive and customer-friendly marketing concepts being introduced – including ideas imported from overseas as well as new twists on more familiar UK products. In some countries the more innovative players have been so successful in developing their propositions that, dare I say it, customers actually

want to buy from them, through intermediaries, even though their prices may not be the cheapest! The same concept already works in other industries here. If it didn't, why would anyone choose a Jaguar over a Ford? So why not life and health insurance?

The Role of Hannover Life Re (UK)

At Hannover Life Re (UK) we believe we have an important role to play in all this. Our experience in the UK is second to none. We also bring to the table the benefit of our worldwide network, which allows us to import some of the most successful ideas from other sophisticated markets around the globe.

We have been working on a variety of different concepts over recent months and years. For example, on the product front, you may find the ideas we have been developing around what we call 'new style' critical illness policies of particular interest. If we haven't already talked to you about these, please give us a call! In the area of underwriting and claims we have identified a number of strategies for improving underwriting processes so as to minimise non-disclosure – which we think you will find well worth looking into!

At Hannover Life Re (UK) we have embraced the concept of partnership continuously for many years. I understand that certain other reinsurers are now purporting to have rediscovered the idea of partnership after long practicing something rather different! Forgive me for being a little sceptical as to the sincerity of their conversion. Partnership is not something you pick up and discard as changing circumstances dictate. We have been partnership-focused all along and fully intend to remain so. And, unlike other reinsurers, we have the track record to bear us out on this. As I say year after year, we are all in this together!

Happy Christmas!

In closing I would like to register my sincere thanks to all our customers for your support – and to all my staff at Hannover Life Re (UK), whose expertise and dedication make us the exceptional company I firmly believe we are. And finally, here's wishing you all a very Happy Christmas and a Healthy New Year!



David Brand
Managing Director

Skin Cholesterol

Skin cholesterol, also known as skin sterol is a good indicator of the atherosclerosis risk. It is a better for insurance purposes than a serum cholesterol test where only one test is desired. It is quick and non-invasive (no blood). It measures the historic deposition of cholesterol, mirroring the build-up of cholesterol in the arteries. It cannot be affected by short-term changes in diet or through the use of statins.

Cholesterol can be found in a number of places in the body in addition to the bloodstream. Eleven percent (11%) of all cholesterol on the body is in the skin. Cholesterol in the skin is usually called skin cholesterol or sterol, as opposed to cholesterol in the blood which is usually called serum cholesterol.

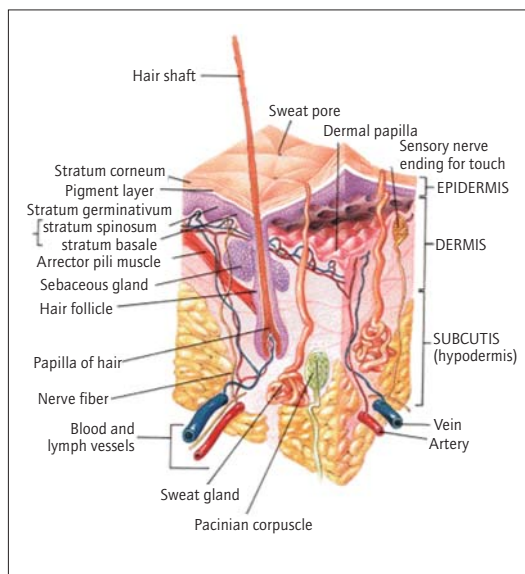
There are distinct differences between cholesterol found in skin and cholesterol in the serum. Skin cholesterol accumulates over time in the tissues of the skin. Unlike serum cholesterol it is therefore a measure of the long-term deposition of cholesterol in the body. The deposition rate is dependent on the levels of cholesterol in the body (serum) and the rate at which the skin manufactures cholesterol. Cholesterol accumulates in the skin in proportion to the accumulation of cholesterol in the coronary arteries.

In contrast, serum cholesterol binds to protein in the blood and its levels respond to the current diet and levels of production of cholesterol in the individual. Unlike skin cholesterol serum cholesterol breaks down into fractions: HDL, LDL and others.

Serum cholesterol	Skin sterol
Blood based	↔ Skin based
Protein bound	↔ Tissue bound
Point in time	↔ Long-term view
Fractions (HDL, LDL, others)	↔ No fractions

It is perhaps not surprising that skin cholesterol has been found to be an independent risk marker for cardiovascular disease (e.g. myocardial infarctions) to LDL-C in serum cholesterol. For insurance myocardial infarctions lead directly to critical illness claims, which are a leading cause of death and can also lead to IP claims.

PreMD have introduced both a point of use and laboratory test that can accurately measure skin cholesterol called PREVU *. These are available in the UK and Irish markets through Gemini Biomedical. The point of use test is currently being trialled in Ireland, and the even easier laboratory test will be introduced in early 2008.



Skin cholesterol

Skin consists of an epidermal layer on top of the capillary-bearing dermis layer. The epidermis itself consists of a number of layers, with new outer layers being formed continually, as the old exterior is shed into the environment. To protect the body the epidermis forms a barrier to control the diffusion of hydrophobic and hydrophilic substances.

The effective working of this barrier is highly dependent on the presence of lipids, including none-sterified cholesterol. Some of this cholesterol is produced by the epidermal cells themselves, but some is taken-up from blood serum via low-density lipoprotein (LDL) and Scavenger Receptor class B type I (SR-B1) receptors on the interface with the dermal layer. The relative importance of the two sources is still an open topic.

As the outer layer of cells is shed into the environment so are lipids. It is estimated that 10% to 15% of body cholesterol is removed in this way, making it the second most important route after the liver.

The effect of skin cholesterol has been explored in a number of studies.

Skin cholesterol and myocardial infarction (MI)¹

A study of 649 Canadian patients, not on lipid lowering medications, undergoing non-emergency diagnostic catheterisation had their skin cholesterol measured. The reason for the investigation included anginal symptoms (>90%) and positive stress tests (>60%), therefore this was a population already identified as high-risk.

¹ Sprecher DL et al. Elevated skin tissue cholesterol levels and myocardial infarction. *Atherosclerosis* 2005; 181:371-373

Patients with a history of MI (n=225, 35%) had significantly higher skin cholesterol than those without MI (skin cholesterol measure of 127 ± 29 SD versus 120 ± 20). Even after adjustment for traditional risk and extent of angiographic disease the results showed that skin cholesterol may indicate increased risk of coronary-artery events than simply the presence of angiographic narrowing.

Skin cholesterol related to angiographically-defined cardiovascular disease²

The same study had previously been used to show that skin cholesterol was correlated with the number of vascular narrowings. See Graph 1.

Skin cholesterol and serum LDL-cholecholesterol

The same study showed that skin cholesterol and serum LDL-cholecholesterol (or total serum cholecholesterol) were not correlated with disease as measured by angiography. This observation raises an issue that in this and other studies serum LDL-cholecholesterol has not been particularly valuable in predicting the extent of disease^{3,4}.

Skin cholesterol and carotid intima-media thickness⁵

This separate study concluded that skin cholesterol was an easy-to-measure, non-invasive marker that can help identify subclinical atherosclerosis in asymptomatic middle-aged adults. Levels of skin cholesterol correlated with the thickness of the carotid intima-media (C-IMT). This is important as C-IMT is a proven determinate of cardiovascular disease risk and of future coronary events.

Skin cholesterol and Framingham risk score

The Mancini⁶ study showed that skin cholesterol and the Framingham risk score were correlated.

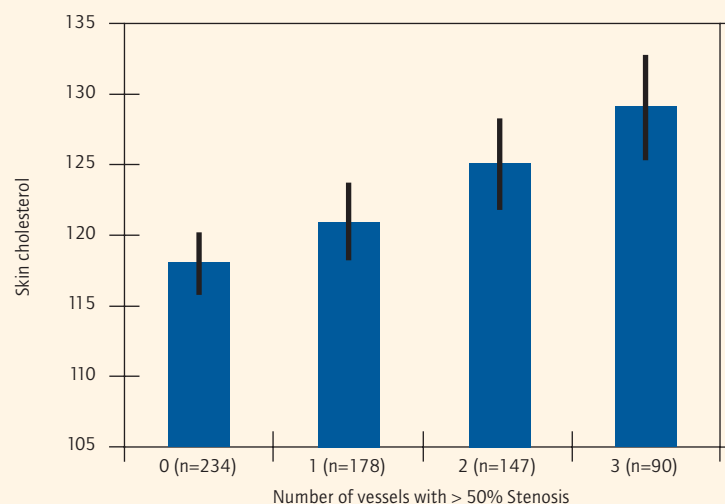
The Framingham risk score was developed from a large-scale, long-term longitudinal study on inhabitants of Framingham, Massachusetts. The major risk factors the study identified are high blood pressure, high blood cholesterol, smoking, obesity, diabetes and physical inactivity. It is a widely-used scoring system in the medical community to quickly identify high-risk patients.

Skin cholesterol and positive stress tests⁷

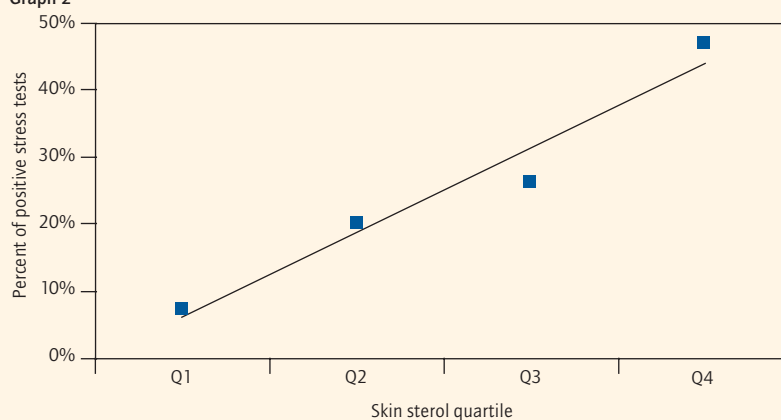
A pilot study for PREVU* was run on 111 generally healthy, patients of median age 50 and no known history of coronary artery disease (CAD), who had undergone treadmill stress testing because of reported chest discomfort. This showed that skin cholesterol was strongly correlated with positive stress tests. See Graph 2.

The predicative value of skin cholesterol was not diminished even after adjusting for serum lipids (e.g. LDL, HDL), age, sex, body mass index (BMI), hip-waist ratio, familial history of CAD, diabetes, hypertension and smoking.

Graph 1



Graph 2



A US 10,000 patient study (the PREPARE study) of subjects applying for life insurance has recently been completed for the purpose of determining the relationship between PREVU* laboratory test and Framingham Score in this low-risk population. Results from this study will be available in early 2008.

PREVU* tests

The PREVU* point of use test works by incubating a drop of a synthetic copolymer conjugated with digitonin and horseradish peroxidase (HRP) on the cleansed surface of the palm. The palm is used as the epidermal layer is only 0.8mm or less thick at this point and skin-produced lipids are minimal at this point.

After a minute in contact with the skin the digitonin has complexed with the cholesterol in the skin, the quantity of which can be read from a spectrophotometer measuring the reaction of an indicator solution with the HRP bound with the digitonin.

The laboratory test is even easier with only the application of the test strip to the palm for a short period of time, before it is then safely stored and sent off to the laboratory for analysis.

Both tests are totally painless and non-invasive.

The results are shown as units of skin Tc.

²Sprecher DL et al. Skin tissue cholesterol is related to angiographically-defined cardiovascular disease. *Atherosclerosis* 2003; 171:255-258

³Frick MH et al. Serum lipids in angiographically assessed coronary atherosclerosis. *Chest* 1978;73(1):62-5

⁴Ponec M et al. Cultured human skin fibroblasts and keratinocytes: differences in the regulation of cholesterol synthesis. *J Invest Dermatol* 1983;81(2):125-30

⁵Tzou WS et al. Skin cholesterol content identifies increased carotid intima-media thickness in asymptomatic adults. *American Heart Journal*; December 2005;1135-1139

⁶Mancini J et al. Association of skin cholesterol content, measured by a non-invasive method, with markers of inflammation and Framingham risk predictor. *The American Journal of Cardiology*; 2002 89(11):1313-1316

⁷Zawdyiwski R. *Clin Chem* 2001;47:1302

Ratings

Gemini, in conjunction with the actuaries at Redmayne Consulting, have developed a rating scale for skin cholesterol which is available with supporting evidence on request.

Cholesterol is also used to flag potential diseases that require further investigation. For example high cholesterol is a marker for hypercholesterolaemia, hypothyroidism, diabetes, nephrotic syndrome, porphyria and chronic hepatitis, whilst low cholesterol could mean acute hepatitis, hyperthyroidism, uraemia and malnutrition.

Application

Ideally one would want clients to have both skin and serum cholesterol tests. However time, and more importantly money, will usually dictate that only one test is required. In this case the skin cholesterol test can be seen to be a better test for insurance purposes than serum cholesterol.

- Skin cholesterol is quick and non-invasive. Serum cholesterol currently implies at least a finger-prick blood test.

- Skin cholesterol measures our main risk: the deposition of cholesterol in the body. Serum cholesterol only measures cholesterol moving round the body now.
- Skin cholesterol measures the effect of a person's history on their health. Serum cholesterol can be lowered in the short-term through diet or the use of cholesterol-lowering drugs such as statins. This need not be anti-selective, but could be on medical grounds.

Summary


Skin cholesterol testing provides an exciting new tool for underwriters. Medical research has shown a powerful correlation with high-risk diseases. The results of the US insurer study are expected to show that it is an effective risk marker for the insured population.

Overall skin cholesterol can be seen to have many advantages over serum cholesterol from both the client and insurer perspective.

Nigel Bradshaw

Managing Director, Redmayne Consulting
Commercial Director, Gemini Biomedical Limited

The Critical Path



Our successful annual Underwriting Seminar was held at the Royal College of Physicians, London in October attended by over 40 underwriting and claims professionals from within the life and health industry.

This year we covered the life cycle of a protection product, from sale to underwriting through to claim.

The morning session included a presentation by Ian Nicholson, who is a partner with Cavendish Financial Services. He gave a first hand account of the sales experience including the point of sale process and shared with the audience his perceptions of underwriting and claim issues.

Andrew Gething, Managing Director of Morgan Ash covered tele-underwriting and Sarah Brown of HLRUK gave an overview of how Critical Illness Cover has evolved over the years and where we believe it is heading. Sarah also spoke about some of the new underwriting technologies that are available or soon will be.

The afternoon session was dedicated to claims handling. Stephen Chapman, HLRUK, gave an overview of claim handling techniques including the ABI Statement of Best Practice and some handy hints on spotting non-disclosure. John Saunders, Linden Claims International, gave an interesting and entertaining presentation focusing on his area of expertise, overseas claims and the day finished with a presentation entitled Critical Illness Complaints: An Ombudsman's Perspective, given by Melissa Collett of the Financial Ombudsman Service.

Look out for future seminars or contact us at uk.marketing@hannover-re.com.

Competition

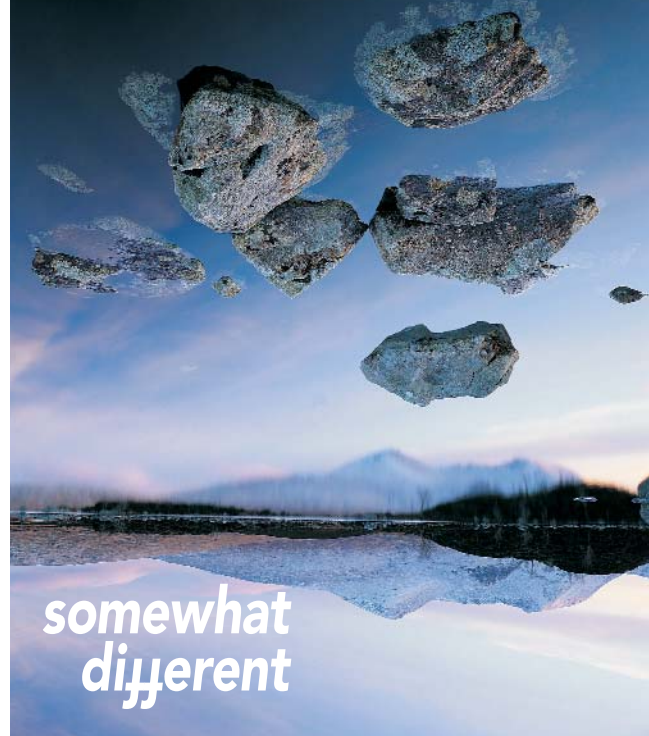


For your chance to win the challenging Optix memory game for Christmas please answer the following questions.

1. What are the three different types of memory?
2. In what year were the first electric Christmas lights used?

3. When singing the "12 days of Christmas" what is the total number of gifts given?

Send you answers to uk.marketing@hannover-re.com by **14th December 2007** to be entered into the prize draw.



**somewhat
different**

Our office hours over the Christmas holiday period

Monday 24th December 2007	Closed	Friday 28th December 2007	9am – 4pm
Tuesday 25th December 2007	Closed	Monday 31st December 2007	Closed
Wednesday 26th December 2007	Closed	Tuesday 1st January 2008	Closed
Thursday 27th December 2007	9am – 4pm	Wednesday 2nd January 2008	Normal office hours

From all at Hannover Life Re (UK) we wish you a Merry Christmas and successful New Year.

We hope you enjoy **In Focus** and we welcome your feedback, please forward any comments to Kirsteen Grant. If you wish to be added to our mailing list contact Kirsteen on 01344 846833 or email uk.marketing@hannover-re.com.

© Hannover Life Re (UK) Ltd
All rights reserved.

The opinions expressed in this publication are those of the authors. This publication is subject to copyright. All rights reserved. Apart from any fair dealing for the purposes of research or private study, no part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior permission in writing of Hannover Life Re (UK) Ltd. Single copies may be made for the purposes of research or private study. Multiple copying of the content of this publication without permission is always illegal.

CONTACT




**The Shooting Star
Children's Hospice**

Supporting 'The Shooting Star Children's Hospice' who believe in enhancing quality of life, when every moment counts.

Published by: Hannover Life Reassurance (UK) Ltd
Registered Office: Hannover House, Virginia Water, Surrey GU25 4AA
Tel: 01344 845282 Fax: 01344 845383
www.hannoverlifere.co.uk Registered in England 1752067.
Authorised and regulated by The Financial Services Authority.