Continuous Mortality Investigation

Life Office Mortality Committee

WORKING PAPER 36

The mortality of impaired assured lives: Report on 1995-2006 experience and consultation on the future of the investigation

January 2009

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CMI Working Paper 36

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1 Introduction

The CMI's investigation into the mortality of impaired assured lives has run from 1 January 1982 and includes only policies written on or after that date. Key features of the data collected include:

- The investigation covers an extensive list of impairments, including Hypertension, Ischaemic Heart Disease, Cerebrovascular Disorders and Tumours.
- Some of these impairments are sub-divided by the degree of impairment.
- All assured lives classes are included (whole life and endowment, temporary, etc).
- As with the main CMI life office mortality investigation, policies subject to exclusions on cover, rather than increased premiums, are not included.
- Inclusion does not depend on the policy being rated; if there is medical evidence to indicate that it falls within the impairment coding list it can be included, whether or not it is treated adversely by the office. (Such cases not adversely treated can also be included in the assured lives (normal rates) investigation.)
- Lives with two or more major impairments (i.e. where each would be rated in its own right) should, in general, be omitted from the investigation. An exception to this rule is hypertension and overweight, when the weight is ignored and the life included in the hypertension group.

The reports on the mortality of impaired assured lives cover a rolling period of twelve years. A report on the latest data, covering the years 1995-2006, is contained in section 2 of this paper.

In recent years, the investigation has received data from a small, and reducing, number of offices, because of the difficulties in supplying data. In recent years, the number of offices participating in the investigation as well as the volumes of new business reported by these offices under this investigation has reduced. Further falls in data volumes for 2006 have cast doubts over the credibility of the results, and the CMI has now decided to cease collecting data in its current form for years after 2006.

The CMI believes that the information yielded by this investigation has strategic importance to the insurance industry, in demonstrating the need to underwrite, to charge additional premiums for impaired lives and also to help better understand trends in non-impaired mortality and is therefore seeking views on possible approaches for the future.

Section 3 sets out possible options for a revamped future investigation into impaired lives, including a set of questions on which specific feedback is being sought. Responses to this consultation are requested by 28 February 2009 and should be sent to mortality@cmib.org.uk and include name, position, company name and contact details.

2 The mortality of impaired assured lives, 1995-2006

2.1 Summary

The reports on the mortality of impaired assured lives cover a rolling period of twelve years. The Life Office Mortality Committee believes that this period maximises the number of deaths available for investigation while still being short enough to preclude secular changes in mortality from having too big an influence on the results. On this occasion data for the years 1995-2006 is covered. The previous report (CMI Working Paper 10) covered data for the period 1991-2002.

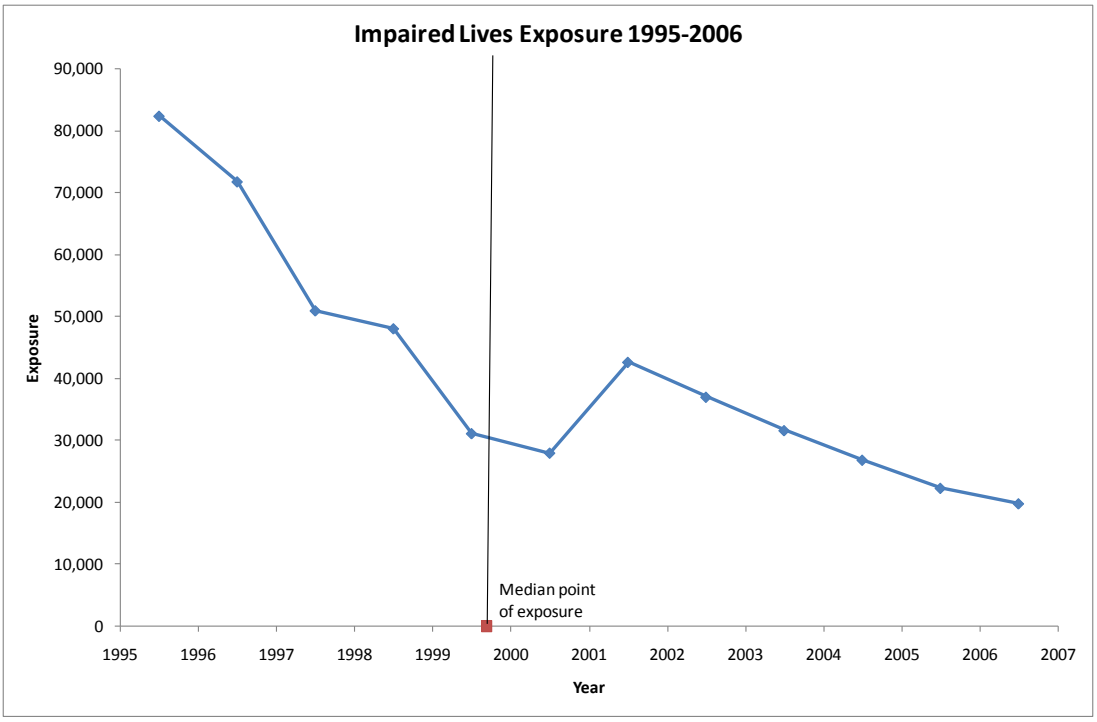
The sections that follow cover the data build up, the results in general, and comments on a number of impairments with sufficient data to allow more detailed study. The tables relating to the text are placed together at the end of this section on pages 7 to 14.

2.2 The Data

Tables IMP 1a and IMP 1b show, for males and females respectively, the exposed to risk and the deaths in the same impairment groups as were shown in the last report.

The investigation covers policies, separately coded, from each of the major categories of life assurance business investigated by the CMI. These are single life permanent (whole life and endowment), both linked and non linked, and temporary, plus joint life first death. However, again in order to maximise the data, all classes are combined for the purposes of this report. The number of offices participating in the investigation has reduced since the last report. Further, the volume of new business reported under this investigation by these offices has also been reducing, in part reflecting reducing sales of the underlying products.

The following figure illustrates the decline in data volumes over the period considered, showing the total exposure, for males and females combined, received for each investigation year. The vertical line represents the median point of exposure, and is discussed further in section 2.3 below.



2.3 The Results – General Comments

The results are presented in Tables IMP 2a and IMP 2b. These show, for broad impairment groups, the exposed to risk, the actual deaths and the percentage ratios of the actual deaths to those which would have been expected using the AMC00 select table for males, and the AFC00 select table for females. An index showing the additional mortality per 1000 exposed to risk is also given. The 100A/E and additional mortality figures are also provided using the AM92 and AF92 select tables as comparison bases in order to allow comparison with the previous report on the 1991-2002 experience.

The weighted average of the individual years 1995 to 2006 has been calculated, where the weight for each year is the total (male + female) in force at the start of that year. Based on this calculation, the median point for the impaired lives exposure is estimated to lie somewhere around the middle of 1999. It should be noted that falling data volumes in recent years means that this is only three years more than the equivalent median point applicable in the previous report on the 1991-2002 experience. The mortality experience during 1999 of unrated lives in the Permanent Assurances (whole life and endowment, non-linked) investigation against AMC00/AFC00 select for all durations was approximately 104% for males and 101% for females (83% and 93% respectively using the relevant "92" Series table as comparison basis).

In some earlier reports an analysis by duration was possible for some impairment groups, though for many groups there was only enough data to give results for all durations combined. However, as data volumes have continued to fall and as was the case for the last report, there is no longer sufficient data to validate any analysis by duration. Therefore, all analysis and commentary in this report is based on all duration data only.

It should always be kept in mind that the results in most impairment groups are based on a limited number of deaths, and that there are wide variations between the sub-groups in each category.

2.4 The Results by Impairment

The following paragraphs cover only those groups of impairment where there are sufficient data to provide significant results. In the following commentary, additional risk is measured by comparing the 100A/E for the impairment group with the 100A/E for unrated lives.

a. Hypertension

For all age groups it is clear that hypertension is a significant extra risk both for males and females. As seen in the previous report on impaired lives, the lower the age at entry, the higher the additional risk for females. For males the additional risk is greatest at the middle age range and increases with the severity of the hypertension. For females, the data are too few to allow a full analysis by severity of the hypertension.

b. Ischaemic heart disease without surgery

The additional risk is very heavy among males entering at ages below 50. There is not enough data for females entering at ages below 50 to reach any conclusions. At ages over 50, the additional risk for both males and females is less than that for those entering below age 50, but tends to increase as the time since onset lengthens, converging at a point for both sexes about twice the mortality recorded for standard lives.

c. Ischaemic heart disease with surgery

There are a significant number of deaths among the males and the additional mortality recorded is heavy though not as much as in the last report. Similarly to the previous report, a higher additional mortality is recorded among the females, but the number of deaths on which this conclusion is based is again small.

d. Nervous disorders

The distinct difference, for both males and females, between those whose disorder is defined as mild or moderate and those whose disorder is severe continues to be observed. For males, those with a mild or moderate diagnosis experience a level of mortality similar to that experienced by standard lives, while for females the level is higher than for standard lives. Those with a severe diagnosis suffer a significant additional risk; this is higher for females, than for males.

e. Disseminated sclerosis

There is a severe additional risk apparent, with the additional risk being higher for females. The additional risk for males is broadly similar to that observed in the previous report, while for females it is significantly higher.

f. Peptic ulcer

For males, there is some extra risk for cases both with and without surgery; this was also the case in the previous report although in both cases the experience appears to have deteriorated. The risk is higher for those with surgery and as noted in previous reports logic would suggest that these are the more serious cases. While there is relatively little female data, the mortality is broadly at the level of that recorded for standard lives, as was observed in the last report.

g. Epilepsy

For both sexes, the recorded additional risk is significant, but for females the number of deaths on which this conclusion is drawn is small.

h. Diabetes mellitus

Among males there is a clear distinction between the mortality experience of early onset and late onset cases, with that of early onset being much the heavier. There is a similar pattern for females, although the number of deaths is smaller.

i. Respiratory disorders

There is some additional risk for males suffering bronchial asthma. Where this degenerates to chronic bronchitis the risk is much heavier. Emphysema on its own shows very severe additional mortality.

j. Tumours

For females, the additional risk for malignant tumours appears to be extremely high. The number of deaths for non-malignant tumours is too small to reach any conclusions. The number of male deaths is also too small to reach any conclusions.

k. Overweight

Like the previous report there appears to be significant additional risk for males and females with the additional risks generally increasing with the extent of being overweight.

2.5 Conclusions

The exposed to risk has continued to reduce, particularly at durations 0 and 1, due to fewer offices contributing data across a number of years. Volumes of new business reported by the remaining offices under this investigation are also falling.

While the investigation has yielded what the Executive Committee believes to be useful results, their credibility is limited by the data volumes available. As noted previously, the CMI has now decided to cease collecting data in its current form for years after 2006 and section 3 of this paper contains a consultation on possible approaches to the future of the investigation.

It remains to thank those offices that have contributed data over the years.

Table IMP 1a. Impaired lives 1995-2006, males: deaths and exposed to risk in impairment groups, by curtate duration.

	Duration 0		Duration 1		Durations 2 & over		All durations	
Impairment	Deaths	Exposed to risk	Deaths	Exposed to risk	Deaths	Exposed to risk	Deaths	Exposed to risk
Hypertension	0	620	2	815	277	19,321	279	20,755
IHD without surgery	4	553	12	774	486	17,283	502	18,610
IHD with surgery	2	273	2	381	92	4,796	96	5,449
Cerebrovascular disease	0	107	1	131	39	2,026	40	2,264
Nervous disorders	1	976	3	1,177	110	20,081	114	22,233
Disseminated sclerosis	1	72	0	94	31	2,310	32	2,475
Peptic ulcer	0	53	1	102	89	8,158	90	8,313
Ulcerative colitis	0	235	0	330	22	5,968	22	6,532
Crohn’s disease	0	165	0	197	20	4,011	20	4,373
Epilepsy	0	81	3	124	39	5,630	42	5,835
Diabetes mellitus	5	1,354	8	1,865	346	34,583	359	37,801
Respiratory disorders	7	2,152	9	2,602	216	35,676	232	40,430
Urinary disorders	0	54	0	73	28	2,870	28	2,996
Malignant tumour	1	85	0	86	3	410	4	581
Overweight	3	2,264	9	3,242	309	54,389	321	59,894
All impairments in investigation	24	9,040	50	11,989	2,107	217,508	2,181	238,537

Table IMP 1b. Impaired lives 1995-2006, females: deaths and exposed to risk in impairment groups, by curtate duration.

	Duration 0		Duration 1		Durations 2 & over		All durations	
Impairment	Deaths	Exposed to risk	Deaths	Exposed to risk	Deaths	Exposed to risk	Deaths	Exposed to risk
Hypertension	3	239	3	354	217	9,859	223	10,451
IHD without surgery	2	126	0	210	122	3,858	124	4,193
IHD with surgery	0	36	0	53	18	499	18	588
Cerebrovascular disease	0	42	0	68	24	1,078	24	1,187
Nervous disorders	3	1,845	2	1,983	110	26,378	115	30,206
Disseminated sclerosis	0	110	0	168	42	3,019	42	3,296
Peptic ulcer	1	29	0	47	13	1,948	14	2,024
Ulcerative colitis	0	164	1	242	9	3,262	10	3,668
Crohn’s disease	0	190	0	251	14	3,263	14	3,704
Epilepsy	1	89	0	145	14	4,966	15	5,200
Diabetes mellitus	1	626	12	949	123	13,916	136	15,491
Respiratory disorders	4	2,543	5	3,068	164	33,955	173	39,566
Urinary disorders	0	32	0	36	8	1,430	8	1,498
Malignant tumour	1	162	4	194	76	4,170	81	4,526
Overweight	5	4,135	13	6,794	361	113,727	379	124,655
All impairments in investigation	21	10,365	40	14,559	1,315	225,324	1,376	250,248

Table IMP 2a. Impaired lives, 1995-2006, males, all investigations and all durations combined: exposed to risk, actual deaths, percentage ratios of actual deaths to those expected using the AMC00 and AM92 select tables (100A/E) and excess deaths per 1000 exposed to risk (A–E $^{o}/_{oo}$).

					AMC00 Select table		AM92 Select table	
Impairment			Exposed to risk	Actual deaths	100 A/E	A–E $^{o}/_{oo}$	100 A/E	A–E $^{o}/_{oo}$
Hypertension								
Entry ages	SAP	DAP						
Under 40	all	all	5,737	17	141	0.9	112	0.3
40-59	155 & over	under 95	3,737	43	196	5.6	153	4.0
40-59	155 & over	95-105	4,637	34	126	1.5	98	0.0
40-59	under 155	95 & over	2,411	17	122	1.3	95	0.0
40-59	155 & over	over 105	1,674	26	228	8.7	178	6.8
40-59	all	all	12,459	120	161	3.7	126	2.0
60 & over	160 & over	under 100	1,487	78	121	9.2	103	1.6
60 & over	160 & over	100-110						
60 & over	under 160	100 & over	971	53	130	12.7	110	4.9
60 & over	160 & over	over 110	102	11	273	68.4	230	60.9
60 & over	all	all	2,560	142	130	12.8	110	5.2
Ischaemic heart disease (without surgery)								
Entry ages	Onset							
Under 50	within 4 years		3,285	32	271	6.2	211	5.1
Under 50	4 years & over		2,616	37	366	10.3	284	9.2
50 & over	within 2 years		3,123	83	131	6.3	108	1.9
50 & over	2-4 years		2,510	62	146	7.8	118	3.8
50 & over	4-6 years		2,192	77	204	17.9	165	13.9
50 & over	6 years & over		4,885	211	201	21.7	166	17.1
Ischaemic heart disease (with surgery)			5,449	96	176	7.6	140	5.0

Table IMP 2a. (Continued).

Impairment		Exposed to risk	Actual deaths	AMC00 Select table 100 A/E	AMC00 Select table A–E ‰	AM92 Select table 100 A/E	AM92 Select table A–E ‰
Cerebrovascular disorders		2,264	40	170	7.3	138	4.9
Nervous disorders							
Mild or moderate		15,112	66	101	0.1	81	0.0
Severe (including schizophrenia & attempted suicide)		7,122	48	165	2.7	132	1.6
Disseminated sclerosis		2,475	32	406	9.7	320	8.9
Peptic ulcer							
Without surgery		6,520	56	138	2.4	111	0.9
With surgery		1,793	34	210	9.9	172	8.0
Ulcerative colitis		6,532	22	121	0.6	96	0.0
Crohn's disease		4,373	20	205	2.3	164	1.8
Epilepsy		5,835	42	201	3.6	163	2.8
Diabetes mellitus							
Entry ages	Years since diagnosis						
Under 50	all	29,600	139	288	3.1	232	2.7
50 & over	under 10	5,549	129	167	9.3	134	5.9
50 & over	10 or more	2,652	91	278	22.0	222	18.9

Table IMP 2a. (Continued).

Impairment		Exposed to risk	Actual deaths	AMC00 Select table 100 A/E	AMC00 Select table A–E ‰	AM92 Select table 100 A/E	AM92 Select table A–E ‰
Respiratory disorders							
Bronchial asthma		38,653	172	137	1.2	110	0.4
Chronic bronchitis without emphysema		1,234	32	276	16.6	224	14.4
Chronic bronchitis with emphysema		315	17	250	32.4	208	28.1
Emphysema without bronchitis		229	11	560	39.5	444	37.3
Urinary disorders		2,996	28	153	3.3	126	1.9
Tumours							
Breast, malignant		581	4	108	0.5	88	0.0
Overweight							
Entry ages	Overweight %						
Under 30	20-30	13,832	12	130	0.2	114	0.1
Under 30	over 30	5,663	4	94	0.0	81	0.0
30-49	20-30	19,198	69	187	1.7	150	1.2
30-49	over 30	11,935	51	200	2.1	159	1.6
50 & over	20-30	6,537	125	139	5.3	111	1.8
50 & over	over 30	2,730	60	181	9.9	145	6.8
Non-rated lives - 1999				104		83	

Table IMP 2b. Impaired lives, 1995-2006, females, all investigations and all durations combined: exposed to risk, actual deaths, percentage ratios of actual deaths to those expected using the AFC00 and AF92 select tables (100A/E) and excess deaths per 1000 exposed to risk (A–E $^{o}/_{oo}$).

					AFC00 Select table		AF92 Select table	
Impairment			Exposed to risk	Actual deaths	100 A/E	A–E $^{o}/_{oo}$	100 A/E	A–E $^{o}/_{oo}$
Hypertension								
Entry ages	SAP	DAP						
Under 40	all	all	2,035	6	194	1.4	164	1.2
40-59	all	all	5,538	52	182	4.2	167	3.8
60 & over	all	all	2,878	165	124	11.0	133	14.3
all	all	all	10,451	223	135	5.6	140	6.1
Ischaemic heart disease (without surgery)								
Entry ages	Onset							
Under 50	all durations		823	4	201	2.4	174	2.1
50 & over	within 4 years		1,653	52	170	12.9	173	13.3
50 & over	4 years & over		1,717	68	175	17.0	181	17.7
Ischaemic heart disease (with surgery)			588	18	333	21.4	325	21.2
Cerebrovascular disorders			1,187	24	199	10.1	200	10.1
Nervous disorders								
Mild or moderate			21,552	70	120	0.6	111	0.3
Severe (including schizophrenia & attempted suicide)			8,654	45	187	2.4	171	2.2
Disseminated sclerosis			3,296	42	594	10.6	524	10.3
Peptic ulcer								
With or without surgery			2,024	14	107	0.5	105	0.3

Table IMP 2b. (Continued).

Impairment		Exposed to risk	Actual deaths	AFC00 Select table 100 A/E	AFC00 Select table A–E $^{o}/_{oo}$	AF92 Select table 100 A/E	AF92 Select table A–E $^{o}/_{oo}$
Ulcerative colitis		3,668	10	168	1.1	148	0.9
Crohn's disease		3,704	14	301	2.5	257	2.3
Epilepsy		5,200	15	164	1.1	145	0.9
Diabetes mellitus							
Entry ages	Years since diagnosis						
Under 50	all	12,209	50	410	3.1	343	2.9
50 & over	under 10	1,987	51	187	12.0	187	11.9
50 & over	10 or more	1,296	35	238	15.6	233	15.4
Respiratory disorders		39,566	173	202	2.2	187	2.0
Urinary disorders		1,498	8	230	3.0	212	2.8
Tumours							
All malignant excluding cervical		3,455	75	300	14.5	289	14.2
Breast, non malignant, and uterine fibroids		1,071	6	236	3.2	207	2.9

Table IMP 2b. (Continued).

Impairment		Exposed to risk	Actual deaths	AFC00 Select table 100 A/E	AFC00 Select table A–E $^{o}/_{oo}$	AF92 Select table 100 A/E	AF92 Select table A–E $^{o}/_{oo}$
Overweight							
Entry ages	Overweight %						
all	20-40	97,653	292	123	0.6	113	0.3
all	over 40	27,002	87	149	1.1	135	0.8
all	all	124,655	379	128	0.7	117	0.5
Non-rated lives - 1999				101		93	

3 Consultation on options for a revamped future investigation into the experience of impaired lives

3.1 Background to this consultation

The CMI is currently updating the data submission for the main life office mortality investigation to "Per Policy" data. The first coding guide was issued alongside CMI Working Paper 19 in December 2005 and subsequent versions are available from the website. At that time no changes were made in respect of impaired lives; i.e. the previous coding guidelines were retained without any amendments. Whilst the CMI recognised that few offices would be able to complete the impairment field, we did not wish to defer the main move to per-policy submission further. We were also keen to continue to collect impaired lives' data from those offices that were able to supply it.

In Working Paper 19, we indicated that we intended to consult on alternative approaches for impaired lives in due course. That paper also included some discussion of possible approaches, perhaps using the type of rating (e.g. medical) rather than the underlying reason for the rating (e.g. high blood pressure) or discussing standardisation of the impairment codes for reinsurance data as well as CMI analyses. This document initiates that consultation.

3.2 The scope of a future investigation

The original investigation was restricted to impaired assured lives but substantial markets now exist in impaired annuities and critical illness insurance. Different underwriting considerations apply to these products, with impaired annuities looking to segregate high-risk cases that may have been declined for assurances and critical illness insurance focusing on diagnosis rather than death. Hence questions are included in the consultation on whether, if a new investigation is launched, its scope should include these products. The inclusion of either product may increase the range of impairments that need to be addressed.

The existing investigation did not encompass lives subject to exclusions on cover. Such practice is probably more prevalent for critical illness insurance than mortality-only assurances (and is obviously irrelevant to annuities) so an additional question is included in the consultation on whether, if a new investigation is launched, it should be broadened to cover exclusions.

If a new investigation encompasses exclusions, it will be essential to separate exclusions from increased premiums, as the claims experience should be quite different – i.e. experience of settled claims may be lighter than normal for business subject to exclusions, whereas heavier experience would be expected for lives subject to increased premiums.

It could also be useful to collect information on claims declined as a result of the exclusion, even though such information may be incomplete (as such claims may not even be notified to the office).

3.3 Data to be collected in a future investigation

A number of high-level approaches have been identified and are set out below. These should all be viewed in the context of business that is subject to an underwriting process. The approaches range from one that collects no information on the nature of the impairment itself (option 1, below) to one that seeks to use more up-to-date categorisation of impairments than the existing investigation (option 4). The first will provide least value in terms of results, but data submission should be relatively straightforward; subsequent options become more complex but potentially yield greater benefits if it is possible for data contributors to supply the relevant data fields. Their views are therefore especially welcome. Suggestions for other approaches are also welcomed.

Option 1 – no details regarding impairment

With "Per Policy" data submissions the CMI has requested details of all policies/lives regardless of whether there is a rating or exclusion applied. However there is then a mandatory field to indicate whether or not the benefit has been issued on non-standard terms for that life.

Under this option, the CMI would only seek the basic information of whether the benefit has been issued on standard terms, subject to a rating or subject to an exclusion. Analyses could be undertaken on "standard business", "rated business", "business with exclusions" and combinations of these, but we would not be able to undertake any further analysis of the non-standard benefits, for example by type of impairment.

The CMI anticipates that it would be relatively easy for offices to submit data under option 1. The benefits from the investigation are limited though:

- The data should help to demonstrate the case for underwriting, if mortality experience on rated business exceeds that on standard business. It cannot, though, provide justification for the terms applied on any particular impairment.
- It might also provide high-level data on the proportion of cases that are issued on non-standard terms that an individual office could compare itself with.
- It may help to demonstrate whether changes in standard rates experience arose from changes in underlying mortality or from changes in underwriting practices.

Option 2 – collect data by type of rating

Under this option, the CMI would seek a single additional field for those benefits issued on "non-standard terms", differentiating according to the nature of the additional risk. Further consideration would be given to the options for this field but is anticipated that these would include medical, occupation and avocation.

An additional field would be required to distinguish between increased premiums and exclusions of cover, if the latter are included within the investigation.

In addition to the benefits suggested under option 1, above, some segregation of the non-standard business would be possible under this option. However if most non-standard business falls within the medical category, rather than say occupational, the benefits of collecting this additional field would be limited.

Option 3 – collect data by level of premium rating

Under this option, the CMI would seek a single additional field for those benefits issued subject to ratings, differentiating according to the level of the rating applied. Such ratings are often expressed in terms of a percentage extra mortality and for these cases the actual additional risk could be compared (in aggregate) with the level assumed. Consideration would need to be given to whether other forms of rating would also be included (and how they would be treated).

This would allow assessment of whether the amounts of ratings are supported by the mortality experience in aggregate, but it would not be possible to analyse which impairments give rise to differences.

Note that it would be possible to pursue both option 2 and option 3, if offices are able to supply the required fields and they are considered worthwhile.

Option 4 – collect data by type of impairment

This option would come closest to replacing the current investigation. A full review of the codes would be needed, which is likely to involve medical underwriters and perhaps even access to CMOs to produce a draft for consultation. The data requirements will be difficult for offices to implement so data is only likely to be available for future new business, giving rise to considerable delays until meaningful results can be generated. It would also necessitate the greatest resource from offices to supply the data, but would have the greatest potential benefits of the options being proposed if it helps to justify the differential treatment of policyholders.

Working Paper 19 suggested that such an approach might be more practical if it were possible for these impairment codes to be used more widely, for example in relation to reinsurance data. Views on the desirability of such industry standardisation are welcomed.

Note that it would be possible to pursue both option 3 and option 4. Indeed if it is possible to collect the level of rating, then it may be feasible to simplify some of the impairment codes, relying on the level of rating to reflect the severity of the impairment. Such an approach would be vulnerable to changes in underwriting standards or medical opinions, though.

Appendix – Consultation questions

Please differentiate your responses between mortality-only assurances, annuities and critical illness insurance as appropriate.

Question 1:
Should the CMI replace the terminated investigation with a new impaired lives' investigation?

Question 2:
Should the scope of a new impaired lives investigation cover:

a) Mortality-only assurances?
b) Annuities?
c) Critical illness insurance?

Question 3:
Should a new impaired lives investigation cover exclusions of cover as well as premium ratings?

Question 4:
Please express your views regarding the potential benefits from the impaired lives investigation under the options outlined in section 3.3. Please differentiate between mortality-only assurances, annuities and critical illness insurance if relevant.

Question 5:
Please express your views on the practicalities of industry standardisation of impairment codes under option 4.

Question 6
Please make any additional suggestions for approaches to an impaired lives investigation that might be followed.

Question 7 (current and potential data contributors only):
What fields do you currently hold on your main systems that you would expect to be able to provide to an impaired lives investigation?

Question 8 (current and potential data contributors only):
Do you expect that you would be able to contribute data to an impaired lives investigation under each of the options outlined in section 3.3? Please give an initial indication, separately for mortality-only assurances, annuities and critical illness insurance of:

a) When you might be able to submit data under each option;
b) Whether this would apply only to new policies or to existing policies also; and
c) Approximate data volumes.

Please send responses by 28 February 2009 to mortality@cmib.org.uk, including name, position, company name and contact details.