Continuous Mortality Investigation

Mortality Committee

Working Paper 13

Draft Mortality Investigation Coding Guide

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Introduction

This Coding Guide provides a description of required data for offices contributing per policy to the Mortality investigation. As it contains certain new rules it should be handed to the person who prepares the office's returns to the CMI and studied carefully. This Coding Guide replaces the previous rules that applied to data being submitted as a schedule of lives.

This Coding Guide may be subject to revision from time to time in the light of the CMI's experience of data collection, market developments and analysis methodology.

1. GENERAL INFORMATION

1.1 Policies to be included in the data submitted

Offices should submit data for all life assurance products sold to individuals in the UK and Republic of Ireland that have any with death or longevity benefit. For the avoidance of doubt, data on savings policies with minimum death cover should also be submitted.

For group products, data should be submitted for defined contribution group stakeholder products. Data should not be submitted for any other group products.

Offices may also offer multiple benefit products where death cover is optional. For such products, data must be submitted on all benefits for all policies sold, regardless of whether death cover has been selected by the policyholder.

1.2 Data required

Data required for each investigation year (N) are:

- In force (i.e. on risk for benefits) on 31st December in year N.
- Policies going out of force in year N

The exact definitions of the data required and the definition of claim year 'N' are given in section 4 below. Whatever the approach used, a consistent approach from one year to the next should be used

1.3 Data submission

All data and queries should be sent to:

Kim Kyle
CMI
Cheapside House
138 Cheapside
London
EC2V 6BW
Tel: 020 7776 3820
Fax: 020 7776 3810
Email: mortality@cmib.org.uk

In the event that Kim is unavailable, Simon Spencer should be able to help you with your query.

Offices are encouraged to contact the CMI at an early stage with any questions and to let us know if any difficulty arises or seems likely to arise with regard to a submission. We are more than happy to assist you.

Details of the format and mode of submission are given in Section 2 below.

1.4 Submission deadlines

Offices are requested to submit data to us by the end of September of the year following that to which they relate, i.e. we would like data on policies going out of force in year N as well as data on policies in force at the end of year N to be supplied by 30/9/N+1.

1.5 Confidentiality

Data supplied to the CMI must contain no personal details whereby the policy holder can be identified, other than a policy number or other internal identifier which permits ready identification of a record should a query or the need for correction arise. The policy number or internal identifier must not change from one submission to the next as it will be used to validate the data submitted against data submitted previously. Beyond this the policy identifier is not used and does not appear in any published results or communication, other than between the CMI and the office concerned. The CMI is registered under the Data Protection Act.

An office's own data are confidential to that office and the CMI takes great care that neither data nor details of an office's claims experience are distributed to third parties without the permission of the office concerned other than as part of pooled industry experience.

2. DATA SUBMISSION

2.1 Physical methods of submission

We are happy to accept data on CD.

The CMI may, however, be able to accept any other commonly used form of electronic data transmission (ZIP disk, JAZ drives etc.) but please contact us beforehand to discuss the matter.

The receipt of data in written form is discouraged due to the processing time required, although this would be acceptable for minor corrections to data after initial submission.

2.2 Submission of data by e-mail

Data can now be accepted as an attachment to an e-mail. The attaching file should, where possible, be compressed (e.g. using WINZIP). The covering e-mail should contain the information set out in 2.3 below.

As with many organisations, filters and firewalls restrict the transmission of emails to the CMI that may contain harmful software. From experience, spreadsheets frequently contain macros, sometimes without the sender's knowledge. For this reason we ask that all files are checked to ensure that they are free of macros before being sent to us.

It would be appreciated if large files could be sent at the end of the working day so as not to block transmission lines. Very large files, i.e. in excess of 5Mb, should be sent on CD as set out in 2.1 above. E-mails should be sent to:

mortality@cmib.org.uk

2.3 Labelling and accompanying information

The CMI receives a regular stream of data from many sources. In order to ensure proper control of data, offices are requested to:

§ Physically label floppy disks, etc. with details of their contents, i.e. office name, investigation (in this case 'mortality'), type of data (in force or policies going out of force) and year.

§ Enclose a covering letter (or email) with the submitted data indicating the person(s) to contact in case of queries (ideally with a summary of contents, e.g. number of records).

3. DATA FORMAT

3.1 Flexibility

The CMI accepts that the resources necessary to convert data from an office's own database(s) into a rigidly specified format may be a discouragement to potential contribution. Clearly though, each office's data will have to be converted into a standard format before being combined with other offices' data. It would be most helpful if the data could be formatted in as near to the standard form as possible (as set out in 3.3 below) but in order to encourage contribution, we are happy to take on a portion of the formatting, given enough explanatory information regarding the submitted format.

3.2 Types of electronic data file

Text/CSV files
Historically, data has been received for CMI investigations in the form of text files and it continues to be a useful default standard. The format should be as described below in Table 1, where either a comma (or other appropriate character) separates each field or the file is arranged in a fixed width format.

Each record should appear on a separate line and, ideally, both a header and 'end of file' record should be included.

Databases
We are happy to accept data in spreadsheet or database format but we would request that database formats are Microsoft Access. For offices using different database software, though importing into Access is often easy, we suggest the data be converted into Text/CSV as described above. Where possible, please include header and 'end of file' records.

3.3 Data records

A record is required for each benefit for each life insured on each policy. This may mean more than one record is required for most policies. For example, on a single life policy with death and waiver of premium benefits, a separate record is required for each of the death and waiver of premium benefits. Each record should occupy one database record or text line and should contain the information in Table 1 below. Data should be provided on all lives, both rated and non-rated, on all ordinary branch policies assurance policies. For annuities, data should be provided on both standard and impaired annuities sold in the UK.

General guidelines on coding are given in Section 4 while guidelines pertinent to a specific field are given in Section 5.

Table 1

Field	**Character Length** (for fixed length submissions)	**Values of Format**
Record type		I = in force at the end of the record year O = policy taken out of force in the record year
Office Number		NNN
Record Year		YYYY
Territory		1 = UK 2 = Eire
Product code		Any alphanumeric
Policy identifier [a]		Any alphanumeric
Benefit identifier [a]		Any alphanumeric
Sex		M, F
Medical type code		M = Life medically examined on entry N = Life not medically examined on entry but satisfactory evidence of health received P = Lives accepted after paramedical examination S = Lives accepted on minimum evidence of health via a shortened proposal form. U = Undifferentiated W = Sold without underwriting
Smoker status		S = smoker N = non-smoker U = undifferentiated
Date of birth		DDMMYYYY
Date of policy proposal		DDMMYYYY
Date of policy commencement		DDMMYYYY
Date of benefit commencement		DDMMYYYY
Date benefit first brought into force during the year		DDMMYYYY
Benefit maturity date		DDMMYYYY
Business Type		H = Hybrid N = Non profits U = Unit linked W = With profits
Premium frequency		P = Recurrent Single Premium R = Regular Premium S = Single Premium
Premiums in payment or paid up		N = Paid up Y = Premium paying
Single or joint life		D = Dual J = Joint life first death or joint life annuity K = Joint life second death S = Single life benefit
Rated or non-rated		N = Not Rated

Field	Character Length (for fixed length submissions)	Values of Format
		R = Rated
Impairment code		See Section 5.22
Benefit type		AC = Accelerated Critical Illness AN = Annuity CA = Critical Illness component of Accelerated Critical Illness Benefit DA = Death component of Accelerated Critical Illness Benefit DB = Death benefit IP = Income Protection OT = Other SC = Standalone Critical Illness
ABI new business code		Any alphanumeric
Benefit code for riders / flexible benefit policies		I = Increment to benefit M = Main benefit on multiple benefit policy R = Rider benefit on multiple benefit policy S = Standard policy with one benefit only
Distribution channel code		B = Bancassurer D = Direct marketing F = IFA I = Internet M = Multi-tied agent O = Other S = Own sales force T = Tied agent U = Unknown
Location		Any alphanumeric area postcode (first part only)
Benefit amount at beginning of year		NNNNNNNNN.NN
Benefit amount at end of year`		NNNNNNNNN.NN
Date of amount review		DDMM Or blank if not relevant
Rate of annuity increment		Any alphanumeric Rate or type e.g. LPI, with-profit
Blank Field 1		Leave Blank
Blank Field 2		Leave Blank
Blank Field 3		Leave Blank
Blank Field 4		Leave Blank
Blank Field 5		Leave Blank
The fields below should be completed only for benefits going out of force during the year.		
Date of exit		DDMMYYYY or blank if no exit occurs
Type of exit		D = Death claim paid E = Ex-gratia claim paid F = First death on joint life second death policy

Field	**Character Length** (for fixed length submissions)	Values of Format
		L = Lapse
		M = Maturity
		N = Claim not paid due to breach of contract or due to not meeting policy conditions
		O = Other contractual claim paid
		S = Surrender
		T = Terminal Illness claim paid
		X = Other exit
		or blank for no exit
Date of death		DDMMYYYY
Date of notification of death		DDMMYYYY
Date of claim admission		DDMMYYYY
Date of claim settlement		DDMMYYYY
Blank Field 6		Leave Blank
Blank Field 7		Leave Blank
Blank Field 8		Leave Blank
Blank Field 9		Leave Blank
Blank Field 10		Leave Blank

[a] It is important that the combination of the policy and benefit identification codes provided for each policy benefit record is unique and consistent from year to year.

- **Header record – a one line record with each field's title.**
- **End of File record – a one line, one field record simply with the text "EOF".**

4. GENERAL CODING GUIDELINES

4.1 In Force – Definition

The investigation aims to maintain a consistent coding of data, however the practice regarding administration and acceptance of claims varies between offices.

It is important that the date of commencement given in the data submitted to the CMI represents the true policy commencement following acceptance of terms and underwriting, rather than a proposal (or any other) date. For the purposes of data submission to the CMI, policies should be counted as "on risk" from the policy commencement date only.

Many offices provide a 'free cover period' (FCP) between the proposal date and policy commencement. However, the treatment of claims in this period varies by office. Some offices consider policies as 'on risk' from the proposal date and treat claims within this period as contractual claims. Other offices treat claims in this period as ex-gratia payments. For the purposes of data submission to the CMI, all such claims should be counted as ex-gratia payments.

If you are unsure as to whether a policy should be included or there are significant revisions to data other than for the above reasons then please contact the CMI.

4.2 Claims and policies going out of force in the year

Data on policies going out of force in the year must include policies that were only temporarily brought into force during the year. Offices may do this to process a claim or for other reasons. Therefore, any policy experiencing a movement during the year must be included in the data submitted, either as in force at the year end or as a policy going out of force in the year.

Offices may bring policies into force to pay a claim in certain circumstances. An example is where on a term assurance policy, the policy is treated as lapsed when the premiums are stopped on the policyholder's death as the office is not notified of the death. On notification of the death, the office may then pay out the claim without the policy being brought in force first. Therefore, data must be submitted on any claim settled in the year, regardless of whether the policy was in force or not when the claim was settled. No 'normal' claim should be either missed out or double-counted. **In no circumstances should claims data be submitted in respect of claims that have yet to be settled.**

4.3 Reinsurance

The investigation covers directly written business only. Reinsurance business ceded to other offices should be included in full (i.e. not just the retained portion). Reinsurance business accepted from other offices should be excluded.

4.4 Underwriting

For policies sold without underwriting (e.g. policies effected under guaranteed insurability options), the "Medical type code" field must be set to "W". If you are unsure whether particular policies should be counted as being underwritten for the purposes of submitting data to the CMI, please contact us and we will be happy to advise you on the correct treatment.

4.5 Joint life cases

A separate record should be submitted for each life for both first and second death joint life policies as well as for joint life annuities.

For joint life first death policies, in the event of a claim being paid on a first death, the record in respect of the life that gave rise to the event being claimed for should show the type of exit as Death (or if appropriate, Terminal Illness). The second life's policy record should show type of exit as Lapse. In the rare event of both lives being subject to a covered event, such as might result from a motor accident, both lives' records should show type of exit as Death.

For joint life second death policies, in the event of a first death, the type of exit for the life experiencing the first death should show the type of exit as a first death. In the year that the second death occurs, the record for this life should show the type of exit as Death (or if appropriate, Terminal Illness).

For joint life annuities, in the event of death of either life, an exit should be recorded for that life regardless of whether annuity payments continue due to the death occurring within any guaranteed payment period.

Any cases where the smoker status cannot be determined for both lives separately should be treated as 'undifferentiated' in the smoker code field for both lives. This might occur where offices code the policy internally where only one of the lives is a smoker. Again, care should be taken to treat the records consistently for policies in force at the year end and for policies exiting during the year.

4.6 Multiple policies

Multiple policies should be treated as a single policy where they arise from one underwriting process (e.g. clustered policies for tax purposes, automatic increments etc.). If new underwriting is involved, a separate record should be submitted for the new policy element with the commencement date set to the date the new cover commences.

5. GUIDELINES FOR CODING DATA FIELDS

5.1 Record type

Record I for policy benefits in force at the end of the year. In force is interpreted as on risk. Record O for policy benefits taken out of force during the year.

For the avoidance of doubt, records must be submitted for policies and benefits that are brought into force and then taken out of force within the year.

5.2 Office number

An office is allocated a unique number when it first joins the CMI. If, when preparing data, this office code is not known then please contact us and we will be happy to help.

5.3 Record year

The full four digit calendar year for which data is being supplied should be recorded.

5.4 Territory

Data should only be submitted in respect of polices sold in the UK or the Republic of Ireland. Record 1 for UK policies and 2 for Republic of Ireland policies.

5.5 Product code

This should be a code that identifies what product the record relates to. If this is not the product name or a recognisable part of it, a list of codes that can be used to derive the product name must be separately provided.

5.6 Policy identifier

This would normally be the policy number or any other internal code that uniquely identifies the policy concerned. This code must be consistently applied between records from one year to the next year. All benefit records on a single policy must have the same policy identifier.

5.7 Benefit identifier

This would normally be the benefit number or any other internal code that uniquely identifies the benefit concerned. This code must be consistently applied between records from one year to the next year.

Separate records must be submitted for increments to benefits if policyholders are required to undergo underwriting again. If benefit increments are automatic, a separate record is not required though the Benefit amount fields must be updated as appropriate.

5.8 Sex

Record M for male and F for female.

5.9 Medical type code

For policies with multiple benefits, this field in the record for each benefit should reflect the underwriting carried out in respect of that benefit.

5.10 Smoker status

For all policies, including annuities, the smoker status at the date of commencement of the benefit should be recorded (using offices' own definition of what constitutes a smoker) as N for non-smokers and S for smokers

If offices that do not ask for smoker status or are unable to differentiate for the purpose of data submission, they should record U.

5.11 Date of birth

Code as DDMMYYYY text where possible.

5.12 Date of policy proposal

The format should be as for 5.11 above.

5.13 Date of policy commencement

N.B. It is also important that the definition in 4.1 above is adhered to so far as the date of commencement is concerned. The format should be as for 5.11 above.

5.14 Date of benefit commencement

The benefit commencement date should reflect the date the benefit commences. For non-annuity benefits and for the main benefit, the benefit commencement date must equal the policy commencement date.

The format should be as for 5.11 above.

5.15 Date of benefit first brought into force during the year

This date is required for calculating the exposure for benefits brought into force during the year. These benefits will have been sold in previous years and were treated as out of force for the previous year's data submission. Therefore, for such benefits, the data entered should be the date during the year when the policy status is first changed to in force.

For policies in force at the start of the year, the date entered should be 0101YYYY and for benefits sold during the year, the benefit commencement date should be entered.

5.16 Benefit maturity date

The maturity date of the benefit should be recorded in this field. If the benefit does not have a maturity date, the field should be left blank.

5.17 Business Type

Record N for non profit business, W for with profits business or unitised with profits business where there are no other investment options and U for unit linked business where with profits is not one of the investment options. Record H for unit linked business where with profits is one of the investment options.

5.18 Premium Frequency

Record S for single premiums, R where regular premiums must contractually be paid and P where the policyholder has the option to pay recurrent single premiums. Where policies allow both single and regular premiums to be paid, separate data records must be submitted in respect of the benefits purchased by the single and regular premiums.

5.19 Premiums in payment or paid up

Record N for single and recurrent single premium benefits. Record Y for regular premium benefits unless the premiums have lapsed.

5.20 Single or joint life

Record S for single life benefits, J for joint life annuity and joint life first death benefits and K for joint life second death benefits. Record D for dual life benefits where two separate claims are payable on both lives.

5.21 Rated or non-rated

Record N if the benefit has been issued under the office's standard terms and the standard premium has been charged. Otherwise, record Y.

For joint life cases, benefits may be issued on non-standard terms or additional premiums charged even if only one of the lives is considered sub-standard. However, data is to be submitted separately for both lives. In these cases, only the life considered sub-standard should record Y in this field. If offices consider that a life would be treated as a standard life if it bought a single life policy, it must record N for this life.

5.22 Impairment Code

This field should only be left blank if the "Rated or non-rated" field records N. Otherwise one of the relevant impairment codes, given in Appendix A, should be recorded.

5.23 Benefit Type

Record AN for annuity benefits.

Record DB only for benefits payable on death or terminal illness. Record SC for benefits payable only on critical illness or dread disease. For benefits payable on the earlier of death or critical illness, record AC.

On some multiple benefit policies, accelerated critical illness benefits may be provided by having separate death and critical illness benefits where on a claim on one benefit, the other is lapsed. In these cases, separate records should still be provided on both the benefits with CA recorded for the critical illness benefit and DA recorded for the death benefit.

For income protection benefits payable on sickness, including waiver of premium benefits, record IP.

For all other products, record OT.

5.24 ABI new business code

This should be the ABI new business code applying to the policy as reported by the office in its FSA returns.

5.25 Benefit code for riders/flexible benefit policies

For multiple benefit policies, record M for the first benefit sold and record R for each additional benefit. Some policies are not structured as multiple benefit policies but can still have rider benefits attaching. For these policies, record M for the main benefit and R for each of the rider benefits.

Record S for a standard policy that cannot have any riders or additional benefits attached at any point.

5.26 Distribution channel code

This should indicate the sales channel through which the policy was sold, if known. Record U if the sales channel is not known.

5.27 Location

This should record the first part of the policyholders' postcode at the date the benefit commenced. In no circumstance should the full postcode be entered.

5.28 Benefit amount at beginning of year

Code as a numeric rounded to the nearer pence.

For with-profits policies and annuities, this amount should be the sum payable on a contractual event on 1 January of year for which data is being submitted.

5.29 Benefit amount at end of year

Code as a numeric rounded to the nearer pence.

For with-profits policies and annuities, this amount should be the sum payable on a contractual event on 31 December of the year for which data is being submitted.

5.30 Date of amount review

This is the date when the benefit amount will next be reviewed. The format should be as for 5.11 above.

5.31 Rate of benefit increment

This is the annual change in benefit amount that is contractually required. Record WP for with profits benefits, RPI for benefits increasing in line with price inflation and LPI for annuities increasing in line with LPI. For benefits increasing/decreasing at a constant annual rate, the annual percentage change applied to benefits should be recorded instead using the format "NN.NN%".

The following fields must only be completed for policies that are no longer in force at the end of the year!

5.32 Date of exit

This is the date that the policy or benefit is taken out of force by the office. This date should therefore **always** fall during the year for which data is being submitted.

Where a claim is settled on a benefit that had been taken out of force in previous years, a record must be submitted in the year that the claim is settled regardless of whether the policy is first brought back into force or not (see 5.37).

For annuity business, this must field must be completed where the death of an annuitant has been notified during the year, regardless of whether the annuity benefit continues to be paid due to a surviving joint annuitant or a guaranteed payment period.

The format should be as for 5.11 above.

5.33 Type of exit

For multiple benefit policies, only the benefit under which a claim is paid should record either D, E, F, M, O or T, as appropriate. Other benefits should record L if cover under these benefits ceases on a claim on one of the benefits.

If a claim event occurs but a claim is not paid due to a breach of policy conditions or non-disclosure, then N should be recorded.

On surrender or lapse, only benefits that pay a surrender value should record S. All other benefits should record L.

5.34 Date of death

This should be the date of death as recorded on the death certificate. The format should be as for 5.11 above.

5.35 Date of notification of death

This should be the date the office was notified of the death. The format should be as for 5.11 above.

5.36 Data of claim admission

This is the date the office admitted the claim. The format should be as for 5.11 above.

5.37 Date of claim settlement

This should be the date the claim was actually paid. The format should be as for 5.11 above.

When a claim is settled, a record must be submitted for the benefit and this field must be completed, regardless of whether the benefit was in force on the day or not

Appendix A – Impairment Coding

The list of impairment codes, given below, is fairly extensive. However, this list is not exhaustive. Therefore, the impairment code, "MM" should be recorded in the following circumstances:

- If the impairment does not fully satisfy the requirements of any of the listed codes
- If the office does not have sufficient information about the impairment
- If the life has two or more major impairments, with the exception that if the life is overweight and has hypertension but no other impairments, the relevant hypertension code is to be recorded.

Please note that the letter O and the letter I do not appear at all in any of the codes. This is to prevent confusion with numbers 0 and 1 which appear as the second character in some cases.

Hypertension

(Uncomplicated, but may include slight or moderate tachycardia or slight arteriosclerosis. Overweight cases should be included.)

The blood pressure reading to be used for coding purposes is the fifth phase. Offices using fourth phase readings are asked to deduct five points from both S.A.P. and D.A.P. before coding. Where several recent readings have been taken, offices are asked to average them. If only a M.A.R. is available, the case should not be included. In cases of treated hypertension, the mean between the average pre-treatment reading and the average post-treatment reading should be taken.

Code	Age at entry	S.A.P.	D.A.P.
A0	Under 40	150-165	Under 95
A1	Under 40	Over 165	Under 95
A2	Under 40	150-165	95-105
A3	Under 40	Over 165	95-105
A4	Under 40	150-165	Over 105
A5	Under 40	Over 165	Over 105
A6	Under 40	Under 150	95 or over
AA	40-59	155-170	Under 95
AB	40-59	Over 170	Under 95
AC	40-59	155-170	95-105
AD	40-59	Over 170	95-105
AE	40-59	155-170	Over 105
AF	40-59	Over 170	Over 105
AG	40-59	Under 155	95 or over
AM	60 and over	160-175	Under 100
AN	60 and over	Over 175	Under 100
AP	60 and over	160-175	100-110
AR	60 and over	Over 175	100-110
AS	60 and over	160-175	Over 110
AT	60 and over	Over 175	Over 110
AU	60 and over	Under 160	100 or over

Ischaemic Heart Disease

This group includes the following impairments of the coronary arteries: thrombosis, occlusion, ischaemia, infarction, angina. It does not include valve lesions.

Code	Age at entry	Duration since onset
Cases without surgery		
B0	Below 50	Within 2 years
B1	Below 50	2-4 years ago
B2	Below 50	4-6 years ago
B3	Below 50	Over 6 years ago
B4	50 and over	Within 2 years
B5	50 and over	2-4 years ago
B6	50 and over	4-6 years ago
B7	50 and over	Over 6 years ago
Cases with surgery		
BA	Below 50	Within 2 years
BB	Below 50	2-4 years ago
BC	Below 50	4-6 years ago
BD	Below 50	Over 6 years ago
BE	50 and over	Within 2 years
BF	50 and over	2-4 years ago
BG	50 and over	4-6 years ago
BH	50 and over	Over 6 years ago

Cerebrovascular Disorders

Code	Episode within 4 years
C0	Spontaneous subarachnoid haemorrhage - treated conservatively
C1	Spontaneous subarachnoid haemorrhage - treated surgically
C2	Cerebrovascular accident (stroke or cerebral haemorrhage): entry age under 40
C3	Cerebrovascular accident (stroke or cerebral haemorrhage): entry age 40 and over

Code	Episode over 4 years ago
C4	Spontaneous subarachnoid haemorrhage - treated conservatively
C5	Spontaneous subarachnoid haemorrhage - treated surgically
C6	Cerebrovascular accident (stroke or cerebral haemorrhage): entry age under 40
C7	Cerebrovascular accident (stroke or cerebral haemorrhage): entry age 40 and over

The above codes apply without regard to any residual disability.

Nervous Disorders

The distinction between “mild”, “moderate” and “severe” psychoneurosis is necessarily subjective; but “mild” cases will often be accepted at normal rates. “Moderate” and “severe” cases will frequently carry an accident exclusion clause.

Code		
D0	Psychoneurosis	mild
D1	Psychoneurosis	moderate
D2	Psychoneurosis	severe
D3	Psychoneurosis	with features suggestive of psychosis (including schizoid cases)
D4	Attempted suicide	one attempt only
D5	Attempted suicide	more than one attempt

Disseminated Sclerosis

Code		
DA	Onset before age 25	abnormal physical signs at entry - nil
DB	Onset before age 25	abnormal physical signs at entry - mild
DC	Onset before age 25	abnormal physical signs at entry - moderate
DD	Onset after age 25	abnormal physical signs at entry - nil
DE	Onset after age 25	abnormal physical signs at entry - mild
DF	Onset after age 25	abnormal physical signs at entry - moderate

Intestinal Disorders

Peptic ulcer (Gastric or duodenal proved by X-ray or gasteroscopy)

Code	
E0	Symptoms within 3 years - apparently resolved: no surgery
E1	No symptoms for 3 years - resolved: no surgery
E2	Infrequent symptoms, occasional medication: no surgery
E3	Frequent or chronic symptoms, frequent medication: no surgery
E4	Symptoms within 3 years - apparently resolved (i.e. medication ceased): surgery
E5	No symptoms for 3 years - resolved: surgery performed
E6	Infrequent symptoms, occasional medication: surgery performed
E7	Frequent or chronic symptoms, frequent medication: surgery performed

Ulcerative colitis

Code	
EA	Symptoms within 3 years, but apparently resolved
EB	No symptoms for 3 years, apparently resolved
EC	Mild symptoms, intermittent medication
ED	Moderate to severe symptoms, continuous medication (where EC and ED overlap, the criterion should be whether intermittent or continuous medication).

Crohn's disease (with or without history of surgery)

Code	
EE	Symptoms within 3 years, but apparently resolved
EF	No symptoms for 3 years, apparently resolved
EG	Mild symptoms, intermittent medication
EH	Moderate to severe symptoms, continuous medication

Epilepsy

Code	
F0	Petit Mal (excluding temporal lobe epilepsy)
F1	Temporal Lobe Epilepsy (excluding grand mal)
F2	Grand Mal (idiopathic or traumatic) not more than 6 episodes per year
F3	Grand Mal (idiopathic or traumatic) 7 - 12 episodes per year
F4	Grand Mal (idiopathic or traumatic) over 12 episodes per year

Where there is doubt as between petit mal and grand mal, code as grand mal.

Diabetes Mellitus

Code		
G0	Age under 30 at entry	duration since diagnosis 0-5 years
G1	Age under 30 at entry	duration since diagnosis 5-10 years
G2	Age under 30 at entry	duration since diagnosis 10-15 years
G3	Age under 30 at entry	duration since diagnosis over 15 years
G4	Age 30-39 at entry	duration since diagnosis 0-5 years
G5	Age 30-39 at entry	duration since diagnosis 5-10 years
G6	Age 30-39 at entry	duration since diagnosis 10-15 years
G7	Age 30-39 at entry	duration since diagnosis 15-20 years
G8	Age 30-39 at entry	duration since diagnosis over 20 years
GA	Age 40-49 at entry	duration since diagnosis 0-5 years
GB	Age 40-49 at entry	duration since diagnosis 5-10 years
GC	Age 40-49 at entry	duration since diagnosis 10-15 years
GD	Age 40-49 at entry	duration since diagnosis 15-20 years
GE	Age 40-49 at entry	duration since diagnosis over 20 years
GF	Age 50 & over at entry	duration since diagnosis 0-5 years
GG	Age 50 & over at entry	duration since diagnosis 5-10 years
GH	Age 50 & over at entry	duration since diagnosis 10-15 years
GJ	Age 50 & over at entry	duration since diagnosis 15-20 years
GK	Age 50 & over at entry	duration since diagnosis over 20 years

Respiratory Disorders

Code		
H0	Entry age under 30	Bronchial asthma, mild
H1	Entry age under 30	Bronchial asthma, moderate
H2	Entry age under 30	Bronchial asthma, severe
H3	Entry age under 30	Chronic bronchitis, without emphysema
H4	Entry age under 30	Chronic bronchitis, with emphysema
H5	Entry age under 30	Emphysema without bronchitis
HA	Entry age 30-49	Bronchial asthma, mild
HB	Entry age 30-49	Bronchial asthma, moderate
HC	Entry age 30-49	Bronchial asthma, severe
HD	Entry age 30-49	Chronic bronchitis without emphysema
HE	Entry age 30-49	Chronic bronchitis with emphysema
HF	Entry age 30-49	Emphysema without bronchitis
HG	Entry age 50 & over	Bronchial asthma, mild
HH	Entry age 50 & over	Bronchial asthma, moderate
HJ	Entry age 50 & over	Bronchial asthma, severe
HK	Entry age 50 & over	Chronic bronchitis without emphysema
HL	Entry age 50 & over	Chronic bronchitis with emphysema
HM	Entry age 50 & over	Emphysema without bronchitis

“Asthma” includes allergic asthma.

Bronchitis with no knowledge as to whether emphysema is present should be taken as bronchitis without emphysema.

Urinary Disorders

Code	
J0	Urinary calculus, no operation, symptoms within 3 years
J1	Urinary calculus, no operation, symptoms more than 3 years ago
J2	Urinary calculus, voided or removed per urethram, symptoms within 3 years
J3	Urinary calculus, voided or removed per urethram, symptoms more than 3 years
J4	Urinary calculus, removed by nephrotomy, symptoms within 3 years
J5	Urinary calculus, removed by nephrotomy, symptoms more than 3 years ago
J6	Urinary calculus, removed by nephrectomy, symptoms within 3 years
J7	Urinary calculus, removed by nephrectomy, symptoms more than 3 years ago
JA	Cystitis without calculus
JB	Pyelitis without calculus
JC	Albuminuria, not orthostatic
JD	Albuminuria, with history of renal disease
JE	Nephrectomy for trauma
JF	Nephrectomy other than for calculus or trauma
JG	Renal failure treated by dialysis
JH	Renal failure treated by transplant

Pyelonephritis is not included in JA and JB.

Tumours

Code		Duration since diagnosis
K1	Non-malignant tumours of the breast	
K2	Uterine fibroids	
KA	Malignant breast tumours	within 3 years
KB	Malignant breast tumours	over 3 years
KC	Malignant tumours of prostate, seminomas, adenocarcinomas, hydatidiform mole	within 3 years
KD	Malignant tumours of prostate, seminomas, adenocarcinomas, hydatidiform mole	over 3 years
KE	Other malignant tumours (excluding cervical cancer and rodent ulcers)	within 3 years
KF	Other malignant tumours (excluding cervical cancer and rodent ulcers)	over 3 years

Cervical cancer and rodent ulcers will not be included in the investigations.

Overweight

Where possible "Standard" weight should be in accordance with the attached tables which are taken from Tables 24 & 25 of the "Build Study 1979" published by the Society of Actuaries. However, offices using other tables may code by those tables, but they are asked to inform the Bureau of the table which they are employing.

If hypertension is present, the overweight should be ignored and the case should be included in the hypertension group.

Code	Age of entry	Percentage weight over standard
L0	Under 30	20 - 30%
L1	Under 30	30 - 40%
L2	Under 30	Over 40%
L3	30-49	20 - 30%
L4	30-49	30 - 40%
L5	30-49	Over 40%
L6	50 and over	20 - 30%
L7	50 and over	30 - 40%
L8	50 and over	Over 40%