Continuous Mortality Investigation

‘Per Policy’ Coding Guide for

Mortality and Critical Illness Investigations

Version 1.0 – issued to data contributors December 2005

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Introduction

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

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. In particular it is anticipated that further guidance will be issued as offices attempt to use the guide in earnest. Please see the CMI's pages on the profession's website for the latest version of the guide.

There are many differences between the approach taken in this Coding Guide and prior guides applicable to scheduled data for mortality. Some of the key differences are included below for clarity, but this list is not intended to be comprehensive:

- We are no longer asking offices to submit data under a particular 'Investigation Number'. The intention is to use the product code to allocate policies to particular investigations. This has the benefit that investigations can be amalgamated or separated as appropriate within the CMI without offices needing to alter their data submissions. We are asking offices where possible to advise the investigation number where data was previously submitted on a scheduled basis. This will help with reconciliation and may also highlight the reason for apparent changes in experience.
- We are no longer proposing to adopt a 'Census' approach to the investigation. Instead we are seeking to capture sufficient information in the end-year data submission to allow an accurate exposure to be calculated. One particular consequence of this is that the data submission must include details of cases that have exited (by any means) during the investigation year.
- The CMI is happy to receive data for the Mortality and Critical Illness investigations on a consistent basis with this new Coding Guide.
- The approach to claim notification has changed. Previously offices were requested to delay submitting data until virtually all claims were expected to have been notified. Claims will now be included according to the date they are processed, with delayed claims reported in subsequent years. This may mean that an adjustment is needed in respect of IBNS when compared with the previous approach. It also means that offices should be able to submit data earlier in the year, allowing the CMI to release results earlier.

The differences between this Coding Guide and prior guides applicable to the critical illness investigation are less fundamental, mainly consisting of additional data fields. Offices are still free to use the existing Coding Guide for Critical Illness for the foreseeable future.

1. GENERAL INFORMATION

1.1 The scope of the investigation

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

Group products are generally outside the scope of this investigation, however data should be submitted for "grouped-individual" defined contribution products (stakeholder and pre-stakeholder versions).

Data for the Mortality and Critical Illness investigations can both be submitted using this Coding Guide. Where there are differences in data requirements for the various investigations, these are highlighted in the relevant section. For Critical Illness business, the investigation covers:

Stand alone - where the benefit is paid on diagnosis of critical illness.
Full acceleration - where the benefit is payable on the diagnosis of critical illness or death, whichever occurs first.

Further details of the scope of data required are contained in section 3.1. In order to aid the CMI's understanding of offices' submissions, offices are requested to provide a high-level summary of business that has not been included within their submission compared to FSA Returns. A precise reconciliation is not required.

1.2 Data required

Data required for each investigation year (N) are:

- In force (i.e. on risk for benefits) on 1st January in year N+1.
- Policies going out of force (including claims) in year N

The exact definitions of the data required, of 'normal claims and 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, 3rd floor, Cheapside House, 138 Cheapside, London, EC2V 6BW
Tel: 020 7776 3820
Fax: 020 7776 3810
Email: mortality@cmib.org.uk or ci@cmib.org.uk

Where e-mail is used, please use the appropriate address. Either can be used where data/queries relate to both Mortality and Critical Illness.

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 June 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 30/6/N+1.

1.5 Confidentiality

Data supplied to the CMI must not contain personal details whereby any life insured (or policyholder) 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.

An office's own data and claims experience 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, DVD or 3½" floppy disk.

The CMI may be able to accept any other commonly used form of electronic data transmission but please contact us beforehand to check.

Data can not be accepted in written form due to the keying time required, except for minor corrections to data after initial submission.

2.2 Submission of data by e-mail

Data can 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 e-mails 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 or ci@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 CDs, etc. with details of their contents, i.e. office name, investigation (in this case 'mortality', 'critical illness' or 'mortality and CI'), type of data (in force or policies going out of force) and year.

- Enclose a covering letter (or e-mail) with the submitted data indicating the person(s) to contact in case of queries and, ideally, with a summary of contents, including the 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 discourage a potential contributor. 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.

Similarly, if an office finds it easier to submit data including benefits that fall outside the scope of the Mortality and Critical Illness investigations, the CMI is happy to accept these provided it is clear which cases we should exclude, without needing to examine policies individually. Examples of categories include:

- If offices offer products with multiple benefits (including death or critical illness cover) then data for all benefits may be submitted, regardless of whether death or critical illness cover has been selected by the policyholder. There is no current intention to investigate the experience under these other benefits.
- Rated policies (unless data is being submitted for the Impaired Lives investigation).
- Policies written on more than 2 lives.
- Joint Life Second Death policies
- 'Family Income Benefit' policies where offices are unable to express the benefit amount as an equivalent lump sum and cannot identify the policies to allow the CMI to exclude such policies from amounts investigations. (See section 4.11 below).

[Offices may use their discretion to exclude certain policies from the investigation – examples could be staff policies written as part of the pension scheme or mortgage protection policies issued as part of the redress in a mortgage endowment mis-selling case (although the latter can be included with "Type of Entry" coded as "C").]

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.

Spreadsheets and 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 many policies. For example, on a single life policy with death and waiver of premium benefits, separate records may be submitted for each of the death and waiver of premium benefits, or only the death benefit record submitted.

Each record should occupy one row in a spreadsheet, one database record or one text line and should contain the information in Table 1 below.

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

Table 1

Field	Field Position (for fixed length submissions)	Values of Format	Mandatory?	Notes for this field
Record type	1	I = in force at the end of the record year O = policy taken out of force in the record year	Y*	5.1
Office Number	2 – 4	NNN	Y*	5.2
Record Year	5 – 8	YYYY	Y*	5.3
Territory	9	1 = UK 2 = Republic of Ireland	Y*	5.4
Product code	10 -19	Any alphanumeric (up to 10 characters*)	Y*	5.5
Client identifier	20-29	Any alphanumeric (up to 10 characters*)	N	5.6
Policy identifier	30-39	Any alphanumeric (up to 10 characters*)	Y	5.7
Benefit identifier	40-49	Any alphanumeric (up to 10 characters*)	Y (if >1 benefit)	5.8
Sex	50	M, F	Y	5.9
Medical type code	51	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	Y	5.10
Smoker status	52	N = non-smoker S = smoker U = undifferentiated	Y	5.11
Date of birth	53-60	DDMMYYYY	Y	5.12
Original Type of Entry	61	C = Compensation case G = Effected by exercising a GIO N = New Business O = Other U = Unknown	Y	5.13
Date of policy commencement	62-69	DDMMYYYY	Y	5.14
Date of benefit commencement	70-77	DDMMYYYY	Y	5.15
Entry into Current Status	78	A = alteration (on) -see 4.5 C = Compensation case G = Effected by exercising a GIO I = In force at previous submission N = New Business O = Other R = Reinstatement U = Unknown	Y	5.16

* The maximum of 10 characters is only relevant to fixed length data submissions

Field	Field Position (for fixed length submissions)	Values of Format	Mandatory?	Notes for this field
Movement on date	79-86	DDMMYYYY	Y	5.17
Benefit maturity/expiry date	87-94	DDMMYYYY	Y	5.18
Business Type	95	H = Hybrid N = Non profits U = Unit linked W = With profits	Y*	5.19
Premium frequency	96	P = Recurrent Single Premium R = Regular Premium S = Single Premium	N	5.20
Premiums in payment or paid up	97	N = Paid up Y = Premium paying	N	5.21
Single or joint life	98	D = Dual J = Joint life first death benefit or joint life annuity S = Single life benefit	N	5.22
Rated or non-rated	99	N = Not Rated Y = Rated	Y	5.23
Impairment code	100-101	2-digit alphanumeric	N	5.24
Benefit type	102-103	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 SC = Standalone Critical Illness	Y*	5.25
ABI new business code	104-106	NNN	Y	5.26
Distribution channel code	107	A = Basic Advice (i.e. Stakeholder products) B = Bancassurance I = IFA/Whole of Market M = Multi-tie / Limited Range N = Non-intermediated S = Single Tie U = Unknown	Y*	5.27
Location	108-111	Any alphanumeric area postcode (first part only)	N	5.28
Initial benefit amount	112-123	NNNNNNNNN.NN	N	5.29
Benefit amount at beginning of year	124-135	NNNNNNNNN.NN	Y	5.30
Benefit amount at end of year`	136-147	NNNNNNNNN.NN	Y	5.31
Date of amount review	148-151	DDMM	Y (if relevant)	5.32
Type of increment / decrement	152	C = RPI subject to a cap D = Decreasing (non-Mortgage)	Y*	5.33

Field	Field Position (for fixed length submissions)	Values of Format	Mandatory?	Notes for this field
		F = fixed rate increase L = LPI M = Decreasing (Mortgage) N = No increment (i.e. level) R = RPI W = With-profit		
Rate of increment / decrement	153-157	NN.NN Rate of increase or decrease in benefit`	Y*	5.34
Previous Investigation Number	158-159	NN	N	5.35
The fields below should be completed only for benefits going out of force during the year.				
Date of exit	160-167	DDMMYYYY	Y	5.36
Type of exit	168	A = alteration (off) -see 4.5 B = cover ceases due to a claim on another benefit C = Critical Illness claim paid D = Death claim paid E = Ex-gratia claim paid L = Lapse M = Maturity S = Surrender T = Terminal Illness claim paid U = Unknown X = Other exit	Y	5.37
Date of claim	169-174	DDMMYYYY	N*	5.38
Date of notification of claim	175-184	DDMMYYYY	N*	5.39
Date of claim admission	185-192	DDMMYYYY	N*	5.40
Date of claim settlement	193-200	DDMMYYYY	N*	5.41
Cause of CI Claim	201-250	Any Alphanumeric	N	5.42

Fields indicated as Y* for "Mandatory?" are not mandatory if the value is the same for the entire data submission and is clearly specified in accompanying documentation (e.g. the file only contains UK business for office 999 relating to 2006).

In such cases and for non-mandatory fields that are not being supplied, the relevant fields should be filled with blanks where data is submitted in a fixed length format.

The Dates of Claim are shown as N* for "Mandatory?"; however at least one of these **must** be supplied. The date of the claim event (death or diagnosis) is the preferred field.

The file should also include:

- 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

The CMI aims to maintain a consistent coding of data; however the practice regarding policy administration and acceptance of claims varies between offices. If you are unsure as to how best to reflect your office's practices then please contact the CMI. We will be pleased to help.

4.1 In Force – Definition

It is important that the date of commencement given in the data submitted to the CMI represents the true benefit commencement following acceptance of terms and underwriting, rather than a proposal (or any other) date.

For the purposes of data submission to the CMI, non-annuity policies should be counted as "on risk" from the benefit commencement date only. Any 'free cover period' between the proposal date and benefit commencement should not be regarded as "on risk". Equally, for the purposes of data submission to the CMI, all such claims are considered as ex-gratia payments and should be excluded.

4.2 Policies going out of force in the year

The data submission must include details of cases that have been processed as exits (by any means) during the preceding investigation year. This must include policies that were only temporarily brought into force during the year. Offices may do this to process a claim, following a bank error or for other reasons.

Therefore, any policy experiencing a movement during year N must be included in the data submitted, either as in force on 1st January N+1 or as a policy processed as going out of force in year N. In some cases, this could result in multiple records for one benefit if, for example, a case is brought back into force on more than one occasion during a year.

4.3 Lapses and Reinstatements

In normal circumstances, a lapse will be submitted as an exit during the appropriate investigation year, but on occasion more complex scenarios can arise.

If a case is reinstated during the same investigation year that it lapses, then the CMI would like to receive two records:

(i) An exit showing the benefit as a lapse, with the "Date of exit" equal to the date the lapse is processed.

(ii) The second record will be either an in force record as at 1st January (if the case remains in force after being reinstated) or a second exit, if it lapses again or claims. This record will include the "Original Type of Entry" and the "Date of Benefit Commencement" unchanged (i.e. the original type and date of entry) and the "Movement on date" (see 5.17) equal to the effective date of the reinstatement (i.e. when the policy returns to an 'on risk' status).

Alternatively, if a policy is reinstated with no break in cover (e.g. when a banking error is rectified) then the office may submit a single record with no indication that the lapse/reinstatement occurred.

If a case is reinstated in a later investigation year than the one in which it lapses, then the CMI does not expect to re-state previous years' exposure in normal situations, even if the effective date of the reinstatement predates the 1st January. The CMI would like to receive an exit in year N for the lapse and the subsequent record will be similar to that described in (ii) above but with "Movement on date" equal to the 1st January of the relevant year (which will normally be N+1).

It may help offices to understand how the CMI expects to use the data in this regard. It would be theoretically possible to consider reinstatements that are subject to re-underwriting as a separate category and to initially re-assign them to duration 0. However, the CMI does not expect that offices will be able to distinguish in their data submissions according to whether re-underwriting has occurred. It is not obvious whether it would be more accurate to re-start the duration on all reinstatements (regardless of whether they have been subject to re-underwriting) or to continue to use the original date of entry, but the CMI has decided to maintain its historic approach which is to base duration on the original date of entry.

4.4 Claims

The investigations analyse claims paid under the policy terms, on the policies on risk. All 'normal' claims should be included, i.e. claims arising during a Free Cover Period and ex-gratia claims should be excluded.

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. However data must be submitted on any 'normal' claim settled in the year, regardless of whether the policy was in force or not when the claim was settled.

A consistent coding of policy attributes should always be adopted between claims and in force policy records. This is particularly important to consider when claims and in force data are obtained from separate databases or by separate departments. Particular care is required when some attributes are coded as unknown or undifferentiated (e.g. if the smoker status of a policy is coded as Unknown during its lifetime, then the claim should also be coded as "U", even if the status of that policy is then known) .

Claims submitted in respect of a particular year should be based, where possible, on the year of settlement. If the settlement date is not known then it should be based upon the date of admission or, failing this, one of the other dates. Whatever the approach used, a consistent approach from one year to the next should be used. 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.**

For the purposes of the CMI investigations, Stand-alone Critical Illness policies are defined as those with no or a minimal benefit payable on death. In the event of a death under such a benefit, "Type of Exit" should be coded as "B" (cover ceases due to a claim on another benefit), not as "D".

4.5 Alterations

The CMI will be using the end-year submission to calculate the exposure during the year. Where policies are altered during the course of the year (other than regular contractual changes to the benefit amount), the CMI's preferred approach is that two records are submitted in respect of the altered policy – the first reflecting its pre-alteration status and including a date of exit and 'Type of Exit' coded as "A", the second reflecting its post-alteration status and with 'Type of Entry' coded as "A".

Where an alteration occurs, the 'Original Type of Entry' and benefit commencement dates should not change in the new record, however the date of the alteration should be recorded in the "Movement on date" (see 5.17.)

Contractual changes to the benefit amount do not necessitate separate records as they can be identified from fields 5.30 to 5.34.

4.6 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. Data is not accepted from reinsurers.

4.7 Underwriting

For policies sold without underwriting, the "Medical type code" field must be set to "W" or such policies excluded. For policies effected under guaranteed insurability options or issued as part of redress (e.g. resulting from mis-selling), this field should also be set to "W"; in addition, "Type of Entry" should be coded accordingly (see 5.13).

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.

4.8 Rated lives

The main CMI investigations cover cases issued on standard premium rates only. Cases subject to additional ratings for medical or other reasons should only be included in the 'Impaired Lives' mortality investigation (see 5.24 and Appendix A).

If you cannot submit Impairment Codes then please exclude such cases. If this is not possible please still submit the data but inform us that rated cases have been included and indicate how the CMI can identify the records to which ratings apply (e.g. by the inclusion of additional fields).

If you are in any doubt on how to proceed, please contract the CMI.

4.9 Joint life cases

A separate record should be submitted for each life for both joint life first event benefits and joint life annuities.

For joint life first event policies, in the event of a claim being paid on a first event, the record in respect of the life that gave rise to the event being claimed for should show the type of exit as "D" (for example, if a death claim). The second life's record should show type of exit as "B". 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 "D" (for example), if offices are aware of this.

Joint life second death benefits should be excluded from the investigations.

For joint life annuities, in the event of the 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. Where the amount of an annuity reduces after the death of one of the lives, the CMI would like the policy commencement date to remain as the start of the original annuity and the benefit commencement date to show the start of the contingent annuity. The latter would only be submitted after the death of the first life.

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' systems hold smoker status at benefit level, rather than life level. Again, care should be taken to treat the records consistently for benefits in force at the year end and for benefits exiting during the year (i.e. the claim must also be categorised as "U", even if the smoker status of the life that claimed is known).

4.10 Multiple benefits

Multiple benefits should be treated as a single benefit where they arise from one underwriting process (e.g. clustered policies for tax purposes, automatic increments etc.). The exception to this is where benefits are purchased with both a single premium and regular premiums simultaneously, in which case separate records should be submitted.

If new underwriting is involved, a separate record should be submitted for the new benefit element with the commencement date set to the date the new cover commences. Even where no medical underwriting is involved (e.g. a single premium purchasing additional annuity benefit), a separate record is preferred.

4.11 Family Income Benefits

These policies provide a benefit expressed as an annual or monthly amount, rather than as a lump sum. For amounts data, offices are requested to use the commuted value if possible. It is obviously essential that claims and in force are treated consistently in this regard.

If offices are unable to supply the commuted value for both in force and claims data, then such cases will be excluded from the amounts analysis, and therefore need to be identifiable.

4.12 Different benefit levels for Life cover and Critical Illness cover

Some policies may be written as flexible protection policies where policyholders can choose from a mix of critical illness and death cover benefits which can be for different amounts.

Where offices treat each benefit independently within their administration systems (i.e. they have separate *Accelerated Critical Illness*, *Stand Alone Critical Illness* and *Life Cover Only* benefits and a claim on one of the benefits does not reduce or otherwise affect the amounts paid on any of the other benefits), then each *Stand Alone Critical Illness*, *Accelerated Critical Illness* and/or *Life Cover Only* benefit should be treated as a separate benefit for the purpose of submitting data to the CMI.

However, where offices' administration systems do not treat the underlying benefits independently, the data submission process is more complex. Here, a policy may have life cover and/or critical illness benefits and, where both benefits are present they may be equal or one benefit may be greater than the other. In such cases, the office will need to consider the benefit amounts on both the *Critical Illness* and *Life Cover* benefits and submit data according to the rules below:

a) Where there is no *Critical Illness* benefit (or it is set to nil), the benefit should be treated as a Life Cover Only benefit and submitted for inclusion in the mortality investigation.

b) Where there is no *Life Cover* benefit (or it is set to nil), then the policy should be treated as a *Stand Alone Critical Illness* policy with a sum assured equal to the *Critical Illness* benefit amount.

c) Where the Critical Illness cover and Life cover operate independently, i.e. no claim is payable under the *Critical Illness* benefit under a death claim and where the *Life Cover* benefit is not reduced by an earlier critical illness claim, the policy should be treated as two benefits:

   - a *Stand Alone Critical Illness* benefit with a sum assured equal to the Critical Illness benefit amount, and
   - a *Life Cover* benefit with a sum assured equal to the Life cover benefit amount.

d) Where the *Critical Illness* and the *Life Cover* benefit amounts are the same and only one claim is payable on the earlier of the two events to occur, the policy should be treated as an Accelerated Critical Illness policy. The sum assured is equal to the *Critical Illness* benefit amount.

e) Where the *Life Cover* benefit is greater than the *Critical Illness* benefit and the *Life Cover* benefit is reduced by the amount of an earlier critical illness claim, for data submission purposes this should be viewed as a combination of an

Accelerated Critical Illness and a *Life Cover* policy. The *Accelerated Critical Illness* benefit would have a sum assured equal to the *Critical Illness* benefit amount and the *Life Cover* policy would have a sum assured equal to the excess of the *Life Cover* benefit amount over the *Critical Illness* benefit amount.

- On a critical illness claim, only one claim record should be submitted, relating to the *Accelerated Critical Illness* benefit. The *Life Cover* benefit will normally remain In Force.
- On a death claim, two claim records should be submitted, one for each of the policies.

f) Where the *Life Cover* benefit is less than the *Critical Illness* benefit and only one claim is payable on the earlier of the two events to occur, for data submission purposes this should be viewed as a combination of an *Accelerated Critical Illness* and a *Stand Alone Critical Illness* policy. The *Accelerated Critical Illness* policy would have a sum assured equal to the *Life Cover* benefit amount and the *Stand Alone Critical Illness* benefit would have a sum assured equal to the excess of the *Critical Illness* benefit amount over the *Life Cover* benefit amount.

- On a critical illness claim, two claim records should be submitted, one for each of the policies.
- On a death claim, only one claim record relating to the *Accelerated Critical Illness* policy should be submitted but an exit should also be submitted for the *Stand Alone Critical Illness* benefit with Type of Exit coded as "B".

4.13 Scaled critical illness benefits

In some products, certain critical illnesses or events may be subject to a lower level of benefit than the full benefit amount. Where the lower benefit levels apply to a significant element of the cover, such benefits are outside the scope of the current investigation and should be excluded. However, where they apply to only one or a small number of events (e.g. angioplasty only) they can be incorporated. In such cases offices should not submit claim records for such claims where the lower benefit amount is paid – claim records should only be submitted where the full benefit amount is paid leading to the termination of the critical illness benefit.

We are more than happy to assist offices in assessing whether the specified critical illnesses or events with lower benefits constitute a significant element of the cover.

4.14 Other non-standard benefit structures

Critical illness products are evolving but the current investigation is limited to what can now be termed "traditional" products. If you have any doubts as to how to treat a particular product and whether to include it in your submitted data, please contact the CMI and we will be happy to advise you on the correct treatment.

5. GUIDELINES FOR CODING DATA FIELDS

5.1 Record type

Record I for benefits in force on 1st January. See section 4.1 for the interpretation of "In force". Record O for benefits taken out of force during the year.

For the avoidance of doubt, records must be submitted for 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 for its data submissions to the CMI. If, when preparing data, this office code is not known then please contact us and we will be happy to help. The CMI is happy to supply several numbers if an office wishes to differentiate its business, for example between separate funds. Results will then be produced separately for each office number.

This field is not shown as mandatory, as it need not be incorporated within the data record if all records apply to a single office as will normally be the case. However it obviously must be clear to the CMI which office a submission relates to.

5.3 Record year

The full four digit calendar year for which data is being supplied should be recorded. Again this is not mandatory within a record if it is made clear in the header or elsewhere.

The data records should be a snapshot as at 1st January of the policies in force at that date and the policies that have gone out of force during the preceding year.

Offices supplying data in respect of financial years not corresponding to calendar year should advise the CMI.

5.4 Territory

Data should only be included in respect of polices sold in the UK or the Republic of Ireland. Where data for both territories is being submitted, please record 1 for UK policies and 2 for Republic of Ireland policies. Where data is only being submitted for one territory, this field is not mandatory if the covering note makes clear the territory.

Lives who move abroad during the lifetime of their policy should not be removed from the investigation if their policy remains in force.

5.5 Product code

This should be a code that identifies what product the record relates to. This may be the product name (e.g. "Level Term Assurance Plan") however if the type of product is not recognisable from the code (e.g. where this is an internal code), then offices are asked to provide a list of codes and the corresponding product types.

5.6 Client identifier

This will be the internal code that uniquely identifies the life insured, if such exists.

5.7 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.

5.8 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.

For many products, the benefit and the policy may be synonymous. If this is always the case within a submission, then it is not necessary to submit a benefit identifier or a date of benefit commencement (see 5.15).

5.9 Sex

Record M for male and F for female.

5.10 Medical type code

This field should reflect the underwriting carried out at the time the benefit is taken out.

5.11 Smoker status

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

Offices that do not use smoker status or are unable to differentiate for the purpose of data submission, should record U.

5.12 Date of birth

Code as DDMMYYYY text where possible.

5.13 Original Type of Entry

This field should record how the benefit originally entered the investigation. C and G should both be used to code new benefits that have not arisen through the normal new business route:

C is a 'Compensation' case, where a benefit is issued to provide cover or compensation following a mis-selling verdict or similar.

G is applied to benefits taken out as a result of a Guaranteed Insurability Option being exercised.

In previous investigations, the CMI has not sought to segregate new business according to the type of entry, although offices may have chosen to exclude the unusual cases. If offices can code these separately, then the CMI hopes to report separately on the different categories of business as well as analysing experience for all business (regardless of type of entry) to provide consistent results.

5.14 Date of policy commencement

It is important that the definition in 4.1 is adhered to so far as the date of commencement is concerned. The format should be as for 5.12 above.

In the case where a deferred annuity vests, offices are requested to submit an "exit" record in respect of the deferred benefit and a new record for the annuity in payment with the vesting age as the date of policy commencement.

5.15 Date of benefit commencement

The benefit commencement date should reflect the date the benefit commences. For many products, the benefit commencement date and the policy commencement date are necessarily the same.

The format should be as for 5.12 above.

5.16 Entry into Current Status

This field should record the status of the benefit as at the start of the exposure period covered by the record. If it was in force on the previous 1 January and the record covers the period from this date, it should be recorded as I. If not it should be recorded as A, C, G, N. O or R. U is used if offices are unable to differentiate.

5.17 Movement on date

This date is required for calculating the exposure for benefits during the year and should be set as the date at the start of the exposure period covered by the record. For benefits 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. However there may also be occasions where benefits were 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 effective date of the reinstatement.

See also 4.3 regarding Lapses and Reinstatements.

5.18 Benefit expiry/maturity date

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

5.19 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.

5.20 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 should be submitted in respect of the benefits purchased by the single and regular premiums.

5.21 Premiums in payment or paid up

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

5.22 Single or joint life

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

Joint life second death benefits should be excluded from the investigations.

5.23 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 the avoidance of doubt applying an exclusion to the cover under a policy should be recorded as 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. 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 he or she was covered under a single life benefit, it should record N for this life.

5.24 Impairment Code

This field should 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, if possible. The CMI recognises that most offices will be unable to complete this field and intends consulting on alternative approaches in due course.

5.25 Benefit Type

Record AN for annuity benefits in payment.

Record DA for deferred annuity benefits.

Record DB only for benefits payable on death or terminal illness.

Record SC for benefits payable only on critical illness (where no benefit or a minimal benefit is payable if death precedes diagnosis of one of the range of critical illnesses).

Record AC for full acceleration critical illness benefits (where the benefit is payable in full on the earlier of death or the diagnosis of a critical illness)..

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.

All other codes will be excluded from the investigation.

5.26 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. If no such code exists, please leave blank.

5.27 Distribution channel code

This should indicate the sales channel through which the policy was sold, if known. The categories correspond to our understanding of those used for reporting new business to the ABI.

These categories correspond to the post-depolarisation environment – pre-depolarisation business should be coded as follows:

- All business sold through IFAs should be coded as "F"
- Business sold through tied agents or direct sales forces should be coded as "S"
- Business sold via direct marketing should be coded as "N"

No pre-depolarisation business should be coded as "A" or "M".

Record U if the sales channel is not known.

5.28 Location

This should record the first part of the postcode of the main residence of the life insured. This should be the latest available value. If this is not known or if the life insured has moved abroad, please leave blank.

In no circumstance should the full postcode be entered.

5.29 Initial benefit amount

Code as a numeric rounded to the nearer pence or to the nearer pound.

This is the benefit amount at commencement.

5.30 Benefit amount at beginning of year

Code as a numeric rounded to the nearer pence or to the nearer pound.

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.

5.31 Benefit amount at end of year

Code as a numeric rounded to the nearer pence or to the nearer pound.

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.

5.32 Date of amount review

This is the date the benefit amount was reviewed, where this is done on a regular, annual basis (e.g. RPI escalation or mortgage decreasing). It should be coded as DDMM.

5.33 Type of benefit increment/decrement

This is the type of change in benefit amount that applies contractually.

5.34 Rate of benefit increment/decrement

This is the annual change in benefit amount that applies contractually. This field should be left blank if 5.33 equals “C”, “L”, “N”, “R” or “W”.

Code as a numeric using the format “NN.NN%”.

5.35 Previous Investigation Number

This is the CMI Mortality Investigation under which the policy was previously submitted. Please leave blank if unknown or not previously submitted. Offices may prefer to submit this information in a descriptive format, instead of including within each data record.

The following fields must only be completed for policies that are no longer in force at the end of the year. Please note that the CMI does not necessarily expect all the claim dates to be supplied in all cases.

5.36 Date of exit

This is the date that the office processes the exit. 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 5.41).

For annuity business, this 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 5.12 above.

5.37 Type of exit

For multiple benefit policies, only the benefit under which a claim is paid should record one of C, D, E, M, and T, as appropriate. Other benefits should record B if cover under these benefits ceases on a claim on another benefit. B should also be used to record the exit applicable to the life not giving rise to a claim under a Joint Life First Death benefit.

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

5.38 Date of claim

This should be the date of death as recorded on the death certificate for death claims. For Critical Illness and Terminal Illness claims, this will be the date of diagnosis of Critical Illness or Terminal Illness, using the office's own definition of what constitutes a terminal illness. The format should be as for 5.12 above, or blank if unknown.

For both mortality and critical illness investigations, this date is used to calculate the age and duration at claim. **With this in mind, this is an important date to include and, though it is not mandatory, we would be very keen to see as many records as possible with this date.** Where date of death or diagnosis is not known, our analysis calculates an approximate date based upon other types of date available.

5.39 Date of notification of claim

This should be the date the office was notified of the claim. The format should be as for 5.12 above, or blank if unknown.

5.40 Data of claim admission

This is the date the office admitted the claim. The format should be as for 5.12 above, or blank if unknown.

5.41 Date of claim settlement

This should be the date the claim was actually paid. The format should be as for 5.12 above, or blank if unknown.

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.

The date of settlement is the date used to determine whether the claim falls within a particular investigation year.

5.42 Cause of Claim (Critical Illness investigation only)

Please complete this as accurately as possible to identify the critical illness event under which the claim was admitted. The table below gives a list of all the causes of claim used by the CMI. Offices are asked to avoid using "Other" and "Unknown" causes as far as possible. For Cancer claims, offices are asked to advise the site of the cancer so that analysis by site may be undertaken in the future.

Causes of Claim (for Critical illness investigation only)

List of
Deaths
Terminal Illness
Heart Attack
Stroke
Coronary Artery Bypass Graft (CABG)
Multiple Sclerosis
Kidney Failure
Major Organ Transplant (MOT)
Total Permanent Disability (TPD)
Aorta Graft Surgery
Benign Brain Tumour
Blindness
Deafness
Heart Valve Replacement / Repair
Loss of limbs
Loss of speech
Motor Neurone Disease
Paralysis / Paraplegia
Coma
Parkinson's Disease
Third Degree Burns
Alzheimer's Disease
Angioplasty
Other
Unknown
Cancer - site not specified
Malignant neoplasm of lip, oral cavity and pharynx
Malignant neoplasm of digestive organs and peritoneum - unspecified
Malignant neoplasm of oesophagus
Malignant neoplasm of stomach
Malignant neoplasm of small intestine including duodenum
Malignant neoplasm of colon
Malignant neoplasm of rectum, rectosigmoid junction and anus
Malignant neoplasm of liver
Malignant neoplasm of pancreas
Malignant neoplasm of respiratory and intrathoracic organs - unspecified
Malignant neoplasm of larynx
Malignant neoplasm of trachea, bronchus and lung
Malignant neoplasm of bone, connective tissue, skin and breast - unspecified
Malignant neoplasm of bone and articular cartilage
Malignant melanoma of skin
Other malignant neoplasm of skin
Malignant neoplasm of female breast
Malignant neoplasm of genitourinary organs – unspecified
Malignant neoplasm of ovary and uterine adnexa
Malignant neoplasm of prostate
Malignant neoplasm of testis
Malignant neoplasm of bladder
Malignant neoplasm of kidney and other urinary organs
Malignant neoplasm of other sites
Malignant neoplasm of brain
Malignant neoplasm of lymphatic and haematopoietic tissue
Hodgkin's disease
Leukaemia
Myeloid Leukaemia
Malignant neoplasm - multiple sites

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%