

ISSUES IN BRIEF

UK GENERAL INSURANCE

OWN RISK AND SOLVENCY
ASSESSMENT (ORSA) 1

PPOs AND REINSURANCE 4

FUTURE LATENT CLAIMS 6

NO-FAULT MEDICAL
COMPENSATION SCHEMES 8

AS WE ISSUE OUR FIRST UPDATE OF 2013,

THE UNCERTAINTY FACED BY THE INSURANCE INDUSTRY ABOUT SOLVENCY II IMPLEMENTATION IS PERHAPS AS GREAT AS IT HAS EVER BEEN. DIFFICULTIES CREATED BY THE HIGH COST OF LONG-TERM GUARANTEES IN CURRENT CONDITIONS NOW SEEM CERTAIN TO DELAY IMPLEMENTATION TO AT LEAST 2016. MANY ASPECTS OF THE NEW REGULATIONS STILL PRESENT CHALLENGES FOR INSURERS, SO THE ADDITIONAL TIME TO PREPARE WILL BE WELCOMED. WE HAVE INCLUDED AN ARTICLE DISCUSSING THE OWN RISK AND SOLVENCY ASSESSMENT (ORSA) AS A NUMBER OF EUROPEAN REGULATORS ARE SERIOUSLY CONSIDERING THE INTRODUCTION OF THE ORSA AHEAD OF THE FULL IMPLEMENTATION OF THE SOLVENCY II REQUIREMENTS.

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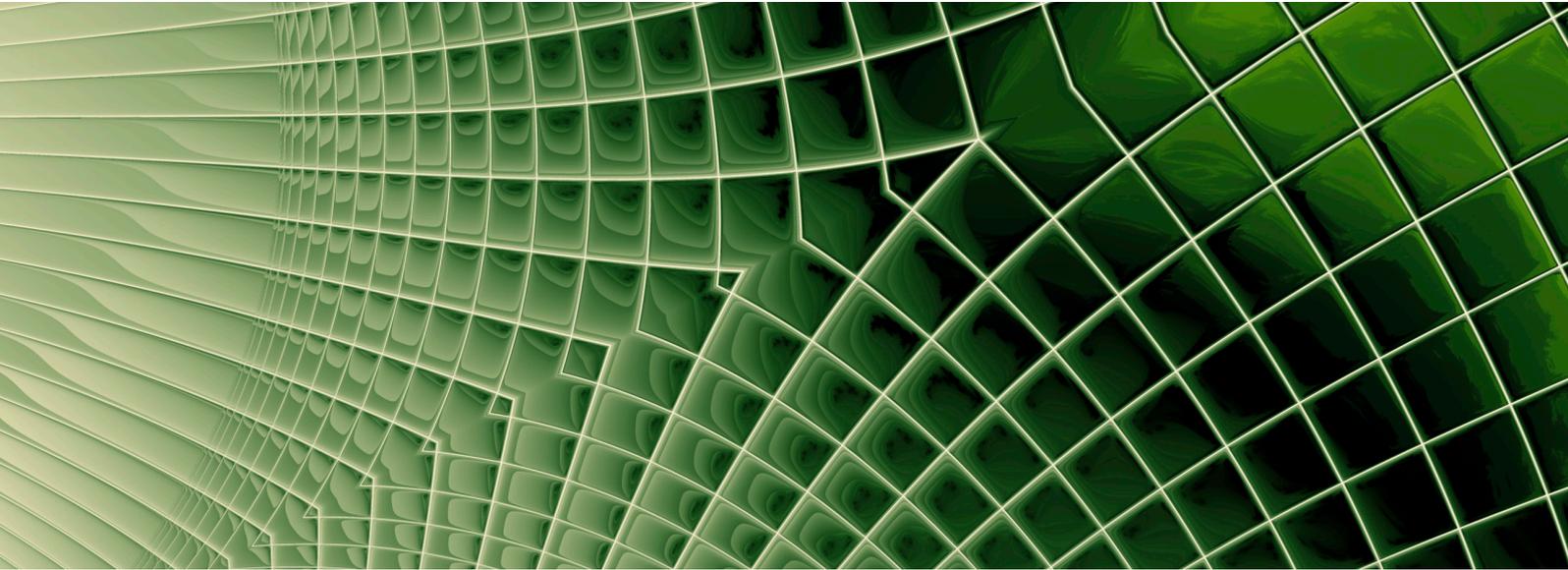


With the new regulations being delayed, attention is returning to more pressing strategic issues such as the growing challenge of periodic payment orders, or PPOs. In this issue we discuss how PPOs affect reinsurers and, in turn, how reinsurers might seek to control their PPO exposures.

An area of the industry that continues to surprise is the ongoing rise in the estimated cost of US-related asbestos claims. Most recently A.M. Best raised its ultimate estimate from \$75 billion to \$85 billion. While asbestos is now a well-established claim class, it started out as latent claim type. What other latent claims might be emerging, and could they be a serious cost to the insurance industry? In this issue we discuss how establishing a framework for analysing "candidate" latent claims can be helpful in ranking such potential claims.

We finally take a look at no-fault medical compensation schemes. Such schemes might improve the efficiency of the compensation process in medical cases. However, there will be additional costs as well as benefits, and these additional costs are likely to be material.

OWN RISK AND SOLVENCY ASSESSMENT (ORSA)



The implementation of Solvency II is in a state of flux. At present, it appears that full implementation will be set for 2016 (or potentially even later).

Against this background an interim phase is being mooted whereby regulators start to incorporate in the supervisory process some of the key features of Solvency II, namely some elements related to Pillars 2 and 3 (see Figure 1 below).

Under Pillar 2, a key supervisory tool will be introduced, known as the Own Risk and Solvency Assessment (ORSA). This requires every firm to carry out a regular assessment of its solvency needs and its

compliance with those needs, and submit the results to the supervisor.

While the ORSA is usually seen as purely a Pillar 2 requirement, in practice it is closely linked to Pillar 1 (the SCR internal model/ standard formula) and Pillar 3 (production of the ORSA report).

As the ORSA will be a key supervisory tool and links with Pillars 1 and 3 it is not surprising that a number of European regulators are seriously exploring the introduction of the ORSA ahead of the (full) implementation of Solvency II.

The remainder of this article considers the current thinking on and some of the challenges to implementing an ORSA.

ORSA UNDER SOLVENCY II

Article 45 of the Solvency II directive defines the conceptual framework for the ORSA:

- As part of its risk-management system every (re)insurance undertaking shall conduct an ORSA
- The ORSA shall include at least the following:
 - (a) The **overall solvency needs** taking into account the specific risk profile, approved **risk tolerance limits** and the **business strategy** of the undertaking

FIGURE 1



- (b) **The compliance, on a continuous basis**, with capital requirements and with the requirements regarding technical provisions
- (c) The significance with which the risk profile of the undertaking concerned deviates from the assumptions underlying the SCR

In addition to Article 45, EIOPA has published a Consultation Paper on Proposed Guidelines for the ORSA. This paper includes 24 guidelines and hence guidance on what is to be achieved by the ORSA. In particular, these guidelines cover:

- General considerations on the ORSA (proportionality, the active role of the administrative, management or supervisory board, documentation, and the ORSA policy itself)
- The need to document and record each ORSA process, including an internal

report on the ORSA, and an ORSA supervisory report (at least annually)

- Specific features concerning the structure of the ORSA, i.e., assessment of overall solvency needs, forward looking perspective, regulatory capital requirements, technical provisions, deviations from SCR assumptions, link with strategy and decision making, and the frequency of the ORSA
- Specific requirements for a group-wide ORSA

Figure 2 below illustrates the ORSA framework based on the guidance provided to date.

The ORSA framework leads an undertaking to adopt the following principles:

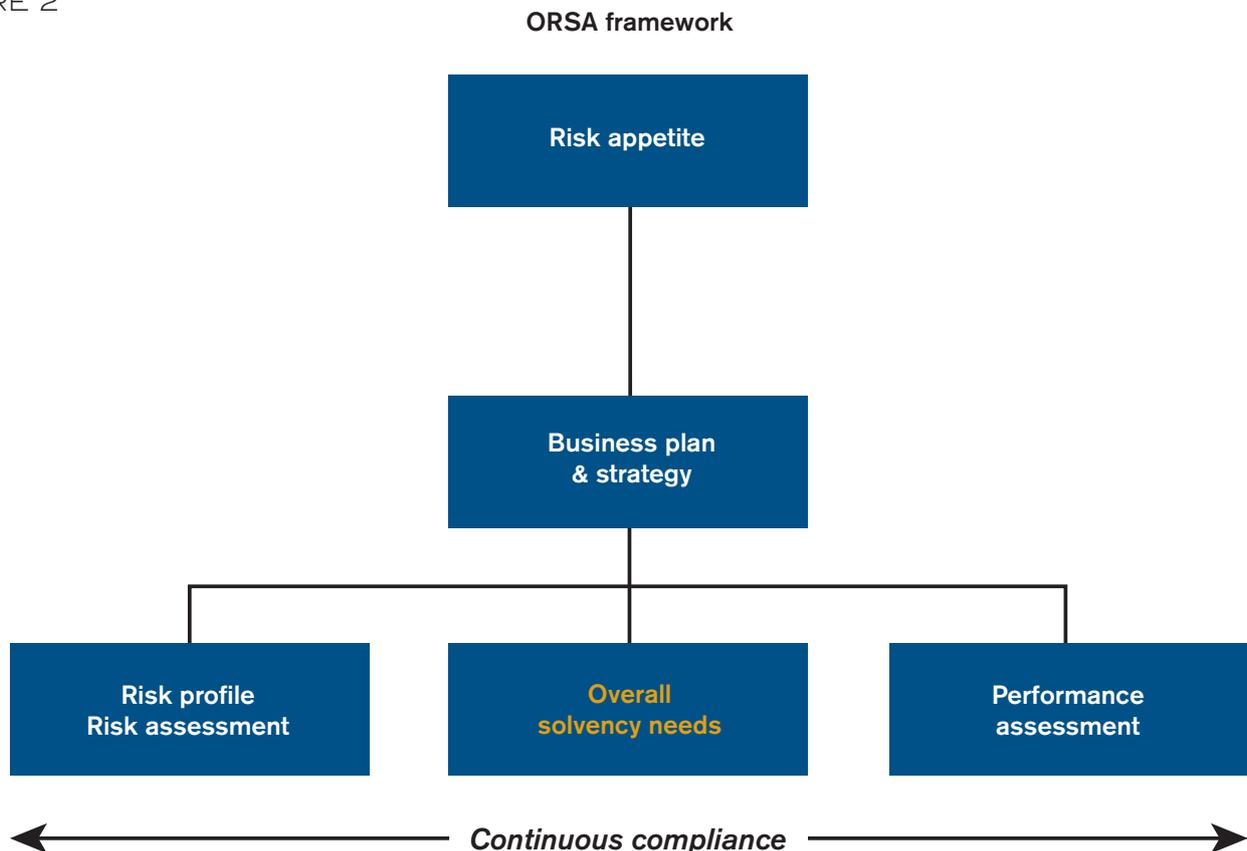
- Calculation of solvency requirements with a **multi-year time horizon** (the same horizon as the business plan, e.g., three

years). The calculation needs to consider all periods of the time horizon.

- Taking into account **multi-year new business** and **other risks**.
- A **change in risk tolerance**, e.g., 98.5% over a three-year time horizon.
- Evolution of economic or technical indicators between $t=0$ and the time horizon, in **non-central situations**.

The calculation of solvency requirement under an ORSA should not be underestimated. It requires a path for the business over (say) a three-year time horizon that is consistent with the risk tolerance level defined by management; is multi-year, including new business; incorporates all risks measured at the selected risk tolerance level; requires aggregation to allow for diversification benefits; and must be tested against the SCR over a one-year time horizon.

FIGURE 2



Various methodologies can be devised to meet these calculation requirements that range from purely deterministic (scenario, sensitivity and stress testing) to fully stochastic (an internal model approach). For non-life (re)insurance undertakings, where insurance risk typically dominates their projected capital needs, a partial internal model approach may well provide an effective and pragmatic way of assessing solvency through the ORSA framework. Furthermore, for UK (re)insurance undertakings, this calculation approach may well be similar to that currently employed in their individual/economic capital assessments made for regulatory/management purposes.

IMPLEMENTATION OF THE ORSA

The main steps identified for the implementation of the ORSA based on the ORSA framework are illustrated in Figure 3 below.

SUMMARY

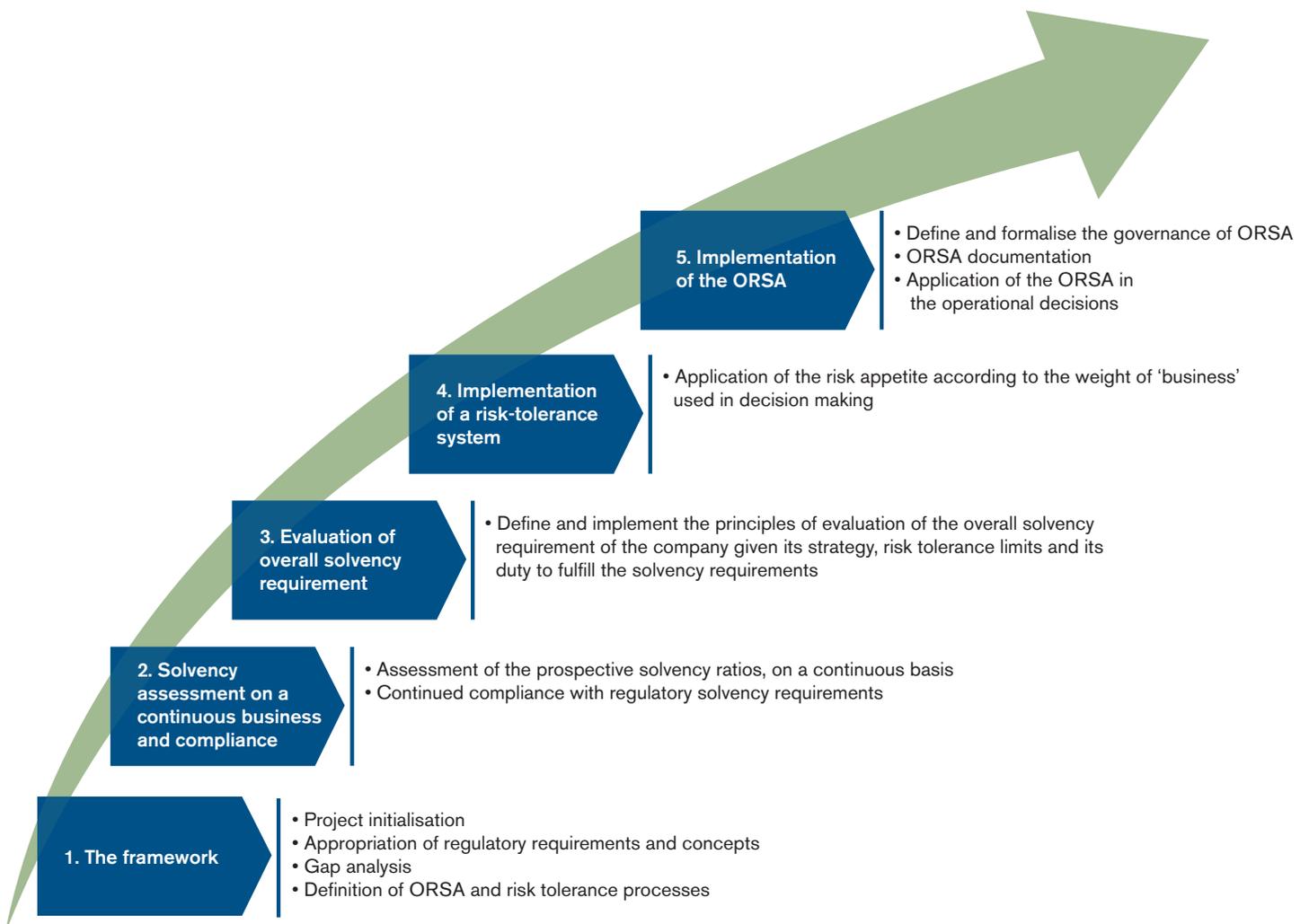
In summary, the purpose and benefits of the ORSA are as follows:

- To help undertakings manage their specific short-term and medium-/long-term risks

in a pro-active fashion, including risks not included in the SCR

- To align the business strategy with an undertakings risk appetite, i.e., maintain consistency between risk, capital and business performance
- Efficient capital management
- To help demonstrate the continuous compliance of the capital needed relative to the risk appetite of the undertaking

FIGURE 3



PPOs AND REINSURANCE

Structured settlements have been a viable option for seriously injured claimants since before the 2003 Courts Act, but it was only after this new law came into force that they could be imposed by the court. Known as periodic payment orders, or PPOs, the implications of this judicial option have loomed large in reinsurers' rear-view mirrors. Immateriality arguments may have sufficed until now, but the ever growing awareness and popularity of PPOs means this approach no longer passes muster for many reinsurers. Much has been written about PPOs from the perspective of insurers, but in this article we consider the reinsurers' position. For the purpose of our discussion we have limited attention to non-proportional motor reinsurance. In practice, PPOs can appear within any reinsurance portfolio where serious bodily injury is an underlying peril; as well as the motor reinsurance treaty portfolio, this most commonly means the employer's liability and general liability treaty accounts.

From the outset, we need to be absolutely clear that however much of a headache PPOs may be for insurance industry players, there is no doubt they are good news for victims. PPOs are a good match to future care costs and they transfer risk from the individual to the insurer. The insurer is in a much better position to handle that risk.

The non-proportional motor reinsurer usually attaches well above day-to-day property claims (bar property claims that aggregate following, say, hail or flood) and above most small bodily injury claims (whiplash, minor injuries etc.). Indeed, the reinsurer may only see action above individual claims of £2 million or higher, precisely the kinds of serious spinal and head injuries where PPOs will be on the negotiating table. By value, therefore, where PPOs might comprise 20% of a direct insurer's reserve fund, they could form 60%, or more, of the reinsurer's non-proportional motor reserve fund. PPOs really matter to reinsurers.

The role of non-proportional reinsurance is to transfer unwanted volatile risk off the cedant's balance sheet for a fair price. But it is also important for the whole package to make sense. The reinsurance

programme must be structured so that the cedant retains some 'skin in the game'; otherwise the reinsurer is too exposed to an original underwriting process over which it has practically no control. Reinsurance treaty indexation clauses have evolved as a simple way of sharing uncertain future claims inflation and ensuring that neither the reinsurer nor the insurer is left with a disproportionate claim burden. For a fixed limit layer, the indexation benefits both the insurer and the reinsurer since both deductible and limit increase with the index. For an unlimited layer, the indexation clause protects the reinsurer. Alternative solutions such as severe inflation clauses or franchise clauses are also available, and these oil the negotiation process so that a sensible reinsurance renewal outcome is reached.

As a product, non-proportional motor reinsurance is not structured to deal with longevity risk: It is built around the concept of full and final settlement by lump-sum payment at an uncertain date after an accident. Critically, the importation of longevity risk into a reinsurance portfolio from PPOs leads to a higher average duration of reinsurance payments and eliminates this final certainty. Indexation clauses, as currently structured, are very likely to over-simplify the financial impact of claims escalation. The weighting effect of any initial lump sum, in particular, can slow down the rate of indexation, meaning that the PPO reaches a given retention sooner and stays within the layer for longer: bad news for the reinsurer.

Figure 1 on page 5 shows this 'lump-sum' effect for a £5 million x £5 million layer (ignoring any mortality effects and assuming annual PPO escalation of 5%). At year 15, the cedant has paid £7.5 million in both cases, but where the higher initial lump sum has slowed down the indexation of the deductible, the reinsurer has paid £1.0 million compared with only £0.7 million when the lump sum is the lower figure of £2 million.

Conversely, for underlying fixed limit business such as general liability, the indexation clause can revalue the reinsurance deductible above the underlying insurance limit: good news

for the reinsurer, but clearly missing the original point of the reinsurance cover in providing protection to the cedant.

Moreover, the PPO does not import 'normal' longevity risk onto a reinsurer's balance sheet, but a relatively small cohort of impaired lives with very different future life expectancies. This breaks almost every rule in providing a manageable mortality experience that can be assessed using actuarial techniques. Again the principle of an equitable sharing of costs between insurer and reinsurer becomes difficult to manage: Just a handful of early deaths could significantly benefit the reinsurer while longer than expected survival of PPO recipients could cost the reinsurance treaty dearly. Such costs, or savings, will then gear up for the reinsurer, given its lower premium base.

Even how the insurer decides to manage the PPO affects the risk experience of the reinsurer. If the insurer decides, with the court's agreement, to purchase annuity cover for the PPO, then the reinsurer may effectively foot much of the expense bill. For example, if the insurer purchased a £5 million x £5 million layer of protection, then whether the annuity buy-out costs £7 million or £6 million makes no net difference to the insurer but, ignoring indexation effects, it is a 100% difference in cost for the reinsurer. How hard a negotiation stance is the insurer going to take with the annuity provider?

The long duration of PPOs means capital strain, especially for those reinsurers writing high excess of loss layers. Claims may not reach the programme deductible for many years, decades even, yet capital still needs to be held in support of the portfolio. The economic opportunity cost of tying up this capital for perhaps 40 years or more is considerable for a non-life reinsurer whose business model is based upon a relatively short-term cyclical underlying market. Even when the economics suggests favourable return on capital, a headline expected loss ratio of 150%, perhaps higher, can be extremely difficult to explain and justify to top management, regulators and analysts. Familiar management measures, such

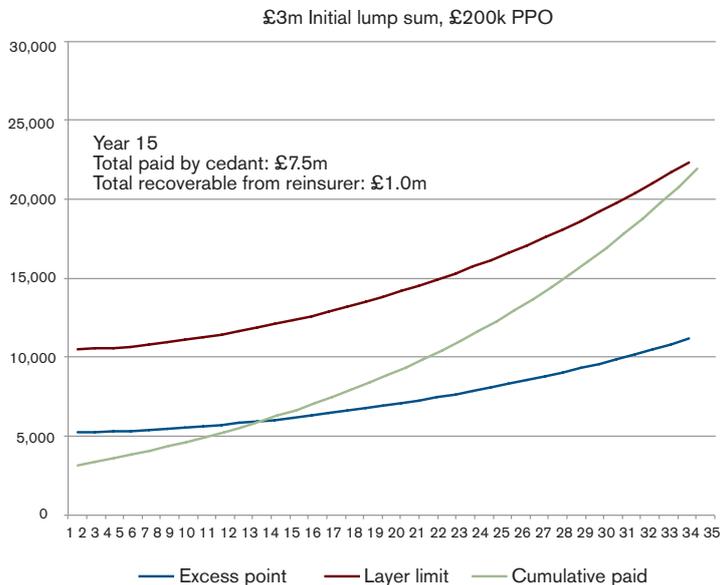
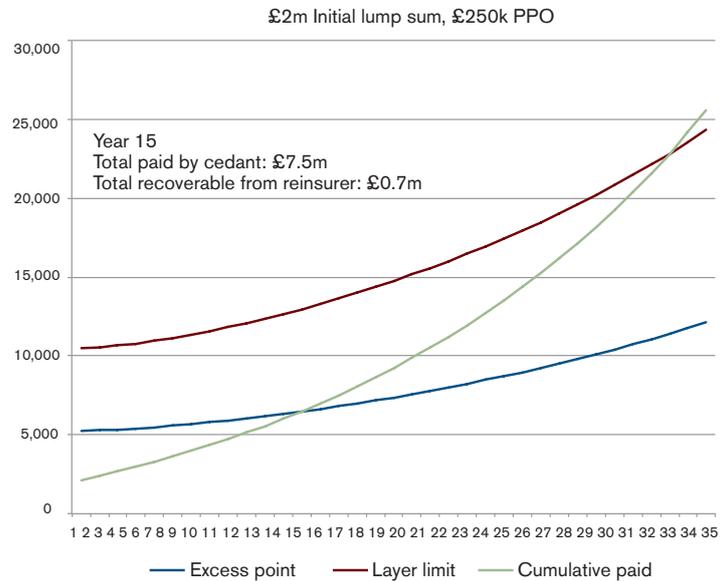
as loss ratio and combined ratio, do not normally make sense for PPOs, and this leads to a communication headache for reinsurers and their management.

Fundamentally, there are two solutions to the PPO problem for reinsurers. The first is to recover a level of certainty appropriate to the original design of motor treaty programmes. The second is to redesign the reinsurance product entirely to reflect a new risk environment. The industry is currently focusing on the first of these options and capitalisation clauses, in particular, may be a 'quick win' in terms of recovering the balance between reinsured and reinsurer. However, given that insurers are facing mirror image issues from their own perspective, getting agreement to a capitalisation clause is, inevitably, very tricky. Another solution most naturally open to composite reinsurers is to transfer the PPOs off the non-life reinsurer's balance sheet and onto a life reinsurer's balance sheet in a systematic way; but this is a tougher call for pure non-life reinsurers where the economics of a deal with an external life reinsurer may not stack up.

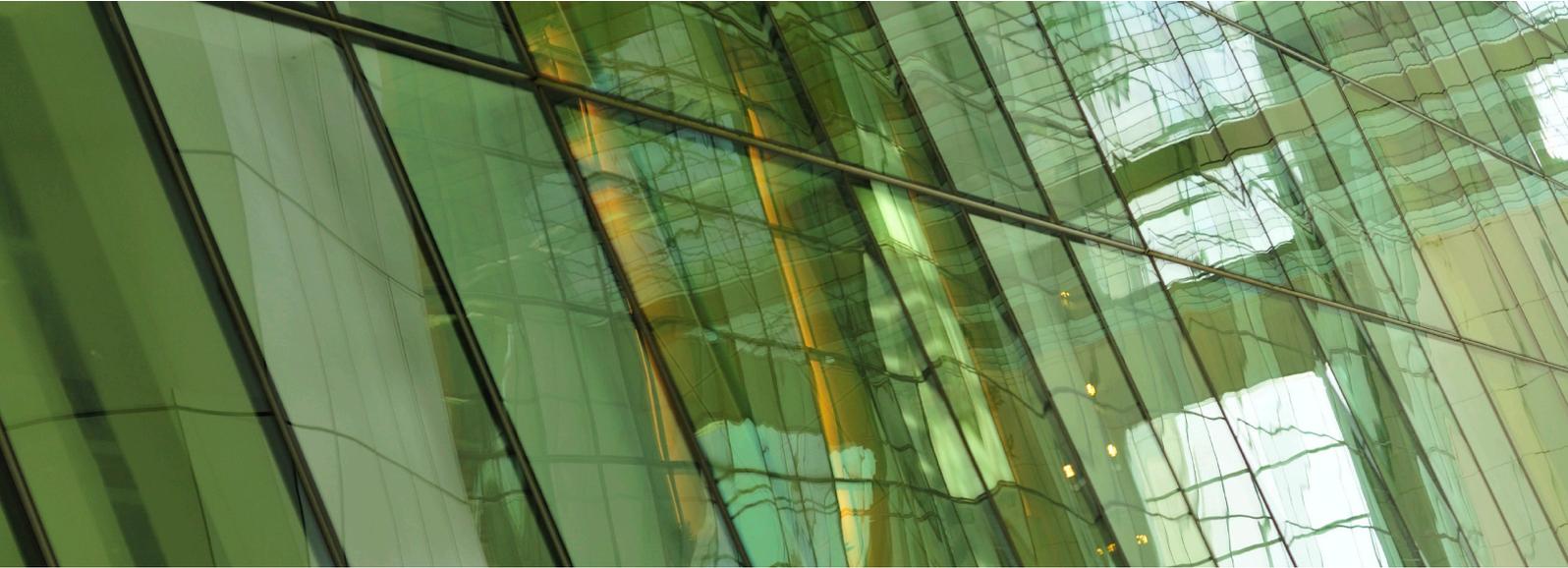
Ultimately, change is most likely to happen when the pain is being felt on all sides—within the net accounts of insurers as well as the loss experience of reinsurers. Such change will probably accelerate if the management of structured settlements in other countries moves towards something akin to the UK's PPO regime. In the meantime, reinsurers will manage the issue by adjusting risk appetites, perhaps writing more proportional deals, while choosing to support only a limited number of UK motor insurers on a non-proportional basis, and offering lower written lines.

There is no doubt that the UK motor treaty renewal season will be one to watch for a few years yet.

FIGURE 1



FUTURE LATENT CLAIMS



What is the next latent claim going to be? It is in the nature of things that a very simple question like this has anything but a simple answer. It can, nevertheless, be helpful to establish a framework for analysing 'candidate' latent claims. A good framework can then act as an effective filter and enable businesses to focus their limited resources on areas where latency could genuinely become a problem.

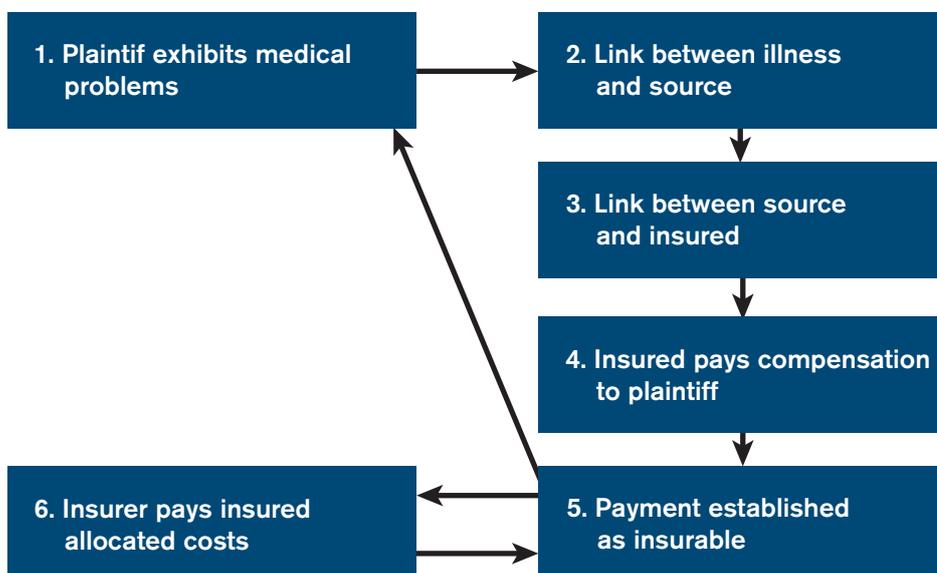
The heart of such a framework is a structured understanding of the process by which latent claims tend to emerge. We have set this out in the diagram below, which labels each stage of a latent's emergence, from 1 to 6.

The diagram is useful because it shows all the links that need to be established before an insurance payment is made.

The complexities associated with defining, proving and understanding these links is usually the key reason why latent claims are so tricky to deal with. In particular:

1. The time taken for plaintiffs to exhibit a medical problem can be years or even decades. A side-effect of this long latency period is that many people (such as a whole workforce in an industry) might be exposed, perhaps for more than one generation, before a medical problem becomes apparent. This is an important explanatory factor for the high level of ultimate claim frequency normally associated with latent claims. An example here might be the increasing reported frequency in the UK of claims relating to noise-induced hearing loss (or NIHL).
2. Establishing the link between a medical problem and a surmised toxic source. Disputes over proving the original cause can last many years, adding to the delays involved in Stage 1. No conclusive link has been found, for example, between electromagnetic fields and the incidence of cancer—but the arguments continue.

FIGURE 1



3. Establishing the link between the surmised toxic source and the insured risk, such as a particular producer or user of asbestos. This supposed link will often be disputed by the insured, and such issues as market practice of the time and prevailing legislation become very important in these arguments. For this step, protracted legal proceedings will tend to add to the delays of 1 and 2. In this context it is important to bear in mind statute of limitation defences (for non-disease claims). These prevent plaintiffs from bringing actions against insureds after a certain amount of elapsed time.
4. Establishing the level of compensation payment that is insurable, identifying the insurer that is liable and allocating claim costs. Again, this is a complicated stage of the latency process. The genealogy of insured companies, for example, needs to be understood and traced back to the time of original exposure. The insurance provider from the time also needs to be identified, but may no longer exist or have gone insolvent. An important tool available to insurers in protecting themselves at this stage is the use of appropriate policy forms (for example, claims occurring versus claims made) and of explicit exclusions. The most important historical example of this is the introduction of asbestos exclusion clauses as standard insurance practice in 1986.

These stages highlight the propensity of latent claims to generate a high level of legal cost. Indeed, even when all the links in the chain fail to establish an insurer's liability to meet indemnity costs, the primary layers of insurance programmes may still end up being eroded by the costs of legal defence. Understanding how these defence costs are allocated to insurers becomes another important part of the process.

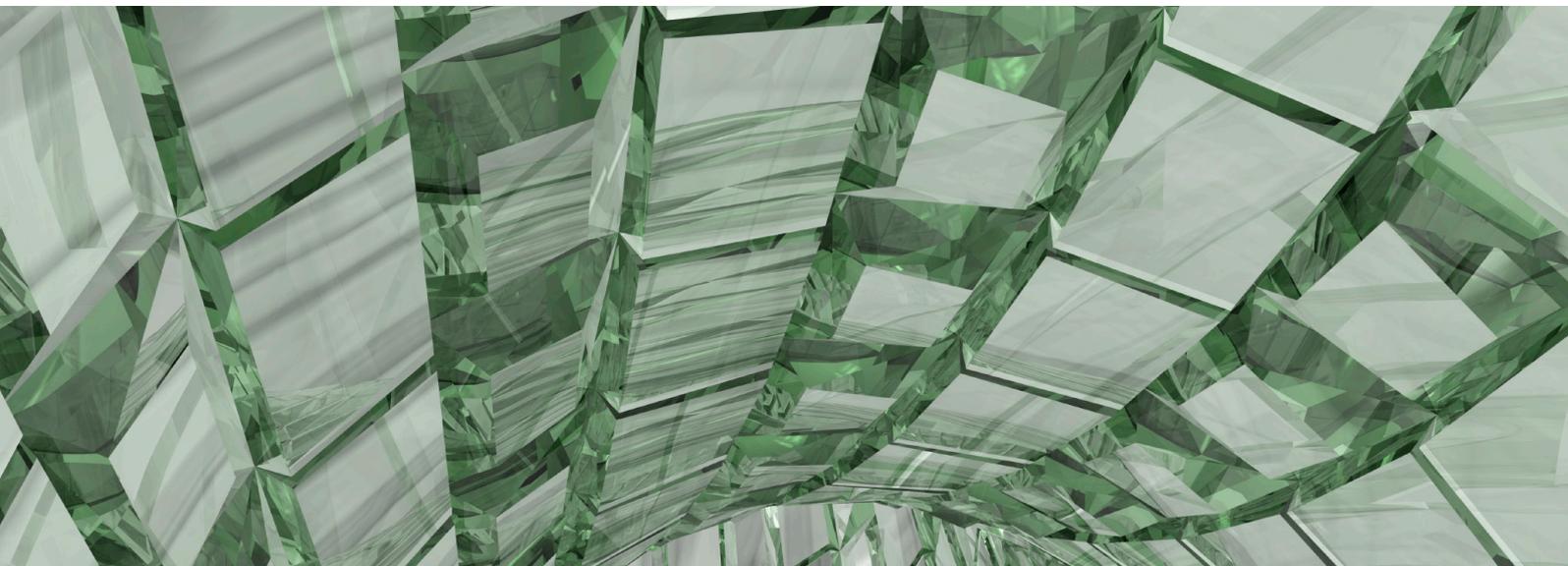
Not all latent claims are necessarily directly medical in nature although they normally concern the wellbeing of the broader community in some way. Environmental pollution, for example, is not directly medically related, nor are sexual abuse claims. Sexual abuse claim frequency, in particular, has increased over the last couple of decades as victims have gained the courage to come forwards and as institutions have become more willing to admit their culpability. It is interesting to observe in this example how cultural and sociological changes have played a pivotal role in allowing this important class of claim to gain a hearing. It remains to be seen how far the claims will filter through the insurance system.

Sadly, it is impossible to eliminate any latent claim candidates with 100% certainty, but the framework outlined above can assist in identifying whether a potential latent claim can be relegated to a low risk tier. A good example might be silica. Like asbestos, silica was used widely in various industrial processes and indeed many original silica claims were presented alongside asbestos claims. However, unlike asbestos, no definitive link has been proved between the use of silica and any specific medical problem. On this basis, it would not seem unreasonable to place silica claims in the low risk tier of potential latents.

Owing to their complexity, evaluating latent claims is an extensive and costly exercise for insurers to undertake. It is therefore appropriate for companies to establish a framework that can assist in ranking (or 'tiering') the potential latent claims of the future. Hopefully, this article has assisted in providing a brief outline of the considerations involved in making such a classification.

A GOOD FRAMEWORK CAN ACT AS AN EFFECTIVE FILTER AND ENABLE BUSINESSES TO FOCUS THEIR LIMITED RESOURCES ON AREAS WHERE LATENCY COULD GENUINELY BECOME A PROBLEM.

NO-FAULT MEDICAL COMPENSATION SCHEMES



In the UK, if one suffers injury or loss as the result of medical intervention, compensation can be sought and can be awarded by courts, but only if the claimant can prove that the injury or loss was due to negligence on the part of the healthcare provider or physician. This fault-based compensation practice has been established for many years. However, periodically there are suggestions that the UK shifts to a system that does not require proof of negligence. Indeed, a few years ago the Scottish government established a working group to explore the possibility of introducing a no-fault scheme in Scotland, at least in respect of claims against NHS Scotland, and the working group started consulting on its initial findings and proposals in the second half of 2012. In this article we consider some of the issues surrounding a no-fault system.

Proponents of no-fault arrangements cite two major advantages over the existing fault-based practice: greater fairness to the injured parties and potential savings to those funding the compensation.

Considering first the fairness to claimants, it undoubtedly appears more equitable that anyone who is unfortunate to suffer as a result of medical treatment would be able to obtain financial redress rather than just those who could prove that the treatment was administered negligently. On the other

hand, under the no-fault scheme proposed for Scotland and those that have been implemented elsewhere in the world, claimants still have to prove causation, i.e., a direct link between their worsened condition and the medical treatment administered. Those unfortunate in health, who cannot prove that their misfortune is attributable to treatment, would not benefit from such a scheme.

There is a question about consent. Some treatments are considered very risky but may be undertaken in particular circumstances, usually with the patient's explicit consent. Should injury caused in such cases be eligible under a no-fault system? Risk, however small, attaches to most treatments and in many cases physicians and other medical practitioners will take steps to make patients aware of the risks. If the patient does not raise objections to the treatment proposed, having been told of the risks, does he or she accept liability if things subsequently to go wrong? If that were the case then, were the patient unable to give consent, for example through dementia or loss of consciousness, would liability transfer to the physician and the treatment centre? Would this change adversely affect the behaviour of members of the medical professions and of the medical centres?

The cost-saving argument is even less clear. It is accepted that, under a no-fault system, those claims settled under the

current system would still be settled. Other claims that would currently be rejected, as negligence could not be proven, might now be settled if a causation link could be established. And other incidents that would not have become claims under the current system would now be reported and some of those would also be settled as legitimate claims. So it is apparent that there will be increased payments under a no-fault scheme to those injured by medical treatment. However, those in favour of a no-fault system argue that the additional settlement costs are more than outweighed by savings to be made through no longer needing to prove, or defend against allegations of, negligence.

It is an argument that undoubtedly has some merit. Legal and other administration costs comprise a high proportion of the claims-related expenditure of healthcare providers, or their insurers and these costs would undoubtedly fall were the negligence criteria to disappear. But how much would be saved and by how much would the settlement costs increase depends on a number of assumptions regarding future claims activity. In particular:

- What proportion of claims currently made but then rejected would succeed under a no-fault scheme?
- What would be the settlement cost of those claims that would now succeed?

- What increase could be expected in the numbers of claims being reported once the burden of establishing liability had been set aside? A study conducted in England a few years ago suggested that the lowering of the barrier to claims success and the attached publicity would lead to an increase of about 80% in the numbers of claims made. That percentage is very uncertain and likely to vary depending on the prevailing economic conditions, increasing in times of austerity.
- What proportion of those additional claims would be successful under a no-fault system, and at what cost?
- How much of the current legal and claim management costs would be saved through introducing a no-fault system? This is particularly unclear. Causation could be costly to establish. Although it was always a prerequisite to a claim under the existing system, in many cases the lawyers did not pursue it if they regarded it unlikely that they would subsequently be able to prove negligence as well. Moreover, experience of other claim types suggests that courts are willing to award higher damages in cases where there has been negligence; if this were to carry over to medical claims then it may be that claimants still wish to establish negligence where possible, so at least some of the cost savings become illusory.

Ideally the above assumptions, which would be needed to establish the financial costs and benefits, could be derived from existing UK statistics, with further support from other countries that had already introduced their own no-fault schemes. Unfortunately, little by way of relevant data is available centrally. Most of it is maintained by the NHS or by the Department of Health but, while they have good information on claims that have succeeded, there is little information about claims that have been closed without settlement, in particular anything that could be used to indicate whether there would have been a different outcome under a different system. The systems employed by other countries are also of only limited relevance: there are differences between each country's

systems; there are differences between the countries in matters such as litigiousness, acceptance of medical dominance, etc.; and there are also differences between the countries in the prevailing social welfare systems, of which this is part.

Having said that, the Scottish government commissioned a team from the School of Law at the University of Manchester to research the potential operating costs should a no-fault system be introduced in Scotland. The Manchester University team published its findings and conclusions in June 2012. Its report included estimates of what public expenditure would have been in a typical year over the recent past for cases handled by the NHS in Scotland had the suggested no-fault system then been in existence. These estimates were based on a range of assumptions and suggested that the no-fault system would have increased past costs by between 0% and 50%.

These additional costs were based on a no-fault scheme applying just to NHS Scotland cases. But it has been suggested that such a scheme should be extended to all healthcare providers, including the private sector. Such an extension would probably further increase costs (as a proportion of historic costs) as, in cases where medical services were provided by a mixture of private providers or by private and public providers, there would be considerable debate as to the proportion of any award and associated costs that should fall upon each of the parties. This debate would doubtless be conducted through legal representatives.

Regardless of any additional cost, it would appear equitable were all healthcare providers, both public and private, to be included within any no-fault scheme. If the scheme were applied in a limited way then identical claims could be valid, partially valid or not valid at all under the scheme, depending simply on who had been involved and where particular treatment/care had been administered. However, it could also be argued that, for those who have opted to pay for private healthcare, being excluded from the no-fault arrangements is just another cost of private healthcare, to be weighed up along with the monetary cost against the benefits of private treatment.

Even were a no-fault system to be introduced the transition arrangements would need to be handled carefully. For example, would the new system be applied retrospectively, i.e., so that all notified claims that had not been resolved as at the time that this system was implemented would be covered under the terms of the new system and would no longer have to prove negligence as part of establishing the claim? This would seem fair in that otherwise existing claims that could not prove negligence would be rejected at the same time as identical cases that had been reported after the implementation were being settled. On the other hand, this could materially increase costs, both for the public sector which funds on a pay-as-you-go basis and for the private sector, the insurers of which set reserves for claims incurred, funded by premiums or members' subscriptions. One would hope that there would be no intention to reopen claims that had already been rejected because negligence had not been proved.

Retrospective application of a new system would probably affect the behaviour of pursuers and their legal advisors between the announcement of the system and its implementation. It would be in the interests of many to delay attempts to settle the question of negligence. Conversely, defendants would be keen to accelerate the process, to eliminate as many of the non-negligent cases as possible before the implementation date.

It is largely a societal issue whether the existing negligence-based system should be replaced by a no-fault scheme. Society is moving towards compensating individuals for misfortune as well as for the effects of the negligent behaviour of others. A no-fault scheme would be a further manifestation of that progression. Such a scheme might also improve the efficiency of the compensation process in medical cases. However, it is important to recognise that there will be additional costs as well as benefits, and that these additional costs, although hard to quantify, are likely to be material.

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