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Session 33PD
Critical Illness Issues

Track: Product Development

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Summary: Critical Illness (CI) policies are designed to alleviate the financial burden caused by "dread diseases." Panelists address current issues of CI products, including underwriting, state filing, distribution and marketing. Attendees gain a better appreciation of the issues the actuary must be aware of in developing a CI product in today's marketplace.

MS. SUSAN KIMBALL: I am executive director of living benefits for ING Re and the only actuary on the panel. ING Re provides CI product development and reinsurance for our clients. We help with everything from pricing and underwriting guidelines to providing knowledge on state filing requirements and agent training. We have been in this market for over four years and have developed CI accelerated riders as well as standalone products in individual, work site, direct response and group markets.

Mike Harper is vice president of voluntary benefits underwriting for Colonial Supplemental Insurance. Mike has worked in the past for AFLAC, The Harper Group, Cotton States, Occidental Life of North Carolina, Mutual Benefit Life and Manhattan Life. He has also been a senior policy examiner at the Bureau of Insurance for the Commonwealth of Virginia, which gives him a unique perspective. Mike holds the

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CLU and Fellow of the Life Management Institute (FLMI) designations and is currently president of the Southeastern Home Office Underwriter's Association.

Sandy Meltzer is the president of Sandra K. Meltzer & Associates Inc., compliance consultants to the insurance industry. She worked for Tillinghast in Atlanta from 1974 to 1993 specializing in insurance contracts and regulation. Sandy's experience in life insurance contracts and compliance include group and individual universal life (UL), interest-sensitive whole life and variable annuity and life products. Her experience in the area of health insurance contracts and compliance includes long-term care, group and individual health, accidental death, hospital indemnity, disability income, and CI products. Ms. Meltzer is an FLMI, a Chartered Property and Casualty Underwriter, and a CLU. She is also an active member of the Life and Health Compliance Association.

Sean Long has been a successful insurance broker for 26 years. He has achieved life member status in the Million Dollar Round Table and sold over 1,500 CI policies within two years of the product's introduction in the Canadian market. Sean was asked to consult with Swiss Re for three years to introduce CI insurance to the North American marketplace. Each of the top four CI insurance carriers in Canada have used Sean's seminars, marketing ideas, and Web-site training to significantly increase production and the quality of the underwriting of the applications that they receive. This has led those companies to lower underwriting costs and significantly improve the morale of agents by helping them to understand morbidity versus mortality.

We are going to talk about the CI market. I've been in this market about three-and-a-half years, and I've seen a huge difference between 2001 and 2002. When we went out to talk to clients in 2001, we had to tell them what CI was. This year, they're actually saying it is a product that they've heard about and want to have in their portfolio. Their agents are starting to ask about it. So when you hear about those kinds of things happening, I believe it's a precursor to this market taking off. There are, however, some issues and concerns about this product. For actuaries, one of the biggest concerns is incidence rates and pricing. I've done a fair amount of speaking and, with actuaries, that tends to be the focus. I want to focus on some of the other concerns that product development actuaries, who might be talking to the company about developing this product, need to think about. There are other issues in addition to pricing that are involved with this product. Those issues are underwriting, regulatory issues and producer issues. We have experts on each of those issues here.

Mike is going to talk about the concerns that underwriters have. Many of those concerns are the same concerns that actuaries have. He'll touch on teleunderwriting as well. Sandy will talk about regulatory issues, product features of CI policies, and some of the unique requirements that states have for CI products. Finally, Sean will talk about producer issues. As you might know, a main issue with this product is that agents haven't fully embraced it yet, so that is an issue we definitely have to

address. Sean will talk about the United States versus Canada, how to educate your field force, and then he'll have a fun quiz for us at the end.

MR. MIKE HARPER: I'd like to talk about how an underwriter would like to underwrite CI and the natural adverse selection with this product. I'll also discuss what agents want, some of the CI underwriting challenges, what kind of underwriter you need to underwrite this product, and what the ideal platform is for an underwriter.

In the ideal world, which doesn't exist, the underwriter gets family history and all the medication information. We get blood work with reflex testing. So, if someone's glucose is high, I get a glycohemoglobin and a urine albumin to see if there is any kidney involvement in addition to the diabetes. I get physician statements and lifestyle/personality profiles. I know something about the applicant's insurance portfolio and why they have it. That's the ideal world.

In the real world, we have to sell our agents on the need for this product. Many of our agents don't understand the product and don't understand the need for it. The agents want and need a simplified product design and simplified underwriting. They prefer to have guaranteed issue, which won't happen in my lifetime. At our company, the average sale is $26,000, and we sell about 1,500 policies a month.

Who buys CI? Our experience and what I've seen so far shows that potential customers are diabetics and hypertensives, but there are fewer smokers than you'd expect. I thought more smokers would be applying for this product, but they aren't, probably because it's so high-priced for smokers. We also see those with family histories of cardiovascular disease and cancer. The people buying CI are those who need the coverage. It makes sense, right?

Who should buy CI? Well, I think there's a market for singles who want to supplement their health coverage to cover the out-of-network costs with health insurance plans. It's certainly an opportunity for those in high-risk occupations that can't get disability coverage. It creates an opportunity for young people that normally buy cancer insurance. The reason for that is that cancer insurance has a composite rate, whereas CI insurance has an issue-age rate. The composite rate breakeven is at about age 45. Who should buy it? Those that need it.

What should we be doing in underwriting to protect ourselves? This product, I'd say, is as tough to underwrite as long-term care. I'll explain that a little more later. It is tough to underwrite, because you don't have all the information, and it is a combination of morbidity and mortality. Once you go ahead and get disability underwriters and life underwriters together, it's very hard to get them to understand that gray area in between. We should have our senior, more experienced underwriters looking at CI cases. It's a real good fit for teleunderwriting, where you actually call the applicant to get the information. This

is, of course, like truth serum when you call them on the phone. And get rid of the agent filtering. No offense, Sean.

MR. SEAN LONG: None taken yet.

MR. HARPER: Finally, this is probably a good product for which you can use a pharmaceutical database. I think most of you are familiar with the pharmaceutical databases out there that Lab One and MIB (Medical Information Bureau) are doing. It is a good fit to do a pharmaceutical check on those applying for CI insurance because there is a potential for adverse selection.

One thing we've learned in our three years in the business is that we do not see adverse selection by face amount. I anticipated seeing a lot of that across the board. We found that complex underwriting doesn't work. We had a one-page application with 17 questions, and our agents just refused to sell it. They said, "We don't know what you're going to do with this. We don't know if you're going to approve or decline it. We have to have some idea what action you're going to take as underwriters. Otherwise, we don't want to waste our time. This is a new product for us and we want to sell it." The other thing we found is that the smoker experience was well below expected. We found that our smokers, those who applied, are much healthier than we thought or that we priced the policies much too high. That's probably the case.

Another underwriter's nightmare is Alzheimer's disease. There are products out there that cover you for Alzheimer's. That's just an opportunity to select against the company. Multiple sclerosis (MS) has a long incubation period. You can get diagnosed with MS in your 30s and 40s and not have it manifest itself. And not just that, but is it really a critical illness? Does it hit you at once and then put you out? No, it's more of a long-term disability. It's more of a fit for a disability policy. There are other dread diseases out there. Some policies cover you for Lou Gehrig's and some other things. How do you underwrite against those things? It really is more like long-term-care underwriting. The question, of course, is, how much underwriting is this priced for? The flip side of it is, how much underwriting will agents tolerate. That's the issue. What will they sell?

So what types of conditions concern underwriters in underwriting CI? By far, I'd say probably a third, if not more, of the applications we see are from diabetics. The question is, is insulin use a true "knockout" for this kind of underwriting, or should we be asking different questions? Just an observation: Someone who's being treated with insulin is not necessarily a better risk than someone who is being treated with oral medications. Now, the actuaries in the room will disagree with me, but hear me out. There are plenty of controlled diabetics on oral medication that have highly abnormal glycohemoglobin, or Hb1Ac. We really should be focusing on age of onset. With the proliferation of diabetes that's coming about because of our new couch-potato generation, we should ask about the age of onset and their latest Hb1Ac result as we're getting information on the phone. If they don't know what a

glycohemoglobin is, then you decline them. If diabetics don't know what their glycohemoglobin is, they're not a good risk for us, because they're not educated and probably not well-medicated either.

What about those who have high blood pressure or are off the weight charts. You should look at age of onset and medications. If someone is on three or more medications for blood pressure, you can use that as a knockout and, obviously, go ahead and get them out of the criteria for being accepted. Who are the hypertensives we're really worried about? It's the younger hypertensives more than the older hypertensives, in many cases. We could debate that. Certainly, young hypertensives in their 20s are not the best risk for CI insurance because, typically, there's some organic thing going on with the kidneys or whatever else. Here, again, I'm making generalizations.

In summary, should we be taking those who are not well educated about or medicated for their disease? If they're not educated, don't know what they have, don't understand what they have, and don't properly medicate themselves, then they're probably not a good risk for us on any product, for that matter.

Family history is critical. Family history cannot be used effectively on smaller cases because you don't know what to do with it. If, for example, you find out that someone in the family died at age 60 from heart disease, you can't be sure what to think of it, because it just could be related to the fact that 20 years ago, we didn't know what we know now. That person might have lived 20 years longer. It's real sloppy to deal with. What do you do with family history on cancer? All we know is it's a hereditary disposition, but we don't know much more than that. We don't know what to do with those cases. Lastly, some states consider family history as being related to genetic testing and they've tied it into their genetic legislation. So, it's quite possible that, in the future, genetic legislation will prohibit us from using family history. It's already happening right now.

If we're getting history and information on family history, we really should pay more attention to the sibling heart history as opposed to that of the parents. That's more indicative of bad genes than anything else. If it has been passed on to the kids and they've had a heart attack, or a bypass, or something else, that has a whole lot more significance than a parent having a cardiac event. It's due to the time lag and the nature of what we have now versus what we had back when that event occurred.

Hypertension and age at diagnosis. Younger hypertensives in combination with any diabetes is not a good deal. It's not something we get real crazy about, and it's something you have to be very, very careful about. You can accept your maturity-onset diabetics with mild hypertension. Those are OK, but, certainly, younger hypertensives with any diabetes would be declined. Anyone on three or more medications concurrently should not be insurable for this product. There's a good chance that they'll have a heart attack, end-stage renal disease, stroke, you name

it. Finally, if someone does have hypertension, we should automatically be getting EKGs and blood work in the higher face amounts. When I say EKGs and blood work, I mean blood work with microalbumin. Go ahead and see what else might be going on with the kidneys.

Let's get back to diabetes. The age of onset, not the insulin use is most important. The issue is, are they taking responsibility for their illness? Are they taking accountability? That gets into all the information or all the documentation and discussion that's going on with alternative medicine now. What's the real big issue with that? The issue is that those who might be on alternative medications or therapies might be a better risk, in some cases, than some of the folks in this room, because, No. 1, they're paying for it out-of-pocket. No. 2, they are taking accountability. They're seeing a different way to take accountability for their disease, and they're taking the proper steps.

Underwriting concerns on weight. Would the following statement be correct: Agents don't judge weight well. I had a case recently that turned out to be one that we were thinking of contesting, but we realized we really couldn't. The person was 5' 8", and he actually weighed 410 pounds at his death, which occurred while he was scuba diving in the Cayman Islands. Why he was scuba diving in the Cayman Islands I have no idea. He's a minister, too.

But the agent listed him as 5' 8", 260 pounds. He really was 5' 8". They figured they couldn't weigh him at the time of the death. They had to use a fish scale. The issue is that agents do not do a good job of judging weight well. So whatever you do, you set that into your pricing. You set that into your height and weight tables, recognizing that that's a fact. Add two tables. That's the agent factor.

The other issue is you can't set the weight so low that no one qualifies, because the people who buy this are the people who have hypertension and diabetes. We have to take someone, right? So the question is, what's your height and weight tolerance. Is it two tables? That's probably too tight. Four tables? Maybe. Add another table or two for the agents, and you're probably there.

The question comes down to this: Why is teleunderwriting a good fit for this product? First of all, there's a strong need to probe for further information when you develop information on an application. Agents are agents. They're selling, and I think they do their best job to go ahead and take accurate information. There are a few bad apples out there, just like there are a few bad underwriters. The issue is that sometimes applicants do not want to give their agent the information. It might be because they're a personal friend or they just feel uncomfortable. Maybe the setting is not right. They do feel comfortable talking to a "qualified underwriter." I'm not talking about a housewife that one of the examination facilities might use to do teleunderwriting. That's not teleunderwriting. Teleunderwriting is using qualified underwriters, preferably senior types who know what types of probing questions to ask once they get a positive response. They know how to reflex properly.

We can reduce the need for attending physician statements (APSs). Studies out there show that you can reduce your need for APSs by a third or more by using teleunderwriting, which will save you a bunch of money. The caveat is that it must be done by a skilled underwriter. You can ask whether they are diabetic. You can ask for the medications. If you were going to ask for information on a CI case, and all you could ask is one question, what would you ask? You can't ask about family history. I'd ask about medication because, if I get a truthful answer, it will tell me almost everything I need to know.

It reduces to agent filtration, as they call it. It does increase your decline rate. When I used this at another company, we tested it for three years. The decline rate for life insurance went from 3 percent to 6 percent. It doubled due to agent filtration. You can capture family history if you're asking it. You can reduce underwriting costs, but only if you've added onto an existing teleunderwriting operation. A big company in the Midwest had a teleunderwriting operation. It cost $5 million to put it up. It's not cheap to set up a good teleunderwriting operation. The operation does not consist of underwriters making phone calls; it's really a call-center environment, where you can do this at the right time of the day so you get to clients. You have to catch them during off-hours.

Finally, teleunderwriting allows for higher placement rates. The offshoot is that some people hang up on you, saying, "I told the agent I didn't want this insurance. I told him he wasn't going to layer it. I signed the application because I was pressured." You have to weed out the real responses for the agent to see if he can salvage a case. There's a certain number of cases that would have gone by the wayside if not taken, right? You get them up front where you haven't gone through the underwriting expense. You end up with higher placement rates.

In summary, you have to keep the product design simple, and don't cover the complicated conditions such as MS or Alzheimer's. I think it's a great idea to use teleunderwriting. Do we use it? No, but I think it's a great idea. Our market doesn't support it. The work site does not support teleunderwriting for a $25,000 case. You've got to be on the lookout for adverse selection on individual sales. When I say individual sales, I'm talking about the solicitation coming through the agent.

Your worst nightmare, as actuaries, is the call that comes to the agent saying, "I want to buy CI insurance." People don't ask to buy insurance, do they? It has to be sold, not bought. That's what you have to be on the lookout for in any individual sales base. If we're selling in a group setting, who has invited you in? The group. The employer has invited you in. You make the presentation. You sell to everyone at the same time. It's an open enrollment, and then they're gone. You don't have the same sort of selection issues that we do on the individual side.

Finally, the main rule of underwriting is use your common sense. If it looks too good to be true, it is. Always ask whether it makes sense.

MS. SANDRA K. MELTZER: My piece of this session is what we call the "jungle" of state regulation, which is truly difficult today. It is more difficult than it has ever been.

Regulatory issues complicate any products you want to get on the market, but they particularly complicate CI products. The states now have come out with product outlines and checklists. Many of them started with the property/casualty lines, have gone to life, and now they're coming out with a lot of product outlines and checklists for health insurance and some for CI. We expect to see more of these over time. There are about 30 states that have life and health checklists out there, and we make a habit of checking every state's Web site before we start a project to see what's new.

A recent experience I had with Oregon was I thought I knew what its checklist was like from its code section. The checklist was not on its Web site. When I filed it, I got a letter back saying, "Check our Web site." Sure enough, the same day I did the filing, a new checklist went up on the Web site. So you have to keep checking them and be up to date on what the states are doing. There are specific problems in specific states, which we'll get into later. Some states have restrictions, and some states put additional requirements on the product. It's truly a "jungle" that you have to negotiate.

Today, you have to do a state filing by creating a filing that you think is in compliance with what the state wants to see. You include not only the auxiliary filing documents, but also your policy forms and actuarial material as well. We see a lot of "top-drawer" rules on these checklists so that at least you know about them, and when you file you can deal with them up front. The effect of this is that it takes longer to get a filing out the door, but the approval process is shortened. Many of the questions are short-circuited because you've already done what the state wants you to do.

What are the usual product features that you want. They are the lump-sum payment, the illnesses that you cover, the 30-day survival period, the gatekeepers and the loss ratio. As we've mentioned before, those features are really important in the scope of the product, for selling the product, and how it's going to be priced. Also, terminology is important. Some states call a specified disease product an indemnity product, but a CI product is one that pays a lump sum. You have to watch out for terminology. Other states will call CI a specified disease, but it really doesn't matter.

The 30-day survival period says that when someone is diagnosed, they have to survive for 30 days after their diagnosis or you won't pay the benefit. That's a problem in some states.

What are the gatekeepers? The diagnosis has to be made after the waiting period. The insured has to satisfy the survival period. There are conditions that have to be covered. Do you have a preexisting condition limitation and do you satisfy the state's requirements? Do you pay any limited benefits for some of the conditions that you cover? The ones that you're really interested in are the loss-ratio requirements. I'll give you some more information on that later.

Basically, you have to choose the pieces of your product and the actuarial implications of the pieces that you choose and put it together like a Rubik's cube. You want to come up with a solution that doesn't cause you to lose your shirt, but still provides a product that's salable.

The lump-sum payment was not allowed in Connecticut, Georgia, Iowa, Pennsylvania and Utah the last time I checked. Their objection is not one that's in the code sections. Their state laws do not allow lump sums. They only allow a hospital indemnity or an expense-incurred benefit. Therefore, they won't allow it because the law doesn't address it.

The waiting period is usually 30 days after issue. If the diagnosis is made during the waiting period, then no benefits are paid. The policy is terminated and the premium is returned. The 30-day waiting period corresponds with the 30-day free look period, so those two can be taken together.

The states that disallow a waiting period are Arizona, Kentucky, Minnesota, Missouri, New Jersey, Oklahoma, South Carolina and South Dakota. The reason they disallow the waiting period is because they believe that you have underwritten for this product and should have all the information about whether or not the risk is acceptable. Thirty days will not make any difference. Therefore, they won't allow a 30-day waiting period.

The survival period is not acceptable in Arizona, Arkansas, Kansas, New York, and Tennessee. They feel that, once a person is diagnosed, you have to pay the benefit. I think that this is particularly true of workplace products. The people who buy this product in the workplace think they're paying for a benefit, so they want to get the benefit. They don't necessarily understand or care that they would need to live for 30 days after they've been diagnosed. They bought the product and they want to get the benefit.

In addition to the states shown in Table 1, New Jersey passed legislation in October 2001 to have a 60 percent loss ratio. These loss ratios are for individual products. Group products' loss ratios are higher, sometimes as high as 75 percent. All the other states that are not shown in Table 1 have a maximum loss ratio of 50 percent.

Table 1

Florida	60%
Maryland	60%
Michigan	55%
Minnesota	65%
New Jersey	60%
New York	60%
South Dakota	60%
Vermont	55%

There are other features that vary by state, and this is more compliance-related than product-related. There are differing definitions of dependent children from state to state having to do with adopted children or, in some cases, even covering grandchildren.

A preexisting condition is usually something that was in existence six months before the policy date, and it can only be excluded for six months after. There are also mandated covered illnesses. Massachusetts has a CI law, a specified disease law that mandates you cover certain illnesses as a minimum. Then you can put in others that you want. There are also definitions of conditions and diagnoses. If you require a pathological diagnosis, and it is not practical to have that kind of diagnosis, you must have a clinical diagnosis that would allow you to cover the benefits. There are certain definitions of certain kinds of cancer and certain language must be used in that definition of cancer according to the state's law.

This is a health product, and you have things like timely payment of claims (which is when you have to pay a claim), notice of claim, claim forms, and all the usual provisions that go into a health product. Again, these particular provisions vary state-by-state. There are health claims provisions, particularly now with the new laws about clean claims, and what you do if you deny a claim, and if somebody wants to argue about the denial.

There are loads of disclosure regulations. You must have an outline of coverage. Most of what goes in the outline of coverage is mandated. You have to have certain disclosures on the policy form that talk about what CI is and what it does not cover. There are disclosures in the application pertaining to what this does and does not cover.

The accelerated-benefit rider is a much easier product to go with. There's no problem with the survival period because the benefit is paid whether they survive for 30 days or not because they get the death benefit under the base life policy. Lump-sum payment is not a problem under this product either. There's no loss-ratio requirement. There is some additional disclosure on the riders about what this policy covers. There's quite often no upfront premium, but there could be a back-end charge. If there is an upfront premium, it usually goes with one of those

products where the base plan benefits are reduced as soon as the rider benefit is paid, where you reduce the cash value and the death benefits. Another way of doing this is with the lien approach, where the amount paid out is a lien against the policy, and it accumulates as interest. It is usually based on Moody's or the same interest rate that's allowed for policy loans. When the death occurs, it's deducted from the death benefits.

There's a Chinese curse that says, "May you live in interesting times." We certainly do. The states are changing their positions and putting out more information. It's like aiming at a moving target. The new product outlines and checklists are on Web sites that we have to check frequently because there are always loads and loads of changes. Before you have any of your people do a filing, make sure they get updated on what's out there on the Web sites and know what the current positions of the states are. As I said before, that takes a good bit of time and effort but, in the long-run, it's worth it. Good luck in the jungle.

MR. LONG: Now I know why I can't sell it in the United States. Anyone here from Canada? No? It amazes me when I come down to the United States. Canada has one rule for insurance from coast-to-coast, one kind of policy and one kind of application. Isn't that amazing? I think the problem with U.S. insurance companies is you have too many lawyers, way too many. A few months ago, *Newsweek* magazine said that, for every person studying medicine in the United States, there were seven people studying to be lawyers. When is the last time you ever heard of a shortage of lawyers?

The Canadian market is very different from the U.S. market. Some other conditions are covered in Canada. Some companies cover as many as 23, some companies cover as many as six, and some companies only cover three, so it's all over the map. We have more guaranteed products in the Canadian marketplace.

I worked with Swiss Re for three-and-a-half years. They hired me to show people how to market after my own agency. I did marketing in Trinidad, Barbados, Chile and in parts of the United States with another Midwestern company. It's very different from how the United States does it.

The average policy size in Canada is $126,000. We do a lot more individual policies as well. Currently, in Canada, individual is sold by 26 companies. The smaller number of companies in Canada are more aware of competition. Nobody wants to be first. There are seven companies ready to launch by the end of this year, and they're quite large companies. They're finding that agents and brokers are doing more life business where the carriers are doing CI because of the incentive programs that are being offered.

The need is there. The danger is real. We look at it in a very, very different way from marketing. And I'll get to underwriting in a second. I'm just going to pick on the lady in front. If you were diagnosed with breast cancer today, which of your

creditors are paid of immediately? You're wondering, what is paid off? The way we market it is very, very different, so we have huge marketing strategies. That led me to change something that we did in educating the agents and field force.
Last year I traveled 202 days. I'm not doing that anymore. We have this massive Web site learning. I'm very glad to say the Web site learning is simply more cost efficient for the companies. We have more than 2,300 agents on it learning everything you want to know about underwriting, such as the BMI (body mass index). We're seeing that the agents with a higher education are spending time online. Contrary to what you might believe, we have American webholders as well as Canadians. We find that the American agent/broker goes online an average of three times a week and spends on average 34 minutes per time. Of the 34 minutes, they spend, on average, 22 minutes in the underwriting field. They do want to get into it. It's how you do it.

The amount can be significant, affordable, and the product is politically correct. There's more awareness of health issues. Peter Jennings did an amazing piece on the drug scams for all the different companies. The product is appealing to women and the middle class.

Does the market want what you sell? In Canada, it certainly does. The market is definitely there for the products. As a marketing piece, we give prospects a piece of paper that asks them about who they know who, in the past five years, has had a heart attack, stroke, cancer and so on. That was created for two reasons: I want to get you emotionally involved in the sale, and I want you to understand it.

Who do you know that in the past five years who has had a heart attack, stroke, cancer, whatever? Of those people on the list, which of them planned on being on that list? None. Of those people on that list, which of those people could have used $50,000, $100,000, or $150,000? What would they use it for? Do you think the health care system will get better or worse in the next 10 years? The other thing is, unlike an actuary, agents don't know how to price it. When I market this to a client or prospect, or I teach the brokers how to do it, I base it on cost per day. I do an annual, and I break it down. What does it cost per day for one cup of coffee? I'm not going to go into what parking costs in Toronto, but we won't even buy a car because of parking it. I'm going into what does it cost per day. So that's what we do for the prospect or client. What is the cost per day of this product? For about $2 a day, I have no problem with doing that. That's what we do.

Train the trainers. There was a seminar I attended given by one of the company's trainers and it was pretty sad. I've spoken in front of almost 18,000 agents in seven countries. I worked for this company before, and they just said, "Let us know what you think." No. 1, it's very difficult to have a man stand up from the head office who's 275 pounds and talk about health issues. You don't get any credibility. No. 2, the agents are a lot more educated because of the Web sites, and they asked questions that the trainer couldn't answer. When you have a room of 250 brokers, and it's a four-hour session, they're motivated to be there. Every question

that you can't answer destroys your credibility. The person simply did not know the product and didn't know it well.

The trainers have to know the product inside-out. They also must have a very close relationship with underwriting. Agents for the online learning system have the lowest amount of declines. In other words, they're not submitting that business to the head office. They already know because that Web site just hammers it into them. Here's a family history. It is massive. Here's the BMI. They're no longer submitting the applications because they know they'd be declined.

If you're thinking of getting involved in CI insurance as a company, you've got to think of having breakfast. You're having bacon and eggs. The chicken's involved, but the pig is committed. If you're not committed to the learning process, you're just wasting a lot of money. There's just too much money that's going to be flying out your window. It is a high-intensity learning product and you have to have education and the educators have to be well-versed in it. The time frame is a big thing.

We're finding that for the agents who are online, their declines are less dramatic at 8 percent, versus 23 percent for the companies that don't use the online training system. They're only given a brochure, agent information, the rates and how to market it. It's not that way at all. With online training, there is a total commitment to it.

The companies in the Canadian marketplace have spent the most money on education. The top seven companies who've spent the most money on education by some sheer coincidence are the top seven in sales. It is an absolute miracle. We don't know how that happens.

The agents aren't going to work for you if you can't inspire them, or if there's no dynamic leadership out there. Who's leading? I know one company in Canada that did very, very well in 2001. They won't do well this year. I told them that last year when I ran their training program for them. The reason they won't do well this year is because they've changed the compensation for the field managers. The field managers now get paid more for hiring new career agents. They are paid more for bringing the bodies in than they are for what they do. Who thought that one up?

What makes your product successful? It's not the number of illness you cover. It truly is not. There are agents across Canada that sell 200 and 300 policies a year. Believe it or not, they cover less than 10 illnesses. There are companies that have 23 illnesses and they don't sell that many. Price is a factor, yet the most inexpensively priced product in Canada is nowhere in the top seven at all. That company has decided to offer its product based on price. It offers no reinforcement of education and nothing else for field support. It's well-priced, but the agents don't feel it. If you want my business, I have to know what you've done today to earn the right to my business. Do you deserve it? Loyalty is a two-way street. A broker

wants to know what he is going to get paid. If you're not looking after me, and if you're not educating me, and if you're not helping me, who is?

What we're finding is that the companies with the highest compensation, are not getting the business. Why would that be? The highest commissions and the highest bonuses are still not getting the business. The company that I think had the best product in all of Canada is still not getting significant business whatsoever. They're not educating the brokers and their field force. So the loyalty relates to what are we doing to get it, and what are we doing to keep it.

How you educate your field force is the biggest thing. Like I said, you can spend as much time as you want on pricing, including everything, and compliance issues. If you don't spend an equal amount of time on education, you will not succeed. Go on to another product, go do your term insurance or do whatever. Market, again, by carrier pigeon. Do whatever you have to do. But unless you spend an equal amount of time and effort on the education factor, you won't be successful in it. I've consulted with a lot of companies and asked them to show me their budget for education. If you don't have it, walk away from this product, because you'll lose your shirt on it. In the Canadian marketplace, I tell most of the field force that, when they submit an application, if you've done your education, 83 percent or 84 percent will be standard, and you're going to get a good 10 percent heavily rated up to 100 percent. It's about how we educate.

How do you explain a rating? Joe, the client, is 28. I explain to an agent that we initially insured Joe for his face age of 28. However, his body is behaving like a 34-year-old; subsequently, he is five years closer to making a claim. That's because of the family history and other things. It's how you explain all those things all the way through.

The agents that have gone through the education system have no problems with it. No. 1, there are higher commissions. If you're not Twiggy, don't expect Twiggy rates. Everybody knows that. They know the height and weight issue. Most of my guys who go through training will tell you exactly what the BMI is. They know it. They know their cholesterol stuff, because they have to. I hammer it into them again and again. If you don't know it, don't blame the underwriter. You had the first crack at it, and you chose not to know. I can't help you.

Exploit your claims. Tell your field force. You don't have to name the person. You can name the state. There's one or two companies in Canada that, for whatever reason, want to keep the number of claims a secret. Their brokers say to me, "Sean, how many claims have we had to date?" I say "Don't you know?" They say they don't. I said, "You've had 78." They want to know how I know? I got it from the reinsurers and the insurance company.

They ask, "Why won't they tell us?" I don't know. Ask the big guys. They're keeping it a big secret. A company in the Midwest did a video on some of the claims guys. I think it's remarkable, so exploit your claims.

There's another marketing thing we use in Canada. This is something I devised, again, for the Canadian field force. We have a similar thing we use in the Trinidad, Barbados, Grand Cayman and South American markets. In Canada, one in every 115 people will die every year before age 65. One in 97 homes will catch fire. One in 86 cars is involved in a serious accident. One in every 10 people will become disabled. One in every three will be diagnosed with a critical illness. I use the high numbers and go right down.

You'll probably want to know about claims in the Canadian marketplace. I'd be glad to share this with you. Six percent of all claims are denied for misrepresentation, and 4 percent of cancer claims are made prior to the 30-day waiting period. You've got to tell your field force up front about the CI decline rate. The CI decline rate is three times higher than the decline rate for life insurance. The decline rate in claims is two to three times higher than the decline rate for life insurance due to misrepresentation. Ninety-three percent of all the claims so far from 22 companies are on five illnesses — heart attack, stroke, cancer, coronary artery bypass and renal kidney failure. Those conditions will make up 93 percent of your claims. So, it doesn't make any difference how many conditions you cover.

The last thing I'll share with you is something you might or might not know. Unfortunately, you cannot do this in the United States. In the United Kingdom, they said it took five years for sales to take off. That's partially true. The other reason that sales took off after year five in the United Kingdom was that the Association of Insurance Brokers of England wouldn't sell the product. There were 106 companies selling it, and the association refused to endorse it until such time that the companies standardized their definitions.

I see this coming out now in the Canadian marketplace as well, and it's not to the credit of the insurance companies. Everybody's saying, "My heart attack definition is better than your heart attack definition." That kind of banter is the worst possible thing. I do not know in Canada who will enforce it, but the agents and brokers are clamoring for change and for standardization of definitions.

MR. ERNEST REYNOLDS: I have a question and, also, an observation. We're in the process of developing a policy and we are filing an accelerated-benefits rider for our traditional products. I believe Sandy said, in her explanation of the rider for the acceleration that there was no upfront cost. We've had for several years what we term a terminal-illness rider. There is a six-month to 12-month survival rate expected. That's at no cost. This CI accelerated death benefit is quite expensive. It comes out to be almost as much as the policy, because it's paid so early and it does have an upfront cost. Florida will not consider it life insurance. They're requiring a loss-ratio filing with it. Pennsylvania has basically said they won't allow it because,

in their terminology, they're relating it to terminal illness. We cannot use specified illnesses to accelerate. You have to accelerate them all.

My real question comes down to: Is anyone familiar with what's happening with the IRS and the Treasury Department on the 7702 disclosure for riders on UL policies? It's my understanding it's not a qualified benefit. Therefore, you end up with some problems in adding the premium to it if you're anywhere close to guidelines. Is there anything any of you know that's happening on that front?

MS. MELTZER: I'm not aware of anything. I know we've had some clients that have looked into putting a rider onto UL and run into so many issues and uncertainties that they tended to say, "No, I'd rather do it on term or something else and not UL."

MR. REYNOLDS: We were going to do two on traditional, which we are filing with the level premium, but, at this point, we're about ready to back off of the UL because it's very hard to get it to work.

MS. MELTZER: That's what I think.

MR. MIKE T. RAUCH: My question is mostly for Mike Harper. Have you seen or considered the impact of the body scans or of their growth that's happened at least on the West Coast? I sort of think that, as an agent, maybe the first thing I'd do would be go sit outside one of these places and try and sell policies to those people. I'm wondering whether you've seen any impact or considered any potential impact from that.

MR. HARPER: No, not at this point. I think that would be a consideration for an individual market, because we are work site and have a different sales presentation. We really haven't looked into it yet, but as this movement makes its way across the country, as it always does from West to East, it's certainly something we're all going to have to look at.

MS. LISA HENRY: Sandy, since this is a health product, have you had an inclination from clients regarding Section 125 or the tax implications of any of that?

MS. MELTZER: No, not really. Most of what we've done are individual policies, although we have done some discretionary group. The Section 125 issues just haven't come up.

MR. LONG: I don't think I heard the whole question, but we do offer Section 125 as the pretax option. But we have a pretty long disclosure. If you're going to sell it, I would encourage the disclosure. But you do run into accounts, particularly municipalities, where they'll mandate that all benefits be pretax, including CI, if you want to sell it that way. It's just a bad deal for the customer.

MS. KIMBALL: Sean, what are some of the objections that you've seen from consumers, and how do you combat those objections?

MR. LONG: It's too expensive. That's the normal one. They want to know why life insurance is so much cheaper. Look at your "who do you know" list. How many of those people died right away? Your chances of having a critical illness are significantly higher than dying. When driving by a hospital, I've always looked for this huge neon sign outside of hospitals: "Patients Wanted." There are none. Here's your chance of getting a critical illness, here's your chance of dying. The big issue is price. Many of the agents will say, "Forget it, Sean, I don't need this. I can go out and make the same money selling life insurance instead of CI." I said, "Yes, you could, but you'd have to see an awful lot more people if you do it right."

In the education process, I encourage the agents to see only your existing client base first. No. 1, it's because they know you. No matter what, they're going to see you. You've sold them life insurance, but you might or might not have a very good indication about their health, so you have an open door.

Many of our agents suffer an illness called FTI. I don't know if you're aware of it down here or not. Are you familiar with the failure-to-implement disease? Actuaries don't suffer from that, obviously. Agents communicate a lot with me on the Web. They say, Sean, "I didn't do it." What did I show you how to do? How many times do I have to show you this? I truly believe the partnership between the agent and the broker is there, but the objections that you'll get are related to price. The big one is, if someone is overweight, you'll hear, he is not overweight — he is just six-and-a-half feet too short. We're just starting to get the same thing in Canada as you already have in the United States. That is the high body mass. Canadians used to be lean and mean. That's why we won the gold in Olympic hockey.

Unfortunately, what has happened is Canadians are just in love with fast food from McDonald's, Burger King, Dairy Queen and everything else. They're eating out a lot more frequently and sitting in front of the television. In spite of what everybody thinks, they're not getting the exercise that they used to at all. So the agents have to be cognizant of all those things.

The biggest objection to the agent is underwriting. So, when we created the Web site for learning, we had to deal with that right up front. When you say to an agent right up front, "If this is your first six months of marketing this product, please, do not beat yourself up. You're going to get a 15 percent decline and that's because of education." I've sold over 1,000 policies, so my decline rate is about 2 percent. I know so much more about it, so it's just a matter of repetition. That's all that it is, and that's the biggest thing. I can't stress it enough. If you're truly going to go into it, whether it's work site or not, the individual comes first. We're just getting into the work site in Canada. The individual is first.

We're selling a lot of the million-dollar polices. Those are very heavily underwritten, but generally are part of an executive compensation package. "Ma'am, I know you're working for this corporation. Do you work more than 35 hours a week? Yes? Do you find that you're driving more and taking work home with you on weekends? Would you say you're under more stress today than 10 years ago? If you had a heart attack today, how would your corporation reward you for surviving the heart attack? Do you think you'd have more time off and higher paychecks?" Those are the kind of scenarios we use for the advanced guys. There's a three-step education process. We don't let people come to my level-three education seminars until they've sold 45 or 50 policies. I want some medical background. Agents and brokers who are selling health products or CI have a whole new learning process to deal with. There is a learning curve, and it is very steep. Those who want to be successful in it truly will.

There's one gentleman in Vancouver this year who made top of the table, which is a big thing in insurance. He made over $485,000 two years in a row. He's the first insurance agent in the world to do it. He sold CI insurance policies in, I believe, 47 days and made that first-year commission. He just focuses on CI, but he has a bunch of doctors on retainer to educate him about all aspects of it. There will be leaders in it. You're at the right place at the right time, and I think you're also in the right economic and health environment to make a lot of money at it, but your key is proper underwriting.

I want to go into something else. Last month there was a critical thing on my Web site put in by a chief actuary from a reinsurance company. We got flack for it, but I knew what he was talking about, and it's about the claims that some companies are getting. The claims aren't because of the agents or the salespeople. The claims are because the insurance companies are not properly training the underwriters. This gentleman said it: It's a senior underwriting thing. There's a huge learning curve for underwriters as well. Unless you have underwriters that are truly knowledgeable in all aspects of the policy, you're going to get losses. Neil's piece was quite controversial. We received a number of e-mails from insurance companies saying, why are you singling us out. There was no company named. Everybody felt we were speaking specifically to them, and that's because they had not properly educated their underwriters at the head office. It is a very different product to underwrite. Besides educating your field force, your head office underwriters truly require different education for this product.

MR. HARPER: Amen. I can share the same story just to confirm what Sean is saying. When we first started selling this stuff, we took some early first claims and started doing some analysis. We had junior underwriters doing this stuff, and they just did not understand combination impairments and how things work against each other. It wasn't until we got the cases underwritten by senior underwriters that we really turned the thing around. And now we have good results, but we basically have some good, strong underwriting people that really know what they're doing. I don't think our decline rates are mirroring what Sean has experienced with his

agents, but our decline rates are running around 9 percent. I think it's about what you'd expect for this market, certainly for the workplace market.

FROM THE FLOOR: You'll have to forgive my ignorance, but could one of you just briefly describe what the structure of the product is. A permanent product is, generally, term, level premium.

MR. HARPER: They're probably different in each country.

MR. LONG: In Canada, we have five-year products and 10-year products. We also have a limited product. In other words, the product is limited to three illnesses only. At the same time, the other product is 21 illnesses. It also goes to ages 65, 75, or 100. In Canada, we're not as inclined to tie it to a UL product. We're very cognizant of the fact that the federal government in Canada is going to announce legislation in 2002 about taxation. At the moment, the government looks at it as a health product. They have some concerns. What they're going to do is probably make a decision that no one's going to be happy with. They will grandfather some stuff, but then come down very severely on other aspects of it. It is very different from five years, or 10 years.

MS. MELTZER: In the United States, many states require the guaranteed renewable to age 65, and New Jersey requires it to be guaranteed renewable to age 100. So, usually I've seen products to age 65. We've seen level premium. Annual renewable term seems to be the most popular. There are all different types similar to life insurance.

MR. HARPER: It's not unusual to see benefit reductions of a percentage at age 70. Maybe benefits are reduced by 50 percent. That's pretty typical of this type of product. The ones I've seen in the United States, most of them are ranging anywhere from six to 10 conditions. I don't see many products out there with more than that covered.

FROM THE FLOOR: Did I understand you correctly that some of the states — and the ones you listed are not insignificant with us — do not allow a lump sum on the policies?

MS. MELTZER: On a stand-alone policy.

FROM THE FLOOR: What form of benefit is usually used there?

MS. MELTZER: We haven't been able to get one approved, because they want an incidental hospital indemnity policy, but the benefits that we use are not rich enough for them to accept. There are problems that are either expected to be in an indemnity product or an expense-incurred product. They have no provision for lump-sum payment in their health care.

FROM THE FLOOR: One of the things I wanted to add is we did get a lump-sum benefit product approved in Georgia, even though AFLAC's lobbyist is pretty strong.

MS. MELTZER: Yeah, that particular product is unique. It was the result of a hearing, and it's mostly a cancer product. They will accept another product that is exactly like the one they approved, but they won't take anything that's different. Believe me, I tried.

FROM THE FLOOR: Pennsylvania is another state that doesn't allow lump sum.

MS. KIMBALL: I'd like to address your accelerated-rider question earlier. We've also done some pricing on accelerated riders and tend to have an upfront cost that is maybe 60 percent to 70 percent of what a standalone product is, so that is similar to what you were saying.
I have a question for Mike about guaranteed issue. You said you're not going to see that in your lifetime. We're actually hearing a little bit about that. If you did guaranteed issue for an employer on a pretty small amount, where everybody was covered and the employer paid for it, is that something that you think would be reasonable?

MR. HARPER: Absolutely, if it is on an employer-paid basis. I think everyone in this room would agree with that, given a certain number. Being the conservative person I am, I'd rather see that policy in our group platform, where I had the ability either to cancel the policy in the future or raise premiums. There are some companies out there offering some guaranteed issue, but it's on a group platform with some fairly high participation. The guaranteed issue amounts being offered are fairly low. I think it's a real gamble when you look at the types of conditions we're covering here, and the fact that you're paying a lump sum pretty quickly. I think it's a real opportunity to get hurt. Everyone has been clamoring for guaranteed issue throughout all our companies in our organization. We basically have it on the back shelf if we need it, but it's on a group basis with a limited benefit amount in case we have to.

MR. NORMAN HILL: I just wanted to clarify something. I've heard you say on a CI acceleration rider that there's some kind of a cost of an upfront payment. I've seen the riders structured in such a way with regular premiums of their own just as any other rider. I was just wondering if you've seen this or if we're talking about the same thing.

MS. KIMBALL: I'm not sure what your question is exactly. What I've seen is, you might have rider for the life policy, but you have an additional amount to pay to add on that CI rider. Sometimes it's marketed as a package and then the premium is just one premium that's larger than life only.

MR. HILL: Maybe we're saying the same thing, but I've seen identifiable sets of rider premiums for the CI. I was just surprised to hear you say what seems to be different than my own understanding of how the benefits have been sold.

MR. HARPER: There are two different camps out there, the one where it's in addition to the death benefit and the other one where it reduces the death benefit. I think that's where some confusion comes to your mind.

MR. HILL: Perhaps, but what I'm talking about is, what reduces the benefit? I was thinking on a term basis. The logic is that you're going to pay out claims where you accelerate the life benefit that you would not have to pay at the end term period via a death benefit.

MS. KIMBALL: Right. That's why there's a cost to that.

FROM THE FLOOR: I don't know if this would help Norm or not, but the product we were in the process of filing goes on the traditional product — really whole life. It does accelerate the benefit rather than add to it, and there is a significant standalone premium for it. In fact, I was a little surprised at how expensive it is. There's a lot more involved than just the discounting of paying a claim a few years earlier. There's a lot more involved in that, because you have those profits you're not going to get if the policy stays in force. I think we've found that you're right but, at some ages and for some underwriting classes, our cost is almost as much as for the standalone policy. The standalone rider or the rider that accelerates the benefit is quite expensive.

MS. KIMBALL: That's right. Much of the reason for that is because a policyholder might die at age 70, but you could very easily pay this rider out at age 35. The payment is so much sooner. Even if it's at 50 percent acceleration, for example, it's so much sooner that you lose a good deal of interest and extra premium. The costs of these riders tend to be higher than people expect.

MR. HARPER: The CI rider is confused with accelerated death benefits as a result of an illness that's going to result in death within 12 months.

MS. KIMBALL: That is called a terminal-illness rider, which is a lot cheaper.

MR. HARPER: That is also called an accelerated death benefit rider by most companies. You have to make sure you understand what you're talking about. I was referring to that.

MS. KIMBALL: I think that's a good clarification. Thank you.

MR. LEROY PRUITT: Essentially, you just answered my question. I'm having a lot of trouble with this confusion between accelerated death benefit and CI among my agents. One covers the onset of a specific illness, whereas. in the other case, you have to be diagnosed to be terminal within 12 months. Sean, have you had any

success in educating your agents about the difference between an accelerated-benefit rider and a CI rider. My agents love to go out and give away the accelerated death benefit, because there is no real premium for it, and I can't get them to sell the CI.

MR. LONG: I totally understand. It's very easy. In one year, you're dead and here's so much of your money up front. Agents say, "Fine, I don't do any underwriting?" No. There's no extra premium. What is CI? Well, you bought a car. Why did you buy a house? Isn't the car enough? You can live in it. You can eat in it. You can sleep in it. You can do whatever you want. What did you buy a house for? They're entirely different products for entirely different needs, and that's what you have to think about.

I want to clarify something. Earlier, I was talking about the Insurance Association in England. They had this big meeting recently. It's a huge, massive thing in England, and it's a major concern for all the agents and brokers. As an association, it's very powerful. One of the things it has agreed to do is change the policies in the United Kingdom. CI has been available in the United Kingdom for 17 years. They're going to reduce benefits massively. The reason for that was, when CI insurance was introduced in the market in 1984 or 1985, the medical technology that existed then was very different. The whole set of medical criteria has changed. Everybody throws out Prostate AA when we know there's no such thing. It's type one. They have now said, "No, it's not a full benefit; it is a 10 percent benefit." They have reduced a whole bunch of things.

This association is exceedingly powerful. Woe to the company in the United Kingdom that says it won't toe the line because your product will just sit there on the shelf. As an association, it has said, "Look, the rules have changed in medicine. The product has to change. We hear what you, as a company, are saying, and we totally agree." They have listed a whole bunch of different things that now will not be a full claim for a CI payment at all, but will be a partial claim, graduating from 10 percent up to 25 percent, based on very strict medical criteria.

MR. RAUCH: I have a question for you, Sean. Have you seen any work being done with combination CI/long-term-care policies?

MR. LONG: We're looking. There's one company that's doing it in Canada and, again, they're underwriters. I don't know if they truly know what they're doing. They said, "Sean, they're yours for four or five months." I said, "Great, I'll make you No. 1." However, they sent something out through e-mails to the field force that scares me. It's partially true, but, again, my little rankle goes up on this. They said that, just because someone is a decline for CI, he or she might be a standard for long-term-care insurance. I understand that. The agents have taken that and stretched it. I've done a few things as an agent and broker. I brought two people into a room. They didn't know that they would be in the same meeting. One was from marketing and the other was from claims. Talk about one person being from

Mars and someone else being from Venus — they were talking about two entirely different aspects of the same policy.

The long-term-care market in Canada is virginal to say the least. There are probably 1,000 or 2,000 policies in the country. However, there are 17 companies ready to launch long-term-care products in the next 24 months. We're all looking down south to the Americans for your experience on long-term care and how you structure it, because I don't think any company in Canada currently knows what its doing in that aspect at all.

MR. RAUCH: I have a follow-up on that, and that thought occurred to me a few times during this discussion. I was struck by the similarities between the sales objections that you get in CI and the objections that we see in long-term care, which are, basically, denial and price. Have you done any cross–training?

MR. LONG: I've done a lot. One of the things that I did as a demonstration for some people in long-term care is, I asked, "What do you plan on retiring on at age 65?" Let me bring you up to date. I'm looking after my dad in a long-term-care facility in Toronto. It costs me $4,000 a month. There's no tax deduction for that in Canada." What I tell the agents is, "Could you live on 97 percent of your retirement income without dramatic changes? Yeah. Then I want you to start setting 3 percent aside now." Now, when it comes to someone who is older than age 65, there are three choices. You can look after yourself, you can trust the government to look after you, or you can trust your children to look after you. Who do you think will be quick to make that decision?

FROM THE FLOOR: Yet in Canada, I'd presume they'd say the government.

MR. LONG: No, they don't. The same thing applies to your pension plan. What if I asked you to put aside 3 percent of your pension to look after yourself. You have a choice — the government, your children or yourself. I'll also give you the cost. That's all that it is. They're emotional sales. If I asked everyone of you in this room to tell about someone you know, I'm going to hear some gut wrenching stories, because you all know someone who had cancer or some other dread disease.

I think the best example I can think of is a lawyer who had a stroke at 42 years old. She's a litigator. It was the most bizarre thing. You all know how a stroke can affect you. With her it was one thing. She could walk perfectly. She could do everything. She could even speak properly. The only thing she could never do the rest of her life was read. The stroke affected that part of the brain. All she sees is jumbles. It makes no sense to her. She's a litigator who earned a quarter-million dollars a year. Her career is over. What does the disability insurance company say? She's still alive. She's not totally physically disabled, is she? So that's where CI would have come in. But I think the Canadians will be moving ahead with the long-term care and the CI thing together.

The one thing that the company has not done is have the long-term-care division sit down with the CI market people. That's absolutely ridiculous. I'm going to say this, but it's not because I'm pushing ING Re or Swiss Re or Munich Re. I've worked with all the reinsurers. As an insurance company, go to your reinsurer for education because, for your underwriters, you're going to need proper training right up front. Not all the underwriters are good at that. I know that because of my experience in the Canadian market, and I've met with a lot of underwriters. One, particularly, came from a disability background. She said her decline rate was almost 45-50 percent. Why? She said she had trouble as a disability-income person justifying $4,000 or $5,000 a month. She couldn't OK a quarter-million dollars for a heart attack the guy recovered from. She declined. So there is a big learning curve.

I can't stress enough that the major thing to prevent failure from agents selling a product is to spend time with underwriting. In Canada, agents are deriving from 35 percent to 39 percent of their income from selling CI insurance. That's a lot. Those are the successful ones, but they have spent a lot of time with underwriting. For every hour you spend in marketing, you better spend an equal hour in underwriting; otherwise, the disappointments will just drive you away. How many times can you hear "no" before you say, "I give up"? I keep reminding my field guys, if you do something 181 times and you fail each time, would you continue to do it? Anybody? Then don't go with guys called Orville and Wilber. They flew. They failed again, and again, and again. Agents have to know that. You can hit a bad patch, but what are you doing as an agent to underwrite? What are you looking at? Not everybody's going to be an NBA player. Reject them out of hand, anyway.

We're also getting the drug things. In Canada, we have geographic areas for underwriting in which we look for drugs. We just know to look for drugs in the Quebec area — Montreal or Quebec City. Guess what? The highest cocaine usage is in these areas of Canada. To ignore that is just stupid. When you're looking at the market for loggers for this or that, you'd better also do a liver test because you're going to find high alcohol usage. Just know where your markets are and underwrite accordingly.

And that's the biggest thing in training your agents. Don't expect them to sell it. Many of the companies in the Canadian market are not making money. Take a product that's properly priced. We've done everything. I've seen magnificent brochures from marketing, but they'll never go anywhere. The product is still sitting on the shelf. They're shocked that there's no sales. They haven't educated their field force, and the agents don't feel secure. Everybody goes where they're secure. I watched the kids out in the pool this morning. None of the little kids went to the deep end. Why? They're all secure in the shallow end. Yet there was one little girl who was three years old. The parents said she goes off to the deep end. They trained her with a lot of repetition with mom and dad in the deep end. The same thing applies to CI. Train them.