RGA

Global Claims Views

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Dear Claims Colleagues,

Welcome to the January 2015 edition of Global Claims Views, a newsletter for our clients from RGA's Global Claims Team. This edition features the following articles about topical claims issues in markets around the world, written by local RGA experts.

- **Australia:** **Disability: RGA's Claims Management Pathway for Disability Assessment**
  A report from Australia, outlining our Claims Management Pathway initiative.
- **U.S.:** **Disability: Assessing Claimant Effort and Reliability**
  A view from PsyBar LLC, on assessing claimant effort and reliability when self-reporting symptoms and limitations for disability claims.
- **Global:** **Critical Illness: Challenges Associated with Gastrointestinal Stromal Tumours (GISTs)**
  Dr. Phil Smalley, RGA Global Chief Medical Officer, considers the factors critical illness assessors should take into account when considering claims arising from gastrointestinal stromal tumours (GIST).
- **Asia:** **Contestability Periods in Asia Pacific: Are There Unforeseen Consequences?**
  Kah Tin Tan, Executive Director of Claims, RGA Singapore, discusses contestable period policy language and asks: Are there any unforeseen consequences?
- **Global:** **Overcoming Challenges Associated with Foreign Death Claims**
  A feature explaining the Overseas Death Claims Guide section of RGA's Global Underwriting Manual.

RGA has a global network of offices in 26 countries and clients throughout North America, Europe, Africa, Asia, Australia, the Middle East and South America. While each of these markets has the same objective – the efficient and timely processing and adjudication of claims – the processes and procedures, as well as the pressures, are not necessarily the same. One of the intentions of this newsletter is to provide local perspective on common claims issues, so you can see how other markets are dealing with problems that may also impact your market.

We hope that you find *Global Claims Views* interesting, informative, and helpful!

If you would like more information on any of the articles here, wish to suggest a topic for a future edition, or are interested in further information on any market issue, please contact your local RGA representative. We are always available to help, and eager to share our global expertise.

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IN THIS ISSUE

Disability: RGA's Claims Management Pathway for Disability Assessment

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The last couple of years have seen tough times for insurers and reinsurers active in the Australian market, and these have been widely reported both in Australia and beyond. There has been significant deterioration in disability experience particularly, impacting total permanent disability and group markets. Many insurers have reported losses and significant strengthening of reserves.

A range of changes are being discussed throughout the Australian market, in relation to product design and to the general approach to risk management practices.

One key element of RGA's response to the deterioration in experience has been to initiate a paradigm shift in claims management. The aim is to move away from the traditional medically focused claims assessment model toward a more proactive, effective and holistic "best practice" model. It is hoped this will impact disability experience in a positive way for claimants and insurers and allow for an upgrade in current disability claims management capability.

To support this initiative RGA Australia has created a new training programme covering all aspects of disability claims assessment. The programme, called Claims Management Pathway (CMP), plays a crucial role in this paradigm shift initiative, assisting with implementing change and raising disability claims management standards across the industry.

What is the CMP?

CMP is an all-encompassing claims assessment approach developed by RGA Australia to enhance the assessment processes for disability claims (total and permanent disability [TPD], income protection and group salary continuance). RGA has invested significant resources to create a model that is proactive and holistic, and moves away from a medically focused model that relied heavily on the treating doctor as a gatekeeper for claims decisions.

Most insurers' existing claims assessment training programs are separate standalone modules; e.g. financial, medical, information-gathering, etc. Where CMP differs is that each training module flows into another and while each can still be undertaken as a separate session ultimately they work together, covering the end-to-end assessment process and providing a guide to best practice claims management.

CMP modules deal with the full term of the claim from notification through on-going assessment until termination. They include the following items:

- **Strategy setting:** Claims assessors learn a holistic management approach, rather than a process-driven or reactive method of claims assessment, to achieve an appropriate and balanced outcome based on all relevant factors.

- **Duration management and risk profiling:** The focus of this module is for assessors to utilize the information contained in the Medical Disability (MD) guidelines to predict the lifecycle and duration of a claim. The module aims to provide assessors with the skills and confidence to discuss return-to-work outcomes with claimants and their treating doctors while also improving their understanding of the claimed condition.
- **Functional assessment:** Here the emphasis is on claimant abilities as opposed to inabilities, part of which focuses on the claimant's bio-psychosocial factors. Assessors are given tools to break down the claimant's pre-disability occupation into its key duties and to consider these in relation to a claimant's functioning.

- **Use of medical and investigative resources:** This module considers how assessors can communicate most effectively with treating doctors, with a focus on asking the right questions, building rapport and returning the claimant to work. In doing so, assessors can appropriately gather information directly from a treating doctor, hospital or allied health provider and get the most out of an independent medical examination.
- **Internet searching:** The Internet is an important tool in claims assessment. This module identifies search techniques and information gathering from social media and/or other sites as part of the claims assessment process.
- **Effective use of surveillance:** This module, which is still under development, is a web-based interactive case management simulation, designed to get assessors thinking about the purpose of their investigations and understand how they can be used in the most effective manner.

Another differentiating factor of the CMP is that the learning process does not stop at the completion of its training modules. Once assessors have completed a module, the lessons are reinforced and embedded with them through on-site RGA claims consultants, who assist assessors in applying their newly acquired knowledge to their day-to-day claims assessments. This on-site support is provided in the form of one-on-one claim file reviews, case conferences and file discussions.

What value does CMP add?

By combining the training with on-site support and coaching, the application of these best practice principles continues to be reinforced. In addition, the focus on setting strategy and placing greater emphasis on capability and bio-psychosocial factors should enable insurers to support claimants in earlier and sustained return-to-work outcomes, leading to shorter claim durations and reduced benefit payments.

What has been rolled out?

To date, RGA has rolled out the following modules to more than 800 participants from clients across Sydney, Melbourne and Brisbane:

- TPD Legal Concepts
- Use of Medical and Investigative Resources
- Strategy Setting
- Duration Management and Risk Profiling
- Functional Assessment
- Internet Searching
- Serious Game (an interactive instructional game for claims assessors)

We are continuing to develop online training modules for effective use of Internet searches and surveillance, which will be available in 2015 for assessors to use as a reference tool. GCV

Disability: Assessing Claimant Effort and Reliability

Although most disability claimants accurately report their symptoms and limitations during an independent medical examination (IME) it is a fact of life that not all claimants are credible. For this reason psychologists use a range of psychological tests to objectively evaluate claimant reliability.

It is important that doctors administer such validity tests in all forensic mental health evaluations, not just ones that have been flagged as questionable. This is because initial cursory case reviews often inaccurately identify which claimants are truthful.

A hundred years of research shows that objective psychological tests can be far more accurate than doctors' subjective opinions. There is no other finding in social science research that has been more firmly established than the superiority of objectively-based psychological assessment over clinical judgments alone regarding many psychological and psychiatric issues. Fortunately, such tests have largely been validated and can be used effectively with individuals coming from many different cultures around the world. A claims assessor should therefore appoint an appropriately qualified independent doctor who can incorporate objective test findings into their assessments.

David Fisher Ph.D., ABPP, LP

President and Chairman of the Board

PsyBar, LLC

About validity tests

Validity tests help independent doctors determine if claimants:

- Are putting forth full effort on mental abilities tests (such as memory and intelligence quotient);
- Are reliably reporting their symptoms, such as depression;
- Understand the meaning of test questions; and
- Have cultural backgrounds that might affect other test results.

In many countries, there is strong evidence that validity tests greatly improve the independent doctor's ability to fairly evaluate a claimant's effort and honesty during evaluations. This is particularly valuable to the insurer because if a claim is appealed, objective data is available to support the doctor's opinions. Overall, objective psychological testing should remove concerns over subjective bias, reassuring both insurer and claimant that the evaluations have been conducted fairly.

Objective tests evaluate two types of claimant reliability: symptom validity and performance validity. Symptom validity tests help the examining psychologist evaluate the reliability of what a person says about his or her psychological symptoms such as depression and anxiety. Performance validity tests, on the other hand, measure the credibility of demonstrated abilities during testing (for example, how credible was the claimant's performance on memory testing).

Symptom validity testing

Perhaps the best known symptom validity scales are found on the Minnesota Multiphasic Personality Inventory (MMPI), which is available in many languages. The MMPI is the most commonly used psychological test in the world and currently is represented by the second version of the MMPI, the MMPI-2, and by a more recent version, the MMPI-2-RF (Restructured Form). The MMPI-2-RF ("RF") is a shorter test and is completed much more quickly than the MMPI-2. The RF is valid and useful even though it has about 240 fewer items than the MMPI-2. The RF can be completed in 60-75 minutes, while the MMPI-2 typically takes 90 minutes to two hours to complete. Most licensed clinical and forensic psychologists as well as neuropsychologists are qualified to administer and interpret this test.

No other test is as well-researched or as well-developed as the MMPI for evaluating symptom credibility. Other personality assessments, such as the Personality Assessment Inventory (PAI), have validity scales, but they do not provide the same scope or depth of the MMPI validity scales. Some pain and physical functioning inventories also comment on the credibility of response, but they primarily address whether claimants have taken on the role of being disabled.

When interpreting claimant MMPI responses, examiners first consult the MMPI validity scales. If the results show that the claimant's self-report is unreliable, the psychologist usually does not also interpret the other MMPI scales related to emotional problems such as depression and anxiety. If the validity scale results show the claimant was being truthful, the psychologist can use the rest of the MMPI data to more accurately assess claims of issues such as depression, anxiety and somatic worries. This greater precision helps doctors conduct scientifically sound evaluations with a better chance of withstanding challenges in court.

Performance validity testing

Performance validity tests typically assess the plausibility of cognitive complaints. These include claims of trouble with memory, focus, and concentration. Many but not all of the appropriately qualified professionals who administer these tests are board-certified neuropsychologists. So while the MMPI provides an evaluation of the reliability of symptoms such as depression, performance validity tests actually measure cognitive abilities by the performance exhibited by the claimant. For example, these tests can help answer the question about whether a claimant's display of memory problems in the neuropsychologist's office is credible.

There are five main standalone performance validity tests, which are designed to evaluate only credibility. They include: the Test of Memory Malingering (TOMM); the Validity Indicator Profile (VIP); the Word Memory Test (WMT); the Medical Symptom Validity Test (MSVT); and the B Test. Other such tests include the Victoria Symptom Validity Test, the Nonverbal Medical Symptom Validity Test, the Portland Digit Recognition Test, and the Dot Counting Test.

In contrast to these standalone measures, neuropsychologists also examine claimant test scores on measures originally designed to assess cognitive skills such as memory. These test scores are generally referred to as "embedded measures of malingering." The most common embedded measure of malingering is from the Wechsler Adult Intelligence Scale Digit Span subtest, and is known as "Reliable Digit Span."

Standalone performance validity tests do add time to the IME, but they often have the advantage of better evaluating performance credibility. Most standalone tests take at least 15 minutes to administer, and almost all of them focus on measurement of performance on memory tasks. The VIP takes longer to administer, but it measures credibility of performance on tasks involving intelligence, reasoning and verbal ability. There is a consensus among neuropsychologists that such performance standalone and embedded validity measures are a critical portion of any medical/legal assessment of cognitive skills.

In summary, good IME evaluations of emotional and cognitive problems almost always include direct evaluation of claimant credibility with validity tests. IME evaluations without a fully developed objective assessment of credibility often fall below the standard of care in forensic mental health assessment. GCV

David Fisher, Ph.D., L.P., ABPP, has been President and Chairman of the Board of PsyBar LLC since 1995. He is a Diplomate in Clinical Psychology. Dr. Fisher oversees psychological and psychiatric IMEs, file reviews, and fitness for duty evaluations performed nationally through a network of 1,700 psychologists and psychiatrists.

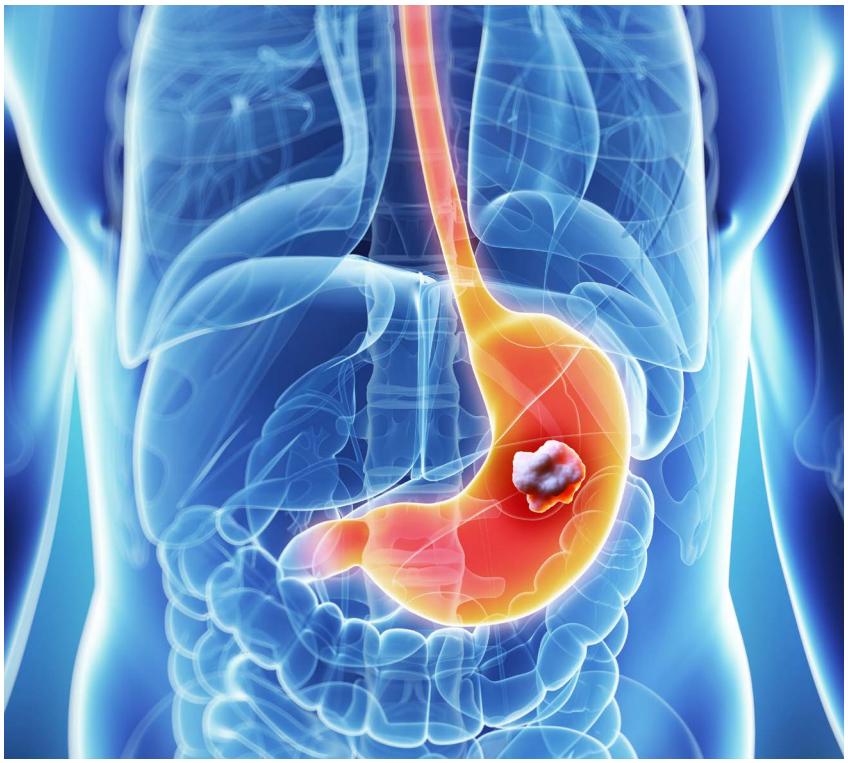
Critical Illness: Challenges Associated with Gastrointestinal Stromal Tumours (GISTs)

Gastrointestinal Stromal Tumours (GISTs) can occur anywhere along the GI tract but are most commonly found in the stomach (60% to 70%), and occur less frequently in the small intestine (20% to 30%), colon and rectum (5%), and esophagus (<5%). Rarely, GISTs can occur in the omentum, mesentery and peritoneum.

Malignant GIST tumours represent less than 1% of GI cancers. Hematogenous metastases from GIST most commonly involve the liver, omentum, and peritoneal cavity.

Global GISTs incidence is relatively rare at between 7 - 20 per million, although true frequency is unknown. Incidentally found microscopic GIST tumors can be more common. Small GIST tumours have been co-incidentally found in 35% of patients when their stomach was removed due to underlying gastric adenocarcinoma. With increased screening and use of imaging techniques, it is expected that we will see a further increase in GIST tumor incidence rates in the future.

The mean age of diagnosis is 63 years old. These tumours appear relatively rarely in individuals under 40 years of age. Most GISTs are sporadic but some are familial, due to inherited mutations in the KIT gene, and some will appear in patients with neurofibromatosis.



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The majority of patients with gastric or small bowel GISTs present with GI bleeding, anemia, or abdominal pain. These tumours can also be found incidentally when investigating a patient for some other gastrointestinal disease or on routine imaging of the GI tract.

These GISTs originate within the wall of the stomach or bowel and can grow into or away from the GI tract lumen. This means that simple endoscopy can miss these tumors or underestimate their size. Endoscopic ultrasound better estimates the size of these tumors.

In terms of staging, 53% of GIST tumours stage as localized, 19% as regional, 23% as distant, and 5% as unstaged. These tumours are staged by the American Joint Committee on Cancer 7th Edition Cancer Staging manual as Stage I to IV based on:

- Tumour size;
- Number of mitoses seen per 50 high-powered fields (HPF) or the so-called "Mitotic Index".

GIST tumours have also been stratified by risk into four levels, tagged I to IV, also based on tumour size and mitotic index. The designations are: "very low risk"; "low risk"; "intermediate risk"; and "high risk".

Management of a patient presenting with GISTs typically involves a combination of surgical and pharmacologic interventions. Existing consensus-based clinical practice guidelines from the National Comprehensive Cancer Network suggests, for patients with high-risk GIST, the administration of adjuvant imatinib for at least 36 months. (High-risk GIST is defined as a tumour >5 cm in size with a high mitotic rate [>5 mitoses/50 HPF] or a risk of recurrence that is >50%.) Some data shows imatinib therapy can also benefit if the GIST is 3 cm or larger.

Risk of recurrence is very low if the tumor is less than 2 cm and has a low mitotic rate (less than 5 mitoses per 50 HPFs). Gastric GISTs have better prognoses than non-gastric GISTs. The cumulative 5-year disease-specific survival rates for GISTs classified at risk levels I, II, III, and IV were 100%, 96%, 67%, and 25%, respectively. (GIST survival statistics can be found on the website at http://nomograms.mskcc.org/GastroIntestinal/GastroIntestinalStromalTumor.aspx.)

Critical Illness Claims Issue # 1 — Is the tumour a GIST?

Histologically, the appearance of GISTs usually falls into one of three categories: spindle cell type (70%), epithelioid type (20%) and mixed type (10%). Those with spindle cell GISTs have a slightly better survival rate compared to epithelioid or mixed histology GIST tumours.

The differential diagnosis of a subepithelial tumor arising in the GI tract is broad, including GISTs and other benign and malignant tumours. By light microscopy alone the distinction among GISTs and other tumours in the differential diagnosis (particularly leiomyomas, true leiomyosarcomas, and GI tract schwannomas) can be difficult, because the histologic findings do not reliably or specifically relate to the immunophenotype or the molecular genetics of the lesions. Accurate diagnosis of GIST typically relies on a combination of cytologic and immunohistochemical characteristics to distinguish them from other GI mesenchymal tumors.

By the early 1990s, it became apparent that there were inconsistencies and ambiguities in the heterogeneous collection of tumours classified as GISTs. Greater than 90% of GISTs express the CD117 antigen as evidence of the KIT mutation, which helps distinguish this tumour from other bowel wall tumors such as leiomyomas and other spindle cell tumors (which are CD117 negative). Another tyrosine kinase mutation that is occasionally seen in KIT mutation-negative GIST tumours is the platelet-derived growth factor receptor alpha (PDGFRA). Also up to two-thirds of GISTs are CD34 immunopositive. Approximately 10% of adult GISTs lack mutations in either the KIT gene or the PDGFRA.

Critical Illness Claims Issue # 2 — Is a GIST malignant?

The biologic behavior of GIST is variable. In terms of their pathology, GISTs invade the stomach or bowel wall and have the potential to spread regionally to lymph nodes and metastasize to distant sites as well.

GIST tumours can be coded as benign, borderline or malignant (ICD-O-3 codes 8936/0, 8936/1, or 8936/3), respectively, making critical illness claims adjudication challenging. The majority of GIST tumours were previously ▶

thought to be benign due to their characteristically bland histopathologic features. However, it is becoming increasingly clear that virtually all GISTs, over time, have the potential to express malignant behavior. Academics state that it is not appropriate to define any GIST as "benign" (although the /0 code is still used clinically).

Most low or very low risk GISTs can be designated as benign or borderline. There is some debate that non-gastric GISTs that are designated as "low risk" and are between 2 cm and 5 cm should be labelled malignant.

GISTs that are classed as intermediate or high risk would be labelled as code /3 and therefore designated as malignant. This would mean that any GIST greater than 5 cm or has greater than 5 mitoses per 50 HPFs would be labelled as malignant.

The RGA view

If a critical illness definition of cancer requires a malignant tumor, and if the cancer definition does not make specific reference to GISTs in the exclusions, then the following claims approach could be justified.

Subject to the underlying definition, we are likely to consider the following as valid CI cancer claims:

- Any gastric GIST > 5 cm in size.
- Any non-gastric GIST > 2 cm in size.
- Any GIST of any size, and originating in any site, that has > 5 mitoses per 50 high-powered fields (mitotic index).
- Any GIST, in any organ, of any size and any degree of mitotic index, if there is nodal involvement, or distant metastases, or if the claimant is treated with biologic therapy such as imatinib (Gleevic) or chemotherapy.

What assessors should do with a CI claim for GIST

- Check their company's critical illness definition to ensure GISTs are not excluded.
- Ensure the clinical diagnosis of GIST was based on both pathological examination of the surgically removed tumor and appropriate immunohistochemical proof of a GIST (where available).
- Review the pathology report of the resected tumour to assess size and mitotic index along with tumour location.
- Read the clinical notes to determine if adjuvant biologic- or chemotherapy has been used, or if there is evidence of nodal or distant metastases.
- Consult your medical adviser where you have any doubt as to whether the cancer definition in your policy has been satisfied. GCV

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Contestability Period Language in Asia Pacific: Are There Unforeseen Consequences?

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Many life insurers will be familiar with the concept of a contestability period. Typically, for two to three years after a policy is issued, an insurer can investigate and deny a claim if it turns out material information was either misrepresented or not disclosed at application – material information that would have led to substandard underwriting terms.

Once the contestable period has expired, claims can usually only be challenged if there is evidence of fraud.

The governance of contestability periods varies. In some countries, local legislation oversees its application while in others it falls into the hands of the industry regulator, or is established by industry practice in the market. Either way, the essence of the contestability clause must strike a balance between protecting the insurer against anti-selection or predictable claims while at the same time offering consumers assurance that their claims will be paid.

Illustrated below are two sample contestability clause wordings:

"The company will not contest the policy because of any incorrect declaration or statement made in connection with it after it has been in force for two years from the date of the policy issue."

OR

"The Policy shall be incontestable, except for non-payment of full premium, or for fraud, after it has been in force during the lifetime of the Insured for a period of two (2) years from the Effective Date."

Both of the above examples state in effect that the contestable period ends two years after the policy's inception. A claim submitted during this time frame will usually trigger an investigation by the insurer to ensure that the correct information was provided at application stage. Omission of material information may result in the policy being cancelled from inception and consequently the claim being denied. Although this viewpoint may reflect the intent of contestable periods, a recent RGA review of the Asian market found that contestability clauses are not quite as watertight as we may think.

At first glance, these definitions may seem to represent the intention of the clause, but closer examination of these wordings reveal a number of loopholes. In practice, insurers may be denied the right to avoid claims and rescind policies even though a deniable claim arises within the contestability period. The two main challenges for insurers are:

- Clarity around when the contestability clause ceases to operate.
- What we mean by "during the lifetime of the insured".

When does the contestability clause end?

While insurers in most markets consider the claim event date the key driver for determining the relevancy of the contestability period, an alternate approach — and one mandated in markets such as Australia and Taiwan — is the claim notification date.

Neither of the contestability clause wording examples specifically mandates that the claim event must occur within two years from policy commencement. Both definitions only make reference to the age of the policy, and state that once the policy has been in force for two years the insurer will not be able to contest a filed claim.

A claimant could delay notification of their claim past the two-year point (although the event occurred within two years) in order to nullify the impact of the contestability period. However in some markets, such as North America, the determinant of whether the contestable period applies is the date of death. For example, if a death is reported 18 months after the actual death date, the insurer still has the right to perform a contestable investigation on the claim as long as the timeframe from issuance of the policy to the date of death are within the contestable period.

A further possible complication (which applies in Australia) is that if a claim is notified within the contestable period, insurers face the challenge of having to complete their investigations and reach a decision *before* the contestable period expires. Even though the date of the event and of the notification were within the contestable period, once the clock ticks over, insurers may lose the right to amend the policy and claim for anything other than fraud, which has a much higher evidentiary bar.

What is meant by "during the lifetime of the insured"?

The use of this phrase may create an added complication when considering the execution of the contestability clause. Consider two separate claims: one a death claim and the other a critical illness claim.

- The death of Mr. X occurs within two years of the policy going into force. Mr. X's beneficiary makes a claim after the policy has been in force for two years. Does the contestable clause still apply?
  - Yes, because the claim arose within two years during the lifetime of the insured.
- Mrs. Y suffers a critical illness within two years of the policy going into force. Mrs. Y makes a claim after the policy has been in force for two years. Does the contestable period still apply?
  - Arguably no, because at the point of notification (still during the lifetime of the insured) more than two years have passed from the policy start date.

What does this mean for insurers?

What these issues highlight is that while the insurer may have a clear philosophy concerning the function of a contestable period, this could be undermined by an ambiguous wording of the clause, which might turn out not to provide the protection during the contestability period that the insurer expects.

What can insurers do to ensure they are protected?

Policy provisions have recently received greater scrutiny from legal experts and industry regulators, ensuring that the consumer is not penalized by unfair terms and practices. So, while the existence of contestability clauses in policies is beyond challenge, what is important is that the clause should specifically mention (where local laws permit) that claims will be contestable when the claim event arises within the relevant time period from commencement.

To ensure insurers are sufficiently protected against non-disclosure and misrepresentation, they should consider:

- When did your company last review its contestable clause language?
- How reliable is the language — is the wording appropriate?
- Does it clearly set out what you intend? GCV

Death: Overcoming Challenges Associated with Foreign Death Claims

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For most insurers, experience of death claims will be limited to their home or neighboring countries. When a death claim occurs in a foreign territory, the unfamiliarity of the necessary documentation and the procedures surrounding registration and investigation of the death often leaves claims assessors feeling hesitant.

As one of RGA's Value-Added Services, we provide in our Global Underwriting Manual (GUM) a proprietary Overseas Death Claims Guide. This guide, an on-line manual incorporating a range of assessment tools and guides, includes:

Country Guides

This directory provides guidance on the practices, procedures and documentation used to evidence death in several countries around the world. It includes information and examples of certificates relating to evidence requirements, such as death certificates, medical evidence, guidance on death registration and documentation, and formalities surrounding deaths that require additional investigations such as suspicious circumstances or sudden deaths.

This guide is a living document, and is reviewed periodically. However, we also need your help to enhance and develop the guide by sharing your own experiences and knowledge. If you can help, please contact your local RGA office or Jennie Calder-Brown at jcalderbrown@rgare.com.

Death Abroad Questionnaire

A death abroad questionnaire is a useful tool for gathering details about the circumstances of death, purpose of travel and the funeral/burial arrangements. It is a good starting point for any overseas death claim assessment. A sample questionnaire template is provided for assessors to use.

Red Flags

The guide provides an overview of key factors that can be indicative of potential fraud, including:

- **Policy Red Flags** such as claims occurring shortly after policy inception or expiry of the contestability period.
- **Circumstantial Red Flags** such as domestic or financial difficulties.
- **Evidential Red Flags** such as inconsistencies and inaccuracies in the evidence.
- **Claim Red Flags** relating to the causes and circumstances of death.

Fraud Risk Ratings

A Fraud Risk Rating indicates the likelihood of fraud occurring in a particular region. The ratings have been compiled based on the risk of corruption,

dependability and quality of official documentation, the sophistication of each country's infrastructure and socioeconomic factors, and the quality of health services and accessibility of evidence.

Supporting this guide is our Risk Calculator, which calculates the extent of the risk for individual claims. The tool uses specific features of a claim to assess the likelihood of fraud occurring, the appropriateness of further investigations, and provides advice on obtaining evidence for overseas death claims.

How can one access this information?

You can access our guides by logging onto RGA's GUM website at https//gum.rgare.com. If you do not yet have an account, please contact your local RGA office for help. GCV

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