

Claims as a Mirror: What Underwriters Can Learn from Sales-Driven Risks



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What Underwriters Can Learn from Sales-Driven Risks

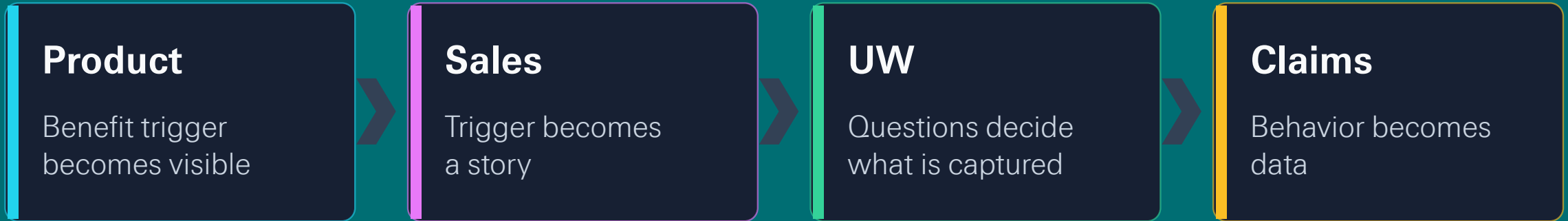
**How sales behavior shows up in claims
- and what UW can do about it.**

**CLAIMS
as signal**

**Use Korea as a lens,
not an exception**

The basic mechanism

Claims reflect how product, sales, UW and customer behavior interact.



Claim patterns can reveal sales-driven risk before assumptions catch up

The question for UW: what signals can we read early enough to act?

Why Korea is a useful lens

Not unique - but fast, dense and easy to observe.

9.4%

2024 insurance
penetration
Top 10 globally / high
by mature-market
standards

Mature market

High customer
familiarity with
L&H products

Rich benefits

Diagnosis, surgery,
disability and
health riders

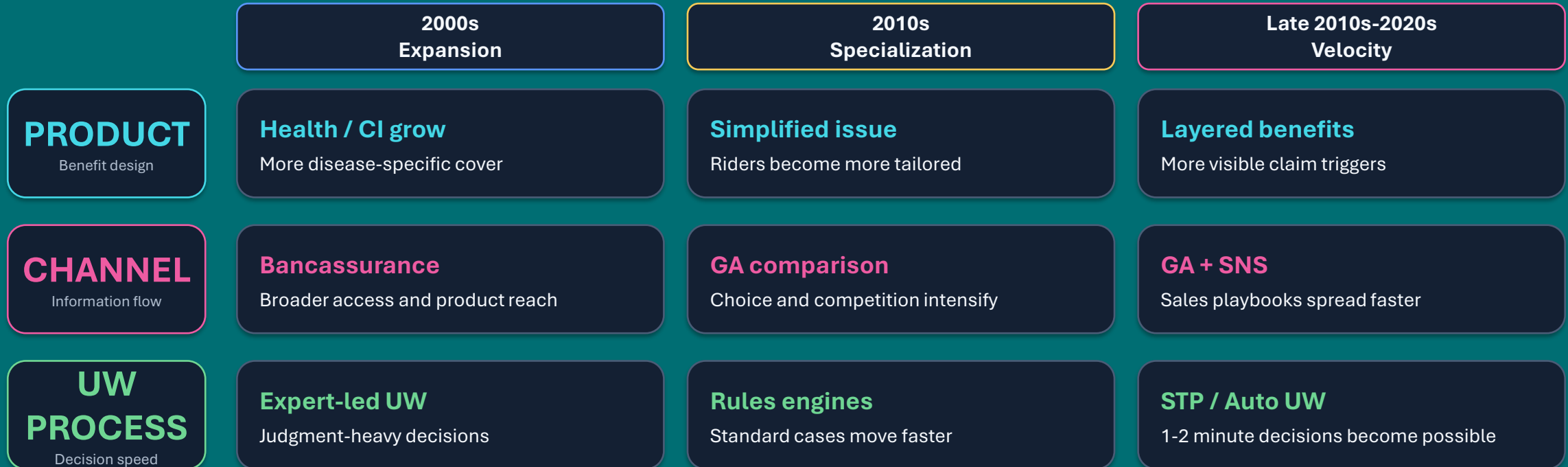
Fast learning

GA, SNS and
communities move
information quickly

Korea is an early mirror of incentive, trigger and information-flow dynamics

Korea's market history explains the three lenses

Product design, channel behavior and underwriting process evolved together.



Claims become the mirror: early duration · age band · rider mix · channel cluster

Product sets the trigger → Channels transmit the signal → UW decides what is captured at issue

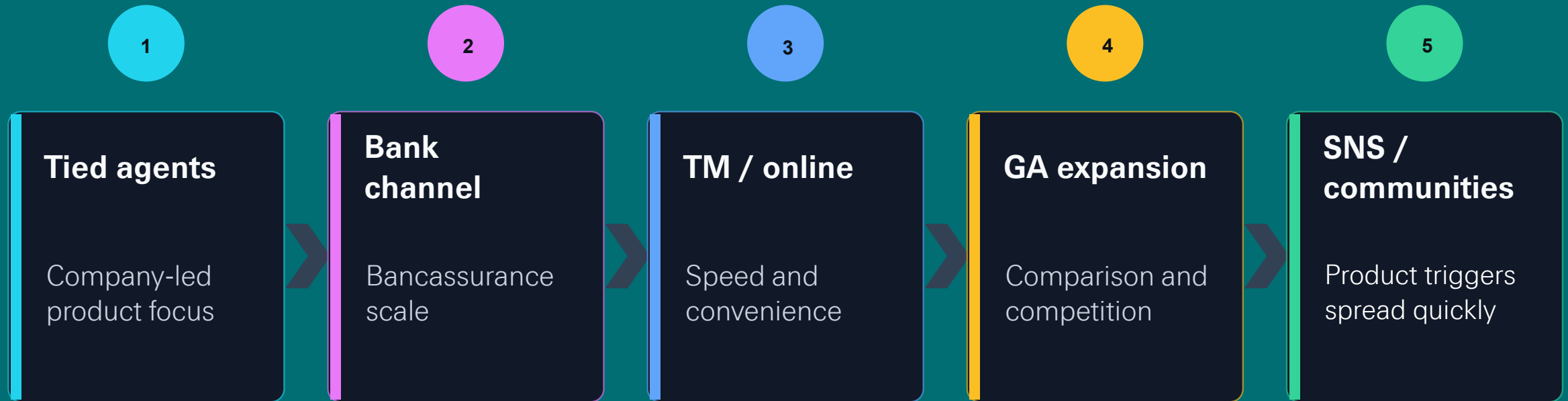
From Product Innovation to Benefit Accumulation

Innovation expanded access and choice. Competition changed how benefits are packaged and sold

	Diagnosis		HC/OP	SC	Treatment/Test	
Cancer	<ul style="list-style-type: none"> • Cancer • Pseudo cancer • Relapse cancer(MMM) • Metastatic cancer • High-cost cancer • R.O. cancer (Male/Female) 	<ul style="list-style-type: none"> • Liver, gallbladder, biliary tract, pancreatic cancer • Colon, small intestine, anal cancer • Kidney, bladder, ureteral cancer • Stomach cancer • Lung cancer • Severe thyroid cancer • 11 major specific cancers 	<ul style="list-style-type: none"> • Cancer HC (All/ ICU/ Nursing Home) • Cancer OP (All/General Hospital/Advanced General Hospital) 	<ul style="list-style-type: none"> • Cancer SC (Normal/Increasing) • Pseudo cancer SC • Da Vinci Robot Cancer SC • 7 Major Cancers SC • Hematopoietic Stem Cell Transplantation • Female mastectomy • Major Organ Transplantation • Total lung resection 	<ul style="list-style-type: none"> • Cancer Treatment • Anticancer radiation, drug treatment (general/per session) • Targeted anti-cancer drug licensed treatment (general/per session) • Intensity-modulated radiation therapy (IMRT) 	<ul style="list-style-type: none"> • Anti-cancer proton radiation therapy • Major Cancer Rehabilitation • Major Cancer Palliative Care • Female Biopsy (Thyroid/Breast) • Male Biopsy (Thyroid/Prostate)
2CI	<ul style="list-style-type: none"> • Brain Hemorrhage • Stroke • Cerebrovascular Disease • Integrated Brain • Acute Myocardial Infarction • Ischemic Heart Disease • Integrated Cardiology 	<ul style="list-style-type: none"> • Cardiomyopathy • Heart Valve Stenosis • Diagnosis of major cardiac inflammatory diseases • Brain Aneurysm • Epilepsy • Benign brain tumor • Diagnosis of cerebral heart disorders (Normal/Severe) 	<ul style="list-style-type: none"> • Brain/Cardiac HC (ICU) • Cerebrovascular Disease HC • Ischemic Heart Disease HC • Cerebrovascular Disease HC (All/General Hospital/Advanced General Hospital) • Ischemic Heart Disease HC (All/General Hospital/Advanced General Hospital) 	<ul style="list-style-type: none"> • Brain Aneurysm SC • Cerebrovascular Disease SC (Normal/Increasing) • Benign Brain Tumor SC • Major Heart, Brain, and 5 Vascular SC 	<ul style="list-style-type: none"> • PTCA SC • Coronary artery bypass SC • Heart Valve SC • Major Heart Disease SC • Ischemic Heart Disease SC (Normal/Increasing) 	<ul style="list-style-type: none"> • Thrombolysis Treatment • Internal Cardiac Pacemaker Implantation Lip • CT, MRI, Ultrasound, EEG, Cerebrospinal Fluid Testing • Angiography

Channel evolution

From company-led sales to information networks.



Information velocity increased: products can be compared, tested and shared faster

Distribution is not only a sales issue; it changes the risk feedback loop

UW UW Became a sales enabler

Faster UW supported sales competitiveness - but changed how risk signals are captured

UW response to sales needs

1-2 min

auto decision after application

90%+

auto-underwriting in many major standard portfolios

What changed for underwriters?

Expertise gap

Borderline patterns may be sensed by underwriters before rules can code them.

Auto trade-off

Ambiguous information may be dropped to keep straight-through processing smooth.

Sales pressure

Relaxed criteria and promotions support sales, but can invite anti-selection.

The role is shifting: from case approval to early signal detection and feedback

Look for clusters before trends

Sales-driven risk often appears locally before it appears in the portfolio loss ratio.

Early duration

0-3M / 3-12M
claim concentration

Rider mix

Minimum base premium
Maximum rider SA

Channel cluster

GA / agent / provider
concentration

Age band

Unusual cohort
concentration

External trigger

Screening / regulation
SNS / court signals

Claims become an early warning system when UW monitors movement, not only averages

Same fundamentals, different labels

The case names change - the underwriting questions stay familiar

Colon polyps

Screening pathway
+ fixed benefits

When does frequency
become over-insurance?

Conjunctivochalasis

Senior-risk migration
+ adjacent procedures

How do we detect
the next hotspot?

Obesity

Metabolic risk
+ UW thresholds

What can sales observe
before portfolio data shows
it?

Let us look at where the mirror reflected the risk first

CASE 1

Gastrectomy

Planned-event selection inside a disease-disability rider

Disease-disability rider in Korea

Benefit logic

- Disease causes permanent impairment
- paid by impairment grade
- from 3% impairment

Case focus

Sleeve gastrectomy for obesity / weight reduction

Thoraco-abdominal / GU impairment examples

Loss of heart function	100%
Loss of thoraco-abdominal / GU function	75%
Severe impairment	50%
Distinct impairment	30%
Mild impairment	15%

50% payout example:
Total resection of stomach

30% payout example:
> 50% stomach resection

Issue-stage watchpoints

What makes this hard to catch at policy issue?

Limited history

3% impairment trigger: limited experience

BMI control gap

SI: no BMI / Full UW: limited leverage

Targeted sale

Bariatric-surgery pathway positioned by agents

High SA / no cap

Typical max SA ~KRW 100m; accumulation risk

Core idea: the pathway was hard to foresee at design stage — so early claims became the warning system.

Targeted sale

Policy issued

Sleeve surgery

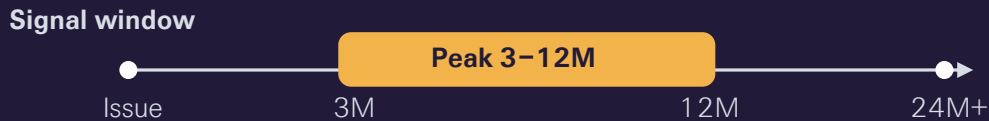
30% payout

Monitoring logic, not just one bad claim

When sales-engineered pathways are hard to foresee, early-duration claims become the first practical defense.

Claims signals to read quickly

- Early-duration incidence**
Claims concentrated in the 3–12M window after issue.
- Young-age concentration**
20–30s claims were atypical for disease-disability exposure.
- Channel / GA concentration**
Patterns appeared disproportionately in specific GA / channel clusters.
- Obesity / metabolic history**
Related diagnosis or treatment history should trigger review.



UW response ladder

Monitor first, then structural controls.

Immediate

- Early-claim monitoring by agency, channel & provider cluster
- Medical review: obesity / metabolic history where visible

Mid-Term






- 1st-year reduction period (e.g., 50% payout)
- Aggregate issue limits / cross-company accumulation rules

CASE 2

Colon polyp

Routine screening can turn a minor procedure into a high-frequency surgery-benefit claim

Korea National Cancer Screening Program (selected items)

 Stomach cancer	 Colorectal cancer	 Breast cancer	 Cervical cancer	 Liver cancer
Screening target Men and women age 40+	Screening target Men and women age 50+	Screening target Women age 40+	Screening target Women age 20+	Screening target High-risk people age 40+
Interval Every 2 years	Interval Every year	Interval Every 2 years	Interval Every 2 years	Interval Every 6 months
Method Gastroscopy	Method FIT; colonoscopy if positive	Method Mammography	Method Pap smear	Method Liver ultrasound + Serum AFP

Current Korea NHIS program also includes lung cancer screening. It is omitted here to preserve the legacy 5-cancer visual format and keep focus on colorectal screening.

Why this became a sales-driven risk

- Easy clinical flow**
Screening → detection → removal → surgery claim
- Check-up sales norm**
“Buy health cover before screening”
- Known frequency risk**
Polyp removal already drove surgery claims
- Benefit inflation**
Benefits raised competitively to drive GA sales

CASE 2

Benefit inflation changes the risk profile

A known frequency risk becomes dangerous when the benefit amount is pushed too high.

How the loss emerged

- 1 Baseline known risk**
Polyp removal was frequent and partly priced into experience.
- 2 GA sales competition**
Surgery benefit amounts increased to support sales.
- 3 Over-insurance**
Some products reportedly paid up to ~KRW 3.6m per single polyp removal.
- 4 Inforce tail**
Sales stopped, but claims impact remained on existing policies.

Historical market echo

- Hypertension / diabetes diagnosis benefits**
Large lump-sum benefits for common chronic diagnoses produced very high early loss ratios.

Lesson: a sales hook can become larger than the base risk it was meant to support.

Risk management points

- Severity tiering**
Routine procedures = lowest tier
- Carve-outs / sub-limits**
For known leakage items
- Benefit inflation control**
Avoid over-insuring frequency
- Sales-aware pricing**
Price for promotion risk

Key principle: over-insurance of common, low-severity events creates experience worse than expected.

CASE 3

Conjunctivochalasis / risk migration

When a familiar leakage hotspot is constrained, adjacent senior conditions can rise instead

60+

Restriction / Exclusion /
Scrutiny on known leakage

Adjacent condition

Age-related eye disease; often conservative first



Familiar hotspot

Cataract

- Major social and insurance issue when combined with private health insurance
- Teams know the disease; controls often focus on this visible problem.



Emerging adjacent risk

Conjunctivochalasis

- Degenerative eye condition in which the conjunctiva becomes loose, wrinkled, and folded, typically with age
- The risk is not the name itself, but how quickly it becomes the next payable adjacent procedure.

Core idea: catching the old hotspot does not mean the risk is solved – it may simply move.

CASE 3

Risk migration: monitor the sector, not just the disease

For senior risks, one leakage point can move to the next adjacent condition, provider cluster or sales channel.

Migration logic

- 1 Closing one known leakage never solves the underlying issues**
e.g., cataract scrutiny or stricter claims review
- 2 How do we monitor the broader sector around this risk?**
Looking beyond one diagnosis code
- 3 SA Reduction? Exclusion?**
new disease name; same commercial logic

Where to watch

Migration usually starts in clusters, not evenly across the market.

Senior cohort
Track the age band, not only one diagnosis

Adjacent disease / ICD codes
Watch adjacent codes and procedure families

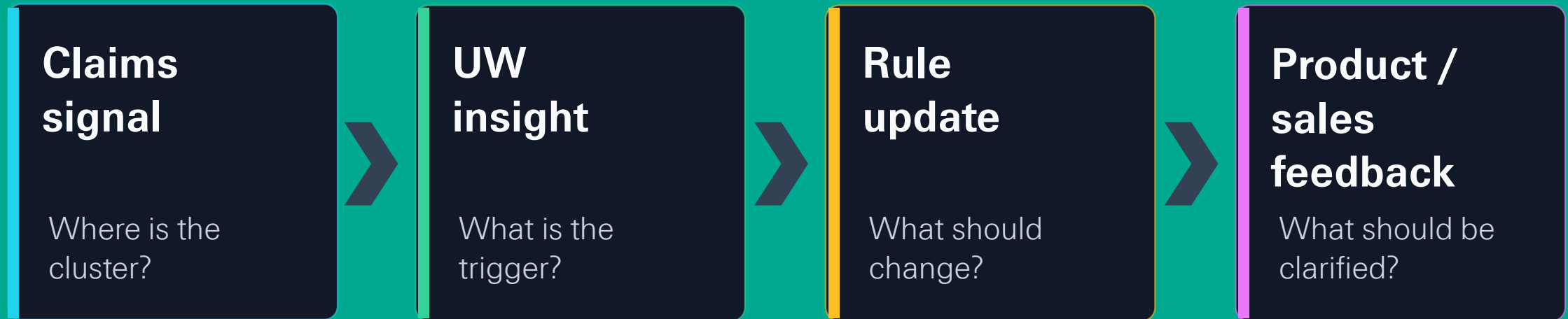
GA / sales channel
Look for channel-led concentration

Provider / clinic cluster
Overlay claims with provider concentration

Open question: What operating model helps us catch senior-risk migration before the next disease name becomes obvious?

A Lens for the Case Studies

What we should listen for in each case



Feed the learning back before the next sales wave

The best defense is a short feedback loop between claims, UW, product and distribution.

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