GENERALI USA
Life Reassurance Company

VIEWPOINT
more information than you might expect

Volume 4 Spring 2008

Our Viewpoint: 2007 In Review

By J.C. Brueckner, President & COO

As we close the books on 2007, I thought I would share with you some of the highlights and bring you up to speed on the progress we have made relative to our 2004 strategic plan. In previous articles, I discussed the shift that Generali USA made in 2004 to focus on the mid to large size life insurance companies. Each year starting in 2004 we have made significant progress towards establishing Generali USA as a top tier life reinsurance company; 2007 was no exception as we added a number of new clients and also expanded share at targeted accounts.

As a result of this activity, we saw a 17% increase in new business production over 2006. This is even more impressive when you take into consideration that the total U.S. market for recurring new business dropped 6% in 2007. Our new business production of $74 billion moved us into fourth place, putting Generali USA solidly in the upper tier for production. Comparing our

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eGFR: Estimated Glomerular Filtration Rate

By Richard Rougeau, M.D., VP and Chief Medical Officer

GFR stands for the glomerular filtration rate, which represents the volume of blood filtered by the kidneys per minute. GFR is widely considered to be the best overall index of kidney function however, it cannot be directly measured. As a result, a variety of estimating formulas have arisen over the years, each of which makes use of the endogenous filtration marker creatinine. Creatinine (Cr) is a breakdown product of skeletal muscle which is produced at a relatively steady rate corresponding to an individual's muscle mass and is excreted unchanged by the kidneys. As kidney function declines, the serum creatinine is seen to rise indicating possible kidney dysfunction. Despite the occasional complaint from an applicant only a very small proportion of the serum creatinine

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View On...Chris Carnicelli

The ViewPoint (TV) is pleased to feature another installment in our View On series. In each issue we feature an interview with various key players within the Generali USA circle. The objective behind 'View On...' is to profile members of our team and give everyone the opportunity of hearing directly about their respective responsibilities and business activities, their involvement and contribution to our business, information about market issues and/or challenges affecting business initiatives, plus individual ideas and views on current business developments. Finally, it will provide an interesting personal perspective on them, e.g. hobbies, interests.

This installment spot-

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comes from dietary protein causing only a minor transient elevation.

For many years the insurance industry relied on serum creatinine as a guide to estimating kidney function. Unfortunately, serum creatinine is not a sensitive index to detect mild to moderate declines in renal function which lead to elevations in the unfiltered serum creatinine concentration. [1] In fact, a rough rule of thumb is that an individual must loose 50% of their kidney function before the serum creatinine will begin to rise above the upper limit of most normal ranges. [2,3] Further, the serum Cr result is also influenced by factors other than GFR such as renal tubular secretion of Cr which does not depend upon filtration and individual variation in Cr production based on a host of factors including activity levels and hydration status. Variations in these processes both between and within individuals over time result in a wide range for serum creatinine values in normal individuals. All of the foregoing reflects serious limitations in use of serum creatinine as an index of kidney function and should have all but lead to its abandonment for underwriting ratings purposes.

By way of background, normal GFR varies according to an individual's age (Table 1), sex and body size or body mass index (BMI). In young healthy adults the GFR ranges between 120 – 130 ml/min 1.73 m^2. [2] While GFR is known to decline with age, it does so only gradually and even into one's eighties lays above 60 ml/min/1.73 m^2 according to NHANES III data. [5] It is also thought that a persistently reduced GFR is a specific indication of chronic kidney disease (CKD).

Why is screening and monitoring of GFR thought to be important to health and more specifically, relevant to Underwriting? Current U.S. estimates suggest that asymptomatic and undiagnosed CKD is thought to affect 11% of the population greater than age 65 without diabetes or hypertension or approximately 33 million individuals.[6] CKD is also known to represent a significant and independent risk factor for Coronary Artery Disease which remains the greatest mortality risk in the Underwriting of insurable applicants. [3] Finally, there is today a variety of effective treatments available which are able to slow progression of CKD towards End Stage Renal Disease, necessitating dialysis and hastening early death. [5] CKD has been defined as either known kidney disease or an eGFR < 60 ml/min/1.73 m^2 that is present for 3 or more months and can be diagnosed without specific knowledge of the underlying cause. [2]

Complications of CKD arise as a result of a reduction in GFR, disorders of renal tubular function or a reduction in renal endocrine function and are known to increase in prevalence at levels of GFR < 60 ml/min/1.73 m^2. [2] The list of complications is extensive and includes: hypertension, malnutrition, anemia, low serum albumin, low serum calcium, high serum phosphate and high serum parathyroid hormone. [2] A combination of effects frequently manifests as reduced activities of daily living in those afflicted. The prevalence of various complications can be seen stratified by age group and eGFR in Table 2.

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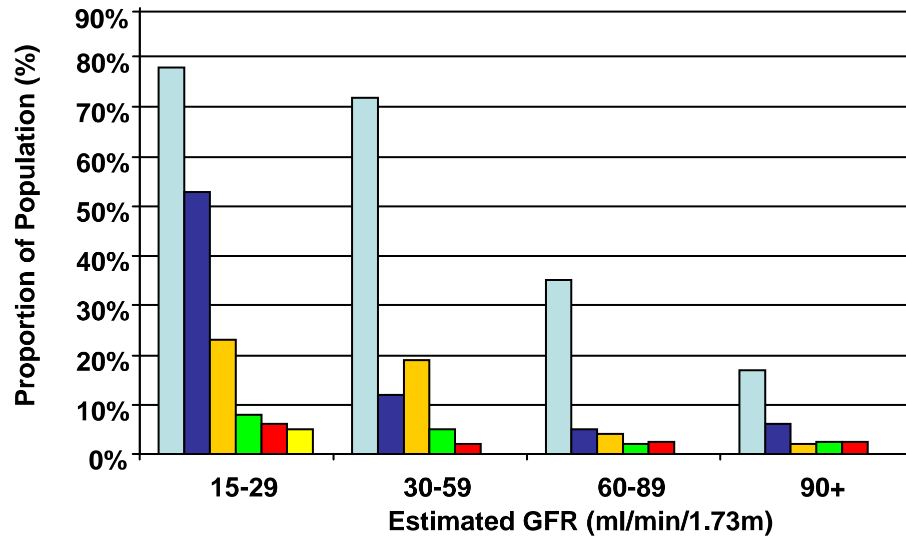
CKD is also known to represent a significant and independent risk factor for Coronary Artery Disease...

Table 1	
Age (years)	Average Estimated GFR
20-29	116
30-39	107
40-49	99
50-59	93
60-69	85
70+	75
Coresh AJKD 41 (1) 1-12. 6 [4]	

eGFR (continued from page 2)

Table 2 [2]



≥ 140/90 or antihypertensive medication p-trend < 0.001 for each abnormality

Hypertension	Hemoglobin <12.0 g/dL	Unable to walk 1/4 mile
Serum Albumin <3.5 g/dL	Serum Calcium <8.5 mg/dL	Serum Phosphorus >4.5 mg/dL

As previously mentioned there are several formulas available that facilitate calculating an estimate of the GFR and as such are grouped as eGFR or estimated GFR. At least three of these may be familiar: Cockroft-Gault, Mayo Clinic Equation and the Modification of Diet in Renal Disease (MDRD). Each has been validated in a different clinical population and as a result has its relative strengths and weaknesses. Briefly, the Cockroft-Gault formula has proven to be less accurate than the MDRD formula in head to head testing and tends to overestimate the GFR due to the fact that it does not account for the significant fraction of creatinine which is secreted in the proximal portion of the kidney nephron which does not reflect filtration. [1,2] While not considered a significant criticism at higher levels of GFR, at lower levels the secreted fraction becomes increasingly important as it may actually exceed the proportion of creatinine which is filtered. The Mayo Clinic equation was derived from the population of Olmstead County, Minnesota who are largely healthy, Caucasian and older than many of the other population groups previously studied. This formula is considered to be more accurate in provision of estimates in those considered to have less impaired GFR. [3] The third formula or MDRD was validated in a CKD patient group who were predominately Caucasian. It has now however, been validated in diabetics, kidney transplant recipients and African Americans. [2] It has been proven to be the most robust and clinically valid measure and has been recommended for use by the: National Kidney Disease Education Program (NKDEP), National Institute of Diabetes and Diseases of the Kidney (NIDDK), National Kidney Foundation (NKF) and the American Society of Nephrology (ASN). [2] This method is also referenced for definition of CKD in the Seventh Report of the Joint National Commit-

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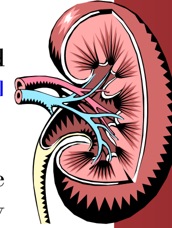
eGFR (continued from page 3)

tee on Prevention, Detection and Treatment of High Blood Pressure (JNC 7) of the National Institutes of Health. [1] It has not to date been validated as a screening procedure in those with presumed normal kidney function, but efforts are underway to remedy this aspect. [1]

Underwriters may have noted several clinical labs are now reporting eGFR and most using the MDRD formula. [2] Serial measures of eGFR are thought to lead to the identification, staging and monitoring of individuals with CKD and to facilitate a determination of prognosis. Further, it is now considered to be even more accurate than estimates obtained from 24 hour urine collections for Cr clearance which require a timed collection and as a result are both inconvenient and inaccurate [7,8].

Specifically, the MDRD formula is considered applicable to adults > age 18 and requires input of only four variables (age, sex, serum creatinine, ethnic origin). For individuals of African or Caribbean descent the eGFR value obtained should be multiplied by a factor of 1.2 to reflect a greater inherent muscle mass. [2] All other races are to use the basic formula provided. The MDRD does not require the input of height or weight variables and avoids inaccuracies introduced through these measures. It also has been standardized to a 1.73 m^2 body surface area (BSA) which is the normal average for young adults. Adjusting the formula for BSA allows comparisons of an individual's result with age/sex/race appropriate norms. In doing so it also provides a convenient means to compare an individual's renal function to defined stages of CKD [1] (Table 3).



As an initiative of the National Kidney Foundation a widespread program has been undertaken designed to increase public awareness of CKD. One of the goals is to replace terms like chronic renal failure and renal insufficiency with CKD. The division of CKD into the five stages as seen in Table 3 based on eGFR level is meant to foster research and understanding. It is hoped that each time a serum Cr is ordered an eGFR result is reported in tandem. [5]

The MDRD formula is not considered applicable to individuals < age 18, those with rapidly changing kidney function such as individuals experiencing acute renal failure,

As an initiative of the National Kidney Foundation a widespread program has been undertaken to increase public awareness of CKD.

Table 3

Stage	Description	GFR	Clinical Action Plan
1	Kidney damage with normal GFR	≥90	Diagnosis and treatment, slow progression, CVD risk reduction
2	Kidney damage with mildly reduced GFR	60-89	Estimating progression
3	Moderately reduced GFR	30-59	Evaluating and treating complications
4	Severely reduced GFR	15-29	Preparation for kidney replacement therapy
5	Kidney Failure	<15	Kidney replacement therapy

Stage 1 and 2 CKD are terms that are only applied when there is a structural renal abnormality such as PKD or a functional abnormality such as persistent asymptomatic proteinuria or microscopic hematuria. If there is no such abnormality, an eGFR> 60 ml/min/1.73 m^2 is considered normal.

Source: National Kidney Foundation. KDOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification [10]

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The underwriting implications of this is that we now have a new tool to better assess those at risk for CKD…

pregnant females, edematous states such as Congestive Heart Failure (CHF), individuals with muscle wasting diseases/ rhabdomyolysis/recent trauma, amputees/ paraplegics/quadriplegics, malnourished individuals and those at both extremes of body size (BMI). [2] In the above circumstances a 24 hour creatinine clearance is acknowledged to provide a better estimate of the GFR.

The underwriting implications of this is that we now have a new tool to better assess both those at risk for CKD (diabetics, hypertensives, personal history of Cardiovascular disease, positive family history of CKD) and those with known CKD to gauge severity. [1] Historical eGFR values can be compared or averaged over several months to gauge stability of renal function over time, similar to the way in which blood pressure is underwritten in many offices. If the current value is a significant deviation from that expected consideration should be given to repeating the test, especially where there is a paucity of previous eGFR estimates. In this regard the estimated normal annual decline in eGFR is 0.5 ml/min/1.73 m^2. One caveat is that the MDRD formula tends to provide falsely low estimates in young healthy individuals (especially well muscled males) and for this reason many authorities suggest these individuals should not be screened and or the results disregarded. [3,5,9] In fact, some authorities suggest routine reporting of specific eGFR values >60 ml/min/1.73 m^2 is not recommended. [5,9] Again, this issue arises as the MDRD has not been validated for screening in healthy normal individuals. Its use should be restricted to screening those at risk of CKD and those with known CKD to gauge severity and ascertain prognosis.

In summary, eGFR is an index of kidney function that was derived for clinical purposes from a population with known CKD. It is used to identify those with Stage 3-5 CKD and tends to downwardly bias results for young, healthy, muscular individuals. eGFR uses BSA standardized values to facilitate comparisons between individuals to age standardized norms and to follow a given individuals renal function over time. Values of eGFR which are consistently < 60 ml/min/1.73 m^2 likely represent risk of underlying CKD on their own merit. Values of eGFR between 60 – 90 ml/min/1.73 m^2 with associated hematuria and or proteinuria are also likely indicative of underlying significant CKD.

Finally, the prognosis for Stage 5 CKD / ESRD in terms of 5 year survival lies between 20 – 30%. [1] In those aged 70 – 74 the average life expectancy after initiating dialysis is approximately 3 years. [6]

Dr. Richard Rougeau is Vice President and Chief Medical Officer at Generali USA. He received his Medical Degree in 1988 and is Board Certified in Insurance Medicine (2001). He also earned an MBA in 1982. Prior to Generali USA, Dr. Rougeau worked at RGA as Medical Director, International Division. He is a member of AAIM (American Academy of Insurance Medicine), CLIMOA (Canada Life Insurance Medical Officers Association), and the MMDA (Midwest Medical Directors Association). You can contact Dr. Rougeau at:

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eGFR (continued from page 5)

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Mike Augustine Receives FALU!

Mike Augustine, Senior Underwriting Consultant, recently received a Fellow, Academy of Life Underwriting designation (FALU) with distinction, and will be honored at the Association of Home Office Underwriters Annual Meeting in June. Way to go, Mike! If you would like to contact Mike, you may do so at:

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or 816.412.3691.

Generali USA Launches New Website!

Generali USA launched its newly enhanced website in January. Along with a new look and feel, you will enjoy better navigation, better functionality, and a more user-friendly design. We've also added new sections to our website. In our ***Focus On*** section, you can find the latest Generali USA news, recently published articles by our staff, as well as some Generali Group information and updates. The ***Community Involvement*** section highlights our efforts to give back to the community through various donations, services and philanthropic activities.

Please peruse our website at your convenience, www.GeneraliUSALifeRe.com

Have any questions or suggestions? Please contact Amy Cascone, Manager – Marketing & Communications, at 816.412.3724 or via e-mail, acascone@generaliusa.com.

View On... (continued from page 1)

lights one of our Board Members, Chris Carnicelli.

Chris Carnicelli, Legal Representative Of Generali in the United Kingdom

TV: Chris, please introduce yourself to our readers and tell us a little about your role within the Generali Group.

CC: First of all, thank you very much for inviting me to answer questions for *The Viewpoint's* readers. To introduce myself, I would start by saying that, although I was born and raised in New York, I have been living in London, England with my family (wife Elizabeth and two sons William (age 4) and Lance (age 3)) for the past several years. We moved to London in 2003 when Generali asked me to assume leadership of its U.K. operations. As such, I was appointed Legal Representative of Generali in the United Kingdom. As Legal Representative, I am the Chief Executive Officer of our U.K. Branch. The U.K. Branch is comprised of several entities: Generali Global, our Group Centre for multi-national and large corporate clients; our Employee Benefits unit (this is the Group's second largest Employee Benefits unit worldwide); and our discontinued centre (non-life and life), where, in addition to handling our U.K. run-off business, we are aiming to handle all of the Group's run-off business worldwide. Finally, I continue to be the Chairman of our U.S. Branch in New York, where I started my Generali career back in 1996.

TV: What is Generali Global's primary responsibility within the Group and what is its' target market?

CC: Generali Global Risk is a unique Generali brand which specializes in providing risk solutions to Generali's multinational and large corporate clients from around the world. Global Risk offers these clients a single point of access to the worldwide network of the Generali Group. We offer a wide array of product lines including: property, casualty, engineering, aviation and marine.

Although the majority of our clients today come from our five major producing companies (Spain, France, Austria, Israel and Italy), Generali Global has business which emanates from across all our Group companies and partners in over 115 countries. Because our primary aim is to work in strategic partnership with our Generali Group companies, our target markets are naturally those in which we have a strong presence. Our growth opportunities arise from areas where our Group is growing rapidly; for example, in Central and Eastern Europe, China and India.

TV: What is the history of the U.S. Branch and how does it fit into the Global picture?

CC: The U.S. Branch of the Generali Insurance Company of Trieste and Venice commenced business in 1935. After a withdrawal in 1940, shortly after the outbreak of World War II, the Branch re-entered the U.S. in 1952. Until 2000, the Branch wrote both direct and reinsurance non-life business. Currently, in addition to handling the run-off of the former business, we have re-activated the Branch's licences in order to handle and service the United States exposures of our Global corporate clients.

TV: What do you like most about your job? What do you like least?

CC: I love being actively engaged in our various businesses. I believe that to manage effectively, solve problems and bring value, the organization's leader needs to be close to the "team", be aware of the problems they face on a day to day basis, and listen to their ideas, concerns and suggestions. I really enjoy working with people and I strive to find the time to listen to everyone in our organization. Fundamentally, I believe the

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people working on our business on a day to day basis are our best resource and frequently have great, creative solutions.

As to what I like the least, I would have to say the constant travel. My responsibilities require me to travel extensively on "the continent" and both sides of "the pond". Before my two little guys arrived, I didn't mind the business travel as much. However, now the long stretches mean I miss too much of their day to day activities. They are growing so fast and even a few days away means I miss a lot of "firsts". It breaks my heart when I talk with them from the road and hear them say "Daddy, when are you coming home?"

TV: Enough about the business. We would like to hear more about you. What is your background, how did you come to work for Generali?

CC: My professional background is as an attorney. I know – an attorney representing an insurance company in New York. I can hear the jokes from here. It probably sounds like I am some sort of piranha. Actually, I am not a bad guy. You can ask anyone.

I represented Generali – U.S. Branch in New York as an external attorney for several years before they decided my hourly fee was much too high. Therefore, I was hired as Generali Counsel of the Branch in 1996. I was then promoted to Chief Executive of the Branch in 1999.

TV: What do you enjoy doing when you finally have a chance to be at home or on vacation? What are your hobbies?

CC: I am actually a bit of a sports nut. Although I love all sports, my favorites are still American football and baseball. It may seem as though I am playing to the home audience with this comment, when it comes to baseball I was a huge fan of George Brett and the Kansas City Royals. To understand that, it might help to say I am really a New York Mets fan. I loved Brett because he was always such a "Yankee" killer.

I was recently rummaging through my parents attic and found my old notebooks from when I was a kid. I had saved many clippings of George Brett including the pine-tar year when he was going for .400. Since living in London, I have started to really follow European football (a.k.a soccer – again playing to the American audience). I enjoy it (except the nil-nil draws), but will always love my American sports, even though it is tough to follow from overseas. I also love to play all sports. Right now my main sport is chasing my two boys around; this seems to take most of my free time.

TV: Finally is there a message or moral in the form of an anecdote you would like to share with us?

CC: That's a tough one. I recently saw one quote which I liked and I have put it under my keyboard. It states: "A person can succeed at almost anything for which they have unlimited enthusiasm." It really hit home for me because I know we all face many challenges both in our personal and business lives. However, we all need to get up and keep fighting. I am a true believer in the human spirit and believe that a positive mindset will overcome all obstacles.

TV: Chris, it's been a pleasure talking to you and thank you for sharing your time with us. We wish you every success with your plans for 2008.

CC: Thanks for giving me this opportunity to share our story with your readers. I would welcome any questions or comments. Just pass them over to anyone on The Viewpoint's Editorial Team and they can forward them to me.

...when it comes to baseball, I was a huge fan of George Brett...

Weighing In

By Randy Makin, FSA, Vice President, Chief Pricing Actuary

When one of our Regional Sales VP's reminds me that mortality is improving, I usually respond: "I feel better already!" In all seriousness, there are a number of sources indicating both the tendency towards and the slope of such improvements. These range from general sources such as the Center For Disease Control's data on population mortality to studies by several consulting firms to the Society of Actuaries ILEC study for 2002-2004. Generali USA's internal studies support this thesis as well.

The most recent support for mortality improvements came during the Refocus meeting held this month in Las Vegas. I recommend one source in particular: the "Emerging Medical Advancements" presentation, in which one of the speakers, Dr. Carl Holowaty of RGA Re, covered such advances in medicine as bioinformatics, RNA interference and gene therapy. Examined against the backdrop of past and ongoing mortality improvements, such events as the influenza epidemics and the HIV / AIDS epidemic appear as "bumps in the road."

Many actuaries take such improvements into account in pricing or projections, as illustrated in the 2007 SoA Mortality Table Construction Survey. All reinsurers surveyed responded that they make explicit adjustments for future mortality improvements, whereas only 28% of the direct writers so indicated. But at least one or two of the latter responded that they assume mortality improvements for the lifetime of the insured. The median response for either group (reinsurers or direct writers) was 15-20 years of improvement. The full survey results can be viewed at the SoA web site, www.soa.org.

But the improvements, in my mind, are certainly uneven. Are they the same for an insured population as for the general population? Are they the same by gender? By age group? By socioeconomic class? Do super-preferred risks improve at the same percentage rate as standards? Or have they already "arrived"? And what about substandard risks? A table 4 is 200% of standard mortality under most systems. If a standard non-smoker improves x % per year, does the table 4 keep pace, or does it eventually become equivalent to a table 5 in mortality? Obviously, we will each need to draw on as many resources as we can, weigh the evidence carefully, and come to our own conclusions about mortality improvements.

It is also interesting to note that dissenting voices have begun to appear as well. In Vol. 21 n.2 (2005) of *On the Risk*, Lawrence Segel, M.D., writing in an article entitled "Super Size Me" considers the balancing of improved mortality trends with Dr. Jay Olshansky's belief that the trend toward longer life will level off and even turn downwards. Dr. Olshansky, a demographer, is focused on the obesity epidemic, and only secondarily on such threats as Avian Flu.

A more recent discussion of this topic was provided in the ***Global Best Practices in ERM for Insurers and Reinsurers Webcast*** in January of this year. Dr. Achim Regenauer, Chief Medical Director of Munich Reinsurance Company provided startling slides indicating the pattern by state (in Europe, by country) of obesity trends, as well as U.S. diabetes mellitus trends following the first wave by a decade or two--with concerns about what he calls the potential third wave of coronary heart disease.

For those, like I, who have been sedentary this winter, and have somehow managed to migrate down one class on the build chart, it is high time to make a few dietary changes and get out the bicycle, lest we become another data point for the naysayers.

Abnormal Mortality Stop Loss Reinsurance

By Steve Dvorak, Marketing & Underwriting VP, Group Reinsurance

ABSL reinsurance coverage provides protection from a significant negative variance to a company's expected annual aggregate net retained claims.

Abnormal Mortality Life Stop Loss reinsurance coverage (ABSL) is a viable risk management solution for many medium and smaller sized carriers who have determined that traditional catastrophe coverage on life portfolios is either unaffordable or has unacceptable limitations.

ABSL reinsurance coverage provides protection from a significant negative variance to a company's expected annual aggregate net retained claims. Whether the variance is due to adverse fluctuations in individual mortality, catastrophic loss(es) or a combination of both, ABSL reinsurance coverage can help safeguard a company's bottom line. Reinsurance is provided by treaty on an excess of loss basis over an annual aggregate claim attachment point and can be written on Individual Life and/or Group Life Insurance coverages.

ABSL reinsurance is particularly well suited for medium and smaller carriers that are primarily focused on Individual Life and Small Group insurance products. These companies tend to have lower net retentions and, typically, do not have major concentrations of risk within their blocks of business. In addition, these companies are just as concerned with the impact of natural disasters, epidemics and automobile accidents as they are with acts of terrorism.

The most important aspect of ABSL coverage is the establishment of an Attachment Point. In most instances the Ceding Company and the Reinsurer will have a different idea of what expected claims are going to be in any year. At Generali USA we avoid that problem by using the last five years of annual statements to develop the average ratio of net claims to net retained inforce.

Defined claims (DC) are equal to net retained incurred claims (NRIC), minus reserves released from death (RRD), minus matured endowments (ME):

DC=NRIC-RRD-ME

The ratio is then entered into an algorithm which accounts for sample standard experience deviation, theoretical deviation based on block characteristics and normal claim distribution to develop the final Attachment Point.

Generali USA Welcomes Two New

Dr. Richard Rougeau recently joined the Generali USA team as Vice President & Chief Medical Officer. He comes to Generali USA after spending 7 ½ years at RGA as Medical Director, International Division, and 3 ½ years at Manulife Financial as Assistant Vice President – Medical Director.

Dr. Rougeau received a Bachelor of Science degree from the University of Manitoba (1980), and a Master of Business Administration degree from the University of British Columbia (1982). He earned his Medical Degree from the University of Manitoba (1988) and became Board Certified in Insurance Medicine in 2001.

Dr. Rougeau is a member of the American Academy of Insurance Medicine (AAIM), Canadian Life Insurance Medical Officers Association (CLIMOA), and Midwest Medical Directors Association (MMDA).

Originally from Canada, Dr. Rougeau is relocating to the Kansas City area from St. Louis. Dr. Rougeau has a wife, Kerin, and two children, ages 11 and 8. In his free time he enjoys boating and his children's sports activities.

If you would like to contact Dr. Rougeau, you may do so at: rrougeau@generaliusa.com or 816.412.3741.

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numbers to 2004 production, we have grown new business output by 54%. Again, this growth was accomplished despite a 34% decline in the overall market over this time frame.

Generali USA has also benefited greatly from the strong support of Generali, our parent company. This support is demonstrated by placing key Head Office representatives on our board of directors who have worked hard to find ways to support our business plan. In 2007, we put in place an agreement that would allow us to pass our coinsurance business onto the books of the Head Office. As a result, we have increased the number of options available to handle the reserve strain. Generali USA also gained approval to double our retention to $4 million. This is the second time in the past three years they have allowed us to double our retention.

I would like to close by saying "thank you" to our valued clients who have given us the opportunity to provide reinsurance support. We appreciate your confidence in our ability to support your business and value greatly our continued relationship.

Generali USA Welcomes (continued from page 10)

Amanda Morrison joined Generali USA in December as Treaty Counsel. Prior to joining Generali USA, Amanda was employed at MassMutual in Springfield, Massachusetts for three years as a Treaty Analyst. She was also a Life Insurance Agent with New York Life during her undergraduate studies at Missouri State University, where she received dual Bachelor of Science degrees in Finance and Insurance and Risk Management (2002). In 2007, Amanda graduated from Western New England College School of Law.

Originally from Columbia, Missouri, Amanda resides in Overland Park, Kansas with her husband. In her free time, Amanda enjoys golfing and traveling.

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We value your business!