

# *LCP's response to DWP Consultation on Retirement Collective Defined Contribution pension schemes*

**4 December 2025**

*This document sets out LCP's response to the DWP's consultation on policy proposals for the creation of Retirement Collective Defined Contribution (r-CDC) provision, published on 23 October 2025 (the "Consultation").*

## **Our high-level comments on the consultation proposals**

We believe r-CDC has the potential to be a beneficial product for the retirement market by allowing people who have saved in DC during their careers to access CDC at retirement. In general, we agree with most of the policy proposals set out in the consultation. We highlight below some areas which we think should be considered in parallel with the development of r-CDC regulations.

### **Timing**

The indicative roadmap shows r-CDC regulations are due to be finalised after Guided Retirement requirements commence. It would be helpful if the Government has a strategy in place to ensure that r-CDC is taken into account from the very first wave of Guided Retirement, and that scheme trustees review their retirement pathways sufficiently frequently whilst r-CDC schemes become mainstream.

### **Education**

The Government should consider developing a strategy to educate savers about retirement products in general, and CDC schemes in particular as a new option. Information for trustees and employers will also be required to ensure that they consider CDC schemes as a valid option for their members.

Further, with Guided Retirement requirements, the role of DC scheme trustees may need to focus much more on the at retirement process and supporting members throughout retirement. Trustee guidance from the Pensions Regulator will be helpful.

### **Scheme design**

A cohorting approach, eg by year of entry into the scheme, is likely to be important for trustees and others to be able to compare different r-CDC schemes fairly when selecting default retirement pathways, and for members to be able to make a reasonable comparison between r-CDC benefits and other retirement options.

However, we do not agree with removing the upper threshold and allowing the spreading of cuts over the lifetime of the scheme, as any eg cross-subsidy between healthy and less-healthy lives will be exacerbated with a healthy pensioner possibly living many times longer than a less-healthy pensioner.

## **Responses to consultation questions**

### **Question 1**

**How do you anticipate Retirement CDC investment strategies will need to differ from those of whole-life CDC schemes?**

A Retirement CDC scheme, by definition, provides benefits from Day 1. As such, it is even more important that investment experiences are passed onto members quickly, affecting their immediate pension incomes. There is therefore a need for a certain level of liquidity and lower risk returns.

Compared to UMES, the negative consequence of new business not being kept at pace is potentially higher, because of the immediate cash outgo. A bigger safety net may therefore need to be built into the investment strategy, as well as frequent review of new business volume, will be required, and such considerations may also form part of the business plan.

On the other hand, at Day 1 the scheme also has an immediate large cash injection, with retirees transferring their pension pots into the CDC scheme. It could be expected that, provided the amount of new business is kept at pace, there will be positive cashflow for a significant time period post launch of a r-CDC scheme. As such, we would not expect there to be any particular constraint in investing in a similar way to the decumulation part of a UMES (and Single Employer schemes); in fact, given the large cash injections, arguably there could be more opportunities for investments in illiquid and productive assets. Unlike whole-of-life schemes, there are lower chances of and fewer opportunities for members to transfer their benefits out of the r-CDC scheme (including pension commencement lump sums) and so liquidity requirements at that stage is also reduced.

It is worth noting that, as the investment timeframe is shorter, and actual mortality experience has more impact where this differs from assumption, there potentially needs to be more members in the scheme compared to whole-life CDC schemes. This will in turn affect the investment strategies.

Where an r-CDC scheme is the default pension benefit solution of a DC scheme, especially if it is a Master Trust provided solution, it may be possible for the trustees of the DC scheme or Master Trust to provide a default pre-retirement lifestyling to match the r-CDC's investment strategy at transfer. Such in-specie transfer could mean the overall investment profile to be very close to a UMES, and the collective investment experience enjoyed by the members is optimised.

## Question 2

**What do you estimate the establishment and running costs of an r-CDC scheme to be? Please outline one-off and ongoing costs.**

We expect the bulk of the costs to set up and run an r-CDC scheme would be similar to those of a UMES scheme. These could include IT systems, legal and actuarial work in designing the scheme, modelling and other calculations and related reporting requirements, governance, and costs to comply with other regulatory requirements and authorisation fees. There could be some savings from there being no administration in the accumulation phase.

Both start up and ongoing costs are likely to vary across schemes, depending on how much of the existing UMES or Master Trust IT systems and skill sets could be adapted, the target market (eg large or smaller schemes), sophistication of the administration system etc.

## Question 3

**Should all business plan requirements that would apply to whole-life unconnected multiple employer CDC schemes also apply to Retirement CDC schemes? What, if anything, should change or be added?**

We agree that the principles set out in the business plan as required for UMES should also apply to r-CDC schemes.

As mentioned in Question 1, it is important to review the volume of new business. We would therefore suggest that, as well as the number of members joining and leaving the scheme as set out in paragraph 15 of Schedule 1B, the monetary amounts involved should also be included in the business plan.

We suggest that the mechanism for any cohorting should also be included in the business plan (see question 10 below).

Given r-CDC schemes are expected to be sections of existing UMES or Master Trusts, it would seem appropriate that the business plan should include information about these connections. We have no firm view as to whether this information should be set out in regulations or the Pensions Regulator's code.

Some changes to Schedule 1B of the 2021 Act will be needed to reflect the structure of r-CDC schemes, for example references to participating employers and active members.

#### Question 4

**What numbers of member onflows, and at what pot sizes will be needed to achieve stability in Retirement CDC, given there are no ongoing contributions, and what allowances need to be made for members who opt-out of their default pension benefit solution?**

We have previously estimated that a whole of life CDC scheme would require around 5,000 members to be actuarially viable. We expect more members will be required for an r-CDC scheme compared to a whole of life CDC scheme to achieve stability. This is because the mortality experience of a group of pensioners is likely to be much more variable than that of a scheme with younger members as well as pensioners. This number would also depend on the members' pot size and the homogeneity of membership.

From a commercial perspective, as r-CDC schemes are likely to be established as sections of existing UMES or as part of a suite of post-retirement solutions offered by Master Trusts, some economies of scale are likely to be available already in terms of administration, marketing and systems. New joiners are also transferring existing pots to the schemes, which would provide much higher percentage fees compared to active members starting to contribute. Therefore, the amount of new business required at the early years may be less than that required for UMES for business viability.

We note that, under the current roadmap, Guided Retirement requirements go live before r-CDC legislation and code are in force. Allowing for final adjustments and authorisation period, r-CDC schemes are unlikely to be available for at least a year or two before Guided Retirement requirements are in force. DC scheme trustees will therefore need to set up their pension benefits strategy without full visibility over emerging r-CDC options. Furthermore, many trustees are unlikely to review their strategy to include r-CDCs until they are next required to – the interval at which the strategy must be reviewed is still to be determined (clause 53(3)(e) of the Bill). If this happens, the current timing indicates that there will hardly be any DC schemes using r-CDC schemes as their qualifying benefit solution in the early years. There is a clear risk to obtaining the required critical mass for these r-CDC schemes to be viable.

This may not be the case with r-CDC schemes set up as a section of a Master Trust scheme, which can point their members to the r-CDC section as their default pension benefit solutions. Arguably, this gives Master Trusts an unwarranted advantage over UMES.

While savers investing in schemes' pre-retirement default funds remain high, there is indication that this number is decreasing (PPI DC Future Book 2025). This could be due to increased interaction through use of more sophisticated communications and engagement propositions ([LCP Master Trust report 2025](#)). It is difficult at this stage to envisage how member engagements might improve in the coming years, especially with the development of guided retirement solutions.

An LCP and the University of Bath [report](#) indicates that a “one size fits all” default solution is unlikely to be appropriate. As well as considering the proportion of members who opt-out of their default pension benefit solution, regulations may be required to ensure schemes do not set r-CDC as the only default pension benefit solution to groups of members where this is clearly inappropriate.

#### Question 5

**What do you think the effects of the proposed adaptation to promotion and marketing criteria, including a prohibition on member marketing, would be?**

R-CDC schemes are expected to be sections of UMES or Master Trusts. They all have their individual promotion and marketing requirements, but it is very likely that there will be cross-promotions, for example a Master Trust promoting the pre-retirement Master Trust and post-retirement r-CDC as a package. These regulations therefore need to work well together.

Trustees of DC schemes may look to r-CDC schemes to provide literature that they can use to inform and educate individual members close to retirement. There needs to be clear guidance on how this material may be distinct from marketing and promotion material, so that they can aid DC scheme trustees in their fiduciary duties, and are not caught by the marketing and promotion regulations.

In the October government response to UMES regulations, there was an emphasis on preventing trustees as promoters (paragraphs 76-77). We agree that this continues to be relevant, with a clear distinction in the Regulator's code on how any actions by trustees providing default r-CDC schemes through guided retirement solutions are not considered as promotion of the r-CDC schemes.

## Question 6

**How would an approach to allow access to Retirement CDC via a guided retirement default or formal partnership between trustees, protect members, and impact a developing market? Would there be any unintended consequences?**

Permitting, rather than requiring, schemes to provide r-CDC via guided retirement default could only be beneficial to members, because this gives trustees an extra option for their members post-retirement to supplement any DC offerings. The draft guided retirement legislation requires trustees to determine, and from time-to-time review and if necessary revise, the pension benefits strategy which includes the design or identify pension benefit solutions that take account of the need of its members (clause 53(1)). As such we would not expect there to be negative impacts to members, compared with different defaults providing other types of locked-in retirement products eg annuities.

Maybe in the future the r-CDC market, as well as guided retirement, will be sufficiently mature that trustees of the DC scheme will be able to switch to a different r-CDC scheme or a different default product with little preparation time and relatively minor consequence. However, until such time, r-CDC schemes are likely to rely on a steady stream of new members from partnering DC schemes for a certain "foreseeable" future.

While we would welcome r-CDC to be made available to members as an active choice, rather than as part of a default or qualifying pension benefit solution, it is not clear to us how the "formal partnership" might work which does not "provide a better outcome for the members concerned than any default pension benefit solution" (clause 50(3), given this is not a qualifying pension benefit solution). The trustees' fiduciary duty would likely require them to provide sufficient information for members to make an active decision. Whilst trustees may not be required to provide personalised illustrations, members should still have the ability to receive these illustrations. However, in order for r-CDC schemes to provide such illustrations, requirements similar to those applicable to annuity providers following FCA rules are needed. R-CDC schemes are not designed to be available to the retail market at the start, and it is expected that r-CDC schemes do not have direct contact with members (paragraph 94 of this consultation), which all seem to be contrary to the scheme's ability to provide members with accurate information.

Apart from the above, it would seem sensible that a "formal partnership" follows the same process as a qualifying pension benefit solution under clause 50(5). Until the r-CDC market is fully developed, we would envisage a scheme to only make r-CDC schemes accessible to members if it is already the default or qualifying solution to part of its membership.

As discussed in Question 4, r-CDC schemes are expected to emerge in the next two to three years, after Guided Retirement requirements are live. R-CDC schemes may therefore not be fully included in the first wave of pension benefits strategies. It is critical to align the timing and expectations of trustees between introduction to Guided Retirement requirements and the start of r-CDC schemes to ensure trustees setting up guided retirement pathways have the full options at the outset. The Government also needs to give a clear message to schemes before the Guided Retirement requirements start on how they should consider and allow for r-CDC schemes, and also going forward, to in real time continue to review the market.

## Question 7

**What are your views on the risks, benefits and potential protections for members of FCA-regulated pension schemes being transferred to a Retirement CDC to access their pension savings?**

FCA regulated pension schemes need to follow the Consumer Duty requirements. In particular, the pension arrangement should be suitable for the individual member and fit for purpose.

In a partnership between a non-workplace pension arrangement and an r-CDC scheme, it is important that members continue to be protected and r-CDC meets their needs. Without an advice requirement, any guidance cannot be tailored to individual circumstances, so general education, examples of when an r-CDC scheme may be unsuitable, and clear and factual communication without promotion of the scheme will be required.

Individual consumer needs also need to be balanced with the concept of CDC schemes, for example longevity pooling meaning there will be members worse off than other members. Requirements on helping members choose should also be proportionate compared to other retirement products. It may be useful for some regulatory guidance on where this balance lies.

### Question 8

**What matters should we consider in developing an actuarial equivalence requirement for transfers into the scheme, and are there other factors to address regarding member entry?**

As with whole-of-life schemes, central estimates should be used. Any margins would create a reserve, contrary to the CDC model. It would seem appropriate that conversion terms use the same assumptions as benefit adjustments following an actuarial valuation, allowing for market movements. In this sense, the requirements should be the same for r-CDC schemes compared to whole of life CDC schemes.

We would expect r-CDC schemes to calculate transfers using the same demographic information as DB transfers, ie age, sex, and perhaps postcode, but not details often used for annuity quotations, eg smoking status and health conditions.

However, a pot at the time of transfer is likely to be the largest it would ever be (barring any other uses taken out eg PCLS or previous drawdown). The conversion term at the point of transfer is therefore essential. It would seem pricing should be adjusted frequently to allow for market movements, but the precise frequency could be decided by individual schemes to fit their business model.

Considerations may be needed for the timing of the first benefit adjustment following a transfer. For example, whether a proportional increase should be applied.

In-specie transfers, eg from Master Trusts defaulting into the r-CDC scheme, will likely require different pricing models for the financial assumptions.

### Question 9

**What mechanisms should be introduced to ensure that quotations are accurate and not misleading?**

To enable members to make informed decisions, we suggest that a period of guarantee should be provided. This could be dictated by legislation or through optional guidance.

We agree that quotations should include sufficient information similar to those for the viability report. In addition, there should be strong risk warnings that the pension amount could go down as well as up. However, we note that members are unlikely to appreciate complicated detailed information, and illustrations may be more easily understood. For example, as well as describing how annual adjustments are calculated, these could show members what happened to scheme benefits in the past three years (noting this might be difficult for cohorting schemes) and illustrate the potential upside and downside adjustments at their first full pension adjustment date based on investment returns (either a fixed percentage change, or a 1-in-x chance).

## Question 10

**What are your comments on a ‘cohorting’ approach to helping well-performing schemes remain affordable for members and are there alternative approaches you would recommend? What should scheme rules on cohorting include? And does the illustrative drafting capture the policy intent and would this drafting work in practice?**

We like the “cohorting” proposals for r-CDC schemes. This would appear to be a suitable way for DC scheme trustees to review and compare r-CDC schemes as their default pension solutions. As different cohorts remain in the same section of the scheme, we would expect investment and mortality pooling to continue to be available as older cohorts shrink in the number of members.

The consultation suggests that opening and closing of cohorts are decided by the schemes. We agree with this approach. However, there should be a pre-determined mechanism under which a cohort should be closed and a new one opened, and we suggest that this should form part of the business plan. A business plan’s life span of 3-5 years also seems an appropriate period for the mechanism to be reviewed. The scheme rules may then only state that cohorting will be used, and the target increase at the start of each cohort.

Fixing the cohorts to be yearly may also make r-CDC schemes more comparable and easier for DC scheme trustees to understand.

We also suggest that the decision to continue or not with the current cohort should form part of the annual viability reporting.

Cohorting adds much complexity to the calculations process. For example, there could be a transfer of risk or value between cohorts, and these need to be carefully considered.

## Question 11

**What issues would removal of the upper threshold and allowing the spreading of cuts over the lifetime of the scheme, for schemes using cohorting create, and how might these be mitigated?**

We do not agree with removing the upper threshold and spreading cuts. Whilst the main concern with spreading is intergenerational cross-subsidies, we think the level of other cross-subsidies is still too great. In particular, members in better health might unfairly benefit from the removal of the upper threshold, and be unfairly disadvantaged in having to suffer most of the cuts. This is most apparent at the older ages.

A cohort may also by design or circumstance be of an extended period of time. Intergenerational cross-subsidies could arise with lengthening periods.

Concerns on member satisfaction about reductions could mostly be mitigated by clear communication. As member communications improve, especially through multi-media and the use of AI, we expect these to become more acceptable over time.

## Question 12

**Is there any further information that Retirement CDC schemes should be required to provide to new and prospective members?**

We agree that information provided to new and prospective members of r-CDC schemes should be the same as that provided to new and prospective whole-of-life scheme members at entry and close to retirement. As well as those set out in paragraph 140, we expect more details about actual benefits, for example any guarantee period and reversionary spouse benefits.

Once a member has joined the scheme, information contained in the viability report, actuarial valuation, member booklet etc should be automatically available (although some sign posting may be required). These may also be useful for prospective members wishing to understand more about the scheme, such as its current investment allocations and membership profile.

### Question 13

#### **Are there practical or operational challenges in delivering Retirement CDC communications through DC scheme trustees, and how might these be addressed?**

There needs to be clear guidelines on what constitutes factual material drafted by CDC schemes and delivered through DC scheme trustees, and marketing and promotional material which might be aimed by r-CDC scheme promoters at DC scheme trustees but used in pre-retirement member communications (please see Question 5).

Similarly, clear guidelines are needed to ensure that DC scheme trustees are not caught by CDC marketing and promotion legislation when providing guidance material or illustrations to members. DC scheme trustees are also unlikely to initially be specialists in CDC schemes. The trustees will need guidance to help communicate to members.

Should a member choose (or is defaulted) to do so, there is a conversion from DC pots to lifetime CDC benefits at retirement. Currently, there are strict rules and guidelines by the FCA on what information should be provided to members for the purchase of annuities; for members who join whole-of-life CDC schemes, there is actuarial involvement in reviewing member communications. It would appear appropriate that a similar level of oversight is provided to members whose DC scheme trustees guide them to an r-CDC default retirement solution.

Any provision of personalised information by DC scheme trustees to individual members, where the r-CDC scheme is a “formal partnership”, might be more challenging – please see our response to question 6.

R-CDC schemes using cohorting may need to update their material more frequently than schemes that don't use cohorting. We don't expect this to be an operational challenge as effective communication from r-CDC schemes to DC schemes, and DC schemes to members, via electronic means, should be relatively straightforward. It would nonetheless be useful for any expected update frequencies be communicated between the r-CDC and DC schemes at the promotion / marketing stage.

Finally, many commercial Master Trusts will have to comply with consumer duty in offering decumulation solutions to members. As such, it is expected that members will be required to undertake a series of questions in order to establish their needs post-retirement. There will need to be consideration as to what scenarios r-CDC could be detrimental to members; any guidance on this is likely to be appreciated by commercial Master Trusts as they look to consider ways to ensure member needs are best met in retirement. For example, r-CDC may not be appropriate for individuals looking to front load spending in retirement, or for individuals where it is clearly identifiable that they are unlikely to have a life expectancy in line with the cohort they could be expected to join as part of an r-CDC offering.

### Question 14

#### **What additional costs might a Retirement CDC illustration create, and what considerations should be taken into account to ensure illustrations are realistic, consistent, and not misleading?**

SMPI illustrations assume members take a single non-increasing annuity at retirement. This is the current minority – more than half of current retirees take the entire DC pot as a lump sum (see for example the IFS 2025 [report](#): Individuals' challenges managing pensions through retirement); and an illustration of a non-increasing annuity perpetuates the expectation that individuals should receive higher annuities at retirement than is realistically available to provide a steady income for life in real terms.

For schemes who guide members into an r-CDC arrangement at retirement, such illustrations are unlikely to be achievable or realistic, even allowing for any possible outperformance by CDC schemes compared to annuity products. For any semi-disengaged member this could push them towards either full cash out or level annuities. We therefore suggest that schemes should either provide illustrations based on their default pension benefit solutions, or at the very least provide illustrations with some form of inflationary increases.

Any updates to the requirements to SMPI are outside the scope of this consultation, nonetheless we would like to emphasise that SMPI needs to be achievable and fits with the concept that a pension should be an income for life.

### Question 15

**What charging structure/what charge levels is your organisation considering levying on members? If implemented, at what level should a Retirement CDC charge cap be set?**

We agree a charge cap should be set. It should be consistent with whole of life CDC charge cap. It is most likely that high charges or unexpected increases might be made before an r-CDC scheme is well established and has the desired volume of business, and most damaging to the reputation of the CDC market overall.

### Question 16

**Do you foresee any areas of potential arbitrage, and how should Government and regulators seek to mitigate this?**

We envisage some areas of potential arbitrage arising because of different regulatory regimes in operation, or because some related (but not direct) regulations make certain CDC products more difficult to be set up or take on members. For example:

- Master Trusts gaining an advantage at the start of r-CDC regime coming live compared to UMES, because of the timing of Guided Retirement requirements (see Question 4)
- Different charge caps between r-CDC and whole of life CDC schemes, and restrictions of charge caps in r-CDC schemes compared to annuities
- Consolidation of dormant small pots before retirement into active schemes or Master Trusts, compared to active consolidation of small pots into r-CDC schemes
- Consolidation of pots into a current r-CDC scheme membership, compared to setting up a new member profile possibly because of the closure of a cohort
- Advice requirements under FCA rules, compared to provision of information via DC scheme trustees for r-CDC formal partnership
- Joint promotions for Master Trust – r-CDC schemes, compared to r-CDC schemes set up under UMES or promotions without accumulation phase
- Differences between the FCA's calculation requirements in drawdown illustrations (including any automated drawdown illustrations), vs r-CDC illustrations at retirement
- A UMES ceasing future accruals would eventually become an r-CDC scheme

### Question 17

**Are there any other matters you wish to raise in relation to the possible extension of the CDC authorisation and supervisory framework to include Retirement CDC schemes?**

We strongly believe r-CDC has the potential to be a beneficial product for the retirement market by allowing people who have saved in DC during their careers to access CDC at retirement. However, it can only be successful if members of the public know about its existence and understand the basics of CDCs. The Government should develop a strategy to educate people about retirement products and options in general, and CDCs in particular. This is a new product, and it should not be entirely the responsibility of trustees, employers and the advisory community to explain the concept to savers, especially with the fine line between promotion and education that they need to navigate. Similarly, trustees and employers themselves are likely to also need Government guidance to understand and make use of CDC schemes.

With the Guided Retirement provisions, and in particular the extension of CDC schemes to the decumulation market with the inbuilt risk sharing concept, there may need to be an evolution of the roles of DC scheme trustees, from one of helping members maximise their savings at the point of retirement, to one of focussing far more on helping members through retirement for the remainder of their lives. This needs to be addressed and made clear to DC scheme trustees.

Currently r-CDC schemes are confined to wholesale markets only. Individual members in existing whole of life schemes will not be able to compare their schemes' retirement provisions to other r-CDC schemes in the market. As noted previously, schemes that perform well may appear to give lower benefits unless cohorting is used and schemes always offer new members CPI increases. Whole of life schemes are likely to be incomparable to r-CDC scheme offerings, even if they are expected to provide better benefits in the long term. The Government should consider how to avoid such unfair comparisons before pushing r-CDCs out to the retail market.

It is not clear whether an r-CDC scheme is a standalone scheme in the context of the proposed legislation, even though it is set up as a section of a UMES or Master Trust scheme, or if an r-CDC scheme is part of a wider scheme. In particular, it is not clear whether some events may be considered triggering events. For example, would the closure of the UMES or the Master Trust section of the scheme be a triggering event for the r-CDC scheme?

### Question 18

#### **Do you have any comments on the proposed amendment to Regulation 12 of the Preservation of Benefit Regulations 1991?**

We agree that bulk transfers without consent regulations should extend to allow such transfers of relevant money purchase benefits to CDC schemes.

Transfers to CDC schemes involve the conversion of money purchase pots into target benefits. We expect any advice sought by the transferring scheme trustees would involve actuarial techniques, and as such the "appropriate adviser" in reg12(9)(a) may need to be an actuary. We note that DC schemes are exempt from the scheme actuary requirement under section 47 of PA1995.

CDC benefits are not suitable for all members, for example those with serious ill health. The current and proposed legislation does not explicitly allow members to individually withdraw from the arrangement before the bulk transfer is made. We think there should be an explicit requirement for trustees of the transferring scheme to allow a suitable amount of time for members to withdraw, perhaps to transfer their pots elsewhere, before the bulk transfer is made. This would avoid members having to enter into a CDC arrangement, and then individually transfer out of the arrangement again.

There are also minor changes to the proposed regulations which we suggest should be considered, for example the proposed 12(7) states "receiving scheme" which might need clarifying to include sections of schemes, as CDCs may be part of wider schemes with non-CDC qualifying benefits in different sections. In general, we would appreciate clarification on whether CDC and non-CDC sections within such schemes as distinct "schemes" in general pensions regulations.

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