Combined **Financial Services Guide** and **Product Disclosure Statement**

for doctors and their practice

Medical Indemnity Insurance and Membership

MIGA
The Medical Insurance Group

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Important Notice:

This PDS is for guidance only, and entitlements under the Policy are determined in accordance with the terms and conditions of the particular Policy and Policy Schedule which is issued.

The terms and conditions of the insurance provided by Medical Insurance Australia are fully contained in the applicable Policy Wording, Policy Schedule and any applicable endorsements. This document does not form part of the Policy Wording.

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Defined Terms

APRA –
Australian Prudential Regulation Authority

ECS –
Exceptional Claims Indemnity Scheme

ERB –
Extended Reporting Benefits

FSG –
Financial Services Guide

HCCS –
High Cost Claim Indemnity Scheme

IOS –
Insurance Ombudsman Service

IRM Program –
Interactive Risk Management Program

MDASA –
Medical Defence Association of South Australia Limited

MDO –
Medical Defence Organisation

Medical Insurance Australia –
Medical Insurance Australia Pty Ltd

Medical Student –
Student registered in an approved course of medical study in a medical school or university in Australia

MIGA –
Medical Insurance Group Australia which comprises MDASA and Medical Insurance Australia

MISS –
Medical Indemnity Subsidy Scheme

Nurse Practitioner –
A person registered as a Nurse Practitioner by the Nurses Board in the relevant State or Territory

PDS –
Product Disclosure Statement

Policy Period –
The period of insurance noted on your Policy Schedule

Policy Schedule –
The certificate issued by us to you confirming details of your insurance arrangements for the Policy Period

PPF –
Pacific Premium Funding Pty Ltd

PSS –
Premium Support Scheme

ROCS –
Run-off Cover Indemnity Scheme

SOA –
Statement of Advice

SMO –
Salaried Medical Officer

UMPSP –
UMP Support Payment

Throughout this document, reference to:

- "**Us**", "**our**" or "**we**" means MIGA
- "**You**" or "**your**" means a person who is a member of MDASA or is seeking membership of MDASA and/or medical indemnity insurance with Medical Insurance Australia
- "**Category**" means the practice category of the insured doctor, as set out in the relevant Section of the PDS
- "**Policy**" means the Medical Indemnity Insurance Policy that is issued to you by Medical Insurance Australia
- "**Insured**" has the same meaning as in the Policy

Table of Contents

Contacting MIGA
Defined terms i
Table of contents ii

Financial Services Regulation iv

Preface
About MIGA
About this document 1
About MIGA 1
Group structure 2
Our vision and commitment to members 2

PART 1: FINANCIAL SERVICES GUIDE
a) Introduction 3
b) Financial services licence 3
c) What qualifications do our employees have? 3
d) Selecting the right Category 3
e) Dispute resolution 3

PART 2: PRODUCT DISCLOSURE STATEMENT
Section 1
Membership of MDASA
a) Introduction 4
b) Benefits of Membership 4

Section 2
Medical Indemnity Insurance Policy
a) Introduction 6
b) Overview of the Policy 6
c) Limit of cover 7
d) Key Policy benefits 7
e) Automatic Policy extensions 8
f) Optional Policy extensions 10
g) Cover for treatment of public patients 10
h) Good Samaritan Acts and Gratuitous Advice 11
i) Your Policy Schedule and Certificate of Insurance and Membership 11
j) What the Policy does not cover 12
k) Notification of claims and circumstances 12

Section 3
Claims Made Insurance and Retroactive cover
a) Claims made insurance 13
b) Retroactive cover 13
c) Calculation of premiums 14
d) Claims made premiums – Why they may increase over time 14

Section 4
Specialist Private Practice
a) Introduction 15
b) Category listing 15
c) Cardiology – Non Interventional 16
d) Cardiology – Interventional 16
e) Dermatology 16
f) Dermatology Cosmetic 16
g) General Surgery 16
h) General Surgery – Cosmetic and Plastic, Reconstructive and/or Cosmetic Surgery 16
i) Obstetrics 16
j) Ophthalmology – Non Procedural – Office Practice Only 16
k) Ophthalmology – Procedural 16
l) Ophthalmology – Cosmetic 16
m) Radiology 16
n) Surgical Specialties – Office Practice Only 17
o) Surgical Assistance Only – Specialists 17
p) Surgical Assistance Only – Other 17
q) Special Condition – Liposuction 17

Section 5
General Practice
a) Introduction 18
b) Category listing 18
c) GP Non Procedural 19
d) GP Procedural 20
e) Special Conditions – Shared Care and Ante-natal Care 20

Section 6
Cosmetic Medical Practice
a) Introduction 22
b) Category listing 22
c) Special Condition – Liposuction 23

Section 7
Interns
a) Introduction 24
b) Benefits of being an Intern member 24
c) Free membership 24
d) Medical indemnity insurance for Interns 24
e) What you are covered for as an Intern 25
f) What you are not covered for as an Intern 25
g) How to join as an Intern member 25
h) What happens if you cease your Intern year without completing it? 25
i) What happens if you cancel your MDASA Intern membership? 25
j) When you finish your Intern year 25

Section 8
Employer Indemnified Categories
a) Introduction 27
b) Scope of cover for Employer Indemnified 27
c) Staff Specialist with no private practice – Medical Board, tribunal and coronial cover only 28
d) Staff Specialist with no or restricted private practice 28
e) Salaried Medical Officer with no private practice – Medical Board, tribunal and coronial cover only 28
f) Salaried Medical Officer – with no or restricted private practice 28
g) Salaried Medical Officer with private practice in GP Non Procedural 29
h) Other Employer Indemnified – Private sector 29

Section 9
Other Categories
a) Introduction 30
b) Surgical Assistance Only – Other 30
c) Employed Salaried Medical Officer at a private hospital 30
d) Registrar undertaking training as a Specialist in private practice 30
e) Medical Reporting and Assessment 30
f) Medical Administrator 30
g) Medical Academic 31
h) Non Clinical 31

Section 10
Retired, Compound Life Members and Non Practising Doctors
a) Introduction 32
b) Retired Doctors 32
c) Compound Life Membership 32
d) Non Practising Doctors 33

('Table of Contents' continued on next page)

Section 11
Medical Students
a) Student Membership Package . . . 34
b) Benefits of Student Membership . . . 34

Section 12
Declaration of Gross Income
a) Introduction . . . 35
b) Definition of Gross Income . . . 35
c) Special cases – Gross Income / Sessions . . . 35
d) Adjustment of Gross Income / Sessions . . . 35
e) Audit of Gross Income / Sessions . . . 35

Section 13
Run-Off Cover
a) Why you need Run-Off Cover . . . 36
b) Types of Run-Off Cover . . . 36
c) ROCS . . . 36
d) ROCS Gap Cover . . . 37
e) Standard Run-Off . . . 37
f) More information about Run-Off Cover . . . 37

Section 14
Renewal of your Insurance and Membership
a) Renewal package . . . 38
b) Your Tax Invoice . . . 38
c) Payment and steps to finalise your renewal . . . 38

Section 15
General Administration
a) Steps to joining and obtaining insurance with MIGA . . . 39
b) Once your application has been accepted . . . 39
c) Period of insurance and membership . . . 39
d) Paying your invoice . . . 39
e) Paying your invoice by instalments . . . 39
f) Change in Category . . . 39
g) Changing State or Territory of practice . . . 39
h) Suspension of membership . . . 40
i) Resignation of membership of MDASA . . . 41
j) Cancellation of your insurance . . . 41

Section 16
Claims and Advisory Services
a) Overview . . . 42
b) Key features of our service . . . 42
c) Our advisory services . . . 42
d) Claims management philosophy . . . 42
e) Notification of claims . . . 42
f) Notification of circumstances . . . 42

Section 17
Risk Management
a) Introduction . . . 44
b) IRM Program . . . 44
c) Risk management services . . . 44
d) More information about the IRM Program . . . 44

Section 18
Commonwealth Arrangements
a) Federal Government reform . . . 45
b) Medical indemnity - only offered by licensed insurers . . . 45
c) Summary of key legislation . . . 45
d) Medical indemnity legislation – key facts . . . 46

Section 19
Premium Support Scheme
Part 1 – Scheme Details
a) Introduction . . . 47
b) The nature of the PSS . . . 47
c) Eligibility . . . 47
d) Electing into the PSS . . . 47
e) PSS support calculation . . . 47
f) Definition of Actual and Estimated Income . . . 48
g) Definition of Gross Indemnity Costs . . . 48

Part 2 – Terms and Conditions of PSS
h) Payment of Gross Indemnity Costs . . . 48
i) Provision of information . . . 48
j) Provision of information by those doctors eligible for MISS . . . 48
k) Participation in risk management programs . . . 49
l) Participation in information sharing and confidentiality . . . 49
m) Participation in audits . . . 49
n) Factors affecting a doctor's eligibility . . . 49
o) Medical practice outside Australia . . . 49
p) Change of insurance details or estimated income . . . 50
q) The administration fee . . . 50
r) GST and Stamp Duty . . . 50
s) Dispute resolution . . . 50
t) Alternate PSS calculations – MISS . . . 50

Section 20
Other Information
a) Your duty to disclose . . . 52
b) Cooling-off period . . . 52
c) Dispute resolution . . . 52
d) Contacting us . . . 52
e) Privacy . . . 53
f) Other information . . . 53

Financial Services Regulation

The Financial Services Regulation (Chapter 7 of the Corporations Act) (FSR) provisions is legislation designed to protect consumers of financial services. Medical indemnity insurance is a type of general insurance which is a financial product under the FSR provisions. It came into full effect on 11 March 2004.

For our members this means that:

- When we provide you with personal advice in relation to your insurance objectives, financial circumstances or needs we must provide you with a Statement of Advice (SOA) that sets out, amongst other things, the advice and the basis on which it is given
- We are required to provide you with an FSG and PDS before providing you with a financial service, such as providing you with advice or issuing or renewing your insurance.

The FSG and PDS are designed to:

- Provide a wide range of information on the products and services we offer including their features and benefits
- Help you make informed decisions about our products and services.

> The intention of these documents is that consumers are provided with the same type of information about services and products from different providers, which will make it easier for them to make comparisons.

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Preface

About MIGA

About this document

This document will be given to you when we provide you with a Quotation for insurance and membership with MIGA or when the offer to renew your insurance and membership for 2007/2008 is made.

It applies to our Policy which is available for medical practitioners in Australia, including those who are retired and those who require run-off cover.

It contains our:

- FSG – in Part 1
- PDS – in Part 2.

It is important that you keep this Combined FSG and PDS as it provides comprehensive information on the benefits of your insurance and membership arrangements with MIGA. It also provides you with important information about our claims handling processes and the IRM Program.

A separate Policy wording and Combined FSG and PDS are available for Medical Students.

About MIGA

Medical Insurance Group Australia (MIGA) is a national provider of medical indemnity insurance and associated services to doctors, medical students and the medical profession across Australia.

We have worked with and supported the medical profession for over 100 years and our experience with and knowledge of medical issues and the legal system is extensive.

We are committed to providing our members with high quality and affordable medical indemnity insurance and services and to maintaining the Group as a leading provider of medical indemnity insurance across Australia.

To support our growing interstate membership we have opened offices in Brisbane, Melbourne and Sydney.

We offer:

- Medical indemnity insurance for doctors and medical students throughout Australia
- A range of insurance and membership services including medico-legal advice and support, risk management services and regular newsletters and information.

Medical Insurance Australia is a well funded, national, licensed, regulated insurance company.

Group structure

The Group comprises the following two operating companies, which are collectively referred to as MIGA.

Operating company	Key function
Medical Defence Association of South Australia Limited **(MDASA)** • A doctor-owned, mutual, non-profit organisation • Formed in 1899 • It has no "shareholders", only doctor members	Provides a range of **membership services** to members throughout Australia
Medical Insurance Australia Pty Ltd **(Medical Insurance Australia)** • A wholly owned subsidiary of MDASA • A licensed general insurer • Regulated by the Australian Prudential Regulation Authority (APRA)	Provides **medical indemnity insurance** to the medical profession throughout Australia

Our vision and commitment to members

Our vision is to be recognised as a leading and innovative provider of medical indemnity insurance and services to the medical profession across Australia.

We are committed to:

- Providing security via our medical indemnity insurance products at an affordable premium that represents value
- Offering the benefits of a doctor owned organisation with the prudential management of a licensed and regulated insurer
- Maintaining MIGA as a leading and innovative provider of medical indemnity across Australia
- Maintaining the personal service and individual care that doctors have received and valued from us since 1899.

We strive to be acknowledged as a market leader in terms of:

- The level and quality of our service
- The personal support we provide
- Our skill, professionalism and knowledge
- The breadth of our insurance products, and
- The innovative ideas we develop to better serve and protect our members and insureds.

We have an absolute commitment to strong prudential management, transparency of information and responsible corporate governance and management practices.

We do not aim to be the largest medical indemnity insurer in Australia and history has shown that bigger is not always better.

MIGA's financial strength, depth of expertise and professional approach enable us to deliver our services to our growing membership across Australia.

We strive to be acknowledged as a market leader in terms of the level of our service, the personal support we provide our members, our professionalism, the scope of our policy cover and the innovative ideas we develop to ensure our members are well protected.

MIGA – *Practise with confidence*

Part 1 : Financial Services Guide

a) Introduction

This FSG is provided to assist you in making an informed decision about whether to acquire our financial services. It contains information about who we are, how we can be contacted, what services we are authorised to provide to you, how we and other relevant persons are remunerated and details of how you can make a complaint against us. It contains only general information on the financial services we offer.

When we give you advice that takes into account one or more of your objectives, financial situation and needs, we will give you an SOA. The SOA will set out the advice that you have been given and explain the basis for that advice.

We have summarised within this FSG some very important information which **must** be read before you finalise your insurance and membership arrangements with us.

The terms and conditions of the insurance provided by Medical Insurance Australia, including all applicable exclusions, are fully contained in the Policy wording, Policy Schedule and any applicable endorsements.

This FSG does not form part of the Policy wording.

b) Financial services licence

Medical Insurance Australia is licensed as an Australian Financial Services Licensee pursuant to section 913B of the Corporations Act. Medical Insurance Australia's financial services licence number is 255906.

Medical Insurance Australia is licensed to advise and deal in its own medical indemnity general insurance products.

Medical Insurance Australia is a wholly-owned subsidiary of MDASA and MDASA is an authorised representative (rep number 269222) of Medical Insurance Australia under Medical Insurance Australia's licence. MDASA is authorised to provide these services under a binder arrangement, which means that it acts on behalf of and as the agent of Medical Insurance Australia. In providing these services neither MDASA nor Medical Insurance Australia act on your behalf.

MDASA receives a management fee from Medical Insurance Australia to act on behalf of Medical Insurance Australia in giving financial product advice, providing services and issuing products. The management fee is 93% of expenses incurred by MDASA in the areas of employee expense, property rental and fixed asset depreciation.

Medical Insurance Australia has granted MDASA the authority to distribute this FSG on its behalf. Medical Insurance Australia is liable for the FSG and the information contained within it.

MIGA follows a strict policy of recording in file note form all financial product advice given over the phone. A copy of the documentation in relation to such advice given over the phone will be provided, upon written request, within 5 working days of receipt of the request.

c) What qualifications do our employees have?

We understand that medical indemnity is a complex area and not something that doctors deal with every day. That is why our employees who are involved in the sale of insurance products and services are Tier 2 qualified based on FSR requirements. This enables them to provide you with meaningful advice and assistance when you need it.

d) Selecting the right Category

This Combined FSG and PDS provides information on:

- The services and products offered by MIGA
- Issues you should consider in selecting your Category
- The activities/procedures covered within selected Categories
- The insurance cover provided in each Category.

It is very important all of this information is read before submitting an application for insurance or renewal to ensure you select the right Category and that it provides you with what you require in terms of medical indemnity insurance and membership.

Cover under your medical indemnity insurance is dependent on the Category selected. It is important you select the Category that most accurately describes your specific area of practice and the work you actually undertake (or have undertaken).

Your Category is determined by the following:

- Whether or not you are practising
- The nature of work you undertake
- Your qualifications as registered with the relevant Medical Board
- Whether you are indemnified by your employer for your work (ie employer indemnified)
- Whether you require cover for prescription writing, referrals, ordering pathology, Good Samaritan Acts and/or Gratuitous Advice (if you are no longer practising).

If you are a Medical Student, you need to refer to our Combined FSG and PDS and Student Policy for Medical Students.

e) Dispute resolution

We have in place a formal dispute resolution process, encompassing both internal and external dispute resolution.

Full details are provided in the Section titled 'Dispute Resolution' on page 52.

It is very important that you read the information in this Section to ensure you are fully aware of your rights and our obligations.

Part 2 : Product Disclosure Statement

Section 1 : Membership of MDASA

a) Introduction

You must be a member of MDASA in order to obtain and renew medical indemnity insurance with Medical Insurance Australia.

If medical indemnity insurance is not required you can still be a member of MDASA provided you are a registered medical practitioner or a Medical Student.

You must maintain registration in order to retain your membership of MDASA.

b) Benefits of Membership

Membership of MDASA is governed by the terms and conditions of its Constitution and brings with it the following valuable benefits.

Many of our services and benefits for members are only available via our "members' only" internet access facility.

Membership Benefit	Services available to all members
Bulletins	• Published bi-monthly and also available via the website • Feature articles on risk management, claims management, case studies, key insurance and membership issues, information about MIGA and important medico-legal developments
Long term membership benefit	• After 40 years of continuous financial membership of MDASA, members are entitled to apply for Compound Life Membership • This benefit rewards the loyalty of members to MDASA • Doctors entitled to this benefit receive their annual membership of MDASA at no cost, however, if still practising, they will need to arrange and pay for medical indemnity insurance through Medical Insurance Australia
MIGA Foundation Elective Grants Program (Medical Students only)	• Provides financial assistance to Medical Students who are awarded a grant for undertaking an elective in a developing community
	Additional services only available to insured members
Access to our IRM Program	• Offers a maximum 10% discount off the next year's insurance premium upon full compliance
24 hour emergency support	• Catering for urgent situations where medico-legal advice is required • Provided to all insured members across Australia
Doctors' Support Services	Doctors who are involved in a claim can access the following services: • **Medical Support Service** – provided by one of a group of psychiatrists or psychologists offering professional clinical support • **Peer Support Service** – provided by a group of medical practitioners offering support and understanding
Members' only internet access	Provides members with the following services: **Insurance Services** • On-line completion of Renewal Form • On-line payment • On-line access to Certificates of Insurance and Membership **Medico-legal Services** • On-line lodgement of claims and circumstance notifications **IRM Program** • On-line bookings for workshops • Access to status of IRM points accumulated throughout the year • On-line access to Practice Self Assessments, Questionnaires and Specialty Quizzes, providing doctors with immediate on-line feedback on their input and benchmarking against other participants (continued on next page)

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b) Benefits of Membership – continued

Membership Benefit	Additional services only available to insured members
Risk Management services	Services available on an as needs basis include: • Risk management advice • Member presentations • Practice reviews for members/practices with a higher than average risk profile • Practice visits at member request where specific risk management issues have arisen
Benefits of continuous insurance/membership	• Free or low-cost run-off cover in the following circumstances: – Downgrades in Category * – ROCS Gap Cover * * Refer Section 13 of this PDS
Premium Funding	Offers a payment option via a third party funding arrangement

Section 2 : **Medical Indemnity Insurance Policy**

a) Introduction

Our Medical Indemnity Insurance Policy has been developed to meet the needs of modern medical practice and the unique requirements of our doctor members.

A copy of the Policy will be provided to you with your Quotation or with your renewal package.

It is very important that you read the Policy and familiarise yourself with the scope of cover, terms, conditions and exclusions.

If you are a Medical Student this Policy does not apply to you. Contact us for details of our medical indemnity insurance for Medical Students.

b) Overview of the Policy

The Policy provides cover for:

- Claims, Claim Costs and advisory services arising out of the practice of medicine within the Category you select, and
- Expenses incurred in relation to proceedings, inquests, inquiries, investigations or complaints.

The Policy has been developed recognising that not all members need the full range of cover.

The cover under Division 1 of the Policy is divided into three key areas, as follows:

Section	Cover
Section 1 – Indemnity for claims and/or circumstances arising out of the practice of medicine within the Category	**Provides:** • **Cover for damages and claims for compensation** • **Cover for legal costs incurred in defending claims**
Section 2 – Expenses	**Part A – Specific Expenses** **Provides:** • **Cover for legal costs and expenses incurred in responding to administrative proceedings** Extends to legal costs arising from successfully defending a prosecution or responding to the following inquests, inquiries, investigations or complaints arising from the practice of medicine: • Medical Board, Tribunal or other disciplinary investigations and proceedings • Coronial inquiries, Royal commissions • Health Insurance Act inquiries • Criminal investigations and proceedings • ACCC inquiries • Professional college or association, health service and health care ombudsman inquiries and complaints • Obtaining court orders to protect you and your family from threats to personal safety by patients. (All as detailed in the Policy)
	Part B – General Expenses **Provides:** • Cover for legal costs and expenses arising from other practice issues such as Medicare Australia matters (formerly Health Insurance Commission), employment matters, visiting medical practitioner matters, defamation etc.

You are only entitled to cover if you:

- Are a medical practitioner with current Medical Board registration
- Are a member of MDASA
- Have declared your correct practice information, including Gross Income and Sessions (as defined in Section 12) and paid the premium (including any premium adjustments) and charges in full
- Provide a declaration of Actual Gross Income upon request
- Have been issued a Policy Schedule reflecting the cover provided.

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c) Limit of cover

The limit of cover provided by Medical Insurance Australia is as follows:

- Section 1– $20,000,000 any one claim and in the aggregate in any one Policy Period for claims and associated legal expenses
  - The automatic Policy extension for "Liability for restricting ability to practise" is subject to a sub-limit of $100,000 any one claim and in the aggregate in any one Policy Period
  - The automatic Policy extension for "Loss of Documents" is subject to a sub-limit of $100,000 any one claim and in the aggregate in any one Policy Period
  - The optional Policy extension for "Innocent partner cover" provides cover that is limited by reference to the number of partners in your partnership, up to the aggregate limit of indemnity
- Section 2 – $500,000 any one claim and in the aggregate in any one Policy Period.

The above limits are not cumulative which means that if you have cover for both Sections 1 and 2, then the overall aggregate policy limit is $20,000,000 in any one Policy Period.

If you only have cover for Section 2, then the overall aggregate policy limit is $500,000 in any one Policy Period.

Lower sub-limits may apply in other situations. If other sub-limits do apply they will be detailed in your Quotation and Policy Schedule.

d) Key Policy benefits

Our Policy wording incorporates a range of very important benefits for our members. These include the following:

Benefit	Detail
Who is Insured	Our Policy is structured to respond to the changing nature of doctors' medical practice. It automatically includes as an Insured: • The doctor named in the Policy Schedule • Employees in relation to matters that arise out of their employment whilst they are working in the conduct of the Practice (Some Employees are not included, as outlined below) • A company or trust provided it is owned and controlled by you and provides services for the purpose of your Practice (an Insured Entity) • Medical Students: – Provided they are assigned to the Practice by their university – In relation to matters that arise whilst working in the Practice. Employees who are **not** included as an Insured are: • Employed medical practitioners, as they must arrange their own insurance • Registered Nurse Practitioners* and employed midwives – Unless they are working under your direct control and supervision – If working independently, they must be separately insured • Other employees who charge for and bill in their own name, unless they are working under your direct control and supervision. * *Note – Registered Nurse Practitioners are those who are registered as such by a State or Territory Nurses Board*
Scope of cover for expenses *Expanded for 2007/2008* (table continues on next page)	Under Section 2 of our Policy we provide cover for expenses incurred in relation to proceedings, inquests, inquiries, investigations or complaints. These include: • Medical Board, Tribunal or other disciplinary investigations and proceedings • Coronial inquiries, Royal commissions • Health Insurance Act inquiries • Criminal investigations and proceedings • ACCC inquiries • Professional college or association, health service and health care ombudsman inquiries and complaints • Obtaining court orders to protect you and your family from threats to personal safety by patients • Expenses in defending or pursuing complaints or proceedings in relation to a contract as a Visiting Medical Officer. In terms of allegations re inappropriate practice, transmission of disease, intoxication etc, cover is provided to assist with the defence of these matters, ie we take an innocent until proven guilty approach. This provides very important protection in the event of such allegations.

Benefit	Detail
For doctors who change their area of practice to a lower risk Category	• Subject to a review of claims and practice history, no run-off premium is payable if you change to a Category that MIGA defines as a lower area of a risk, provided you: – Have had 2 or more years of continuous insurance with Medical Insurance Australia, and – Continue to be insured with Medical Insurance Australia in a practising Category • An additional run-off premium may apply to you if you: – Have not reached your 2 year qualifying period, or – Change your arrangements with us to Employer Indemnified, or – No longer require cover for treatment provided to public patients, if previously in a specific Category that covers public work.
Treatment of public patients	Our Policy automatically provides cover for claims that arise out of the treatment of public patients, except where: • You are otherwise indemnified for such claims, or • You are covered in a Category that excludes or does not extend to cover claims arising out of the treatment of public patients (see 'g' on page 10).

e) Automatic Policy extensions

Our Policy automatically provides some important extensions to cover, as follows:

Benefit	Detail
Good Samaritan Acts – Worldwide	Covers you for Good Samaritan Acts anywhere in the world including USA and Canada.
Good Samaritan Acts for Employees in Australia and overseas	Employees are automatically covered for Good Samaritan Acts which occur **in Australia** in the course of employment. Employees are also covered for Good Samaritan Acts **overseas** which occur in the course of their employment by you or an Insured Entity, where you and the Insured Entity are covered for limited private practice undertaken overseas (as defined in the Policy).
Vicarious liability for other Insureds	Covers you and an Insured Entity for legal liability in respect of which you are vicariously liable for acts, errors or omissions committed or alleged to have been committed by other Insureds.
Vicarious liability for employed medical practitioners	Covers you and an Insured Entity for vicarious liability in relation to any act, error or omission committed or alleged to have been committed by an employed medical practitioner in the course of your Practice. Cover is subject to: • The employed medical practitioner being registered and employed by you or an Insured Entity • The employed medical practitioner providing health care treatment, advice or service in the same Category as you, or in a lower risk Category as determined by Medical Insurance Australia • You having obtained written evidence of current insurance covering the employed medical practitioner each year.
Vicarious liability for Contractors **New** *for 2007/2008* (table continues on next page)	Covers you and an Insured Entity for vicarious liability in relation to any act, error or omission committed or alleged to have been committed by a 'Contractor', being a: • registered medical practitioner • registered nurse • Nurse Practitioner • midwife contracted to provide services in the course of your Practice. Cover is subject to: • The Contractor providing services as a contractor, which are charged for and billed by you or an Insured Entity • The employed medical practitioner providing health care treatment, advice or service in the same Category as you, or in a lower risk Category as determined by Medical Insurance Australia • You having obtained written evidence of current insurance covering the Contractor for the whole period of their services.

e) Automatic Policy extensions – continued

Benefit	Detail
Vicarious liability for supervision, training or mentoring *Expanded for 2007/2008*	Covers you for vicarious liability for any act, error or omission committed or alleged to have been committed by a non-employed: • registered medical practitioner • registered nurse • Nurse Practitioner • midwife under your direct supervision, training or mentoring. Cover is subject to the supervised, trained or mentored person: • not being employed by you or an Insured Entity • being required to be directly supervised, trained or mentored by you for the purpose of obtaining, retaining or regaining a recognised professional qualification, award or registration, and • providing health care treatment, advice or service in the same Category as you.
Vicarious liability for locums	Covers you for vicarious liability in relation to any act, error or omission committed or alleged to have been committed by a locum (as defined in the Policy) practising instead of you. Cover is subject to: • The locum being engaged as a contractor (not as an employee) under a written agreement • You having obtained written evidence of current insurance covering the locum for the whole period of their services. • The term of the locum appointment not being for more than: – 12 weeks in any 12 month period, and – 6 continuous weeks in any case, and • The locum providing health care treatment, advice or service in the same Category as you If cover is required for locums contracted beyond the above timeframes, we can assist, but you need to notify us as this additional cover is not automatic.
Practice outside the Commonwealth of Australia *Expanded for 2007/2008*	Covers you for practice overseas, **excluding** USA, Canada and a jurisdiction in which the laws of the USA or Canada apply, provided: • the event occurs on or after 1 July 2005; • the period of overseas practice does not exceed 90 continuous days or 120 days in any 12 month period. • if the event occurs in the UK or Ireland, it must have occurred after 1 July 2007 and must not relate to practice in orthopaedics, neurosurgery, cosmetics or obstetrics.
Volunteer Practice	Covers you for claims arising out of work as an unpaid volunteer in the course of any amateur sporting activity, school or community based event, charity work, aid program or disaster response work.
Liability for restricting ability to practise	Covers you for claims arising in the course of supervising, training or mentoring a registered medical practitioner: • Who was required to be directly supervised, trained or mentored for the purpose of obtaining, retaining or regaining a recognised professional medical qualification, award or registration • Where the allegation is that you have restricted the ability of the registered medical practitioner to provide health care treatment advice or service in the future Cover under this automatic extension is subject to a sub-limit of $100,000 and other conditions as detailed in the Policy.
Medical research and clinical trials **New** *for 2007/2008*	Covers you (and any employee acting under your supervision) for your role in medical research or a clinical trial if: • your role commenced on or after 1 July 2007 • it is approved by a registered ethics committee (registered with the NHMRC) and it is conducted as required by that committee • it is in a field in which you are qualified • if it is sponsored, you must have an indemnity from the sponsor and cover is only provided for your liability in excess of that indemnity
Loss of Documents	Covers you and an Insured Entity for the reasonable cost of replacing or restoring documents (as defined) in your possession if they are destroyed, damaged, lost or mislaid. Cover under this automatic extension is subject to a sub-limit of $100,000 and other conditions as detailed in the Policy.

Benefit	Detail
ROCS Gap Cover *Automatically provided to all insured doctors*	ROCS Gap Cover provides cover for you if you: • permanently cease private practice, and • are not yet eligible for ROCS, ie you have not yet reached age 65, and • have 8 years of continuous insurance/membership with us (excluding insurance as a Medical Student) We provide run-off cover to eligible doctors for up to 3 years on an annually renewable basis until they are eligible for ROCS Any additional premium is capped at $50 per annum, exclusive of statutory charges.

f) Optional Policy extensions

The following extensions to cover are available. If you require any of these extensions please indicate this on your Application or Renewal Form or call our Client Services Department.

If any of these extensions to cover are granted they will be noted on your Quotation and Policy Schedules and a premium loading may apply.

Extension to cover	Details
Trainee doctors and registrars as Insureds	There may be circumstances where you require a trainee doctor/registrar, who you employ, to be included as an insured party under the Policy. Cover can be extended to include employed trainee doctors/registrars as an insured, provided: • They are employed by you or the Insured Entity established for your practice • Their work is undertaken and billed on behalf of your practice • They are working under an approved and accredited training program. Note: In some States the trainee doctor/registrar must maintain their own insurance cover as a requirement of registration.
Innocent partner cover	The Policy can be extended to cover you for the acts of partners who provide health care treatment, advice or service in the conduct of a partnership and with whom you are jointly and severally liable solely by reason of the partnership. Cover is subject to: • The partnership being a partnership within the meaning of the Partnership Act, • You having obtained written evidence of current insurance covering your partners each year. Cover under this extension is limited to your total liability divided by the number of partners in the partnership, or the aggregate limit of indemnity, whichever is lesser.
Practice outside the Commonwealth of Australia *(beyond the automatic cover)*	We can consider providing cover beyond the automatic extension, for example for practice overseas that exceeds the time limits in the automatic extension. **No cover can be granted for practice in United States of America or Canada or in jurisdictions to which the laws of United States of America or Canada apply.**

g) Cover for treatment of public patients

Our Policy covers claims that arise out of the treatment of public patients, subject to its terms and conditions, except where:

- You are otherwise indemnified for such claims, or
- You are insured in a Category that excludes or does not extend to cover claims arising out of the treatment of public patients (see over).

If your practice involves the treatment of public patients, it is important that you clarify whether you are indemnified by any other source (including but not limited to a State Government or your employer) for claims that arise out of such work.

If you are indemnified by any other source (including but not limited to a State Government or your employer) for the treatment of public patients, you will not be insured under our Policy for any claims that arise out of such treatment (Refer Policy exclusion 5.27).

If you require cover for the treatment of public patients, it is important that you:

- Check your Category to make sure it does not exclude cover for the treatment of public patients:
  - Some Categories of practice exclude cover for treatment of public patients eg GP Rural – Private only in SA (see over)
  - If your Category excludes cover for the treatment of public patients, call us to change your Category to one that meets your specific requirements
- Include your Gross Income from public work in your declaration of Gross Income to us.

(continues on next page)

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g) Cover for treatment of public patients – continued

Categories that specifically exclude cover for treatment of public patients

The cover provided for treatment of public patients is determined by the Category that you select.

Some Categories are tailored specifically for the needs of doctors who must have cover for the treatment of public patients.

The Categories that ***specifically exclude*** cover for treatment of public patients are:

- GP Rural – Private only in SA and Obstetrics Private only – refer Section 5
- Interns – refer Section 7
- Employer Indemnified – refer Section 8.

If you select any of the above Categories:

- No cover is provided under Division 1 Section 1 of the Policy for claims for compensation arising from the treatment of public patients
- Cover is provided under Division 1 Section 2 of the Policy for Expenses incurred in relation to inquiries, investigations etc in relation to the treatment of public patients:
  – To the extent you are not otherwise indemnified
  – Subject to specific limitations in some Categories.

    For example, for the Category of "Staff Specialists with no private practice – Medical Board, tribunal and coronial cover only" cover under Division 1 Section 2 Part A of the Policy is restricted solely to inquiries etc by a Medical Board, tribunal or coroner.

In other Categories, the scope of cover for treatment of public patients is determined by the specific activities covered within that Category.

For example, if you select "Medical Academic" you are not insured for any claims that arise from clinical patient contact of any patients, whether they are public or private.

If you provide treatment to public patients and you are not clear on the cover provided by us, please contact our Client Services Department to clarify your entitlements.

Information on cover for public patients

In our Application Form and Renewal Form we ask whether you require cover for the treatment of public patients. This is because we require data on the proportion of our insured doctors who need this cover.

If you answer "yes", it is important that you:

- Make sure the Gross Income from this work is included in your estimated Gross Income
- Advise us on your Form what proportion of your total Income relates to this work
- Check cover for treatment of public patients is not specifically excluded under the Category that you have selected.

If you answer "no" you will still be entitled to indemnity for claims arising from the treatment of public patients, provided:

- You are not otherwise entitled to indemnity for such work
- You have declared income for such work in your estimate of Gross Income; and
- It is not excluded by the specific Category that you have selected.

h) Good Samaritan Acts and Gratuitous Advice

Cover for Good Samaritan Acts and Gratuitous Advice is automatically included within Division 1 of the Policy, provided you have current insurance when the claim is made and the incident occurred after any relevant Retroactive Date in the Policy.

Good Samaritan Acts

These are defined as acts where a doctor provides medical treatment or advice in an emergency situation (e.g. at the scene of an accident) subject to the following:

- It must be for an unforeseen emergency situation
- There is no other indemnity or immunity that applies (e.g. via legislation, from the State Government, your employer or any other party)
- There is no request by you for payment or reward for the service and no ongoing care is provided.

Gratuitous Advice

Cover for Gratuitous Advice is automatically included within Division 1 of the Policy where such advice is provided fortuitously and outside of commercial medical practice, subject to the following:

- You are registered with the relevant Medical Board at the time the advice is given
- There is no payment or reward for the advice
- No cover is provided for prescriptions unless you have insurance for prescription writing with Medical Insurance Australia.

If you are only insured for Good Samaritan Acts and Gratuitous Advice no cover is provided in circumstances where you undertake voluntary medical work or you work on a pro-bono basis.

If you work on a voluntary or a pro-bono basis you must select a practice Category as outlined in this PDS.

i) Your Policy Schedule and Certificate of Insurance and Membership

Once an Application or Renewal Form has been accepted and full payment received by us we will forward a Policy Schedule and Certificate of Insurance and Membership to you.

If your existing insurance Policy with Medical Insurance Australia is subject to any Special Conditions or Endorsements, they will continue to apply for the 2007/2008 renewal, unless we agree that they are no longer relevant.

Full details of all such Special Conditions or Endorsements will be recorded on your Quotation and Policy Schedule.

j) What the Policy does not cover

The Policy does not provide cover in certain instances.

These are set out in the exclusions in the Policy wording but may also be contained within conditions or endorsements.

It is very important you read these exclusions, conditions and additional endorsements and contact us if you have any questions about them.

In particular, you should carefully read the following exclusion (Refer Policy exclusion 5.29), which is new to the Policy this year:

- liability arising our of your conduct as a publisher or author, other than in respect of published health care advice or health care articles or arising out of presentations by you or information provided directly by you to a person in the course of your Practice.

k) Notification of claims and circumstances

The Policy requires that you provide written notice of any claim made against you during the Policy Period, which is the period of insurance noted on your Policy Schedule.

This involves you advising us of the full details of an alleged incident and any subsequent claim as soon as you become aware of it and in any event prior to the expiry of the Policy.

If you do not provide the required notice during the Policy Period then you may not be covered in respect of that claim. It is very important you ensure we are advised as soon as you become aware of a claim and that you ensure this notification is made to us before the Policy expires.

In addition to this, it is important that you note the following in relation to the notification of circumstances during the Policy Period.

The Insurance Contracts Act provides that if, after the end of the Policy Period, a claim is made against you which arises from facts that you notified to us:

- in writing;
- as soon as reasonably practicable after you became aware of them; and
- before the end of the Policy Period

then we will provide cover in accordance with the terms and conditions of the Policy in respect of the claim against you, even if the claim was made against you after the end of the Policy Period.

We therefore encourage you to notify us as soon as you become aware of any circumstance or incident which has the potential to lead to a claim, whether or not a formal claim is made against you.

Note: The Policy does not provide cover for any claims of which you were aware prior to effecting medical indemnity insurance with us. In addition no cover is provided in relation to any circumstances of which you were aware prior to effecting medical indemnity insurance with us with the potential to give rise to a claim in the future.

If you are effecting medical indemnity insurance with us for the first time we recommend you ensure that you report any claims or circumstances to your current insurer prior to expiry of your current insurance.

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Section 3 : Claims Made Insurance and Retroactive Cover

a) Claims made insurance

The Policy offered by Medical Insurance Australia is on a claims made basis. This means the Policy will respond to claims made against you and notified to us in writing during the Policy Period, subject to the Policy terms and conditions.

The Policy will not provide cover in relation to:

- Events that occurred prior to the Retroactive Date specified on the Policy Schedule
- Claims first made against you or claims first notified to Medical Insurance Australia after the expiry of the Policy Period even though the event giving rise to the claim may have occurred during the Policy Period
- Claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy or indemnity arrangement
- Claims made, threatened or intimated against you prior to the commencement of the Policy Period
- Facts or circumstances of which you first became aware prior to the Policy Period, and which you knew or ought reasonably to have known had the potential to give rise to a claim under the Policy
- Claims arising out of circumstances noted on the Application or Renewal Form for the current Policy Period or on any previous Application or Renewal Form
- Any matter contained in the Policy exclusions.

However, where you give notice in writing to us of any facts that might give rise to a claim against you as soon as reasonably practicable after you become aware of those facts but before the expiry of the Policy Period, the Policy will, subject to the terms and conditions, cover you notwithstanding that a claim is only made after the expiry of the Policy Period.

b) Retroactive cover

Retroactive cover and your Retroactive Date

Medical indemnity insurance provided by Medical Insurance Australia covers claims made during the Policy Period for incidents that occur after your Retroactive Date and before the end of the Policy Period. It is important you note the following:

- Your Retroactive Date is recorded in your Quotation and Policy Schedules
- You are not covered for any claim made against you during the currency of your medical indemnity insurance relating to an incident or circumstance that occurred prior to the agreed Retroactive Date
- If you were a member of MDASA prior to 1 July 2000 the Retroactive Date on your insurance Policy will be 1 July 2000. This means the insurance will cover claims made during the Policy Period for incidents that occurred on or after this date, subject to the Policy terms and conditions
- If you were a member of MDASA prior to 1 July 2000, your current insurance and membership arrangements do not affect any prior claims incurred entitlements you have with MDASA
- Different Retroactive Dates may apply in relation to Category upgrades and other changes to cover. Please refer to any Special Conditions in your Quotation and Policy Schedules.

Do you require a change to your Retroactive Date?

It is important to consider whether you require any changes to your retroactive cover.

The Medical Indemnity (Prudential Supervision and Product Standards) Act requires that we make an offer to you:

- before you enter into the Policy;
- whenever you renew the Policy; and
- before the Policy comes into effect

for retroactive cover for claims that may be made against you during the Policy Period in relation to your otherwise uncovered prior incidents.

As a guide, you may require retroactive cover if any of the following circumstances apply:

- Your claims incurred membership with an MDO was not continuous (ie you had gaps in your membership)
- You had claims incurred membership with an MDO but you were not a financial member of the MDO at the time you resigned or left. You may not have been a financial member for example, if you did not pay a call, had outstanding subscriptions or you did not resign in accordance with your obligations under the Constitution of the MDO
- You had claims made membership with your prior MDO and did not purchase run-off cover at the time you resigned or left
- You purchased run-off cover at the time you resigned or left your prior MDO on an annually renewable basis, which you have not maintained
- You had a prior period of claims made insurance with an insurer for which you did not effect and maintain run-off cover
- You practised without membership of an MDO and/or without insurance (ie you were self insured)
- The nature of your practice has changed in the past but you did not inform your prior MDO or insurer of all relevant changes.

In making you an offer for retroactive cover we will rely on you to advise us:

- if you require retroactive cover;
- the period(s) for which you believe you were uncovered; and
- the nature of your practice during the period(s) you believe you were uncovered.

If at any time you believe your claims made Retroactive Date may not be appropriate, (because you have become aware that you may have an uncovered prior period that

you did not take into account at the time of effecting or renewing your medical indemnity insurance) please contact us so that we can review your requirements for retroactive cover.

If you advise us of an uncovered prior period during the Policy Period we will provide you with an offer to amend your retroactive cover mid term.

c) Calculation of premiums

The insurance premium you pay is determined by a number of factors including the following:

- The nature of your practice
- The State(s) in which you practice
- Your declared Gross Income and/or Sessions
- Any discount you are entitled to for participation in the IRM Program
- The period of retroactive cover you require
- Your claims or loss history, and
- Any extensions you require to your cover.

Premiums are determined taking into account independent actuarial advice which includes an assessment of historical and expected future claims costs for MIGA.

An extensive range of information is taken into account to determine both our overall premium pool and premiums at Category level, including the following:

- MIGA's claims experience
- Industry experience
- MIGA's understanding of differences in risk between each Category
- Feedback from reinsurers on their experience of relativity of risk between Categories, and
- Industry benchmarking.

In addition, the following costs are incorporated in our premium pool:

- Expected claims costs
- Expected operating costs
- The cost of buying reinsurance in order to protect us, and
- The capital (surplus) required to meet Medical Insurance Australia's prudential and regulatory requirements.

d) Claims made premiums – Why they may increase over time

One of the reasons that a claims made premium may increase each year that the insurance cover is continuous, is that the Insured has not yet reached what is called a 'mature risk' (generally after five years).

In the early years, the premium is less than that which would be charged for claims incurred indemnity, because it only needs to cover claims that are made in the year for incidents that occurred after the agreed Retroactive Date (which is generally the date you first arranged insurance with Medical Insurance Australia or the date you first had claims made indemnity).

As time progresses, the annual premium needs to cover both incidents which occur and claims made in the year, plus claims that are made in the year for incidents that may have occurred in prior years.

In year 1, the doctor effects insurance and only pays for the current year, unless Medical Insurance Australia has agreed to provide indemnity for incidents that may have occurred in the past (retroactive indemnity).

From year 2 onwards, the premium must steadily increase to reflect that it includes indemnity for incidents that may have occurred in prior years, but which are not reported until the current year. After a period of time, the indemnity in the current year includes incidents that may have occurred in any of the prior four years. Generally, by this stage the premium rate is a 'mature rate'.

If you are effecting medical indemnity insurance with us for the first time with retroactive cover for five or more years prior to the inception of cover, the premium rate charged is mature and will not increase in later years for the reason of maturity.

Section 4 : **Specialist Private Practice**

a) Introduction

There are a range of Categories that apply to Specialists and they are listed in the table below.

The Category you should select is determined by your qualifications and/or the nature of the work you undertake.

If you practise in more than one Category, you will need to record the percentage of practice in each Category on your Application or Renewal Form. If you are performing procedures not normally associated with your Category, please contact us and we will assess your circumstances individually.

If you undertake or intend to undertake any cosmetic procedures you will need to be in a Category that provides cover for such cosmetic procedures. Please refer to the cosmetic procedure definition below.

If you select a Specialist Category, cover is provided under Division 1 Sections 1 and 2 of the Policy but only in relation to the work you undertake as per the Specialist Category you select.

Cover is also provided under Division 1 Sections 1 and 2 of the Policy for claims arising out of Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

Please note you are not covered under either Section 1 or 2 of the Policy for matters that arise from practice undertaken under a rights of private practice agreement.

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

Notes

In considering your Category please note the following:

1. **Cosmetic procedure** means any procedure directed towards the preservation, correction or improvement of appearance and/or where there are no underlying medical, clinical or pathological reasons for undertaking such procedures
2. **Liposuction** of more than 500mls of aspirate in total must be performed in an accredited day surgery or operating theatre (refer page 17)
3. **No cover is provided for fat transfers to breasts.**

b) Category listing

If your Category is not listed below please contact us.

For those Categories marked with an *, please refer to the additional information detailed in this PDS.

Category	
Allergy	
Anaesthesia	
Cardiac Thoracic Surgery	
Cardiology – Non Interventional *	(refer page 16)
Cardiology – Interventional *	(refer page 16)
Cytology	
Dermatology *	(refer page 16)
Dermatology Cosmetic *	(refer page 16)
Emergency Medicine	
Endocrinology	
Endocrine Surgery	
Gastroenterology – Non Procedural	
Gastroenterology – Procedural	
General Medicine	
General Surgery *	(refer page 16)
General Surgery – Cosmetic *	(refer page 16)
Genetics	
Geriatric Medicine	
Gynaecology	
Haematology	
Hair Transplantation	
Immunology	
Infectious Diseases	
Intensive Care – Excluding Neonatal	
Maxillo-facial Surgery – Excluding Cosmetic	
Neonatal Intensive Care	
Nephrology	
Neurology	
Neurosurgery	
Nuclear Medicine	
Obstetrics*	(refer page 16)
Occupational Medicine	
Oncology	
Ophthalmology – Non Procedural – Office Practice Only *	(refer page 16)
Ophthalmology – Procedural *	(refer page 16)
Ophthalmology – Cosmetic *	(refer page 16)
Orthopaedic Surgery	
Otolaryngology Head and Neck Surgery – Excluding Cosmetic	
Otolaryngology Head and Neck Surgery – Including Cosmetic	
Paediatric Medicine – Excluding Neonatal Intensive Care	
Paediatric Surgery	
Palliative Care	
Pathology and/or Laboratory Haematology	
Pharmacology	
Plastic, Reconstructive and/or Cosmetic Surgery *	(refer page 16)
Psychiatry	
Public Health & Preventative Medicine	
Radiology *	(refer page 16)
Radiation Oncology	
Radiotherapy	
Rehabilitation Medicine	
Respiratory Medicine	
Rheumatology	
Surgical Specialties – Office Practice Only *	(refer page 17)
Surgical Assistance Only – Specialists *	(refer page 17)
Surgical Assistance Only – Other *	(refer page 17)
Urology	
Vascular Surgery	

Registrars undertaking training as Specialists in private practice (ie outside of the public hospital system) should select the Category for "Registrar Undertaking training as a Specialist in private practice" on the Application or Renewal Form (refer Other Categories Section 9 page 30).

c) Cardiology – Non Interventional

This Category is for activities normally undertaken by Non Interventional Cardiologists and includes:

- Cardiography
- Cardioversion
- Cardiac ultrasound
- Stress testing – with available resuscitation support.

d) Cardiology – Interventional

This Category is for activities normally undertaken by Interventional Cardiologists and includes:

- Angiograms
- Angioplasty
- Electrophysiology studies
- Insertion of pacemakers
- **Plus** activities listed under Cardiology – Non Interventional.

e) Dermatology

This Category is for activities normally undertaken by Dermatologists and includes:

- Botulinum toxin injections and dermal fillers
- Chemical peels – superficial epidermal only, such as glycocholic acid peels
- Laser therapy, excluding laser resurfacing
- MOHS surgery
- Microsclerotherapy for facial lesions
- Sclerotherapy.

Excluding procedures listed in Dermatology Cosmetic.

f) Dermatology Cosmetic

(refer Notes on page 15)

This Category is for activities normally undertaken by Dermatologists and includes the following cosmetic activities:

- Dermabrasion
- Grafts
- Laser resurfacing
- Liposuction
- Major flaps
- Medium and deep chemical peels (dermal peels using agents such as phenol and trichloroacetic acid)
- **Plus** activities listed under Dermatology.

g) General Surgery

This Category is for activities normally undertaken by General Surgeons and includes:

- Breast reconstruction following cancer surgery.

Excluding plastic and cosmetic procedures as defined under Note 1 on page 15.

h) General Surgery – Cosmetic and Plastic, Reconstructive and/or Cosmetic Surgery

(refer Notes on page 15)

The following activities are covered under this Category:

- Abdominoplasty
- Blepharoplasty
- Cosmetic rhinoplasty
- Dermabrasion
- Dermal fillers
- Face lift
- Labiaplasty
- Laser resurfacing
- Liposuction/lipoplasty
- Maxillo-facial surgery
- Medium and deep chemical peels – dermal peels using agents such as phenol and trichloroacetic acid
- Meloplasty
- Otoplasty
- Penile extension/thickening
- Reduction/augmentation mammoplasty.

i) Obstetrics

This Category is for activities normally undertaken by Obstetricians and includes:

- Cordocentesis
- Decompression of foetal abdominal cavities
- Foetal blood transfusions.

j) Ophthalmology – Non Procedural – Office Practice Only

This Category is for Non Procedural Ophthalmologists who only perform the following activities:

- Cautery/removal of cysts of the eyelids
- Electrolysis of lash follicles
- Incision and curettage of tarsal cysts
- Lavage (syringing, probing) of tear passages
- Pterygium and removal of corneal or scleral foreign bodies
- Punctum snip.

k) Ophthalmology – Procedural

This Category is for activities normally undertaken by Procedural Ophthalmologists and includes:

- Laser surgery for refractive error subject to Gross Income from such procedures not exceeding 20% of annual Gross Income.

Excluding cosmetic procedures as defined under Note 1 on page 15.

l) Ophthalmology – Cosmetic

(refer Notes on page 15)

This Category is for activities normally undertaken by Procedural Ophthalmologists and includes:

- Cosmetic procedures
- Laser surgery for refractive error exceeding 20% of annual Gross Income.

m) Radiology

This Category is for activities normally undertaken by Radiologists and includes:

- Up to 3 employed medical technologists (eg radiographers, sonographers etc) per Radiologist
- If the number of employed medical technologists exceeds 3 full time equivalent per Radiologist please contact us.

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n) Surgical Specialties – Office Practice Only

This Category is for Surgeons who do not perform any surgery but are still practising as a consulting Specialist.

o) Surgical Assistance Only – Specialists

This Category is for Specialists who do not perform any surgery but undertake surgical assistance only. The following must be noted:

- You are not covered in this Category if you are working in any capacity as the primary or supervising surgeon. If you are the primary or supervising surgeon, you need to select the appropriate Specialist Category on your Application or Renewal Form
- You are not covered if you undertake any surgery either during surgery (whether in the presence of the primary or supervising surgeon or not) or on behalf of the primary or supervising surgeon
- This Category includes cover for prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously.

p) Surgical Assistance Only – Other

This Category is for overseas visiting doctors or non-specialists who do not perform any surgery but undertake surgical assistance and/or observational roles only. The following must be noted:

- You are not covered in this Category if you are working in any capacity as the primary or supervising surgeon. If you are the primary or supervising surgeon, you need to select the appropriate Specialist Category on your Application or Renewal Form
- You are not covered in this Category if you undertake any surgery either during surgery (whether in the presence of the primary or supervising surgeon or not) or on behalf of the primary or supervising surgeon
- This Category includes cover for prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously.

q) Special Condition – Liposuction

If you undertake liposuction procedures you must be insured in one of the following Specialist Categories:

- Dermatology Cosmetic
- General Surgery – Cosmetic, or
- Plastic, Reconstructive and/or Cosmetic Surgery.

It is also important you note the following conditions that apply to liposuction procedures:

- No cover is provided for claims arising out of liposuction of over 500mls of aspirate in total performed in a non-accredited day surgery or operating theatre
- If you require insurance for liposuction of more than 500mls of aspirate in total, where the procedure will not be undertaken in an accredited day surgery or operating theatre, the following special conditions apply:
  - you need to confirm in writing to us prior to renewal on 30 June 2007 that you will commit to your day surgery achieving accreditation within the next 12 months, and
  - a loading will apply to your insurance premium for the 2007/2008 year
- If you have an extension in the 2006/2007 Policy Period for undertaking liposuction procedures of more than 500mls of aspirate in total in a non-accredited day surgery or operating theatre, you must confirm in writing to us that accreditation has been (or will be) achieved, in accordance with the terms and conditions of your specific extension, but in any case, no later than 30 June 2007
  - If accreditation has not been achieved by this date, then no cover is provided for liposuction procedures of more than 500mls of aspirate in total undertaken in a non-accredited day surgery or operating theatre on or after 1 July 2007
  - Run-off cover will be provided in this situation for claims made on or after 1 July 2007 that relate to liposuction procedures of more than 500mls of aspirate in total undertaken in a non-accredited day surgery or operating theatre prior to 1 July 2007 and after your Retroactive Date
  - No further extensions will be granted to allow more time for accreditation other than in exceptional circumstances.

Section 5 : General Practice

a) Introduction

There are a range of Categories available for General Practitioners as follows:

- General Practice (including rural other than in SA)
  - GP Non Procedural
  - GP Procedural
  - GP Obstetrics
- GP Rural – for SA doctors only
- GP Registrar.

The Category you should select is determined by your qualifications and/or the nature of the work you undertake.

If your work is not that of a General Practitioner as outlined in one of the categories for General Practitioners and/or your Gross Income is not predominantly derived from traditional General Practice, you need to select an alternative and appropriate Category applicable to the work you are undertaking.

Please note the above Categories do not cover cosmetic procedures as these are covered in the group of Categories called Cosmetic Medical Practice.

Cosmetic procedure means any procedure directed towards the preservation, correction or improvement of appearance and/or where there are no underlying medical, clinical or pathological reasons for undertaking such procedures.

Please refer to Section 6 of this PDS for details of the Categories available for Cosmetic Medical Practice.

If you select a General Practice Category, cover is provided under Division 1 Sections 1 and 2 of the Policy, but only in relation to the work you undertake as per the General Practice Category you select.

Cover is also provided under Division 1 Sections 1 and 2 of the Policy for claims arising out of Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

If you undertake a particular clinical activity and it is not clear if it is a procedural or non procedural activity or which Category will apply, please contact us for clarification.

b) Category listing

General Practice

Category	Includes	Excludes
GP Non Procedural	• All Non Procedural activities undertaken by GPs as listed on pages 19 and 20	• GP Procedural • GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice
GP Procedural	• All GP Non Procedural activities **plus** Procedural activities as listed on pages 19 and 20	• GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice
GP Obstetrics	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20, **plus** Obstetrics	• Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) • Cosmetic Medical Practice

GP Rural – SA only

If you are a GP practising in rural SA, it is important you select one of the four following Categories.

If you require cover as a GP in rural SA for the treatment of public patients, it is important you select one of the two Categories that cover this. If you do not select a Category that covers you for treatment of public patients, you will not be insured for claims arising out of treatment of public patients.

If you are a rural GP located anywhere in Australia other than SA, you must select one of the options listed under General Practice (see above).

('GP Rural – SA only' continued on next page)

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b) Category listing – continued

Category	Includes	Excludes
GP Rural – Private Only (SA Only)	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 undertaken in rural areas • Plus care provided to Private In-patients	• GP Obstetrics • Laparoscopic procedures • Public In-patients • Cosmetic Medical Practice
GP Rural – Public and Private (SA Only)	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 undertaken in rural areas • Plus care provided to Public and Private In-patients	• GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice
GP Rural – Obstetrics Private Only (SA Only)	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 undertaken in rural areas • Plus care provided to Private In-patients • Plus Obstetrics	• Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) • Public In-patients • Cosmetic Medical Practice
GP Rural – Obstetrics Public & Private (SA Only)	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 undertaken in rural areas • Plus care provided to Public and Private In-patients • Plus Obstetrics	• Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) • Cosmetic Medical Practice

GP Registrar

Category	Includes	Excludes
GP – Registrar Non Procedural / Procedural	This Category provides cover equivalent to GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 and is applicable to all GP Registrars in an accredited GP Registrar training program, whether in a hospital or in private practice	• GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice
GP – Registrar Procedural including Obstetrics	This Category provides cover equivalent to GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 (plus Obstetrics) and is applicable to all GP Registrars in an accredited GP Registrar training program, whether in a hospital or in private practice	• Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) • Cosmetic Medical Practice

c) GP Non Procedural

If you select GP Non Procedural then cover is included for non procedural activities normally undertaken by GPs **including**:

- Accident and emergency treatment in hospitals
- Acupuncture
- Allergy testing – Desensitisation
- Anaesthesia – Local anaesthesia only including digital block (no other forms of anaesthesia or sedation for procedures)
- Aspiration of blood
- Blood transfusions
- Cryotherapy for treatment of superficial skin lesions
- Dislocated joints requiring immediate treatment in surgery setting
- Exercise ECG with appropriate resuscitation and back up facilities
- Flaps – Small local flaps and grafts excluding hair transplant flaps
- Genital warts removal
- Haemorrhoid treatments – Banding, injections and ligation
- Hormonal implants
- Hypnotherapy
- Immunisation
- Implanon – Insertion and removal, provided you have completed a training course which was run or approved by the manufacturer Organon and you adhere to the RACGP Guidelines (checklist and consent form) for insertion and removal of Implanon
- Impotence treatments – Assessment, intra-cavenosal injections
- Intra articular steroid injection
- Intravenous injection and venipuncture
- IUCD insertion – Provided you have completed a training program comprising theoretical, clinical and practical components, which is accredited by the RACGP for QA & CPD
- IUCD removal
- Low level hospital admissions
- Lumbar puncture – Where not used as part of epidural, myelogram or cytoxis
- Obstetrics Shared Care (including Ante-natal Care) – As per Shared Care Guidelines (refer pages 20 and 21)

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- Orthopaedics – Fractures requiring no reduction or anaesthesia
- Own simple limb x-rays – Excluding hips and shoulders
- Pathology – Desktop only
- Post mortems
- Prescribing of 'Morning After' pill
- Removal of foreign bodies from eye under local anaesthesia
- Removal of sebaceous cysts
- Removal of small skin lesions
- Repair of superficial skin lacerations with closure by primary suture
- Rigid sigmoidoscopy without biopsy
- Skin grafts – Split skin and full thickness less than 3 centimetres
- Sporting team/events coverage
- Suprapubic bladder tap
- Surgical assistance
- TENS treatment – Electrical nerve stimulator
- Wedge resection of toe nail, excluding complete ablation of the nail bed.

Excluding GP Procedural activities, GP Obstetrics, laparoscopic procedures and procedures listed under Cosmetic Medical Practice Categories.

d) GP Procedural

If you select GP Procedural then cover is included for all GP Non Procedural activities **plus**:

- Anaesthetics – General and regional
- Arterial line insertion
- Breast biopsy
- Bronchoscopy
- Chest tube/drain insertion
- Circumcision
- Colposcopy
- Compartment pressure testing
- Dilation and curettage
- Drainage of priapism
- Egg pickup
- Endometrial biopsy using pipelle aspirator, gynoscan etc
- Endoscopy – Where GP is accredited
- Fine needle aspiration biopsy
- Implanon insertion and removal – If you have not completed a training program which was run or approved by the manufacturer Organon
- IUCD insertion – If you have not completed a training program comprising theoretical, clinical and practical components, which is accredited by the RACGP for QA & CPD
- Limited emergency ultrasounds
- Nerve blocks proximal to wrist and ankle
- Neonatal care up to 72 hours after birth
- Neuromyotomy – Non procedural spinal nerve section
- Orthopaedics including reduction of simple fractures
- Partial or total ablation of nail growth plate
- Pathology
- Spinal manipulation under general anaesthetic
- Surgery – For which you are appropriately trained and accredited to undertake
- Termination of pregnancy up to 20 weeks
- Vasectomy
- X-Rays referred by other practitioners from outside practice.

Excluding GP Obstetrics, laparoscopic procedures and procedures listed under Cosmetic Medical Practice Categories.

e) Special Conditions – Shared Care and Ante-natal Care

All GPs involved in obstetric care must note the following Shared Care and Ante-natal Care Guidelines which applied from 1 July 2006.

GP – Shared Care Guidelines

GPs who treat obstetric cases (including the provision of Ante-natal Care) but who are not insured for obstetrics (under the GP Obstetrics or GP Rural Obstetrics Categories) must adhere to the following minimum guidelines to ensure their entitlement to indemnity is maintained under the Policy:

- *Shared Care Guidelines*
  - All appropriate ante-natal screening tests must be performed
  - The patient must be referred to an Obstetric Hospital/Clinic, Consultant Obstetrician or GP Obstetrician (other than yourself) for consultation between 16 and 20 weeks gestation
  - The Obstetric Hospital/Clinic, Consultant Obstetrician or GP Obstetrician must see the patient at 36 weeks (or as dictated by the relevant Shared Care Guidelines applicable to you) and again at term, providing the ante-natal course is uneventful
  - Should any problems occur before 36 weeks (or as dictated by the relevant Shared Care Guidelines applicable to you), the Obstetric Hospital/Clinic, Consultant Obstetrician or GP Obstetrician must be advised and consulted
  - GPs may continue to see pregnant patients for ante-natal visits or for intercurrent medical problems, but in shared care the obstetric care and the delivery of the baby must rest with the Obstetric Hospital/Clinic, Consultant Obstetrician or with a GP who has GP Obstetric insurance arrangements
  - GPs **without** obstetric cover will not be insured if they provide backup for GP Obstetricians on a part time basis or whilst they are away on leave
- If you are required to adhere to more restrictive Shared Care Guidelines which apply in your State, region, hospital or clinic, then those guidelines must also be complied with to maintain your entitlement to indemnity
- You will be covered in an emergency situation (eg haemorrhage, premature or imminent delivery) if you render emergency assistance, provided you are insured in another GP Category

(continues on next page)

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e) Special Conditions – Shared Care and Ante-natal Care – continued

- **If you are a GP who is, or plans to be, involved in the induction or management of labour or in the delivery of the infant, then no cover is provided unless you are in the GP Obstetrics or GP Rural Obstetrics Categories, irrespective of whether the delivery is in the public or private system.**

Ante-natal Care Guidelines

General Practitioners who are qualified GP Obstetricians and who:

- provide Ante-natal Care which does not comply with the relevant Shared Care Guidelines applicable to them; and/or
- are involved in, or plan to be involved in, the induction or management of labour or in the delivery of the infant

must be insured under the GP Obstetrics or GP Rural Obstetrics Categories, irrespective of whether the delivery is being handled publicly or privately.

If a GP Obstetrician is going to be away from his or her practice, then appropriate handover to an Obstetric Hospital/Clinic, Consultant Obstetrician or GP Obstetrician must occur.

Section 6 : Cosmetic Medical Practice

a) Introduction

There are a range of Categories that apply to Cosmetic Medical Practitioners as follows:

- Cosmetic Medicine Level A
- Cosmetic Medicine Level B
- Cosmetic Surgery Level C
- Cosmetic Surgery Level D.

If you are a Specialist undertaking cosmetic work you must select a Specialist Category that meets your requirements (refer Section 4).

Refer to the table below for details of activities covered under each Category for Cosmetic Medical Practitioners.

If you perform a particular clinical activity and it is not clear which Category will apply, please provide full details in your Application or Renewal Form or contact our Client Services Department.

If you select a Cosmetic Medical Practice Category cover is provided under Division 1 Sections 1 and 2 of the Policy but only in relation to the work you undertake as per the Category you select.

Cover is also provided under Division 1 Sections 1 and 2 of the Policy for claims arising out of Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

b) Category listing

Category	Includes	Excludes
Cosmetic Medicine Level A	• GP Non Procedural activities as listed on pages 19 and 20 **plus** the following: – Botulinum toxin injections – Dermal fillers (non permanent) including polylactic acid – Chemical peels (superficial epidermal only) such as glycocholic acid peels – Intense Pulse Light therapy (IPL) – Laser therapy, excluding laser resurfacing – Microdermabrasion – Photo-rejuvenation – Radio frequency treatment – Microsclerotherapy for facial lesions – Sclerotherapy	• GP Procedural • Cosmetic Medicine Level B • Cosmetic Surgery Levels C and D
Cosmetic Medicine Level B	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 • Activities listed under Cosmetic Medicine Level A	• Cosmetic Surgery Levels C and D
Cosmetic Surgery Level C	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 • Activities listed under Cosmetic Medicine Level A **plus** the following: – Dermabrasion – Dermal fillers (permanent) – Facial thread lifting procedures (not in association with skin excision) – Laser resurfacing – Liposuction/lipoplasty (including breast reduction via liposuction alone) – Medium and deep chemical peels (dermal peels using agents such as phenol and trichloroacetic acid)	• Cosmetic Surgery Level D
Cosmetic Surgery Level D	• All GP Non Procedural and GP Procedural activities as listed on pages 19 and 20 • Activities listed under Cosmetic Medicine Level A and Cosmetic Surgery Level C, **plus** the following: – Abdominoplasty – Blepharoplasty – Breast augmentation/reduction – Cosmetic rhinoplasty – Face lift – Labiaplasty – Otoplasty – Penile extension/thickening	

Notes – In considering your Category please refer to the following notes:

1. **Cosmetic procedure** means any procedure directed towards the preservation, correction or improvement of appearance and/or where there are no underlying medical, clinical or pathological reasons for undertaking such procedures
2. **Liposuction** of more than 500mls of aspirate in total must be performed in an accredited day surgery or operating theatre (refer page 23)
3. **No cover is provided for fat transfers to breasts**.

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c) Special Condition – Liposuction

If you undertake liposuction procedures you must be insured in one of the following Categories:

- Cosmetic Surgery Level C
- Cosmetic Surgery Level D.

It is also important you note the following conditions that apply to liposuction procedures:

- No cover is provided for claims arising out of liposuction procedures of over 500mls of aspirate in total performed in a non-accredited day surgery or operating theatre
- If you require insurance for liposuction of more than 500mls of aspirate in total, where the procedure will not be undertaken in an accredited day surgery or operating theatre, the following special conditions apply:
  - you need to confirm in writing to us prior to renewal on 30 June 2007 that you will commit to your day surgery achieving accreditation within the next 12 months, and
  - a loading will apply to your insurance premium for the 2007/2008 year
- If you have an extension in the 2006/2007 Policy Period for undertaking liposuction procedures of more than 500mls of aspirate in total in a non-accredited day surgery or operating theatre, you must confirm in writing to us that accreditation has been (or will be) achieved, in accordance with the terms and conditions of your specific extension, but in any case, no later than 30 June 2007
  - If accreditation has not been achieved by this date, then no cover is provided for liposuction procedures of more than 500mls of aspirate undertaken in a non-accredited day surgery or operating theatre on or after 1 July 2007
  - Run-off cover will be provided in this situation for claims made on or after 1 July 2007 that relate to liposuction procedures of more than 500mls of aspirate in total undertaken in a non-accredited day surgery or operating theatre prior to 1 July 2007 and after your Retroactive Date
  - No further extensions will be granted other than in exceptional circumstances.

Section 7 : **Interns**

a) Introduction

As an Intern it is important that you carefully select the type of insurance you need and the medical indemnity services you may require.

MIGA offers a special Category for Interns that gives you access to a broad range of insurance and membership benefits.

b) Benefits of being an Intern member

If you first join MIGA as an Intern member during the period 1 July 2007 to 30 June 2008, you will receive the following benefits:

- **Free** membership of MDASA for the period, with access to all of the benefits of membership as outlined in Section 1 and in addition
- Low cost insurance for the period.

If you are already a Medical Student member during the period 1 July 2007 to 30 June 2008 and you commence your Intern year during this period, your free Student Policy with Medical Insurance Australia will be automatically extended to cover you as an Intern at no cost to you, from the time you start your Intern year to the expiry of the Policy ie 30 June 2008.

More details are provided in the following.

c) Free membership

As an Intern member, you will be provided with free membership of MDASA for the period 1 July 2007 to 30 June 2008.

In order to be entitled to access free membership as an Intern for this period, you must:

- Be undertaking your Internship in an Australian hospital
- Be registered as a medical practitioner by the relevant Medical Board in the State(s) in which you are working.

It is important to note membership of MIGA is not insurance and details of the insurance options available to Interns are outlined in the following.

d) Medical indemnity insurance for Interns

As an Intern you may need to arrange insurance cover for the first time.

We offer insurance tailored to the needs of Interns referred to as "Intern – with no Private Practice".

This Category is specifically for employer indemnified Salaried Medical Officers in their intern year.

In Section 8 we have outlined some issues to consider if you are working in the public sector and need to arrange your own insurance. In addition, in some States it is a requirement that doctors have in place medical indemnity insurance as a condition of their registration.

We encourage all Interns to read the information in Section 8 as the reasons why you may be required to have insurance and the benefits of the cover we offer are outlined. If you are not clear on the requirements that apply to you, please contact our Client Services Department.

Insurance cover if you were previously a Medical Student member

If you are a Medical Student member of MIGA during the period 1 July 2007 to 30 June 2008 and you commence your Intern year during this period and you have a free Student Policy, you will automatically be issued with insurance as an Intern at no cost from the time you start your Intern year to the expiry of the Policy on 30 June 2008.

We will contact all Medical Student members in December 2007 to confirm they are graduating and starting their Intern year, and if so, we will then issue them with a new insurance policy covering them as an Intern, at no charge and which will expire on 30 June 2008.

The benefits and scope of cover will be as an "Intern with no Private Practice", as outlined on page 25.

If you join MIGA for the first time as an Intern

If you join as an Intern member for the first time during the period 1 July 2007 to 30 June 2008, and have not previously held a Student Policy with us, but require insurance, you will need to arrange and pay for medical indemnity insurance.

Our Client Services Department will be pleased to help you with this.

Your membership as an Intern will be provided free, however a low premium will be payable for insurance provided as an Intern.

e) What you are covered for as an Intern

As an Intern, insurance cover is provided for claims made against you during the period 1 July 2007 to 30 June 2008 within our Category of cover "Intern - with no Private Practice" which covers you for:

- Expenses in relation to Claims under Division 1, Section 2 of the Policy, arising out of work you undertake in the public system but only to the extent you are not otherwise indemnified by your employer. Cover is limited to complaints, investigations or proceedings arising solely out of your activities during your Internship
- Claims arising out of Good Samaritan Acts and Gratuitous Advice under Division 1 Sections 1 and 2 of the Policy (refer page 11 of this PDS for details).

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

f) What you are not covered for as an Intern

Our Policy does not provide cover in certain instances and these are set out in the exclusions in the Policy wording.

It is very important you read these exclusions and contact us if you have any questions about them.

Under our Category for Interns, you are not insured for Claims, Claim Costs and Expenses (as defined in the Policy):

- In respect of which you are indemnified or are entitled to an indemnity from any other source, including the government or a governmental authority, hospital, health service or health authority
- Arising out of any practice, including private practice, that you might undertake outside of the public hospital system during your Intern year
- That arise out of a clinical placement or practice which is not part of your Intern year.

g) How to join as an Intern member

It's simple – complete the Application Form available via our website *www.miga.com.au* or contact our Client Services Department.

h) What happens if you cease your Intern year without completing it?

If you cease your Intern year at any time during the Policy Period, then both your membership of MDASA and your insurance with Medical Insurance Australia will be cancelled from the date you ceased your Internship.

Your insurance as an Intern with Medical Insurance Australia will immediately convert to run-off for the balance of the Policy Period to 30 June 2008.

As your medical indemnity insurance with Medical Insurance Australia is on a claims made basis, we will contact you to arrange run-off cover once your Policy expires, to protect you against claims that may be made after 30 June 2008 (refer Section 13 for more details).

i) What happens if you cancel your MDASA Intern membership?

If you wish to cancel your Intern membership with MDASA, then both your membership of MDASA and your insurance with Medical Insurance Australia will cease from the date you cancel your membership.

Your insurance as an Intern with Medical Insurance Australia will immediately convert to run-off for the balance of the Policy Period to 30 June 2008.

As medical indemnity insurance with Medical Insurance Australia is on a claims made basis, we will contact you to arrange run-off cover to protect you against claims that may be made after 30 June 2008 (refer Section 13 for more details).

j) When you finish your Intern year

Membership

If you are an Intern member for the period 1 July 2007 to 30 June 2008, and you finish your Intern year during this period and start work as a Salaried Medical Officer (SMO), MDASA will provide you with ongoing free membership through to 30 June 2008. This is the common expiry date for all insurance and membership arrangements for members.

Insurance

If you have insurance with us as an Intern during the period 1 July 2007 to 30 June 2008 and you commence work as an SMO during this period, your insurance as an Intern will be immediately extended to cover you as a "Salaried Medical Officer – with no or limited Private Practice", at no additional cost to you.

This will be from the time you start as an SMO until the expiry of your Policy on 30 June 2008.

This means that:

- If you have insurance as an Intern with Medical Insurance Australia from 1 July 2007 to 30 June 2008, and
- You start work as an SMO during the period of insurance
- Then your insurance as an Intern will be immediately extended to insure you as a "Salaried Medical Officer – with no or limited Private Practice", at no charge to you
- This cover will expire on 30 June 2008.

When you have completed your Intern year, it is important that you review the scope of cover provided as an "Salaried Medical Officer – with no or limited Private Practice" and ensure it meets your needs (refer Section 8 for details).

Prior to renewal in 2008, we will contact you to clarify your ongoing insurance and membership requirements beyond this date.

There are many different types of cover available to you.

In Section 8 called "Employer Indemnified" we have outlined the insurance options available to employed doctors who are working in the public or private sector.

It is important you read this Section carefully as it also provides details on the insurance options available to you after you complete your Intern year.

You will receive a renewal package in late April 2008 which will enable you to advise us of your on-going medical indemnity insurance requirements and we will make you an offer for on-going medical indemnity insurance. The "offer" will outline the terms, conditions and cost of on-going medical indemnity insurance for your consideration.

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Section 8 : Employer Indemnified Categories

a) Introduction

There are a range of Categories that are available for **employer indemnified** doctors as follows:

Category	Details
Staff Specialist With no Private Practice	Only provides cover for: • Expenses as per Division 1 Section 2 Part A of the Policy, restricted to Medical Board, tribunal and/or coronial matters.
Staff Specialist With no or restricted Private Practice	Provides cover for: • Restricted Private Practice (as outlined) – cover for such practice is subject to Gross Income not exceeding $5,000 per annum (excluding claims arising out of Orthopaedics, Neurosurgery, Cosmetics and Obstetrics) • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) • Expenses as per Division 1 Section 2 Part A and Part B of the Policy.
Salaried Medical Officer With no Private Practice	Only provides cover for: • Expenses as per Division 1 Section 2 Part A of the Policy restricted to Medical Board, tribunal and/or coronial matters.
Salaried Medical Officer With no or restricted Private Practice	Provides cover for: • Restricted Private Practice (as outlined) – cover for such practice is subject to Gross Income not exceeding $5,000 per annum and is limited to activities as listed under the GP Non Procedural Category • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) • Expenses as per Division 1 Section 2 Part A and Part B of the Policy.
Salaried Medical Officer With Private Practice in GP Non Procedural	Provides cover for: • A limited amount of private work in GP Non Procedural • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) • Expenses as per Division 1 Section 2 Part A and Part B of the Policy.
Other Employer Indemnified Private sector For doctors who are employed by a private sector employer	Provides cover for: • Expenses as per Division 1 Section 2 Part A of the Policy restricted to Medical Board, tribunal and/or coronial matters • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

If you are an Intern, refer Section 7 for details of the cover available to you.

b) Scope of cover for Employer Indemnified

If you select any of the above Employer Indemnified Categories, it is important to note:

- Cover is provided under Division 1 Section 2 of the Policy for Expenses incurred in relation to inquiries, investigations etc arising from the treatment of public patients:
  - To the extent you are not otherwise indemnified
  - Subject to specific limitations in some Categories
    - » For example, for the Category of "Staff Specialist with no Private Practice – Medical Board, tribunal and coronial cover only" cover under Division 1 Section 2 Part A of the Policy is restricted solely to inquiries etc by a Medical Board, tribunal or coroner
- No cover is provided under Division 1 Section 1 of the Policy for Claims or Claim Costs arising from the treatment of private patients unless the Category you select specifically includes cover for private practice
- No cover is provided under Division 1 Section 1 of the Policy for Claims or Claim Costs arising from the treatment of public patients
- No cover is provided under Division 1 Section 2 of the Policy for Expenses incurred in relation to inquiries, investigations etc in relation to the treatment of private patients unless the Category you select specifically includes cover for private practice.

If you select any of the Employer Indemnified Categories we recommend you:

- Obtain written confirmation from your employer that they will indemnify you for conduct in the course of your employment
- Obtain written confirmation detailing the scope of indemnity provided to you and the extent to which your employer will accept liability for your actions during employment and in particular what insurance they have in place to meet such liabilities. If you are in any doubt, you may refer that document to us so that we can determine the appropriate Category for you
- Clarify the scope of indemnity for consultations with public patients in private rooms and with private patients in public outpatient clinics.

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c) Staff Specialist with no private practice – Medical Board, tribunal and coronial cover only

This Category is for Staff Specialists who are employer indemnified **and only require** cover for Medical Board, tribunal and/or coronial matters.

No cover is provided under Division 1 Section 1 or Section 2 Part B of the Policy.

Cover under Division 1 Section 2 Part A of the Policy is strictly limited to Expenses in relation to complaints made to a Medical Board or a tribunal responsible for your professional discipline or a coronial inquiry, for matters arising out of your conduct as a medical practitioner.

d) Staff Specialist with no or restricted private practice

This Category is for employer indemnified Staff Specialists with no, or restricted private practice or where their private practice is indemnified under a rights of private practice agreement.

If you select this Category, cover is provided under Division 1 Sections 1 and 2 of the Policy, but only in relation to the following:

- Claims for compensation arising from any private work you undertake outside of your employment and/or Private Practice Agreement (if applicable), subject to Gross Income from such work not exceeding $5,000 per annum. Provided they occur on or after 1 July 2006 or the Retroactive Date recorded on your Quotation and/or Policy Schedule whichever is the latter date.

  Claims arising out of Orthopaedics, Neurosurgery, Cosmetics and Obstetrics are excluded.

  The intention of providing cover for a restricted amount of incidental private practice is to assist you in situations where you may need to undertake work on short notice for which you would need to arrange your own insurance.

  So long as any private work you undertake does not exceed Gross Income of $5,000 in the Policy Period and it is not in the excluded practice areas detailed above, you are free to undertake such work at any time without having to notify us.

- Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

Cover is also provided under Division 1 Section 2 of the Policy for Expenses arising out of work you undertake in the public system, but only to the extent you are not otherwise indemnified by your employer.

No cover is provided under Division 1 Sections 1 and 2 of the Policy for matters that arise from practice undertaken under a rights of private practice agreement.

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

If your private practice outside of your employment or outside of your rights of private practice agreement exceeds $5,000 Gross Income per annum, please select the Category that most accurately describes your area of practice.

e) Salaried Medical Officer with no private practice – Medical Board, tribunal and coronial cover only

This Category is for Salaried Medical Officers who are employer indemnified **and only require** cover for Medical Board, tribunal and/or coronial matters.

No cover is provided under Division 1 Section 1 of the Policy or under Division 1 Section 2 Part B.

Cover under Division 1 Section 2 Part A of the Policy is strictly limited to Expenses in relation to complaints made to a Medical Board or a tribunal responsible for your professional discipline or a coronial inquiry, for matters arising out of your conduct as a medical practitioner.

f) Salaried Medical Officer – with no or restricted private practice

This Category is for employer indemnified Salaried Medical Officers with no, or restricted private practice.

If you select this Category, cover is provided under Division 1 Sections 1 and 2 of the Policy, but only in relation to the following:

- Claims for compensation arising from any private work you undertake outside of your employment, subject to Gross Income from such work not exceeding $5,000 per annum. Provided they occur on or after 1 July 2006 or the Retroactive Date recorded on your Quotation and/or Policy Schedule whichever is the latter date.

  Activities are restricted to those listed under the GP Non Procedural Category (refer pages 19 and 20).

  The intention of providing cover for a restricted amount of incidental private practice is to assist you in situations where you may need to undertake work on short notice for which you would need to arrange your own insurance.

  So long as any private work you might undertake does not exceed Gross Income of $5,000 in the Policy Period, you are free to undertake such work at any time without having to notify us.

- Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

Cover is also provided under Division 1 Section 2 of the Policy for Expenses arising out of work you undertake in the public system, but only to the extent you are not otherwise indemnified by your employer.

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

If your private practice outside of your employment exceeds $5,000 Gross Income per annum, please select the Category that most accurately describes your area of practice.

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g) Salaried Medical Officer with private practice in GP Non Procedural

This Category is for employer indemnified Salaried Medical Officers working principally in the public hospital system who undertake a limited amount of private practice in GP Non Procedural. You can select from the following Gross Income bands:

- $5,001 to $10,000 pa
- $10,001 to $25,000 pa.

If your Gross Income from GP Non Procedural work exceeds $25,000 pa you must select the GP Non Procedural Category in your Application or Renewal Form.

If you select this Category, cover is provided under Division 1 Sections 1 and 2 of the Policy but only in relation to:

- Claims for compensation from any private work, restricted to activities as listed under the GP Non Procedural Category (refer pages 19 and 20)
- Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

Cover is also provided under Division 1 Section 2 of the Policy for Expenses arising out of work you undertake in the public system but only to the extent you are not otherwise indemnified by your employer.

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

h) Other Employer Indemnified – Private sector

This Category is for other doctors who are employed in the private sector and are indemnified by their employer but who require cover for:

- Medical Board, tribunal and/or coronial matters
- Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

No cover is provided under Division 1 Section 1 (except in relation to cover for Good Samaritan Acts and Gratuitous Advice) or Division 1 Section 2 Part B of the Policy.

Cover under Division 1 Section 2 Part A of the Policy is strictly limited to Expenses in relation to complaints made to a Medical Board or a tribunal responsible for your professional discipline or a coronial inquiry, for matters arising out of your conduct as a medical practitioner.

Section 9 : **Other Categories**

a) Introduction

The following additional Categories are available for doctors who undertake roles other than those detailed earlier in this PDS:

- **Surgical Assistance Only – Other**
- **Employed Salaried Medical Officer at a private hospital**
- **Registrar undertaking training as a Specialist in private practice** (ie outside the public hospital system)
- **Medical Reporting and Assessment**
- **Medical Administrator**
- **Medical Academic**
- **Non Clinical.**

Details of the cover provided in each Category is summarised in this Section.

If you practise in more than one Category you will need to record the percentage of practice in each Category on your Application or Renewal Form. If you are performing procedures not normally associated with your Category, please contact us and we will assess your circumstances individually.

If you select any of the above Categories cover is provided under Division 1 Sections 1 and 2 of the Policy but only in relation to the work you undertake as per the Category you select.

Cover is also provided under Division 1 Sections 1 and 2 of the Policy for claims arising out of Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

b) Surgical Assistance Only – Other

This Category is for overseas visiting doctors or non-specialists who do not perform any surgery but undertake surgical assistance and/or observational roles only. The following must be noted:

- You are not covered in this Category if you are working in any capacity as the primary or supervising surgeon. If you are the primary or supervising surgeon, you need to select the appropriate Specialist Category in the Application or Renewal Form
- You are not covered in this Category if you undertake any surgery either during surgery (whether in the presence of the primary or supervising surgeon or not) or on behalf of the primary or supervising surgeon
- This Category includes cover for prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously.

c) Employed Salaried Medical Officer at a private hospital

This Category is for doctors who are employed in private hospitals, who are required to **effect and maintain their own medical indemnity insurance**.

You need to declare in your Application or Renewal Form your applicable Gross Income and the shifts you work per week/fortnight.

d) Registrar undertaking training as a Specialist in private practice

This Category is for Registrars undertaking training as a Specialist in private practice, outside of the public hospital system, who are required to effect and maintain their own medical indemnity insurance.

You need to detail the area of specialty in which you are training on the Application or Renewal Form.

e) Medical Reporting and Assessment

This Category is for doctors who do not undertake clinical practice and whose entire practice consists of consultation, examination and assessment for the sole purpose of reporting in their area of specialty. Doctors in this Category have no doctor/patient relationship with the examinee.

Cover in this Category is restricted to:

- Reporting only in the area of specialty in which you are qualified as a registered medical practitioner
- Where the primary purpose of your report or opinion is for use:
  - by a third party in investigating a potential third party claim
  - as evidence in proceedings, proposed proceedings, or the giving of oral evidence in proceedings or proposed proceedings in relation to a third party claim
  - by a third party (eg an insurer or employer) in assessing the examinee for use by a third party.

Doctors in this Category are also covered for claims arising out of prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously.

If you are undertaking any clinical practice you must select a Category applicable to the work you are undertaking as you will not be covered for such work in this Category.

f) Medical Administrator

This Category is for doctors whose role is solely that of a medical administrator **who are not otherwise indemnified in this role and who are required to effect and maintain their own medical indemnity insurance**.

Cover under this Category is restricted solely to patient outcomes arising out of health care treatment, advice or

(continued on next page)

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f) Medical Administrator – continued

service where the medical administrator is alleged to have exercised their medical skill and judgment in their role as a medical administrator, but whose responsibilities do not extend directly to clinical patient contact.

Doctors in this Category are also covered for claims arising out of prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously.

If you undertake any clinical work no cover is provided under this Category. You must select a Category that most accurately describes your specific area of practice and the work you actually undertake.

No cover is provided for claims arising out of managerial or administrative error.

g) Medical Academic

This Category is for doctors whose role is solely that of a medical academic and whose responsibilities are restricted to teaching, training, supervising or mentoring doctors or Medical Students in accredited or formalised training programs leading to professional awards **who are not otherwise indemnified in this role**.

Cover under this Category is restricted solely to patient outcomes arising out of health care treatment, advice or service where the clinical academic is alleged to have exercised their medical skill and judgment in their role as a medical academic but whose responsibilities do not extend directly to clinical patient contact.

Doctors in this Category are also covered for claims arising out of prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously.

If you undertake any clinical work no cover is provided under this Category. You must select a Category that most accurately describes your specific area of practice and the work you actually undertake.

No cover is provided for claims arising out of managerial or administrative error.

h) Non Clinical

This Category is for doctors who maintain Medical Board registration but are not practising and have no clinical patient contact (either directly or indirectly) and who are not in the Categories of Medical Administrator, Medical Academic or Medical Reporting and Assessment.

Doctors in this Category are only covered for claims arising out of prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously, Good Samaritan Acts and Gratuitous Advice.

Section 10 : Retired, Retired Compound Life Members and Non Practising Doctors

a) Introduction

The following Categories are available for retired doctors and doctors who are not practising including those who are Compound Life Members of MDASA:

Category	Details
Prescriptions Plus (Nil Gross Income)	Provides cover for: • Prescription writing • Referrals • Ordering Pathology • Good Samaritan Acts* • Gratuitous Advice* * Refer page 11 for details
Good Samaritan Acts and Gratuitous Advice only	Provides cover for: • Good Samaritan Acts* • Gratuitous Advice* * Refer page 11 for details

If you select one of the above Categories cover is provided under Division 1 Sections 1 and 2 of the Policy but only in relation to the activities outlined in the Category you select.

Details of cover under Division 1 Sections 1 and 2 of the Policy are provided in Section 2 of this PDS.

If you select one of the above Categories it is important that you read and note the following additional information.

b) Retired Doctors

If you are permanently retired from practice with some form of run-off cover from us, we will write to you separately in relation to your ongoing requirements for renewal of your run-off cover.

If you are entitled to access the Commonwealth Run-off Cover Indemnity Scheme (ROCS), we will also write to you in relation to your entitlements. Please refer Section 13 of this PDS.

If you are currently insured with us and intend to permanently retire on or after 1 July 2007 you may be able to access ROCS or alternatively we will make you an offer for run-off cover.

Once we receive your completed Renewal Form we will write to you in relation to your run-off cover from 1 July 2007.

If you resume practice (whether temporarily or permanently), you will have no insurance for claims made after you resume practice unless you contact us before commencing practice and effect insurance. Any run-off cover that you already have in place may also cease if you resume practice.

Note: If you are charging a consultation fee (bulk billed or otherwise) no cover is provided unless you select the appropriate practising Category.

c) Compound Life Membership

Prior to 1 July 2003, members who had continuous financial membership of MDASA for 40 years were entitled to apply for Compound Life Membership.

Historically this benefit was offered to recognise and encourage long term membership.

The effect of Federal legislation introduced in 2003 is that MDASA can no longer provide any form of indemnity to doctors who are still practising. Such cover can only be offered by an APRA licensed insurer via an insurance policy.

Therefore, whilst membership of MDASA remains free for doctors who have achieved Compound Life Membership, MDASA cannot provide free insurance for Compound Life Members who are still practising.

If you are a Compound Life Member of MDASA who is still practising, no insurance is provided for your practice unless you choose the Category most appropriate to the work you are performing and you arrange insurance with Medical Insurance Australia in this Category.

MDASA Membership for Compound Life Members

The terms and conditions of MDASA's Compound Life Membership benefit are as follows:

- You need to have been a financial member of MDASA for at least 40 years
- The membership must have been continuous (note that if there has been a suspension of the membership, the period of suspension will not contribute towards the 40 year requirement)
- Once Compound Life Membership status is achieved, your membership fee for MDASA will be waived, however, you will need to effect and pay for insurance cover if you are still practising or need any insurance
- MDASA reserves the right to review annually the ongoing provision of Compound Life Membership for any and/or all members.

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d) Non Practising Doctors

Non practising doctors can include those who have already ceased or will be ceasing practice temporarily for the following reasons:

- taking maternity leave
- taking long service leave
- studying
- working overseas.

If your membership of MDASA is suspended (other than by reason of maternity leave – in which case you are eligible for ROCS) there is no automatic entitlement to insurance or membership benefits for incidents that may occur or claims that may be made during the period of suspension.

Run-off cover is available to cover you for claims made during the period of suspension for incidents that may have occurred whilst you were still practising.

If you intend to cease practice and/or wish to suspend your membership from 1 July 2007 or if your membership is currently suspended, you will need to indicate on your Renewal Form:

- the date you ceased practice or the date you intend to cease practice
- the reason for ceasing practice and
- if you require indemnity for claims made after the date you ceased practice for incidents which occurred prior to ceasing practice.

If you are ceasing practice because of maternity leave, you will be entitled to access run-off cover via ROCS (refer Section 13).

This Section needs to be read in conjunction with Section 15 regarding Suspension of Membership and continuity of membership benefits.

Section 11 : **Medical Students**

a) Student Membership Package

If you are a Medical Student registered in an approved course of medical study in a Medical School or University in Australia, then you can join us as a Student member.

Student membership provides significant benefits including the opportunity to learn about the legal side of medicine, keep up to date with developments in the medico-legal field and develop a relationship with us, so that when you graduate you are better prepared to face the challenges of your career in medical practice.

We offer a stand alone "Student Policy" for Medical Students.

If you are a Medical Student and you would like details of our package for students, please contact our Client Services Department or access the information at our website *www.miga.com.au* .

This Combined FSG and PDS does not incorporate details of the insurance cover provided to Medical Students via our Student Policy.

b) Benefits of Student Membership

Student membership of MIGA for the period 1 July 2007 to 30 June 2008 is **free** and provides you with the following benefits:

- **Free medical indemnity insurance as a Medical Student** for the period 1 July 2007 to 30 June 2008, including insurance for any elective program or elective scholarship you might undertake where you are required to have your own insurance in place (see details in the Student Policy Combined FSG and PDS)
- **Access to our Elective Grants Program** which provides up to 6 grants of $3,500 each year to assist students fund an elective and support the community in which they will be working (see details in the Student Policy Combined FSG and PDS)
- **Free medical indemnity insurance as an Intern** – if you start your Intern year during the period 1 July 2007 to 30 June 2008, your free Student Policy will be automatically extended to cover you as an Intern until the next renewal of your arrangements with us on 30 June 2008 (see details in Section 7 of this PDS)
- **Free 24 hour emergency support** – Catering for urgent situations where medico-legal advice is required in relation to healthcare treatment you provide as a Medical Student
- **Receipt of our Bulletins**, which are published bi-monthly (and are also available via the website) and include:
  - – Information in relation to risk management, claims management and claims trends as they relate to the medical community
- **Opportunity to attend** our risk management workshops and access valuable educational material
- **Representation via our Medical Advisory Panel** – established to give members, including students, an opportunity to provide feedback on insurance and membership issues.

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Section 12 : Declaration of Gross Income

a) Introduction

Premiums are determined in part by the Category you select and your Gross Income or Sessions.

You are required to declare your estimated Gross Income for the next year from all areas of practice for which you require cover by ticking the appropriate Gross Income band on the Application or Renewal Form. Entitlement to cover is dependent upon provision of accurate information about your practice including your declaration of Gross Income. Failure to provide accurate information (which affects the premium rate) may affect your entitlement to cover.

b) Definition of Gross Income

Gross Income:

Means the total of all billings generated by you from all areas of practice for which you require medical indemnity cover for the Policy Period (in your name) or for work for which you are personally liable, including without limitation Medicare benefits, payments by individuals, and payments by the Department of Veterans' Affairs, workers compensation schemes and third party and/or vehicle insurers and income earned for medical practice overseas that is covered by the Policy, whether retained by you or otherwise and before any apportionment or deduction of any expenses and/or tax.

If as part of practice, you derive income from any other sources (ie professional fees, incentive payments, etc) this income must be included in the declaration of Gross Income.

If your actual Gross Income exceeds your estimated Gross Income you must notify us immediately.

The Gross Income you must declare is the total of the amounts set out above. It is not sufficient to declare only your gross taxable income or net after tax income.

If you are an employee and you are not indemnified by your employer for your work and are paid a salary and/or a percentage of your income, you are still required to determine your Gross Income as per the above definition.

c) Special cases – Gross Income / Sessions

If you have selected any of the following Categories please tick the appropriate box on the Application or Renewal Form to indicate your average number of 'Sessions' per week. You must also declare your Gross Income.

- Cytology
- Emergency Medicine
- Employed SMO at Private Hospital
- GP Registrars
- Pathology
- Radiology
- Surgical Assistance Only – Other
- Surgical Assistance Only – Specialists.

If your actual number of sessions during the Policy Period exceeds, on average, the number of sessions that you declared to us, you need to contact us immediately.

Session means part of a day not exceeding 6 hours in total.

Note: Please refer to Section 2 to determine whether you also need to declare Gross Income for public work.

d) Adjustment of Gross Income / Sessions

Medical Insurance Australia may adjust premiums based on a declaration of actual Gross Income/Sessions after expiry of the Policy Period.

If Medical Insurance Australia requires a declaration of actual Gross Income/Sessions for the Policy Period, a statutory declaration will be forwarded to you for completion within 120 days after expiry of the Policy Period. The statutory declaration must be returned within 45 days.

e) Audit of Gross Income / Sessions

Medical Insurance Australia may, at its discretion and at its cost, require an audit of the declaration referred to in (d) above, in which case you are required to provide Medical Insurance Australia with all information and assistance reasonably required for the purpose of the audit.

The Policy also contains a condition that applies where you do not provide Medical Insurance Australia with the declaration referred to in (d) or if you do not provide the information and assistance referred to above. In such cases, Medical Insurance Australia may audit your Gross Income/Sessions for the Policy Period and you will be required to meet the cost of that audit.

Section 13 : Run-Off Cover

a) Why you need Run-Off Cover

Our medical indemnity insurance cover is on a claims made basis. If you no longer require medical indemnity insurance or move to a lower risk Category, you may require run-off cover.

Run-Off cover insures you for claims made in the future which relate to your prior practice.

When you are considering your renewal, if you select a non practising Category on the Renewal Form or if you wish to suspend your membership, we will write to you to discuss your requirements in relation to run-off cover.

b) Types of Run-Off Cover

Doctors can access three types of run-off cover via Medical Insurance Australia as follows:

Type of run-off	Details
Run-Off Cover Indemnity Scheme (ROCS)	Provides cover for eligible doctors which is free and for an unlimited period of time once triggered whilst the doctor remains eligible
ROCS Gap Cover	Provides cover for eligible doctors until such time as they are eligible for ROCS, subject to a maximum period of three years
Standard Run-Off (ERB)	Is available for doctors who need run-off cover and who are not eligible for either ROCS or ROCS Gap Cover

More details about each of these are summarised in the following:

Type of run-off	Applies	Details – Benefit and funding
ROCS	You become eligible for ROCS when you are: • 65 years of age or more and have retired permanently from private medical practice • permanently disabled • under 65 years of age and have retired permanently from private medical practice for a continuous period of 3 years • on maternity leave • deceased, or • in another qualifying group determined by regulation to be eligible.	• Cover is free and once triggered is provided for as long as the doctor remains eligible for ROCS • ROCS is funded via a levy on all medical indemnity insurers • It is then on charged to all doctors as a loading on their insurance premium • The loading is currently 8.5% of the premium for all insurers other than UMP/AMIL where the levy is higher.
ROCS Gap Cover	Is available from us if you: • Permanently cease private practice before age 65, and • Are not yet eligible for ROCS, and • Have 8 years of continuous membership/insurance with us.	• We will cover the first three years of run-off, via annually renewable insurance, until you are eligible for ROCS • An annual premium of $50 may be payable.
Standard Run-off ERB	• Is available when you need run-off cover and you are not eligible for ROCS or ROCS Gap Cover • This could be when you: – Cease practice for less than 12 months before age 65 – Cease to be insured with us for other reasons (eg insure elsewhere) – Move to a lower risk Category.	• Cover is offered on an annually renewable basis • At the time of triggering the cover, you need to pay a run-off premium for the next year's cover • The Policy will need to be renewed and a premium paid annually.

c) ROCS

ROCS came into effect on 1 July 2004.

The aim of ROCS is to provide eligible doctors with access to free and unlimited run-off cover. Once cover is triggered, it is managed by the doctor's last insurer.

Doctors become eligible for ROCS when they are:

- 65 years of age or more and have retired permanently from private medical practice
- permanently disabled
- under 65 years of age and have retired permanently from private medical practice for a continuous period of 3 years (this group includes those who are no longer in paid employment, those practising medicine solely in the public sector and those no longer practising medicine)
- on maternity leave
- deceased (provided that a claim can still be made against the doctor's estate), or
- in another qualifying group determined by regulation to be eligible.

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c) ROCS – continued

ROCS is funded by a charge on medical indemnity insurers which is incorporated into each doctor's annual insurance premium.

We detail separately on the Tax Invoice the component of premium that relates to ROCS. The charge is currently 8.5% of the premium sub-total (as per the invoice) and it represents the run-off cover support payment payable by Medical Insurance Australia to the Commonwealth in respect of the contribution year commencing 1 July 2007.

If you are or become eligible for ROCS:

- You will be required to complete a ROCS Declaration Form
- You may be required to submit a medical certificate in support of your application for eligibility for ROCS.

We will contact you in relation to these requirements and forward any relevant forms to you.

More information about ROCS is available from the website of the Department of Health and Ageing at *http://www.health.gov.au*.

d) ROCS Gap Cover

If a doctor permanently retires from private medical practice before age 65, they can only access ROCS:

- Once they have been permanently retired from private medical practice for 3 years, or
- When they reach age 65, whichever occurs first.

We offer ROCS Gap Cover to doctors who become entitled to receive a compulsory offer under Section 23 of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003, in accordance with the requirements of Regulation 8.

ROCS Gap Cover will be offered to doctors who:

- Have been financial members of MDASA or who have held a medical indemnity insurance policy with Medical Insurance Australia for a continuous period of at least 8 years, and
- Who are aged under 65

If they inform us of their intention:

- To permanently cease private medical practice (other than if they are eligible for ROCS eg because of permanent disability), or
- To only provide health care treatment, advice or service that is:
  - indemnified by a Commonwealth, State or Territory Government or
  - provided only on a gratuitous basis.

Note: Medical Student membership and/or insurance **does not** accrue to the calculation of a continuous period of financial membership/insurance with MIGA.

ROCS Gap Cover is offered via an annually renewable medical indemnity insurance Policy until such time as the doctor is eligible for ROCS, or until the doctor does not accept or refuses an offer, subject to a maximum period of 3 years.

A premium of no more than $50 per annum (exclusive of taxes and charges) may apply to the ROCS Gap Cover.

ROCS Gap Cover ceases if you resume private medical practice, become eligible for ROCS or cease to be eligible for run-off cover.

e) Standard Run-Off

Extended Reporting Benefits (ERB) cover is available for doctors who need run-off cover and who are not eligible for ROCS or ROCS Gap Cover.

This could be when they:

- Cease practice for less than 12 months before age 65
- Cease practice for at least 12 months before age 65 but do not have at least 8 years continuous insurance/membership with us
- Cease to be insured with us for other reasons (eg they insure elsewhere)
- Move to a lower risk Category.

If you change to a lower risk Category, you will not automatically be covered for claims arising out of incidents that occurred before your change, that are **not** covered under your new Category.

Subject to a review of your claims and practice history, no ERB premium is payable if you change to a lower risk Category and run-off cover is granted, provided:

- You have had 2 or more years of continuous insurance with us, and
- You continue to be insured by us in a Category which is principally for private practice.

An additional run-off premium will apply if you have not reached the 2 year qualifying period.

Subject to a review of your claims and practice history, an additional run-off premium may apply if you:

- Change your arrangements with us to a Category which is not principally for private practice, or
- You no longer require cover for health care treatment provided to public patients in public hospitals.

When ERB is requested and granted:

- Cover is provided on an annually renewable basis
- The Policy will need to be renewed and a premium paid annually.

f) More information about Run-Off Cover

When doctors are eligible for or apply for run-off cover, we will provide more detailed information direct to them about their entitlements and any issues they need to note.

Section 14 : **Renewal of your Insurance and Membership**

a) Renewal package

Your insurance and membership expires at midnight on 30 June each year. You will receive a Pre-Renewal package (including a Renewal Form) in late April each year.

Prior to renewal each year, we will forward to you a Renewal Package. For the 2007/2008 year, your Renewal Package includes the following important documents:

- Covering letter
- Tax Invoice
- Quotation Schedule
- Combined FSG and PDS for 2007/2008
- Policy Wording for 2007/2008
- Payment Options Form
- Premium Funding Instalment Plan Form.

If you do not receive any of the above documents, please contact our Client Services Department.

b) Your Tax Invoice

In preparing your Tax Invoice for the period 1 July 2007 to 30 June 2008, MIGA will consider your particular circumstances, taking into account:

- The information provided by you in your completed 2007/2008 Renewal Form, and any subsequent discussions we have had with you (see note below if your Renewal Form has not been returned)
- Whether you have complied with the requirements to receive a premium discount as a result of completion of the IRM Program for the 2006/2007 year
- Whether you have indicated you would like to access a premium subsidy via the Premium Support Scheme (PSS) and you have complied with the requirements and fulfil the eligibility criteria
- If Medicare Australia has advised us you are required to pay a UMP Support Payment and you have indicated to Medicare Australia that you would like to pay this via us as part of your medical indemnity renewal
- If Medicare Australia has advised us that you applied for and were granted a subsidy under the Medical Indemnity Subsidy Scheme (MISS) in the 2004/2005 year.

If at the time of invoicing you have not submitted a Renewal Form, we will invoice you based on your existing insurance arrangements with us. Your Tax Invoice and Quotation Schedule will assume your Category and Special Conditions are as per the 2006/2007 year.

Your payment cannot be processed nor your Policy Schedule and Certificate of Insurance and Membership issued unless we receive and accept your completed Renewal Form.

It is important you check your Quotation Schedule and Tax Invoice carefully, in particular to ensure that you are in the correct Category as your entitlement to insurance is dependent on the Category selected for the forthcoming year. You must select the Category that most accurately describes your specific area of practice.

This Combined FSG and PDS outlines the different Categories and what insurance and membership benefits are provided within each.

If you are in any doubt about the scope of cover, whether you are in the correct Category and whether you have the required insurance or if any of your details are incorrect, please contact our Client Services Department.

c) Payment and steps to finalise your renewal

To finalise your renewal, you will need to:

- Check your Quotation Schedule and Tax Invoice reflect your Category, level of Gross Income/Sessions and scope of insurance cover required
- Review your eligibility and entitlement to a premium support subsidy under the PSS (refer Section 19)
- Choose one of the following payment options
  - Payment by instalments – complete and return the original Premium Funding Instalment Plan Form
  - On-line credit card payment – Bankcard, Mastercard and Visa only
  - BPay – See your Tax Invoice for Biller Code / Reference details
  - Credit Card – Bankcard, Mastercard, Visa, Diners Club or American Express
  - Cheque
  - Cash
- When you make your payment, check your Renewal Form has already been sent to us. If it has not, you will need to send it with your payment as we will not be able to issue your Policy Schedule and Certificate of Insurance and Membership without your completed Renewal Form
- If payment cannot be made by 1 July 2007, Medical Insurance Australia will provide you with interim insurance cover to midnight, Monday 16 July 2007.

The interim insurance cover will be provided on the terms set out in the Policy wording and will be based on the most recent information you have provided to us in relation to your Category and Gross Income/Sessions. However, your entitlement to interim insurance cover is conditional upon us receiving from you, by no later than Monday 16 July 2007:

- Your completed Renewal Form, and
- Payment in full.

Note: We reserve the right to vary the terms of the interim cover retrospectively depending on the information contained in the Renewal Form.

If we do not receive both your Renewal Form and your payment by 16 July 2007 then you have no entitlement to interim insurance cover and we will treat it as if it was never issued to you.

Alternatively, on receipt of your payment before the due date, we will process it (provided your Renewal Form has been received and accepted) and forward a receipt and Certificate of Insurance and Membership to you.

If you have any queries in relation to how to finalise your renewal please call our Client Services Department.

Note: Interim cover is not triggered if you insure elsewhere on or after 1 July 2007.

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Section 15 : General Administration

a) Steps to joining and obtaining insurance with MIGA

Applying for insurance and membership with MIGA is easy.

Simply call us on free call 1800 777 156 or 08 8238 4444 for a quote and request an Application Form. If you are in Brisbane, Melbourne or Sydney you can call our local office to obtain a quote. Refer to page (i) for contact details.

Alternatively, click on the link on our website (*www.miga.com.au*) to download the Application Form and send it to us.

You can fax your Application Form (and then post the original) if you would like faster service. Our fax number is 08 8238 4445.

When completing your Application Form, you have an obligation to fully disclose all information relevant to MIGA's decision to insure you and your practice and to answer all questions. It is important you read your Duty of Disclosure as outlined in Section 20 and make sure you accurately and correctly answer all questions on your Application Form. For example it is extremely important you provide full details of your claims and circumstances history. If proper disclosure is not made, your Policy may be cancelled from inception, the premium altered or the benefits reduced.

Once we receive your Application Form we will assess it within 2 working days and you will receive confirmation of your insurance and membership within 7 working days of receipt of the Form unless we require additional information or if there are any difficulties with your application.

All applications for insurance and membership are subject to a comprehensive assessment process. This is important to ensure we can assess your individual details and requirements and at the same time carefully manage the risk profile of MIGA.

b) Once your application has been accepted

We will forward to you a confirmation letter and your Tax Invoice.

Once your payment has been received, a receipt, your Policy Schedule and Certificate of Insurance and Membership will be issued.

c) Period of insurance and membership

Insurance and membership with MIGA is on an annual basis from 1 July to midnight 30 June each year. Once you join, your insurance premium will be pro-rated to the next 30 June (subject to our customary or minimum short term rates). Your membership fee will be based on our minimum membership fee scale depending on the period of membership to 30 June.

d) Paying your invoice

You can pay your invoice by the following methods:

- Annually; or
- By instalment (see "e" below).

Depending which of the above options you choose, you have the following payment methods available to you:

- On-line by credit card (Mastercard, Visa, Bankcard only)
- BPay
- Credit card
- Cheque
- Cash
- Direct debit (only for paying by instalment).

e) Paying your invoice by instalments

An instalment plan for payment of your insurance and membership premium is available.

The instalment plan has been arranged by Marsh Pty Ltd, a leading global professional services firm with access to various financial markets, in conjunction with Pacific Premium Funding Pty Ltd (PPF).

MIGA receives an administration fee of $50 for each approved funding application from PPF.

How do monthly instalments work?

- PPF pays your total cost as invoiced to MIGA
- Once your funding application has been approved by PPF it is non cancellable
- You will receive a receipt and Certificate of Insurance and Membership from us confirming your membership fee and insurance premium have been received
- You then repay PPF by a maximum of ten equal monthly instalments either beginning 1 July 2007 (if a renewal) or a later date if you have just joined.

f) Change in Category

Please advise us if your circumstances change during the course of the year as this may mean a change in Category.

In some situations, particularly if you move to a lower risk Category, there may need to be an ongoing run-off charge for claims that may be made in the future that relate to the previous area of practice. If you move to a higher risk Category, there may be an additional premium.

Changes in your Category will need to be advised in writing to us. You may be asked to complete a declaration confirming the change requested.

g) Changing State or Territory of practice

Please advise us in writing whenever there is a change in your place of practice, particularly if this involves a change in your State or Territory of practice.

Depending on where you are planning to practise and in what field, there may be an adjustment to your premium and/or stamp duty payable.

h) Suspension of membership

There are times when you may not need insurance but you may like to suspend your membership so that you can maintain your long term benefits with us.

This can occur, for example, when going overseas to work for an extended period, being on maternity leave, or at other times when no longer practising for a period of time.

There are two options for suspending membership, as follows:

If suspension is for a period of up to 12 months

If suspension is for no more than 12 months, doctors will not lose recognition of their years of prior continuous financial insurance and membership with MIGA as contributing towards any assessment of long term membership for the purpose of future insurance arrangements with Medical Insurance Australia, provided that:

- Suspension is not as a result of suspension of registration by a Medical Board or an equivalent body
- You are not practising as a medical practitioner in Australia during the period of suspension
- Insurance has not been arranged elsewhere during the period of suspension.

  Note – You can however, purchase cover with MIGA for prescription writing, Good Samaritan Acts and Gratuitous Advice during the period of suspension without breaching this condition.

During a period of suspension of up to 12 months, your membership status will be recorded as "Short Term Suspended Membership".

If you reactivate your insurance with us within 12 months of the start of your period of suspension, the period prior to suspension will count towards your continuity of membership for any assessment of your long term membership with MIGA for the purpose of future insurance arrangements with Medical Insurance Australia.

The period of suspension will not count towards any assessment of your length of continuous financial membership with MIGA when you reactivate your insurance and membership with us.

If you arrange insurance for prescription writing, Good Samaritan Acts and Gratuitous Advice during a period of suspension, then the period during which you have this insurance will count towards assessment of your length of continuous financial membership with MIGA.

During the period of suspension, no annual membership fee will be charged and you will not be entitled to any membership services, unless you have arranged ongoing cover for prescription writing, Good Samaritan Acts and Gratuitous Advice with us.

At the end of the 12 month period (or if you resume practice earlier), it is important that you contact us to advise if ongoing suspended membership is required or whether you would like to reactivate your insurance with us.

If suspension is for a period of more than 12 months

If suspension extends beyond 12 months, prior and continuous financial membership of, or insurance with, MIGA does not automatically count towards any assessment of long term membership for the purpose of any future insurance arrangements with Medical Insurance Australia.

If your period of suspension is going to exceed 12 months and you would like to maintain your continuity benefits with us, then we can offer you "Long Term Suspended Membership".

This is available to members who want to suspend their membership for up to 36 months. **It is not available for suspensions beyond 36 months.**

A (low cost) membership fee is payable annually for Long Term Suspended Membership however, you will not be entitled to any membership services during the period of suspension.

The key benefit of Long Term Suspended Membership is that if you reactivate your insurance with MIGA within 36 months of the start of your period of suspension, your prior periods of insurance with MIGA prior to suspension will count towards your continuity of membership for assessment of your long term membership with MIGA.

This applies only if:

- You have paid the annual membership fee each year
- Suspension is not as a result of suspension of registration by a Medical Board or equivalent body
- You have not practised as a medical practitioner in Australia during the period of suspension
- Insurance has not been arranged elsewhere during the period of suspension.

Note – You can however, purchase cover with MIGA for prescription writing, Good Samaritan Acts and Gratuitous Advice during the period of suspension without breaching this condition.

The period of suspension will not however, count towards any assessment of your length of continuous financial membership with MIGA when you reactivate your insurance and membership.

If you arrange insurance for prescription writing, Good Samaritan Acts and Gratuitous Advice during a period of suspension, then the period during which you have this insurance will count towards assessment of your length of continuous financial membership with MIGA.

At the end of the period of suspension (or if you resume practice at any time), it is important that you contact us to advise if insurance or membership is required.

If you do not insure again with MIGA at the end of the 36 months from the date you first suspended, you will lose your long term membership benefits with MIGA, even if you insure with us at a later date.

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Insurance

If you suspend your membership, it is important to note that you have no insurance cover after your date of suspension for:

- Incidents that occur after your date of suspension – unless you arrange ongoing insurance
- Incidents that may have occurred before your date of suspension and after your indemnity changed to a claims made basis – unless you arrange ERB (run-off) insurance (refer Section 13 of this PDS).

ERB insurance is available on an annually renewable basis to cover you for claims made during the period of suspension for incidents that may have occurred whilst you were still practising.

If you are ceasing practice because of maternity leave, you will be entitled to access free run-off cover via ROCS (refer Section 13 of this PDS).

If you intend to cease practice and/or wish to suspend your membership from 1 July 2007 or if your membership is currently suspended, you will need to indicate on your Renewal Form:

- the date you ceased practice or the date you intend to cease practice
- the reason for ceasing practice, and
- if you require cover for claims made after the date you ceased practice for incidents which occurred prior to ceasing practice (and after your Retroactive Date).

If you resume practice at any time (whether temporarily or permanently) you must notify Medical Insurance Australia before you commence practising to arrange appropriate insurance. If you do not, you will not be entitled to any cover for claims that are made in relation to incidents which occur after you resume practice.

This Section needs to be read in conjunction with Section 10, part d) regarding Non Practising doctors.

i) Resignation of membership of MDASA

Two months written notice of resignation as a member of MDASA is required, as per the Constitution of MDASA.

If resignation is accepted during the course of the membership year, there is no refund of the annual membership fee.

In the event of resignation or failure to renew, members must settle in full all outstanding amounts due.

Whilst two months written notice of resignation is required, any such notice lodged within 21 days of receipt of the renewal Tax Invoice will be deemed effective on 30 June of the relevant year, provided such notice is lodged by the member on or before 30 June of that year.

j) Cancellation of your insurance

Your insurance Policy with Medical Insurance Australia is non cancellable once effected (other than in relation to 'cooling-off' obligations or as provided for in the Insurance Contracts Act) (see Section 20).

Medical Insurance Australia will consider a pro-rata refund of the premium at its absolute discretion and in exceptional circumstances if you wish to cancel your insurance Policy. No cover will be provided after the date of cancellation for any claims made after this date unless ERB (run-off cover) is effected.

The cost of ERB will be offset against any applicable premium refund (if granted).

Section 16 : Claims and Advisory Services

a) Overview

MIGA provides an extensive medico-legal advisory and claims service.

Claims management and assistance is provided by an in-house team of solicitors with significant experience in personal injury and medical indemnity claims. We have an important network of external solicitors based in each State and Territory to assist our in-house team and provide direct support to our members.

We offer a 24 hour, 7 day a week emergency legal advisory service to doctors practising in Australia as we recognise medical emergencies which may have legal consequences can occur at any time.

b) Key features of our service

Key features of MIGA's in-house claims management resources are that we:

- Provide a 24-hour emergency legal advisory and claims notification service
- Manage all cases not requiring an external solicitor
- Carefully instruct and monitor external solicitors
- Maintain frequent personal contact with members involved in claims
- Maintain personal contact with instructed solicitors and medical experts engaged to advise on claims
- Provide prompt, personal, pragmatic advice
- Facilitate access to the MIGA Doctors' Support Service
- Ensure we are catering for your needs.

c) Our advisory services

Our advisory service is a feature of membership of MIGA.

We assist doctors with any enquiries they may have which arise in their medical practice and which relate to patient care. This is over and above the support provided in relation to claims.

The type of issues for which we provide support include:

- Patient consent
- Dealing with unhappy patients
- Dealing with complaints
- Statutory obligations
- Medical Board matters
- Coronial matters
- Health Care Complaints Commission matters
- Dealing with solicitors
- Responding to subpoenas
- Providing expert reports
- Privacy Act issues
- Investigations by Medicare Australia.

We encourage our members to call if there is any issue arising in relation to their practice and we will promptly and enthusiastically assist with the enquiry.

d) Claims management philosophy

The philosophy of MIGA with respect to claims management is to:

- Ensure the maintenance of the highest possible standard of legal representation in a manner that facilitates early and economic resolution of claims
- Provide personal and comprehensive support to members who are involved in the claims process. We care about the individual needs of members
- Ensure members are informed about pivotal decisions on a claim
- Manage all claims in a consistently fair and equitable manner
- Enable risk management data to be identified and utilised by the membership to reduce or prevent the recurrence of patient injury, and to minimise the risk of litigation and consequential financial exposure.

A disciplined and consistent process for establishing, managing and reviewing case reserves and claims is in place.

e) Notification of claims

Under the insurance Policy with Medical Insurance Australia, doctors are required to provide Medical Insurance Australia with written notice of any claim made against them during the Policy Period. This involves advising Medical Insurance Australia of the full details of the incident and the subsequent claim as soon as doctors become aware of it and in any event prior to the expiry of the Policy Period.

If doctors do not provide the required notice during the Policy Period then they may not be covered in respect of that claim. It is therefore extremely important that doctors ensure that Medical Insurance Australia is advised as soon as they become aware of a claim and that they ensure this notification is made to Medical Insurance Australia before the insurance cover expires.

Examples of claims are:

- If you are served with a writ, summons, statement of claim or third party notice
- If a letter from a solicitor or patient has been received
- Where the patient asks for reimbursement of fees or for the doctor to pay for anticipated future expenses because of dissatisfaction with the treatment or result.

f) Notification of circumstances

It is also important that doctors note the following in relation to the notification of circumstances during the Policy Period.

The Insurance Contracts Act provides that if, after the end of the Policy Period, a claim is made against a doctor which arises from facts that they notified to Medical Insurance Australia:

- in writing;
- as soon as reasonably practicable after they became aware of them; and

(continued on next page)

f) Notification of circumstances – continued

- before the end of the Policy Period

then Medical Insurance Australia will provide cover in accordance with the terms and conditions of the Policy in respect of the claim against them even if the claim was made against them after the end of the Policy Period.

We therefore encourage all doctors to notify Medical Insurance Australia as soon as they become aware of any circumstance or incident that is not a claim but which has the potential to lead to a claim, whether or not a formal claim is made against them.

Some doctors are uncertain about how to identify incidents or circumstances which are likely to become claims. It is impossible to produce a list which will catch all such circumstances, however the following is a useful guide:

- If a patient gives verbal indication of intention to claim
- If a request for a copy of notes has been received in circumstances where the doctor had already detected patient dissatisfaction and the outcome was not ideal
- Where a patient tells you they are unhappy with the result, outcome or treatment and intends to consult a solicitor or make a claim
- Complications (expected or unexpected) where the patient or relatives are dissatisfied or hostile
- Complications for which you or the patient were unprepared
- An incident has occurred which has led to a significant adverse outcome for the patient leading to a significant permanent disability
- You are concerned about your management or treatment of the patient (even where the patient has not complained).

In our experience the sort of incidents which may become claims include:

- Unexpected brain damage
- Unexpected return to operating theatre
- Perforation during operation resulting in significant increase in pain and suffering and extended stay in hospital
- Burns resulting from procedures or treatment
- Infection following a procedure resulting in significant increase in pain and suffering and extended hospital stay
- Failure or delay in diagnosis resulting in significant compromise of patient health and significant delay in treatment
- Breach of patient confidentiality
- Failure to follow up test results
- Failure to warn of risks associated with a procedure in circumstances where the risk materialises
- Expressed dissatisfaction with the outcome of a cosmetic procedure.

If you are uncertain about whether to notify, then call us and speak to one of our in-house solicitors to discuss the situation.

We encourage early communication and notification.

Early notification of claims, circumstances and incidents allows us to manage claims and potential claims in an early timeframe. This is always of benefit to the doctor. In addition early notification allows us to assess its risks and financial exposures more accurately which builds on the financial security of the organisation.

Please always contact us if there are any issues arising from patient care that we may be able to help you with.

If you would like to contact us about a medico-legal matter or if you need advice, click on the link on our website to send an email message or call and ask to speak to a solicitor in our Medico-legal Department.

Section 17 : Risk Management

a) Introduction

The Group has made a significant commitment to risk management. Our extensive investment in the Interactive Risk Management (IRM) Program and the quality of our senior risk management staff is evidence of this.

We see risk management as a key factor in the control of medical indemnity incidents and claims in the future.

Whilst our IRM Program is voluntary (other than for PSS participants) we encourage all members to participate for both their individual benefit and for that of the profession as a whole.

b) IRM Program

The IRM Program was launched in April 2002.

The key aim of the IRM Program is to assist members in achieving best practice and in doing so, reduce the overall number and severity of claims.

The Program is an innovative and integral part of the Group's services for members and it represents a strong commitment by us to the long-term value of risk management as a vital tool in controlling medical indemnity insurance costs in the future.

Feedback since the launch of the Program from members, the profession generally and our reinsurers has been overwhelmingly positive and we look forward to ongoing support for this valuable initiative.

c) Risk management services

Services available to members on an as needs basis include:

- Risk management advice
- Practice reviews for members/practices with high risk profiles
- Practice visits at member request where specific risk management issues have arisen.

We are continually reviewing the range of services offered to members and during 2007/2008 we will be building on the range of risk management services to members.

The following provides a more detailed outline of what the new services will encompass.

On-line service	Detail
Articles	• Will incorporate risk management tips and articles from the Bulletin plus additional articles which focus on topical issues
Useful Links	• Useful web links are added as the Risk management Department becomes aware of links considered of value to members
Fact Sheets	• The Risk Management Department has developed a number of Fact Sheets which are available to members • They are reviewed, updated and added to throughout the year • The Fact Sheets include: – Office Procedures – Medical Records – Patient confidentiality/Access to Medical Records – Consent Procedures – Infection Control – Complaints – Patient Follow Up – Abnormal Results
Case studies	• On-line case studies are being developed highlighting both medico-legal issues and risk management strategies • Member feedback from workshop evaluations has indicated that members are keen to understand better risk management strategies from closed and open claims files.

d) More information about the IRM Program

Refer to our IRM Program Booklet or visit our website at *www.miga.com.au* to find out more information about the Program and how you can enrol.

Section 18 : **Commonwealth Arrangements**

The comments and observations expressed in this Section are opinion only and are not intended to be legal advice. You should refer to the information published by the Commonwealth Department of Health and Ageing: www.health.gov.au *or obtain your own legal advice about these matters.*

a) Federal Government reform

Since 2003, the Federal Government has progressively released a series of reforms for medical indemnity the key aims of which have been to ensure that medical indemnity in Australia:

- Is financially sustainable, transparent and comprehensible to all parties
- Provides affordable, comprehensive and secure cover for all doctors
- Enables Australia's medical workforce to provide care and continue to practise to its full potential, and
- Safeguards the interests of consumers and the community.

MIGA has been extensively involved in consultation with the Federal Government on implementation of the new arrangements.

b) Medical indemnity – only offered by licensed insurers

From 1 July 2003, the nature of medical indemnity in Australia changed completely.

Federal legislation dealing with regulation of the industry and the introduction of prudential and product standards was passed by the Australian Parliament on 26 March 2003. The legislation meant a total change to medical indemnity for doctors in Australia from 1 July 2003.

The legislation introduced a comprehensive medical indemnity insurance framework which meant that from 1 July 2003:

- Medical indemnity for medical practitioners can only be offered via an insurance contract from a licensed and regulated insurer
- MDOs are prohibited from offering discretionary indemnity to members.

This meant a major change for the medical indemnity industry, MIGA and for doctors.

MIGA responded positively to these changes and implemented a new insurance framework which we believe will ensure long-term access by doctors to secure and sustainable medical indemnity.

c) Summary of key legislation

Following is a brief summary of key legislation that now applies to medical indemnity in Australia.

Arrangement	Key details
Premium Support Scheme (PSS)	• The PSS assists doctors with affordability of medical indemnity premiums
Run-Off Cover Scheme (ROCS)	• The aim of ROCS is to provide eligible doctors with access to free and unlimited run-off cover • ROCS is funded by a charge on medical indemnity insurers which is incorporated into each doctor's annual insurance premium
High Cost Claims Scheme(HCCS)	• The HCCS was introduced as a means to stabilise medical indemnity premiums by reducing the cost of large claims to insurers • The HCCS funds 50% of all claims in excess of $300k up to the limit of a doctor's insurance cover
Exceptional Claims Scheme (ECS)	• The ECS ensures that the Federal Government will cover the cost of claims that exceed an agreed threshold – which is currently set at $20m • The effect of this is that doctors have protection for claims that may ultimately resolve for an amount above the level of their policy cover with their insurer.

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d) Medical indemnity legislation – key facts

Over the past four years there has been a significant amount of legislative change in relation to medical indemnity. Following is a brief summary of key legislation that applies to medical indemnity in Australia.

Arrangement	Key details
Premium Support Scheme (PSS)	The PSS was introduced from 1 January 2004 to assist doctors with affordability of medical indemnity premiums Essentially, doctors are eligible for the PSS if their medical indemnity costs exceed 7.5% of their gross income from medical practice. If so, the PSS will provide funding for 80% of the amount above this threshold In addition to this: • Doctors who were previously entitled to the Medical Indemnity Subsidy Scheme (MISS) maintain this entitlement (to ensure that no doctor previously receiving a subsidy under MISS guidelines will receive less support under the PSS) • Doctors who are procedural GPs in a designated rural area will receive funding for 75% of the difference between their premium and that of a non-procedural GP in similar circumstances The PSS is managed by medical indemnity insurers and is offset against a doctor's total indemnity cost, excluding government charges such as stamp duty and GST.
Run-Off Cover Indemnity Scheme (ROCS)	ROCS came into effect on 1 July 2004 The aim of ROCS is to provide doctors with access to free and unlimited run-off for claims against: • doctors who are aged 65 or more who permanently retire from private medical practice • doctors who die or are forced to retire prematurely due to permanent disablement • doctors on maternity leave • other doctors who have permanently left private medical practice for a continuous period of three or more years, and • doctors in another qualifying group determined by regulation to be eligible ROCS is funded by a charge on medical indemnity insurers which is incorporated into each doctor's annual insurance premium Once cover is triggered, it is provided for as long as the doctor has ceased private medical practice and will be managed by the doctor's last insurer.
High Cost Claim Indemnity Scheme (HCCS)	The HCCS was introduced from 1 January 2003 as a means to stabilise medical indemnity premiums by reducing the cost of large claims to insurers The HCCS funds 50% of all claims in excess of $300k up to the limit of a doctor's insurance cover (note – when first introduced it provided funding for claims above $2m, but the attachment point was reduced to $300k from 1 January 2004) Key features of the HCCS are: • The HCCS does not directly affect doctors as it involves a reimbursement of claims costs to insurers • It will only provide a subsidy to the level of a doctor's policy limit with their medical indemnity insurer (which is currently $20m with MIGA) • It does not reimburse the cost of claims for incidents which occur outside Australia nor for the treatment of Public Patients in Public Hospitals (note – Medical Insurance Australia can still provide this cover).
Exceptional Claims Indemnity Scheme (ECS)	The ECS came into effect on 1 January 2003 It is intended that the Federal Government will cover the cost of claims that exceed an agreed threshold – which is currently set at $20m The intention is that doctors have protection for claims that may ultimately resolve for an amount above the level of their policy cover with their insurer It is intended that the cover is the same as the cover provided by the medical indemnity insurer at the time the claim is notified.
UMP Support Payment (UMPSP)	The Federal Government has provided a guarantee to UMP to fund its IBNR liability The UMPSP was introduced as a mechanism to require certain prior and current members of UMP to repay a proportion of the IBNR liability via the Federal Government The basic parameters of the UMPSP are: • It applies to doctors who were members of UMP as at 30 June 2000 (unless an exemption applies) • Annual levy payments were capped at $1000 for the first 18 months of the scheme (the 2004/2005 year) • UMPSP is only payable for a maximum of 4 years • A doctor's UMPSP will be calculated as the lesser of his or her former IBNR annual levy less $1,000 or 2% of gross income from medical practice less $1,000 or $4,000 • Doctors whose UMPSP would have been less than $1,000 are exempt • The length of time a doctor has to pay the levy is linked to the number of financial years, or part thereof, the doctor was a member of UMP prior to 30 June 2000 (eg doctors who were members for only one year will pay the levy for one year) Doctors can pay their UMPSP levy via their medical indemnity insurer, therefore incorporating the cost as part of the PSS Since inception, many doctors have accessed the facility via us.

Section 19 : **Premium Support Scheme**

Part 1 – Scheme Details

a) Introduction

The PSS is a Commonwealth Scheme introduced to assist eligible doctors to meet the cost of their medical indemnity insurance.

Medical Insurance Australia has entered into an agreement with the Department of Health and Ageing and Medicare Australia to administer the scheme on the Commonwealth's behalf.

To assist you estimate the potential impact on your Policy premium and therefore to help you decide whether to acquire a Policy from Medical Insurance Australia we have prepared the following information about the PSS. It will assist you to make an informed decision regarding your eligibility to participate in the scheme and how participation may impact upon your practice and insurance arrangements.

If you have any queries, please contact us.

b) The nature of the PSS

The Scheme assists eligible doctors through a PSS payment, paid via their medical indemnity insurer, by reducing their medical indemnity costs in one of two ways:

- through a reduction in the premium requested in the doctor's medical indemnity invoice, or
- through a payment made directly to the doctor (if they have already fully paid the full indemnity cost).

c) Eligibility

You may be eligible for the scheme if:

- your Gross Indemnity Costs for the Policy Period exceed 7.5% of your estimated or actual income (for definition of income see paragraph 'f' page 48), or
- you conduct work as a Procedural General Practitioner in an area that is classified by the Department of Health and Ageing as a Remote, Rural or Metropolitan Area (RRMA) 3-7, or
- you previously received a subsidy under MISS and continue to work in the same specialty.

A doctor:

- whose practice is primarily based on public billings; and
- who does not have a liability in a Premium Period for Run-Off Cover or Retroactive Cover for the provision of private medical services prior to the doctor's practice being based primarily on public billings; and
- who obtains Medical Indemnity Cover for some private medical services which are not indemnified under a rights to private practice agreement;

is not eligible for a PSS Payment in respect of Gross Indemnity Costs relating to those private medical services unless the doctor's Estimated or Actual Income, as the case may be, exceeds $1,000 for the Policy Period.

d) Electing into the PSS

You may elect into the PSS when you join MIGA or on renewal of your insurance and membership. To elect in at other times the following must be adhered to:

- If you wish MIGA to calculate your entitlement based on your Estimated Income you must provide these details to MIGA in a timely manner so that we can make an application for PSS on your behalf
- If you wish MIGA to calculate your entitlement based on your **Actual Income**, you must provide these details to MIGA in a timely manner so that we can make an application on your behalf within 12 months after the end of the Policy Period.

e) PSS support calculation

The Basic PSS support calculation

Doctors meeting the basic eligibility criteria qualify for the following PSS support calculation:

80% of the amount by which your Gross Indemnity Costs exceed 7.5% of your estimated or actual income.

PSS support calculation for Rural Procedural General Practitioners

General practitioners who are liable to pay a higher premium for medical indemnity cover for a procedural general practice, and who conduct procedural general practice in an area classified by the Department of Health and Ageing as a Rural, Remote or Metropolitan Area 3-7, qualify for the following PSS support calculation:

75% of the difference between your premium and that of a non-procedural GP in the same income band and state.

This support will not be paid where you are charged a premium higher than the premium charged to non-procedural general practitioners solely because of the performance of non-therapeutic cosmetic procedures.

However, for rural procedural GPs should the application of the basic PSS calculation result in PSS support of greater dollar value, Medical Insurance Australia will apply the basic calculation.

Alternate PSS support calculations

Some groups of doctors may qualify for alternate calculation methods having regard to previous subsidy arrangements under MISS. This is intended to ensure that no doctor who has been receiving a subsidy under MISS is disadvantaged by the application of the basic PSS calculation.

Doctors who have been receiving a MISS subsidy will still need to provide a declaration of estimated income in order to receive any PSS calculated on the basic calculation where PSS calculated on the basic calculation would result in support of a greater dollar value.

f) Definition of Actual and Estimated Income

Actual Income

For the purposes of PSS, actual income is defined as the total of all billings generated by you from all areas of practice for which you require medical indemnity cover for the Policy Period (in your name) or for work for which you are personally liable, including without limitation Medicare benefits, payments by individuals, and payments by the Department of Veterans' Affairs, workers compensation schemes and third party and/or vehicle insurers and income earned for medical practice overseas that is covered by the Policy, whether retained by you or otherwise and before any apportionment or deduction of any expenses and/or tax. If as part of practice, you derive income from any other sources (ie professional fees, incentive payments etc) this income must be included in the declaration of actual income.

Estimated Income

Estimated income means a genuine estimate of your actual income.

g) Definition of Gross Indemnity Costs

Gross Indemnity Costs means, costs charged to you, or for which you are liable, for the Policy Period, comprising:

- the premium payable to Medical Insurance Australia inclusive of any premium discounts and premium for the national ROCS scheme
- membership fees payable to MDASA
- UMP Support Payment (if any)
- any costs payable to another insurer for other Retroactive or Run-off Cover and
- 50% of any risk surcharge charged to you

but does not include:

- GST
- Stamp Duty
- capital calls
- excess payments or deductibles
- charges imposed by the insurer on you for late payment of any of these costs (including the premium)
- late payment penalties under the Medical Indemnity Act or
- any amount of premium primarily for a policy that covers the employees of a medical practitioner or an entity that runs a medical practice (being a company, partnership or other entity).

Part 2 – Terms and Conditions of PSS

h) Payment of Gross Indemnity Costs

Payment of the indemnity costs remains your responsibility.

Whilst this responsibility may be satisfied in part by a PSS support from Medicare Australia, should you subsequently become ineligible for a PSS support, you are liable for the full payment of the Gross Indemnity Costs and repayment of any PSS overpayment.

Similarly, should the amount of the PSS support decrease (because actual income is reported higher than estimated income or because you are ineligible due to factors outlined in paragraph 'n'), you are liable for the remaining proportion of your Gross Indemnity Costs.

i) Provision of information

By electing to participate in the PSS, you will be agreeing to provide to Medical Insurance Australia and to Medicare Australia any information required to assess eligibility and administer the scheme, including but not limited to:

- your estimated income for the Policy Period
- your actual income (in the form of a statutory declaration), for any previous period of insurance (or part of one) if PSS support was made in that Policy Period
- the costs payable to other insurers for Run-Off Cover or Retroactive Cover for any previous period of insurance which are payable by you during the current Policy Period
- your medical specialty
- your provider number(s) and
- whether you practise in an area classified by the Department of Health and Ageing as a Rural, Remote or Metropolitan Area (RRMA 3-7).

If you wish to have PSS support applied to your medical indemnity invoice at the beginning of the Policy Period, you must provide a declaration of estimated income to Medical Insurance Australia in a timely manner so that Medical Insurance Australia can make an application for PSS on your behalf. A declaration of actual income must be provided within 12 months of the end of the Policy Period. Failure to provide a declaration of actual income within 12 months of the end of the Policy Period to which a PSS support payment relates will mean that you cease to be eligible for PSS support for that Policy Period and you will be required to pay the full Gross Indemnity Costs to Medical Insurance Australia.

j) Provision of information by those doctors eligible for MISS

If you are eligible for the MISS calculation you may also be eligible for one of the other PSS calculation methods (see paragraph 't'). In determining the amount of support you may receive a comparison between the methods of calculation will be made. If one of the other methods provides a higher benefit this will be used as the amount

(continued on next page)

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j) Provision of information by those doctors eligible for MISS – continued

of support provided information relating to income is supplied. If income information is not supplied then only the MISS calculation can be used.

k) Participation in risk management programs

If you elect to participate in the PSS, receipt of a PSS benefit is subject to you undertaking agreed risk management activities. This is a Federal Government requirement.

We have determined that enrolment in our IRM Program and completion of activities in categories 1, 2 and/or 3 equivalent to at least 4 IRM Points will be satisfactory for the purpose of meeting this requirement and receiving the Commonwealth PSS benefit. For details of category 1, 2 and 3 activities please refer to the IRM Program 2007/2008 Booklet.

If you elect to participate in the PSS as a retired member, you do not need to enrol in the IRM Program so long as you do not re-commence Practice during the Policy Period. If you do re-commence Practice during the Policy Period, you will need to enrol in and complete IRM Program activities in categories 1, 2 and/or 3 equivalent to at least 4 IRM Points in order to qualify for the PSS.

If you receive a PSS benefit applicable to the 2007/2008 Policy Period and do not comply with the above requirements, you must repay any PSS benefit received. In the event you do not repay a PSS benefit as and when it falls due:

- you will not be eligible to participate in the PSS; and
- it may affect your entitlement to insurance from MIGA,

both now and in the future.

To receive the full benefits of the IRM Program and a premium discount, members must complete a broader range of risk management activities and achieve the required points for the IRM Program, as outlined in the IRM Program 2007/2008 Booklet.

l) Participation in information sharing and confidentiality

By electing to participate in the PSS, you agree to the sharing of your personal information between Medical Insurance Australia, the Department of Health and Ageing, and Medicare Australia.

Medical Insurance Australia, the Department of Health and Ageing and Medicare Australia may also be required to disclose personal information to APRA, by law, for public accountability reasons, including a request for information by parliament or a parliamentary committee, or to meet other reporting requirements. Wherever practicable, this information will be de-identified prior to disclosure.

Medical Insurance Australia acknowledges its responsibilities in the proper handling of personal information it collects and holds and will not do any act or engage in any practice that would breach an information privacy principle contained in section 14 of the Privacy Act as amended.

A copy of Medical Insurance Australia's privacy policy is available upon request or at our website *www.miga.com.au* .

m) Participation in audits

By electing to participate in the PSS, you agree to participate in audits in relation to your stated income and other information provided by you under the scheme.

n) Factors affecting a doctor's eligibility

Regardless of whether you meet the eligibility criteria specified in paragraph 'c', you may cease to be eligible for a PSS support in the current or future Policy Periods if:

- Medical Insurance Australia or Medicare Australia know, or have reason to believe, that you have provided inaccurate information
- you have not provided information to Medical Insurance Australia on actual income in the time specified by Medical Insurance Australia
- you have not repaid to Medical Insurance Australia an overpayment of a PSS support payment within the timeframe specified by Medical Insurance Australia
- you fail to pay a UMP Support Payment (if liable) within the time specified by Medical Insurance Australia or Medicare Australia or
- you have failed to participate in and/or complete risk management programs that are considered by Medical Insurance Australia to be appropriate and designed to assist you to identify risks and implement appropriate risk mitigation strategies.

If you are deemed no longer eligible for the PSS you are liable for the full amount of the Gross Indemnity Costs.

If you applied to the Department of Health and Ageing prior to 30 June 2004 and obtained a subsidy under the MISS, you only remain eligible for that calculation method if you continue to practise in the same specialisation (unless on leave for less than 12 months).

A change in specialty after 1 July 2004 will mean the MISS calculation will no longer be applicable.

o) Medical practice outside Australia

If you practise as a medical practitioner outside Australia for a total of six months or more during the Policy Period you will not be eligible for PSS.

The six month period includes leave taken in the ordinary course of medical practice (such as holiday or illness) but does not include any other absence from practice as a medical practitioner.

If you practise outside Australia during the Policy Period for one of the following reasons this practice is taken to be practice in Australia for PSS purposes:

- where you are on a sporting, cultural or official tour (only if it involves Australian citizens)
- where you are undertaking aid work.

p) Change of insurance details or estimated income

While participating in the PSS you are required to advise Medical Insurance Australia if your estimated income (see definition in paragraph ‘f’) or any other insurance details change. This includes a change in Category, retirement or resignation from MIGA.

Upon receipt of this advice, Medical Insurance Australia will recalculate the Gross Indemnity Costs payable (if required) and revise the PSS support due. This revision may result in one of the following:

- you are now eligible for PSS support and, since you have already paid the full indemnity costs, PSS support will be made by Medical Insurance Australia directly to you, or
- you are entitled to a refund of overpaid premium, or
- you will be required to pay additional premium, offset by PSS support, or
- you are no longer eligible for PSS support and are required to pay the full amount of all indemnity costs from the point at which you became ineligible.

Within 12 months of the end of the Policy Period, you will be required to provide Medical Insurance Australia with confirmation of your actual income in the form of a statutory declaration. At this time, Medical Insurance Australia will again revise the PSS support due and any of the above scenarios may apply.

If you have any queries on how changes in your insurance category or professional details may affect your PSS support calculation, please contact us.

Please note that where any change requires an adjustment to your PSS payment of less than $100 Medical Insurance Australia may not process such an adjustment mid-term.

q) The administration fee

Medical Insurance Australia receives an administration fee from the Commonwealth to reimburse us for the implementation and ongoing costs of administering the PSS.

Apart from receiving such reimbursement, Medical Insurance Australia does not receive commission or benefits, and makes no charge upon the doctor, for administration of the scheme.

r) GST and Stamp Duty

PSS support does not include or attract GST or Stamp Duty.

UMP Support Payments do not include or attract GST or Stamp Duty.

You are liable for the full amount of GST and Stamp Duty payable on your Gross Indemnity Costs.

s) Dispute resolution

If you have any complaints about the insurance product or related services provided by MIGA you should contact us immediately and refer to the dispute resolution information on page 52.

Matters relating to decisions or actions of the Department of Health and Ageing or Medicare Australia should be referred to those bodies and not MIGA.

t) Alternate PSS calculations – MISS

Specialisation	PSS Support Calculation	Applies to
Procedural GP	PSS support is equal to 50% of the difference between your premium and that of a non-procedural GP in the same income band and state.	General Practitioners who: • prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under the MISS • are liable to pay a higher premium for medical indemnity cover for procedural general practice unless that higher premium is solely because of the provision of non-therapeutic cosmetic procedures and • who continue to work as a procedural GP (unless on leave for less than 12 months).
Procedural GP Registrar	PSS support is equal to 80% of the difference between your premium and that of a non-procedural GP in the same income band and state.	General Practitioner Registrars who: • prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS • are liable to pay a premium for medical indemnity cover for procedural general practice unless that higher premium is solely because of the provision of non-therapeutic cosmetic procedures and • continue to work as a procedural GP Registrar (unless on leave for less than 12 months).

(table continues on next page)

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t) Alternate PSS calculations - MISS – continued

Specialisation	PSS Support Calculation	Applies to
Rural Specialist Obstetrician	PSS support is equal to 80% of the difference between your premium and that of a Gynaecologist in the same income band and state.	Specialist Obstetricians who: • prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS • continue to work as a Specialist Obstetrician (unless on leave for less than 12 months) and • conduct Specialist Obstetrician work in an area classified by the Dept of Health and Ageing as a Rural, Remote or Metropolitan Area 3-7.
Specialist Obstetrician (non-rural)	PSS support is equal to 50% of the difference between your premium and that of a Gynaecologist in the same income band and state.	Specialist Obstetricians who: • prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS, and • continue to work as a Specialist Obstetrician (unless on leave for less than 12 months).
Neurosurgeons	• If the total amount of premium for the premium year is $50,000 or less and the premium of a General Surgeon in the same state and income band is less than $50,000, the PSS support is equal to 50% of the difference in premium • If the total amount of premium is more than $50,000 and the premium of a General Surgeon in the same state and income band is less than $50,000, the PSS support is equal to: – 80% of the amount by which the total amount of premium exceeds $50,000, PLUS – 50% of the difference between $50,000 and the premium of the General Surgeon • If the total amount of the premium is more than $50,000 and the premium of a General Surgeon in the same state and income band is $50,000 or more, the PSS support is equal to 80% of the difference in premium.	Neurosurgeons who: • prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS and • continue to work as a Neurosurgeon (unless on leave for less than 12 months).

Section 20 : **Other Information**

a) Your duty to disclose

Before you enter into a contract of general insurance with an insurer you have a duty under the Insurance Contracts Act to disclose to the insurer every matter which you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to us before you renew, extend, vary or reinstate a contract of insurance.

Your duty however does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer;
- that is common knowledge;
- that the insurer knows or, in the ordinary course of business as an insurer, ought to know;
- as to which compliance with your duty is waived by the insurer.

Non-Disclosure

If you fail to comply with your duty of disclosure, Medical Insurance Australia may be entitled to reduce its liability under the contract in respect of a claim or may cancel the contract.

If your non-disclosure is fraudulent, Medical Insurance Australia may also have the option of avoiding the contract from its beginning.

Comment

The requirement of full and frank disclosure of anything which may be material to the risk for which you seek cover (eg. claims, whether founded or unfounded), or to the magnitude of the risk, is of the utmost importance with this type of insurance. It is better to err on the side of caution by disclosing anything which might conceivably influence the insurer's consideration of your proposal.

b) Cooling-off period

When you receive your Policy and Certificate of Insurance and Membership, please read the documents carefully. If you decide that your cover does not meet your needs for any reason, you can cancel it by notifying us in writing or electronically within 14 days of the date of inception of your Policy. This period is known as the 'cooling-off' period. When we receive your instructions to cancel, we will refund any payments (less any tax that may apply to your premium).

You will not be able to cancel your Policy under the cooling-off period provisions if you have made a claim (or notified a circumstance) under your Policy during the cooling-off period.

c) Dispute resolution

If you are not happy with our product or services or you have any complaint about MIGA, we will do our best to resolve the matter in a fair and equitable manner with you.

Our process for resolution of any matters is two tier and is as follows:

Internal Dispute Resolution process

- This process enables you to first raise any matter or concern with our Dispute Resolution Officer
- Simply contact us and then submit details of your complaint in writing to us
- If the matter is not resolved within 10 working days of reference to our Dispute Resolution Officer, your issue will be automatically referred to our Internal Dispute Panel
- Our commitment in terms of how disputes will be resolved and dealt with is as follows:
  - Where the dispute is resolved internally in favour of you any action required by MIGA to resolve the matter will be undertaken immediately and we will then consider the matter resolved
  - Where the dispute is resolved against you the decision will be communicated in writing to you
  - MIGA will consider each dispute on the basis of the specific facts and documentation surrounding the dispute. MIGA is committed to acting with fairness and objectivity at all times when dealing with a dispute and the member lodging it.

External Dispute Resolution process

If you are not satisfied with the steps taken by us to resolve your complaint or you are not comfortable with the resolution, you can seek assistance from the Insurance Ombudsman Service (IOS).

The IOS is an independent industry body established to review consumer disputes in relation to insurance.

You can refer a dispute to the IOS at no cost to you, but you must refer any matters to the IOS within three months of being advised by us of our decision in relation to the disputed matter through our Internal Dispute Resolution process.

The IOS will only consider insurance matters. It cannot consider matters relating to your membership of MDASA nor any entitlements you may have to discretionary indemnity with MDASA.

If you would like more information about the IOS, if you have a dispute or would like to make a complaint, we will provide a summary of the process for handling matters through the IOS to you.

d) Contacting us

See 'Contacting MIGA' on page (i).

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e) Privacy

MDASA and Medical Insurance Australia comply with the Privacy Act and the National Privacy Principles.

MIGA requires the information requested from you in the Application or Renewal Form to undertake its functions as an insurer and medical defence organisation, under the terms of MDASA's Constitution, Medical Insurance Australia's Policy Wording and for your benefit. If you do not declare all the information sought, then the Application or Renewal Form may not be actioned.

MDASA and Medical Insurance Australia may provide your personal information to each other, to their related bodies corporate and to third parties including, but not limited to, insurance agents and brokers, insurers, reinsurers, lawyers, actuaries, auditors and medical boards in Australia and overseas – they may also provide information about the currency of your medical indemnity insurance to any health care provider from which you seek admitting rights or to which you apply for work.

MIGA is required under the terms of the Medical Indemnity Act to provide to Medicare Australia upon request any information that you provide, including the information in the Application or Renewal Form, that may be relevant to determining an entitlement to an indemnity or subsidy scheme payment under that legislation.

In most circumstances you can access the information that MIGA holds about you but sometimes there will be a reason why that access is not possible, in which case you will be told why.

f) Other information

You need to obtain independent tax advice to determine the tax implications of purchasing medical indemnity insurance.

Medical indemnity insurance cannot be on-traded.

Notes

Contacting MIGA

National Free Call:
1800 777 156

24 hour emergency advisory service:
(08) 8238 4444

Website:
www.miga.com.au

Email:
miga@miga.com.au

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MIGA
The Medical Insurance Group

Practise *with confidence*

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