

2008/2009
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.

Defined Terms

Actual Income, Estimated Income, Gross Income and Gross Indemnity Costs have the meanings set out in Sections 13 and 20

APRA means the Australian Prudential Regulation Authority

Category means your practice category, as set out in the relevant Section of this PDS

ECS – Exceptional Claims Indemnity Scheme

ERB means Extended Reporting Benefits

FSG means Financial Services Guide

HCCS – High Cost Claim Indemnity Scheme

Insured has the same meaning as in the Policy

IOS – Insurance Ombudsman Service

IRM Program means Interactive Risk Management Program

MDASA means Medical Defence Association of South Australia Limited

MDO means medical defence organisation

Medical Insurance Australia means Medical Insurance Australia Pty Ltd

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

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

MISS means the Medical Indemnity Subsidy Scheme

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

PDS means Product Disclosure Statement

PPF – Pacific Premium Funding Pty Ltd

Policy means the Medical Indemnity Insurance Policy that is issued to you by Medical Insurance Australia

Policy Period means the period of insurance noted on your Policy Schedule

Policy Schedule means the document issued by us to you confirming details of your insurance arrangements for the Policy Period

PSS means the Premium Support Scheme

ROCS means the Run-off Cover Indemnity Scheme

Session has the meaning set out in Section 13

SMO means a Salaried Medical Officer

SOA – Statement of Advice

us, our or **we** means MIGA

you, your or **yourself** means an individual who is a member of MDASA and has medical indemnity insurance with Medical Insurance Australia



MIGA is committed to service and has voluntarily adopted the general insurance industry 2005 Code of Practice

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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.

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 2008/2009 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 the Group

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.

The Group's Head Office is in Adelaide and our branch offices are located in Brisbane, Melbourne and Sydney.

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

Our vision

Our vision is:

"To be the leading provider of medical indemnity insurance and related services to the medical profession across Australia, providing confidence through personal care, professional service and high quality insurance and risk management products."

We want to be known as the insurer that adds value and creates confidence in medical indemnity by:

- Being the best – but not the biggest
- Being competitive – but not the cheapest
- Delivering the best insurance solutions and products
- Maintaining our culture, professionalism, quality and service – as we grow
- Being seen as leaders in the industry.

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) <ul style="list-style-type: none">• A doctor-owned, mutual, non-profit organisation• Formed in 1899• It has no "shareholders", only doctor members	Provides a range of membership services
Medical Insurance Australia Pty Ltd (Medical Insurance Australia) <ul style="list-style-type: none">• A wholly owned subsidiary of MDASA• A licensed general insurer• Regulated by the Australian Prudential Regulation Authority (APRA)	Provides medical indemnity insurance

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 (i.e. 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 54.

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • After 40 years of continuous financial membership of MDASA, members are entitled to apply for Compound Life Membership (CLM) • This benefit rewards the loyalty of members to MDASA • CLM provides annual membership of MDASA at no cost • If still practising, doctors need to arrange and pay for medical indemnity insurance through Medical Insurance Australia
MIGA Foundation Elective Grants Program (Medical Students only)	<ul style="list-style-type: none"> • Provides financial assistance to selected Medical Students by awarding a Grant to assist with undertaking an elective in a developing community
Additional services only available to insured members	
Access to our Interactive Risk Management (IRM) Program	<ul style="list-style-type: none"> • Offers a maximum 10% discount off the next year's insurance premium upon full compliance
24-hour emergency medico-legal advice and support	<ul style="list-style-type: none"> • Catering for urgent situations where medico-legal advice is required • Provided to all insured members across Australia
Doctors' Support Services	<p>Doctors who are involved in a claim can access the following services</p> <ul style="list-style-type: none"> • Medical Support Service – provided by one of a group of psychiatrists or psychologists offering professional clinical support • Peer Support Service – provided by one of a group of medical practitioners offering support and understanding
Members' only internet access	<p>Provides a range of on-line resources, including:</p> <ul style="list-style-type: none"> • Insurance – On-line completion and lodgement of renewal forms, payment and access to certificates • Medico-legal Services – On-line lodgement of claims and circumstance notifications • IRM Program <ul style="list-style-type: none"> – On line bookings for Workshops – Access to status of IRM points accumulated throughout the year – On-line access to Practice Self Assessments, Questionnaires and Speciality Quizzes providing immediate feedback on their input and benchmarking against other participants <p>(continued on next page)</p>

Membership Benefit	Additional services only available to insured members
Risk management services	Services available on an as needs basis include: <ul style="list-style-type: none">• 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 for downgrades in Category and for ROCS Gap Cover, on completion of qualifying periods
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 and requirements of modern medical practice and the unique requirements of our doctor members.

A copy of the 2008/2009 Policy will be provided to you with your quotation or with your renewal package in June 2008.

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.

The information in this Section is for guidance only. Entitlements under the Policy are determined in accordance with the terms and conditions of the particular Policy and Policy Schedule which are issued.

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 recognizing that not all members need the full range of cover.

c) Limit of Indemnity

The Limit of Indemnity provided by Medical Insurance Australia is as follows:

Division	Limit (any one claim and in the aggregate in any one Policy Period)	Sub-Limit for	Sub-Limits – any one claim and in the aggregate
Division 1 Section 1	\$20,000,000 for Claims and associated legal expenses		
Division 1 Section 2	\$1,000,000 for Expenses and General Expenses	Expenses for breaches of <i>Trade Practices Act 1974</i> or equivalent State or Territory Legislation (Refer clause 1.5(e) of the Policy)	\$20,000
		Expenses in relation to threats to the personal safety of the Named Insured, Employees or their immediate family (Refer clause 1.5(f) of the Policy)	\$20,000
		General Expenses for complaints under an employment contract of the Named Insured (Refer clause 1.7(c) of the Policy) Subject to a Deductible of \$1,000 each claim, inclusive of costs and expenses	\$20,000
		General Expenses for disputes under a visiting medical officer contract of the Named Insured (Refer clause 1.7(b) of the Policy)	\$75,000
Division 2		Liability for restricting ability to practise (Refer clause 2.10 of the Policy)	\$100,000
		Loss of Documents (Refer clause 2.12 of the Policy)	\$100,000
		Out of pocket expenses (Refer clause 2.18 of the Policy)	\$10,000
Division 3		Innocent partner cover (Refer clause 3.1 of the Policy)	Limited by reference to the number of partners in the partnership

The above limits are not cumulative which means that if you have cover for both Sections 1 and 2 of Division 1, 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 \$1,000,000 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.

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

Section	Cover
Division 1 Section 1 – Indemnity for claims and/or circumstances arising out of the practice of medicine within the Category	<p>Provides cover for:</p> <ul style="list-style-type: none"> • Damages and claims for compensation • Legal costs incurred in defending claims
Division 1 Section 2 – Expenses	<p>Part A – Specific Expenses Provides cover for legal costs and expenses incurred in responding to complaints, investigations or proceedings</p> <p>Extends to legal costs arising from defending a prosecution or responding to the following that arise in connection with Practice:</p> <ul style="list-style-type: none"> • Medical Board, Medical Tribunal or other disciplinary body • <i>Health Insurance Act 1973</i> inquiries • Coronial inquiries, royal commissions • Health authority, Medicare Australia a health complaints body or a health care ombudsman • Criminal investigations and proceedings • <i>Trade Practices Act 1974</i> or equivalent provisions in any State or Territory legislation • Professional college or association, hospital or health service • Threats to personal safety. <p>Part B – General Expenses Provides cover for legal costs and expenses arising from other practice matters such as employment, visiting medical officer and employment contracts.</p>
Division 2 – Automatic Extensions	Provides cover for Good Samaritan Acts, Gratuitous Advice, vicarious liability, practice outside Australia, volunteer practice, liability for restricting ability to practise, medical research and clinical trials, loss of documents and out of pocket expenses.

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 13) and paid the premium (including any premium adjustments) and charges in full
- Have provided a declaration of actual Gross Income/Sessions upon request
- Have been issued a Policy Schedule reflecting the cover provided.

d) What you are covered for

The cover you receive from MIGA is in relation to the work you undertake as per the Category you select, as follows:

Category	Division 1 Section 1 – Indemnity for claims and/or circumstances	Division 1 Section 2 – Indemnity for Specific and General Expenses	Division 2 – Indemnity for Good Samaritan Acts and Gratuitous Advice
Specialists			
All Specialist categories	Yes	Yes	Yes
General practitioners			
All GP categories	Yes	Yes	Yes
Cosmetic Medical Practitioners			
All Cosmetic Medical Practitioner categories	Yes	Yes	Yes
Employer Indemnified			
Interns	No	Yes	Yes
Staff Specialists and Salaried Medical Officers			
• With no or limited Private Practice	Yes	Yes	Yes
• With no Private Practice – Medical Board, tribunal & coronial cover only	No	Yes	No
• Salaried Medical Officer – Private Sector	No	Yes	Yes
Other Practice			
All “Other” Categories (Refer pages 31 and 32)	Yes	Yes	Yes

If you are retired or temporarily not practising then you need to refer to Section 11 for the cover that is available to you.

e) 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	<p>Our Policy is structured to respond to the changing nature of doctors' medical practice. It automatically includes as an Insured:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – Provided they are assigned to the Practice by their university – In relation to matters that arise whilst working in the Practice. <p>Employees who are not included as an Insured are:</p> <ul style="list-style-type: none"> • Employed medical practitioners, as they must arrange their own insurance • Other employees who charge for and bill in their own name, unless they are working under your direct control and supervision.
Scope of cover for expenses	<p>Under Division 1 Section 2 of our Policy we provide cover for Expenses incurred in relation to investigations, proceedings or complaints.</p> <p>These include:</p> <ul style="list-style-type: none"> • Medical Board, Medical Tribunal or other disciplinary investigations or proceedings • Coronial inquiries, royal commissions • Hospital, health service or health authority or Medicare Australia • Criminal investigations and proceedings • <i>Health Insurance Act 1973</i> inquiries • <i>Trade Practices Act 1974</i> or equivalent State or Territory legislation • Professional college or association, health care complaints body or a health care ombudsman • Threats to your personal safety or that of your employees • Employee matters • In defending or pursuing matters in relation to a contract as a visiting medical officer of the doctor • In defending or pursuing matters in relation to an employment contract of the doctor. <p>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.</p> <p>This provides very important protection in the event of such allegations.</p>
If you change your area of practice to a lower risk Category	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – 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: <ul style="list-style-type: none"> – 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.

f) Automatic Policy extensions

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

Benefit	Detail
Public Patients	Covers you, your Employees and an Insured Entity for treatment of public patients provided you are not otherwise indemnified for medical services provided to public patients.
Good Samaritan Acts – Worldwide	Covers you for Good Samaritan Acts anywhere in the world including USA.
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 Practice 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: <ul style="list-style-type: none"> • Work that he or she is employed to undertake and for which he or she are registered, if required by law to be registered by a Medical Board • 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 insurance covering the employed medical practitioner when he or she was first employed and subsequently when any material change to their practice occurred and when due for renewal.
Vicarious liability for contractors	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, in the course of providing services for your Practice. Cover is subject to: <ul style="list-style-type: none"> • Work that he or she is contracted to undertake and for which he or she is registered or licensed, if required by law to be registered or licensed • The contracted 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 insurance covering the contractor when he or she was first contracted and subsequently when any material change to their practice occurred and when due for renewal.
Vicarious liability for supervision, training or mentoring	Covers you for vicarious liability for any act, error or omission committed or alleged to have been committed by a non-employed health care professional under your direct supervision, training or mentoring. Cover is subject to the supervised, trained or mentored individual: <ul style="list-style-type: none"> • 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.

(table continues on next page)

f) Automatic Policy extensions – continued

Benefit	Detail
Vicarious liability for locums	<p>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.</p> <p>Cover is subject to:</p> <ul style="list-style-type: none"> • The locum being engaged as a contractor (not as an employee) under a written agreement • You having obtained written evidence of current insurance at the time his or her contract commenced, when any material changes to his or her practice occur and on renewal • The term of the locum appointment not being for more than: <ul style="list-style-type: none"> – 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 <p>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.</p>
Practice outside the Commonwealth of Australia	<p>Covers you for practice overseas, excluding USA and a jurisdiction in which the laws of the USA apply, provided the total period of overseas practice does not exceed 120 days during the Period of Insurance.</p> <p>Cover is provided for you and an Employee accompanying, as a team doctor, an Australian sporting team or cultural group that is travelling, competing or performing in the USA for no more than 120 days during the Period of Insurance.</p>
Volunteer Practice	<p>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.</p>
ACCC inquiries...	<p>Covers you for any action by a government or statutory authority alleging a contravention of or seeking relief under a provision of the <i>Trade Practices Act 1974 or any equivalent State or Territory legislation</i>, subject to a sub-limit of \$20,000 for each claim and in the aggregate per policy period.</p>
Liability for restricting ability to practise	<p>Covers you for claims arising in the course of supervising, training or mentoring a registered medical practitioner:</p> <ul style="list-style-type: none"> • 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. <p>Cover under this automatic extension is subject to a sub-limit of \$100,000 and other conditions as detailed in the Policy.</p>
Medical research and clinical trials	<p>Covers you (and any employee acting under your supervision) for your role in medical research or a clinical trial if:</p> <ul style="list-style-type: none"> • 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 or practice within your category or a lower risk category and for 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	<p>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.</p> <p>Cover under this automatic extension is subject to a sub-limit of \$100,000 and other conditions as detailed in the Policy.</p>

(table continues on next page)

Benefit	Detail
ROCS Gap Cover	<p>ROCS Gap Cover provides cover for you if you:</p> <ul style="list-style-type: none"> • permanently cease private practice, and • are not yet eligible for ROCS, i.e. you have not yet reached age 65, and • have 5 years of continuous insurance/membership with us (excluding insurance as a Medical Student) <p>We provide run-off cover to eligible doctors for up to 3 years on an annually renewable basis until they are eligible for ROCS.</p> <p>Any additional premium is capped at \$50 per annum exclusive of statutory charges.</p>
Threat to personal safety	<p>Covers you for Expenses in relation to any threat to the personal safety of you, an Employee or your or their immediate family that arises in relation to your Practice.</p> <p>Subject to a sub-limit of \$20,000 for each claim and in the aggregate per policy period.</p>
Out of pocket expenses	<p>Covers you for reasonable out of pocket expenses incurred by you in responding to a Claim or a matter that has given rise to Specific Expenses, subject to our prior approval.</p> <p>This is intended to cover costs such as travel, meals and accommodation expenses.</p> <p>Subject to a sub-limit of \$10,000 for each claim and in the aggregate in the policy period.</p>

g) Optional Policy extension – Innocent partner cover

We offer an optional policy extension called “Innocent Partner Cover”.

This extension is available 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.

If you require this extension please indicate this on your Application or Renewal Form or call our Client Services Department.

If this extension to cover is granted it will be noted on your Quotation and Policy Schedules and a premium loading may apply.

h) Cover for treatment of public patients

Our Renewal Guide for 2008/2009, indicated we were considering changing our cover this year so that cover for the treatment of public patients would be provided as an optional Policy extension.

However, we have determined that cover for treatment of public patients will continue to be automatically provided (refer Automatic extension 2.20 of the Policy), subject to the terms and conditions of our Policy, 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/below)
 - 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/Sessions from public work in your declaration of Gross Income/Sessions to us.

(continues on next page)

h) Cover for treatment of public patients – continued

Categories that specifically exclude cover for treatment of public patients

Please note some Categories *specifically exclude* cover for treatment of public patients and they are:

- GP Rural - Private only in SA and GP Obstetrics – Rural Private only in SA – refer Section 6
- Interns – refer Section 9
- 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 complaints, 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, Medical 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, Medical 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:

- Separately note your Gross Income from public work in your declaration of Gross Income to us.
- 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.

i) Good Samaritan Acts and Gratuitous Advice

Other than as detailed in the table on page 6, cover for Good Samaritan Acts and Gratuitous Advice is automatically included within Division 2 of the Policy, provided you have current insurance when the claim is made and the incident occurred after any relevant retroactive date in your 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

Gratuitous Advice is defined as advice 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 Category for practising doctors as outlined in this PDS.

j) Your Policy Schedule and Certificate of Insurance

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 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 2008/2009 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.

k) 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.

I) 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.

Section 3 : Claims Made Insurance and Retroactive Cover

a) Claims made insurance

The Policy offered by MIGA 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 MIGA 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 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 MIGA 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 on your Quotation and/or Policy Schedule
- 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 on your Quotation and/or Policy Schedule.

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 are 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 (i.e. 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 (i.e. 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 currency of the Policy 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 practise
- 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 arranging 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 : Choosing your Category

a) Introduction

There are a range of Categories available to choose from when completing your Renewal or Application Form. The options are detailed in the tables on pages 15 to 16. The Category you should select is determined by your qualifications and/or the nature of the work you undertake.

If you are unclear which Category to select please contact our Client Services Department.

Choose your area of practice from Column 1 and select the nature of your work and cover from Column 2. Column 3 indicates which section of the PDS contains more information to help you select your Category.

(Column 1) Area of Practice <i>Choose one of the following:</i>	(Column 2) Nature of Practice <i>Choose one of the following:</i>	(Column 3) More detail
Specialist		
Allergy	Occupational Medicine	• Specialist in Private Practice
Anaesthesia	Oncology	
Cardiac Thoracic Surgery	Ophthalmology – Non Procedural – Office Practice Only*	or
Cardiology – Non Interventional*	Ophthalmology – Procedural*	
Cardiology – Interventional*	Ophthalmology – Cosmetic*	• Employer Indemnified Staff Specialist with no or limited Private Practice up to \$5,000 Gross Income per annum. Includes cover for Good Samaritan Acts, Gratuitous Advice and private prescription writing
Cytology	Orthopaedic Surgery	Section 8
Dermatology*	Otolaryngology Head and Neck Surgery – excluding Cosmetic*	
Dermatology Cosmetic*	Otolaryngology Head and Neck Surgery – including Cosmetic*	Claims arising out of Orthopaedics, Neurosurgery, Cosmetics and Obstetrics are excluded
Emergency Medicine	Paediatric Medicine – excluding Neonatal Intensive Care*	
Endocrinology	Paediatric Surgery	
Endocrine Surgery	Palliative Care	or
Gastroenterology – Non Procedural	Pathology and/or Laboratory Haematology	
Gastroenterology – Procedural	Pharmacology	• Employer Indemnified Staff Specialist – Medical Board/Tribunal cover only. Excludes cover for Good Samaritan Acts, Gratuitous Advice and private prescription writing
General Medicine	Plastic, Reconstructive and/or Cosmetic Surgery*	
General Surgery*	Psychiatry	
General Surgery – Cosmetic*	Public Health and Preventative Medicine	
Genetics	Radiation Oncology	
Geriatric Medicine	Radiology*	or
Gynaecology	Rehabilitation Medicine	
Haematology	Respiratory Medicine	• Registrar undertaking Specialist training in Private Practice (ie outside the public hospital system)
Immunology	Rheumatology	
Infectious Diseases	Sports Medicine*	
Intensive Care – excluding Neonatal*	Surgical Specialties – Office Practice Only*	
Maxillo-facial Surgery – excluding Cosmetic*	Urology	
Neonatal Intensive Care	Vascular Surgery	
Nephrology		
Neurology		
Neurosurgery		
Nuclear Medicine		
Obstetrics and Gynaecology*		

(Column 1) Area of Practice Choose one of the following:	(Column 2) Nature of Practice Choose one of the following (if applicable):	(Column 3) More detail
General Practice		
General Practice	<ul style="list-style-type: none"> • Non Procedural • Procedural • Rural Private Only (SA Only) • Rural Public & Private (SA Only) 	Section 6
GP Obstetrics	<ul style="list-style-type: none"> • Metropolitan Area (Any State) • Rural (Other than SA) • Rural Private Only (SA Only) • Rural Public & Private (SA Only) 	Section 6
GP Registrar	<ul style="list-style-type: none"> • Non Procedural/Procedural • Procedural including Obstetrics 	Section 6
Cosmetic Medical Practice		
Cosmetic Medicine	<ul style="list-style-type: none"> • Level A • Level B 	Section 7
Cosmetic Surgery	<ul style="list-style-type: none"> • Level C • Level D 	Section 7
Employer Indemnified (Non Specialist)		
Salaried Medical Officer	• Employer Indemnified with Private Practice in GP Non Procedural up to \$25,000 Gross Income per annum	Section 8
	• Employer Indemnified with no or limited Private Practice in GP Non Procedural up to \$5,000 Gross Income per annum, includes cover for Good Samaritan Acts, Gratuitous Advice and private prescription writing	Section 8
	• Employer Indemnified – Medical Board/Tribunal cover only, excludes cover for Good Samaritan Acts, Gratuitous Advice and private prescription writing	Section 8
	• Employer Indemnified Intern	Section 9
Salaried Medical Officer – Private Sector	• Employer Indemnified – includes cover for Medical Board/Tribunal, Good Samaritan Acts and Gratuitous Advice	Section 8
Other Practice		
Medical Officer at private and/or public hospital	• not Employer Indemnified	Section 10
Surgical Assistance Only	<ul style="list-style-type: none"> • Specialist • Other 	Section 10
Medical Administrator	• Not Employer Indemnified	Section 10
Medical Academic	• Not Employer Indemnified	Section 10
Medical Reporting and Assessment	• No clinical practice	Section 10
Non Clinical	• Prescriptions Plus	Section 10
Retired/Compound Life Member/Temporarily Non Practising (Suspended)		
Retired	<ul style="list-style-type: none"> • Prescriptions Plus • Good Samaritan Acts and Gratuitous Advice Only • No Insurance Required 	Section 11
Compound Life Member	<ul style="list-style-type: none"> • Prescriptions Plus • Good Samaritan Acts and Gratuitous Advice Only • No Insurance Required 	Section 11
Temporarily Non Practising (Suspended)	<ul style="list-style-type: none"> • Prescriptions Plus • Good Samaritan Acts and Gratuitous Advice Only • No Insurance Required 	Section 11

Section 5 : Specialists

a) Introduction

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

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; or
- are performing procedures not normally associated with your Category

please provide details in the Additional Information page on your Renewal or Application Form or 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 (Note 1).

Please note you are not covered under Section 1 or Section 2 of the Policy for matters that arise from practice undertaken under a Rights of Private Practice Agreement.

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 21)
3. **No cover is provided for fat transfers to breasts.**

b) Specialist Category listing

Category	Includes	Excludes
Allergy	All activities and procedures normally undertaken by an Allergist which you are appropriately trained, qualified and accredited to undertake	
Anaesthesia	All activities and procedures normally undertaken by an Anaesthetist which you are appropriately trained, qualified and accredited to undertake	
Cardiac Thoracic Surgery	All activities and procedures normally undertaken by a Cardio Thoracic Surgeon which you are appropriately trained, qualified and accredited to undertake	
Cardiology – Non Interventional	All activities and procedures normally undertaken by a Non Interventional Cardiologist which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Cardiography • Cardioversion • Cardiac ultrasound • Stress testing – with available resuscitation support 	Procedures listed in Cardiology – Interventional
Cardiology – Interventional	All activities and procedures normally undertaken by an Interventional Cardiologist which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Angiograms • Angioplasty • Electrophysiology studies • Insertion of pacemakers Plus activities listed under Cardiology – Non Interventional	
Cytology	All activities and procedures normally undertaken by a Cytologist which you are appropriately trained, qualified and accredited to undertake	
Dermatology	All activities and procedures normally undertaken by a Dermatologist which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • 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 	Procedures listed in Dermatology Cosmetic

(continues on next page)

Category	Includes	Excludes
Dermatology Cosmetic (refer Notes on page 17)	All activities and procedures normally undertaken by a Cosmetic Dermatologist which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • 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	
Emergency Medicine	All activities and procedures normally undertaken by an Emergency Medicine Physician which you are appropriately trained, qualified and accredited to undertake	
Endocrinology	All activities and procedures normally undertaken by an Endocrinologist which you are appropriately trained, qualified and accredited to undertake	
Endocrine Surgery	All activities and procedures normally undertaken by an Endocrine Surgeon which you are appropriately trained, qualified and accredited to undertake	
Gastroenterology – Non Procedural	All activities and procedures normally undertaken by a Non Procedural Gastroenterologist which you are appropriately trained, qualified and accredited to undertake	
Gastroenterology – Procedural	All activities and procedures normally undertaken by a Procedural Gastroenterologist which you are appropriately trained, qualified and accredited to undertake	
General Medicine	All activities and procedures normally undertaken by a General Physician which you are appropriately trained, qualified and accredited to undertake	
General Surgery	All activities and procedures normally undertaken by a General Surgeon which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Breast reconstruction following cancer surgery 	Plastic and cosmetic procedures as defined under Note 1 on page 17.
General Surgery – Cosmetic (refer Notes on page 17)	All activities and procedures normally undertaken by a Cosmetic General Surgeon which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Abdominoplasty • Blepharoplasty • Cosmetic rhinoplasty • Dermabrasion • Dermal fillers • Face lift • Hair transplantation procedures • 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 	
Genetics	All activities and procedures normally undertaken by a Geneticist which you are appropriately trained, qualified and accredited to undertake	
(continues on next page)		

b) Specialist Category listing – continued

Category	Includes	Excludes
Geriatric Medicine	All activities and procedures normally undertaken by a Geriatrician which you are appropriately trained, qualified and accredited to undertake	
Gynaecology	All activities and procedures normally undertaken by a Gynaecologist which you are appropriately trained, qualified and accredited to undertake	
Haematology	All activities and procedures normally undertaken by a Haematologist which you are appropriately trained, qualified and accredited to undertake	
Immunology	All activities and procedures normally undertaken by an Immunologist which you are appropriately trained, qualified and accredited to undertake	
Infectious Diseases	All activities and procedures normally undertaken by an Infectious Diseases Physician which you are appropriately trained, qualified and accredited to undertake	
Intensive Care – excluding Neonatal	All activities and procedures normally undertaken by an Intensivist which you are appropriately trained, qualified and accredited to undertake	Neonatal Intensive Care
Maxillo-facial Surgery – excluding Cosmetic	All activities and procedures normally undertaken by a Maxillo-facial Surgeon which you are appropriately trained, qualified and accredited to undertake	Cosmetic procedures as defined under Note 1 on page 17
Neonatal Intensive Care	All activities and procedures normally undertaken by a Neonatal Intensivist which you are appropriately trained, qualified and accredited to undertake	
Nephrology	All activities and procedures normally undertaken by a Nephrologist which you are appropriately trained, qualified and accredited to undertake	
Neurology	All activities and procedures normally undertaken by a Neurologist which you are appropriately trained, qualified and accredited to undertake	
Neurosurgery	All activities and procedures normally undertaken by a Neurosurgeon which you are appropriately trained, qualified and accredited to undertake	
Nuclear Medicine	All activities and procedures normally undertaken by a Nuclear Medicine Physician which you are appropriately trained, qualified and accredited to undertake	
Obstetrics and Gynaecology	All activities and procedures normally undertaken by an Obstetrician which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Cordocentesis • Decompression of foetal abdominal cavities • Foetal blood transfusions 	
Occupational Medicine	All activities and procedures normally undertaken by an Occupational Medicine Physician which you are appropriately trained, qualified and accredited to undertake	
Oncology	All activities and procedures normally undertaken by an Oncologist which you are appropriately trained, qualified and accredited to undertake	
Ophthalmology – Non Procedural – Office Practice Only	This Category is for Non Procedural Ophthalmologists who only perform the following activities: <ul style="list-style-type: none"> • 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 	

(continues on next page)

Category	Includes	Excludes
Ophthalmology – Procedural	All activities and procedures normally undertaken by an Ophthalmologist which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Laser surgery for refractive error subject to income from such procedures not exceeding 50% of annual Gross Income 	Cosmetic procedures as defined under Note 1 on page 17
Ophthalmology – Cosmetic (refer Notes on page 17)	All activities and procedures normally undertaken by an Ophthalmologist which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Cosmetic procedures • Laser surgery for refractive error exceeding 50% of annual Gross Income 	
Orthopaedic Surgery	All activities and procedures normally undertaken by an Orthopaedic Surgeon which you are appropriately trained, qualified and accredited to undertake	
Otolaryngology Head and Neck Surgery – excluding Cosmetic	All activities and procedures normally undertaken by an Otolaryngology Head and Neck Surgeon which you are appropriately trained, qualified and accredited to undertake	Cosmetic procedures as defined under Note 1 on page 17
Otolaryngology Head and Neck Surgery – including Cosmetic (refer Notes on page 17)	All activities and procedures normally undertaken by a Cosmetic Otolaryngology Head and Neck Surgeon which you are appropriately trained, qualified and accredited to undertake including Cosmetic procedures	
Paediatric Medicine – excluding Neonatal Intensive Care	All activities and procedures normally undertaken by a Paediatrician which you are appropriately trained, qualified and accredited to undertake	Neonatal Intensive Care
Paediatric Surgery	All activities and procedures normally undertaken by a Paediatric Surgeon which you are appropriately trained, qualified and accredited to undertake	
Palliative Care	All activities and procedures normally undertaken by a Palliative Care Physician which you are appropriately trained, qualified and accredited to undertake	
Pathology and/or Laboratory Haematology	All activities and procedures normally undertaken by a Pathologist and/or Laboratory Haematologist which you are appropriately trained, qualified and accredited to undertake	
Pharmacology	All activities and procedures normally undertaken by a Pharmacologist which you are appropriately trained, qualified and accredited to undertake	
Plastic, Reconstructive and/or Cosmetic Surgery (refer Notes on page 17)	All activities and procedures normally undertaken by a Plastic, Reconstructive and/or Cosmetic Surgeon which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Abdominoplasty • Blepharoplasty • Cosmetic rhinoplasty • Dermabrasion • Dermal fillers • Face lift • Hair transplantation procedures • 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 	
Psychiatry (continues on next page)	All activities and procedures normally undertaken by a Psychiatrist which you are appropriately trained, qualified and accredited to undertake	

b) Specialist Category listing – continued

Category	Includes	Excludes
Public Health and Preventative Medicine	All activities and procedures normally undertaken by a Public Health and Preventative Medicine Physician which you are appropriately trained, qualified and accredited to undertake	
Radiation Oncology	All activities and procedures normally undertaken by a Radiation Oncologist which you are appropriately trained, qualified and accredited to undertake	
Radiology	All activities and procedures normally undertaken by a Radiologist which you are appropriately trained, qualified and accredited to undertake including: <ul style="list-style-type: none"> • Up to 3 employed medical technologists (eg radiographers, sonographers etc) per Radiologist <p>If the number of employed medical technologists exceeds 3 full time equivalent staff per Radiologist, then advise us in the Additional Information section of the Renewal or Application Form</p>	
Rehabilitation Medicine	All activities and procedures normally undertaken by a Rehabilitation Medicine Physician which you are appropriately trained, qualified and accredited to undertake	
Respiratory Medicine	All activities and procedures normally undertaken by a Respiratory Physician which you are appropriately trained, qualified and accredited to undertake	
Rheumatology	All activities and procedures normally undertaken by a Rheumatologist which you are appropriately trained, qualified and accredited to undertake	
Sports Medicine NEW from 1 July 2008	All activities and procedures normally undertaken by a Sports Medicine Specialist which you are appropriately trained, qualified and accredited to undertake	
Surgical Specialties – Office Practice Only	This Category is for Surgeons who do not perform any surgery but are still practising as a consulting Specialist	
Urology	All activities and procedures normally undertaken by a Urologist which you are appropriately trained, qualified and accredited to undertake	
Vascular Surgery	All activities and procedures normally undertaken by a Vascular Surgeon which you are appropriately trained, qualified and accredited to undertake	

c) 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 2008 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 2008/2009 year

- If you have an extension in the 2007/2008 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 2008
 - 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 2008
 - Run-off cover will be provided in this situation for claims made on or after 1 July 2008 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 2008 and after your retroactive date
 - No further extensions will be granted to allow more time for accreditation other than in exceptional circumstances.

Section 6 : General Practice

a) Introduction

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

- General Practice
 - Non Procedural
 - Procedural
 - Rural Private Only (SA Only)
 - Rural Public & Private (SA Only)
- GP Obstetrics
 - Metropolitan Area (Any State)
 - Rural (Other than SA)
 - Rural Private Only (SA Only)
 - Rural Public & Private (SA Only)
- GP Registrar
 - Non Procedural/Procedural
 - Procedural including Obstetrics.

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 Category applicable to the work you are undertaking.

Please note these Categories do not cover cosmetic procedures as these are covered in the group of Categories called Cosmetic Medical Practice (refer Section 7).

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.

If you require cover as a GP in rural South Australia 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 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

Category	Includes	Excludes
GP Non Procedural	<p>Cover is included for non procedural activities normally undertaken by GPs including:</p> <ul style="list-style-type: none"> • 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-cavernosal 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 24 and 25) • Orthopaedics – Fractures requiring no reduction or anaesthesia • Own simple limb x-rays – excluding hips and shoulders • Pathology – Desktop only <p>(continues on next page)</p>	<ul style="list-style-type: none"> • GP Procedural • GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice

b) Category listing – continued

Category	Includes	Excludes
GP Non Procedural (continued)	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • GP Procedural • GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice
GP Procedural	<p>Cover is included for all GP Non Procedural activities plus:</p> <ul style="list-style-type: none"> • 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 • Endovenous Laser Treatment (EVLV) • 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 – 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 	<ul style="list-style-type: none"> • GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice
GP – Rural Private Only (SA Only)	<ul style="list-style-type: none"> • All GP Non Procedural and GP Procedural activities as listed on pages 22 and 23 undertaken in rural areas • Plus care provided to Private In-patients 	<ul style="list-style-type: none"> • GP Obstetrics • Laparoscopic procedures • Public In-patients • Cosmetic Medical Practice
GP – Rural Public and Private (SA Only)	<ul style="list-style-type: none"> • All GP Non Procedural and GP Procedural activities as listed on pages 22 and 23 undertaken in rural areas • Plus care provided to Public and Private In-patients 	<ul style="list-style-type: none"> • GP Obstetrics • Laparoscopic procedures • Cosmetic Medical Practice
GP Obstetrics – Metropolitan Area (Any State) (continues on next page)	<ul style="list-style-type: none"> • All GP Non Procedural and GP Procedural activities as listed on pages 22 and 23 • Plus Obstetrics 	<ul style="list-style-type: none"> • Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) • Cosmetic Medical Practice

Category	Includes	Excludes
GP Obstetrics – Rural (Other than SA)	<ul style="list-style-type: none"> All GP Non Procedural and GP Procedural activities as listed on pages 22 and 23 Plus Obstetrics 	<ul style="list-style-type: none"> Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) Cosmetic Medical Practice
GP Obstetrics – Rural Private Only (SA Only)	<ul style="list-style-type: none"> All GP Non Procedural and GP Procedural activities as listed on pages 22 and 23 undertaken in rural areas Plus care provided to Private In-patients Plus Obstetrics 	<ul style="list-style-type: none"> Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) Public In-patients Cosmetic Medical Practice
GP Obstetrics – Rural Public & Private (SA Only)	<ul style="list-style-type: none"> All GP Non Procedural and GP Procedural activities as listed on pages 22 and 23 undertaken in rural areas Plus care provided to Public and Private In-patients Plus Obstetrics 	<ul style="list-style-type: none"> Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) Cosmetic Medical Practice
GP Registrar – Non Procedural / Procedural	This Category provides cover equivalent to GP Non Procedural and GP Procedural activities as listed on pages 22 and 23 and is applicable to all GP Registrars in an accredited GP Registrar training program, whether in a hospital or in Private Practice	<ul style="list-style-type: none"> 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 22 and 23 (plus Obstetrics) and is applicable to all GP Registrars in an accredited GP Registrar training program, whether in a hospital or in Private Practice	<ul style="list-style-type: none"> Laparoscopic procedures (other than laparoscopic sterilisation/diagnostic procedures) Cosmetic Medical Practice

c) 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 have applied since 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 (continued on next page)

c) **Special Conditions – Shared Care and Ante-natal Care – continued**

- You will be covered in an emergency situation (e.g. haemorrhage, premature or imminent delivery) if you render emergency assistance, provided you are insured in another GP Category
- **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 7 : 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 5).

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 Renewal or Application Form in the Additional Information page or contact our Client Services Department.

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 27)
3. **No cover is provided for fat transfers to breasts.**

b) Category listing

Category	Includes	Excludes
Cosmetic Medicine Level A	<ul style="list-style-type: none"> • GP Non Procedural activities as listed on pages 22 and 23 • Plus the following: <ul style="list-style-type: none"> – Botulinum toxin injections – Dermal fillers (non permanent) including poly lactic acid – Chemical peels (superficial epidermal only) such as glycolic acid peels – Intense Pulse Light therapy (IPL) – Laser therapy, excluding laser resurfacing – Mesotherapy excluding the injecting of drugs for the primary purpose of dissolving fat – Microdermabrasion – Photo-rejuvenation – Radio frequency treatment – Microsclerotherapy for facial lesions – Sclerotherapy 	<ul style="list-style-type: none"> • GP Procedural • Cosmetic Medicine Level B • Cosmetic Surgery Levels C and D
Cosmetic Medicine Level B	<ul style="list-style-type: none"> • GP Procedural activities as listed on page 23 • Cosmetic Medicine Level A 	<ul style="list-style-type: none"> • Cosmetic Surgery Levels C and D
Cosmetic Surgery Level C	<ul style="list-style-type: none"> • Cosmetic Medicine Level B • Plus the following: <ul style="list-style-type: none"> – Dermabrasion – Dermal fillers (permanent) – Facial thread lifting procedures (not in association with skin excision) – Injecting drugs for the primary purpose of dissolving fat – 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) 	<ul style="list-style-type: none"> • Cosmetic Surgery Level D
Cosmetic Surgery Level D	<ul style="list-style-type: none"> • Cosmetic Surgery Level C • Plus the following: <ul style="list-style-type: none"> – Abdominoplasty – Blepharoplasty – Breast augmentation/reduction – Cosmetic rhinoplasty – Face lift – Hair transplantation procedures – Labiaplasty – Otoplasty – Penile extension/thickening 	

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 2008 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 2008/2009 year
- If you have an extension in the 2007/2008 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 2008
 - 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 2008
 - Run-off cover will be provided in this situation for claims made on or after 1 July 2008 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 2008 and after your retroactive date
 - No further extensions will be granted to allow more time for accreditation other than in exceptional circumstances.

Section 8 : Employer Indemnified Categories

a) Introduction

There are a range of Categories that are available for **employer indemnified** doctors. If you are an Intern, refer Section 9 for details of the cover available to you.

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.

Please note you are not covered under Section 1 or Section 2 of the Policy for matters that arise from practice undertaken under a Rights of Private Practice Agreement.

b) Category listing

Category	Includes	Excludes
Staff Specialist With no or limited Private Practice	Provides cover for: <ul style="list-style-type: none"> • 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 such work occurred on or after 1 July 2006 or the retroactive date recorded on your Quotation and/or Policy Schedule whichever is the later date • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) 	<ul style="list-style-type: none"> • Any private practice when Gross Income exceeds \$5,000 per annum (refer to Specialist Categories Section 5 if Gross Income exceeds \$5,000 per annum) • Any private practice in: <ul style="list-style-type: none"> – Cosmetics – Neurosurgery – Obstetrics – Orthopaedics
Staff Specialist – Medical Board / tribunal cover only	Only provides cover 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	<ul style="list-style-type: none"> • Any private practice • Good Samaritan Acts and Gratuitous Advice
Salaried Medical Officer With Private Practice in GP Non Procedural	Provides cover for: <ul style="list-style-type: none"> • Private practice in GP Non Procedural (refer pages 22 and 23) up to \$25,000 Gross Income per annum • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) 	<ul style="list-style-type: none"> • Any private practice when Gross Income exceeds \$25,000 per annum
Salaried Medical Officer With no or limited Private Practice	Provides cover for: <ul style="list-style-type: none"> • Private work you undertake outside of your employment, subject to Gross Income from such work not exceeding \$5,000 per annum provided such work occurred on or after 1 July 2006 or the retroactive date recorded on your Quotation and/or Policy Schedule whichever is the later date. • Activities are limited to those listed under the GP Non Procedural Category (refer pages 22 and 23) • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) 	<ul style="list-style-type: none"> • Any private practice when Gross Income exceeds \$5,000 per annum
Salaried Medical Officer – Medical Board / tribunal cover only	Provides cover 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	<ul style="list-style-type: none"> • Any private practice • Good Samaritan Acts and Gratuitous Advice
Salaried Medical Officer – Private Sector For doctors who are employed by a private sector employer	Provides cover 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 <ul style="list-style-type: none"> • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) 	<ul style="list-style-type: none"> • Any private practice

Section 9 : Interns

a) Introduction

MIGA offers a special Category for Interns, which is affordable and gives you access to a broad range of membership and insurance benefits.

b) Benefits of being an Intern member

If you first join MIGA as an Intern member during the period 1 July 2008 to 30 June 2009, 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 2008 to 30 June 2009 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 i.e. 30 June 2009.

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 2008 to 30 June 2009.

In order to maintain free membership as an Intern for this period, you must:

- Be undertaking your Internship in a hospital in Australia
- 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 MDASA is not insurance and details of the insurance options available to Interns are outlined in the following.

d) Medical indemnity insurance for Interns

We offer insurance tailored to the needs of Interns referred to as "Employer Indemnified Intern".

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 in Australia 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.

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 2008 to 30 June 2009 within our Category "Employer Indemnified Intern" which covers you for:

- Expenses in relation to Claims under 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
- Good Samaritan Acts and Gratuitous Advice (refer page 11 for details).

f) What you are not covered for as an Intern

Under our Category for Interns, you are not covered for claims and/or circumstances:

- 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) When you finish your Intern year

Membership

If you are an Intern member for the period 1 July 2008 to 30 June 2009, and you finish your Intern year during this period and start work as an SMO, MDASA will provide you with ongoing free membership through to 30 June 2009. 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 2008 to 30 June 2009 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 2009.

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

Prior to renewal in 2009, 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 Categories" we have outlined the insurance options available to

employed doctors who are working in the public or private sectors.

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 2009 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.

Insurance cover if you were previously a Medical Student member

If you are a Medical Student member of MIGA during the period 1 July 2008 to 30 June 2009 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 2009.

We will contact all Medical Student members in December 2008 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 2009.

The benefits and scope of cover will be as an "Employer Indemnified Intern", as outlined on page 29.

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 2008 to 30 June 2009, and have not previously held a Student Policy with us, but require insurance, you will need to arrange 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 may be payable for insurance provided as an Intern.

h) 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.

i) 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 2009.

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 2009 (refer Section 14 for more details).

j) 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 2009.

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 2009 (refer Section 14 for more details).

Section 10 : Other Practice

a) Introduction

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

Category	Includes	Excludes
<p>Medical Officer at private and/or public hospital (not Employer Indemnified)</p> <p>This Category is for non specialists who are employed in private and/or public hospitals, who are required to effect and maintain their own medical indemnity insurance.</p>	<p>All activities and procedures for which you are appropriately trained and qualified to undertake</p>	
<p>Surgical Assistance Only – Specialists</p> <p>This Category is for Specialists who do not perform any surgery but undertake surgical assistance only.</p>	<ul style="list-style-type: none"> • Surgical assistance only • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) • Prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously 	<ul style="list-style-type: none"> • work 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 • any surgery undertaken either during surgery (whether in the presence of the primary or supervising surgeon or not) or on behalf of the primary or supervising surgeon
<p>Surgical Assistance Only – Other</p> <p>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.</p>	<ul style="list-style-type: none"> • Surgical assistance and observational roles only • Good Samaritan Acts and Gratuitous Advice (refer page 11 for details) • Prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously 	<ul style="list-style-type: none"> • work 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 • any surgery undertaken either during surgery (whether in the presence of the primary or supervising surgeon or not) or on behalf of the primary or supervising surgeon
<p>Medical Administrator</p> <p>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.</p>	<p>Cover is restricted solely to patient outcomes arising out of health care treatment, advice or 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</p> <p>Doctors are also covered for claims arising out of prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously</p>	<p>No cover is provided for:</p> <ul style="list-style-type: none"> • Claims arising out of managerial or administrative error • Any clinical practice

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Category	Includes	Excludes
<p>Medical Academic</p> <p>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 and who are required to effect and maintain their own medical indemnity insurance.</p>	<p>Cover 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</p> <p>Doctors are also covered for claims arising out of prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously</p>	<p>No cover is provided for:</p> <ul style="list-style-type: none"> • Claims arising out of managerial or administrative error • Any clinical practice
<p>Medical Reporting and Assessment – No Clinical Practice</p> <p>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.</p>	<p>Cover is restricted to:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – 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 <p>Doctors are also covered for claims arising out of prescription writing, writing referrals and ordering pathology, where undertaken privately and gratuitously</p>	<ul style="list-style-type: none"> • Any clinical practice
<p>Non Clinical</p> <p>This Category is for doctors who maintain Medical Board registration but are not practising and have no clinical patient contact (either directly or indirectly).</p>	<p>Doctors 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</p>	<p>No cover is provided for any clinical practice</p>
<p>Registrar undertaking Specialist training in Private Practice</p> <p>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.</p>	<ul style="list-style-type: none"> • All private work where part of a specialist training program 	

Section 11 : Retired, Retired Compound Life Members and Temporarily Non Practising Doctors

a) Introduction

The following Categories are available for retired doctors, retired Compound Life Members and doctors who are temporarily not practising.

Category	Includes	Excludes
Prescriptions Plus (Nil Gross Income)	Provides cover for: <ul style="list-style-type: none"> • Prescription writing • Referrals • Ordering Pathology • Good Samaritan Acts* • Gratuitous Advice* * Refer page 11 for details	Any other practice
Good Samaritan Acts and Gratuitous Advice only	Provides cover for: <ul style="list-style-type: none"> • Good Samaritan Acts* • Gratuitous Advice* * Refer page 11 for details	Any other practice

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

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.

If you are currently insured with us and intend to permanently retire on or after 1 July 2008 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 2008.

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.

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.

d) Temporarily 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.

e) 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 membership and insurance 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 (refer page 11 for details) 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 (refer page 11 for details) 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.

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e) **Suspension of membership – continued**

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.

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 14 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 14).

If you intend to cease practice and/or wish to suspend your membership from 1 July 2008 or if your membership is currently suspended, you will need to indicate on the Renewal Form in Additional Information page:

- 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.

Section 12 : 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 2008 to 30 June 2009 is **free** and provides you with the following benefits:

- **Free medical indemnity insurance as a Medical Student** for the period 1 July 2008 to 30 June 2009, 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 2008 to 30 June 2009, 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 2009 (see details in Section 9 of this PDS)
- **Free 24 hour emergency support** – Catering for urgent situations where medico-legal advice is required in relation to health care 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.

Section 13 : Declaration of Gross Income

a) Introduction

From 1 July 2008, your Renewal or Application Form requires you to advise us whether you require cover for the treatment of public patients and if so, to provide separate estimates of your Gross Income from both your private and public practice for which you require cover from us.

The reasons for this are:

- Renewing doctors from 1 July 2008 and new members from 1 January 2008 are not eligible for PSS with respect to the proportion of premium payable in relation to Gross Income earned from the treatment of public patients
- This information is required by our reinsurers.

Premiums are determined in part by the Category you select, whether you require cover for the treatment of public patients and your Gross Income or Sessions. Lower premiums are available in most Categories for doctors who work part-time or have limited their practice (subject to the payment of minimum premiums).

Entitlement to cover is dependent upon provision of accurate information about your practice including your declaration of Gross Income or Sessions. 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 which you are personally liable), including without limitation:

- i) Medicare benefits; and
- ii) payments by individuals, the Commonwealth Department of Veterans Affairs, workers compensation schemes and third party and/or vehicle insurers; and
- iii) income earned for medical practice overseas that is covered by the Policy

whether retained by you or otherwise and before any apportionment of any expenses and/or tax.

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

Please also note the following:

- 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
- In relation to Medicare billable procedures, you need to include the amount that you have billed the patient for the procedure not the Medicare rebate amount.

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

c) Special cases

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

- Cytology
- Emergency Medicine
- Medical Officer at private and/or public hospital (not Employer Indemnified)
- Pathology and/or Laboratory Haematology
- Radiation Oncology
- Radiology

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.

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.

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 14 : 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	<p>You become eligible for ROCS when you are:</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 From 1 June 2008 the loading is 5% of the premium for all insurers.
ROCS Gap Cover	<p>Is available from us if you:</p> <ul style="list-style-type: none"> Permanently cease private practice before age 65, and Are not yet eligible for ROCS, and Have 5 years of continuous insurance/membership with us. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Is available when you need run-off cover and you are not eligible for ROCS or ROCS Gap Cover This could be when you: <ul style="list-style-type: none"> Cease practice for less than 12 months before age 65 Cease to be insured with us for other reasons (e.g. insure elsewhere) Move to a lower risk Category. 	<ul style="list-style-type: none"> 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. From 1 June 2008 the charge is 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 2008.

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 the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*.

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 5 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 e.g. 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 insurance/membership 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 5 years continuous insurance/membership with us
- Cease to be insured with us for other reasons (e.g. 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 15 : 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 2008/2009 year, your Renewal Package includes the following important documents:

- Covering letter
- Tax Invoice
- Quotation Schedule
- Combined FSG and PDS for 2008/2009
- Policy Wording for 2008/2009
- 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 2008 to 30 June 2009, MIGA will consider your particular circumstances, taking into account:

- The information provided by you in your completed 2008/2009 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 2007/2008 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 2007/2008 year.

Your payment cannot be processed nor your Policy Schedule and Certificate of Insurance 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 20)
- 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 Certificate of Insurance and Policy Schedule without your completed Renewal Form
- If payment cannot be made by 1 July 2008, Medical Insurance Australia will provide you with interim insurance cover to midnight, Monday 14 July 2008.

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 14 July 2008:

- 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 14 July 2008 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 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 2008.

Section 16 : 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 21 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 and you will receive confirmation of your insurance and membership within 3 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 application has been accepted.

Once your payment has been received, a receipt, your Policy Schedule and Certificate of Insurance 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 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 2008 (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) 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.

i) 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 22).

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 17 : Claims and Advisory Services

a) Overview

MIGA supports our members and policy holders with an extensive medico-legal advisory and claims management service.

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

Claims are handled by an in-house team of solicitors with significant experience in medical indemnity and personal injury claims. We understand the importance of providing support and advice when our members need it.

Our internal solicitors provide legal advice on all medico-legal matters and manage all cases not requiring an external solicitor.

Keeping our members and policy holders' informed on claims matters is very important to us. We and our external solicitors maintain frequent personal contact with members involved in claims.

b) Our advisory services

Our 24 hour emergency legal advisory service is an important feature of the membership services we provide to our policy holders.

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 and circumstances.

There is a wide range of matters for which we provide support, including issues relating to patient consent, dealing with unhappy patients, questions in relation to statutory obligations, issues that may arise in relation to the Medical Board and Coronial Inquiries. We also help members with Health Care Complaints Commission matters in all jurisdictions, dealing with solicitors generally, responding to subpoenas and matters that may arise in relation to the Federal Privacy Act.

We encourage our members to call if any issues arise in relation to their practice and we will promptly and enthusiastically assist with their enquiry.

c) 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.

d) 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 indicating dissatisfaction with a medical service or outcome
- 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.

e) 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
- 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 18 : Risk Management

a) Introduction

MIGA offers an industry leading risk management program to our members and policy holders. The Interactive Risk Management (IRM) Program was launched in April 2002 and is now in its seventh year. It was the first of its kind in Australia and continues to lead the industry.

The Program is an innovative and integral part of the Group's services for members. It represents a strong commitment by us to the long-term value of risk management. The Program is a vital strategy in controlling medical indemnity insurance costs in the future, raising awareness of risk management amongst our members and encouraging members to use their risk management knowledge and making changes to their practice systems and processes and the softer attributes of behaviours and attitudes in communication.

Feedback about 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.

Although the Program is voluntary, the number of members enrolling each year is steadily increasing and we encourage all members to participate for both their individual benefit and for that of the profession as a whole.

b) Value of the IRM Program

We believe the value of the IRM Program is more than the premium rebate that members receive on full completion. We also see the IRM Program as helping members with:

- Improving patient outcomes
- Avoiding the stress and pressure of the claims process
- Expanding their knowledge, awareness and involvement in risk management
- Gaining an educational benefit and in many cases having access to medical College CPD points
- Encouraging improvements in managing risk in their practice.

International studies have reported that patients are more satisfied with the service they receive from their doctor following completion by the doctor of risk management education.

There is a well established link between patient dissatisfaction and a doctor's communication skills – the higher the level of dissatisfaction, the more likely it will lead to a complaint or litigation.

c) CPD points – a double benefit

We have reciprocal arrangements with most Colleges across Australia which means that they grant CPD points when their members complete our risk management activities via the IRM Program.

This has a double benefit if the doctors are also insured with MIGA – as they can earn their CPD points and IRM Points without doubling up on risk management activities

and time – and they then can earn a premium discount from us as well.

Doctors who are not members of MIGA can attend our IRM Workshops and Conferences for a fee and earn CPD points by doing so.

d) 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 offer a number of value added services and regularly review and enhance the range of services offered to members.

The following provides a more detailed outline of our risk management services.

On-line service	Detail
Articles	Incorporate risk management tips and articles from the Bulletin plus additional articles which focus on topical issues
Useful Links	Web links are available via our website to sites of interest and use to members
Fact Sheets and Check Lists	We have a number of Fact Sheets and Check Lists available on topics of relevant to managing risks by members
Case studies	Case studies are available which highlight both medico-legal issues and risk management strategies from closed and open claims files

e) 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 19 : 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)	<ul style="list-style-type: none"> • The PSS assists doctors with affordability of medical indemnity premiums
Run-Off Cover Indemnity Scheme (ROCS)	<ul style="list-style-type: none"> • 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 Indemnity Scheme (HCCS)	<ul style="list-style-type: none"> • 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 Indemnity Scheme (ECS)	<ul style="list-style-type: none"> • 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

(continued on next page)

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)	<p>The PSS was introduced from 1 January 2004 to assist doctors with affordability of medical indemnity premiums</p> <p>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</p> <p>In addition to this:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>
Run-Off Cover Indemnity Scheme (ROCS)	<p>ROCS came into effect on 1 July 2004</p> <p>The aim of ROCS is to provide doctors with access to free and unlimited run-off for claims against:</p> <ul style="list-style-type: none"> • 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 <p>ROCS is funded by a charge on medical indemnity insurers which is incorporated into each doctor's annual insurance premium</p> <p>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.</p>
High Cost Claim Indemnity Scheme (HCCS)	<p>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</p> <p>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)</p> <p>Key features of the HCCS are:</p> <ul style="list-style-type: none"> • 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)	<p>The ECS came into effect on 1 January 2003</p> <p>It is intended that the Federal Government will cover the cost of claims that exceed an agreed threshold – which is currently set at \$20m</p> <p>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</p> <p>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.</p>

Section 20 : 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.

The following information about the PSS 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 total 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 Income or Actual Income (for definition of income see paragraph 'f' page 49), 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 speciality.

A doctor:

- whose practice is primarily based on public billings; and
- who obtains medical indemnity cover for private medical practice for which income is received; and
- is not indemnified under a Rights of 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.

A doctor who practises only in the public sector during the Policy Period (and earns no income from private medical practice) is eligible for a PSS payment for that premium period if their insurance with MIGA provides run-off cover, retroactive cover, or both, for incidents that occurred in the course of, or in connection with, the doctor's private medical practice at a time when the doctor derived income from practising as a doctor.

A doctor who practises as a medical practitioner only in the public sector during the Policy Period (and thereby earns no income from private practice) is not eligible for a PSS payment for that Policy Period if the only contract, or contracts, of insurance the doctor holds with MIGA provides medical indemnity cover only for expenses and/or damages in respect of gratuitous services or both.

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, MIGA 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.

(continued on next page)

e) PSS support calculation – continued

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 which you are personally liable), including without limitation:

- i) Medicare benefits; and
- ii) payments by individuals, the Commonwealth Department of Veterans Affairs, workers compensation schemes and third party and/or vehicle insurers; and
- iii) income earned for medical practice overseas that is covered by the Policy

whether retained by you or otherwise and before any apportionment of any expenses and/or tax.

If as part of practice, you derive income from any other sources (such as 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 2002 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)
- any component of Gross Indemnity Costs that is for public medical services.

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 MIGA and 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 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 MIGA in a timely manner so that MIGA 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 MIGA.

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' pages 51 and 52). 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 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 and completion of any activities in the 2008/2009 IRM Program 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 please refer to the IRM Program 2008/2009 Booklet.

If you receive a PSS benefit applicable to the 2008/2009 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 2008/2009 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 MIGA, the Department of Health and Ageing, and Medicare Australia.

MIGA, 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.

MIGA 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 1988 as amended.

A copy of MIGA'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:

- MIGA or Medicare Australia know, or have reason to believe, that you have provided inaccurate information

- you have not provided information to MIGA on Actual Income in the time specified by Medical Insurance Australia
- you have not repaid to MIGA an overpayment of a PSS support payment within the timeframe specified by Medical Insurance Australia
- you have an outstanding debt to another insurer for overpayment of a PSS subsidy for a previous Policy Period
- you fail to pay a UMP Support Payment (if liable) within the time specified by MIGA or Medicare Australia or
- you have failed to participate in and/or complete risk management programs that are considered by MIGA 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 MIGA if your Estimated Income or any other insurance details change. This includes a change in Category, retirement or resignation from MIGA.

Upon receipt of this advice, MIGA 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 MIGA directly to you, or

(continued on next page)

p) Change of insurance details or Estimated Income – continued

- 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 MIGA with confirmation of your Actual Income in the form of a statutory declaration. At this time, MIGA 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 \$100.00, MIGA may not process such an adjustment mid-term.

q) The administration fee

MIGA receives an administration fee from the Commonwealth to reimburse us for the implementation

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: <ul style="list-style-type: none"> • 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 than a non-procedural GP 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 (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: <ul style="list-style-type: none"> • 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 than a non-procedural GP 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).
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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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).

(table continues on next page)

and ongoing costs of administering the PSS.

Apart from receiving such reimbursement, MIGA does not receive commission or benefits, and makes no charge upon you 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 in our Combined FSG/PDS.

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.

Specialisation	PSS Support Calculation	Applies to
Neurosurgeons	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> – 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 in the same income band and State 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. 	<p>Neurosurgeons who:</p> <ul style="list-style-type: none"> 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).

u) Important Notices in relation to the Premium Support Scheme (PSS)

If at any time you elect to participate in the PSS for the premium period:

- you consent to MIGA receiving payments of PSS benefits on your behalf
- you must provide MIGA with a statutory declaration as to your Actual Income no later than 12 months after the end of the Policy Period
- 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.

MIGA has determined that enrolment in, and completion of any activity the 2008/2009 IRM Program equivalent to at least 4 IRM Points will be satisfactory for the purpose of meeting this requirement and receiving a PSS benefit. For details please refer to the IRM Program 2008/2009 Booklet.

If you receive a PSS benefit for the 2008/2009 Policy Period and you do not comply with these 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

- you must notify MIGA in writing immediately if your circumstances change during the Policy Period or if you become aware that the information on which your Estimated Income (as defined) was calculated is incorrect
- by providing information on Estimated Income and Actual Income you consent to the personal information contained in the Renewal/Application Form being used for the purposes of information sharing and audits under the PSS

- your eligibility may be terminated for any non-payment of a UMP Support Payment or Run-Off Cover Scheme payment that you are liable to pay
- overpayment of a PSS benefit (for any reason) will result in you having a liability to pay to MIGA an amount for any underpaid premium (or other costs of obtaining medical indemnity cover) that result from MIGA returning the amount of the overpayment to Medicare Australia
- where information you provide to MIGA is inaccurate or changes and requires an adjustment to your entitlement to a PSS benefit of less than \$100.00, you consent to MIGA not processing such an adjustment midterm.

If you do not elect to participate in the PSS now, MIGA will not reduce your premium by any PSS entitlement you may have. You can elect to participate in the PSS later; but

- if you wish MIGA to calculate your entitlement based on your **Estimated Income**, you must provide those details to MIGA in a timely manner so that MIGA can make an application for PSS on your behalf no later than 2 months after the end of the Policy Period; or
- if you wish MIGA to calculate your entitlement based on your **Actual Income**, you must provide those details to MIGA within 12 months after the end of the Policy Period.

Irrespective of when you elect to participate, you must comply with the Important Notices in relation to the PSS detailed above.

Regardless of whether you are entitled to, or receive a PSS benefit, you remain liable at all times to MIGA for payment of the full premium.

Section 21 : Important Notices

a) Notice to the Proposed Insured (pursuant to the provisions of the Insurance Contracts Act 1984 (Cth))

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 1984, 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, the insurer 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, the insurer 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 (e.g. 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) Claims made Policy

The Renewal/Application Form is for a 'claims made' policy of insurance. This means that the policy will cover you for claims made against you and notified to the insurer during the period of cover. The policy will not provide cover in relation to:

- events that occurred prior to the retroactive date of the policy, if such a date is specified – see below;
- claims made after the expiry of the period of cover even though the event giving rise to the claim may have occurred during the period of cover;
- claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy;
- claims made, threatened or intimated against you prior to the commencement of the period of cover;

- facts or circumstances of which you first became aware prior to the period of cover, and which you knew (or ought reasonably to have known) had the potential to give rise to a claim under this policy;
- claims arising out of circumstances noted on the Application Form or Renewal Form for the current period of cover or on any previous proposal form.

However, where you give notice in writing to the insurer 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 period of cover, the policy will, subject to the terms and conditions, cover you notwithstanding that a claim is only made after the expiry of the period of cover.

Retroactive cover

The policy does not provide any indemnity in relation to any claims or circumstances that occurred prior to the claims made retroactive date currently agreed with MIGA, unless you were a member of MDASA on a claims incurred basis prior to 1 July 2000.

MIGA will offer to cover you for claims that may arise from any incidents for which you are not otherwise covered and which occurred prior to the agreed claims made retroactive date when you were not a member of MDASA but you must contact MIGA to discuss your requirements so that MIGA can arrange appropriate cover for your needs.

See Section 3 of the PDS for further details.

Section 22 : Other Information

a) Cooling-off period

When you receive your Policy and Certificate of Insurance 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.

b) 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.

c) Contacting us

See 'Contacting MIGA' on page (i).

d) 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.

e) 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.

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*