

MIGA

The Medical Insurance Group

Insurance for Eligible Midwives in Private Practice



Combined Financial Services Guide and Product Disclosure Statement

Medical Insurance Australia Pty Ltd / ABN 99 092 709 629

Applies 1 July 2010 to 30 June 2011

Medical Defence Association of South Australia Limited
ABN 41 007 547 588

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ABN 99 092 709 629

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Welcome to MIGA

This document is an important tool to help you understand the scope of the insurance cover and services provided by MIGA for eligible midwives in private practice in Australia.

We recommend you keep it in a safe place with your Insurance Policy and Schedule.

If MIGA can assist in any way with clarifying any of the information in this document or if you need help with any queries you have about our insurance and associated services for midwives, please don't hesitate to call us.

Important Notice:

This document 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 to you by Medical Insurance Australia are fully contained in the Policy Wording, Policy Schedule and any applicable endorsements that are issued to you. This document does not form part of the Policy Wording.



MIGA is committed to service and has voluntarily adopted the general insurance industry 2010 Code of Practice

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Defined Terms

Claim, Claim Costs and Expenses each have the same meaning as in the Policy.

Code means the General Insurance Code of Practice.

Collaborative Arrangement

A Collaborative Arrangement must provide for:

- consultation between you and an Obstetric Specified Medical Practitioner;
- referral of a patient to a Specified Medical Practitioner; and
- transfer of a patient's care to an Obstetric Specified Medical Practitioner.

A Collaborative Arrangement means one of the following types of arrangements:

a) a patient is referred in writing to you for Midwifery Services by a Specified Medical Practitioner;

or

b) an arrangement in writing between you and one or more Specified Medical Practitioners which provides for consultation between you and the Medical Practitioner(s), referral of patients to the Medical Practitioner(s), transfer of a patient's care to the Medical Practitioner(s) and which is signed by you and the Medical Practitioner(s);

or

c) you have met each of the following requirements for each patient:

- you have recorded the name of the Specified Medical Practitioner who is (or will be) collaborating with you in your written records;
- you have told the patient that you will be collaborating with a Specified Medical Practitioner and recorded this in your written records;
- you have an acknowledgement by the named Medical Practitioner that they will be collaborating with you in the patient's care and you have recorded this in your written records (this acknowledgement may apply to more than one patient);
- you have recorded in your written records plans for the circumstances in which you will consult with an Obstetric Specified Medical Practitioner; refer the patient to a Specified Medical Practitioner and transfer the patient's care to an Obstetric Specified Medical Practitioner;
- you have recorded any consultation or other communication between you and an Obstetric Specified Medical Practitioner about the patient's care in your written records;
- you have recorded any referral of the patient by you to a Specified Medical Practitioner in your written records;
- you have recorded any transfer by you of the patient's care to an Obstetric Specified Medical Practitioner in your written records;
- when you give a copy of the hospital booking letter (however described) for the patient to a named Medical Practitioner, you have recorded the acknowledgement that the named Medical Practitioner has received a copy of the hospital booking letter in your written records;
- when you give a copy of the patient's maternity care plan prepared by you to a named Medical Practitioner, you have recorded in your written records the acknowledgement that the named Medical Practitioner has received the copy of the maternity care plan;

- if you request diagnostic imaging or pathology services for the patient, you have recorded when you give the results of those services to a named Medical Practitioner in your written records; and
- you have given a discharge summary (however described) at the end of your care for a patient to the named Medical Practitioner and the patient's Usual General Practitioner and recorded this in your written records.

An arrangement referred to in paragraph (b) above may apply to more than one patient.

For the purposes of this definition only:

Medical Practitioner

Means a medical practitioner within the meaning given by subsection 3 (1) of the *Health Insurance Act 1973*(Cth)

Obstetric Specified Medical Practitioner

Means

- a) an Obstetrician; or
- b) a Medical Practitioner who provides obstetric services.

Specified Medical Practitioner

Means

- a) an Obstetrician; or
- b) a Medical Practitioner who provides obstetric services; or
- c) a Medical Practitioner employed or engaged by a Hospital Authority and authorised by the Hospital authority to participate in a collaborative arrangement.

Obstetrician

Means a medical practitioner who is a specialist in the specialty of obstetrics and gynaecology (however described).

Specialist

Has the meaning given by subsection 3 (1) of the *Health Insurance Act 1973*.

Usual General Practitioner

For a patient, includes a medical practitioner nominated by the patient.

Hospital Authority

Means a hospital authority within the meaning of subsection 84(1) of the *National Health Act 1953*.

Care Plan

In the event that you are unable to achieve a Collaborative Arrangement, it is acceptable for the purposes of this insurance only, for you to communicate a Care Plan to a public Hospital.

A Care Plan means a documented plan for consultation, referral and transfer of a woman's care with a public hospital providing obstetric services.

In this case you must maintain comprehensive written records which include:

- The name of the public Hospital (and Specified Medical Practitioner, if known) to which the woman will be referred if required
- A record that the woman has been informed about this arrangement
- A record of the planned place of delivery (whether in the public Hospital or not)
- A plan for the circumstances in which you will consult, refer and transfer the woman's care

(continued on next page)

- A record of any actual consultation, referral or transfer of the woman's care
- A record that the hospital booking letter has been sent to the Hospital
- A record that the maternity care plan has been sent to and acknowledged by the Hospital (this could be in writing or a record in your notes of an oral acknowledgement)
- A record that any results from diagnostic imaging or pathology have been sent to the Hospital
- A record that the discharge summary has been sent to the Hospital and the woman's Usual General Practitioner.

For the purposes of this definition:

Medical Practitioner

Means a medical practitioner within the meaning given by subsection 3(1) of the *Health Insurance Act 1973*.

Specified Medical Practitioner

Means a Medical Practitioner employed or engaged by a Hospital Authority and authorised by the Hospital Authority to participate in a collaborative arrangement.

Usual General Practitioner

For a woman, includes a medical practitioner nominated by the woman.

Eligible Midwife means a person who is licensed, registered or authorised to practise midwifery by or under a law of the Commonwealth, a State or a Territory with no restrictions on practice, who has:

- Midwifery experience that constitutes the equivalent of 3 years full time post initial registration as a midwife;
- Current competence, as recognised by the Nursing and Midwifery Board of Australia (the Board), to provide pregnancy, labour, birth and postnatal care to women and their infants;
- Successfully completed a professional practice review program approved by the Board for midwives working across the continuum of midwifery care, or has provided an undertaking to complete (and successfully completes) such a program by not later than 31 October 2010;
- Agreed to undertake 20 additional hours per year of continuing professional development relating to the continuum of midwifery care; and
- Either successfully completed, or provided a formal undertaking to the Board that they will complete within 18 months of recognition as an eligible midwife:
 - an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing; or
 - a program, recognised by the Board, that is substantially equivalent to such an approved program of study.

ERB means Extended Reporting Benefits.

FOS means Financial Ombudsman Service.

FSG means Financial Services Guide.

FSR means Financial Services Regulation given effect by Chapter 7 of the *Corporations Act 2001 (Cth)*.

Hospital means a facility declared to be a hospital under the *Private Health Insurance Act 2007 (Cth)*, which has the facilities to provide appropriate Intrapartum Care for women in pregnancy.

Insured has the same meaning as in the Policy.

Intrapartum Care means the management and delivery of care to a pregnant woman and her baby (or babies) from the onset of labour to the birth of the baby (or babies) and the expulsion or delivery of the placenta and includes the assessment of neonatal wellbeing, basic resuscitation measures after birth, the surgical repair of any episiotomy or genital tract trauma and the stabilisation of maternal physiology especially in relation to uterine tone and blood loss.

IRM Program means MIGA's 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.

Midwifery Services means all midwifery services which you provide to private patients as part of, and in accordance with the terms of, a Collaborative Arrangement and for which you are appropriately trained, qualified and registered. If Midwifery Services are recorded in the Policy Schedule as Option B, then Midwifery Services does not include any Intrapartum Care.

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

Option A means that the Policy Schedule records that the Midwifery Services that you provide are antenatal care, Intrapartum Care and postnatal care.

Option B means that the Policy Schedule records that the Midwifery Services that you provide are antenatal care and postnatal care only and not Intrapartum Care.

PDS means Product Disclosure Statement.

PPF means Pacific Premium Funding Pty Ltd.

Policy means the Professional Indemnity Insurance Policy for Eligible Midwives 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.

ROCS means run-off cover indemnity scheme comprising run-off cover Commonwealth contributions and run-off cover support payments, as set out in the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*.

Service Commitment means the service commitment implemented by MIGA to underpin the Code.

SOA means Statement of Advice.

us, our or we means MIGA.

you, your or yourself means the Eligible Midwife to whom the Policy has been issued.

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Financial Services Regulation

The Financial Services Regulation provisions (Chapter 7 of the Corporations Act) (FSR) is legislation designed to protect consumers of financial services. Professional 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.

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.

An 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 or when we offer to renew your insurance.

It applies to our Policy which is available for Eligible Midwives 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 arrangements with MIGA. It also provides you with important information about our claims handling processes and our Interactive Risk Management Program (IRM Program).

About MIGA

Medical Insurance Group Australia (MIGA) is a national provider of medical indemnity insurance products and associated services to the health care profession across Australia.

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

We have been supporting and protecting the medical profession for over 100 years.

Medical indemnity is our core business – it is a highly specialised area of insurance and we have significant long-term experience in it.

We have extensive knowledge of obstetric and midwifery issues through our insurance of doctors working in the area of obstetrics and paediatrics, which will be invaluable in our management of claims and provision of risk management education for midwives.

Group structure

MIGA 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 mutual, non-profit organisation which was formed in 1899	Provides a range of services to members and policy holders
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 and professional indemnity insurance to the health care sector

MIGA has been appointed by the Commonwealth of Australia (as represented by the Department of Health and Ageing and Medicare Australia) to be the sole provider of Government-supported professional indemnity for privately practising eligible midwives in Australia. The contract period of MIGA's appointment is for a period of three years with an option for up to two additional years.

MIGA must provide insurance in compliance with Australian insurance legislation to assist the Commonwealth in meeting the Government's objective of providing access to professional indemnity insurance for eligible privately practising midwives from 1 July 2010.

Our vision

Our vision is:

“To be the leading provider of medical indemnity insurance and related services to the health care sector across Australia, providing confidence through professional service, personal care and superior insurance and risk management products.”

Our commitment to quality and service

MIGA has voluntarily adopted the general insurance industry's Code of Practice (the Code) and we offer a service commitment to our policy holders to underpin the Code (the Service Commitment). The Service Commitment includes measurable service standards in support of our goal to provide outstanding service to our policy holders.

Adoption of the Code and the development of the Service Commitment reflect our genuine desire to be open, caring and honest in our relationships with our policy holders. They also reflect our commitment to be transparent and accountable in all that we do.

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 a Statement of Advice (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 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 and professional 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 calculated annually on an activity basis to reflect the cost of services provided by MDASA to Medical Insurance Australia.

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 professional indemnity is a complex area and not something that Eligible Midwives 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) Arranging insurance

This Combined FSG and PDS provides information on:

- The services and products offered by MIGA
- Some issues you should consider when arranging your insurance
- What you are covered for and what is excluded.

It is very important all of this information is read before submitting an Application Form for insurance and that it provides you with what you require in terms of professional indemnity insurance.

Cover under your professional indemnity insurance is only in relation to Midwifery Services provided by you to private patients in connection with the practice by you as an Eligible Midwife in the profession of midwifery.

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 17.

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 : Benefits of insuring with MIGA

When you arrange insurance with us, you immediately get access to the following valuable benefits and services, a number of which you can access via our website.

Benefit	Services available
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 issues, information about MIGA and important medico-legal developments
Access to 24-hour emergency medico-legal advice and support	<ul style="list-style-type: none"> • You can call us any time of the day or night for help with urgent situations where medico-legal advice is required
Risk Resources	<ul style="list-style-type: none"> • Providing easy on-line access to a wide range of risk management materials, information and tools to assist you in your day to day practice
Option to pay by instalments	<ul style="list-style-type: none"> • An option to spread your insurance payment across the year via a third party funding arrangement • Some midwives will find that this will help with cash-flow issues through the premium year
Access to our Interactive Risk Management (IRM) Program	<ul style="list-style-type: none"> • Offers a maximum 10% discount off your insurance premium next year, if you fully complete it
Midwives' Support Services	<p>If you have a claim, you can access the following services which we offer to help support you through the process:</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 Eligible Midwives offering support and understanding
Client 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 your Application Form, Change of Details Form, payment and access to Certificates of Insurance • 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 and benchmarking against other participants.

Section 2 : Your Insurance

a) Introduction

MIGA has been appointed by the Commonwealth of Australia (as represented by the Department of Health and Ageing and Medicare Australia) to provide insurance, in compliance with Australian insurance legislation, to assist the Commonwealth in meeting the Government's objective of providing access to professional indemnity insurance for eligible privately practising midwives from 1 July 2010.

Our Policy has been developed to meet the needs of Eligible Midwives and the requirements of the Federal Government and the Department of Health and Ageing under the maternity care reforms announced on 12 May 2009.

A copy of the 2010/2011 Policy will be provided to you with your quotation for insurance.

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

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:

Section	Cover
Division 1 Section 1 – Indemnity for claims arising out of the provision of Midwifery Services in connection with the practice by the Eligible Midwife of the profession of midwifery	Provides cover for: <ul style="list-style-type: none"> • Damages and claims for compensation • Legal costs and expenses incurred in defending claims.
Division 1 Section 2 – Specific Expenses	Provides cover for specific expenses incurred in relation to investigations, proceedings or complaints. These include investigations or proceedings by: <ul style="list-style-type: none"> • The Nursing and Midwifery Board of Australia or other disciplinary investigations or proceedings • A health authority or Medicare Australia • A professional college or association, health care complaints body or a health care ombudsman (and other government/statutory authorities or other bodies performing similar functions or exercising similar powers to the above bodies) • coronial inquiries, royal commissions, and • criminal investigations and proceedings.

The Policy has been developed recognising the requirements of the Commonwealth of Australia (as represented by the Department of Health and Ageing).

c) Limit of Indemnity

Your Policy has a limit of indemnity of \$2,000,000. However, because of Commonwealth legislation and a contractual arrangement between MIGA and the Australian Government, you are also entitled to the benefit of cover from the Commonwealth to an unlimited amount above \$2,000,000 (ie. there is no monetary limit for any claim or claims covered by the Policy). So, the limit of indemnity under the Policy (provided partly by MIGA and partly by the Commonwealth) is \$2,000,000 for each claim made in the Policy Period. The amount of any eligible claim above this Policy limit will be covered directly by the Commonwealth as detailed on page 6.

Under the contract with the Australian Government, MIGA will manage all claims under the Policy for which you have an entitlement to indemnity, even if the amount of a claim is greater than \$2,000,000.

d) You must be an Eligible Midwife to access the insurance

Cover under the Policy is only available to you on the condition that you meet the requirements of a privately practising Eligible Midwife.

An Eligible Midwife is a person who is licensed, registered or authorised to practise midwifery by or under a law of the Commonwealth, a State or a Territory with no restrictions on practise, who has:

- Midwifery experience that constitutes the equivalent of 3 years full time post initial registration as a midwife;
- Current competence, as recognised by the Nursing and Midwifery Board of Australia (the Board), to provide pregnancy, labour, birth and postnatal care to women and their infants;

- Successfully completed a professional practice review program approved by the Board for midwives working across the continuum of midwifery care, or has provided an undertaking to complete (and successfully completes) such a program by not later than 31 October 2010;
- Agreed to undertake 20 additional hours per year of continuing professional development relating to the continuum of midwifery care; and
- Either successfully completed, or provided a formal undertaking to the Board that they will complete within 18 months of recognition as an eligible midwife:
 - an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing; or
 - a program, recognised by the Board, that is substantially equivalent to such an approved program of study.

e) Conditions of 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, if any, and contact us if you have any questions about them.

In particular, the Policy does not provide cover for Claims, Claim Costs and Expenses in any way related to:

- Intrapartum Care other than at a hospital which has the facilities to provide appropriate Intrapartum Care for women in pregnancy, except in an unforeseen emergency where timely access to a hospital was not possible (this means that planned home births are excluded from cover);
- midwifery services that are not provided as part of, and in accordance with the terms of, a Collaborative Arrangement or involving communication of a Care Plan to a public Hospital;
- midwifery services that do not comply with the Australian College of Midwives' (ACM) National Midwifery Guidelines for Consultation and Referral (Sept 2008 or as amended) (the Guidelines) or, if working in collaboration with an obstetrician, either the ACM Guidelines or the guidelines of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, in particular in relation to discussion, consultation and referral
- midwifery services that are provided by you to a woman after she has indicated to you that she does not want you to follow all or part of the Guidelines, unless you have complied with the requirements of Appendix A of the Guidelines (which deals with "When a woman chooses outside the recommended ACM National Midwifery Guidelines for consultation and referral") and if you continue to provide midwifery services to the woman:
 - if you have a written agreement with the medical practitioner or obstetrician with whom you have a Collaborative Arrangement in relation to the ongoing care of the woman, you have a mutually agreed clinical pathway in relation to that woman's ongoing care by you; or
 - you have included in your clinical notes the details of discussions that you have undertaken with the medical practitioner or obstetrician with whom you have a Collaborative Arrangement in relation to the ongoing care of the woman including a mutually agreed clinical pathway in relation to that woman's ongoing care by you; or
 - if you do not have a Collaborative Arrangement for a particular woman but instead you have communicated a Care Plan for that woman to a public Hospital, you have a record in your clinical notes of the details of discussions that you have undertaken with the public Hospital in relation to the ongoing care of the woman
- midwifery services that are provided by you in the course of your employment other than Midwifery Services that are provided by you in the course of Your employment (full or part-time) by a company that is owned solely by You or that is owned solely by practising midwives including You where the only directors of that company are You and other practising midwives (subject to any rules that may be made under the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*);
- midwifery services which are provided by you to a public patient (even if that public patient is in a private hospital);
- events or circumstances that occurred prior to the Retroactive Date of 1 July 2010, or a later date as specified in the Schedule;
- midwifery services provided by you outside the Commonwealth of Australia and its territories;
- midwifery services provided by you within the Commonwealth of Australia and its territories where the recipient of the services was outside the Commonwealth of Australia and its territories at the time the Midwifery Services were provided;
- prescribing where you were not suitably qualified (as determined by the Nursing and Midwifery Board of Australia) to prescribe at the time of the incident.

To be entitled to indemnity you must also pay the premium (including any premium adjustments) and charges in full.

If you select Option B (cover for antenatal care and postnatal care only) it is important you understand that:

- you will not be covered, including for antenatal and postnatal care, if at any time you provide Intrapartum Care as part of your private practice, except in an unforeseen emergency situation where timely access to a Hospital was not possible and where you make no request for payment or reward and where you provide no ongoing Intrapartum Care after the emergency situation has passed;

(continued on next page)

e) Conditions of cover – continued

- if you intend to provide Intrapartum Care then you must immediately advise Medical Insurance Australia and pay any additional premium prior to providing any such Intrapartum Care; and
- if you have selected Option B and you provide Intrapartum Care but do not notify Medical Insurance Australia or you do not pay the additional premium, Medical Insurance Australia may cancel the Policy or Medical Insurance Australia may be entitled to avoid the Policy from the beginning and treat it as if it was never issued to you, in which case you will have **no** entitlement to indemnity from Medical Insurance Australia **not only** for Intrapartum Care but also for any antenatal care or postnatal care that you have provided.

f) Legislation for midwifery claims

The Policy also does not cover any Claim, Claim Cost or Expense that does not meet the 'common requirements' defined in the Commonwealth midwife professional indemnity legislation (subsection 11(3) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*).

In addition to the exclusions above, these requirements mean that the Claim, Claim Cost or Expense must:

- not relate to an incident that occurred in the course of, or in connection with, practice of a kind for which:
 - the Commonwealth, a State or a Territory;
 - a local governing body; or
 - an authority established under a law of the Commonwealth, a State or a Territory;
 indemnifies eligible midwives from liability relating to compensation;
- not relate to an incident or a type of practice specified as not being eligible in the midwife professional indemnity legislation from time to time.

If you incur a liability, cost or expense that does not meet these common requirements, that liability, cost or expense is not covered under the Policy. If the value of the claim exceeds \$100,000 and the Medicare Australia CEO forms that opinion and MIGA has already paid amounts to you or on your behalf in relation to such a claim, you must repay those amounts to MIGA.

The Policy only provides cover for Claims made against you personally and for Claims Costs and Expenses that you incur. No cover is provided to any other person or

company, regardless of their connection to you or your practice, except to your estate and legal representatives, which are covered in the event of your death or permanent disablement.

g) MIGA's entitlements to contribution payments and your entitlement to cover

The Commonwealth midwife professional indemnity legislation provides for contributions to be made by the Commonwealth for midwife professional indemnity claims (including disciplinary and other proceedings) that exceed prescribed thresholds.

The legislation establishes two thresholds, known as a Level 1 threshold and a Level 2 threshold. The Level 1 threshold is currently \$100,000. The Level 2 threshold is currently \$2,000,000.

The legislation provides as follows.

- If you have a liability for a claim (including disciplinary and other proceedings) that exceeds the Level 1 threshold and the claim meets the requirements set out in the legislation (including the 'common requirements' set out in section 1(f) above), then MIGA may apply to Medicare Australia for a 'Level 1 qualifying claim certificate'. If the Medicare Australia CEO issues that certificate and if MIGA is liable to make a payment for that claim under the Policy above the Level 1 threshold, the Commonwealth will pay to MIGA a proportion (currently 80%) of MIGA's payment liability above the Level 1 threshold;
- If your liability for the claim exceeds the Level 2 threshold (and therefore the Limit of MIGA's Indemnity under the Policy) and the claim meets the 'common requirements' and other requirements set out in the legislation, then you (or MIGA on your behalf) may apply to Medicare Australia for a 'Level 2 qualifying claim certificate':
 - If the Medicare Australia CEO issues that certificate, then the Commonwealth will meet the amount of your liability which would have been covered under the Policy but which was not covered because it exceeded the Level 2 threshold;
 - Medicare Australia will direct you or us how any Level 2 contribution is to be applied.

The table below illustrates MIGA's and the Commonwealth's respective liabilities for any claims for which the Medicare Australia CEO has issued a qualifying claim certificate:

The amount of the claim liability	MIGA's liability within this range	Commonwealth's liability within this range
\$0 to \$100,000	100%	Nil
\$100,000.01 to \$2,000,000 (Level 1)	20%	80%
\$2,000,000.01 and above (Level 2)	Nil	100%

For example, if you have a total liability of \$2,500,000 in respect of a qualifying claim, MIGA will be liable for \$480,000 of those costs (\$100,000 + 20% of \$1,900,000) and the Commonwealth will be liable for the balance of the claim costs (\$2,020,000). In this way, the arrangements in place between MIGA and the Australian Government mean that all eligible costs of an eligible claim will be fully met.

Subject to you establishing an entitlement to indemnity under the Policy in respect of any qualifying claim made against you, MIGA will manage all qualifying claims that are made against you, whether or not they exceed the Level 1 threshold or Level 2 threshold.

It is important to note that the Policy will not cover you for any Claim, Claim Cost or Expense for which you or MIGA are entitled to apply for a Level 1 qualifying claim certificate or a Level 2 qualifying claim certificate but where Medicare Australia does not issue that certificate for any reason, or where a certificate is issued but is subsequently revoked.

It is also important to note that MIGA has an obligation under the law to notify Medicare Australia if the incident to which your claim relates has also given rise to a claim against another person (or if it is likely to do so). In those circumstances, Medicare Australia may issue an 'Apportionment Certificate' which will have the effect that the Policy, and any contribution from the Commonwealth, will only cover you for your share of the total liability.

h) Your Policy Schedule and Certificate of Insurance

Once an Application Form has been accepted and full payment is received, we will forward a Policy Schedule and Certificate of Insurance to you.

Full details of all special conditions or endorsements, if any, will be recorded on your Quotation and Policy Schedule.

Section 3 : How much will it cost?

We offer 2 levels of cover, as follows:

- Option A - Midwives who provide Intrapartum Care in their private practice (irrespective of whether insured or not) in addition to antenatal and postnatal care;
- Option B - Midwives who provide no Intrapartum Care (i.e. they only provide antenatal and postnatal care and do not provide any Intrapartum Care at all as part of their private practice).

The maximum annual cost of insurance for a full time privately practising midwife is fixed by agreement with the Australian Government (as represented by Medicare Australia and the Department of Health and Ageing) at \$7,500.00.

This excludes the additional cost of any premium funding arrangement you enter into, as per Section 4.

Factors affecting the premium you will pay include the following:

- your declared caseload; and
- any discount you are entitled to in 2011/2012 and subsequent years for participation in MIGA's IRM Program.

The cost of cover will be reduced for midwives who work less than a full time caseload and also for those who do not provide any Intrapartum Care in their private practice as follows:

Number of women to whom (and to whose babies) you provide midwifery services during the Policy Period	Option A Annual premium including all statutory charges (if providing Intrapartum Care in your private practice)	Option B Annual premium including all statutory charges (if providing no Intrapartum Care at all in your private practice)
Full time (i.e. 40 women or more per year)	\$7,500	\$3,400
Between 30 and 39 women per year	\$6,500	\$3,000
Fewer than 30 women per year	\$5,000	\$2,250

You should only select Option B if you do not intend to provide any Intrapartum Care to any woman in your private practice during the policy period (see information on page5).

You will have the opportunity to receive a 10% saving off your premium (excluding statutory charges) in the 2011/ 2012 and subsequent years by successfully completing MIGA's risk management program for midwives (refer section 7).

The above charges include:

- 10% of any premium attributable to each eligible privately practising midwife for the Run-Off Cover Support Scheme
- Statutory duties or charges such as the Goods and Services Tax and Stamp Duty.

Section 4 : Things you need to know about your insurance arrangements

a) Steps to joining and obtaining insurance with MIGA

Applying for insurance 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.

Alternatively, click on the link on our website (www.miga.com.au) to download the Application Form. Just complete it with all requested information and send it to us in the mail.

You can fax your completed 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 to answer all of the questions on the form. It is important you read your 'Duty of Disclosure' as outlined in Section 10 and make sure that 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 not be accepted or it may be cancelled.

Once we receive your Application Form we will assess it and you will receive confirmation of your insurance 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 are subject to an 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 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) Policy Period

Your insurance cover with MIGA is offered on an annual basis from 1 July (or a later inception date) to midnight on 30 June each year.

In your first year of insurance cover with MIGA, if you commence your cover on a date after 1 July, your insurance premium will be pro-rated to the next 30 June (subject to our customary or minimum short term rates). After that initial year, if we offer you cover for the following year, your policy will generally cover the period from 1 July to 30 June.

d) Your Tax Invoice

In preparing your Tax Invoice MIGA will consider your particular circumstances, taking into account:

- any information that you have previously provided to us;
- any information provided by you to us, including in a Change of Details Form completed by you and in any discussions we have had with you; and
- in the case of renewal for 2011/2012, whether you have complied with the requirements to receive a premium discount as a result of completion of the IRM Program for the 2010/2011 year.

Your tax invoice is made up of the following parts:

- the premium
- IRM Program discount (if applicable)
- Run-Off Cover Scheme Support Payment
- goods and service tax
- stamp duty.

It is important you check your Quotation Schedule and Tax Invoice carefully and contact our Client Services Department if you have any queries.

It is also important you contact our Client Services Department if you are in any doubt about the scope of cover provided under the Policy.

e) Payment and steps to finalise your cover

To finalise your cover, you will need to:

- Check your Quotation Schedule and Tax Invoice to ensure that they correctly reflect your estimate of caseload and scope of insurance cover required.

You can pay your invoice by the following methods:

- annually; or
- by instalments (see paragraph (f) over page).

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

- Payment by instalments – complete and return the original Instalment Facility Form
- On-line credit card payment – Mastercard and Visa only
- BPay – see your Tax Invoice for Biller Code or reference details
- Credit Card – Mastercard, Visa, Diners Club or American Express
- Cheque
- Cash.

Note: some of these payment options will attract additional charges.

The Policy does not come into force until:

- you have provided us with a completed Application Form and we have accepted it; and
- you have paid the premium in full (or have entered into a payment arrangement that is acceptable to MIGA – see above) prior to the start of the Period of Insurance.

e) Payment and steps to finalise your cover – continued

If we have accepted your completed Application Form but you have not paid the Premium in full and have not entered into a payment arrangement that is acceptable to MIGA, we may agree to issue the Policy retrospectively if you pay the Premium in full **within 30 days** of the start of the Period of Insurance. In all other cases, you will have no entitlement to indemnity under the Policy and MIGA will consider that the Policy never came into force.

If you arrange to pay the Premium by instalments under a Premium Funding Arrangement offered by MIGA, we will deem the Premium to have been paid in full on the date that the funder advises us that it has approved your Premium Funding Application.

On receipt of your payment before the due date, we will process it and forward a receipt and Certificate of Insurance to you.

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

f) Paying your invoice by instalments

MIGA offers an instalment plan for payment of your insurance premium. It gives you the opportunity to spread your insurance payment across the year via a third party funding arrangement. Some midwives will find that this will help with cash-flow issues through the premium year.

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). An interest charge is added to the total cost and the level varies depending on the method of Payment you select. Information about this is available via the Instalment Facility Form for midwives.

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

How do instalments work?

- PPF pays your total cost as invoiced to MIGA
- You will receive a receipt and Certificate of Insurance from us confirming your insurance premium has been received
- You then repay PPF by a maximum of ten equal monthly instalments beginning 1 July 2010 (if this is the date of inception). A lower number of instalments may apply if you arrange insurance with us after 1 July.

g) Changing State or Territory of practice

It is important that you 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, we may have to remit more or less stamp duty, although there will be no change to your total cost of insurance.

h) Renewal of your insurance

Your insurance will expire at midnight on 30 June each year. Prior to renewal each year, we will forward to you a Renewal Package. Your Renewal Package will generally include, as a minimum, the following important documents:

- covering letter;
- Tax Invoice;
- Quotation Schedule;
- Combined FSG and PDS; and
- Policy.

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

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 1984 (Cth)*) (see Section 11).

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 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 5 : Declaration of Caseload

a) Introduction

Your Application Form requires you to provide an estimate of the number of women to whom (and to whose babies) you expect to provide midwifery services during the Policy Period for which you require cover from us.

The reason for this is that premiums are determined in part by your estimated caseload in the Policy Period (subject to the payment of minimum premiums).

Entitlement to cover is dependent upon provision of accurate information about your practice including your declaration of caseload. Failure to provide accurate information (which affects the premium rate) may affect your entitlement to cover.

b) Adjustment of caseload

Medical Insurance Australia may adjust premiums based on a declaration after expiry of the Policy Period of the actual number of women to whom (and to whose babies) you provided midwifery services during the Policy Period.

If Medical Insurance Australia requires a declaration of actual caseload for the Policy Period, a statutory declaration will be forwarded to you and you must complete it and return it to us within 45 days.

c) Audit of caseload

Medical Insurance Australia may, at its discretion and at its cost, require an audit of the information you have provided in your declaration referred to in paragraph (b) 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 (b) or if you do not provide the information and assistance referred to above. In such cases, Medical Insurance Australia may audit your caseload for the Policy Period and you will be required to meet the cost of that audit.

Section 6 : Claims and Advisory Services

MIGA is proud of the quality and scope of our claims management and legal advisory service.

Our Medico-legal Department is staffed by legal practitioners who have significant experience in medico-legal matters matched with compassion and a commitment to our policy holders.

a) Key features of our service

We offer a 24 hour a day 7 days per week emergency legal advice service across Australia which recognises the reality that medical emergencies which may have legal consequences can occur at any time.

Claims management and legal advice is provided by an in-house team of solicitors with significant experience in medical indemnity and personal injury claims. We understand the importance of providing genuine support and quality advice to our policy holders.

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

Keeping our policy holders informed on claims matters is very important to us and we maintain frequent personal contact with them throughout the life of a claim.

b) Our advisory service

We will assist you with enquiries you may have which arise in your practice and which relate to care for women and their infants. 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 consent, dealing with unhappy women in your care, questions in relation to statutory obligations and issues that may arise in relation to the Nursing and Midwifery Board, Medicare Australia and coronial inquiries. We also help policy holders 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 1988 (Cth)*.

We encourage you to call us if any issues arise in relation to your practice and we will promptly and enthusiastically assist with your enquiry.

Our 24 hour emergency legal advisory service is an important feature of the services we provide to our policy holders. We understand that some advice may be required outside of business hours and our professional staff operate the emergency legal advice service 24 hours per day, 7 days per week.

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 policy holders who are involved in the claims process. We care about the individual needs of policy holders
- ensure policy holders are informed about pivotal decisions on a claim

c) Claims management philosophy – continued

- manage all claims in a consistently fair and equitable manner
- enable risk management data to be identified and utilised by policy holders to reduce or prevent the recurrence of injury to women and infants in their care, 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, policy holders 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 you become aware of it and in any event prior to the expiry of the Policy Period.

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 therefore extremely important that you ensure that Medical Insurance Australia is advised as soon as you become aware of a claim and that you 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 woman you have cared for has been received indicating dissatisfaction with a health care service or outcome
- where a woman you have cared for asks for reimbursement of fees or for you to pay for anticipated future expenses because of dissatisfaction with the treatment or the result of the treatment.

e) Notification of circumstances

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 Medical Insurance Australia:

- in writing;
- as soon as reasonably practicable after you 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 you even if the claim was made against you after the end of the Policy Period.

We encourage all policy holders 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 policy holders are uncertain about how to identify incidents or circumstances which are likely to become claims. It is impossible to produce a complete list which will describe all such circumstances, however the following is a useful guide:

- if a request for a copy of notes has been received in circumstances where you had already detected that the woman in your care was dissatisfied and the outcome was not ideal;
- where a woman in your care tells you she is unhappy and intends to consult a solicitor or make a claim;
- complications (expected or unexpected) where the woman in your care, her relatives or other persons associated with the provision of midwifery services by you are dissatisfied or hostile;
- complications for which you or the woman in your care were unprepared;
- an incident has occurred which has led to a significant adverse outcome for the woman or infant in your care leading to a significant permanent disability;
- you are concerned about your management of a woman in your care (even where she has not complained).

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

- poor outcome for the baby;
- unplanned transfer to operating theatre;
- infection resulting in significant increase in pain and suffering and extended hospital stay;
- failure or delay in diagnosis resulting in significant compromise of the woman's health and/or significant delay in treatment;
- breach of confidentiality;
- failure to follow up test results;
- failure to warn of risks.

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 policy holder. In addition early notification allows us to assess 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 care for women and their infants 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 7 : Risk Management

a) Introduction

We understand the importance of providing a framework to assist midwives plan and undertake appropriate risk management training to enhance the safety and quality of the care they provide.

MIGA has significant experience in the development and implementation of tailored risk management solutions for the medical profession.

Under the terms of our arrangement with the Commonwealth, Eligible Midwives who insure with MIGA must enrol in and complete MIGA's risk management education program which we call our Interactive Risk Management (IRM) Program.

b) About the risk management program

The key features of the IRM Program for the midwives are:

- You will be automatically enrolled in the IRM Program when you insure with us;
- You will have access to a range of risk management activities that can be completed via attendance at conferences, workshops, virtual classrooms or completion of on-line questionnaires or quizzes (we are looking forward to developing these in collaboration with your College and professional associations);
- In the first year you will be able to complete these activities from July 2010 to March 2011;
- A welcome letter will be sent to you once you insure with MIGA:
 - Setting out the activities available for the year
 - Inviting bookings for workshops
 - Providing instructions for online access to activities, resources and reports
- Successful completion of the activities will enable you to earn MIGA IRM points which will entitle you to up to 10% discount off your next year's professional indemnity insurance premium with MIGA.

More details about the risk management program are available via MIGA's Midwives Insurance Scheme Information Booklet.

c) The value of risk management

We believe in the value of our risk management program and we see it as an important long-term tool to help control midwife professional indemnity insurance costs in the future.

Our IRM Program can help midwives with:

- Improving outcomes for women and their infants
- Avoiding the stress and pressure of the claims process
- Expanding your knowledge, awareness and involvement in risk management
- Making improvements in managing risk in your practice
- Reducing your exposure or vulnerability to complaints and claims.

d) CPD points – a double benefit

MIGA has been offering risk management activities for doctors for many years. These activities have been endorsed or accredited by most Medical Colleges across Australia and form part of their Continuing Professional Development (CPD) requirements.

This means that these Colleges grant CPD points when their members complete our risk management activities via the IRM Program.

MIGA is seeking an endorsement from the Australian College of Midwives as part of the MidPLUS program. If agreed, a midwife will be able to count participation in MIGA IRM Program activities as part of their MidPLUS points, which in turn enable them to meet the new continuing professional development requirements for annual renewal of a licence to practise from the Nursing and Midwifery Board of Australia.

This would have a double benefit for midwives insured with MIGA as they can earn their CPD points and IRM points without doubling up on time, and they can earn a premium discount from us as well.

76% of current MIGA policy holders who were surveyed in the last year advised us they claim CPD points for completion of our IRM activities. This is a benefit that is highly valued by them.

e) Risk Resources

Risk Resources is an on-line resource package available to you as part of your insurance with MIGA.

It gives you easy access to a wide range of risk management materials, information and tools aimed at assisting you in your day to day practice.

Risk Resources is an innovative and very practical way for us to provide midwives with access to the extensive resources and knowledge we have developed and acquired over the years based on our significant claims and risk management experience. They are available via the Client Area of our website and you will need to log in with your user access to access them.

Details of the Risk Resources that are available for Eligible Midwives are outlined at our website. Over the next year the range of Resources will be steadily increased.

Section 8 : Run-Off Cover

a) Why you may need Run-Off Cover

Professional indemnity insurance is provided on a claims made basis (that is, your policy will only cover you for claims that are made and reported to MIGA while you have a current insurance policy with MIGA). If, in the future, you no longer need the insurance because you have ceased private midwife practice, you may require insurance to cover your prior practice. This type of cover is called 'run-off cover'.

Run-off cover insures you for claims made in the future which relate to incidents that occurred in your prior practice. You need to maintain run-off cover for the whole time that you have ceased practice in order to be protected against claims that arise in the future.

If you return to private midwife practice, you are advised to purchase new insurance to cover your private practice and retroactive insurance to cover any claims that might come in for incidents that occurred in your prior practice.

b) Types of Run-Off Cover

You can access two 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 Midwives which is free and for an unlimited period of time once triggered whilst the Eligible Midwife remains eligible. This Scheme is an Australian Government initiative and is detailed in legislation.
Standard Run-off, also known as Extended Reporting Benefits (ERB)	Is available for Eligible Midwives who need run-off cover and who are not eligible for ROCS. Eligible Midwives will only need this type of run-off cover for the first three years after they cease private midwife practice.

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

Type of run-off	Applies	Details – Benefit and funding
ROCS	<p>You may become eligible for ROCS when you:</p> <ul style="list-style-type: none"> • are 65 years of age or more and have retired permanently from private practice as an Eligible Midwife; • have ceased practice as an Eligible Midwife because of permanent disability; • under 65 years of age and have not engaged in private practice as an Eligible Midwife at any time during the preceding period of 3 years; • have ceased practice (temporarily or permanently) as an Eligible Midwife because of maternity; • are deceased; • are 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 Eligible Midwife remains eligible for ROCS; • ROCS is funded via a levy on the professional indemnity insurer; • It is then on-charged to all Eligible Midwives as a loading on their insurance premium; • The loading is currently 10% of the premium. The loading is included in the total cost of insurance (up to \$7,500 maximum) that you pay for your professional indemnity insurance cover.
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 • This could be when you: <ul style="list-style-type: none"> – have ceased practice as an Eligible Midwife for reasons other than those set out above; – cease to be insured with us for other reasons 	<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 following year's cover; • The Policy will need to be renewed and a premium paid annually

c) The Midwife Run-Off Cover Scheme (ROCS)

The aim of ROCS, which is an Australian Government Scheme specifically for midwives, is to provide Eligible Midwives with access to free and unlimited run-off cover. Once cover is triggered, it is managed by us. That means that Medical Insurance Australia will manage any claims against you if we are your last insurer, even if the claim comes in many years after you ceased private midwife practice.

Eligible Midwives become eligible for ROCS when they:

- are 65 years of age or more and have retired permanently from private practice as an Eligible Midwife;
- have ceased practice as an Eligible Midwife because of permanent disability (additional requirements such as certification of the disability must be met);

- are under 65 years of age and have not engaged in private practice as an Eligible Midwife at any time during the preceding period of 3 years (this group includes those who are practising solely as indemnified employees and those no longer practising at all);
- have ceased practice (temporarily or permanently) as an Eligible Midwife because of maternity (additional requirements such as certification of the maternity must be met); or
- are deceased (in which case cover is provided to the legal personal representative of the Eligible Midwife).

ROCS is funded by a charge on the professional indemnity insurer which is incorporated into each Eligible Midwife's annual insurance premium. This charge is already included in your premium.

We detail separately on the Tax Invoice the component of premium that relates to ROCS. The charge is currently 10% 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 Government in respect of the contribution year commencing 1 July 2010.

If you 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 forward any relevant forms to you to assess your eligibility for ROCS.

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

d) Standard Run-Off

Standard run-off or Extended Reporting Benefits (ERB) cover is available for Eligible Midwives who need run-off cover and who are not eligible for ROCS.

This could be when they:

- have ceased practice as an Eligible Midwife for reasons other than those set out in Section 8(c); or
- cease to be insured by us for other reasons.

When ERB is requested and granted:

- cover is provided on an annually renewable basis; and
- the Policy will need to be renewed and a premium paid annually.

e) More information about Run-Off Cover

If you are eligible for or apply for run-off cover, we will provide you with more detailed information about your entitlements and any issues you need to note.

Section 9 : 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 only respond to claims first made against you and notified to us in writing during the Policy Period, subject to the Policy terms and conditions.

In addition to the exclusions already mentioned, the Policy will not provide cover in relation to:

- 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 (you are required to disclose those facts or circumstances to us on your Application Form);
- 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 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.

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 – see Section 6(e) for details.

b) Retroactive cover

Professional 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 1 July 2010 or a later date as specified in your Quotation and/or Policy Schedule
- You are not covered for any claim made against you during the currency of your professional indemnity insurance relating to an incident or circumstance that occurred prior to your retroactive date (i.e. 1 July 2010 or a later date as specified in the Policy Schedule).

Section 10 : Important Notices

a) Your duty of disclosure

Before you enter into a contract of general insurance with an insurer you have a duty, under the *Insurance Contracts Act 1984 (Cth)*, 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) Privacy

The information you provide in your Application Form will be used by MIGA to determine the terms and conditions on which it may offer to provide you with insurance. MIGA may provide your personal information to its related bodies corporate and to third parties including, insurers, reinsurers, reinsurance brokers, lawyers, actuaries, auditors and nursing and midwifery boards in Australia and overseas.

MIGA may also provide personal and other information about the currency of your professional indemnity insurance to any health care provider from which you seek admitting rights or to which you apply for work. If you are contracted to provide midwifery services, MIGA may also provide information to your principal about your claims and circumstances history where you have authorized your principal to receive such information.

MIGA is required under its arrangements with the Commonwealth and under the terms of the Commonwealth midwife legislation to provide to the

Department of Health and Ageing and Medicare Australia any information that you provide, including information in your Application Form that may be relevant to determining an entitlement to an indemnity or subsidy scheme payment under that legislation.

If you refuse to provide information required by MIGA, or fail to provide accurate information, or refuse the use or disclosure of information, this may compromise your entitlement to services from, and cover under current or future insurance contracts issued by MIGA. In most circumstances you can access the information which MIGA holds about you but sometimes there will be reasons why that access is not possible, in which case you will be told why.

Section 11 : Other Information

a) Cooling-off period

When you receive your Policy and Certificate of Insurance, please read both 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 products 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 raise any matter or concern with our relevant staff
- Simply contact us and then submit details of your complaint in writing to us
- We will respond to your complaint with an initial determination within 7 business days
- Where you remain dissatisfied with the initial determination, the MIGA CEO will complete a review of the details provided in relation to the dispute and provide an internal determination on the matter within 14 days of receipt of the written confirmation of the dispute details
- Our commitment in terms of how disputes will be resolved and dealt with is as follows:
 - Where the dispute is resolved internally in your favour 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 internally in favour of the initial determination or supports the initial advice given, this 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 insured 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 Financial Ombudsman Service (FOS).

The FOS is an independent national body which comprises the Banking and Financial Services

Ombudsman, the Financial Industry Complaints Service and the Insurance Ombudsman Service. The FOS is established to review consumer disputes in relation to banking, insurance and investment disputes.

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

The FOS will only consider insurance matters.

Contact information about the FOS is:

Financial Ombudsman Service
GPO Box 3
Melbourne VIC 3001
1300 78 08 08
Fax: (03) 9613 6399
Email: info@fos.org.au
Website: www.fos.org.au

If you would like more information about the FOS, 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 FOS to you.

Where the FOS terms of reference do not extend to you or your dispute, we will give you information about other external dispute resolution options that may be available to you.

c) Contacting us

See 'Contacting MIGA' on page (i).

d) Privacy

MDASA and Medical Insurance Australia comply with the *Privacy Act 1988 (Cth)* and the National Privacy Principles.

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

Please also refer to the "Privacy Notice" in Section 10.

e) Other information

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

Professional indemnity insurance cannot be on-traded.

Contacting MIGA

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1800 777 156

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(08) 8238 4444

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www.miga.com.au

Email:
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