MIGA
The Medical Insurance Group
Always on your side

Insurance for Doctors

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

Medical Insurance Australia Pty Ltd / ABN 99 092 709 629

1 July 2012

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

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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

APRA means the Australian Prudential Regulation Authority

Actual Income, Estimated Income, Gross Income and **Gross Indemnity Costs** have the meanings set out in Sections 5 and 12 of Part 2

Category means your practice category, as set out in the Categories of Insurance Guide

ECS means Exceptional Claims Indemnity Scheme

FOS means Financial Ombudsman Service

FSG means Financial Services Guide

HCCS means High Cost Claim Indemnity Scheme

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

PDS means Product Disclosure Statement

PPF means 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 the details of the insurance arrangements that are specific to you for the Policy Period

PSS means the Premium Support Scheme

RHEP Grant means Rural Health Enhancement Package (applies in SA only)

ROCS means the Run-Off Cover Indemnity Scheme

Run-off cover means cover for claims made in the future which relate to your prior practice

Session has the meaning set out in Section 5 of Part 2

SMO means a Salaried Medical Officer

SOA means 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 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 clients 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 is made.

It applies to our Policy which is available for doctors 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 MIGA's Risk Management 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 health care profession across Australia.

We have worked with and supported the medical profession for over 110 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 empower health care professionals to practise with confidence and achieve safer, better health care for all Australians."

Our commitment to quality and service

MIGA has voluntarily adopted the general insurance industry's Code of Practice (the Code) – even though medical indemnity insurance is exempt from it. We remain the only MDO owned medical indemnity insurer to adopt the Code.

We have also implemented a Service Commitment to underpin the Code, which includes measurable service standards in support of our goal to provide outstanding service to our members and 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 members and policy holders. They also reflect our commitment to be transparent and accountable in all that we do.

More information in relation to the Code is available from the Insurance Council of Australia at www.codeofpractice.com.au.

Group structure

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

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

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 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 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
- Some issues you should consider in selecting your Category
- The insurance cover provided in each Category.

Details of all Categories are in our Categories of Insurance Guide which is available from our website at *www.miga.com.au*.

It is very important all of this information is read before submitting an Application or Change of Details Form 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 (or have undertaken)
- Your qualifications as registered with the Medical Board of Australia
- 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 separate 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 30.

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 doctor 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 the "Client Area" of our website.

Membership Benefit	Services available to all members
Bulletins	• Published bi-monthly and also available via the website • Feature articles on risk management, claims management, case studies, key insurance and membership issues, information about MIGA and important medico-legal developments
Long-term membership benefit	• After 40 years of continuous financial membership of MDASA, members are entitled to apply for Compound Life Membership (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
Risk Resources	• Provides easy access to a wide range of risk management materials, information and tools to assist doctors in their day to day medical practice (Some Case studies are only available to insured members)
	Additional services only available to insured members
Access to our Risk Management Program	• Offers a maximum 10% discount off the next year's insurance premium upon full completion
Access to 24-hour emergency medico-legal advice and support	• Catering for urgent situations where medico-legal advice is required • Provided to all insured members across Australia
Doctors' Support Services	Doctors who are involved in a claim can access the following services: • **Medical Support Service** – provided by one of a group of psychiatrists or psychologists offering professional clinical support • **Peer Support Service** – provided by one of a group of doctors offering support and understanding
Client only internet access	Provides a range of on-line resources, including: • Insurance – On-line completion and lodgement of Change of Details Form, payment and access to Certificates of Insurance • Medico-legal Services – On-line lodgement of claims and circumstance notifications • Risk Management Program – On-line bookings for Workshops – Access to status of Points accumulated throughout the year and activities completed – On-line access to Practice Self Assessments, Questionnaires and Speciality Quizzes providing immediate feedback and benchmarking against other participants

(continued on next page)

Membership Benefit	Additional services only available to insured members
Risk management services	Services available on an as needs basis include: • Risk management advice • Member presentations • Practice reviews for members/practices with a higher than average risk profile • Practice visits at member request where specific risk management issues have arisen
Access to benefits of continuous membership/insurance	Free or low-cost Run-off cover for downgrades in Category and for ROCS Gap Cover, on completion of qualifying periods
Premium funding	A range of payment options via a third party funding arrangement
MIGA Financial Benefits Package	Offered by the Commonwealth Bank exclusively for MIGA members – providing preferential personal services and specialist advice from a dedicated Banker
Doctors in Training – Grants Program	Provides funding to assist doctors in training whilst pursuing specialist training opportunities in Australia and abroad

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 Policy will be provided to you with your quotation or with your renewal package.

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

If you are a Medical Student the Policy details provided in this Section do 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 the Policy Schedule that is issued to you.

b) Overview of the Policy

The Policy provides cover for:

- Claims and Claim Costs
- A range of Expenses including in relation to proceedings, inquests, inquiries, investigations or complaints; and
- Advice and advisory assistance arising out of the practice of medicine.

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

The cover provided is in accordance with the Category you select and as outlined in your Quotation and Policy Schedule.

c) Limits and Sub-Limits of Indemnity

The aggregate Limit of Indemnity and Sub-Limits of Indemnity provided by MIGA are as follows:

Section	Limit (any one claim and in the aggregate in the Policy Period)	Sub-Limit for	Sub-Limits – any one claim and in the aggregate in the Policy Period
Claims and Claim Costs	$20,000,000 for Claims and Claim Costs (associated legal expenses)		None
Expenses	$1,000,000 for Expenses	In relation to threats to the personal safety of the doctor, Employees or their immediate family (Refer clause 1.3(f) of the Policy)	$175,000 ($5,000 in the case of Interns)
		For complaints under an employment contract or contract for services (Refer clause 1.4(b) and 1.4(c) of the Policy). Subject to a Deductible of $1,000 each claim, inclusive of costs and expenses	$50,000
		For disputes under a visiting medical officer contract of the doctor (Refer clause 1.4(d) of the Policy)	$75,000
Other matters that we cover you for		Loss of Documents (Refer clause 2.8 of the Policy)	$100,000
		Out of pocket expenses (Refer clause 2.14 of the Policy)	$10,000
		Innocent partner cover (Refer clause 2.18 of the Policy)	Limited by reference to the number of partners in the partnership
		Protection of reputation (Refer clause 2.19 of the Policy). Subject to a Deductible of $1,000 each claim, inclusive of costs and expenses.	$20,000

The above limits are not cumulative which means that cover for Claims and Claim Costs and Expenses are subject to an overall aggregate Limit of $20,000,000 in any one Policy Period.

Cover for Expenses is sub-limited to $1,000,000 in any one Policy Period.

Lower Sub-Limits may apply in other situations and if applicable to you they are detailed in your Quotation and Policy Schedule.

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

Section	Cover
Claims and Claim Costs – cover for claims arising out of the practice of medicine within the Category	**Provides cover for:** • Damages and claims for compensation • Legal costs incurred in defending claims
Expenses	Provides cover for legal costs in defending or responding to various matters in connection with practice. Includes cover for defending a prosecution or responding to inquests, inquiries, investigations or complaints arising from the practice of medicine within the Category selected. Also covers legal costs in defending or pursuing complaints or proceedings involving employment and visiting medical officer matters and allegations of discrimination, harassment and breach of equal opportunity law.

You are only entitled to cover as per your Category and as outlined in your Quotation and Policy Schedule if you:

- Are a member of MDASA
- Are registered by the Medical Board of Australia
- Have declared your correct practice information, including Gross Income and Sessions (as defined in Section 5) and paid the full amount of any premium, adjustments and charges due to MIGA
- Provide a declaration of actual Gross Income upon request
- Have been issued a Policy Schedule reflecting the cover provided.

d) What you are covered for

The cover provided by MIGA is in relation to the work you undertake as per the Category selected, as follows:

Category	Cover for Claims and Claim Costs	Cover for Expenses
Specialists		
All Specialist categories	**Yes**	**Yes**
General Practitioners		
All GP categories	**Yes**	**Yes**
Cosmetic Doctors		
All Cosmetic Doctor categories	**Yes**	**Yes**
Staff Specialists		
• With limited Private Practice	**Yes**	**Yes**
• With no Private Practice – Medical Board and Tribunal cover only	**No***	**Yes**
Salaried Medical Officers		
• SMO in Training includes Private Practice	**Yes**	**Yes**
• SMO >PGY5 with limited Private Practice	**Yes**	**Yes**
• With no Private Practice – Medical Board and Tribunal cover only	**No***	**Yes**
Interns	**No***	**Yes**
Other Practice		
All "Other" Categories (Refer pages 20 to 21 of the Categories of Insurance Guide)	**Yes**	**Yes**

* Other than in relation to Good Samaritan Acts and Gratuitous Advice.

For full details of all Categories including retired and temporarily not practising please refer to the Categories of Insurance Guide which is available from our website at *www.miga.com.au*.

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	Our Policy is structured to respond to the changing nature of doctors' medical practice depending on your Category and Policy Schedule. It includes as an insured: • The doctor named in the Policy Schedule • Employees in relation to matters that arise out of their employment whilst they are working in the conduct of the Practice (some employees are not included, as outlined below) • A company or trust owned and controlled by the doctor and which provides services for the purpose of the Practice by the doctor • Medical Students: – Provided they are assigned to the Practice by their university – In relation to matters that arise whilst working in the Practice. Employees who are **not** included as an insured are: • Doctors, as they must arrange their own insurance • Any person who is registered as a midwife by the Nursing and Midwifery Board of Australia whose registration has an eligible midwife notation • Any other person who provides health care treatment, advice or service charged for and billed in their own name.
Scope of cover for Expenses	Our Policy provides cover for Expenses incurred in relation to investigations, proceedings or complaints. These include: • Medical board, medical tribunal or other disciplinary investigations and proceedings • Hospital, health service or health authority, private health insurer or Medicare Australia • Professional college or association, health service and health care ombudsman inquiries and complaints (and other such government/statutory authority or other body performing similar functions or exercising similar powers to the above bodies) • Coronial inquiries, royal commissions • Criminal investigations and proceedings • Health Insurance Act 1973 inquiries • Competition and Consumer Act 2010 or equivalent State or Territory legislation • Threats to your personal safety or that of your employees • In defending complaints and proceedings by persons (including employees) who provide services to the practice • In defending or pursuing matters in relation to your contract as a visiting medical officer • In defending or pursuing matters in relation to your employment contract. In terms of allegations re inappropriate practice, transmission of disease, intoxication etc, cover is provided to assist with the defence of these matters, i.e.we take an innocent until proven guilty approach. This provides very important protection in the event of such allegations.
If you change your area of practice to a lower risk Category	• Subject to a review of your claims and practice history, no Run-off premium is payable if you change to a Category that MIGA considers to be a lower area of risk, provided you were insured continuously by Medical Insurance Australia for a period of at least: – 2 years, if the Category is for ongoing practice (other than an employer indemnified, non clinical, retired, compound life or suspended Category), or – 5 years, if the Category is an employer indemnified Category • An additional Run-off premium may apply if you: – Have not reached the respective 2 year or 5 year qualifying period; or – Downgrade to a non clinical, retired, compound life or suspended Category; or – No longer require cover for treatment provided to Public Patients.

f) Other matters that we cover you for

Depending on your Category and your Quotation and Policy Schedule our Policy provides some important extensions to cover, as follows:

Benefit	Detail
Public Patients	Covers you for the treatment of public patients provided you are not otherwise entitled to indemnity 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 a Practice Entity, where you and the Practice Entity are covered for Practice overseas (as defined in the Policy).
Vicarious liability	Covers you and the Practice Entity for vicarious liability in respect of acts, errors or omissions committed or alleged to have been committed by: a) Another insured in the course of Practice b) An employed doctor, contractor or locum (No cover is provided in relation to these parties unless they provided you with written evidence of insurance when you first employed or contracted them and thereafter when any material change to their practice occurred and when their insurance is renewed.) Cover is subject to: • Work that he or she is employed or contracted by you or a Practice Entity to undertake; and • Where he or she is registered if required by law to be registered; and • The work is within your Category or a lower risk Category as determined by us. c) A non-employed health care professional under direct supervision, training or mentoring by you in the course of providing health care treatment, advice or service within the same Category as you. A non-employed health care professional means a person who, at the time of the act, error or omission: • Was a registered doctor, a registered nurse, a registered nurse practitioner or a registered midwife, respectively, who was not employed by you or a Practice Entity or in partnership with you; and • Was required by a college, training institution, medical board or nursing and midwifery board to be directly supervised, trained or mentored by you for the purpose of obtaining, retaining or regaining a recognised professional medical or nursing or midwifery qualification, award or registration.
Practice outside the Commonwealth of Australia	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 Policy Period. Cover is provided for you and an Employee accompanying you, as a team doctor for an Australian sporting team or cultural group that is travelling, competing or performing in the USA for no more than 120 days during the Policy Period.
Volunteer Practice	Covers you for claims arising out of work as an unpaid volunteer in the course of volunteer activities, including any amateur sporting activity, school or community based event, charity work, aid program or disaster response work.
Competition and Consumer Complaints	Covers you for any action by a government or statutory authority alleging a contravention of or seeking relief under a provision of the Competition and Consumer Act 2010 or any equivalent State or Territory legislation.
Liability for restricting ability to practise	Covers you for claims arising in the course of supervising, training or mentoring a registered doctor: • 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 doctor to provide health care treatment advice or service in the future.

(table continues on next page)

f) Other matters that we cover you for – continued

Benefit	Detail
Medical research and clinical trials	Covers you (and any Employee acting under your supervision) for your role in medical research or a clinical trial if: • It is approved by a registered ethics committee (registered with the NHMRC) and it is conducted as required by that committee • It is within your Category or a lower risk Category (as determined by us) and for which you are qualified.
Loss of Documents	Covers you and a Practice Entity for the reasonable cost of replacing or restoring documents (as defined) in your possession if they are destroyed, damaged, lost or mislaid. Cover under this automatic extension is subject to a Sub-Limit of $100,000 and other conditions as detailed in the Policy.
ROCS Gap Cover	ROCS Gap Cover provides cover for you if you: • 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). We provide Run-off cover to eligible doctors for up to 3 years on an annually renewable basis until they are eligible for ROCS. Any additional premium is capped at $50 per annum exclusive of statutory charges.
Threat to personal safety	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. Subject to a Sub-Limit of $175,000 for each claim and in the aggregate per Policy Period. The Sub-Limit for Interns is $5,000 for each claim and in the aggregate per Policy Period.
Out of pocket expenses	Covers you for reasonable out of pocket expenses incurred by you in responding to a Claim or a matter that has given rise to Expenses, subject to our prior approval. This is intended to cover costs such as travel, meals and accommodation expenses. Subject to a Sub-Limit of $10,000 for each claim and in the aggregate in the Policy Period.
Liability for Complaints about others	Covers you for Claims arising from you: • Having reported an incident and/or a health care professional to a Medical Board or other body responsible for the professional discipline of health care professionals; or • Assisting in an investigation in relation to the incident or the reporting of an incident to any one or more bodies responsible for the professional discipline of health care professionals.
Innocent partner cover	Covers you for Claims arising out of your joint and several liability in partnership if: • The partnership is a partnership within the meaning of the Partnership Act • You have obtained written evidence of current insurance covering your partner(s) each year; and • Your partner(s) work within the Category for which you are insured, or a lower risk Category as determined by us. 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.
Protection of reputation	Covers you against Expenses incurred in relation to complaints and proceedings pursued by you alleging defamation in connection with Practice, provided the complaint or proceeding is not pursued against persons insured by us. Subject to a Sub-Limit of $20,000 each claim and in the aggregate in the Policy Period and a Deductible of $1,000 inclusive of costs and expenses.

g) Cover for treatment of public patients

Cover for treatment of public patients is automatically provided (refer clause 2.16 of the Policy), subject to the terms and conditions of the Policy, except where you are:

- Otherwise indemnified for such claims; or
- Insured in a Category that excludes or does not extend to cover claims arising out of the treatment of public patients (see following).

If your practice involves the treatment of public patients, it is important that you clarify whether you are entitled to be 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 entitled to indemnity from 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 5.26).

Where cover for the treatment of public patients is required, it is important that you:

- Check your Category to make sure it does not exclude cover for the treatment of public patients (refer 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.

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 3 of our Categories of Insurance Guide
- Interns – refer Section 6 of our Categories of Insurance Guide
- Employer Indemnified – refer Section 5 of our Categories of Insurance Guide.

For information about the Categories of Insurance we offer please refer to our website at www.miga.com.au.

If you select any of the above Categories:

- No cover is provided for Claims and Claim Costs under the Policy for claims for compensation arising from the treatment of public patients
- Cover is provided for Expenses under the Policy for costs incurred in relation to complaints, inquiries, investigations etc in relation to the treatment of public patients:
  - To the extent you are not otherwise entitled to indemnity
  - Subject to specific limitations in some Categories and as detailed in your Quotation and Policy Schedule.

    For example, for the Category of "Employer Indemnified Staff Specialist – Medical Board and Tribunal cover only" cover for Expenses under 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 e.g. if you select "Medical Academic" you are not insured for any claims that arise from clinical patient contact of any kind, whether 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

You are required to provide an accurate estimate of your Gross Income/Sessions for the treatment of public patients for which you require cover from us. This is because we require data on the proportion of our insured doctors who need this cover.

It is important to note that 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 advise us of your income/sessions for such work in your declaration of Gross Income/Sessions; and
- It is not excluded by the Category that you have selected.

h) Good Samaritan Acts and Gratuitous Advice

Cover for Good Samaritan Acts and Gratuitous Advice is automatically included, 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 Medical Board of Australia at the time the advice is given
- There is no request by you for 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 the Categories of Insurance Guide.

i) Your Policy Schedule and Certificate of Insurance

On receipt of full payment for renewal, or once an Application Form has been accepted and full payment is received, we will forward a Policy Schedule and Certificate of Insurance to you.

If your insurance Policy with Medical Insurance Australia is subject to any Special Conditions or Endorsements, they will continue to apply when your Policy is renewed, unless we agree that they are no longer relevant.

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

j) What the Policy does not cover

The Policy does not provide cover in certain instances.

These are set out in Section 5 of the Policy wording (Claims and Expenses that we do not cover you for) but may also be contained within conditions or endorsements or where specifically excluded under the Category.

It is very important you familiarise yourself with your Category by reference to the Categories of Insurance Guide (available via our website) and read these exclusions, conditions and additional endorsements and contact us if you have any questions about them.

k) Notification of claims and circumstances

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

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

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

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

The Insurance Contracts Act 1984 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 in 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 any Change of Details Form or on any previous Application or Renewal Form
- Any matter referred to in Section 5 of the Policy.

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 in your Quotation and 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 in your Quotation and 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 2003 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 Risk Management 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) What will your tax invoice include?

Your tax invoice is made up of the following parts:

- Membership Fee
- Base Premium
- Risk Management discount (if applicable)
- Run-off premium (if applicable)
- Run-Off Cover Scheme levy
- GST
- Stamp Duty
- Premium Support Scheme (PSS) (if applicable).

e) 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 doctor 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**

There are a range of Categories from which you can select.

Details of all Categories are in our Categories of Insurance Guide which is available from our website at *www.miga.com.au*. If you do not have access to the internet please call us for a copy of the Guide.

The Category you 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 us with the details and we will assess your circumstances individually.

Note: In selecting a Category you should also consider whether you have undertaken any procedures in the past that are not covered under the Category you have selected.

If you are unsure which Category is appropriate for your circumstances please contact our Client Services Department.

Section 5 : **Declaration of Gross Income**

a) Introduction

Your Change of Details 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:

- Doctors are not eligible for PSS on the proportion of premium payable in relation to Gross Income generated from the treatment of public patients
- This information is required by Medicare and 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.

If you do not provide us with an updated estimate of Gross Income prior to the end of May each year, for the purpose of your renewal as at 1 July, we will assume that your estimate of Gross Income for the next Policy Period is the same as your estimate of Gross Income for the previous Policy Period or if updated since, as held on our file at the time of invoicing.

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 total amount that you have billed the patient for the procedure not just the Medicare rebate amount.

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

c) Special cases

If you are practising in any of the following Categories please advise your average number of 'Sessions' per week.

- 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 6 : **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 Change of Details Form (available via our website) 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	Is available for doctors who need Run-off cover and who are not eligible for either ROCS or ROCS Gap Cover

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

Type of Run-off	Applies	Details – Benefit and funding
ROCS	You become eligible for ROCS when you are: • 65 years of age or more and have retired permanently from private medical practice • Unable to practise because you are permanently disabled • Under 65 years of age and have not engaged in private medical practice at any time during the preceding period of 3 years • No longer practising because of maternity • Deceased, or • In another qualifying group determined by regulation to be eligible.	• Cover is free and once triggered is provided for as long as the doctor remains eligible for ROCS • ROCS is funded via a levy on all medical indemnity insurers • It is then on charged to all doctors as a loading on their insurance premium • From 1 June 2008 the loading is 5% of the premium for all insurers.
ROCS Gap Cover	Is available from us if you: • Permanently cease private practice before age 65; and • Are not yet eligible for ROCS; and • Have 5 years of continuous insurance/membership with us.	• We will cover the first three years of Run-off via annually renewable insurance, until you are eligible for ROCS • An annual premium of $50 may be payable.
Standard Run-off	• Is available when you need Run-off cover and you are not eligible for ROCS or ROCS Gap Cover • This could be when you: – Cease practice for less than 12 months before age 65 – Cease to be insured with us for other reasons (e.g. insure elsewhere) – Move to a lower risk Category.	• Cover is offered on an annually renewable basis • At the time of triggering the cover, you may 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 (if applicable).

c) ROCS

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
- Unable to practise because they are permanently disabled
- Under 65 years of age and have not engaged in private medical practice at any time during the preceding 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)
- No longer practising because of maternity

- 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.

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

We detail separately on the Tax Invoice the component of premium that relates to ROCS. The charge is 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.

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 retired from private medical practice for a continuous period of 3 years, or
- When they reach age 65, whichever occurs first.

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

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

Standard Run-off 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 Run-off premium is payable if you change to a Category that MIGA defines as a lower area of risk, provided you were insured continuously by Medical Insurance Australia for a period of at least:
  - 2 years, if your new Category is for ongoing practice (other than an employer indemnified, non clinical, retired, compound life or suspended Category), or
  - 5 years, if your new Category is an employer indemnified Category
- An additional Run-off premium may apply if you:
  - Have not reached the respective 2 year or 5 year qualifying period, or
  - Downgrade to a non clinical, retired, compound life or suspended Category, or
  - No longer require cover for treatment provided to public patients.

When Run-off is requested and granted:

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

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 7 : **Renewal of your Insurance and Membership**

a) Renewal package

Your insurance and membership expires 30 June each year with the exception of Interns and SMO's in their 2nd post graduate year whose Renewal will be changing to 1 January each year from 1 January 2013. Prior to renewal each year, we will forward to you a Renewal Package which includes the following important documents:

- Covering letter
- Tax Invoice
- Quotation Schedule
- Combined FSG and PDS
- Policy Wording
- Payment Options Form
- Monthly Instalment Facility 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, MIGA will consider your particular circumstances, taking into account:

- Any information that you have previously provided to us
- The information provided by you in your Change of Details Form (if submitted), and any subsequent discussions we have had with you
- Whether you have complied with the requirements to receive a premium discount as a result of completion of the Risk Management Program in the prior Policy Period
- 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 that you applied for and were granted a subsidy under the Medical Indemnity Subsidy Scheme (MISS) in the 2004/2005 year
- Whether you are eligible for a RHEP Grant from Country Health SA (applies to SA Rural doctors only).

If at the time of invoicing you have not submitted a Change of Details Form, we will invoice you based on your existing insurance arrangements with us. Your Tax Invoice and Quotation Schedule will therefore assume your Category and Special Conditions are as per the prior Policy Period.

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.

Details of the Categories available can be obtained in our Categories of Insurance Guide from our website *www.miga.com.au*.

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 12)
- Choose one of the following payment options:
  - Payment by instalments – complete and return the original Monthly Instalment Facility Form
  - On-line credit card payment – Mastercard and Visa only
  - BPay – See your Tax Invoice for Biller Code / Reference details
  - Credit Card – Mastercard, Visa, Diners Club or American Express
  - Cheque
  - Cash

If payment cannot be made by 1 July each year, Medical Insurance Australia may extend the time for payment to 14 July.

The Policy does not come into force until you have paid the premium in full prior to the start of the Policy Period.

If you have not paid the premium in full by the due date each year, we may agree to issue the Policy retrospectively if you pay the premium in full **by 14 July.** In all other cases, you will have no entitlement to indemnity under the Policy and the Policy will never have come 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.

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

Section 8 : **General Administration**

a) Steps to joining and obtaining insurance with MIGA

Applying for insurance and membership is easy.

The following options are available:

- Complete the on-line Application via the link on our website (available for Employer Indemnified doctors only)
- Download an Application Form from our website and post or fax it to us
- 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.

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 13 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.

If you are an Employer Indemnified doctor applying on-line, you will receive automatic feedback from us if your application is accepted or not.

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) Period of insurance and membership

Insurance and membership with MIGA is on an annual basis from 1 July to 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.

For Interns and SMO's in their 2nd post graduate year, insurance and membership is on an annual basis from 1 January to 31 December each year, (commencing from 1 January 2013).

d) Paying your invoice

You can pay your invoice by the following methods:

- Annually; or
- By instalments (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 or Visa, only)
- BPay
- Credit card – Mastercard, Visa, Diners Club or American Express
- Cheque
- Cash
- Direct debit (only if paying by instalments).

If you are an Employer Indemnified doctor applying on-line via our website you will have the option to pay on-line by Visa or Mastercard once your application is accepted.

e) Paying your invoice by instalments

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

The instalment plan is not available if you are an Employer Indemnified doctor paying on-line via our website.

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
- 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 10 or 12 (depending on the option selected) equal monthly instalments either beginning 1 July (if a renewal) or a later date if you have just joined.

Please note: For Pacific Premium Funding to satisfy Federal Government Anti-Money Laundering Legislation, doctors funding for the first time, **may** be required to provide a certified copy of their passport or drivers licence.

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. You may be asked to complete a declaration confirming the change requested.

g) Changing State or Territory of practice

Please advise us 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 (or 31 December in the case of an Intern or SMO in their 2nd post graduate year).

i) Cancellation of your insurance

Your 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 14).

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 Run-off cover is effected.

The cost of Run-off cover will be offset against any applicable premium refund (if granted).

Section 9 : **Claims and Advisory Services**

a) Overview

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

We offer a 24 hour a day, 7 days per week emergency legal advice service across Australia, as we recognise medical emergencies which may have medico-legal consequences can occur at any time. The advice is provided by our expert team of in-house solicitors.

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

Our in-house solicitors provide advice on all medico-legal matters and manage all claims, noting that for some claims representation and additional support is provided by our expert external legal panel.

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

b) Our advisory service

We assist doctors with any enquiries they may have which arise in their medical practice and which relate to patient care and are of a medico-legal nature. This is over and above the support provided in relation to claims and incident notifications.

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 and issues that may arise in relation to Medical Board, Medicare Australia 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.

Our 24 hour emergency legal advice service is an important feature of the membership 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 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 and requesting a payment
- Where a 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

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 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 type 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 during 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 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 of a medico-legal nature 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, send an email message via our website or call and ask to speak to a solicitor in our Claims Department.

Section 10 : **Risk Management**

a) Introduction

MIGA has a strong focus on risk management and it is a very important tool to help us and our members control medical indemnity insurance costs in the future.

MIGA's Risk Management Program was the first of its kind introduced in Australia and we believe it remains at the forefront of risk management initiatives in the medical indemnity insurance industry.

As part of the Risk Management Program, you have access to an exciting range of risk management initiatives that you can complete either in person or on-line. By completing the activities, you have access to a premium discount of up to 10% off your next year's premium.

b) Value of MIGA's Risk Management Program

One of the key reasons we have been able to offer premium reductions in the last few years is that our claims results have improved significantly - claims frequency is reducing and our average cost of claims is stable. Our analysis shows that this improvement has been driven more by those doctors who have completed the Risk Management Program than those who have not.

We believe there is a real correlation between these results and our extensive focus on risk management. You are now benefiting from this via reduced premiums.

We also see the Risk Management Program as helping you with:

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

When claims start reducing, it's tempting to forget about risk management. We understand that completing risk management takes time but we hope you will see that the time and effort is worth it with the reductions in premiums we have offered over the last few years.

We strongly encourage all of our members to maintain their focus on risk management and complete the Risk Management Program in the next year, as there is a direct benefit.

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 Risk Management Program.

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

Doctors who are not members of MIGA can attend our Risk Management 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, or where specific risk management issues have arisen.

e) Risk Resources

Risk Resources gives our members easy access to a wide range of risk management materials, information and tools which are aimed at assisting them in their day to day medical practice. They are available via the Client Area of our website.

Risk Resources is an innovative and very practical way for us to provide members 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.

The following provides a more detailed outline of our Risk Resources.

Risk Resources	Detail
Articles	Incorporate articles and risk management tips from our Bulletin plus additional articles which focus on topical issues
Case Studies	Our Case Studies address topical and emerging medico-legal and risk management issues across specialties
Fact Sheets and Check Lists	Practical and useful information on a wide range of practice management topics and risk management issues
Useful Links	Web links are available via our website to sites of interest and use to members

f) More information about MIGA's Risk Management Program

Refer to our Risk Management Program Booklet or visit our website at www.miga.com.au to find out more information about the Program and, if you are a new member, how you can register to participate.

Section 11 : **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 was extensively involved in consultation with the Federal Government on implementation of these 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 doctors 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 has ensured long-term access by doctors to secure and sustainable medical indemnity.

c) Summary of key legislation

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

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

d) Medical indemnity legislation – key facts

Over recent years there has been a significant amount of legislative change in relation to medical indemnity.

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

Arrangement	Key details
Premium Support Scheme (PSS)	The PSS was introduced from 1 January 2004 to assist doctors with affordability of medical indemnity premiums Essentially, doctors are eligible for the PSS if their medical indemnity costs exceed 7.5% of their gross income from medical practice. If so, the PSS will provide funding for 70% of the amount above this threshold In addition to this: • Doctors who were previously entitled to the Medical Indemnity Subsidy Scheme (MISS) maintain this entitlement (to ensure that no doctor previously receiving a subsidy under MISS guidelines will receive less support under the PSS) • Doctors who are procedural GPs in a designated rural area will receive funding for 75% of the difference between their premium and that of a non-procedural GP in similar circumstances The PSS is managed by medical indemnity insurers and is offset against a doctor's total indemnity cost, excluding government charges such as stamp duty and GST.
Run-Off Cover Indemnity Scheme (ROCS)	ROCS came into effect on 1 July 2004 The aim of ROCS is to provide doctors with access to free and unlimited Run-off for claims against: • Doctors who are aged 65 or more who permanently retire from private medical practice • Doctors who die or are forced to retire prematurely due to permanent disablement • Doctors who have ceased medical practice due to maternity • Other doctors who have not engaged in private medical practice at any time during the preceding period of three or more years; and • Doctors in another qualifying group determined by regulation to be eligible ROCS is funded by a charge on medical indemnity insurers which is incorporated into each doctor's annual insurance premium Once cover is triggered, it is provided for as long as the doctor has ceased private medical practice and will be managed by the doctor's last insurer.
High Cost Claim Indemnity Scheme (HCCS)	The HCCS was introduced from 1 January 2003 as a means to stabilise medical indemnity premiums by reducing the cost of large claims to insurers The HCCS funds 50% of all claims in excess of $300k up to the limit of a doctor's insurance cover (note – when first introduced it provided funding for claims above $2m, but the attachment point was reduced to $300k from 1 January 2004) Key features of the HCCS are: • The HCCS does not directly affect doctors as it involves a reimbursement of claims costs to insurers • It will only provide a subsidy to the level of a doctor's policy limit with their medical indemnity insurer (which is currently $20m with MIGA) • It does not reimburse the cost of claims for incidents which occur outside Australia nor for the treatment of Public Patients in Public Hospitals (note – Medical Insurance Australia can still provide this cover).
Exceptional Claims Indemnity Scheme (ECS)	The ECS came into effect on 1 January 2003 It is intended that the Federal Government will cover the cost of claims that exceed an agreed threshold – which is currently set at $20m The intention is that doctors have protection for claims that may ultimately resolve for an amount above the level of their policy cover with their insurer It is intended that the cover is the same as the cover provided by the medical indemnity insurer at the time the claim is notified.

Section 12 : **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 subsidy, 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 subsidy 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 25), or
- You conduct work as a Procedural General Practitioner in an area that is classified by the Department of Health and Ageing as a Remote, Rural or Metropolitan Area (RRMA) 3-7, or
- You previously received a subsidy under MISS and continue to work in the same specialty.

A doctor:

- Whose practice is primarily based on public billings; and
- Who 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 Subsidy 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 subsidy 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 doctor only in the public sector during the Policy Period (and thereby earns no income from private practice) is not eligible for a PSS subsidy 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 subsidy calculation

The Basic PSS subsidy calculation

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

70% of the amount by which your Gross Indemnity Costs exceed 7.5% of your Estimated or Actual Income.

PSS subsidy 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 subsidy calculation:

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

This subsidy 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 subsidy of greater dollar value, MIGA will apply the basic calculation.

Alternate PSS subsidy 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 a subsidy 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.

Do not include any income which you receive relating to the provision of medical services for which medical indemnity cover is provided by a public sector organisation.

For the purposes of the calculation of PSS, Actual Income is limited to billings generated by you from the provision of private medical services.

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 in respect of private medical services 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 (other than where a Rural Procedural General Practitioner or MISS calculation is used)

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 doctor 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 subsidy from Medicare Australia, should you subsequently become ineligible for a PSS subsidy, 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 subsidy 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 subsidy 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 subsidy 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 subsidy payment relates will mean that you cease to be eligible for PSS subsidy 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' page 27). In determining the amount of subsidy 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 subsidy, 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 subsidy 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 MIGA's Risk Management Program equivalent to at least 4 Points will be satisfactory for the purpose of meeting this requirement and receiving the Commonwealth PSS subsidy. For details please refer to the Risk Management Program Booklet.

If you receive a PSS subsidy and do not comply with the above requirements, you must repay any PSS subsidy received. In the event you do not repay a PSS subsidy 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 Risk Management Program and a premium discount, members must complete a broader range of risk management activities and achieve the required Points for the Program, as outlined in the Risk Management Program 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 subsidy 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 subsidy 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 doctor 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 doctor.

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 subsidy due. This revision may result in one of the following:

- You are now eligible for PSS subsidy and, since you have already paid the full indemnity costs, PSS subsidy will be made by MIGA directly to you, or
- You are entitled to a refund of overpaid premium, or
- You will be required to pay additional premium, offset by PSS subsidy, or
- You are no longer eligible for PSS subsidy 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 subsidy 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 subsidy calculation, please contact us.

Please note that where any change requires an adjustment to your PSS subsidy of less than $100.00, MIGA may not process such an adjustment midterm.

q) The administration fee

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

Apart from receiving such reimbursement, MIGA does not receive commission or benefits, and makes no charge upon you for administration of the scheme.

r) GST and Stamp Duty

PSS subsidy does 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.

t) Alternate PSS calculations – MISS

Specialisation	PSS Subsidy Calculation	Applies to
Procedural GP	PSS subsidy is equal to 50% of the difference between your premium and that of a non-procedural GP in the same income band and state.	General Practitioners who: • Prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under the MISS • Are liable to pay a higher premium for medical indemnity cover 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 • Who continue to work as a procedural GP (unless on leave for less than 12 months).
Procedural GP Registrar	PSS subsidy is equal to 80% of the difference between your premium and that of a non-procedural GP in the same income band and state.	General Practitioner Registrars who: • Prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS • Are liable to pay a 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 Registrar (unless on leave for less than 12 months).
Rural Specialist Obstetrician	PSS subsidy is equal to 80% of the difference between your premium and that of a Gynaecologist in the same income band and state.	Specialist Obstetricians who: • Prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS • Continue to work as a Specialist Obstetrician (unless on leave for less than 12 months) and • Conduct Specialist Obstetrician work in an area classified by the Dept of Health and Ageing as a Rural, Remote or Metropolitan Area (RRMA) 3-7.
Specialist Obstetrician (non-rural)	PSS subsidy is equal to 50% of the difference between your premium and that of a Gynaecologist in the same income band and state.	Specialist Obstetricians who: • Prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS and • Continue to work as a Specialist Obstetrician (unless on leave for less than 12 months).

(table continues on next page)

Specialisation	PSS Subsidy Calculation	Applies to
Neurosurgeons	• If the total amount of premium for the premium year is $50,000 or less and the premium of a General Surgeon in the same state and income band is less than $50,000, the PSS subsidy 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 subsidy is equal to: – 80% of the amount by which the total amount of premium exceeds $50,000, PLUS – 50% of the difference between $50,000 and the premium of the General Surgeon 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 subsidy is equal to 80% of the difference in premium.	Neurosurgeons who: • Prior to 30 June 2004, applied to the Dept of Health and Ageing and obtained a subsidy under MISS and • Continue to work as a Neurosurgeon (unless on leave for less than 12 months).

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 subsidies 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 subsidy 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 activities in the Risk Management Program equivalent to at least 4 Points will be satisfactory for the purpose of meeting this requirement and receiving a PSS subsidy. For details please refer to the Risk Management Program Booklet.

  If you receive a PSS subsidy and you do not comply with these requirements, you must repay any PSS subsidy received. In the event you do not repay a PSS subsidy 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 Change of Details or Application Forms 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 subsidy (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 subsidy 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 subsidy, you remain liable at all times to MIGA for payment of the full premium.

Section 13 : **Important Notices**

a) Notice to the Proposed Insured

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, 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 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 in 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 any Change of Details Form 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.

c) Retroactive date

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.

See Section 3 for further details.

d) Privacy

The information you provide to MIGA will be used to determine the terms and conditions on which it may offer to renew or provide you with insurance and membership. MIGA may provide your personal information to its related bodies corporate and to third parties including insurance agents, brokers, insurers, reinsurers, reinsurance brokers, lawyers, actuaries, auditors and medical boards in Australia and overseas. MIGA may also provide personal and other 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.

If you are an employee (or you are contracted to provide medical services), MIGA may also provide personal and other information to your employer or prospective employer about your claims and circumstances history where you have authorised your employer or prospective employer to receive such information. MIGA is required under the terms of the Medical Indemnity Act 2002 to provide to Medicare Australia upon request any information that you provide to MIGA 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.

e) Third Party Authority for Privacy reasons

You may require other persons, such as your spouse, partner, personal assistant or practice manager to access personal and other information about you and your insurance (including claims information) and membership and to request and make changes to your arrangements with us.

We must have your written authority to:

- Provide personal and other information about you and your insurance; and
- Accept instructions to request and make changes to your insurance

from such persons.

If you wish to provide such an authority, please contact us and we will forward a Privacy Authority Form for your completion.

In the absence of a written Third Party Authority, personal and other information and requests for changes to your insurance will only be accepted from you.

Section 14 : **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 21 days of the date your Policy is issued or within 21 days of the date your cover commences, whichever is the earlier date. 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
- Your complaint can be notified to us verbally or in writing
- We will respond to your complaint with an initial determination within 7 business days
- Where you remain dissatisfied with the initial determination, the 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 two years 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. It cannot consider matters relating to your membership of MDASA nor any entitlements you may have to discretionary indemnity with MDASA.

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 and the National Privacy Principles.

MIGA requires the information requested from you in an Application or Change of Details 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 any Application or Change of Details Form may not be actioned.

Please also refer to the Privacy Notice in Section 13.

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.

How to contact Us

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

Always on your side