Medical Indemnity
Insurance and Membership

Combined Financial Services Guide and Product Disclosure Statement for Doctors

1 July 2016

2016

miga ALWAYS

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

Medical Insurance Australia Pty Ltd
ABN 99 092 709 629

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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.

Information in this combined Financial Services Guide and Product Disclosure Statement for Doctors or on MIGA's website does not constitute legal or professional advice.

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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

Period of Insurance
Means the period of insurance noted on your Policy Schedule

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

Policy Schedule
Means the document issued by us to you confirming the details of the insurance arrangements that are specific to you for the Period of Insurance

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

RRMA
Means Rural, Remote and Metropolitan Area

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

Contents

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.

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.

Financial Claims Scheme

The Policy may be protected by the financial claims scheme administered by the Australian Prudential Regulation Authority (APRA), which only applies in the unlikely event of an insurer becoming insolvent. A person who is entitled to make an insurance claim under a protected policy may be entitled to payment under the financial claims scheme, if they satisfy the eligibility criteria. More information may be obtained from APRA at www.apra.gov.au or 1300 55 88 49.

Medical Practitioners Practising in New South Wales

When making a decision concerning cover provided to a practitioner who practises in New South Wales, the Insurance Regulation Order made under the Health Care Liability Act 2001 requires us to:

- provide a claims history on request to the practitioner; and
- comply with certain conditions when refusing cover to the practitioner (the conditions vary depending on whether the practitioner is an existing policyholder or a new applicant).

A copy of the Order is set out at: http://www.health.nsw.gov.au/pubs/2006/ins_reg_orderjul2006.html

Welcome to MIGA

About MIGA

About the Group

We are a national provider of indemnity insurance products and associated services to the health care profession across Australia.

With our Head Office in Adelaide and with offices in Sydney, Melbourne, Brisbane and Perth we have been supporting and protecting the medical profession for over 115 years and the broader healthcare profession for close to 10 years.

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.

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 us. It also provides you with important information about our claims handling processes and our Risk Management Program.

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

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 APRA	Provides medical indemnity insurance

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.

We follow 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 we offer
- 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 32.

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 are only available via the "Client Area" of our website.

In the following we have outlined the services and benefits that are available to those who are members of and/or are insured with MIGA.

	Services and benefits
Payment by direct debit	• Most doctors have the option to pay by automatic direct debit (bank or credit card) with monthly instalments available at no additional cost where the annual cost exceeds the agreed minimum
24 hour emergency telephone support	• Provided by MIGA's staff across Australia and catering for emergency situations where claims and legal advice is required
MIGA Plus	• Access to insurance products and services aligned with our clients' business and day-to-day practice • Initial product available is business insurance, offered under a partner arrangement providing cover for a range of day-to-day business insurance matters including property damage, business interruption, public liability, burglary, tax audit, employee dishonesty and products liability
Bi-monthly Bulletins	• Published bi-monthly, they feature articles on risk management, claims management, case studies, key insurance and membership issues, information about MIGA and important medico-legal developments
Industry leading Risk Management Program	• MIGA offers a range of risk management education opportunities via our Risk Management Program which gives doctors access to a maximum 10% discount off the next year's insurance premium upon full completion. • The Program is free to our clients and is accredited by most of the Medical Colleges for reciprocal CPD points.
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
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 still need to arrange and pay for medical indemnity insurance through Medical Insurance Australia
Personal advice	• Available from our dedicated service staff
Practitioners' Support Service	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

Section 1: Membership of MDASA *(continued)*

	Services and benefits
Doctors' Well-being Program	• MIGA offers a range of ways to support, encourage and promote the importance of doctors looking after their own health • The program includes information and tools to help them identify and manage their personal health risks
Starting Private Practice Package	• An attractive benefit which recognises the significant cost and time it takes to establish a private practice for the first time and reflects our support of doctors transitioning to private practice
On-line services	• Includes completion and submission of key forms, lodgement of claims notifications and completion of our risk management activities
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
Doctors in Training - Grants Programs	• Provides funding to assist doctors in training whilst pursuing specialist training opportunities in Australia and abroad
iPhone App Technology	• MIGA supports a free iPhone App offering access to the latest Australian Medicare Benefits Schedule. The MBS Search Application enables doctors and their practices to obtain the latest Australian Medicare Benefits Schedule free on their iPhone.

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 renewal.

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 us are as follows:

Section	**Limit** (any one claim and in the aggregate in the Period of Insurance)	**Sub-Limit for**	**Sub-Limits** (any one claim and in the aggregate in the Period of Insurance)
Claims and Claim Costs	$20,000,000 for Claims and Claim Costs (associated legal expenses)		None
Expenses	$1,500,000 for Expenses	In relation to threats to the personal safety of the doctor, Employees or their immediate family (Refer clause 1.4(f) of the Policy)	$200,000 ($5,000 in the case of Interns)
		For complaints under an employment or 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 For disputes under a visiting medical officer contract of the doctor (Refer clause 1.4(d) of the Policy)	$150,000 (Combined)
		For complaints in relation to the by-laws of a professional college or association. (Refer clause 1.4 (e) of the Policy)	$50,000
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 $5,000 each claim, inclusive of costs and expenses.	$75,000
		Public relations expenses (Refer clause 2.21 of the Policy)	$25,000
		Communicable disease cover (Refer clause 2.23 of the Policy)	$100,000

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 Period of Insurance.

Cover for Expenses is sub-limited to $1,500,000 in any one Period of Insurance.

The aggregate limit and each sub-limit of cover is exclusive of GST to the extent that we are entitled to a GST credit.

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

Section 2: Medical Indemnity Insurance Policy *(continued)*

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 or complying with a requirement to produce medical records 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 or Sessions (as defined in Section 5) and paid the full amount of any premium, adjustments and charges due to us
- Provide a declaration of actual Gross Income/Sessions upon request
- Have been issued a Policy Schedule reflecting the cover provided.

d) What you are covered for

The cover we provide is limited 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 20-24 of the Categories of Insurance Guide)	Yes	Yes

* Other than in relation to Good Samaritan Acts and Gratuitous Advice
# Other than in relation to private work approved by the Medical Board and 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.

Section 2: Medical Indemnity Insurance Policy *(continued)*

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
	• A company owned and controlled solely by the doctor and which provides services solely for the purpose of the Practice by the doctor
	• Persons who are Employees for 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)
	• Medical Students:
	  o Provided they are assigned to the Practice by their university
	  o 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 an eligible 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 the Department of Human Services in relation to Medicare • Professional college or association, health service and health care ombudsman inquiries and complaints • investigations and proceedings by the Office of the Australian Information Commissioner (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 • Complaints or proceedings in relation to the by-laws of a professional college or association in respect to your participation in a training program. 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.

f) Other matters that we cover you for

Our Policy provides some important extensions to cover, as shown in your Policy Schedule. Some extensions are more important for some practices than others so refer to your Categories Guide and consider their application to your situation.

For example, some extensions to cover may only apply if your Category includes cover for claims for compensation.
Other extensions to cover may only be relevant to you if your Category includes cover for private practice.

Section 2: Medical Indemnity Insurance Policy *(continued)*

Benefit	Detail	Intern	Salaried Medical Officer in Training	Other Doctors
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 **(excluding the USA and jurisdictions to which the laws of the USA apply)** 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 (including a locum) (No cover is provided in relation to these parties unless they held a valid policy of insurance at the time of the act, error or omission that covered claims arising from health care.) 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.	✘	✔	✔

Section 2: Medical Indemnity Insurance Policy *(continued)*

Benefit	Detail	Intern	Salaried Medical Officer in Training	Other Doctors
Practice outside the Commonwealth of Australia	Covers you for practice overseas, **excluding** the USA and jurisdictions to 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.	✘	✘	✔
Medical research and clinical trials	Covers you and any Employee under your direct control and supervision for any claim arising solely out of your role in any medical research or clinical trial as an investigator or co-investigator, if the medical research or clinical trial is: • approved by a properly constituted human research ethics committee approved and registered by the NHMRC; • conducted in accordance with the requirements of that ethics committee; and • within the Category for which you are insured.	✘	✘	✔
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.	✘	✘	✔
Advice and advisory assistance	Is provided to you in respect of any cover provided to you under the Policy and where you are in Australia and require emergency claims and legal advice, it will be available 24 hours a day.	✔	✔	✔

Section 2: Medical Indemnity Insurance Policy *(continued)*

Benefit	Detail	Intern	Salaried Medical Officer in Training	Other Doctors
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.	✔	✔	✔
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.	✔	✔	✔
Run-off cover	Covers you at no additional cost for work undertaken under a prior Category if that work is not covered under your current Category where we have covered you continuously for a period of at least: (i) 2 years, if the Category is for ongoing practice (other than an employer indemnified, non-clinical, retired, compound life or suspended Category); or (ii) 5 years, if the Category is an employer indemnified Category. We may otherwise require an additional premium, including for where cover is no longer required for Public Patients and based on Your claims and practice history.	✔	✔	✔
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.	✔	✔	✔

Section 2: Medical Indemnity Insurance Policy *(continued)*

Benefit	Detail	Intern	Salaried Medical Officer in Training	Other Doctors
Innocent partner cover	Covers you for Claims arising out of your joint and several liability in partnership if: • 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.	✘	✘	✔
Pursuit of indemnity	Covers you for Expenses incurred in pursuing a third party (e.g. insurer, hospital etc) for indemnity in respect of any Claim where you are entitled to indemnity from the third party.	✘	✘	✔
Public relations expenses	Covers you for Expenses incurred in engaging a public relations consultant for the purpose of protecting your reputation as a result of a Claim.	✘	✘	✔
Unintentional intellectual property rights infringements	Covers you for any Claims, Claim Costs or Expenses from an unintentional infringement of a third party's intellectual property rights in the course of Practice.	✘	✘	✔
Cover for prior practice	Covers you at no additional cost for claims which are not covered by the policy because they arise from health care treatment, advice or service that was undertaken by you and determined by us to be a lower risk category, provided we have insured you continuously. This includes for claims arising in relation to when you were a medical student or intern.	✔	✔	✔
Communicable Diseases Cover	Covers you if you first test positive for a Communicable Disease during the Period of Insurance provided that the policy conditions are met, including a 3 month waiting period after the start of the Period of Insurance.	✘	✔	✔

The above is a brief summary of the cover provided and you must refer to our Policy for full details of the cover provided under these extensions.

Section 2: Medical Indemnity Insurance Policy *(continued)*

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 indemnified, or entitled to be indemnified, by any other source (including but not limited to a State Government or your employer) for the treatment of public patients, you will not be insured under our Policy for any claims that arise out of such treatment (Refer Policy exclusion 5.25).

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.

Section 2: Medical Indemnity Insurance Policy *(continued)*

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

Your Policy Schedule summarises the terms and conditions of cover.

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 Period of Insurance, 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, investigation or other covered matter 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 Period of Insurance 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 Period of Insurance.

The Insurance Contracts Act 1984 provides that if, after the end of the Period of Insurance, 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 Period of Insurance

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 Period of Insurance.

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 we offer 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 Period of Insurance, 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 us after the expiry of the Period of Insurance even though the event giving rise to the claim may have occurred during the Period of Insurance
- 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 Period of Insurance
- claims arising out of facts or circumstances of which:
    - you first became aware prior to the Period of Insurance,
    - you failed to notify us; 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 Period of Insurance, the Policy will, subject to the terms and conditions, cover you notwithstanding that a claim is only made after the expiry of the Period of Insurance.

b) Retroactive cover

Retroactive cover and your retroactive date

Our medical indemnity insurance covers claims made during the Period of Insurance for incidents that occur after your retroactive date and before the end of the Period of Insurance. 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 Period of Insurance 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 Period of Insurance 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

Section 3: Claims Made Insurance and Retroactive Cover *(continued)*

- 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 us.

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

- Our claims experience
- Industry experience
- Our 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)
- GP Indemnity Support Grant or RHEP Grant (for SA Doctors only, if applicable)
- Monthly instalment direct debit or annual direct debit (whichever is applicable).

Section 3: Claims Made Insurance and Retroactive Cover *(continued)*

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 the Department of Human Services 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 Period of Insurance is the same as your estimate of Gross Income for the previous Period of Insurance or if updated since, as held on our file at the time of invoicing.

Section 5: Declaration of Gross Income *(continued)*

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 Period of Insurance (in your name or for which you are personally liable), including without limitation:

(i) Medicare benefits; and

(ii) payments by individuals, the 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 Period of Insurance 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 Period of Insurance.

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

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 Period of Insurance 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: o cease practice for less than 12 months before age 65 o cease to be insured with us for other reasons (e.g. insure elsewhere) o 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).

Section 6: Run-Off Cover *(continued)*

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 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.

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.

Section 6: Run-Off Cover *(continued)*

If you change to a lower risk Category, we will cover you at no additional cost for claims which are not covered by the policy because they arise from health care treatment, advice or service that was previously undertaken by you and determined by us to be a lower risk category, provided we have insured you continuously and subject to a claims and practice history review.

This includes for claims arising in relation to when you were a medical student or intern.

- An additional Run-off premium may apply if you:
    - Have not reached the respective 2 year (if your new Category is for on-going practice) or 5 year (if your new Category is an employer indemnified, non-clinical, retired, compound life or suspended Category) qualifying period, 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.

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

Section 7: Renewal of your Insurance and Membership

a) Renewal

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 is 1 January each year. Prior to renewal each year, we will make available to you the following important documents:

- Covering letter
- Tax Invoice
- Policy Schedule
- Certificate of Insurance
- Categories of Insurance for Doctors
- Combined FSG and PDS
- Policy Wording
- Payment Options Form
- Direct Debit Request Form and Direct Debit Request Service Agreement.

If you do not receive any correspondence from us with your membership or renewal documents or details of how to access your membership and renewal documents on-line, please contact us.

b) Your Tax Invoice

In preparing your Tax Invoice, we 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 Period of Insurance
- 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 the Department of Human Services 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 SA Government GP Indemnity Support Grant or a RHEP Grant from Country Health SA (these Grants apply to SA Rural doctors only)
- Whether you have applied to pay your premium by monthly or annual direct debit

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 Period of Insurance.

Section 7: Renewal of your Insurance and Membership *(continued)*

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 Policy 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 annual direct debit or monthly instalments is available to most doctors – complete and return the original Direct Debit Request Form and Direct Debit Request Service Agreement. This option for monthly instalments is only available where the total cost of renewal is greater than the agreed minimum
    - On-line credit card payment – Mastercard, Visa, Diners Club or American Express via the link provided with your on-line renewal email or via the Client Area of our website at www.miga.com.au
    - BPay – See your Tax Invoice for the Biller Code / Reference details
    - Credit Card – Mastercard, Visa, Diners Club or American Express
    - Cheque
    - Cash

If you would prefer to pay by credit card but do not wish to provide your details on-line or alternatively want to pay via cheque, please complete the Payment Options form provided as part of your renewal documents and send back to us. This form is also available in the Download Documents section of our website at www.miga.com.au.

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

If you have not paid the premium in full by the due date of your Policy each year, we may agree to issue the Policy retrospectively if you pay the premium in full **within 14 days of the due date of the Policy.** 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 monthly instalments by the direct debit facility we offer, we will deem the premium to have been paid in full for the purpose of providing you with confirmation of renewal on confirmation of the successful draw down of your first instalment payment.

Note: Interim cover is not provided if you insure elsewhere on or after the due date of your Policy.

d) Paying by instalments

If you are paying via instalments for the first time we will deduct instalments every month on the agreed date in accordance with the terms and conditions of Your Direct Debit Request Service Agreement.

Details of your instalments are recorded on your tax invoice.

We will continue to deduct instalments on the agreed date, unless you tell us otherwise at least 7 days prior to the agreed date.

If any instalment remains unpaid for one month or more, we will cancel your Policy and we will refuse any claim or request for cover under the policy if payment is 14 days or more late.

If we elect to cancel your Policy as above, we will provide you with a written notice of cancellation.

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 (only available for Hospital doctors that are employer indemnified)
- Download an Application Form from our website and post or fax it to us
- Call us on Free Call 1800 777 156 for a quote and request an Application Form.

When completing your Application Form, you have an obligation to fully disclose all information relevant to our 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 our risk profile.

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.

d) Paying your invoice

You can pay your invoice annually by the following payment methods:

- On-line by credit card - Mastercard, Visa, Diners Club or American Express
- BPay
- Credit card – Mastercard, Visa, Diners Club or American Express
- Cheque
- Cash.

If you are a hospital doctor that is employer indemnified you can apply on-line via our website and you will have the option to pay on-line once your application is accepted.

Most doctors also have the option to payment by monthly instalments by direct debit or annual direct debit by completing and returning the original Direct Debit Request Form and Direct Debit Request Service Agreement. This option is only available where the total cost of your invoice is greater than the agreed minimum.

e) Paying your premium by instalments

If you choose to pay your premium via instalments we will deduct instalments every month on the agreed date in accordance with the terms and conditions of your Direct Debit Request Service Agreement.

Details of your instalments are recorded on your Tax Invoice.

We will continue to deduct instalments on the agreed date, unless you tell us otherwise at least 7 days prior to the agreed date.

If any instalment remains unpaid for one month or more, we will cancel your Policy and we will refuse any claim or request for cover under the policy if payment is 14 days or more late.

If we elect to cancel your Policy we will provide you with a written notice of cancellation.

Section 8: General Administration *(continued)*

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 in place.

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

Section 9: Claims and Advice Services

a) Overview

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

We offer a 24 hours a day, 7 days per week emergency claims and 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 team of in-house solicitors who have extensive 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 national panel of external solicitors.

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 advice service

We assist members 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 are 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, Department of Human Services 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 privacy.

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.

Section 9: Claims and Advice Services *(continued)*

c) Claims management philosophy

Our philosophy 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 where appropriate
- 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 Period of Insurance. This involves advising Medical Insurance Australia of the full details of the incident and any subsequent claim as soon as doctors become aware of it and in any event prior to the expiry of the Period of Insurance.

If doctors do not provide the required notice during the Period of Insurance 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 notifiable matters include:

- 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, reimbursement or compensation
- 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 Period of Insurance, 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 Period of Insurance

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 Period of Insurance.

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).

Section 9: Claims and Advice Services *(continued)*

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 our financial security.

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 and Legal Services 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.

Our 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 our Risk Management Program

One of the key reasons we have been able to offer stability in our premium in recent years and a Renewal Rebate in 2009 and 2014, is that our claims results have been good, with our claims frequency reducing and our average cost of claims relatively stable. We believe this result is because of our strong focus on risk management, via our industry leading Risk Management Program and the other risk management support we offer doctors, such as our on-line package of Risk Resources.

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 each year, as there is a direct benefit.

Section 10: Risk Management *(continued)*

c) CPD points – a double benefit

We have arrangements with most Colleges across Australia which means that CPD points can be claimed 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 us 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 ours 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.

f) More information about our 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 Department of Health: 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.

We were 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, for us and for doctors.

We 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

Section 11: Commonwealth Arrangements *(continued)*

d) Medical indemnity legislation – key facts

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 60% 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 Claims 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 us) • 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 Australian Government 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 Period of Insurance exceed 7.5% of your Estimated Income or Actual Income (for definition of income see paragraph 'f' page 30), or
- you conduct work as a Procedural General Practitioner in an area that is classified by the Department of Health as a 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 Period of Insurance.

A doctor who practises only in the public sector during the Period of Insurance (and earns no income from private medical practice) is eligible for a PSS subsidy for that premium period if their insurance with us 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 Period of Insurance (and thereby earns no income from private practice) is not eligible for a PSS subsidy for that Period of Insurance if the only contract, or contracts, of insurance the doctor holds with us 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 us or on renewal of your insurance and membership. To elect in at other times the following must be adhered to:

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

e) PSS subsidy calculation

The Basic PSS subsidy calculation

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

60% 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 as a RRMA 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, we will apply the basic calculation.

Section 12: Premium Support Scheme *(continued)*

Alternative PSS subsidy calculations

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

Doctors who have been receiving a MISS subsidy will still need to provide a declaration of Estimated Income in order to receive any PSS calculated on the basic calculation where PSS calculated on the basic calculation would result in 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 Period of Insurance (in your name or for which you are personally liable), including without limitation:

(i) Medicare benefits; and

(ii) payments by individuals, the 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 Period of Insurance, 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).

Gross Indemnity Costs 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.

Section 12: Premium Support Scheme *(continued)*

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 the Department of Human Services, 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 'm'), 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 us and the Department of Human Services any information required to assess eligibility and administer the scheme, including but not limited to:

- your Estimated Income for the Period of Insurance
- 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 Period of Insurance
- your medical specialty
- your provider number(s) and
- whether you practise in an area classified by the Department of Health as a RRMA 3-7.

If you wish to have PSS subsidy applied to your medical indemnity invoice at the beginning of the Period of Insurance, you must provide a declaration of your Estimated Income to us in a timely manner so that we 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 Period of Insurance. Failure to provide a declaration of Actual Income within 12 months of the end of the Period of Insurance to which a PSS subsidy payment relates will mean that you cease to be eligible for PSS subsidy for that Period of Insurance and you will be required to pay the full Gross Indemnity Costs to us.

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 's' on page 33). 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 information sharing and confidentiality

By electing to participate in the PSS, you agree to the sharing of your personal information between us and the Australian Government.

We and the Australian Government may also be required to disclose personal information to other Government departments and agencies, 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.

We acknowledge our 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 our privacy policy is available upon request or at our website www.miga.com.au.

l) 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.

m) 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 Period of Insurance if:

- We or the Department of Human Services know, or have reason to believe, that you have provided inaccurate information
- you have not provided information to us on Actual Income in the time specified by Medical Insurance Australia
- you have not repaid to us 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 Period of Insurance
- you fail to pay a UMP Support Payment (if liable) within the time specified by us or the Department of Human Services.

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

Section 12: Premium Support Scheme *(continued)*

If you applied to the Department of Health 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.

n) Medical practice outside Australia

If you practise as a doctor outside Australia for a total of six months or more during the Period of Insurance 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 Period of Insurance 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.

o) Change of insurance details or Estimated Income

While participating in the PSS you are required to advise us 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, we 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, payment of the PSS subsidy will be made by us 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 Period of Insurance, you will be required to provide us with confirmation of your Actual Income in the form of a statutory declaration. At this time, we 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, we may not process such an adjustment midterm.

p) The administration fee

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

Apart from receiving such reimbursement, we do not receive commission or benefits, and make no charge upon you for administration of the scheme.

q) 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.

r) Dispute resolution

If you have any complaints about the insurance product or related services we provide 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 Australian Government should be referred to the relevant department or agency and not to us.

Section 12: Premium Support Scheme *(continued)*

s) Alternative 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 Department of Health 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 Department of Health 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 Department of Health 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 Department of Health as a 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 Department of Health and obtained a subsidy under MISS; and • continue to work as a Specialist Obstetrician (unless on leave for less than 12 months).

Section 12: Premium Support Scheme *(continued)*

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: o 80% of the amount by which the total amount of premium exceeds $50,000, PLUS o 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 Department of Health and obtained a subsidy under MISS; and • continue to work as a Neurosurgeon (unless on leave for less than 12 months).

t) 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 us receiving payments of PSS subsidies on your behalf
- you must provide us with a statutory declaration as to your Actual Income no later than 12 months after the end of the Period of Insurance
- you must notify us in writing immediately if your circumstances change during the Period of Insurance 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 us an amount for any underpaid premium (or other costs of obtaining medical indemnity cover) that result from us returning the amount of the overpayment to the Department of Human Services
- where information you provide to us is inaccurate or changes and requires an adjustment to your entitlement to a PSS subsidy of less than $100.00, you consent to us not processing such an adjustment midterm.

If you do not elect to participate in the PSS now, we 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 us to calculate your entitlement based on your **Estimated Income**, you must provide those details to us in a timely manner so that we can make an application for PSS on your behalf no later than 2 months after the end of the Period of Insurance; or
- if you wish us to calculate your entitlement based on your **Actual Income**, you must provide those details to MIGA within 12 months after the end of the Period of Insurance.

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 an insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to insure you and on what terms. You have this duty until we agree to insure you.

You have the same duty before you renew, extend, vary or reinstate an insurance contract.

You do not need to tell us anything that:

- reduces the risk we insure you for
- is common knowledge
- we know or should know as an insurer
- we waive your duty to tell us about.

Non-Disclosure

If you do not tell us anything you are required to, we may cancel your contract or reduce the amount we will pay you if you make a claim, or both.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

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 our consideration of your proposal.

b) Claims made insurance

The Policy we offer is on a claims made basis. This means the Policy will cover you for Claims made against you and notified to us in writing during the Period of Insurance, subject to the Policy terms and conditions.

The Policy will not provide cover in relation to:

- events that occurred prior to the retroactive date of the Policy as specified in the Policy Schedule
- Claims first made against you or Claims first notified to us after the expiry of the Period of Insurance even though the event giving rise to the Claim may have occurred during the Period of Insurance
- 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 Period of Insurance
- Claims arising out of facts or circumstances of which
    - you first became aware prior to the Period of Insurance,
    - you failed to notify us; 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 Period of Insurance, the Policy will, subject to the terms and conditions, cover you notwithstanding that a Claim is only made after the expiry of the Period of Insurance.

Section 13: Important Notices

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 us.

See Section 3 for further details.

d) Privacy

The information you provide to us will be used to determine the terms and conditions on which it may offer to renew or provide you with insurance and membership. We 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, premium funders and medical boards in Australia and overseas. We 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), we 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. We are required under the terms of the Medical Indemnity Act 2002 to provide to the Department of Human Services upon request any information that you provide to us that may be relevant to determining an entitlement to an indemnity or subsidy scheme payment under that legislation.

If you refuse to provide information we require, 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 us. In most circumstances you can access the information which we hold about you but sometimes there will be reasons why that access is not possible, in which case you will be told why.

From time to time we may offer you information on our products or services that may be of interest to you. Please contact us if you do not wish to receive the information.

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 us, 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 us 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
    - We will consider each dispute on the basis of the specific facts and documentation surrounding the dispute. We are 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.

Section 14: Other Information *(continued)*

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 contact details on inside front cover.

d) Privacy

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

We require 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.

General Enquiries and Client Service

Free Call 1800 777 156
Facsimile 1800 839 284

Claims and Legal Services

(During Office hrs and 24hr emergency legal support)

Free Call 1800 839 280
Facsimile 1800 839 281

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