Insurance for Eligible
Midwives in Private Practice

Combined Financial Services Guide and Product Disclosure Statement

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

General Enquiries and Client Service

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Facsimile 1800 839 284

Claims and Legal Services

(During Office hrs and 24hr emergency legal support)

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

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

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Welcome to MIGA

This document is an important tool to help You understand the scope of the insurance cover and services We provide for eligible midwives in private practice in Australia.

We recommend You keep it in a safe place with Your Insurance Policy and Schedule.

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

Board

Means the Nursing and Midwifery Board of Australia.

Care Plan

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

A Care Plan means a documented plan for consultation, referral and transfer of a woman's care with a public hospital providing obstetric services and pursuant to which You record the following information in Your written records:

(a) the name of the public Hospital to which the woman will be referred if required and, if known, the Medical Practitioner employed or engaged by the Hospital Authority and authorised to participate in a maternity care plan with You;

(b) a record that the woman has been informed about this arrangement;

(c) a record of the planned place of delivery (whether in the public Hospital or not);

(d) a plan for the circumstances in which You will consult, refer and transfer the woman's care;

(e) a record of any actual consultation, referral or transfer of the woman's care;

(f) a record that the hospital booking letter has been sent to the Hospital;

(g) a record that the maternity care plan has been sent to and acknowledged by the Hospital (e.g. in writing or a record in Your notes of an oral acknowledgement);

(h) a record that any results from diagnostic imaging or pathology have been sent to the Hospital; and

(i) a record that the discharge summary has been sent to the Hospital and the woman's usual general practitioner or a Medical Practitioner nominated by the woman.

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

Collaborative Arrangement

Means an arrangement between You and a Specified Medical Practitioner and which arrangement provides for:

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

and which arrangement is one of the following:

(a) an arrangement under which a patient is referred in writing to You for the provision of Midwifery Services by a Specified Medical Practitioner
or

(b) an agreement in writing between You and one or more Specified Medical Practitioners, signed by You and each Specified Medical Practitioner;
or

(c) an arrangement under which You record the following for a patient in Your written records:

(i) the name of at least one Specified Medical Practitioner who is, or will be, collaborating with You in the patient's care (a 'Named Medical Practitioner');

(ii) that You have told the patient that You will be providing midwifery services to the patient in collaboration with one or more Specified Medical Practitioners in accordance with regulation 2E of the Health Insurance Regulations 1975;

(iii) acknowledgement by a Named Medical Practitioner that the practitioner will be collaborating in the patient's care;

(iv) plans for the circumstances in which You will do any of the following:

(A) consult with an Obstetric Specified Medical Practitioner;

(B) refer the patient to a Specified Medical Practitioner; and

(C) transfer the patient's care to an Obstetric Specified Medical Practitioner;

(v) any consultation or other communication between You and an Obstetric Specified Medical Practitioner;

(vi) any referral of the patient by You to a Specified Medical Practitioner;

(vii) any transfer by You of the patient's care to an Obstetric Specified Medical Practitioner;

(viii) when You give a copy of the hospital booking letter (however described) for the patient to a Named Medical Practitioner – acknowledgement that the Named Medical Practitioner has received the copy;

(ix) when You give a copy of the patient's maternity care plan prepared by You to a Named Medical Practitioner – acknowledgement that the Named Medical Practitioner has received the copy;

(x) if You request diagnostic imaging or pathology services for the patient – when You give the results of the services to a Named Medical Practitioner; and

(xi) that You have given a discharge summary (however described) at the end of Your care for the patient to:

(A) a Named Medical Practitioner; and

(B) the patient's usual general practitioner or a Medical Practitioner nominated by the patient;

or

(d) a written agreement between You and an entity, other than a Hospital, that employs or engages one or more Obstetric Specified Medical Practitioners;

or

(e) an arrangement with a Hospital that employs or engages one or more Obstetric Specified Medical Practitioners and under which arrangement You are:

(i) credentialed to provide midwifery services after successfully completing a formal process to assess Your competence, performance and professional suitability;

(ii) given clinical privileges for a defined scope of clinical practice for the Hospital; and

(iii) permitted to provide midwifery care to Your own patients at the Hospital;

A Collaborative Arrangement, other than one referred to in paragraph (c) above, may apply to more than one patient.

Eligible Midwife
Means:

(a) where any act, error or omission giving rise to the Claim or other matter covered by the Policy occurs on or before 31 December 2016, a person who is at that time an Eligible Midwife (Notated); and

(b) where any act, error or omission giving rise to the Claim or other matter covered by the Policy occurs on or after 1 January 2017, a person who is at that time either:

  (i) an Eligible Midwife (Endorsed); or

  (ii) an Eligible Midwife (Notated) and has not been an Eligible Midwife (Endorsed) at any time on or after 1 January 2017.

Eligible Midwife (Endorsed)
Means a person who is endorsed by the Board to prescribe Schedule 2, 3, 4 and 8 medicines and to provide associated services required for midwifery practice in accordance with relevant State and Territory legislation, being a person who:

(a) first applied on or after 1 January 2017 for endorsement as described in paragraph (a) or whose endorsement was renewed on or after 1 January 2017 and who has:

  (i) current general registration as a midwife in Australia with no conditions or undertakings relating to unsatisfactory professional performance or unprofessional conduct;

  (ii) registration as a midwife that is the equivalent of three years' full-time clinical practice (5,000 hours) in the past six years that is either:

    (A) across the continuum of care; or

    (B) in a specified context of practice,

  as at the date when the complete application seeking endorsement for scheduled medicines is received by the Board; and

  (iii) successfully completed:

    (A) a Board-approved program of study leading to endorsement for scheduled medicines; or

    (B) a program that is substantially equivalent to such an approved program of study, as determined by the Board; or

(b) first applied on or before 31 December 2016 for endorsement as described in paragraph (a) and who has:

  (i) current general registration as a midwife in Australia with no restrictions on practice;

  (ii) midwifery experience that constitutes the equivalent of three years' full time post initial registration as a midwife;

  (iii) current competence to provide pregnancy, labour, birth and post-natal care to women and their infants;

  (iv) successfully completed an approved professional practice review program for midwives working across the continuum of midwifery care;

  (v) undertaken 20 additional hours per year of continuing professional development relating to the continuum of midwifery care;

  (vi) successfully completed:

    (A) an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing, or

    (B) a program that is substantially equivalent to such an approved program of study, as determined by the Board; or

and, in each case, who has complied with all current Board-approved mandatory registration standards and any other applicable codes and guidelines approved by the Board including the *Safety and quality guidelines for privately practising midwives.*

Eligible Midwife (Notated)
Means a person who has:

(a) current general registration as a midwife in Australia with no restrictions on practice;

(b) midwifery experience that constitutes the equivalent of three years' full time post initial registration as a midwife;

(c) current competence to provide pregnancy, labour, birth and post-natal care to women and their infants;

(d) successfully completed a professional practice review program for midwives working across the continuum of midwifery care;

(e) undertaken 20 additional hours per year of continuing professional development relating to the continuum of midwifery care; and

(f) either successfully completed, or provided a formal undertaking to the Board that they will complete within 18 months of recognition as an Eligible Midwife:

  (i) an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing; or

  (ii) a program that is substantially equivalent to such an approved program of study, as determined by the Board;

ERB
Means Extended Reporting Benefits (also known as run-off cover).

FOS
Means Financial Ombudsman Service.

FSG
Means Financial Services Guide.

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

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

Hospital Authority
Has the meaning given to that term by subsection 84(1) of the National Health Act 1953.

Income
Means the total of all billings generated by You from all areas of Your Midwifery Practice for which You require cover (in Your name or for which You are personally liable, whether retained by You or otherwise and before any apportionment of any expenses or tax).

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

Medical Practitioner
Has the meaning given to that term by subsection 3(1) of the Health Insurance Act 1973.

Midwifery Services
Means all midwifery services which, except as otherwise provided in the Policy, You provide to private patients as part of, and in accordance with the terms of:

(a) a Collaborative Arrangement; or

(b) if You are unable to achieve a Collaborative Arrangement, a Care Plan that You have communicated to a public Hospital,

and for which You are appropriately trained, qualified and registered as an Eligible Midwife. If Midwifery Services are recorded in the Policy Schedule as Option B, then Midwifery Services does not include any Intrapartum Care.

Obstetric Specified Medical Practitioner
Means a Medical Practitioner who:

(a) is a specialist in the specialty of obstetrics and gynaecology (however described); or

(b) provides clinical obstetric services.

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

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

PDS
Means Product Disclosure Statement.

Period of Insurance
Means the period of insurance noted on Your Policy Schedule.

Policy
Means the Professional Indemnity Insurance Policy for Eligible Midwives that is issued to You by Medical Insurance Australia, unless You are not an Eligible Midwife at the start of that period, in which case the Period of Insurance commences on the date during that period on which You become an Eligible Midwife .

Policy Schedule
Means the document issued by Us to You confirming details of Your insurance arrangements for the Period of Insurance.

Risk Management Program
Means Our Risk Management Program.

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

Specified Medical Practitioner
Means a Medical Practitioner who is:

(a) an Obstetric Specified Medical Practitioner; or

(b) employed or engaged by a Hospital Authority and authorised by the Hospital Authority to participate in a collaborative arrangement.

SOA
Means Statement of Advice.

We, Us or **Our**
Means MIGA, which comprises Medical Defence Association of South Australia Limited and Medical Insurance Australia Pty Ltd.

You or **Your**
Means the registered midwife identified in the Policy Schedule.

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On 1 February 2016, the Board published new mandatory registration standards and also new safety and quality guidelines for privately practising midwives.

Key dates

1 June 2016

New registration standards commence in relation to:

- continuing professional development
- recency of practice
- professional indemnity insurance arrangements

You need to be compliant with these standards on and from 1 June 2016.

1 January 2017

revised versions of the following commence:

- *Registration standard: Endorsement for scheduled medicines for midwives*
- *Safety and quality guidelines for privately practising midwives*

Transition period

From now until 1 January 2017, the Board has provided a transition period for current Eligible Midwives.

For Eligible Midwives that have an endorsement for prescribing, there will be no change, however You will need to ensure You are familiar with and can meet the requirements of the *Safety and quality guidelines for privately practising midwives* by 1 January 2017.

For Eligible Midwives who do not have an endorsement for prescribing, You will need to understand what You need to do in relation to Your undertaking to complete an approved program within 18 months of becoming notated as an Eligible Midwife.

For midwives who are not currently Eligible Midwives and who plan to apply for endorsement, the current two-step (notation) process will be in place until 31 December 2016. If You submit an application by 31 December 2016 You will have 18 months from the date of Your application to become endorsed.

From 1 January 2017 only applicants that meet the new *Registration standard: Endorsement for scheduled medicines for midwives* will be endorsed.

Full details are available at http://www.nursingmidwiferyboard.gov.au/

About this document

This document will be given to You when We provide You with a quotation for insurance or when We offer to renew Your insurance.

It applies to Our Policy which is available for Eligible Midwives in Australia, including those who are retired and those who require run-off cover.

It contains Our:

- FSG – in PART 1
- PDS – in PART 2.

It is important that You keep this Combined FSG and PDS as it provides comprehensive information on the benefits of Your insurance arrangements with Us. It also provides You with important information about Our claims handling processes and Our Risk Management Program.

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 on 10 years.

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

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

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

We were first appointed by the Commonwealth to be the sole provider of Government-supported professional indemnity for eligible privately practising midwives in Australia on 1 July 2010 for an initial term of 3 years which has since been extended.

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

Our vision

Our vision is to empower health care professionals to practise with confidence and achieve safer, better health care for all Australians.

Group structure

We comprise 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 mutual, non-profit organisation which was formed in 1899	Provides a range of services to members and policy holders
Medical Insurance Australia Pty Ltd (Medical Insurance Australia) • A wholly owned subsidiary of MDASA • A licensed general insurer • Regulated by the Australian Prudential Regulation Authority	Provides medical and professional indemnity insurance to the health care sector

a) Introduction

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

When We give You advice that takes into account one or more of Your objectives, financial situation and needs, We will give You a Statement of Advice (SOA). The SOA will set out the advice that You have been given and explain the basis for that advice.

We have summarised within this FSG some very important information which **must** be read before You finalise Your insurance arrangements with Us.

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

This FSG does not form part of the Policy wording.

b) Financial Services Licence

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

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

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

MDASA receives a management fee from Medical Insurance Australia to act on behalf of Medical Insurance Australia in giving financial product advice, providing services and issuing products. The management fee is calculated annually on an activity basis to reflect the cost of services provided by MDASA to Medical Insurance Australia.

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

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

d) Arranging insurance

This Combined FSG and PDS provides information on:

- The services and products We offer
- Some issues You should consider when arranging Your insurance
- What You are covered for and what is excluded.

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

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

e) Dispute resolution

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

Full details are provided in the Section titled 'Dispute resolution' on page 22.

It is very important that You read the information in this Section to ensure You are fully aware of Your rights and Our obligations.

Section 1: Benefits of insuring with MIGA

When You arrange insurance with Us, You immediately get access to the following valuable benefits and services, a number of which You can access via Our website.

Benefit	Services available
Payment by direct debit	Option to pay by direct debit (bank or credit card) with monthly instalments available at no additional cost where the annual cost exceeds the agreed minimum
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 dishonestly and products liability
Bi-monthly Bulletins	• Published bi-monthly, they feature articles on risk management, claims management, case studies, key insurance issues, information about MIGA and important medico-legal developments
24 hour emergency telephone support	• You can call Us any time of the day or night for help with urgent situations where medico-legal advice is required
Risk Resources	• Providing easy on-line access to a wide range of risk management materials, information and tools to assist You in Your day to day practice
Industry leading Risk Management Program	• Offers a maximum 10% discount off Your insurance premium next year, if You fully complete it
Midwives' Support Services	If You have a claim, You can access the following services which We offer to help support You through the process: • Medical Support Service – provided by one of a group of psychiatrists or psychologists offering professional clinical support • Peer Support Service – provided by one of a group of Eligible Midwives offering support and understanding

Client only internet access	Provides a range of on-line resources, including:
	• Insurance – On-line payment and access to Certificates of Insurance
	• Medico-legal Services - On-line lodgement of claims and circumstance notifications
	• Risk Management Program
	  o On-line bookings for Workshops
	  o Access to status of points accumulated throughout the year
	  o On-line access to Practice Self Assessments, and Questionnaires providing immediate feedback and benchmarking against other participants.

Section 2: Your Insurance

a) Introduction

Our Policy has been developed to meet the needs of Eligible Midwives and the requirements of the Australian Government.

A copy of the Policy that applies from 1 July 2016 will be provided to You with Your renewal or quotation for insurance.

It is very important that You read the Policy and become familiar with the scope of cover, terms, conditions and exclusions.

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

b) Overview of the Policy

The Policy provides cover for the following matters that arise from Midwifery Services that You provide as an Eligible Midwife:

Section	Cover
Section 1 – Claims against You and Claim Costs	Provides cover for: • Damages and claims for compensation • Legal costs and expenses incurred in defending claims.
Section 2 – Expenses	Provides cover for specific expenses incurred in relation to investigations, proceedings or complaints. These include investigations or proceedings by: • The Board or other disciplinary investigations or proceedings • A health authority or the Department of Human Services in relation to Medicare • A professional college or association, health care complaints body or a health care ombudsman • the Office of the Australian Information Commissioner (and other government/statutory authorities or other bodies performing similar functions or exercising similar powers to the above bodies) • coronial inquiries, royal commissions, and • criminal investigations and proceedings.

c) Limit of indemnity

Your Policy has a limit of indemnity of $2,000,000. However, because of Commonwealth legislation and a contractual arrangement between Us and the Australian Government, You are also entitled to the benefit of cover from the Commonwealth to an unlimited amount above $2,000,000 (i.e. there is no monetary limit for any claim or claims covered by the Policy). So, the limit of indemnity under the Policy (provided partly by Us and partly by the Commonwealth) is $2,000,000 for each claim made in the Period of Insurance. The amount of any eligible claim above this Policy limit will be covered directly by the Commonwealth as detailed on page 9.

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

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

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

Because of the changes made by the Board to the registration standards for Eligible Midwives (referred to on page 2), different definitions of 'Eligible Midwife' apply before and after 1 January 2017.

Before 1 January 2017, an Eligible Midwife is now known as an 'Eligible Midwife (Notated)'.

On and after 1 January 2017, an Eligible Midwife will be known as an 'Eligible Midwife (Endorsed)'. A midwife who meets the criteria of 'Eligible Midwife (Notated)' will still be considered an Eligible Midwife after that time but only if they have never been an 'Eligible Midwife (Endorsed)'. In other words, an 'Eligible Midwife (Endorsed)' cannot give up her or his endorsement to prescribe scheduled medicines and revert to their registration as an 'Eligible Midwife (Notated)'.

'Eligible Midwife (Endorsed)' means a person who is endorsed by the Board to prescribe Schedule 2, 3, 4 and 8 medicines and to provide associated services required for midwifery practice in accordance with relevant State and Territory legislation, being a person who:

(a) first applied on or after 1 January 2017 for endorsement as described in paragraph (a) or whose endorsement was renewed on or after 1 January 2017 and who has:

  (i) current general registration as a midwife in Australia with no conditions or undertakings relating to unsatisfactory professional performance or unprofessional conduct;

  (ii) registration as a midwife that is the equivalent of three years' full-time clinical practice (5,000 hours) in the past six years that is either:

    (A) across the continuum of care; or

    (B) in a specified context of practice,

  as at the date when the complete application seeking endorsement for scheduled medicines is received by the Board; and

Section 2: Your Insurance

(iii) successfully completed:

(A) a Board-approved program of study leading to endorsement for scheduled medicines; or

(B) a program that is substantially equivalent to such an approved program of study, as determined by the Board; or

(b) first applied on or before 31 December 2016 for endorsement as described in paragraph (a) and who has:

(i) current general registration as a midwife in Australia with no restrictions on practice;

(ii) midwifery experience that constitutes the equivalent of three years' full time post initial registration as a midwife;

(iii) current competence to provide pregnancy, labour, birth and post-natal care to women and their infants;

(iv) successfully completed an approved professional practice review program for midwives working across the continuum of midwifery care;

(v) undertaken 20 additional hours per year of continuing professional development relating to the continuum of midwifery care;

(vi) successfully completed:

(A) an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing, or

(B) a program that is substantially equivalent to such an approved program of study, as determined by the Board; or

and, in each case, who has complied with all current Board-approved mandatory registration standards and any other applicable codes and guidelines approved by the Board including the *Safety and quality guidelines for privately practising midwives*.

Important: if an Eligible Midwife (Endorsed) is registered on the basis of experience in a specified context of practice and not across the continuum of care, then she or he will only be covered for claims that arise from midwifery practice within that specified context of practice.

'Eligible Midwife (Notated)' means a person who has:

(a) current general registration as a midwife in Australia with no restrictions on practice;

(b) midwifery experience that constitutes the equivalent of three years' full time post initial registration as a midwife;

(c) current competence to provide pregnancy, labour, birth and post-natal care to women and their infants;

(d) successfully completed a professional practice review program for midwives working across the continuum of midwifery care;

(e) undertaken 20 additional hours per year of continuing professional development relating to the continuum of midwifery care; and

(f) successfully completed, or provided a formal undertaking to the Board that they will complete within 18 months of recognition as an Eligible Midwife:

(i) an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing; or

(ii) a program that is substantially equivalent to such an approved program of study, as determined by the Board;

e) Conditions of cover

The Policy does not provide cover in certain instances.

These are set out in the exclusions in Section 5 the Policy wording but may also be contained within conditions in Sections 3 and 4 of the Policy wording or in any endorsements.

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

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

- Intrapartum Care other than at a hospital which has the facilities to provide appropriate Intrapartum Care for women in pregnancy, except in an unforeseen emergency where timely access to a hospital was not possible (this means that planned home births are excluded from cover);
- midwifery services that are not provided as part of, and in accordance with the terms of, a Collaborative Arrangement or involving communication of a Care Plan to a public Hospital, except the following services:

(a) pre-pregnancy counselling advice;

(b) initial contact from a woman, before the woman has made a decision on her maternity care or where the woman has miscarried early in pregnancy;

(c) postnatal care exceeding six weeks after birth, but only where the woman has had a stillbirth, a premature birth or is experiencing post-natal depression;

(d) lactation, sleeping and settling consultation and advice,

(e) group antenatal education classes which do not involve individual ante natal care;

(f) ad hoc antenatal or postnatal advice to women at maternity expositions and other events and where You are contracted by a retail outlet; or

(g) other services agreed between You and Us from time to time,

but, in each case, only where the service is one for which You are appropriately trained, qualified and registered and is within the current scope of midwifery practice as determined by the Board

- midwifery services that do not comply with the Australian College of Midwives' (ACM) National Midwifery Guidelines for Consultation and Referral (3rd edition, Issue 2) (the Guidelines) or, if working in collaboration with an obstetrician, either the ACM Guidelines or the guidelines of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, in particular in relation to discussion, consultation and referral
- midwifery services that are provided by You to a woman after she has indicated to You that she does not want You to follow all or part of the Guidelines, unless You have complied with the requirements of Appendix A of the Guidelines, which deals with *"When a woman chooses outside the recommended ACM National Midwifery Guidelines for consultation and referral",* and if You continue to provide midwifery services to the woman:
    - if You have a written agreement with the medical practitioner or obstetrician with whom You have a Collaborative Arrangement in relation to the ongoing care of the woman, You have a mutually agreed clinical pathway in relation to that woman's ongoing care by You and You have completed a Record of Understanding, as per Appendix B of the Guidelines; or
    - You have included in Your clinical notes the details of discussions that You have undertaken with the medical practitioner or obstetrician with whom You have a Collaborative Arrangement in relation to the ongoing care of the woman including a mutually agreed clinical pathway in relation to that woman's ongoing care by You and You have completed a Record of Understanding, as per Appendix B of the Guidelines: or
    - if You do not have a Collaborative Arrangement for a particular woman but instead You have communicated a Care Plan for that woman to a public Hospital, You have a record in Your clinical notes of the details of discussions that You have undertaken with the public Hospital in relation to the ongoing care of the woman and You have completed a Record of Understanding, as per Appendix B of the Guidelines
- midwifery services that are provided by You in the course of Your employment other than Midwifery Services that are provided by You in the course of Your employment (full or part-time) by a company that is owned solely by You or that is owned solely by practising midwives including You where the only directors of that company are You and other practising midwives (subject to any rules that may be made under the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010);*
- midwifery services which are provided by You to a public patient (even if that public patient is in a private hospital);
- events or circumstances that occurred prior to the Retroactive Date of 1 July 2010, or a later date as specified in the Schedule;
- midwifery services provided by You outside the Commonwealth of Australia and its territories;
- midwifery services provided by You within the Commonwealth of Australia and its territories where the recipient of the services was outside the Commonwealth of Australia and its territories at the time the Midwifery Services were provided;
- prescribing or any context of practice for which You were not registered by the Board or for which You were not appropriately trained, qualified and experienced at the time of the incident.

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

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

- You will not be covered, including for antenatal and postnatal care, if at any time You provide Intrapartum Care as part of Your private practice, except in an unforeseen emergency situation where timely access to a Hospital was not possible and where You make no request for payment or reward and where You provide no ongoing Intrapartum Care after the emergency situation has passed;
- if You intend to provide Intrapartum Care then You must immediately advise Medical Insurance Australia and pay any additional premium prior to providing any such Intrapartum Care; and
- if You have selected Option B and You provide Intrapartum Care but do not notify Medical Insurance Australia or You do not pay the additional premium, Medical Insurance Australia may cancel the Policy or Medical Insurance Australia may be entitled to avoid the Policy from the beginning and treat it as if it was never issued to You, in which case You will have **no** entitlement to indemnity from Medical Insurance Australia **not only** for Intrapartum Care but also for any antenatal care or postnatal care that You have provided.

f) Legislation for midwifery claims

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

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

- not relate to an incident that occurred in the course of, or in connection with, practice of a kind for which:
    - the Commonwealth, a State or a Territory;
    - a local governing body; or
    - an authority established under a law of the Commonwealth, a State or a Territory;

  indemnifies eligible midwives from liability relating to compensation;
- not relate to an incident or a type of practice specified as not being eligible in the midwife professional indemnity legislation from time to time.

If You incur a liability, cost or expense that does not meet these common requirements, that liability, cost or expense is not covered under the Policy. If the value of the claim exceeds $100,000 and the Commonwealth forms that opinion and We have already paid amounts to You or on Your behalf in relation to such a claim, You must repay those amounts to Us.

Section 2: Your Insurance *(continued)*

The Policy only provides cover for Claims made against You personally and for Claims Costs and Expenses that You incur. No cover is provided to any other person or company, regardless of their connection to You or Your practice, except to Your estate and legal representatives, which are covered in the event of Your death or permanent disablement.

g) Our entitlements to contribution payments and Your entitlement to cover

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

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

The legislation provides as follows.

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

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

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

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

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

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

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

h) Your Policy Schedule and Certificate of Insurance

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

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

Section 3: How much will it cost?

We offer 2 levels of cover, as follows:

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

The maximum annual cost of insurance for a full time privately practising midwife is fixed by agreement with the Australian Government at $7,500.

Factors affecting the premium You will pay include the following:

- Your declared Income; and
- any discount You are entitled to for participation in Our Risk Management Program.

The cost of cover will be reduced for midwives whose private midwifery practice generates less income and also for those who do not provide any Intrapartum Care in their private practice as follows:

New basis Gross income band	**Option A** Annual premium including all statutory charges (if providing Intrapartum Care in Your private practice)	**Option B** Annual premium including all statutory charges (if providing **no** Intrapartum Care at all in Your private practice)
$90,000 or more	$7,500	$3,400
$70,000 - $89,999	$6,500	$3,000
$50,000 - $69,999	$5,000	$2,250
$25,000 - $49,999	$3,375	$1,530
Less than $25,000	$2,400	$1,350

You should only select Option B if You do not intend to provide any Intrapartum Care to any woman in Your private practice at any time (see information in Section 2(e)).

You will have the opportunity to receive a 10% saving off Your premium (excluding statutory charges) in the 2017/2018 and subsequent years by successfully completing Our Risk Management Program for midwives (refer to Section 7).

The above charges include:

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

Section 4: Things You need to know about Your insurance arrangements

a) Steps to joining and obtaining insurance with MIGA

Applying for insurance with Us is easy. Simply call Us on Free Call 1800 777 156 or 08 8238 4444 for a quote and request an Application Form.

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

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

When completing Your Application Form, You have an obligation to fully disclose all information relevant to Our decision to insure You and to answer all of the questions on the form. It is important You read Your 'Duty of Disclosure' as outlined in Section 10 and make sure that You accurately and correctly answer all questions on Your Application Form. For example it is extremely important You provide full details of Your claims and circumstances history. If proper disclosure is not made, Your Policy may not be accepted or it may be cancelled.

Once We receive Your Application Form We will assess it and You will receive confirmation of Your insurance within 3 working days of receipt of the Form unless We require additional information or if there are any difficulties with Your application.

All applications for insurance are subject to an assessment process. This is important to ensure We can assess Your individual details and requirements and at the same time carefully manage Our risk profile.

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

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

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

d) Your Tax Invoice

In preparing Your Tax Invoice We will consider Your particular circumstances, taking into account:

- any information that You have previously provided to Us;
- any information provided by You to Us, including in a Change of Details Form completed by You and in any discussions We have had with You; and
- in the case of renewal for 2016/2017, whether You have complied with the requirements to receive a premium discount as a result of completion of the Risk Management Program for the 2015/2016 year
- Whether You have applied to pay Your premium by monthly or annual direct debit.

Your Tax Invoice is made up of the following parts:

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

It is important You check Your Quotation Schedule and Tax Invoice carefully and contact Our Client Services Department if You have any queries.

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

e) Payment and steps to finalise Your cover

To finalise Your cover, You will need to:

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

You can pay Your invoice by the following methods:

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

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

- Payment by annual direct debit or monthly instalments – 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 Biller Code or reference details
- Credit Card – Mastercard, Visa, Diners Club or American Express
- Cheque
- Cash.

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

The Policy does not come into force unless and until:

- You have provided Us with a completed Application Form and We have accepted it;
- You are, or become, an Eligible Midwife during the Period of Insurance; and
- You have paid the premium in full (or have entered into a payment arrangement that is acceptable to Us - see above) 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 30 June 2016

If You are not an Eligible Midwife on the date the Policy is issued to You, the Period of Insurance will commence on the date You become an Eligible Midwife but if You do not become an Eligible Midwife during the Period of Insurance then You have no entitlement to cover from Us.

On receipt of Your payment before the due date, We will process it and forward a receipt and Certificate of Insurance to You.

If You have any queries in relation to how to finalise Your insurance please call Our Client Services Department.

f) Paying 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.

g) Changing State or Territory of practice

It is important that You advise Us in writing whenever there is a change in Your place of practice, particularly if this involves a change in Your State or Territory of practice. Depending on where You are planning to practise, We may have to remit more or less stamp duty, although there will be no change to Your total cost of insurance.

h) Renewal of Your insurance

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

- Covering letter
- Tax Invoice
- Policy Schedule
- Certificate of Insurance
- 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 of the above documents, please contact Our Client Services Department.

i) Cancellation of Your insurance

Your insurance Policy with Medical Insurance Australia is non-cancellable once effected (other than in relation to 'cooling-off' obligations or as provided for in the *Insurance Contracts Act 1984 (Cth))* (see Section 11).

Medical Insurance Australia will consider a pro-rata refund of the premium at its absolute discretion and in exceptional circumstances if You wish to cancel Your Policy. No cover will be provided after the date of cancellation for any claims made after this date unless Run-off cover is in place.

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

Section 5: Declaration of Income

a) Introduction

Your Application Form requires You to provide an estimate of the gross income You expect to derive from midwifery services that You provide during the Period of Insurance and for which You require cover from Us.

The reason for this is that premiums are determined in part by Your estimated Income in the Period of Insurance (subject to the payment of minimum premiums).

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

b) Adjustment of income

Medical Insurance Australia may adjust premiums based on a declaration after expiry of the Period of Insurance of the actual Income You earned from midwifery services You provided during the Period of Insurance.

If Medical Insurance Australia requires a declaration of actual Income for the Period of Insurance, a statutory declaration will be forwarded to You and You must complete it and return it to Us within 45 days.

c) Audit of income

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

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

Section 6: Claims and Advisory Services

a) Overview

We support Our clients with an extensive medico-legal advice and claims management service.

We offer a 24 hour 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 clients 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 clients informed on claims matters is very important to Us. We and Our external solicitors strive to maintain frequent personal contact with members involved in claims.

b) Our advisory service

We assist You with enquiries You may have which arise in Your practice and which relate to care for women and their infants and are of a medico-legal nature. This is over and above the support provided in relation to claims and incident notifications.

There is a wide range of matters for which We provide support, including issues relating to consent, dealing with unhappy women in Your care, questions in relation to statutory obligations and issues that may arise in relation to the Board, the Department of Human Services and coronial inquiries. We also help policy holders with Health Care Complaints Commission matters in all jurisdictions, dealing with solicitors generally, responding to subpoenas and matters that may arise in relation to the *Privacy Act 1988 (Cth)*.

We encourage You to call Us if any issues arise in relation to Your practice and We will promptly and enthusiastically assist with Your enquiry.

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

c) Claims management philosophy

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
- provide personal and comprehensive support to policy holders who are involved in the claims process. We care about the individual needs of policy holders
- ensure policy holders are informed about pivotal decisions on a claim
- manage all claims in a consistently fair and equitable manner
- enable risk management data to be identified and utilised by policy holders to reduce or prevent the recurrence of injury to women and infants in their care, and to minimise the risk of litigation and consequential financial exposure.

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

d) Notification of claims

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

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 therefore extremely important that You ensure that Medical Insurance Australia is advised as soon as You become aware of a claim and that You ensure this notification is made to Medical Insurance Australia before the insurance cover expires.

Examples of claims are:

- if You are served with a writ, summons, statement of claim or third party notice
- if a letter from a solicitor or woman You have cared for has been received indicating dissatisfaction with a health care service or outcome and requesting a payment
- where a woman You have cared for asks for reimbursement of fees or for You to pay for anticipated future expenses because of dissatisfaction with the treatment or the result of the treatment
- You receive a subpoena to produce Your records relating to the midwifery services You have provided to a woman.

Section 6: Claims and Advisory Services *(continued)*

e) Notification of circumstances

The Insurance Contracts Act 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 Medical Insurance Australia:

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

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

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

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

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

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

If You are uncertain about whether to notify, then call Us and speak to one of Our in-house solicitors to discuss the situation.

We encourage early communication and notification.

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

Please always contact Us if there are any issues arising from care for women and their infants of a medico-legal nature that We may be able to help You with.

If You would like to contact Us about a medico-legal matter or if You need advice, send an email message via Our website or call and ask to speak to a solicitor in Our Claims Department.

Section 7: Risk Management

a) Introduction

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

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

Under the terms of Our arrangement with the Commonwealth, Eligible Midwives who insure with Us must enrol in and complete Our risk management education program which We call Our Risk Management Program.

b) The value of risk management

We believe in the value of Our Risk Management Program and We see it as an important long-term tool to help control midwifery professional indemnity insurance costs in the future.

Our Risk Management Program can help midwives with:

(a) Improving outcomes for women and their babies

(b) Reducing Your exposure or vulnerability to complaints and claims

(c) Avoiding the stress and pressure of the claims process

(d) Expanding Your knowledge, awareness and involvement in risk management

(e) Making improvements in managing risk in Your practice.

c) CPD points – a double benefit

MIGA risk management activities can be used to claim CPD points for the Australian College of Midwives.

This has a double benefit for midwives insured with Us as they can earn their CPD points and Risk Management Points without doubling up on time, and they can earn a base premium discount from Us as well.

d) Risk Management services

Services available to members on an as needs basis include:

- Risk management advice
- Practice reviews for midwives with high risk profiles, or where specific risk management issues have arisen.

e) Risk Resources

Risk Resources is an online resource package available to You as part of Your insurance with Us.

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

Risk Resources is an innovative and very practical way for Us to provide midwives with access to the extensive resources and knowledge We have developed and acquired over the years based on Our significant claims and risk management experience. They are available on Our website for You to access and use in Your practice.

Details of the Risk Resources that are available for Eligible Midwives are outlined at Our website.

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.

Section 8: Run-Off Cover

a) Why You may need Run-Off Cover

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

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

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

b) Types of Run-Off Cover

You can access two types of run-off cover via Medical Insurance Australia as follows:

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

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

Type of run-off cover	Applies	Details – Benefit and funding
ROCS	You may become eligible for ROCS when You: • are 65 years of age or more and have retired permanently from private practice as an Eligible Midwife; • have ceased practice as an Eligible Midwife because of permanent disability; • under 65 years of age and have not engaged in private practice as an Eligible Midwife at any time during the preceding period of 3 years; • have ceased practice (temporarily or permanently) as an Eligible Midwife because of maternity; • are deceased; • are in another qualifying group determined by regulation to be eligible.	• Cover is free and once triggered is provided for as long as the Eligible Midwife remains eligible for ROCS; • ROCS is funded via a levy on the professional indemnity insurer; • It is then on-charged to all Eligible Midwives as a loading on their insurance premium; • The loading is currently 10% of the premium. The loading is included in the total cost of insurance (up to $7,500 maximum) that You pay for Your professional indemnity insurance cover.
Standard Run-Off cover (ERB)	• Is available when You need run-off cover and You are not eligible for ROCS • This could be when You: o have ceased practice as an Eligible Midwife for reasons other than those set out above; o cease to be insured with Us for other reasons.	• Cover is offered on an annually renewable basis; • At the time of triggering the cover, You need to pay a run-off premium for the following year's cover; • The Policy will need to be renewed and a premium paid annually.

Section 8: Run-Off Cover *(continued)*

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

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

Eligible Midwives become eligible for ROCS when they:

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

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

We detail separately on the Tax Invoice the component of premium that relates to ROCS. The charge is currently 10% of the premium sub-total (as per the invoice) and it represents the run-off cover support payment payable by Medical Insurance Australia to the Commonwealth Government in respect of the contribution year commencing 1 July 2015.

If You become eligible for ROCS:

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

We will forward any relevant forms to You to assess Your eligibility for ROCS.

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

d) Standard Run-Off cover

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

This could be when they:

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

When ERB is requested and granted:

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

e) More information about Run-Off cover

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

Section 9: Claims Made Insurance and Retroactive Cover

a) Claims made insurance

The Policy We offer is on a claims made basis. This means the Policy will only respond to claims first made against You and notified to Us in writing during the Period of Insurance, subject to the Policy terms and conditions.

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

- events that occurred prior to the retroactive date specified in the Policy Schedule;
- claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy or indemnity arrangement (You are required to disclose those facts or circumstances to Us on Your Application Form);
- claims made, threatened or intimated against You prior to the commencement of the Period of Insurance;
- facts or circumstances of which You first became aware prior to the Period of Insurance, and which You knew (or ought reasonably to have known) had the potential to give rise to a claim under the Policy;
- claims first made against You or claims first notified to 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.

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 – see Section 6(e) for details.

b) Retroactive cover

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

Section 10: 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.

Your 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.

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 9 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.

Section 10: Important Notices *(continued)*

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 11: 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 the date of inception of Your Policy 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
- Simply contact Us and then submit details of Your complaint in writing to Us
- We will respond to Your complaint with an initial determination within 7 business days
- Where You remain dissatisfied with the initial determination, Our 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 We require 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.

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

The FOS will only consider insurance matters.

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

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

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

c) Contacting Us

See contact details on inside front cover.

d) Privacy

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

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

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

Section 11: Other Information *(continued)*

e) Other information

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

Professional indemnity insurance cannot be on-traded.

f) Financial claims scheme

This policy may be protected by the financial claims scheme administered by 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.

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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