

Professional Indemnity Insurance Policy

Combined Financial Services Guide, Product Disclosure Statement and Policy Wording V.7





Introduction

This brochure is divided into four sections.

Section 1 is our financial services guide. It contains information about who we are and the financial services that we provide. **2**

Section 2 is the product disclosure statement. It contains information about the Professional Indemnity Insurance Policy. **6**

Section 3 is the policy wording. **16**

It is important that you read all of these documents carefully before deciding whether to acquire the Professional Indemnity Insurance Policy.

Section 4 contains an extract of the Insurance Regulation Order issued under the *Health Care Liability Act (2001)* for the attention of NSW medical practitioners. **28**

SECTION 1: Financial Services Guide

This Financial Services Guide (FSG) provides you with information about MDA National Insurance Pty Ltd (MDA National Insurance) to help you decide whether to use the financial services we provide.

It also explains:

- how MDA National Insurance, our staff and other parties are remunerated in relation to those services;
- other documents you may receive in relation to the provision of our financial products and services;
- how we safeguard your personal information; and
- details of our internal and external complaints handling procedures should you need them.

Who are we?

MDA National Insurance Pty Ltd (ABN 56 058 271 417) is a general insurer authorised by the Australian Prudential Regulation Authority. We hold an Australian Financial Services Licence Number 238073 and are authorised to advise and deal in general insurance products. We are a wholly owned subsidiary of the Medical Defence Association of Western Australia (Incorporated), ARBN 055 801 771, trading as MDA National.

Who do we act for?

MDA National Insurance acts on its own behalf as an insurer. We do not act on your behalf.

What financial services and products do we offer?

Our insurance products are available only to Members of MDA National, with limited exceptions.

We currently offer the following medical indemnity insurance products:

- Professional Indemnity Insurance Policy
- Run-off Indemnity Policy
- Practice Indemnity Policy
- Student Indemnity Policy
- Run-off under the Run-off Cover Scheme (ROCS)

MDA National Insurance does not provide financial services and products from related or non-related product providers.

How can you do business with us?

You can obtain the financial services we offer through trained employees of MDA National Insurance.

They can help you apply for our products and may also give you general financial product advice in relation to these products. When giving general financial product advice our employees will not take into account your personal objectives, financial situation and needs. We may give personal financial product advice in limited situations.

You can give us instructions by telephone, in writing, in person, by email or via our website. In some cases, however, before we provide our products we may require written confirmation and the return of specific documents and completed forms.

How are we remunerated for the services we provide?

We charge a premium for our financial products.

If you choose to finance the cost of our products through a nominated finance corporation, where applicable we may be paid a referral fee of 1% of the amount financed by you.

The Commonwealth Government pays us an administration fee to reimburse the costs of administering the Premium Support Scheme (PSS) and the Run-off Cover Scheme (ROCS). These fees may be based on the number of policyholders and/or Members and are not based on any premium amount. No fee paid to us relating to the PSS or ROCS is deducted out of premiums or any monies paid by policyholders.

How are our employees remunerated for services provided?

The employees of MDA National Insurance who provide our services to you do not receive specific payments or commissions for giving that service. These employees receive salaries.

When and how do we pay other parties?

If you acquire our financial products through an approved broker, we will pay that broker a commission of up to 10% of the total premium and subscription paid by you. We receive the total premium paid by you and pay commissions in a separate transaction back to the broker.

How do we safeguard your personal information?

At MDA National Insurance, the privacy of your personal information is important to us. We collect your personal information to ensure that we are able to provide you with appropriate products and services. We collect, handle, store and disclose personal and sensitive information in order to:

- decide whether to issue a policy;
- determine the terms and conditions of the policy;
- analyse data;
- handle claims;
- meet our legal obligations;
- administer Government Schemes; and
- provide our products to you and improve the delivery of our products and services.

MDA National Insurance has adopted the National Privacy Principles set out in the Privacy Act as required by law and as part of our commitment to client service and the protection of client confidentiality. For further details of our Privacy Policy please visit our website at www.mdanational.com.au or contact us for a copy.

Marketing information

We are committed to providing you with access to leading products and services. From time to time we may provide you with information on other MDA National Insurance or third party products or services that may be of interest to you. We may also disclose your personal information on a confidential basis to our related entities and to the MDA National Group so that they can also offer you products and services. If you do not wish to receive this information please contact Member Services on 1800 011 255 or write to us at any of the addresses set out on the back of this document.

What to do if you want to make a complaint

A complaint is an expression of dissatisfaction relating to our product or service conveyed to us, together with a request to remedy the complaint.

MDA National Insurance is committed to dealing openly with all of our clients and we will endeavour to resolve any complaint quickly, efficiently and fairly. We view complaint resolution as an important part of our continuous improvement process.

Internal dispute resolution

In our experience, most issues can be resolved with a quick phone call. If you do have a complaint in relation to our products or services, please contact our Complaints Officer by:

Phone: 1800 011 255 (Freecall)
Fax: (08) 9415 1492
Email: complaintsofficer@mdanational.com.au
In writing: PO Box 1557
SUBIACO WA 6904

We will respond to you with a decision within 15 business days. If you are satisfied with our response, the matter will be considered resolved. If you are not satisfied with our response and wish to pursue the matter further you may wish to refer your complaint to the external dispute resolution scheme to which we belong.

External dispute resolution

If you are not satisfied with the outcome of our internal dispute resolution process, you can refer the dispute to the Financial Ombudsman Service Limited (FOS). FOS is an independent and impartial national body established to handle enquiries and complaints and to resolve disputes between consumers and their financial services provider. Their service is free to consumers.

FOS will only review complaints if they have first gone through our internal complaints and dispute resolution process. Please note that FOS can consider insurance matters only. FOS are not able to consider matters relating to Membership of MDA National.

For more information about FOS and the types of matters they can resolve, visit their website at www.fos.org.au or contact our Complaints Officer. Online dispute forms are available on their website.

You can contact FOS by:

Phone: 1300 780 808 (local call fee applies)
In writing: GPO Box 3
MELBOURNE VIC 3001

Further information and updates

This FSG is issued 15 May 2009 and applies to financial services provided on or after that date. Please check our website for updates.

SECTION 2: Product Disclosure Statement

Your MDA National Insurance Product Disclosure Statement

This Product Disclosure Statement (PDS) is designed to help you make an informed decision about acquiring the Professional Indemnity Insurance Policy (policy) underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence Number 238073. You can contact us at any of the addresses shown on the back of this booklet.

MDA National is a medical defence organisation, owned by its Members. With limited exceptions, the policy is only available to Members of MDA National.

It is important that you carefully read all of the information in this PDS, including the standard policy wording in Section 3, its terms and conditions, the exclusions and the defined terms. If a policy is issued to you, you should also read the schedule and any endorsements issued in conjunction with the policy wording.

Any advice in this document is of a general nature only and does not take into account your particular circumstances.

Information in this PDS may need to be updated from time to time. You can obtain a copy of any updated information by contacting us. If there is a material change to anything that generally affects the policy, we may provide all policyholders with a new or supplementary PDS.

Updates will also be available on our website www.mdanational.com.au

This PDS is issued on 15 May 2009 and applies to policies commencing on or after 1 July 2009.

Applying for Professional Indemnity Insurance

You must fill out a proposal to apply for this insurance. In the case of renewal, you must confirm that your details are correct and that you have given us all the information relevant to your risk.

A policy proposal is included in the application pack, or is available by calling 1800 011 255 or visiting the Download Centre of our website www.mdanational.com.au

Your duty of disclosure

Before you enter into or renew a contract of general insurance with us, you have a duty, under the *Insurance Contracts Act (1984)*, to disclose to us every matter that you know, or could reasonably be expected to know, is relevant to our decision whether to accept the risk of insurance and, if so, on what terms. The duty extends up until the time that we issue a policy to you.

You have the same duty to disclose those matters to us before you extend, vary or reinstate the policy.

Your duty however does not require disclosure of something:

- that diminishes the risk to be undertaken by us; or
- that is of common knowledge; or
- that we know or in the ordinary course of our business ought to know; or
- when compliance with the duty of disclosure is waived by us.

If you fail to comply with your duty of disclosure, we may be entitled to reduce our liability under the contract of insurance in respect of a claim or cancel the contract of insurance.

If your non-disclosure is fraudulent, we may also have the option of avoiding the contract of insurance from its beginning.

About the Professional Indemnity Insurance Policy

The Professional Indemnity Insurance Policy is a contract of insurance. The following is a summary of the insurance only and does not form part of the contract of insurance. All of the features, terms and conditions of this insurance are set out in the policy wording (Section 3 of this document).

The policy insures you, and your estate, for civil liability arising out of claims of professional negligence including Good Samaritan acts (clauses 1 and 2 of the policy). The policy also provides cover for certain claims arising out of you reporting an incident or healthcare practitioner to a hospital, area health authority or professional body, or participating in an investigation of such an incident (clause 3). Certain claims of professional negligence against a practice entity controlled by you are also covered, but only when the claim arises directly in connection with the provision of healthcare services by you (clause 4). The policy also insures legal costs incurred in connection with the defence or settlement of a claim covered under the policy and for legal costs in seeking an Apprehended Violence Order where there is a threat to you or your family related to the provision of healthcare services by you (clause 5).

The policy also covers defence costs incurred by you with our consent for investigations by a Professional Registration Board or Professional Services Review Committee and for inquiries arising from the provision of healthcare by you such as inquiries by a professional body, health services authority, Coroner's Court, Anti Discrimination Board or Medical Advisory Committee (clause 5).

You must comply with the conditions in the policy. For example, you must obtain our consent before you incur any legal costs. The policy also excludes certain claims and these are detailed in clauses 10 and 11.

What makes up the insurance contract?

The insurance contract is made up of:

- the policy wording contained within this booklet;
- the policy schedule we issue to you; and
- any endorsement issued to you.

You must read all of these documents carefully. They should be kept in a secure place.

A claims made policy

The Professional Indemnity Insurance Policy is a claims made contract of insurance. This means that the policy responds to claims made against you and notified to us during the period of insurance.

The policy does not cover matters you were aware of prior to the commencement of the period of insurance, whether you told us about them on your proposal or not.

If you have a policy with us and you notify us in writing during your period of insurance of circumstances that may give rise to a claim, the fact that you do not give us written notice of a claim relating to those circumstances before your policy has expired will not, of itself, relieve us of liability. However, you must notify us of the claim as soon as you become aware of it.

Continuity of cover

Professional negligence claims are often made years after the healthcare services have been provided so if you want to remain insured it is important that you continue to renew your policy or obtain alternative insurance. If you notify us of a claim after your policy has expired or is cancelled, you may not be indemnified by us for that claim.

Retroactive cover

With limited exceptions, your policy will contain a retroactive date which is specified on the policy schedule. The policy coverage is limited to incidents that occur on or after the retroactive date. So, if you have a retroactive date of 1 July 2003, for example, your policy will not cover a claim arising from an incident that occurred prior to this date, even if you first learn about the claim and report it to us during the period of insurance. In a limited number of cases, unlimited retroactive cover has been granted.

Everyone's circumstances are unique. As a guide, you may require retroactive cover for any periods where you practised and did not have medical indemnity insurance or indemnity from your employer or under a Government Indemnity Scheme. You may also require retroactive cover if you were previously insured by a claims made policy.

Once your retroactive date has been agreed by us, in most cases, you will retain this retroactive date for each subsequent renewal. However if you do require additional retroactive cover, you can apply for this at any time.

You may also apply for additional retroactive cover for non continuous periods. If we agree to provide this, your policy schedule will specify the additional retroactive periods.

How much we insure you for

The maximum amount we will indemnify you for is \$20,000,000 in the aggregate for all claims made under the policy. The maximum amount of our indemnity includes defence costs. A sub-limit of \$500,000 in the aggregate applies to defence costs for investigations, inquiries and allegations of sexual misconduct or criminal conduct and legal costs in seeking an Apprehended Violence Order. Both amounts will be specified in the schedule.

Policy excess

Most policies issued by us to medical practitioners do not specify an excess. However if an excess is to apply, it will be detailed in your policy schedule and you must pay us the amount specified as the excess for each and every claim made under the policy.

Where the same act or omission or one or more related acts or omissions give rise to more than one claim whether by one or more claimants, all such claims will constitute a single claim under the policy and will be treated as if first made at the time the earliest claim by any claimant was made.

What we do not insure you for

The policy will not provide insurance cover in certain circumstances. Clauses 10 and 11 of the policy wording set out what the policy does not cover. Please ensure that you read the policy exclusions carefully in order to understand what is not covered.

Policy conditions

There are things that you must do. If you do not do them, we may be able to reduce or avoid our liability under the policy. These conditions are set out in clauses 12 - 20 of the policy wording. For example, you must pay the premium when it is due. You must also notify us in writing as soon as practicable after you become aware of any claim, investigation or inquiry, or circumstances that could give rise to such.

General terms

There are some general terms that apply to all of the insuring clauses. These are set out in clauses 21 - 30 of the policy wording.

For example, when a claim includes both allegations that are indemnified under the policy and allegations that are not indemnified, we may reduce the amount of defence costs to an amount that we regard as attributable to the allegations that we provide indemnity for (clause 21).

We also have the right to conduct and control any proceedings.

How much will the policy cost?

In order for you to receive a policy, you must be a Member of MDA National and pay your MDA National Membership subscription. The amount of this subscription is specified separately in the quotation or renewal documentation.

The total insurance premium is made up of the basic premium, the ROCS Support Payment and Government taxes and charges. The basic premium will vary depending on the risk covered. We use a system of rating factors to calculate this component including your specialty or field of practice, your gross annual billings, your retroactive date and the state(s) in which you practice.

The ROCS Support Payment component of the premium goes to fund the Australian Government's Run-off Cover Scheme (ROCS). Regulations require that we pay the Government a certain percentage of premiums collected.

The Premium Support Scheme (PSS) has been established to provide financial assistance with medical indemnity premiums. You must apply separately for each year that you wish to be assessed for eligibility. The scheme may also require that you provide a Statutory Declaration of your Actual Income in order to be eligible. You will be required to complete specified risk management activities in order to remain eligible for payments under the PSS. You may also apply for an advance payment and if we receive your PSS application in time and you are eligible, we can collect the PSS payment directly from Medicare Australia and you will only need to pay the balance. Otherwise, you will be required to pay the full amount and we will refund any premium support due to you.

If you receive an advance payment and it is later determined that you are not eligible to receive a PSS payment or you received a higher subsidy than you are entitled to, you will need to repay the PSS payment or that portion of the PSS payment that you are not entitled to.

If you would like further information in relation to the PSS, please refer to the PSS Information Booklet available from the Download Centre of our website www.mdanational.com.au or contact Member Services on 1800 011 255.

Paying your insurance premium

Your premium is an annual premium. Subject to a minimum premium, you can choose to pay quarterly. If you choose to pay quarterly an administration charge is added so your total premium will be more than if you paid in one lump sum.

If you would like to pay monthly, we can provide you with the contact details of a premium funding provider who can provide a loan for the premium which is repayable in monthly instalments. The premium funding provider will charge you interest on the amount borrowed. We receive a referral commission from the premium funding provider.

Unless we advise otherwise, any payment reminder we send you does not change the due date for payment of your premium under the terms of your policy.

Policy variations

Treatment of public patients in public hospitals

Occasionally, medical practitioners find they are not able to obtain State or employer indemnity for claims arising from the treatment of public patients in public hospitals. Medical practitioners in this situation should notify us of their specific circumstances and will need to complete a Treatment of Public Patients Proposal and return it to us with written confirmation from the hospital regarding your indemnity status. An additional premium may apply if this cover is issued.

Not practising for 3 months or more

If you are planning to take a continuous break of 3 months or more during the insurance year, you may be eligible for a premium reduction. Please contact Member Services for more information. While on your break, it is advisable not to let your policy lapse without first having some other cover in place. In the event a claim is made against you while you are on your break, the claim may only be covered if you have a current insurance policy at the time the claim is notified.

Practising outside Australia

With the exception of Good Samaritan acts, the policy excludes cover for acts or omissions outside Australia unless we have agreed in writing to extend cover for your work outside Australia. Please contact us to discuss your plans if you are proposing to work abroad. Cover is subject to underwriting approval and is generally granted only for short periods of time.

If your practice takes you outside Australia regularly, please notify us of this fact. Unless you receive specific advice to the contrary, you will need to request cover for each separate overseas trip.

Team doctors

If you are accompanying an Australian sporting or cultural team overseas as the team doctor, we can arrange cover for the healthcare services you provide to team members. You will need to provide us with details of your trip and request cover in writing. Cover is subject to underwriting approval.

Cooling off period

You have a cooling off period that allows you to cancel your policy within 21 days of it being issued if you are not completely satisfied.

You must cancel the policy in writing. We will refund the premium (including any Government duties and charges) that you have paid.

Your cooling off right does not apply if you make a claim under your policy prior to your request to cancel it.

Cancellation

You may cancel your policy at any time by telling us in writing. We will refund the premium for the unexpired period of insurance on a pro-rata basis less an amount equal to 45 days premium, unless you have made a claim or notified a potential claim under the policy in which case we will not make any refund.

We may cancel the policy by giving you 3 business days written notice if:

- you failed to disclose or misrepresented to us any information that you knew (or could reasonably be expected to have known) was relevant to our decision to insure you and on what terms;
- you failed to comply with your duty of utmost good faith to us;
- you fail to comply with a provision of this policy, including the provision to pay the premium or a premium instalment;
- you fail to comply with any provision of this policy which requires you to notify us; or
- you make a fraudulent claim under the policy.

Run-off cover

Run-off cover is a form of cover generally taken out by professionals when they retire or in the event they stop practising for a significant period of time. Medical negligence claims can be made against a medical practitioner years after the medical services were provided. A Run-off Indemnity Policy covers claims that first come to light and are notified to us in writing after a nominated cessation date, but only in respect of medical services provided during the period from your retroactive date to your nominated cessation date. The cessation date is normally the day after your last day of practice for which you require our cover.

If you would like to find out more about our Run-off Indemnity Policy, please contact Member Services and we will be happy to discuss your needs and send you a Run-off Indemnity Policy Product Disclosure Statement (PDS). You can also download the PDS from the Download Centre of our website. When considering run-off cover, you should be aware that the Australian Government has introduced a statutory Run-off Cover Scheme (ROCS), which means you may not need to purchase a Run-off Indemnity Policy from us.

Run-off Cover Scheme (ROCS)

From 1 July 2004, the Australian Government introduced a run-off cover statutory indemnity scheme for medical practitioners who practise in Australia. The scheme provides run-off cover to certain eligible medical practitioners without the requirement for premiums to be paid once the medical practitioner is eligible. The scheme is funded by Medical Indemnity Insurers contributing a percentage of premiums and your renewal notice and tax invoice/receipt will detail the ROCS Support Payment we have paid on your behalf. Please keep these documents in a secure place.

You are eligible for ROCS if you:

- (a) are aged 65 years or over and have retired permanently from private medical practice;
- (b) have not engaged in private medical practice at any time during the preceding period of 3 years;
- (c) have only ever worked in public medical practice and have not undertaken any paid medical practice at any time during the preceding period of 3 years;
- (d) have ceased (temporarily or permanently) medical practice because of maternity;
- (e) have ceased medical practice because of a permanent disability; or
- (f) have left Australia permanently having practised in Australia on a Visa sub-class 422 or 457.

A medical practitioner's estate will also be eligible for ROCS after the medical practitioner's death.

If you believe you may be eligible for ROCS, please contact Member Services as you may not need to purchase or renew your Professional Indemnity Insurance Policy. More information on this scheme is available upon request or from the Department of Health at www.health.gov.au

How to make a claim under the policy

Claim and incident reporting is critical and allows us to properly investigate the matter and provide you with sound advice. You must notify us in writing as soon as practicable by fax to 1300 011 235, by mail to any of our offices or via our online notification form if any of the following occur.

Incidents or circumstances that may give rise to a claim

If at any time during the period of insurance you become aware of a matter that you believe may result in a claim against you, let us know as soon as you can. Prompt reporting will enable us to manage the process at an early and crucial time and allow us to advise you as to how you might respond. Don't wait until a claim is made against you. Your written advice to us should include:

- your name and Member number;
- the date, time and place of the event;
- the specific nature of the incident as well as a detailed account of the healthcare service you performed;
- the name and address of any other professionals involved; and
- the name, address and date of birth of the patient involved.

If you suspect that the law may have been broken you should immediately notify us, as it may need to be reported to the police.

You must immediately send us all legal documents and other correspondence you receive relating to any circumstances that have resulted in, or may result in, a claim.

To assist you further, an incident notification form is available on our website www.mdanational.com.au

You receive advice that a claim has or will be made against you

Hopefully you will have told us about the matter well before it becomes a claim. However, whether we have been notified or not, send all the details of the claim to us as soon as possible, including all legal documents and correspondence from lawyers.

Any investigation, coronial inquiry, hearing or proceeding arising from your work as a medical practitioner

Should you become involved in any investigation or inquiry, let us know as soon as you can. We have a wealth of experience in handling such matters but in some cases we may need to engage lawyers to represent you.

What to do when something goes wrong

Speak to us first. Patients are always entitled to a full, accurate, sympathetic and prompt account of the facts, but you must not admit liability or do anything that may compromise our ability to defend a claim.

Refrain from entering into any correspondence with the patient, hospital or supervisor without first contacting us.

What to do if you want to make a complaint

Internal dispute resolution

We are committed to dealing openly with all of our Members and will endeavour to resolve any complaint quickly, efficiently and fairly. We view complaint resolution as an important part of our continuous improvement process.

A complaint is an expression of dissatisfaction relating to our product or service conveyed to us, together with a request to remedy the complaint.

In our experience, most issues can be resolved with a quick phone call. If you do have a complaint in relation to our products or services, please contact our Complaints Officer by:

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Email: complaintsofficer@mdanational.com.au
In writing: PO Box 1557
SUBIACO WA 6904

We will respond to you with a decision within 15 business days. If you are satisfied with our response, the matter will be considered resolved. If you are not satisfied with our response and wish to pursue the matter further you may refer the matter to the external dispute resolution scheme to which we belong.

External dispute resolution

If you are not satisfied with the outcome of our internal dispute resolution process, you can refer the dispute to the Financial Ombudsman Service Limited (FOS). FOS is an independent and impartial national body established to handle enquiries and complaints and to resolve disputes between consumers and their financial services provider. Their service is free to consumers.

FOS will only review complaints if they have first gone through our internal dispute resolution process. Please note that FOS can consider insurance matters only. FOS is not able to consider matters relating to your Membership of MDA National.

For more information about FOS and the types of matters they can resolve, you can visit their website www.fos.org.au or contact our Complaints Officer. Online dispute forms are available on their website.

You can contact FOS by:

Phone: 1300 780 808 (local call fee applies)

**In writing: GPO Box 3
MELBOURNE VIC 3001**

SECTION 3: Policy Wording

Professional Indemnity Insurance Policy

This Professional Indemnity Insurance Policy is issued by MDA National Insurance Pty Ltd ABN 56 058 271 417, AFS Licence No. 238073.

When issuing this policy we have relied on the information you have given us in your proposal. You must tell us without delay if any of this information is incorrect or if it changes.

Please read the policy and schedule carefully and keep it in a safe place. When reading this policy, please note the use of specially defined words which are listed at the end of the policy.

What we insure you for

Professional negligence

1. We will indemnify you for any civil liability arising out of a claim of professional negligence against you, but only when:
 - (a) the claim arises directly in connection with the provision of healthcare services by you; and
 - (b) the claim is first made against you during the period of insurance; and
 - (c) you tell us about the claim in writing during the period of insurance; and
 - (d) the claim arises from an act or omission occurring on or after the retroactive date or within any additional retroactive period specified in the schedule.

Good Samaritan acts

2. We also indemnify you for any civil liability arising out of a claim of professional negligence against you when the claim arises directly from the provision of emergency medical assistance by you where you are in attendance as a bystander and where you have no expectation of payment or other reward, but only when:
 - (a) the claim is first made against you during the period of insurance; and
 - (b) you tell us about the claim in writing during the period of insurance; and
 - (c) the claim arises from an act or omission occurring on or after the retroactive date or within any additional retroactive period specified in the schedule.

This indemnity only applies to acts necessary to stabilise the patient or to prepare the patient for transfer.

Additional coverage

3. We will indemnify you for any civil liability in respect of a claim (including a claim for defamation) that arises directly out of you, in good faith and in the public interest, reporting an incident or a registered healthcare professional to a hospital, area health authority or professional body or participating in the investigation of such an incident, but only when:
 - (a) the claim is first made against you during the period of insurance; and
 - (b) you tell us about the claim in writing during the period of insurance; and
 - (c) the claim arises from a report made on or after the retroactive date or within any additional retroactive period specified in the schedule.
4. We will indemnify a practice entity controlled by you for any civil liability arising directly out of a claim of professional negligence, but only when:
 - (a) the claim arises directly in connection with the provision of healthcare services by you personally; and
 - (b) the claim would be covered under this policy if made against you; and
 - (c) the practice entity complies with the terms and conditions of the policy that you must comply with and you have paid the premium; and
 - (d) the claim is first made against the practice entity during the period of insurance; and
 - (e) you tell us about the claim in writing during the period of insurance; and
 - (f) the claim arises from an act or omission occurring on or after the retroactive date or within any additional retroactive period specified in the schedule.

If the practice entity is not 100% owned by you, then our indemnity is limited to the same proportion of liability as your ownership of the entity.

Legal costs

5. We will indemnify you for:
 - (a) defence costs that we incur on your behalf for any claim covered by this policy under clauses 1, 2, 3 and 4; and
 - (b) defence costs (up to the sub-limit stated in the schedule) incurred with our consent for any investigation that you first become aware of and tell us about in writing during the period of insurance but only if the investigation relates to an act or omission occurring on or after the retroactive date or within any additional retroactive period specified in the schedule; and

- (c) defence costs (up to the sub-limit stated in the schedule) incurred with our consent for any inquiry which arises solely from the provision of healthcare services by you and that you first become aware of and tell us about in writing during the period of insurance but only if the inquiry relates to an act or omission occurring on or after the retroactive date or within any additional retroactive period specified in the schedule; and
- (d) legal costs (up to the sub-limit stated in the schedule) incurred with our prior written consent by you seeking an Apprehended Violence Order or equivalent relief where there is a threat to the personal safety of you or a member of your immediate family and the threat is related to the provision (or non-provision) of healthcare services by you.

Defence costs for allegations of sexual misconduct and criminal matters

6. Notwithstanding exclusion 10.14, we will indemnify you against defence costs for the successful defence of any claim, investigation or inquiry which arises out of any alleged sexual misconduct or criminal conduct by you against a patient arising out of the provision of healthcare services but only if and when you are exonerated from all allegations of misconduct, criminal conduct or wrongdoing and all appeal rights of any party in relation to those allegations have been exhausted or in the case of a civil claim, if and when the final judgment does not order that you pay damages or make any other restitution, or the claim, investigation or inquiry has been discontinued and only when:
 - (a) you tell us about the claim, investigation or inquiry in writing during the period of insurance; and
 - (b) the claim, investigation or inquiry arises from an act or omission occurring on or after the retroactive date or within any additional retroactive period specified in the schedule.
7. We may at our absolute discretion agree to advance the defence costs referred to in clause 6 to you as they are incurred and prior to the finalisation of any claim, investigation or inquiry. If we do advance defence costs and we subsequently determine that we have no liability under clause 6, then you must repay those defence costs to us. We may cease to advance defence costs to you at any time.

How much we insure you for

8. The total amount (including defence costs and claimant's costs) payable by us for all claims under this policy will not exceed the amount set out as our limit of indemnity in the schedule and applies after you have paid any excess set out in the schedule. If an excess applies, you must pay an excess in respect of each claim made under the policy.
9. Where the same act or omission or one or more related acts or omissions give rise to more than one claim whether by one or more claimants, all such claims will constitute a single claim under the policy and will be treated as if first made at the time the earliest claim by any claimant was made.

What we exclude from the policy

10. We will not indemnify you under this policy when:
- 10.1 and to the extent that you are entitled to indemnity for the claim, investigation or inquiry under a previous policy issued by us or another insurer (to the extent allowed by law) or you have the benefit of a prior indemnification arrangement with a Medical Defence Organisation or you are indemnified under a government scheme or you are entitled to any indemnity from your employer or other indemnity provider;
 - 10.2 the claim, investigation or inquiry arises from any act or omission or claim, investigation or inquiry that you have or should have told us about in your proposal;
 - 10.3 the claim, investigation or inquiry arises from circumstances which you notified to us or to another insurer or Medical Defence Organisation or other indemnity provider before the period of insurance;
 - 10.4 the claim arises in any way out of the provision of healthcare services to a public patient in a public hospital;
 - 10.5 the claim arises out of the provision of elective medical treatment by you on or after 1 July 2004 to a member of your immediate family;
 - 10.6 the claim, investigation or inquiry arises in any way out of a practice or procedure not associated with your field of practice except where the claim, investigation or inquiry relates to the provision of emergency medical assistance by you where you are in attendance as a bystander and where you have no expectation of payment or other reward;
 - 10.7 the claim arises from the acts or omissions of an employee, contractor or any other person when those acts or omissions were:
 - (a) outside the terms and conditions of his or her employment or contract;
 - (b) outside the boundaries of his or her training and/or qualifications; or
 - (c) not under your supervision;
 - 10.8 the claim, investigation or inquiry arises because of your continuing use of a procedure or practice in the provision of healthcare services 14 days after you have received notice from us under clause 15 asking you to stop using the procedure or practice;
 - 10.9 the claim, investigation or inquiry arises in any way out of you providing healthcare services that you were not permitted to provide because you were not registered, were prohibited from practising or you acted outside of, or did not comply with, the terms or conditions placed on your registration;

- 10.10 the claim or inquiry arises in any way out of or in connection with defamation or any allegation of defamation except to the extent that we agree to indemnify you under clause 3;
- 10.11 the claim arises in any way from any activity in connection with or sponsorship of a clinical trial or research project. This exclusion does not apply to your provision of healthcare services to a participant in a clinical trial or research project provided that the clinical trial or research project has been approved by a properly constituted Ethics Committee in accordance with National Health and Medical Research Council Guidelines and has been conducted in accordance with any conditions or approvals made by such Ethics Committee;
- 10.12 the claim or inquiry arises in any way out of the provision of healthcare services by a person while intoxicated or otherwise impaired by the use of an intoxicant or drug except for the reasonable refusal to provide healthcare services because of the influence of such intoxicant or drug;
- 10.13 the claim or inquiry arises in any way as a result of the transmission of a contagious disease from you or someone for whom you are vicariously liable to a patient when at the time of transmission, you knew or should have reasonably known that the infected person was carrying the disease;
- 10.14 the claim, investigation or inquiry arises in any way out of any actual or alleged sexual harassment, sexual misconduct, criminal conduct or unlawful discrimination except to the extent that you are indemnified for your defence costs under clause 6;
- 10.15 the claim, investigation or inquiry arises in any way out of any wilful violation or breach of any statute or regulation or out of any act committed with dishonest, malicious or criminal intent;
- 10.16 a person makes a claim because, and only because, that person is or was an employee or agent of you or a practice entity controlled by you or because you or a practice entity controlled by you did not employ that person;
- 10.17 the claim, investigation or inquiry arises in any way out of a dispute between you and a current, former or prospective partner or co-owner in your practice entity other than a claim of professional negligence;
- 10.18 or to the extent that the claim involves a legal obligation:
- (a) to refund any fee charged to a patient;
 - (b) to pay a fine or a civil or criminal penalty; or
 - (c) to pay punitive, aggravated or exemplary damages;
- 10.19 the claim arises in any way out of the development, manufacture, storage or supply of any good or product. This exclusion does not apply to the manufacture or supply of a product by you as an intrinsic part of you providing healthcare services to a patient;

- 10.20 the claim or inquiry arises in any way out of the unlawful sale, supply, use or application of any substance;
- 10.21 the claim, investigation or inquiry arises in any way out of the ownership, use or occupation or state of any premises or anything done or omitted to be done in respect of the state of any premises;
- 10.22 the claim, investigation or inquiry arises in any way out of or in connection with an actual or threatened pollution of the environment (including exposure to asbestos) or a requirement for you to deal with that pollution exposure. This exclusion does not apply to the provision of healthcare services to any patient who has symptoms, whether actual or alleged, as a result of any exposure to pollution including asbestos whether directly or indirectly;
- 10.23 the claim arises out of or is connected with any contractual liability, warranty or guarantee except if you would have been otherwise liable in the absence of the contractual liability, warranty or guarantee;
- 10.24 the claim, investigation or inquiry arises out of or is connected with acts of terrorism, war, invasions, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, insurrection, military or usurped power. This exclusion shall not apply to any healthcare procedure performed as a result of any injuries arising out of any terrorism, war or warlike situation;
- 10.25 the claim, investigation or inquiry arises out of:
- (a) a judgment or order:
 - (i) by a court in the United States of America or its territories;
 - (ii) by a court elsewhere exercising jurisdiction under a Local, State or Federal Law of the United States of America; or
 - (iii) based on, derived from or to enforce a judgment or order by a court referred to in (i) or (ii);
 - (b) acts or omissions which occur within the territorial limits of the United States of America or its territories.
- This exclusion does not apply to Good Samaritan acts;
- 10.26 the claim, investigation or inquiry arises from any act or omission occurring or allegedly occurring outside the Commonwealth of Australia or its territories or protectorates unless we have agreed in writing to extend cover and then only to the jurisdictions and for the period of time specified by us in writing. This exclusion does not apply to Good Samaritan acts;
- 10.27 you have admitted liability for the claim or settled or agreed to settle the claim without our consent; or

10.28 the claim arises from an actual or alleged contravention of any provision of the Trade Practices Act 1974 (Cth) or any equivalent State or Territory fair trading legislation. This exclusion does not apply to any civil liability arising out of an alleged breach of Part V of the Trade Practices Act 1974 (Cth) (or any equivalent State or Territory fair trading legislation) where the alleged breach is directly related to the provision of healthcare services to a patient and does not arise from conduct which is fraudulent or intended to mislead or deceive.

Fraudulent claims

11. We may reject a fraudulent claim for indemnity or any part of a claim that is fraudulent.

Conditions

Payment of premium

12. You must pay the premium, or any instalment of premium, on or before the date when it is due.

When you have to notify us

13. You must notify us in writing as soon as practicable after you become aware of:
 - (a) any claim, investigation or inquiry; and
 - (b) any circumstance that might lead to a claim against you or to an investigation or inquiry involving you.
14. If you seek indemnity under this policy you must tell us about any other insurance or entitlement to indemnity that may indemnify you in respect of such claim, investigation or inquiry, including the identity of the other insurer, the policy number and any other information that we may reasonably require.

Stop notice

15. You must stop using a procedure or practice in providing healthcare services if:
 - (a) we consider that the practice or procedure poses an unreasonable risk of professional negligence; and
 - (b) we give you 14 days notice asking you to stop using the procedure or practice.

Your duty to co-operate

16. You must, at your expense:
 - (a) give us, our investigators and legal representatives all information, documents and assistance we reasonably require including without limitation access to books and records of your healthcare practice; and
 - (b) co-operate fully with us, our investigators and legal representatives.

17. You agree to waive any legal professional privilege to the extent only that the privilege would otherwise prevent any legal representative appointed by us from disclosing information to us.

Prevention of loss

18. You must not, without our prior written consent:
- (a) admit liability for a claim or potential claim;
 - (b) do or not do anything which may compromise our ability to defend a claim or potential claim; or
 - (c) make any payment or settlement, or offer of payment or settlement, of any claim or potential claim;
- in respect of which we may be liable to indemnify you.
19. You must use all reasonable measures to avoid or reduce any liability under this policy.

Alteration of risk

20. You must give us notice as soon as practicable of any material alteration of the risk during the period of insurance including without limitation any material change in your field of practice or the nature or extent of the healthcare services provided by you, or the risk category you have previously declared.

General terms

Allocation of defence costs

21. If a claim, investigation or inquiry includes both allegations in relation to which you are entitled to indemnity under this policy and allegations in relation to which you are not entitled to indemnity under this policy, we will pay only that proportion of defence costs which are attributable to the covered allegations. We will determine in our absolute discretion the allocation of defence costs between the covered allegations and the uncovered allegations and will inform you of our determination in writing. In determining the allocation of defence costs, we will have regard to the proportion which that part of the claim consisting of covered allegations bears to the whole of the claim.

Our right to the conduct and control of proceedings

22. You agree that:
- (a) we have the right to conduct and control all matters that we agree to indemnify under this policy, including the investigation, defence, avoidance, reduction, settlement and, subject to clause 23, any appeal as we see fit; and
 - (b) we may do so in your name.

However we will not admit liability for or settle any claim against you without your prior consent. If you refuse to consent to our settling a claim, our liability is then limited to the amount we recommend in settlement plus defence costs up to the date we recommend settlement of the claim to you.

Appeals

23. If you are dissatisfied with the decision made by a court, board, tribunal or other decision making body in a matter in which we have represented you under this policy, and you want to appeal against that decision, you must request our written approval within 7 days after the decision is handed down. You must do so in writing, setting out your reasons for wanting to appeal. We will inform you in writing within 10 working days after we receive your request whether we consent or not to pay the costs and expenses of the appeal.

If you decide to appeal without our consent, we will not pay any additional expenses associated with the appeal or any further expenses which may be an outcome of the appeal. If your appeal is successful and you are entitled to a payment or refund of defence costs and/or any money that we paid the claimant, that payment or refund becomes a debt due to us and you must forward that payment or refund to us less any legal fees and expenses you have incurred in the appeal.

Subrogation

24. You agree not to surrender any right to, or settle any claim for, contribution, indemnity or recovery, without our consent.
25. If we make a payment under this policy, we are subrogated to all your rights of contribution and indemnity or recovery.

Cancellation

26. You may cancel this policy at any time by notifying us in writing. We will refund the premium for the unexpired period of insurance on a pro-rata basis less an amount equal to 45 days premium, unless you have made a claim or notified a potential claim under this policy in which case we will not make any refund.
27. We may cancel this policy by giving you 3 business days written notice if:
- (a) you failed to disclose or misrepresented to us any information that you knew (or could reasonably be expected to have known) was relevant to our decision to insure you and on what terms;
 - (b) you failed to comply with your duty of utmost good faith to us;
 - (c) you fail to comply with a provision of this policy including the provision to pay the premium;
 - (d) you are paying your premium by instalments and at least one instalment remains unpaid for over one month;

- (e) you fail to comply with any provision of this policy which requires you to notify us (including your obligation to notify us of any change in the healthcare services provided by you); or
- (f) you make a fraudulent claim under the policy.

Governing law

28. Any dispute that arises between you and us under this policy will be subject to the law and jurisdiction of Western Australia.

Interpretation

29. The headings in this policy are included for descriptive purposes only and do not form part of this policy for the purposes of construction or interpretation.
30. Under this policy the masculine includes the feminine and the singular includes the plural and vice versa.

Definitions

31. In this policy:

Additional retroactive period means the period set out in the schedule as the additional retroactive period.

Claim means:

- (a) a demand for, or an assertion of a right to, compensation, damages or injunctive relief from you; or
- (b) an intimation of an intention to seek compensation, damages or injunctive relief from you.

Claimant's costs means legal costs, disbursements and related expenses you have to pay to the person making the claim against you.

Criminal conduct means conduct that is or could be in breach of a criminal law, regardless of whether or not a criminal charge has been brought in relation to the conduct.

Defence costs means legal costs, disbursements and related expenses reasonably and necessarily incurred in:

- (a) defending any proceedings;
- (b) attending or assisting in an investigation or inquiry;
- (c) prosecuting any proceedings for indemnity, contribution or recovery; or
- (d) investigating, avoiding, reducing or settling any claim.

Excess means the amount you must pay to us for each claim made and notified under the policy, as set out in the schedule.

Field of practice means the field of practice in which you ordinarily provide healthcare services as set out in the schedule and any other field of practice notified to us for which we have agreed to extend cover in writing.

Healthcare services means the following services that you provide:

- (a) healthcare treatment, services or advice or a report of those things provided to a patient or in relation to a patient in a professional capacity;
- (b) supervision, training or direction of a healthcare student or registered healthcare professional who is undertaking a recognised healthcare training program;
- (c) supervision or direction of a person who is not a medical practitioner to assist you in providing healthcare treatment, services or advice to a patient;
- (d) a healthcare report or opinion not for the purpose of treatment;
- (e) healthcare advice to a person or organisation in relation to a person's fitness to carry out certain duties or activities; or
- (f) writing an academic paper or an article in a peer reviewed, refereed healthcare journal;

provided that the activity is of a type that a qualified registered healthcare professional would ordinarily provide if he or she were carrying out your field of practice.

Immediate family means your current or former spouse, de facto or domestic partner, your children or the children of your current or former spouse, de facto or domestic partner, your brother, your sister or your parents.

Inquiry means a hearing, inquiry, disciplinary or administrative proceeding established to investigate by a professional body, health services authority, tribunal, Royal Commission, Coroner's Court, health or medical benefits fund or Anti Discrimination Board (or equivalent) but not before a Professional Registration Board or Professional Services Review Committee.

Insured means the person named in the schedule.

Investigation means an investigation or disciplinary or administrative proceeding by a Professional Registration Board or Professional Services Review Committee.

Medical practitioner means an individual registered or licensed as a medical practitioner under a law of any State or Territory of Australia that provides for the registration or licensing of medical practitioners.

Period of insurance means the period of insurance set out in the schedule.

Policy means this policy wording, the schedule and any endorsements.

Professional negligence means actual or alleged negligence or breach of duty or statutory duty in connection with the provision of or failure to provide healthcare services.

Proposal means all documents comprising your application for, or renewal of, this policy including any pre-renewal questionnaire.

Registered healthcare professional means a medical practitioner or an individual who practises a healthcare related vocation and who is registered under a law of any State or Territory of Australia to practice that vocation.

Retroactive date means the date specified in the schedule as the retroactive date.

Schedule means the current schedule to this policy.

We, our and **us** means MDA National Insurance Pty Ltd ABN 56 058 271 417, AFS Licence No. 238073 being the insurer named in the schedule.

You and **your** means:

- (a) the individual named in the schedule as the insured; and
- (b) the executor or administrator of that individual's estate.

SECTION 4: NSW Healthcare Liability Act (2001)

We are required to provide NSW medical practitioners applying for insurance with the following extract from the Insurance Regulation Order made pursuant to the Act.

Insurance Regulation Order 2003

Part 2 - Decisions concerning individual cover

Division 1

1. Preliminary

- (1) For the purposes of this Part: a refusal to provide approved insurance includes:
- (i) not accepting an offer to enter into a contract for such insurance, or
 - (ii) cancelling a contract for such insurance, or
 - (iii) not renewing such insurance, or
 - (iv) not offering such insurance.

Copy of requirements of this Part to be provided to practitioners

- (2) An insurer must provide an applicant for approved insurance or an existing policyholder with a copy of the conditions the insurer must comply with under this Part.

Provision of claims history upon request by practitioner

- (3) An insurer, within ten working days of receiving a written request from a medical practitioner who:
- (a) is covered by approved insurance by the insurer, or
 - (b) within the immediately preceding six years has been covered by professional indemnity insurance by the insurer, must provide to the medical practitioner his or her record of claims history for whichever is the lesser of the following periods:
 - (i) the most recent six year period of the insurance cover, or
 - (ii) the total period that the insurer has provided professional indemnity insurance to the practitioner.

Division 2

2. Decisions concerning individual cover

- (1) During the period that an adverse decision applies to an existing policy holder, access to risk management activities, which have the purpose of assisting the policyholder to reduce his or her individual claims risk, are to be offered or facilitated by the insurer.

Withdrawal of cover

- (2) An insurer must not refuse to provide approved insurance to an existing policyholder:
 - (a) who has been registered as a medical practitioner for a period of less than three years and who has not previously had his or her name removed from the medical register following disciplinary proceedings, or
 - (b) who has held specialist qualifications recognised under the Health Insurance Act for a period of less than three years and who has not previously had his or her name removed from the medical register following disciplinary proceedings, or
 - (c) in the case of a medical practitioner to whom paragraph (a) or (b) does not apply, unless the medical practitioner has an incident and claims history the insurer considers warrants such a decision.
- (3) Sub-clause (2) does not apply where an insurer refuses to provide approved insurance:
 - (a) for a reason which is of a similar kind to a reason that enables the cancellation of a contract of general insurance, or the avoidance of a claim or policy, in accordance with the relevant provisions of the Insurance Contracts Act, or
 - (b) for a reason which relates to a breach or non-observance by the medical practitioner of the terms and conditions of the relevant insurance policy, or the non-payment of the relevant premium, or
 - (c) because the insurer ceases to engage in the business of providing professional indemnity insurance to non-exempt medical practitioners.
- (4) For the purposes of this clause a decision by an insurer to charge a medical practitioner a premium which is at least twice the premium charged by the insurer to all, or a majority of, medical practitioners of the same premium category is taken to be a decision to refuse to provide approved insurance.

Division 3

3. Proper notice and explanation

- (1) Subject to clause 4 of this Part, an insurer must not (whether upon renewal or otherwise), because of the incident and claims history of an existing policy holder, make an adverse decision in respect of the approved insurance of the policy holder or a decision to refuse to provide approved insurance to the policy holder, unless the insurer:
 - (a) in the case of any adverse decision, has given the policy holder 28 days' written notice prior to the decision taking effect, or
 - (b) in the case of a decision to refuse to provide professional indemnity insurance, has given the policyholder two months' written notice prior to the decision taking effect, together with a copy of the claims history specified at clause 1 (3) of this Part.
- (2) Prior to giving such notice under sub-clause (1) (a) the insurer must:
 - (a) give the relevant medical practitioner a reasonable opportunity to discuss the proposed decision and the reasons for it with the insurer, and
 - (b) take into account any matters raised by the medical practitioner in the course of those discussions.
- (3) If requested by the relevant medical practitioner, the insurer must provide to him or her a written explanation of the reasons for its refusal to provide approved insurance.
- (4) This clause does not apply where an insurer upon renewal of professional indemnity insurance continues to give effect to an adverse decision made prior to the insurance being renewed.
- (5) For the purposes of this clause a decision by an insurer to charge a medical practitioner a premium which is at least twice the premium charged by the insurer to all, or a majority of, medical practitioners of the same premium category is taken to be a decision to refuse to provide approved insurance.

Division 4

4. Opportunity for consideration by Medical Board at practitioner's election

- (1) This clause applies to a refusal to provide approved insurance because of the incident and claims history of an existing policyholder.
- (2) For the purposes of this clause a decision by an insurer to charge a medical practitioner a premium which is at least twice the premium charged by the insurer to all, or a majority of, medical practitioners of the same premium category, is taken to be a decision to refuse to provide approved insurance.

- (3) If within 28 days of receiving notice of a decision to refuse to provide approved insurance in respect of an existing policyholder, the policyholder:
 - (a) authorises the insurer, in writing, to notify the Medical Board of any matter which forms the basis of the decision and to provide to the Medical Board information and documentation relevant to such matter, and
 - (b) authorises the Medical Board, in writing, to provide to the insurer a copy of its advice to the practitioner as to the outcome of any such notification, if made, and in those cases where the Medical Board refers a matter to an Impaired Registrants Panel or for assessment under Part 5A of the Medical Practice Act 1992, copies of any relevant decisions, reports and recommendations arising from the referral, an insurer is to forward the relevant information to the Medical Board.
- (4) If an insurer is authorised to forward information to the Medical Board under sub-clause (3), an insurer is not to give effect to the decision to refuse to provide professional indemnity insurance pending whichever of the following occurs first:
 - (a) the expiration of a period of three months from the date of forwarding the relevant information pursuant to sub-clause (3), or
 - (b) receipt and consideration by the insurer of copies of the information referred to under sub-clause (3) (b).
- (5) If such matters are the subject of a referral to an Impaired Registrants Panel or form the basis of a referral for assessment under Part 5A of the Medical Practice Act 1992, the insurer is to:
 - (a) review its decision (whether or not it has already given effect to that decision) following receipt and consideration by the insurer of any reports and recommendations arising from the referral, and of advice on any action taken by the Medical Board consequent upon those reports and recommendations, and
 - (b) take reasonable steps to advise the relevant practitioner of the outcome of that review.
- (6) Nothing in this clause prevents an insurer from charging a premium of an amount that does not constitute a refusal to provide approved insurance under sub-clause (2) pending receipt of the Medical Board's advice or the expiration of three months, whichever first occurs, in accordance with subclause (3).

Division 5 - New Applicants

5. Decisions concerning individual cover

- (1) In this clause a refusal of an application for approved insurance includes a decision to not accept an offer to enter into a contract for such insurance.

Newly qualified practitioners

- (2) An insurer must not make a significant adverse decision in respect of an application for approved insurance from a medical practitioner who has not previously held professional indemnity insurance with that insurer:
 - (a) if the applicant has been registered as a medical practitioner for a period of less than three years and has not previously had his or her name removed from the medical register following disciplinary proceedings, or
 - (b) if the applicant has held specialist qualifications recognised under the Health Insurance Act for a period of less than three years and has not previously had his or her name removed from the medical register following disciplinary proceedings.

Refusal of cover

- (3) Before giving effect to a decision to refuse an application for approved insurance from a medical practitioner an insurer must give the medical practitioner a reasonable opportunity to discuss the proposed decision and the reasons for it with the insurer.
- (4) If requested by a medical practitioner whose application for approved insurance is refused, the relevant insurer must provide him or her with a written explanation of the reasons for its refusal.



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