

Guidelines

Medical Indemnity Run-off Cover Indemnity Scheme (ROCS) payment application form



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Part 1: Important information for applicants

Introduction

The Run-off Cover Indemnity Scheme (ROCS) legislation was introduced by the Australian Government on 1 July 2004. The legislation was developed following recommendations from the Medical Indemnity Policy Review Panel which was concerned about the ability of medical practitioners to pay for run-off cover when they no longer earned an income from medical practice. The scheme ensures that eligible doctors receive medical indemnity cover that is secure, free and based on the medical indemnity insurance they last held.

These guidelines will help Medical Defence Organisations (MDOs) and Medical Indemnity Insurers (MIIs) complete a medical indemnity run-off cover indemnity scheme payment application form for eligible claims. They do not stand alone and must be read in conjunction with the relevant acts, regulations and other associated documentation.

Relevant legislation

Acts Interpretation Act 1901 *Medical Indemnity Act 2002*

Medical Indemnity Regulations 2003

Medical Indemnity (Prudential Supervision and Product Standards) Act 2003

Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003

Medical Indemnity (Terms and Conditions) Determination 2004

Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006 (No. 2)

Submitting applications

A separate ROCS payment application form must be submitted to Medicare Australia for each member or policy holder who is subject to the same claim.

In the event a policy holder or member is subject to multiple claims which relate to the same plaintiff and the same incident (for example, a coronial and a civil claim), these claims must be lodged with Medicare Australia as part of one application.



Supporting documentation must be attached to the application form. Medicare Australia has developed a **checklist**, which is attached to the application form. The checklist details the documents that Medicare Australia needs to verify ROCS eligibility and if the claim is payable.

The provision of supporting documentation is mandatory and prevents delays in assessing your application.

Request for further information by Medicare Australia

The *Medical Indemnity Act 2002* (the Act) states that the Medicare Australia CEO may request further information in writing to determine if an application for payment is acceptable, and if so, the amount payable. This information may need to be verified by statutory declaration.

A response to a request for further information must be given within 28 days. Failure to comply is an offence. If there are difficulties in meeting the deadline a written application for a reasonable extension may be made to Medicare Australia.

Payment of ROCS indemnity

If a ROCS payment application meets all of the legislative requirements, Medicare Australia must pay the indemnity to the MDO or MII before the end of the month that immediately follows the month the application is received. For example if an application for payment is received by Medicare Australia on 28 June 2007, and is subsequently approved, payment to the MDO or MII must be made before 31 July 2007.

In the case of an application where there has been a further information request by the Medicare Australia CEO, the indemnity must be paid before the end of the month that immediately follows the date that the information is received (providing this information satisfies the request). For example if an application for payment is received by Medicare Australia on 28 June 2007, additional information is requested on 5 July, and this information is received by Medicare Australia on 1 August, the payment to the MDO or MII must be made before 30 September 2007.

What cannot be claimed under ROCS

- Incidents or a series of related incidents which did not occur within the course of, or in connection with, a person's practice as a medical practitioner
- incidents that were notified to the insurer before 1 July 2004
- insurer-to-insurer payments
- incidents that would not normally be covered within the ordinary course of business for the MDO or MII.

High Cost Claim Indemnity Scheme (HCCS)

The High Cost Claim Indemnity Scheme (HCCS) covers claims or incidents notified on or after 1 January 2003. For claims notified on or after 1 July 2004 the HCCS threshold is \$300 000.

The ROCS covers claims or incidents notified on or after 1 July 2004, so in some circumstances an MDO or MII will be entitled to make an application for payment against the same claim under both HCCS and ROCS. Section 5 of the ROCS application form has been designed to enable applicants to submit one application for payment by taking into account itemised HCCS amounts.

If an application is submitted under both the ROCS and HCCS, all subsequent applications should continue to be submitted under both schemes.

What cannot be claimed under HCCS

- Incidents or a series of related incidents which did not occur within the course of, or in connection with, a person's practice as a medical practitioner, or
- incidents that were notified to the MDO or MII prior to 1 January 2003, or
- incidents or a series of related incidents that arise from the treatment of a public patient in a public hospital, or
- incidents that occur or a series of related incidents that all occur outside Australia or one of its external territories. (At least one of the incidents in a related series of incidents must occur within Australia or one of its external territories to be eligible under the HCCS).

Conflict resolution

If a dispute arises from an application for payment under a medical indemnity claim scheme, Medicare Australia will take all necessary steps to resolve the dispute informally with the relevant MDO or MII.

If a satisfactory resolution cannot be reached through an informal process, the applicant may elect to request a review of a decision. The request must be in writing and should set out the details of the dispute.

The internal review is an administrative service that Medicare Australia provides to MDOs and MIIs. It is not set out in the Act or in other legislation. Medicare Australia will notify applicants of the outcome of a request for a review within 28 days of the request being received, unless another timeframe is agreed between the applicant and Medicare Australia.

Applications for review should be forwarded to:

Medical Indemnity Claims section

Medicare Australia

PO Box 9822

Hobart TAS 7001

or fax to **03 6215 5322**

Recovery of payments

Section 41 of the *Medical Indemnity Act 2002* and Section 10 of the Medical Indemnity Protocol 2006 (No. 2) set out the terms and conditions for recovery of over payments and incorrect payments. Unless otherwise notified, all recoveries will be offset against a future claim payment.

Notification to Medicare Australia of certain circumstances

Medicare Australia must be notified within 28 days if any of the following circumstances arise after a ROCS payment has been paid to an applicant:

- the applicant subsequently recovers from a third party an amount paid, which relates to the amount paid to the applicant, or
- the ROCS payment has been made for judgment costs, where the judgment or order becomes subject to an appeal or stay, or
- the amount paid is subsequently part of a claim where the applicant withdraws support for the policy holder or member, or
- the amount paid is later found to be not payable under the terms of the ROCS. For example the policy holder or member had in fact returned to work and was working as a private medical practitioner at the time of the claim notification.

Should the applicant identify an overpayment of any type, please notify Medicare Australia using the medical indemnity refund application form.

Privacy note

Information provided to Medicare Australia in the ROCS payment application form will be used to assess and calculate the amount of indemnity payable. The collection of information is authorised by the *Medical Indemnity Act 2002*.

Information provided may be disclosed to the Department of Health and Ageing or the Australian Government Actuary for the purpose of administering the Act or as authorised by law.

Contact details

Medical Indemnity Claims section

Medicare Australia

PO Box 9822

Hobart TAS 7001

call **1800 813 167****

fax **03 6215 5322**

** Call charges apply from mobile and pay phones only

Part 2: Glossary

Act	The <i>Medical Indemnity Act 2002</i> as amended from time to time.
Aggregation	<p>An amount formed or calculated by the combination of many separate items. For the purposes of ROCS where both an MDO and an MII have paid, or are liable to pay amounts in relation to the same member or policy holder in respect of the same claim, they may aggregate those costs and make a single application for payment.</p> <p>Note: Where the application relates to amounts paid or payable by both an MDO and an MII in relation to the same claim, and the MII elects to aggregate the amounts, the MDO must lodge the application. A Run-off cover indemnity is not payable to the MII in respect of the MII amount if aggregation has been elected—see Sections 31 (for HCCS) or 34ZE (for ROCS) of the Act.</p>
Applicant	<p>The entity applying for a run-off cover indemnity scheme payment. The applicant must be a:</p> <ol style="list-style-type: none">MDO,MII, orMDO or MII under external administration.
Application form	The run-off cover indemnity scheme payment application form approved by the CEO of Medicare Australia under the Act.
Apportionment	The distribution of damages between parties to a claim, proportionate to their legal liability. For the purpose of assessing a ROCS payment application Medicare Australia requires this information in writing.
Claim	<p>Please refer to Section 4 of the Act for a full definition.</p> <ol style="list-style-type: none">A claim or demand of any kind (whether or not involving legal proceedings).Proceedings of any kind including:<ol style="list-style-type: none">proceedings before an administrative tribunal or of an administrative naturedisciplinary proceedings (including disciplinary proceedings conducted by or on behalf of a professional body)an inquiry or investigation.Notification of an incident to an MII or MDO by or on behalf of a medical practitioner.
Claim against a person	Includes an inquiry into, or an investigation of, the person's conduct, or notification of an incident as above.
Claim for contribution	A claim by a party to an action or proceeding to recover a portion of his or her liability from another party who is also liable for the same damage to the plaintiff.
Claim handling fee	An administrative cost, payable under the ROCS Protocol at 5% of the gross claim amount.

Consent judgment	A court decision or document which embodies the settlement terms agreed upon by the parties to proceedings and which is filed in court. Unless set aside or varied, a consent judgment is the final disposition of proceedings. For the purpose of assessing a ROCS payment application Medicare Australia requires this information in writing.								
Costs	The fees, charges, disbursements and expenses incurred in connection with legal work undertaken in relation to the proceeding (by either plaintiff or defendant).								
Costs order	An order of a court or tribunal to pay the costs. These orders are generally made against an unsuccessful party in favour of a successful party. Courts generally have power to determine by whom, and to what extent, costs are to be paid by an unsuccessful party.								
Cost-sharing arrangement	Any arrangement in which legal costs or disbursements are to be shared between parties to a claim or proceedings.								
Costs inclusive settlement	A settlement that includes an unspecified amount for the plaintiff's legal costs and disbursements. If unspecified, these costs are to be claimed entirely under "settlement or judgment amount".								
Damages	Compensation for loss or injury suffered by a plaintiff or claimant as a consequence of an incident involving a defendant.								
Deductibles	Specified amounts a member is required to pay towards each claim. Also known as excess or exceeds. A member may also choose an excess in an effort to reduce their annual premium.								
Defence costs	Legal costs, fees, charges, disbursements and expenses incurred by or on behalf of the defendant(s) to a claim.								
Defendant	A person against whom civil proceedings are brought.								
Discontinuance of proceedings	One of the methods used to end proceedings. A document must be filed with the court, discontinuing proceedings in that forum.								
Excess/Exceeds	Specified amounts a member is required to pay towards each claim. A member may also choose an excess in an effort to reduce their annual premium. Also known as deductibles.								
HCCS	High Cost Claim Indemnity Scheme.								
High cost claim threshold	<p>The amount which a claim must exceed before a high cost claim application can be lodged. The applicable threshold is determined by earliest date the claim or the incident which gives rise to a claim that was notified to the MDO or MII. The high cost claim threshold is fixed within the medical indemnity legislation and reflects the notification date the MDO or MII was first notified of:</p> <p>an incident that gave rise to a claim; or</p> <p>a claim against the member or policy holder.</p> <table border="1"> <thead> <tr> <th>Notification date</th> <th>Applicable threshold</th> </tr> </thead> <tbody> <tr> <td>1 January 2003 to 21 October 2003 (inclusive)</td> <td>\$2 000 000</td> </tr> <tr> <td>22 October 2003 to 31 December 2003 (inclusive)</td> <td>\$500 000</td> </tr> <tr> <td>On or after 1 January 2004</td> <td>\$300 000</td> </tr> </tbody> </table>	Notification date	Applicable threshold	1 January 2003 to 21 October 2003 (inclusive)	\$2 000 000	22 October 2003 to 31 December 2003 (inclusive)	\$500 000	On or after 1 January 2004	\$300 000
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22 October 2003 to 31 December 2003 (inclusive)	\$500 000								
On or after 1 January 2004	\$300 000								

IBNR	Incurred-But-Not-Reported Indemnity Scheme
Incident	An act, omission or circumstance and includes an alleged incident.
Incident-occurring based cover	<p>For the purposes of subparagraph 34ZB(1)(e)(ii) of the Act), an arrangement that existed between a MDO and a person on 30 June 2002, under which the MDO would, in the ordinary course of business, indemnify a person for incidents occurring within their period of membership.</p> <p>Note: incident-occurring based cover is defined in greater detail in Section 7 of the Act.</p>
Insurer-to-insurer payment	A payment that is made by an MDO or insurer to an MDO or an insurer, and is not made by the MDO or insurer on behalf of another person – see section 4 of the Act.
Judgment	The decision of a court, or a court order for the payment of compensation, costs or otherwise. A person will generally have a right to appeal to a higher court against a judgment of a lower court.
Medicare Australia's claim identifier	The claim identifier which is unique for each medical indemnity claim made against a practitioner.
Medical Defence Organisation (MDO)	<p>Defined by Section 5 of the Act as:</p> <ol style="list-style-type: none"> a) a body corporate that is incorporated by or under a law of the Commonwealth, a state or territory, and b) a body corporate that was in existence on 30 June 2002, and c) a body corporate that, in the ordinary course of its business as at 30 June 2002, indemnified persons relating to claims in relation to incidents that occurred in the course of, or in connection with, the practice of a medical profession by a person provided that person was a member or former member of the body corporate or the legal personal representative of a member or former member of the body corporate. <p>Note: even if indemnity is provided at the discretion of the body corporate, if it comes within the scope of the above definition, the body corporate entity is an MDO for the purposes of the Act.</p>
Medical indemnity cover	<p>In Section 4 of the Act, a contract of insurance provides medical indemnity cover for a person if:</p> <ol style="list-style-type: none"> (a) the person is specified or referred to in the contract, whether by name or otherwise, as a person to whom the insurance cover provided by the contract extends, and (b) the insurance cover indemnifies the person (subject to the terms and conditions of the contract) in relation to claims that may be made against the person in relation to incidents that occur or occurred in the course of, or in connection with, the practice by the person of a medical profession. <p>Note: a single contract of insurance may provide medical indemnity cover for more than one person.</p>
Medical Indemnity Insurer (MII)	In Section 4 of the Act, a body corporate that is authorised to carry on insurance business in Australia under the <i>Insurance Act 1973</i> , or a Lloyd's underwriter, and in carrying on that business enters into contracts of insurance to provide medical indemnity cover.

Medical practitioner	In Section 4 of the Act, a person registered or licensed as a medical practitioner under a state or territory law or a person who has been a medical practitioner.
Member	A person who is a member or former member of an MDO.
Party or parties	The person(s) or organisation(s) that make or respond to a claim.
Payment made in relation to a claim	In subsection 4(3) of the Act, an amount is a payment in relation to a claim if: <ul style="list-style-type: none"> a) it is made to satisfy or settle a claim, or b) it is made to meet legal or other expenses that are directly attributable to any negotiations, arbitration or proceedings in relation to the claim.
Plaintiff	A person or persons who commence civil action in a court.
Policy holder	A person who held or holds a contract of insurance with an MII.
Private medical practice	In subsection 34ZB (5) of the Act, practice as a medical practitioner, other than: <ul style="list-style-type: none"> a) practice consisting of treatment of public patients in a public hospital, or b) practice for which: <ul style="list-style-type: none"> (i) the Commonwealth, a state or a territory, or (ii) a local governing body, or (iii) an authority established under a law of the Commonwealth, a state or a territory; indemnifies medical practitioners from liability relating to compensation claims (within the meaning of the <i>Medical Indemnity (Prudential Supervision and Product Standards) Act 2003</i>); or <ul style="list-style-type: none"> c) practice conducted wholly outside both Australia and the external territories, or d) practice of a kind specified in the regulations.
Public hospital	A recognised hospital within the meaning of the <i>Health Insurance Act 1973</i> .
Public patient	Has the same meaning as in the <i>Health Insurance Act 1973</i> . ‘public patient, in relation to a hospital, means a patient in respect of whom the hospital provides comprehensive care, including all necessary medical, nursing and diagnostic services and, if they are available at the hospital, dental and paramedical services, by means of its own staff or by other agreed arrangements.’
Qualifying payments	In the HCCS these are amounts paid or liable to be paid by an MDO or MII as defined by subsection 30(2) of the Act. (See also ‘qualifying payments’ page 5 in these guidelines).
Run-off cover indemnity	A run-off cover indemnity paid or payable under Division 2B of Part 2 of the Act. Note: amounts payable under the ROCS Protocol are not covered by this definition.
ROCS	Run-off Cover Indemnity Scheme
ROCS Protocol	The Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006, No 2 (as amended and in force from time to time) determined by the Minister under Section 34ZN of the Act.

Remuneration	To pay someone for work or services done. Payment may be in the form of money, gifts or other gratuities.
Settlement	The compromise or resolution of a claim or dispute agreed to by the parties.
Unrecoverable GST amount	The amount of goods and services tax (GST) that may not be claimed back as an input tax credit.

Speciality codes

Code	Classification
CANAES	Anaesthetist
CDERMI	Dermatologist
CDIETN	Dietician
CGPCOS	General Practitioner with Cosmetic Surgery
CGPNPR	General Practitioner—Non-procedural
CGPOBS	General Practitioner with Obstetrics
CGPPRC	General Practitioner—Procedural
CGYNAE	Gynaecologist (no obstetrics)
COBSTE	Obstetrician (including gynaecology)
CPATHO	Pathologist
CPHYSN	Physician—Non-procedural
CPHYS P	Physician—Procedural
CPSYCH	Psychiatrist
CRADOL	Radiologist
CSRCOS	Cosmetic / Plastic / Reconstructive Surgeon
CSRGEN	General Surgeon
CSRNEU	Neurosurgeon
CSRORT	Orthopaedic Surgeon
CSROTH	Surgeon—not otherwise classified
COTHER	Medical practitioner not otherwise classified

Part 3: Guidelines for completing the Run-off Cover Indemnity Scheme (ROCS) payment application form

Note: The *Medical Indemnity Act 2002* is abbreviated to the Act
The *Medical Indemnity (Prudential Supervision & Product Standards) Act 2003* is abbreviated to the PSPS Act

Section 1: Claim details

Questions 1–10

Question 1	Applicant's registered business name (and company name if applicable).	The full registered business name of the MDO or MII who is applying for a ROCS payment and the company name if the applicant is a company.
Question 2	Claim identification reference.	The unique identification number allocated by the MDO or MII to the claim against the member or policy holder.
Question 3	Member or policy holder identification number.	The unique identification number allocated by the MDO or MII to the member or policy holder named in question 4 who is the subject of the claim.
Question 4	Full name of the member or policy holder who is the subject of the claim.	A separate application form must be submitted by the applicant for each ROCS eligible member or policy holder that the applicant is seeking payment for in relation to the same claim.
Question 5	If the member or policy holder is deceased and the claim is made against their legal representative, the full name of the legal representative.	In the case of deceased members, complete both question 4 and question 5
Question 6	Member or policy holder's Medicare provider number.	As a general rule, most medical practitioners apply for a Medicare provider number when they wish to have Medicare benefits payable for their services. Medicare provider numbers are allocated to medical practitioners to provide an easy method of identifying the place from which the service is provided. The provider number required is the full provider number at the location of the medical practitioner's practice at the time the incident occurred (even if the practitioner has more than one provider number). In rare cases where a ROCS eligible member or policy holder does not have a Medicare provider number please write N/A.
Question 7	Member or policy holder's speciality code.	Show only the speciality code for the speciality that the member or policy holder was practising at the time the incident occurred (even if the practitioner has more than one speciality).

Question 8	Date of the incident or a date range of a series of related incidents.	For a single incident, the date the incident occurred that gave rise to the claim, or may give rise to a claim. For a series of related incidents, the date range of the incidents that occurred that gave rise to the claim, or may give rise to a claim.
Question 9	Where did the incident or series of incidents occur?	Providing all the ROCS requirements are met, ROCS indemnity may be payable to an applicant even if an incident to which the claim relates occurred outside Australia and the external territories (Section 34ZF(b) of the Act).
Question 10	Full name(s) of the plaintiff(s) who made the claim.	The application form must include the full name of all plaintiff(s) who have lodged the claim against the member or policy holder named in question 4 of the application for payment.

Section 2: ROCS eligibility criteria

Questions 11—16

Question 11	Date the member or policy holder become eligible for ROCS.	The first date on which the member or policy holder met one of the ROCS eligibility criteria, under which they were still eligible at the time of notification, as set out in question 16 (Section 34ZB(2) of the Act and associated Regulation 12).
Question 12	Date the applicant was first notified of either the claim or the incident that gave rise, or may give rise to a claim.	The date that the applicant was notified of the claim or of the incident: <ul style="list-style-type: none"> • by the member or policy holder, or • through a subpoena, statement of contribution from another party, or other claim documentation. A ROCS indemnity payment will not be payable if this date is before 1 July 2004 (Section 34ZC(d) of the Act). A copy of documentation showing the date of notification must be submitted to Medicare Australia with the application form.
Question 13	Does the claim relate to an incident or a series of related incidents that occurred in the course of, or in connection with, the member or policy holder's practice as a medical practitioner?	ROCS will only cover claims that arise from or occur in connection with a member or policy holder's practice as a medical practitioner (Section 34ZB(1)(b) of the Act).

Question 14	Was the member or policy holder registered or licensed as a medical practitioner under a state or territory law at the time the incident(s) giving rise to the claim occurred?	It is a requirement of ROCS that the member or policy holder must have been registered under a state or territory law as a medical practitioner at the time of incident.
Question 15	Does the member or policy holder have medical indemnity cover under ROCS that indemnifies them in relation to the claim?	<p>Claims will be paid only where they are indemnified under:</p> <ul style="list-style-type: none"> • a ROCS contract granted by an MII (Section 26A of the PSPS Act) in the ordinary course of business, or • incident-occurring based cover by an MDO in the ordinary course of business (Section 34ZC of the Act).
Question 16	For this to be an eligible claim under ROCS, the person against whom the claim was made must have satisfied one or more of the ROCS eligibility classes at the time the claim or incident was first notified to the applicant.	<p>Maternity and permanent disability</p> <ul style="list-style-type: none"> • (E) maternity <p>or</p> <ul style="list-style-type: none"> • (F) permanent disability <p>The original completed maternity or permanent disability certificate completed by a medical practitioner who is not the member or policy holder is required.</p> <p>It is a legislated requirement that this medical certificate is supplied. You can not provide evidence of maternity or permanent disability with a statutory declaration only.</p> <p>All other eligibility classes</p> <p>A statutory declaration is sufficient evidence of eligibility. However the following documents should be supplied if obtainable:</p> <ul style="list-style-type: none"> • (G) Policy holder is deceased—copy of the death certificate. • (H) Subclass 422 or a subclass 457—a copy of the visa documentation. <p>If copies of the visa or death certificate can not be provided with the application for payment, a statutory declaration (the original, not a copy) must be attached, detailing the circumstances satisfying the eligibility requirements. The statutory declaration must be signed by the member or policy holder.</p> <p>Refer to Section 34ZB(2) of the Act and associated Regulation 12 for further information regarding eligibility.</p>

Section 3: Application details

Questions 17–28

Question 17	Applicant's registered business name (and company name if applicable).	The full registered business name of the MDO or MII applying for a ROCS payment and the company name if the applicant is a company.
Question 18	Applicant's Australian Business Number (ABN).	The Australian Business Number of the applicant who is applying for a ROCS payment.
Question 19	Is the applicant under external administration?	Indicate if the applicant applying for a ROCS payment is under external administration.
Question 20-24	Contact person's details	Full contact details of the person responsible for any correspondence initiated by Medicare Australia in relation to the application for a ROCS payment.
Question 25-26	Account details for EFT payments.	Full bank account details for any payments to be made in relation to this ROCS claim.
Question 27	Medicare Australia's claim identifier.	For all first applications, please leave this field blank. Medicare Australia will inform the applicant of the unique claim identifier in the format ARN000-D. The unique identifier must be included in all subsequent applications for payment and correspondence lodged by the applicant in respect of the same claim.
Question 28	What is the estimated outstanding liability for this claim for the member or policy holder named in this application for payment?	The estimated future reserve for the costs or damages to be incurred in connection with the claim against the member or policy holder. The estimated amount should not include any payments made in relation to the claim prior to submitting this application for payment. If this estimation accounts for potential future contributions for other parties, Medicare Australia requires: <ul style="list-style-type: none">• name of party who may make a contribution• estimated amount of liability (\$).
Question 29	Has a Medical Indemnity Insurer (MII) elected to aggregate the amount(s) in this application for payment?	Where both the MDO and MII have paid, or are liable to pay amounts in relation to the same member or policy holder in respect of the same claim, they may aggregate those costs and make a single application for payment (Section 34ZE of the Act). In this case, the application for payment must be lodged by the MDO. No application can be made by the MII. A written election form (Section 6 must be completed by the MII for each member or policy holder for whom the costs have been aggregated.

Question 30	<p>Are the payments claimed in this application for payment, made:</p> <p>a) consistently with an indemnity arrangement and</p> <p>b) in the ordinary course of business?</p>	<p>Applicants should note that ROCS is designed to mirror the last indemnity cover the medical practitioners had. Claims should be handled as they would by MIs or MDOs in the ordinary course of business (Section 34ZC of the Act).</p>
Question 31	<p>Has this claim been finalised?</p>	<p>A claim may be finalised by way of judgment, settlement, claim withdrawn (discontinued), deed of release or by some other method.</p> <p>In the course of a claim being discontinued:</p> <ul style="list-style-type: none"> • the parties may have entered into an agreement in respect of costs incurred in the matter, or • the court may have ordered the payment of costs by a particular party. <p>A copy of all the documentation finalising the claim must be submitted to Medicare Australia with the application form.</p>
Question 32	<p>Is this the final application for payment against this claim?</p>	<p>This information is required so that Medicare Australia can provide accurate reports to the Australian Government Actuary on the number of claims that have been finalised.</p>

Section 4: Apportionment and cost-sharing arrangements

Questions 33—34

Question 33	<p>Has liability for this claim been apportioned (divided) between parties to the claim?</p>	<p>Apportionment refers to the division of damages between parties to a claim, proportionate to their legal liability.</p> <p>The amount of damages apportioned, if any, to other members or policy holders that are not the subject of this application is to be shown in question 39 and deducted from the amount sought in this application in question 41.</p> <p>If the application includes an amount paid to satisfy or settle the claim, the applicant must provide details of any apportionment of liability for all members or policy holders subject to this claim, including the member or policy holder subject to this application. If there is an apportionment, Medicare Australia requires for each party:</p> <ul style="list-style-type: none"> • the Medicare Australia claim identifier (if known) • full name • the percentage of liability attributable • an indication as to whether an application form will be lodged for the member or policy holder from the applicant • if the application will be for ROCS, HCCS or an IBNR claim.
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continued next page.

Question 33
continued...

Evidence of the apportionment liability must be provided at the time of the application.

Where the applicant's in-house legal advisors or an external law firm act for a Medical Indemnity Claim Scheme indemnified member or policy holder and a non-Medical Indemnity Claim Scheme indemnified member or policy holder certification of apportionment is required from an independent barrister.

Question 34 Are there any cost-sharing arrangements?

Cost-sharing arrangements apply if there is an agreement between parties to share the costs or disbursements incurred in connection with a claim or part thereof.

Any cost-sharing amounts relating to members or policy holders or other parties that are not the subject of this application are to be deducted from the amount sought in this application.

If there are cost-sharing arrangements Medicare Australia requires for each party:

- the Medicare Australia claim identifier (if known)
- full name
- amount of the liability attributable
- All amounts attributed to other parties (as a deduction at question 39).

Section 5: Amounts being claimed

Questions 35—44

Total application cost

Question 35 Judgment or settlement amount (net of exceeds or deductibles).

The judgment or settlement amount refers to the amount of money that a court orders to be paid as damages. This amount may include GST that is unrecoverable by the applicant through normal taxation avenues.

To be eligible to claim a judgment or settlement amount the amount being claimed must not be under appeal.

Question 36 Amount of plaintiff's legal costs or disbursements payable under the judgment or settlement.

These are the legal costs incurred by the plaintiff who made the claim against the member or policy holder.

The only time the plaintiff's costs should appear on the ROCS application form

is if costs have been awarded in the judgment to the plaintiff or if they form part of a settlement between the parties involved in a claim.

If the settlement amount includes plaintiff costs and the amount of plaintiff costs are not specified, leave this question blank and include the total amount (including plaintiff costs) in the judgment or settlement amount field (question 35).

Question 37	Amount of applicant's defence costs or disbursements.	<p>These are the legal costs associated with the defence of the member or policy holder. The defence costs can be incurred through the engagement of the applicant's internal legal team or an external legal service provider acting on behalf of the applicant.</p> <p>Costs incurred in connection with the notification of the incident, prior to the time the claim is made, can be included here.</p> <p>Any defence costs claimed must be verified by invoices attached to the application for payment.</p>
Question 38	Gross application cost.	<p>The total cost of this application before any deductibles have been removed.</p> <p>This is the sum of all amounts claimed in questions 35, 36 and 37.</p> <p>(A + B + C) on the application form.</p>
Question 39	<p>Less any amount:</p> <ul style="list-style-type: none"> • apportioned to members or policy holders that are not the subject of this application • attributed to other parties under a cost-sharing arrangement • not payable under the ROCS (see guidelines and the Act). 	<p>Amounts for which other parties are responsible, or which relate to incidents or claims which are not payable under ROCS, and therefore must be subtracted from the amounts being claimed in the application.</p> <p>ROCS does not cover:</p> <ul style="list-style-type: none"> • incidents or a series of related incidents that do not occur within the course of, or in connection with, a person's practice as a medical practitioner, or • incidents for which the MDO or MII is not liable to make a payment in relation to the claim (for example, procedures subject to exclusions), or • incidents or a series of related incidents that were notified before 1 July 2004, or • claims that involve insurer-to-insurer payments, or • incidents or a series of related incidents that would not be covered within the ordinary course of business for the MDO or MII.
Question 40	Total deductions.	<p>The total of all deductions allowable for this claim.</p> <p>This is the sum of all amounts claimed in question 39.</p> <p>(E + F + G) on the application form.</p>
Question 41	Total application cost.	<p>The total cost of this application once all deductibles have been subtracted.</p> <p>This is the difference between the amounts claimed in questions 38 and 39.</p> <p>(D - H) on the application form.</p>
Question 42	Total of payments made previously under the ROCS (net of the claim handling fee).	<p>Any amounts paid to the MDO or MII under ROCS for this claim previously must be included here to enable correct assessment of the HCCS threshold.</p>

Question 43	Total amount relevant to this claim.	The total of previous payments relevant to this claim and the net application cost for this application. This is the sum of all amounts claimed in questions 41 and 42. (I + J) on the application form.
Question 44	Is the total amount relevant to this claim (K) more than \$300 000?	If the total amount relevant to this claim (K) is greater than \$300 000 and the incident or at least one of a series of related incidents occurred in Australia or one of its external territories, complete the HCCS eligibility and recovery sections (question 45 onwards). If not, go to the ROCS recovery section (question 55 onwards).

Questions 45—46

HCCS eligibility

Question 45	Did the incident occur within Australia or one of its external territories?	To be eligible for a HCCS payment the incident, or at least one of a series of related incidents, must have occurred in Australia or one of its external territories. Australia's external Territories are: <ul style="list-style-type: none"> • Norfolk Island • Ashmore and Cartier Islands • Christmas Island • Cocos (Keeling) Island • Coral Sea Islands • Australian Antarctic Territory • Heard and McDonald Islands. Applications relating solely to an incident(s) that occurred outside Australia or its external territories are not eligible for a HCCS payment (Section 31(c) of the Act).
Question 46	Does the claim relate to an incident or a series of incidents that occurred in the course of, or in connection with, the member or policy holder's practice as a medical practitioner?	The relevant incident giving rise to the claim must have occurred in the course of, or in connection with, the person's practice in a medical profession. The practice of a medical profession means any professional activity for which registration as a medical practitioner is required. An incident that occurs outside the scope of these circumstances will not be reimbursed under the HCCS (Section 4(1) and 30(1)(b) of the Act).

Questions 47—54

High Cost Claim Scheme (HCCS) recovery

Question 47	Total claim costs.	The total amount relevant to the application. (K) in question 43 of the application form. Note: to be eligible to apply for a HCCS payment in this application the amount in (K) must be greater than the HCCS Threshold amount of \$300 000.
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Question 48	Less any amounts not claimable under the HCCS.	See the Act for a full description of items to be deducted. Any amounts that are not claimable under HCCS are to be deducted from the amount the applicant is claiming on this application form. Amounts are not claimable under the HCCS if they relate to: <ul style="list-style-type: none"> the provision of treatment to a public patient in a public hospital (Section 32 of the Act), or an incident that occurred outside Australia or it's external territories unless an incident in the series occurred in Australia or it's external territories (Section 30 of the Act), or incidents or a series of related incidents which did not occur within the course of, or in connection with, a person's practice as a medical practitioner and the MDO or MII is not liable to make a payment in relation to the claim (if these amounts have not been already deducted in question 39), or incidents or a series of related incidents that were notified to the MDO or MII prior to 1 January 2003.
Question 49	Total HCCS application costs.	The amount in question 47 less any amount recorded in question 48. (L – M) on the application form.
Question 50	Less the HCCS threshold.	The prescribed HCCS threshold for ROCS claims notified on or after 1 July 2004 is \$300 000 (Regulation 5 in relation to Section 29(1)(b) of the Act).
Question 51	Total above the threshold.	The amount in question 49 less the HCCS threshold in question 50. (N – O) on the application form.
Question 52	Amount claimable under HCCS (50% of P).	The amount in question 51 divided by 2. (P ÷ 2) on the application form (Section 34 of the Act).
Question 53	Less previous amounts claimed under HCCS for this claim.	Any amount previously paid to the applicant under the HCCS must be deducted to ensure correct payment.
Question 54	Total HCCS amount for this application.	The HCCS amount in question 52 less previous amounts paid under the HCCS for this claim in question 53. (Q – R) on the application form.

Questions 55—57

Run-off Cover Indemnity Scheme (ROCS) recovery section

Question 55	Total application costs.	The amount in question 41. (I) on the application form.
Question 56	Less any amounts claimed under the HCCS.	The amount in question 54. (S) on the application form.
Question 57	Total ROCS amount.	The amount in question 55 less the amount in question 56. (T – U) on the application form.

Questions 58—60

Total application amounts

Question 58	Total ROCS/HCCS amount.	The amount of question 58 (if applicable) plus the amount in question 57. (S + V) on the application form.
Question 59	Claim handling fee	5% of the amount in question 58. Note: the claim handling fee is set at 5% of the total ROCS/HCCS amount. (5% of W) on the application form.
Question 60	Total amount claimed in this application.	The amount in question 58 plus the amount in question 59. (W + X) on the application form.

Section 6: Written election form

In accordance with sections 31 and 34ZE of the Act, an MDO and an MII may elect to aggregate amounts paid or amounts that are payable in respect of the same claim against a member or policy holder, so that the claim may qualify for payment under the ROCS/HCCS.

The written election form must be completed by a person authorised to act on behalf of the MII and must accompany the application form for a ROCS/HCCS payment.

The application **must be submitted by the MDO with the written election form completed and signed by the MII.**

Section 7: Statutory declaration form

The statutory declaration must be completed, signed by a person authorised to sign on behalf of the MDO or MII, dated and appropriately witnessed.

The statutory declaration, among other things, verifies that:

- the answers to the questions in the attached application form are correct to the best of the applicant's knowledge and belief,
- the requested documents are attached and (where applicable) are true copies of the original documents, and
- all payment(s) in relation to the claim against the member or policy holder nominated in the application form were made by the applicant in the ordinary course of their business
 - consistently with the indemnity arrangements between the MDO and the member, or
 - consistently with the terms of the insurance contract between the MII and the policy holder.

Persons authorised by the *Statutory Declarations Act 1959* and regulations to witness a statutory declaration include a medical practitioner, dentist, legal practitioner, registered nurse, patent attorney, pharmacist, physiotherapist, optometrist, members of the Institute of Chartered Accountants in Australia, the Australian Society of Certified Practising Accountants, National Institute of Accountants, Association of Taxation and Management Accountants, and a justice of the peace. A comprehensive list is attached to the ROCS application form.
