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CTP INSURANCE REGULATOR

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Rules

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The Scheme, the CTP Regulator and the Rules

Overview of the Scheme

Compulsory Third Party (**CTP**) insurance protects motorists from the financial impact of causing injury or death as a result of a motor vehicle accident anywhere in Australia. The South Australian CTP Insurance Scheme (**Scheme**) is fault-based, meaning a claim must be made against the insurer of an at-fault vehicle. Drivers who were entirely at fault for an accident, or involved in an accident where no person was at fault, are not covered by the Scheme.

However, the Scheme provides funding for reasonable and necessary treatment, care and support to children injured while under the age of 16 in South Australia, regardless of fault.

The Scheme ensures that people injured by others in motor vehicle accidents have access to funding for reasonable and necessary treatment, care and support. Depending on the severity of their injuries, an injured person may also be eligible for compensation.

CTP insurance is paid for at the same time as motor vehicle registration. The policy attaches to the vehicle, not the purchaser. This means that CTP insurance protects the owner of the vehicle and anyone who drives or is a passenger in or on the vehicle.

There are five Government approved insurers providing CTP insurance in South Australia: AAMI, Allianz, NRMA, QBE and Youi. Motorists choose between these insurers when renewing their vehicle registration. The CTP Insurers provide the Policy of Insurance (which is identical for all CTP Insurers) and manage claims made against the policy. They are required to act in the best interests of policy holders, injured people, and the CTP Scheme. The insurers obligations are set through contractual arrangements with the State, including compliance with these Regulator Rules and with the laws applying to CTP insurance, including those set out in the *Motor Vehicles Act 1959* (**MV Act**), *Civil Liability Act 1936* (**CLA**), and *Civil Liability Regulations 2013* (**CLR**).

The CTP Scheme is complemented by the Lifetime Support Scheme, which provides treatment, care and support to people who have sustained very serious injuries in motor vehicle accidents in South Australia, regardless of fault. A person may have a CTP claim and be a participant in the Lifetime Support Scheme at the same time.

Role of the CTP Regulator

The CTP Regulator is an independent Statutory Authority established under the *Compulsory Third Party Insurance Regulation Act 2016*. The CTP Regulator monitors and regulates South Australia's CTP Scheme for the benefit of road users and injured people. The Regulator is responsible for:

- Overseeing, monitoring and reporting of CTP Insurer activities in South Australia
- Maintaining a fair and affordable Scheme
- Continuing to improve Scheme outcomes for injured people
- Overseeing the CTP insurance premium setting process
- Providing information to the community about the Scheme and CTP Insurers.

Purpose of the Rules

The Rules:

- Set out obligations for CTP Insurers and provide guidance for Scheme stakeholders about the operation of the Scheme. The aim is to ensure fairness, transparency, and consistency of service standards for motorists and injured people regarding market practice, claims management, and dispute resolution processes.
- Apply to all CTP Insurers approved by the South Australian Government to provide CTP insurance to South Australian motor vehicle owners for accidents occurring on or after 1 July 2016.
- Do not override or substitute CTP Insurers' obligations under the MV Act, the CLA or other relevant legislation or applicable common law, which obligations prevail to the extent of any inconsistency.

All reasonable care has been taken to ensure the information published is correct. The Rules:

- Provide general information only and are not intended to be exhaustive
- Are continuously reviewed, and subsequent updates will be published
- Are available to the public to make the Scheme more efficient
- Contain information on policy and legal matters which may be subject to alternative interpretation
- Are not intended to be a substitute for legal advice.

Definitions

accident means a collision or impact caused by, or arising out of, the use of a motor vehicle;

Accredited Medical Practitioner (AMP) means an Accredited Health Professional as described in the CLR (i.e. a person who is accredited under a scheme established by the designated Minister pursuant to section 76(2) of the CLA);

ARF means an Accident Report Form in such form as may be issued by the Regulator from time to time;

ASIC means the Australian Securities and Investments Commission;

Australian Privacy Principles means the principles described as the 'Australian Privacy Principles' in the *Privacy Act 1988* (Cth), as amended and replaced from time to time;

business day means any day except Saturdays, Sundays and declared public holidays in South Australia;

business hours means 0830 to 1700 hours Australian Central Standard Time;

child means a person under the age of 18 years;

CLA means the *Civil Liability Act 1936* (SA), as amended and replaced from time to time;

claim means a claim for loss or damage:

(a) under, asserted to be under, or capable of being validly made under, a Policy; or

(b) a nominal defendant claim;

claimant means an individual who makes a claim or on whose behalf a claim is made, including their properly appointed representative, agent or their lawyer where applicable;

claimant's lawyer means a legal practitioner acting in that capacity on behalf of a claimant in relation to the claimant's claim;

claim form means an Injury Claim Form or Fatality Claim Form approved by the designated Minister; or any other form prescribed by the Regulator to facilitate claims management;

CLR means the *Civil Liability Regulations 2013* (SA), as amended and replaced from time to time;

complaint means an expression of dissatisfaction relating to a CTP Insurer operating its CTP insurance business;

complainant means a person who makes a complaint;

conciliator means a person suitably qualified to be a conciliator;

CTP insurance means compulsory third party insurance under Part 4 of the MV Act;

CTP insurance business means business relating to CTP insurance;

CTP Insurer means any person or body (whether incorporated or not) approved by the designated Minister under Part 4 of the MV Act to carry on CTP insurance business in South Australia, including any legal representative acting on their behalf, but excludes the Motor Accident Commission;

customer means a person who holds or intends to hold a Policy with a CTP Insurer;

data means all hard copy and electronic representation of Scheme information including:

(a) open, closed and archived documents;

(b) accounts, records and all other information relating to claims made against the Scheme;

(c) document reproduction, document imaging, correspondence and file communication;

(d) reports and reporting specifications which outline how each reported data element is defined or derived; and/or

(e) any other storage form directed by the Regulator;

GEPIC means *The Guide to the Evaluation of Psychiatric Impairment for Clinicians* prepared by MWN Epstein, G Mendelson and NHM Strauss as published in the Victorian Government Gazette on 8 May 2008;

good faith to act in good faith means to act cooperatively with fairness, honesty, decency and respect;

guardian means a person who is the parent or legal guardian of a child or a person under legal incapacity; or a person appointed as the litigation guardian of the child or person under legal incapacity;

health professional means a legally qualified medical practitioner, registered occupational therapist, registered physiotherapist, registered chiropractor, or health practitioner designated under section 4 of the RTW Act;

IDR means internal dispute resolution which provides a process for a claimant or motor vehicle owner to resolve a complaint or dispute directly with the CTP Insurer;

IME means an independent medical examination;

IME examiner means a legally qualified medical practitioner conducting an IME, but who is not the claimant's treating medical practitioner;

incentive means any reward, benefit or gift, including a commission or rebate, membership or loyalty program, administration payment or general financial support offered or provided, directly or indirectly, to the customer or any other person (and includes for the avoidance of doubt any inducement), unless permitted by the MV Act. Without limiting the foregoing, "incentive" includes:

(a) the offering of any inducement; and

(b) the offering or provision of any benefit given directly or indirectly in respect of a product or service sold or distributed by or through a CTP Insurer or any related company of a CTP Insurer, where that benefit is given by reason of or in connection with the actual or proposed issue or holding of a Policy;

independent assessment has the meaning given to that term in Rule 8.1;

inducement means any commission, discount, gift, rebate or any other form of financial benefit or inducement within the meaning of section 129A of the MV Act;

injury means:

(a) bodily injury including pure mental harm or nervous shock; or

(b) where the context admits – the death of a person;

insured person means a person insured by a Policy that complies with Part 4 of the MV Act;

interim payment means an advance payment of monies the subject of a claim that would otherwise not be available until settlement of a claim;

investigation provider means an investigator licensed under the *Security and Investigation Industry Act 1995* (SA), as amended and replaced from time to time;

ISV means the injury scale value described in the CLR;

ISV medical assessment means an independent assessment conducted by an AMP for the purposes of the CLR;

LA Act means the *Limitation of Actions Act 1936* (SA);

litigation guardian means a person (which may be the parent or guardian of the claimant) who acts as a personal representative of a claimant in respect of any legal proceedings or litigation because the claimant is under a legal incapacity due to age, disability or other such reasons as governed by the UCR;

LSA means the Lifetime Support Authority of South Australia established under the LSS Act;

LSS means Lifetime Support Scheme as established under the LSS Act;

LSS Act means *Motor Vehicles (Lifetime Support Scheme) Act 2013* (SA), as amended and replaced from time to time;

marketing communications materials means all marketing communications, advertising, public information, promotional campaigns, commercial sponsorships and other materials related to a CTP Insurer's CTP insurance business, which a CTP Insurer wishes to publish, communicate or release to the market;

medical report includes any clinical information provided by a health professional that the claimant or CTP Insurer obtains in relation to the claim;

mid-term nomination, without limiting any rights that may arise under section 99A(9A) of the MV Act, means a non-binding nomination of a CTP Insurer by a customer at any time during the term of the customer's Policy;

month means:

(a) a calendar month; or

(b) if calculating a month from a certain date, the period from that date to the day prior to the same date in the next calendar month (or if the next month does not contain the same date then the last day of the next month);

motor vehicle means a vehicle that is built to be propelled by a motor that forms part of the vehicle, as described in the MV Act;

MV Act means the *Motor Vehicles Act 1959* (SA), as amended and replaced from time to time;

MVR means the *Motor Vehicle (Third Party Insurance) Regulations 2013* (SA), as amended and replaced from time to time;

nominal defendant means a person appointed by the Minister to be the nominal defendant, and for the time being holding that appointment, as described in the MV Act;

nominal defendant claim means a claim for loss or damage:

(a) against, or capable of being validly made against the nominal defendant as contemplated by Part 4 of the MV Act; or

(b) in relation to a self-propelled wheelchair or other motor vehicle that is taken to be subject to a Policy, as described in section 12A of the MV Act;

person under a legal incapacity means a child or any person (whether under statutory protection or not) who by reason of physical or intellectual impairment is unable to give sufficient instructions to conduct or compromise a claim or legal proceedings;

personal information has the meaning given by the Privacy Act, or where the context relates to another privacy law the corresponding term and meaning given by that privacy law (for example, the relevant term is 'personal data' under the *General Data Protection Regulation 2017/679*);

personnel means any employee or contractor of a CTP Insurer who is engaged by the CTP Insurer in conducting the CTP insurance business but not including third party service providers or subcontractors;

Policy has an equivalent meaning to the term "policy of insurance" as used in the MV Act;

prescribed authority means a statement authorising the CTP Insurer to access documentary information relevant to the claim, as required by section 126A(2)(d) of the MV Act;

Privacy Act means *Privacy Act 1988* (Cth) as amended or replaced from time to time;

privacy laws means, as applicable:

(a) the Privacy Act including the Australian Privacy Principles (irrespective of whether the CTP Insurer would otherwise be required to comply with the Australian Privacy Principles at law);

(b) the confidentiality provisions in section 139D of the MV Act as amended or replaced from time to time;

(c) any other Australian or overseas privacy related statute, regulation, directive, standard, by-law, ordinance, subordinate legislation, industry code of conduct or government order, decree or other instrument which a CTP Insurer is required to comply with whether by operation of law or contract in connection with its CTP insurance business;

Regulator means the State acting through its designated agent the CTP Regulator established under the *Compulsory Third Party Insurance Regulation Act 2016* (SA);

related entity has the meaning defined in section 9 of the *Corporations Act 2001* (Cth);

Return to Work SA means the Return to Work Corporation of South Australia trading as ReturnToWorkSA established pursuant to the *Return to Work Corporation of South Australia Act 1994* (SA), as amended and replaced from time to time;

RTW Act means the *Return to Work Act 2014* (SA);

Scheme means the South Australian Compulsory Third Party Insurance Scheme;

Scheme stakeholders means any party that may have an interest in and/or provide services to the Scheme, aside from a CTP Insurer;

subcontractor means any subcontractor or agent engaged by a CTP Insurer to fulfil all or part of its obligations to conduct CTP insurance business, not including a third party service provider;

third party service provider means any person who provides services to a CTP Insurer for the purposes of conducting CTP insurance business;

treatment, care and support services means medical treatment (including pharmaceuticals); dental treatment; rehabilitation; ambulance transportation; aids and appliances; prostheses; and such other kinds of treatment, care support or services as may be prescribed by the MVR;

UCR means the *Uniform Civil Rules 2020,* as amended and replaced from time to time*;*

unsolicited contact includes targeted contact with customers or potential customers of any kind, including via mail, email, telephone, text message, selective online advertising or social media, whether in person or by any other method;

vulnerable customer means a customer who, because of personal circumstances or the actions of others, is especially susceptible to loss, harm or disadvantage. Vulnerability may be due to: language or literacy barriers; disability; domestic and family violence; mental health; or other circumstances.

1 Market practice

1.1 Act in good faith with all customers

1.1.1 CTP Insurers are required to:

(a) accept all motor vehicles required to be insured under the MV Act for the issue of a Policy; and

(b) provide timely service to all customers who approach them for information, irrespective of the risk characteristics of the motor vehicle and/or its owner.

1.1.2 CTP Insurers and their agents must use processes and business practices that do not unfairly discriminate against individual, or groups of, customers or claimants. With the exception of pricing differentiation otherwise expressly permitted under the Rules, CTP Insurers and their agents must treat customers and claimants in the same manner irrespective of the risk profile of the motor vehicle, or customer or claimant, or the term of the Policy.

1.1.3 CTP Insurers must avoid marketing techniques that prejudice this Rule 1.1 in any way.

1.1.4 CTP Insurers and their agents must not encourage customers to take their business to another CTP Insurer.

1.2 Transparent and practical business processes

1.2.1 A CTP Insurer's communication with the customer or claimant must include any information required by the Regulator. The CTP Insurer must ensure that, when required by the Regulator, the CTP Insurer uses specific scripts or pro-forma documents.

1.2.2 The CTP Insurer must at all times have a sufficient number of appropriately skilled personnel to maintain the systems, customer interface and processes required to perform CTP insurance business up to date, operational and consistent to all customers.

2 Marketing

2.1.1 CTP Insurers must notify the Regulator when marketing communications materials have been published, with details about the media used to market, and the start and end date of the marketing. This Rule applies to both new materials and existing materials with substantive variations.

2.1.2 CTP Insurers:

(a) must ensure any marketing communications materials are accurate;

(b) should ensure the marketing communications materials are consistent with any Regulator guidelines;

(c) may align their other brands with CTP insurance in South Australia;

(d) may cross-advertise CTP insurance products with other insurance products; and

(e) may engage in targeted marketing or unsolicited contact with customers or potential customers (including organisations and fleets); but

(f) must not produce any marketing communications materials in conflict with Regulator messaging.

3 CTP Insurer obligations

3.1 Guiding principles

3.1.1 When issuing CTP Policies or administering claims a CTP Insurer, its personnel, subcontractors or third party service providers must:

(a) act in good faith with all customers and claimants;

(b) inform each claimant of applicable service level timeframes (as determined by the CTP Insurer), and its commitment to manage the claim in accordance with these timeframes;

(c) ensure its processes for dealing with claims are efficient, cost effective and in accordance with law;

(d) support injury recovery through early, reasonable and necessary rehabilitation, treatment, care and support for injured people in accordance with Regulator guidelines or directions;

(e) protect and manage the personal information of customers and claimants in line with its privacy policy and in accordance with privacy laws;

(f) use processes and business practices that do not unfairly discriminate against individual, or groups of, customers or claimants;

(g) maintain service standards and business practices for all customers and keep the Regulator informed of any key changes to these service standards or business practices that impact customers;

(h) make the Policy readily accessible and available to all customers;

(i) accept all motor vehicles presented to it for the issue of a Policy; and

(j) not selectively discourage or de-incentivise customers from selecting the CTP Insurer, or attempt to do so.

3.1.2 CTP Insurers must not adopt tactics, practices or techniques that prejudice these obligations in any way, irrespective of the risk profile of the customer, their motor vehicle or the motor vehicle owner.

3.2 Contact points

3.2.1 Unless otherwise agreed by the Regulator in writing, a CTP Insurer must have an office in South Australia to conduct CTP insurance business staffed with personnel who are competent and authorised to deal with claims on the CTP Insurer's behalf.

3.2.2 That office, and any other locations in Australia where the CTP Insurer provides CTP insurance business must:

(a) be open for business on every business day during business hours; and

(b) be staffed sufficiently to deal with enquiries and provide CTP insurance business within the stated service level timeframes.

3.3 Other contact requirements

A CTP Insurer must have:

(a) a telephone line (listed in the white pages and yellow pages, in hard copy) that is available to take telephone calls on every business day during business hours;

(b) a dedicated facsimile line;

(c) a dedicated email address; and

(d) such other or replacement methods as may be notified by the Regulator as being, in the Regulator's opinion, convenient having regard to changes in communications technology.

3.4 Website

A CTP Insurer must have a website in place that:

(a) directs customers and claimants to the Regulator's website to lodge forms, including claim forms;

(b) is prominently linked to the Regulator's website;

(c) is up to date, and provides information for claimants, customers, Scheme stakeholders and members of the public that is clear, relevant, appropriate and accurate, and is not misleading in any way;

(d) provides general contact information for the CTP Insurer;

(e) contains any other information as directed by the Regulator; and

(f) includes a reference and hyperlink to any materials the Regulator requires the CTP Insurer to provide.

3.5 Distribution of Scheme information

CTP Insurers must distribute any leaflets, brochures or other publications produced by the Regulator about CTP insurance to Scheme stakeholders in their complete and unaltered form, as provided by the Regulator:

(a) openly displaying those publications:

(i) at their office and any other locations where their CTP insurance business is provided in South Australia;

(ii) on their website; and

(b) forwarding those publications to Scheme stakeholders expeditiously upon request.

3.6 Service levels

CTP Insurers must:

(a) deal with enquiries from claimants, customers, and their representatives, in a professional and courteous manner, within the insurer's stated service level timeframes;

(b) contact insured persons as soon as they become aware of, or are notified of, an insured person's involvement in an accident;

(c) provide assistance to claimants to ensure they are able to comply with claim lodgment requirements;

(d) provide clear and accurate information about the progress and assessment of the claim;

(e) ensure early assessment of claims;

(f) explain to claimants any decisions they make about their claim and provide them with the opportunity to provide feedback;

(g) where additional information is identified as being required to progress a claim, advise claimants within seven business days;

(h) make fair and reasonable assessments of claims in accordance with law;

(i) have a clear process to deal with complaints; and

(j) have appropriate processes in place to identify and assist vulnerable customers.

4 Incentives and inducements

4.1 Incentives for CTP insurance business prohibited

4.1.1 Unless permitted to do so by the MV Act or these Rules, a CTP Insurer or other person acting for a CTP Insurer must not give, or offer to give, a discount or incentive, whether financial or non-financial, to any person:

(a) in respect of a Policy; or

(b) in order to influence, directly or indirectly, the selection of the CTP Insurer by a customer,

whether directly or indirectly through a broker, agent or other representative or intermediary of the CTP Insurer (including without limitation a motor dealer).

4.1.2 The restriction in Rule 4.1.1 applies irrespective of whether such discounts or incentives are:

(a) linked directly to the Policy; or

(b) linked to any other product provided to the same customer or provided separately, but conditional upon or related to the holding of, renewal or issue of a Policy.

4.2 Prohibition on incentives with no direct benefit

CTP Insurers must not offer or propose to offer any incentive, unless:

(a) the incentive is an inducement of a class approved by the Minister pursuant to section 129A(2) of the MV Act;

(b) each person to whom the offer is made (or proposed to be made) is capable of receiving direct benefit and real value from the incentive; and

(c) the offer made (or proposed to be made) clearly and prominently outlines any eligibility criteria or other impediments which might prevent each such person from obtaining the full benefit or value of the incentive.

4.3 Application to Regulator for new inducement class

CTP Insurers may, by written notice to the Regulator, request approval by the Minister of a class of inducement pursuant to section 129A(2) of the MV Act. The Regulator will convey any such request received from a CTP Insurer to the Minister, together with such other information, materials or recommendation as the Regulator may consider relevant to the request.

4.4 Submission of information regarding inducements

Where a CTP Insurer proposes to implement any inducement of a class approved by the Minister pursuant to section 129A(2) of the MV Act, the CTP Insurer must, for the information of the Regulator, provide details in writing, including the monetary value of the proposed inducement at least seven business days prior to releasing to the market.

4.5 Regulator to notify CTP Insurers of changes to inducement classes

The Regulator will, prior to publishing on the Regulator's website any changes in inducements of a class approved by the Minister pursuant to section 129A(2) of the MV Act, provide notice in writing to all CTP Insurers.

4.6 Evidence of consent for mid-term nominations

A CTP Insurer must obtain evidence of a customer's consent to a mid-term nomination prior to performing the mid-term nomination for that customer, which consent must be retained and promptly provided to the Regulator by the CTP Insurer on request by the Regulator.

5 Claimant obligations

It is acknowledged that claims will be managed more efficiently when claimants:

(a) complete a claim form to the best of their ability;

(b) comply with any legal requirements and obligations;

(c) provide honest and accurate information about their claim. Claimants must not deliberately withhold information or consent from their CTP Insurer to obtain information about the claim;

(d) advise if circumstances change that affect their claim;

(e) provide information in a timely manner to assist in the decision making process and resolution of their claim;

(f) cooperate with their CTP Insurer to facilitate, when required, timely access to reasonable and necessary treatment, care and support services; and

(g) commit to optimising recovery from their injuries and make all efforts to participate in recovery programs and return to usual activities.

6 Information and privacy

6.1 Compliance with privacy laws

In addition to any statutory requirements which apply to CTP Insurers, when performing CTP insurance business, CTP Insurers, their personnel, contractors, subcontractors and third party service providers must comply with the privacy laws.

6.2 Contractors' privacy obligations

A CTP Insurer must ensure any personnel, contractors, subcontractors and third party service providers it engages to provide CTP insurance business, also comply with the privacy laws and any additional obligations imposed by this Rule 6.

6.3 Collection of personal and health information

6.3.1 When a CTP Insurer collects personal information about any person in connection with a claim they must provide all notices and obtain all consents required by the privacy laws.

6.3.2 Without limiting any such obligation, a CTP Insurer must take reasonable steps to ensure that claimants are aware of:

(a) the CTP Insurer's identity and contact details;

(b) the circumstances of any indirect collection of personal information about the claimant (that is any personal information collected by the CTP Insurer other than directly from its dealings with the claimant);

(c) the purposes for which the information is collected;

(d) the persons or entities to which the CTP Insurer usually discloses personal information of that kind (unless disclosure of such personal information without notifying the person to which the information relates is expressly permitted by law);

(e) any law that requires or authorises the personal information to be collected;

(f) the main consequences, if any, for the person if all or some of the information is not collected by the CTP Insurer;

(g) whether the CTP Insurer is likely to disclose the personal information to overseas recipients, and if so, the countries in which such recipients are likely to be located if it is practicable to specify those countries in the notification or to otherwise make the individual aware of them; and

(h) the CTP Insurer's privacy policy and that the CTP Insurer's privacy policy includes information about:

(i) how the person may access the personal information the CTP Insurer holds about them and seek correction of such information; and

(ii) how the person may complain about a breach of the Australian Privacy Principles by the CTP Insurer and how the CTP Insurer will deal with such a complaint.

6.4 Use of data

6.4.1 CTP Insurers will take all reasonable steps to ensure Policy holder data, data collected through the claim process and subsequent data collected by use of the prescribed authority (as applicable) will remain protected and only be used and disclosed for the purposes of a function conferred on them to provide CTP insurance business or to comply with a legal obligation.

6.4.2 Without limiting a CTP Insurer's obligations under any other provision of this Rule 6, CTP Insurers must only use personal information, or disclose personal information to another person, body or agency, for a secondary purpose if:

(a) it is necessary and relevant to perform their claims management obligations and functions under the MV Act;

(b) they have the individual claimant's consent;

(c) a claimant would reasonably expect the use or disclosure;

(d) the use or disclosure is required, authorised or permitted by the MV Act or another law (e.g. court orders, subpoenas, statutory demands by agencies such as Centrelink, Medicare Australia or the Australian Taxation Office); or

(e) the use or disclosure is necessary for the enforcement of a criminal law, law imposing a financial penalty or the protection of public revenue (e.g. a criminal investigation for providing false or misleading information or to detect and prevent fraud).

6.4.3 This list is not exhaustive and the above uses/disclosures are not mutually exclusive. More than one purpose or exception may be applicable.

6.5 Research

CTP Insurers must notify the Regulator prior to conducting or participating in any research or trial that is likely to impact claimants. Such a notification must allow the Regulator sufficient time to review the research or trial proposal before it is commenced.

6.6 Access

CTP Insurers must not allow personnel to access personal information or other data held in connection with their CTP insurance business, including:

(a) viewing/browsing of information on a screen or in hard copy;

(b) making a record of the information (e.g. printing out material); and/or

(c) disclosing the information to third party service providers,

except in connection with their role and then only where there is a reasonable purpose for such access related to their CTP insurance business.

6.7 Incidents

6.7.1 On becoming aware that there has been, or is likely or reasonably suspected to have been, unauthorised access, unauthorised use, unauthorised disclosure or loss of personal information, or any other suspected or known breach of this Rule 6, the CTP Insurer must:

(a) immediately provide preliminary notice to the Regulator (whether by email, telephone or otherwise and for the avoidance of doubt, at the same time as, or as soon as is reasonably practical following any notification to a regulator, including APRA); and

(b) provide further details in writing within ten business days of providing the preliminary notice.

6.7.2 Exceptions to these reporting requirements may include:

(a) an employee working on a claim file identifies and rectifies/removes foreign records from a claim file;

(b) collecting/viewing another employee's print out/fax in error from a utility room only to realise and return it;

(c) an employee identifying and remedying an incorrect, outdated address or wrong enclosures before sending/posting correspondence; and

(d) an internal check/audit identifying areas or issues for improvement about privacy,

except where such circumstances are required by law to be notified to a regulator, affected individual or other third party.

6.8 Information from the State

6.8.1 Any personal information made available to CTP Insurers by or on behalf of a State agency may be provided subject to additional handling restrictions. CTP Insurers must comply, and must ensure their personnel, contractors, subcontractors and third party service providers also comply with such additional handling conditions.

6.8.2 The conditions referred to in Rule 6.8.1 include conditions necessarily imposed on CTP Insurers by a State agency to enable the State agency to comply with the terms of an exemption granted to the State agency by the Privacy Committee of South Australia exempting the State agency from compliance with any part of the Information Privacy Principles (as set out in *Part II of Cabinet Administrative Instruction No. 1 of 1989*) in connection with the disclosure of personal information to CTP Insurers.

6.9 Requests for information

6.9.1 A request for information related to a claim may be made by:

(a) a claimant; or

(b) a person authorised by the claimant to obtain the information.

6.9.2 A request must be made in writing and clearly describe the information, document or documents being requested.

6.9.3 The request may be made directly to the CTP Insurer that manages the claim and holds the information or documents requested.

6.9.4 If a request is from an authorised representative of a claimant, it must be accompanied by a current and properly executed consent or authority. If there is any doubt about the validity of the consent, the CTP Insurer may contact the person(s) nominated as the authorised representative.

6.9.5 CTP Insurers must assist claimants with the information they require to make a valid request.

6.9.6 CTP Insurers can release information to the claimant or, if authorised, the claimant's representative.

6.10 Exemptions from information requests

Unless otherwise required by law, a CTP Insurer is not required under these Rules to release documents which are protected by legal professional privilege or which the CTP Insurer is otherwise required by law not to disclose, which documents may include:

(a) internal briefings or memoranda by the CTP Insurer or Regulator;

(b) documents relating to negotiation strategy or future planned activities (such as surveillance);

(c) draft documents; or

(d) documents containing an opinion, deliberation or intention of a CTP Insurer about negotiations with claimants that would expose the CTP Insurer to an unreasonable disadvantage.

6.11 Freedom of information

CTP Insurers must provide any assistance required by the Regulator to enable the Regulator to comply with the Regulator's obligations under the *Freedom of Information Act 1991* (SA).

6.12 Vehicle Collision Reports

A CTP Insurer that receives a Vehicle Collision Report (VCR) from SA Police pursuant to a claimant's prescribed authority must:

(a) within 21 days of receiving the VCR, send a copy of the VCR to that claimant (or a legal practitioner engaged by that claimant);

(b) prior to sending a copy of the VCR in accordance with this Rule 6.12(a):

(i) redact all information appearing in the "witness" field within the VCR; and

(ii) redact the following information relating to any person other than the relevant claimant or witnesses (for instance, the at fault driver, another claimant or passenger):

(A) address;

(B) date of birth;

(C) alcohol and drug test results; and

(D) any other information which may identify or disclose an offence or likely offence as it pertains to that person.

(c) provide the VCR in the form received from SA Police to another CTP Insurer with a financial interest in accordance with any Regulator approved sharing agreement entered into between CTP Insurers in connection with the handling of multi-insurer claims.

7 Claims management

7.1 Process

CTP Insurers must optimise a claimant's experience throughout the claim process by:

(a) providing information and assistance to claimants and helping them to understand each step of the process;

(b) being proactive in obtaining sufficient information early to be in a position to assess, manage and resolve the claim as soon as possible and advising claimants, if and when, additional information is required;

(c) if there are issues affecting the claim (such as liability or payment of treatment expenses), explaining the issues to the claimant, including how they affect their claim and any entitlement to compensation;

(d) paying for reasonable and necessary treatment, care and support services to support the claimant's recovery (as detailed in Rule 15);

(e) referring to the SA CTP Framework for Injury Recovery and Early Intervention; and

(f) in respect of an interstate motor vehicle that is uninsured, obtaining proof from the relevant interstate insurer or authority responsible for regulating the relevant interstate compulsory third party insurance scheme, that the interstate motor vehicle was uninsured and outside of the relevant jurisdiction's grace period at the time of the accident.

7.2 The prescribed authority

7.2.1 The prescribed authority is required by section 126A(2)(d) of the MV Act to accompany a claim form and enables the CTP Insurer to obtain documentary information relevant to processing and assessing the claim. This is required to progress the claim and make sound and timely decisions throughout the life of the claim, and to ensure the accurate assessment of damages.

7.2.2 The CTP Insurer must disclose to the claimant and/or, where applicable, their representative, when the prescribed authority is being used and for what purposes, at least seven business days before each use.

7.2.3 The CTP Insurer may use the prescribed authority prior to the lapsing of seven business days if the claimant has acknowledged the notification under Rule 7.2.2 and does not object to earlier use.

7.2.4 The CTP Insurer must provide the claimant with a copy of any information obtained using the prescribed authority within 21 days of receiving the information, as prescribed by section 126A(4) of the MV Act.

7.3 Making a claim

Section 126A of the MV Act provides that a person who seeks to make a claim must provide a CTP Insurer with a claim form which sets out or is accompanied by:

(a) a statement setting out details of the claim;

(b) a certificate or opinion as to the nature and probable cause of the death or injury (as the case requires) provided by a medical practitioner;

(c) the relevant police report number for any report provided to a police officer under the *Road Traffic Act 1961* (SA) in connection with the relevant accident;

(d) a prescribed authority enabling the CTP Insurer to have access to records and other sources of information relevant to the claim; and

(e) such other report or other information in relation to the accident or claim as may be prescribed by the MVR from time to time.

7.4 Time limits for lodgment of claims

7.4.1 Regulation 4 of the MVR requires a claimant to submit the claim form within six months of the date of the accident, except in the case of a nominal defendant claim.

7.4.2 In the case of a nominal defendant claim, the claim form is required, as soon as reasonably practicable after it becomes apparent that the identity of the relevant motor vehicle is not readily ascertainable or the relevant motor vehicle is uninsured.

7.4.3 If the claimant fails to comply with these timeframes, the consequences are:

(a) CTP Insurer or the nominal defendant may decline to deal with the claim, while the failure continues; and

(b) the claimant is not entitled to commence or continue proceedings until they have complied with the requirements in section 126A of the MV Act.

7.4.4 However, under regulation 4(2) of the MVR, these consequences will not apply to the claimant if delay was caused by:

(a) ignorance or mistake on the part of the claimant;

(b) absence of the claimant from South Australia;

(c) inability of the claimant to lodge within the prescribed timeframe due to injury or a legal incapacity; or

(d) any other reasonable cause,

provided that the proper assessment of a claim by the CTP Insurer has not been substantially prejudiced.

7.4.5 A CTP Insurer must provide information, support and assistance to claimants to ensure they are aware of their obligations to comply with the notice requirements in section 126A of the MV Act.

7.4.6 Where a non-compliant claim is submitted, the claimant must be advised, and provided with the opportunity to correct the situation.

7.5 Accepting notice of claim

7.5.1 The CTP Insurer must accept the claim form and related documents supplied by the claimant by any of the following means:

(a) online lodgment;

(b) mail or in person;

(c) electronic methods (if the original signed document is scanned);

(d) facsimile; or

(e) such other or replacement methods as in the opinion of the Regulator are convenient having regard to changes in communications technology.

7.5.2 Photocopies, faxes or scans of claim forms are acceptable if the claimant has provided legible copies of all pages including the signed prescribed authority required by the MVR.

7.5.3 While the claimant should forward the original claim form to the CTP Insurer, the CTP Insurer must start the claim registration and liability process using the photocopied/faxed/scanned copy of the claim form.

7.6 Acknowledging a claim

Upon receipt of a claim a CTP Insurer must:

(a) ensure accident and claim information is accurately recorded;

(b) register all participants and witnesses to the accident;

(c) assign a unique accident number to each accident;

(d) assign a unique number to each claim;

(e) identify and link participants from previous accidents to the current claim as facilitated by the Regulator;

(f) link each claim to an accident number;

(g) ensure a claim receipt notification letter is sent to the claimant within seven business days;

(h) ensure there are reasonable attempts to make early contact with the claimant individually, or if represented, the claimant's lawyer;

(i) where further contact is warranted to manage the claim, contact the:

(i) insured person;

(ii) other known parties involved in the accident; and

(iii) witnesses to the accident;

(j) assign a claims consultant as the primary contact responsible for the future management of the claim; inform the claimant of the name of their claims consultant, direct telephone number and email address; and inform the claimant of any changes in these contact details;

(k) ensure the claimant and the insured person receive the unique identifier for the claim; and

(l) comply with any other requirements as directed by the Regulator.

7.7 Contacting claimants

7.7.1 A CTP Insurer is to contact claimants directly, or if the claimant is legally represented, the claimant's lawyer, subject to the below exceptions.

7.7.2 The CTP Insurer may send correspondence directly to a claimant who is legally represented if:

(a) it contains only generic information about making and resolving claims;

(b) it provides details about an ISV medical assessment or other medical assessment arranged by the CTP Insurer; or

(c) it is in relation to a claimant's rehabilitation, treatment, care and support,

provided that a copy of the correspondence is also sent to the claimant's lawyer.

7.7.3 A CTP Insurer may contact a claimant directly when the claimant is legally represented if:

(a) requested to do so by the claimant;

(b) there is no substantive reply from the claimant's lawyer to the CTP Insurer's offer of settlement within 10 business days of likely receipt and an attempt has been made by the CTP Insurer to confirm receipt of the offer of settlement with the claimant's lawyer;

(c) there is no substantive reply from the claimant's lawyer to the CTP Insurer's correspondence (excluding offers of settlement) within 20 business days of likely receipt, and an attempt has been made by the CTP Insurer to confirm receipt of the correspondence; or

(d) in response to a complaint by the claimant.

7.7.4 A CTP Insurer must ensure that its legal representatives communicate in plain English when engaging directly with unrepresented claimants.

7.8 Enquiries required to make a liability determination

7.8.1 The enquiries a CTP Insurer makes in relation to determining liability will be based on the facts of each claim and cannot be specified but may include:

(a) making enquiries appropriate to the accident circumstances;

(b) obtaining a police report of the accident;

(c) requesting an ARF from the driver(s) and the insured person (excluding the claimant);

(d) where an ARF is not received from the insured person, ensuring reasonable efforts are made by the claims consultant to contact the insured person and to ascertain and record their version of events;

(e) obtaining witness statements where applicable.

7.8.2 Where liability is contentious, or the circumstances of the accident are unclear, or a nominal defendant claim is involved, further enquiries will be conducted and consideration given to refer the matter to an appropriate investigation provider.

7.9 Determining liability

7.9.1 A CTP Insurer must ensure the liability determinations are:

(a) made appropriately according to the evidence on the claim file;

(b) made in a timely fashion;

(c) made in accordance with relevant law;

(d) based on sound evidence to support the decision;

(e) based on rationale documented on the claim file; and

(f) notified promptly to the claimant or legal representative.

7.9.2 A CTP Insurer must, within 10 business days of the determination, provide written notice to the claimant advising:

(a) whether the CTP Insurer admits or denies liability for the claim;

(b) the reasons for the CTP Insurer's decision; and

(c) the nature of evidence that supports those reasons.

7.9.3 Where contributory negligence (including any applicable statutory reductions under Part 7 of the CLA, such as failure to wear a seatbelt/helmet or the claimant/driver being affected by alcohol/drugs) is a reason for not wholly admitting liability, the CTP Insurer must provide written notice to the claimant of:

(a) the percentage of contributory negligence attributed to the claimant;

(b) the relevant provisions of Part 7 of the CLA relied on for the statutory reduction;

(c) the reasons for that decision; and

(d) the nature of evidence that supports the contributory negligence alleged.

7.10 Interpreters

7.10.1 If required, a CTP Insurer must provide, at its cost, interpreting services for claimants to assist them in the claims process including attendance at medical assessments.

7.10.2 If a CTP Insurer is uncertain as to whether an interpreter is required, they should make enquiries with the claimant when arranging the assessment.

7.10.3 Professional interpreters must be used rather than a claimant relying upon family members or friends to interpret.

8 Independent assessments and reports

8.1 Purpose of the independent assessment

An assessment by a health professional, obtained by either the claimant or by the CTP Insurer, provides an independent opinion regarding the claimant's injury and treatment to assist with decisions about treatment, rehabilitation, activities of daily living, including return to work, and the claimant's entitlement to compensation.

The independent assessment may be undertaken either by an IME examiner, or by a health professional (**independent assessment**).

8.2 Provision of independent assessment report to claimant

A CTP Insurer must, on receipt of an independent assessment report relevant to a claim, provide the claimant to whom the report relates a copy of the report within 21 days of receipt by the CTP Insurer.

8.3 Selection of health professional

When selecting a health professional to undertake an independent assessment, a CTP Insurer must:

(a) match the specialty of the health professional to the claimant's injury/injuries, medical treatment or rehabilitation issue to be resolved;

(b) ensure the choice of health professional is not motivated by the opportunity to obtain an opinion from a health professional who is considered to hold particular views (adverse to claimants) on specific medical conditions or treatment issues; and

(c) not exert influence on the health professional about the outcome of the assessment and report.

8.4 Arranging the independent assessment

8.4.1 In arranging an independent assessment, a CTP Insurer must:

(a) identify issues that may impact a claimant's ability to attend the independent assessment, for example:

(i) if a claimant has limited ability to use stairs this may make it unsuitable to attend a particular health professional's rooms;

(ii) if a claimant is from a rural or remote location they may require an afternoon or early evening appointment; or

(iii) cultural or religious factors which may influence the selection of the appropriate health professional;

(b) advise the claimant, in writing, at least seven business days prior to the appointment occurring, of:

(i) the date, time and location of the appointment;

(ii) the name of the health professional, street address and contact telephone number;

(iii) the specialty of the health professional;

(iv) the reason for attending the independent assessment;

(v) the need to take any relevant documentation about the claimant's injury (for example, medical reports and/or x-rays), that has not already been provided to the CTP Insurer, to the independent assessment;

(vi) any information prescribed by the Regulator for that purpose;

(vii) their obligation to attend and that failure to do so, without reasonable cause, may adversely affect their claim and incur a cancellation fee; and

(viii) the need to notify the CTP Insurer if they are unable to attend the independent assessment due to a change in circumstances at least two business days before the assessment or earlier to avoid any cancellation fee;

(c) send all available relevant documentation (except those previously provided) to the health professional at least two business days prior to the independent assessment, which may include:

(i) details, if and when, that health professional has previously examined the claimant;

(ii) claim forms;

(iii) medical certificates (limited to first and last unless otherwise relevant);

(iv) any relevant medical history, records or notes (including hospital notes);

(v) any previous reports, including diagnostic reports, from other health professionals;

(vi) details of treatment;

(vii) details of a claimant's relevant personal, family, occupational and past medical history;

(viii) mechanism of injury; and

(ix) copies of the relevant Rules of Court, including Chapter 7, Part 14, of the UCR, to ensure that the health professional complies with the provisions of these Rules as an expert witness;

(d) only disclose information to the health professional that is relevant to the assessment;

(e) not request a health professional to provide an opinion on matters outside their area of expertise; and

(f) if a CTP Insurer believes there is a potential safety risk for the health professional in assessing a claimant, the CTP Insurer must discuss security requirements with the health professional before confirming the appointment, implement any security arrangements required or requested and allow the health professional the option to decline the referral.

8.4.2 In addition to the above, when arranging an independent assessment for a claim in relation to a child, CTP Insurers must, wherever possible:

(a) reach agreement with the child's parent, guardian or litigation guardian as to the relevant health professional;

(b) attempt to minimise the need for multiple assessments (this may be achieved through using the Guideline for Arranging Joint Independent Medical Assessments available on the CTP Regulator's website); and

(c) arrange assessments so as to minimise interference with educational commitments.

8.5 Payment for independent assessments and reports

8.5.1 A CTP Insurer must pay for the cost of an independent assessment and report when the CTP Insurer:

(a) arranged the independent assessment; or

(b) approved the independent assessment arranged by the claimant, with reasonable notice to the CTP Insurer before the proposed date of the independent assessment.

8.5.2 If a claimant fails, without reasonable cause, to attend an independent assessment as required by a CTP Insurer then:

(a) when a cancellation fee is paid by the CTP Insurer, the claimant must be advised that a cancellation fee has been incurred and the amount;

(b) a CTP Insurer may request the claimant makes payment of any cancellation fees incurred because of the claimant's non-attendance; and

(c) if a request is made by the CTP Insurer, the claimant is liable to pay for any fees incurred by the CTP Insurer and the CTP Insurer may set this off against any liability for payment of damages or compensation.

9 ISV medical assessments and reports

9.1 Purpose of the ISV medical assessment and medical reports

A CTP Insurer may arrange an ISV medical assessment to obtain a medical report from an AMP in order to determine:

(a) the claimant's injuries sustained in the accident;

(b) the ISV item number; and

(c) the claimant's entitlements,

for the purposes of determining the appropriate level of compensation.

9.2 Provision of the ISV medical report to the claimant

A CTP Insurer must, on receipt of a medical report relevant to a claim, provide the claimant to whom the medical report relates, with a copy of the report within 21 days.

9.3 Selection of AMP

9.3.1 When selecting an AMP, a CTP Insurer must:

(a) match the specialty of the AMP to the claimant's injury/injuries; and

(b) ensure the choice of the AMP is not motivated by the opportunity to obtain an opinion from an Accredited Medical Practitioner who is considered to hold particular views (adverse to claimants) on specific medical conditions.

9.3.2 Under regulation 4 of the CLR, a medical assessment by an AMP is not required if:

(a) there is no AMP accredited to undertake the assessment;

(b) the CTP Insurer and the claimant mutually agree that such an assessment is not required, provided that if such agreement is reached, the CTP Insurer confirms the agreement in writing to the claimant within seven business days, including details of the reasoning for the agreement; or

(c) a court determines an ISV medical assessment is not required.

9.4 Arranging an ISV medical assessment

9.4.1 In arranging an ISV medical assessment with an AMP, a CTP Insurer must:

(a) identify issues that may impact on a claimant's ability to attend the ISV medical assessment, for example:

(i) if a claimant has limited ability to use stairs this may make it unsuitable to attend a particular AMP's rooms;

(ii) if a claimant is from a rural or remote location they may require an afternoon or early evening appointment; or

(iii) cultural or religious factors which may influence the selection of the appropriate AMP;

(b) advise the claimant at least seven business days prior to the appointment occurring in writing of:

(i) the date, time and location of the appointment;

(ii) the name of the AMP, street address and contact telephone number;

(iii) the specialty of the AMP;

(iv) the reason for attending the ISV medical assessment;

(v) the need to take any relevant documentation about the claimant's injury(for example, medical reports and/or x-rays), that has not already been provided to the CTP Insurer, to the appointment;

(vi) any information prescribed by the Regulator for that purpose;

(vii) the obligation to attend and that failure to do so may adversely affect their claim; and

(viii) the need to notify the CTP Insurer if they are unable to attend the ISV medical assessment due to a change in circumstances at least two business days before the ISV medical assessment or earlier to avoid any cancellation fee;

(c) send all available relevant documentation (except those previously provided) to the AMP at least two business days prior to the ISV medical assessment, which may include:

(i) details, if and when, that AMP has previously examined the claimant;

(ii) claim forms;

(iii) medical certificates (limited to first and last unless otherwise relevant);

(iv) any relevant medical history, records or notes (including hospital notes);

(v) any previous reports, including diagnostic reports, from other Accredited Medical Practitioners and/or health professionals;

(vi) details of treatment;

(vii) details of a claimant’s relevant personal, family, occupational and past medical history;

(viii) mechanism of injury; and

(ix) copies of the relevant Rules of Court, including Chapter 7, Part 14, of the UCR, to ensure that the AMP complies with the provisions of these Rules as an expert witness for the court;

(d) only disclose information to an AMP that is relevant to the examination;

(e) not request an AMP to provide an opinion on matters outside their area of accreditation; and

(f) if a CTP Insurer believes there is a potential safety risk for an AMP in examining a claimant, the CTP Insurer must discuss security requirements with the AMP before confirming an appointment, implement any security arrangements required or requested by the AMP and allow the AMP the option to decline the referral.

9.4.2 In addition to the above, when arranging an ISV medical assessment for a claim in relation to a child, CTP Insurers should, wherever possible:

(a) reach agreement with the child's parent, guardian or litigation guardian as to the choice of AMP;

(b) attempt to minimise the need for multiple ISV medical assessments (this may be achieved through using the Guideline for Arranging Joint Independent Medical Assessments available on the CTP Regulator's website); and

(c) arrange appointments so as to minimise interference with educational commitments.

9.4.3 Where the CTP Insurer has requested the ISV medical assessment, the CTP Insurer must only accept the ISV medical report if the AMP has used the prescribed ISV medical report template.

9.5 ISV medical assessments for pure a mental harm GEPIC rating

9.5.1 This Rule applies to ISV medical assessments for a pure mental harm GEPIC rating via telehealth video conferencing permitted by the Minister for a finite period. For the purposes of this Rule, the designated Minister has been appointed under section 76 of the *Civil Liability Act 1936*.

9.5.2 Before arranging an ISV medical assessment via telehealth video conferencing for a GEPIC rating for psychiatric impairment caused by pure mental harm, a CTP Insurer must:

(a) confirm a face-to-face ISV medical assessment is not available with an AMP;

(b) provide the AMP with all relevant information for the AMP to determine the claimant's suitability for telehealth video conferencing; and

(c) attempt to obtain an opinion from at least one of the claimant's treating health practitioner for the claimant's suitability to undertake a telehealth ISV assessment and provide to the AMP. A minimum of three attempts is required to obtain this opinion.

9.5.3 After the AMP confirms the claimant is suitable for the ISV medical assessment to proceed via telehealth under this Rule, and no later than seven business days prior to an appointment, the CTP Insurer must ensure the claimant (directly or through their legal representative) is:

(a) provided with a consent form for the telehealth video conference to proceed; and

(b) provided with the Motor Accident Injury Accreditation Scheme (MAIAS) telehealth information sheet.

9.5.4 For telehealth assessments arranged by the CTP Insurer, the CTP Insurer must ensure a consent form, signed by the claimant, is provided to the AMP prior to the commencement of the assessment.

9.5.5 Any reference to an ISV medical assessment in Rule 9 includes an ISV medical assessment conducted via telehealth video conferencing for pure mental harm GEPIC assessments.

9.5.6 Rule 9.4.1 applies as if the ISV medical assessment was being conducted via face-to-face, with the exception of 9.4.1(a)(i) and 9.4.1(a)(ii).

9.5.7 The CTP Insurer must not accept an ISV medical assessment report conducted via telehealth video conferencing unless it is on the prescribed GEPIC ISV telehealth template with a declaration signed by the AMP.

9.6 Payment for ISV medical assessments and reports

9.6.1 A CTP Insurer must pay for the cost of an ISV medical assessment by an AMP and the report when the CTP Insurer:

(a) arranged the ISV medical assessment; or

(b) authorised or approved the ISV medical assessment arranged by the claimant with reasonable notice to the CTP Insurer before the proposed date of the ISV medical assessment.

9.6.2 If a claimant fails, without reasonable cause, to attend an ISV medical assessment as required by a CTP Insurer then:

(a) when a cancellation fee is paid by the CTP Insurer, the claimant must be advised that a cancellation fee has been incurred and the amount;

(b) a CTP Insurer may request the claimant makes payment of any cancellation fees incurred because of the claimant's non-attendance; and

(c) if a request is made by the CTP Insurer, the claimant is liable to pay for any fees incurred by the CTP Insurer and the CTP Insurer may set this off against any liability for payment of damages or compensation.

9.7 Claimant arranged ISV medical assessments

9.7.1 A claimant may request in writing that a CTP Insurer arrange an ISV medical assessment and the CTP Insurer must, subject to Rule 9.7.2, arrange that ISV medical assessment if:

(a) 12 months have passed since the date of injury or, if earlier, a medical report from a health professional has been obtained that the injury is stable;

(b) liability in relation to the accident has been accepted; and

(c) a settlement of damages has not been reached between a CTP Insurer and a claimant.

9.7.2 If requirements in Rule 9.7.1 are met, then a CTP Insurer may only refuse a request if:

(a) it is unlikely a person's injury or injuries will score above ISV 7; or

(b) the claimant's injury or injuries are not sufficiently stable for an ISV medical assessment to occur.

9.7.3 If a CTP Insurer accepts the request under Rule 9.7.1 it must:

(a) promptly arrange the ISV medical assessment, including by attending to booking the ISV medical assessment within seven business days of such acceptance with an Accredited Medical Practitioner in accordance with these Rules;

(b) notify the claimant of its determination and the details of the ISV medical assessment; and

(c) pay any reasonable costs associated with the ISV medical assessment.

9.7.4 If a CTP Insurer refuses a request under Rule 9.7.1 then it must:

(a) expediently notify the claimant;

(b) provide to the claimant details of the basis of the denial; and

(c) if the denial is a result of insufficient evidence, advise the claimant of what further evidence is required.

10 Cost of travel

10.1.1 A CTP Insurer must pay travel expenses reasonably incurred during a claimant's attendance for treatment, or attendance at an assessment undertaken by an AMP or a health professional.

10.1.2 Travel by private motor vehicle is reimbursed on a per kilometre basis at the Return to Work SA gazetted rate which includes allowance for petrol and like expenses.

10.1.3 CTP Insurers are not required to reimburse the claimant's travel in relation to court appearances and appointments with legal representatives, damage or loss of property resulting from travel, and infringements incurred whilst travelling to these appointments.

11 Investigations

11.1.1 The CTP Insurer must only engage an investigation provider who is licensed under the *Security and Investigation Industry Act 1995* (SA) to conduct any investigation under that Act.

11.1.2 A CTP Insurer must ensure any investigation provider engaged by it:

(a) complies with all relevant laws; and

(b) is aware of and complies with any relevant requirements placed on a CTP Insurer by these Rules.

12 Use of subcontractors

12.1.1 A CTP Insurer must not, without the prior written consent of the Regulator, permit another person to exercise its responsibility for the determination or resolution of claims by way of assignment, transfer, agency agreement or other similar arrangement (except that, for the avoidance of doubt, the Regulator's approval will not be required under this Rule 12 for the entry by the CTP Insurer into arrangements for the provision of professional services to the CTP Insurer by its actuarial, legal, IT and/or ordinary accounting services providers).

12.1.2 Such prior approval may be granted by the Regulator's express acceptance of the CTP Insurer's business plan containing full details of each relevant subcontractor and the scope of its proposed role.

12.1.3 The Regulator's approval of subcontractors may be withdrawn by notice in writing to the CTP Insurer at any time, at the Regulator's absolute discretion.

12.1.4 A CTP Insurer must ensure that any subcontractor performs its obligations in accordance with these Rules as if that subcontractor were so bound by these Rules.

13 Use of third party service providers

13.1.1 A CTP Insurer must not, without the prior written consent of the Regulator, engage a third party service provider where there is a relationship between the CTP Insurer and the third party service provider (e.g. rehabilitation, investigative, forensic medical and accounting service providers) except that, for the avoidance of doubt, the Regulator's approval will not be required under this Rule 13.1.1 for the entry by the CTP Insurer into arrangements for the provision of professional services to the CTP Insurer by its actuarial, legal, IT and/or ordinary accounting services providers.

13.1.2 For the purpose of Rule 13.1.1, the CTP Insurer will be considered to have a "relationship" with the third party service provider if the third party service provider is:

(a) a director or secretary of the CTP Insurer;

(b) a related entity of the CTP Insurer; or

(c) a director or secretary of a related entity of the CTP Insurer.

14 Children's claims

14.1.1 If the claimant was under the age of 16 years at the time of the accident, and the accident occurred in South Australia, under section 127B of the MV Act the CTP Insurer is liable to pay all necessary and reasonable expenses relating to the claimant's treatment, care and support needs arising from the injury, including after the claimant turns 16 years. These no-fault benefits may be in addition to, the common law right of the child to seek compensation for damages and to which the LA Act time limits apply (outlined in Rule 20).

14.1.2 In relation to any claim involving any children's claim, the CTP Insurer must ensure:

(a) an appropriate claims management strategy is in place which recognises the unique nature of children's claims and the effect on families of such claimants;

(b) children's claims are actively managed;

(c) children's claims are reviewed at regular intervals;

(d) depending on the significance of the injuries, the CTP Insurer's claims staff are experienced in managing children's claims; and

(e) children's claims are managed in accordance with any other directions given by the Regulator.

15 Assessment of reasonable and necessary treatment, care and support services

15.1.1 CTP Insurers must respond in writing to funding requests relating to treatment, care and support services within seven business days of receipt of any such request where the claimant has completed a prescribed authority which remains valid.

15.1.2 The response must either:

(a) approve the funding request; or

(b) if the CTP Insurer requires further information in order to make a decision on the treatment, care and support service request, provide detail of what clarification or further information is required from the service provider, health professional or claimant (as applicable) to assist in the approval of the request; or

(c) if the funding request is declined or partially approved, include reasons for the CTP Insurer's decision.

15.1.3 In establishing whether the treatment, care or support service is reasonable and necessary, a CTP Insurer must consider the following:

(a) appropriateness of the proposed injury recovery services for the injuries;

(b) expected benefit of the proposed injury recovery services for the claimant;

(c) quality of the service provider;

(d) any advice provided to the claimant by treating practitioners;

(e) background and medical history of the claimant;

(f) the relationship of the service to the injury caused by or arising out of the accident;

(g) whether evidence exists that the proposed service is not recommended;

(h) the proposed number and frequency of services;

(i) whether other services have been undertaken and the outcomes to date; and

(j) whether refusing to fund would result in a deterioration in the claimant's condition, rate of recovery and return to usual activities, including return to work.

16 Court approval in claims of persons under legal incapacity

16.1.1 If a claimant is a person under a legal incapacity, a CTP Insurer must not settle entitlements under section 127B of the MV Act without the consent of the claimant's litigation guardian.

16.1.2 A CTP Insurer must not compel the claimant's litigation guardian to enter into settlement negotiations with respect to entitlements under section 127B of the MV Act, no fault entitlements for children under 16 years or common law damages in relation to a claim.

16.1.3 In relation to the settlement of a claim, including entitlements under section 127B of the MV Act or damages corresponding to those entitlements, a CTP Insurer must advise the parent or legal guardian to obtain court approval in relation to the settlement where the claimant is a child or person under a legal incapacity at the date of settlement and is not legally represented.

16.1.4 A CTP Insurer must allow the claimant to obtain an opinion from independent legal counsel to enable the court to approve or reject the proposed settlement and make orders in relation to the manner in which settlement funds are to be paid.

16.1.5 CTP Insurers must ensure that the parent or legal guardian is made aware that there is an entitlement to recover from the CTP Insurer the costs of the counsel opinion and application to the court, in particular the fees applicable to advise on compromise or settlement for a person under a legal incapacity under the cost scales in the UCR.

17 Payments

17.1 Interim payments

17.1.1 A claimant may request in writing that a CTP Insurer make an interim payment in relation to their claim.

17.1.2 A CTP Insurer must only consider making an interim payment to a claimant where:

(a) there is evidence of financial hardship demonstrated by the claimant's:

(i) incapacity for work;

(ii) spouse or partner being unable to work; and

(iii) inability to focus on their recovery due to financial stress;

(b) fault has been established in relation to the accident;

(c) there is enough evidence to establish the claimant's entitlement to damages;

(d) that interim payment would not exceed the overall estimated value of the claim;

(e) there is no suspicion of fraud on the part of the claimant; and

(f) the claimant has completed a prescribed authority which remains valid.

17.1.3 In determining financial hardship a CTP Insurer may take into account and request from a claimant:

(a) sick certificates;

(b) letters from employers confirming leave taken or the claimant's inability to work;

(c) particulars of pre and post injury income and expenditure;

(d) outstanding bills, invoices or other requests for payment; and/or

(e) financial records including business activity statements, bank account statements or correspondence with Centrelink.

17.1.4 A CTP Insurer must assess requests received from a claimant for an interim payment within seven business days of receipt of the request.

17.1.5 If, following a CTP Insurer's assessment, the request is approved the CTP Insurer must:

(a) expediently notify the claimant;

(b) ensure any necessary statutory clearances are obtained (e.g. Centrelink);

(c) ensure the claimant signs a discharge releasing the CTP Insurer from making future payment of damages in respect to the amount of the interim payment; and

(d) on receipt of a signed discharge and statutory clearances, make interim payment to a claimant within five business days.

17.1.6 If, following a CTP Insurer's assessment, the request is denied, the CTP Insurer must:

(a) expediently notify the claimant;

(b) provide to the claimant details of the basis of the denial; and

(c) if the denial is a result of insufficient evidence, advise the claimant as to what further evidence is required.

17.2 Reimbursement of claimant expenses

If liability has been determined for a claim, the CTP Insurer must respond in writing to all requests for reimbursement of claimant expenses, which are accompanied by valid receipts or remittance notices, within seven business days of receipt of the request. The CTP Insurer must:

(a) pay all expenses assessed as valid expenses;

(b) if the CTP Insurer requires further information in order to make a decision on whether or not the expense is valid, include in the response what clarification or further information is required from the claimant to assist in the request; and

(c) if the payment request is declined or partially approved, include in its response the reasons for its decision.

17.3 Settlement payments

CTP Insurers must ensure settlement payments:

(a) take into account all statutory repayments, statutory reductions, interim payments, reductions for negligence and credit for special damages; and

(b) are promptly authorised for payment, which ordinarily should be no longer than five business days, following the receipt of final statutory and other clearances and notices.

18 Lifetime Support Scheme

18.1 Referral of claimants to the LSS

CTP Insurers must:

(a) consider whether application to LSA is appropriate;

(b) provide early notification of possible LSS claims to LSA where appropriate;

(c) refer claimants to the LSS with available supporting evidence required under the LSS Rules; and

(d) inform claimants of their potential eligibility for the LSS and make information available to claimants who qualify for or may qualify for the LSS.

18.2 Management of claimants who are (or may become) LSS participants

18.2.1 CTP Insurers must not discourage injured people from making a CTP claim or continuing to receive benefits in the event they qualify for participation in the LSS.

18.2.2 Subject to any other eligibility criteria prescribed by legislation, a CTP Insurer must fund necessary and reasonable treatment, care and support services for claimants who are no longer participants in the LSS.

18.3 Notification to be given to the Regulator

A CTP Insurer must notify the Regulator if they are involved in a dispute with the LSA or a claimant regarding a claimant's participation in the LSS.

19 Offers

19.1 Offers (at any time prior to pre-action claim)

19.1.1 A CTP Insurer must endeavour to resolve a claim expeditiously and reduce costs associated with the claim by making a settlement offer when reasonable to do so or by giving proper consideration to any offer received from a claimant.

19.1.2 If a CTP Insurer receives an offer from a claimant, the CTP Insurer must respond to the settlement offer in writing within 30 days or such later date agreed by the parties.

19.1.3 CTP Insurers must ensure any offers of settlement made to a claimant:

(a) are in writing;

(b) explain the basis for the dominant injury item number;

(c) explain the entitlements to compensation arising from the chosen ISV, including where there is no entitlement;

(d) explain the value and assessment for each head of damage.

19.1.4 After an initial offer has been made in accordance with Rule 19.1.3, if agreed with the claimant, CTP Insurers are not required to comply with that Rule during negotiations, but once an agreement has been reached, the final agreed offer must be detailed in accordance with Rule 19.1.3.

19.1.5 If an unrepresented claimant's offer, or an exchange of offers between the claimant and their CTP Insurer, fails to resolve the claim, the CTP Insurer must explain to the claimant the steps required to comply with the pre-action claim notice under the UCR.

19.2 Pre-action claim

19.2.1 Unless exempted by the provisions of the UCR, a claimant is required to give a written pre-action claim notice to their CTP Insurer prior to issuing an action in the court, which complies with the UCR containing or accompanied by:

(a) an offer to settle the claim on a basis set out in the notice;

(b) sufficient details of the claim, and sufficient supporting material, to enable the CTP Insurer to assess the reasonableness of the claimant's offer of settlement and to make an informed response to that offer; and

(c) if the claimant is in possession of expert reports relevant to the claim, copies of the expert reports.

19.2.2 CTP Insurers must comply with the UCR when receiving a pre-claim notice, by responding to the pre-action claim in writing within 30 days after receipt, or at a later date agreed by the parties, by either:

(a) accepting the claimant's offer; or

(b) making a counter-offer which is accompanied by sufficient details and supporting material to enable the claimant to assess the offer and to make an informed response to it; or

(c) stating that liability is denied and the grounds on which it is denied; or

(d) accepting the date and time for a pre-action meeting proposed by the claimant or agreeing an alternative date with the claimant and agreeing the manner of the pre-action meeting whether to be conducted in person, by video visual link or telephone conference; or

(e) considering whether some form of alternative dispute resolution would be suitable, including a conciliation conference under Rule 21.4 with the agreement of the claimant.

20 Time limits for issuing court proceedings

20.1.1 At least three months prior to the three year anniversary of the accident date, the CTP Insurer must take reasonable steps to inform the claimant of the time limits for issuing proceedings and where the claimant can find more information about how to lodge proceedings in a court.

20.1.2 Under the LA Act:

(a) if the claimant was 18 years of age or over at the date of the accident, and the claim is not resolved within three years of the anniversary of the accident date, legal proceedings must be commenced by the claimant in a court of relevant jurisdiction prior to the expiration of the three year anniversary. Failure to do so may result in the claimant being barred from issuing or continuing legal proceedings and recovering any entitlement to compensation for damages or costs.

(b) If the claimant was a person under a legal incapacity at the date of the accident, the time to issue legal proceedings may be extended by the period or periods for which the incapacity exists or continues after the date of the motor vehicle accident, for a period not exceeding 30 years.

(c) If the claimant was a child at the date of the accident, and the time for bringing legal proceedings is extended by more than six years from the accident date, notice of an intended claim must be given to the CTP Insurer within six years of the anniversary of the accident, by or on behalf of, the child.

21 Complaints

21.1 Complaints to be initially raised with CTP Insurers

It is expected in the first instance, complaints will be raised with the relevant CTP Insurer as the first point of contact. In most instances, the CTP Insurer is best positioned to address concerns and resolve issues. If the issue cannot be resolved in the first instance, internal dispute resolution (IDR) or conciliation may be appropriate. IDR is not required to precede conciliation.

21.2 Managing complaints

21.2.1 CTP Insurers must develop and maintain a fair, equitable and non-discriminatory process for addressing complaints efficiently.

21.2.2 The CTP Insurer's process for addressing complaints must, at a minimum:

(a) ensure the complaint is dealt with appropriately by its personnel;

(b) ensure complaints are managed efficiently and individual complaints are promptly responded to;

(c) investigate complaints in a timely and effective manner and, where a prolonged investigation is necessary, provide regular feedback to the complainant;

(d) endeavour to resolve all complaints within 10 business days of receiving the complaint;

(e) provide a final response about the complaint in writing to the complainant within 30 calendar days;

(f) ensure a consistent approach is in place for managing and recording complaints;

(g) ensure Scheme stakeholders and members of the public are advised of the complaint management process in a variety of forms of communication, formats and languages appropriate to the needs of claimants or members of the public;

(h) train personnel involved in the complaints management process;

(i) ensure their dealings with complainants are clearly recorded;

(j) handle complaints at no charge to the complainant including interpreting services; and

(k) record:

(i) the date;

(ii) the name of the complainant;

(iii) the complainant's contact details;

(iv) the claim number;

(v) a brief description of the complaint;

(vi) the action in progress; and

(vii) the resolution of the complaint.

21.2.3 CTP Insurers must, where appropriate, introduce service improvements to reduce the incidence of complaints.

21.3 IDR processes

21.3.1 If a claimant disagrees with a determination made by a CTP Insurer in relation to a claim, the CTP Insurer acknowledges that:

(a) the claimant may ask to have that decision reviewed by the CTP Insurer's State claims manager (or person holding the equivalent position); and

(b) if the claimant disagrees with the determination made by the CTP Insurer's State claims manager, the claimant may ask to have that decision referred to the CTP Insurer's IDR process.

21.3.2 CTP Insurers must ensure their IDR processes comply with the standards and requirements made or approved by ASIC, including ASIC Regulatory Guide 271.

21.3.3 CTP Insurers must inform the Regulator of their IDR processes and notify of any changes.

21.3.4 CTP Insurers must have detailed IDR processes and the IDR processes must be fully explained to claimants.

21.3.5 Subject to any restriction imposed by law, medical reports, assessor's reports, witness statements, private investigator's reports and anything else obtained by claimants or CTP Insurers with respect to a claim will be exchanged between the claimant and CTP Insurer as part of the IDR process.

21.4 Conciliation

21.4.1 If a claimant disagrees with a determination by a CTP Insurer, and the claimant requests the CTP Insurer conciliate the dispute, the CTP Insurer:

(a) must, in respect of unrepresented claimants, agree to conciliate the dispute with a conciliator;

(b) may, in respect of claimants who are legally represented, but is not obligated to, agree to conciliate the dispute with a conciliator,

if the claimant's request to conciliate the dispute is made within 30 business days of the date of the relevant determination.

21.4.2 If a claimant requests conciliation, then, subject to Rule 21.4.1, a CTP Insurer must arrange a conciliation with a conciliator within 30 business days of the request being made.

21.4.3 The CTP Insurer must consider in good faith any directions given by the conciliator.

21.4.4 CTP Insurers must pay the costs of a conciliation conference, including the costs of the conciliator.

21.4.5 A claimant who attends a conciliation conference is entitled to seek reimbursement from a CTP Insurer for:

(a) reasonable expenses of the claimant's transport to and from the conciliation; and

(b) loss of income incurred by the claimant as a result of attending the conciliation.

21.4.6 Conciliation may be in addition to or in place of IDR.

22 Receiving a summons

CTP Insurers must accept service of proceedings on behalf of their insured persons in accordance with the CTP Insurer's powers under section 125 of the MV Act, if an action is being brought against their insured person in relation to a policy:

(a) where a valid policy of insurance under the MV Act is in force; and

(b) in circumstances where that policy responds in relation to that action.