Australian Capital Territory

Motor Accident Injuries (Defined Benefits Application) Guidelines 2025

Disallowable instrument DI2025–159

made under the

Motor Accident Injuries Act 2019, section 487 (MAI guidelines)

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1 Name of instrument

This instrument is the *Motor Accident Injuries (Defined Benefits Application) Guidelines 2025.*

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocation

The *Motor Accident Injuries (Defined Benefits Application) Guidelines 2021* (DI2021-279) is revoked.

Nicola Clark

MAI Commissioner
MAI Commission
30 June 2025

Defined Benefits Application Guidelines

Contents

1. INTRODUCTION

The defined benefits application guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The purpose of the guidelines is to set out requirements for the making and handling applications for defined benefits under Part 2.3 of the MAI Act.

Specifically, this material details an insurer's obligations in providing information and support to potential applicants, accepting applications and administering payments for treatment and care, income replacement and funeral and death benefits.

2. STATUTORY FRAMEWORK

Part 2.3 of the MAI Act makes provision for the following people to make an application for defined benefits to the insurer:

- a person injured in the motor accident
- the dependant of a person who died as a result of a motor accident, or
- the person who has paid or is liable the funeral expenses of a person who dies as a result of a motor accident.

An application may also be made on behalf of a person with a legal disability by their guardian, or for a dependant of a person who died as a result of a motor accident, by the personal representative of the deceased person.

The legislative framework for defined benefits includes:

- the MAI Act;
- the Motor Accident Injuries Regulation 2019 (the Regulation); and
- these Guidelines.

3. INFORMATION AND SUPPORT FOR POTENTIAL APPLICANTS FOR DEFINED BENEFITS (Section 52 and Paragraph 56(2)(e))

These Guidelines make provision for the information and support an insurer is obliged to give a person enquiring about making an application for defined benefits under the MAI scheme for the purposes of section 52 of the MAI Act. The guidelines also make provision for medical expenses incurred as a result of a motor accident and before making an application that may be reimbursed.

3.1 Preliminary Information

3.1.1 When an insurer is first contacted by, or on behalf of, any person that has been injured or died as a result of a motor vehicle accident the insurer must give the person preliminary information about applying for defined benefits under the MAI scheme. This is to include information about:

- how to access, complete and submit an application form;
- information or documents required to accompany an application;
- defined benefits that may be payable on application;
- the time limits for making an application;
- to whom the application must be given; and
- information services available to assist the person.

3.1.2 This information should be provided regardless of whether the insurer is likely to be the relevant insurer for the accident. That is, the insurer is obliged to provide information that will assist the person, including about how to identify the relevant insurer. If the person cannot work out the relevant insurer, the contacted insurer should accept the application and then identify the relevant insurer.

3.2 Medical expenses incurred before making an application

3.2.1 When first contacted by an injured person, or a person acting on their behalf, the insurer should also advise the person about the medical expenses incurred before a person makes a personal injury application that can be reimbursed on making an application.

3.2.2 These medical expenses are to be limited to:

- up to two consultations with a general practitioner, being no higher than a level B consultation for initial treatment and a further consultation no higher than a level C consultation that is necessary to prepare a medical report; and
- up to two allied health treatments (such as physiotherapy) on referral by a registered medical practitioner, with each session capped at $150 for reimbursement.

3.2.3 Accounts and receipts for these expenses should be given to the insurer with a personal injury application. These expenses should be verified and reimbursed by the insurer, as soon as practicable, after a completed application is acknowledged by an insurer.

3.3 How information and support may be given

Preliminary information and support may be provided to a person by the best available means with the agreement of the person. This could include through a phone conversation, an email or through the post.

4. PERSONAL INJURIES APPLICATION (Section 56)

These Guidelines are for making an initial application so an insurer can determine liability for personal injury benefits. An initial application does not need to include all information to decide whether a person is entitled to income replacement benefits. This information can be provided by an applicant to an insurer at a later stage.

4.1 Information to be included in a complete application

The application must include or be accompanied by the following information about the motor vehicle accident and the injured person:

- the time, date, location, circumstances, and the details of the vehicle/s involved in the accident;
- notification details to police (an online AFP Crash report and submission number) or a police accident report number (as provided by police);
- the full name, date of birth, and addresses of the injured person;
- if the application is on behalf of an injured person, the name, address, relationship to the applicant, and their reason for being the person making the application;

- whether the injured person was a driver/rider, passenger/pillion, or a pedestrian, cyclist, or other person injured in the accident;
- a motor accident medical report from a registered medical practitioner describing the injured person's injuries and certifying the injuries are consistent with a motor vehicle accident;
- any offence the injured person has been charged with, in relation to the accident;
- an explanation for the delay in making a late application (if applicable); and
- if an application is made to the nominal defendant in relation to an unidentified motor vehicle, that a reasonable search or inquiry was carried out to identify the vehicle and evidence of that search/inquiry.

4.2 Consents, authorities and declarations

The application must include or be accompanied by the following consents, authorities, and declarations given by the person making the application:

- a consent and authority to release, use, disclose and exchange personal and health information by, to and between the persons and entities listed in paragraph 4.2.1 below for the purposes of processing and managing the application for defined benefits; and
- a declaration that all information provided in the application is true and correct.

4.2.1 The following persons and entities are listed for the purposes of paragraph 4.2:

- a treating health service provider, member of a treating team or a rehabilitation provider
- a health practitioner that conducts an assessment of treatment and care needs or fitness for work, including a medical or other examination.
- an independent medical examiner (IME), independent assessor and an authorised IME provider
- the NDIA and Services Australia
- the Coroner's Court of the ACT
- any personal injury insurer or workers compensation insurer
- the relevant insurer or another MAI insurer
- the ACT MAI Commission
- any police service
- any employer or accountant of the injured person
- any property damage insurer
- the ACT Lifetime Care and Support Scheme
- the ACT Civil and Administrative Tribunal.

4.3 Form and manner that an application may be given

A personal injury application and a motor accident medical report must be made using forms prescribed by the MAI Commission and made available on the MAI Commission's website or provided by an insurer. A personal injury application is to be given in writing and may be given to the insurer by electronic means, by personal delivery or by post.

5. FUNERAL OR DEATH BENEFIT APPLICATION (Section 56)

These guidelines are for making an application for death or funeral benefits.

Separate applications should be made for funeral and death benefits. A death benefit application may cover more than one dependant of a deceased. Information in a death benefit application will be provided to the ACT Civil and Administrative Tribunal (ACAT) who will then make a decision about the distribution of benefits to dependants. It is expected an application will be made by the deceased's personal representative.

5.1 Information to be included in a complete application

5.1.1 The application must, include, or be accompanied by, the following information about the motor accident, the deceased, and the person making the application, and for an application for death benefits, about any dependants of the deceased:

- the time, date, location, circumstances, and details of the vehicle/s involved in a motor vehicle accident;
- a police accident report (an AFP online crash report will not be sufficient) where the death occurs at the accident scene or shortly afterwards;
- the name, address, date of birth and date of death of the deceased;
- the name, capacity and addresses of the person making the application, i.e. executor, legal personal representative or next of kin;
- a document/s showing the deceased died from personal injuries sustained as a result of a motor accident;
- an explanation for the delay in making a late application (if applicable); and
- if an application is made to the nominal defendant in relation to an unidentified motor vehicle, that a reasonable search or inquiry was carried out to identify the vehicle and evidence of that search/inquiry.

5.1.2 The following additional information must be included or accompany an application for death benefits:

- A certified copy of a death certificate (an interim certificate will not be sufficient);
- the name, residential address and date of birth, and relationship with the deceased of any dependant covered by the application;
- any known details of any other dependants not covered by the application;
- a financial document or other document/s showing a person covered by the application was a dependant of the deceased at the time of the accident; and
- if a dependant covered by the application was a former domestic partner, or an adult child with a disability, evidence that the person was financially dependent on the deceased, at the time of the accident.

5.1.3 A document that shows the deceased died from injuries sustained as a result of a motor accident may include a certified copy of a death certificate, a notice of the cause of death given by a health service provider or a letter from the Coroner's Court of the ACT.

5.1.4 A death certificate may be used as primary evidence to show a person was a dependant of a deceased person but may not be conclusive or list all dependants of a deceased for the purposes of an application for death benefits. Other evidence of

dependency could include a certified copy of a marriage certificate, certified copies of children's birth certificates, copies of joint bank statements, taxation returns, household bills in joint names, property titles or lease agreements, a letter from a school, college or university confirming a child's enrolment in full- time study or a statutory declaration. An insurer may need a number of pieces of evidence to confirm a dependency for a given dependant.

5.1.5 An insurer may, at their discretion, accept a funeral or death benefit application as being complete, if the application does not include, or is not accompanied by any information that must be included with an application. For example, a police accident report may not be available prior to the finalisation of a case with the Coroner's Court of the ACT. If the insurer is unable to obtain a police report for an application for a funeral benefit, they may rely on other sources of information prior to accepting liability for the application. This could include media reports, witness statements, property damage insurance claim information or photos of an accident scene. The discretion should not be exercised to waive the requirement for a certified copy of a death certificate to accompany a death benefit application unless a death certificate is unavailable 11 months after the date of the motor accident.

5.1.6 A funeral or death benefit application should also be treated as being complete if an insurer has already received information, such as a death certificate or police report, in relation to another application.

5.2 Consents, authorities and declarations

5.2.1 The application must include or be accompanied by the following consents, authorities, and declarations, given by the person making the application.

- a consent and authority to release, use, disclose and exchange personal and health information by, to and between the persons and entities listed in paragraph 5.2.2 below for the purposes of processing and managing the application for defined benefits; and
- a declaration that all information in the application is true and correct.

5.2.2 The following persons and entities are listed for the purposes of paragraph 5.2:

- any police service
- property damage insurer
- any funeral director or mortuary service
- any personal injury insurer or workers compensation insurer
- the relevant insurer or another MAI Insurer
- the ACT MAI Commission
- the Coroner's Court of the ACT
- the ACT Civil and Administrative Tribunal (ACAT).

5.2.3 If an insurer is unable to conclude from the information provided in the application, and from making reasonable inquiries, that a person died from injuries sustained as a result of a motor accident, the insurer must request an authority to obtain personal health information relating to the deceased, signed by the person making the application, so the insurer can make a decision about accepting liability for the application. In these circumstances the person making the application must provide the name of, and contact details for, any treating health service provider, or the deceased person's treating team, for injuries that were sustained in the motor accident.

5.3 Form and manner that an application may be given

5.3.1 An application for death benefits should preferably be made by the deceased's personal representative and cover all dependants of the deceased identified by the personal representative. If the deceased does not have a personal representative, or an application made by a personal representative does not cover a given dependant, an application or additional applications can be made by one or more of a deceased's dependants, or if the dependant is under a legal disability by a person acting on their behalf. An application for funeral benefits is to be made by a person that is liable, or has paid expenses, for the funeral.

5.3.2 Any documents showing the cause of death, or dependency, which are not from an Australian source, must be in English, or accompanied by a certified English translation.

5.3.3 A funeral or death benefit application must be made using a form prescribed by the MAI Commission and made available on the MAI Commission's website or provided by an insurer. The application is to be given in writing and may be given to the insurer by electronic means, by personal delivery or by post.

6. ACTIONS FOLLOWING THE RECEIPT OF A DEFINED BENEFITS APPLICATION (Sections 52 and 60)

These guidelines make provision for actions an insurer must take on receiving an application for defined benefits.

Section 60 of the MAI Act requires an insurer to acknowledge receipt of an application, which contains all the information required by these guidelines or the regulation, by giving a receipt notice or late receipt notice to an applicant. An application that is complete is made on the date it is received by an insurer, and not on the date a receipt notice is given.

If a late application is complete, a late receipt notice is to be given to the applicant. The insurer must then be satisfied the explanation for the delay in making the application is a full and satisfactory explanation within the 28 day period to accept liability for the application. Section 35 of the MAI Act sets out the meaning, and examples, of a full and satisfactory explanation for a delay in applying for defined benefits.

Where a personal injury application or death benefit application is made on behalf of an applicant under a legal disability, or a death benefit application covers more than one dependant, the receipt notice should be given to the person that signed the application on behalf of the applicant. In these circumstances a receipt notice will be taken to have been given to an applicant or multiple applicants.

If an application is incomplete the insurer must return the application with a required additional information notice. If a late application is incomplete because it did not include an explanation for the delay in making the application, an additional information notice is to be given to the applicant requesting an explanation for the delay.

6.1 Giving a receipt notice, late receipt notice, or a required additional information notice

6.1.1 A receipt notice, late receipt notice, or a required additional information notice, must be given to an applicant within 5 business days of the application being received unless the notice is affected by a significant event. A significant event is an event which disrupts the continuity of an insurer's MAI business arising from human, physical, or technological events. A significant event declaration must be notified to the MAI Commission in writing by the insurer. If a notice is delayed because of a significant event, it must be given to the applicant no later than 7 business days, or other reasonable period agreed by the MAI Commission, after the application was received. The notice is to be given in writing and may be given by electronic means, or by post. If a notice is given by electronic means it is not necessary for a notice to then be sent by post. For the purpose of these guidelines a notice given, under section 60, by post will be taken to be given on the day it is posted, and not on the day that it would have been delivered to the applicant.

6.1.2 If another insurer appears to be liable for the application, the first insurer should give a receipt notice, or late receipt notice for the application and then transfer the application to another insurer under the provisions of section 69 of the MAI Act. This is a mandatory requirement on an insurer and shall not be avoided by sending back applications to injured persons. An applicant should not be put in the position of forwarding their application to the other insurer.

6.2 Information to be included in a receipt notice

A receipt notice or late receipt notice is to include the following information:

- name of any person making the application on behalf of an applicant;
- name of the injured or deceased person;
- name of the applicant or all applicants (dependants) covered by the death benefit application;
- date and time of the motor vehicle accident;
- date the application was received;
- date the notice is given;
- an individual application identifier as provided by an insurer;
- contact details for the insurer; and
- the date the insurer must accept or deny liability for the application.

6.3 Information to be given with a receipt notice

6.3.1 A receipt notice for a personal injury application is to be accompanied by information about:

- allowable expenses payable during the initial application period and how to claim these expenses;

- evidence needed to show a person is entitled to, and to calculate income replacement payments, and determine start dates for these payments;
- Income replacement payments for the initial application period only being payable by the insurer once the insurer accepts liability for the application; and
- outstanding reasonable and necessary treatment and care expenses incurred from the date of the accident that can be claimed if liability is accepted for the application.

6.3.2 A late receipt notice for a personal injury application is to be accompanied by:

- a statement that defined benefits are only payable by the insurer once the insurer accepts liability for the application;
- information about evidence needed to show a person is entitled to, and to calculate, income replacement payments; and
- information about the start dates for defined benefit payments for late applications and the need to satisfy the insurer there are exceptional circumstances to justify an earlier payment.

7. ALLOWABLE EXPENSES (Section 63)

Allowable expenses are expenses for treatment and care an applicant incurs during the period starting after an insurer receipts a personal injury application (other than a late application) and ending when an insurer accepts or denies liability for the application. Insurers have 4 weeks to make their decision. If a decision to deny liability is made before the 4 week period expires the insurer is not liable for medical expenses incurred after the date of the decision (Section 61 of the MAI Act).

An insurer that gives an applicant a receipt notice, must reimburse an applicant for allowable expenses incurred to the date of a decision irrespective of whether the insurer accepts liability for an application (Sections 61 and 62 of the MAI Act). An insurer that provides a receipt notice, and then does not accept liability for a valid application, due to an application being transferred to another insurer will have a right of recovery for the amount of allowable expenses from the relevant insurer. If the application for defined benefits was based on false and misleading information, an insurer will also be able to recover allowable expenses from an applicant (Section 64 of the MAI Act).

These guidelines make provision for allowable expenses under section 63 of the MAI Act.

7.1 Medical treatments available as allowable expenses

Allowable expenses are the following medical treatments:

- up to 4 consultations from a general practitioner, no higher than a level C consultation; and
- up to 8 allied health treatments provided by a registered health practitioner on referral from a registered medical practitioner, provided no more than four treatments are provided for any one given allied health service (such as physiotherapy or psychology) with each session capped at $150 for reimbursement.

7.2 Period allowable expenses are payable

Allowable expenses are only payable for expenses incurred during the initial period, for a defined benefit application, as set out in section 61 of the MAI Act. These expenses can only be reimbursed to an applicant and cannot be bulk billed by a treatment provider. They are not payable for the period prior to an application being receipted by an insurer. Allowable expenses are separate expenses from pre-application medical expenses in section 3.2 of these guidelines, which an insurer must reimburse on receipting an application.

7.3 Verifying allowable expenses

7.3.1 An insurer must reimburse an applicant any allowable expenses incurred by the person upon verification of an account and accompanying receipt. The account and/or receipt should include the following information:

- injured person's first and last name;
- name, address and provider number of the health service provider;
- name of the referring medical practitioner or evidence of referral;
- date the service was provided (if more than one date, includes each date);
- the services provided by the provider, and the cost of each service; and
- service duration (if applicable).

7.3.2 An insurer may accept an electronic copy or a photocopy of an account or receipt. The insurer may ask for the original if not satisfied of the accuracy of the account or receipt or ask the health service provider to confirm the information in the account or receipt is accurate. An insurer is to pay an allowable expense, as soon as practicable, but no later than 10 business days after verifying an account and receipt.

8. PROCESSING AN APPLICATION FOR DEATH BENEFITS (Section 176)

These guidelines make provision for procedures to be undertaken by an insurer and information to be given to ACAT in relation to an application for death benefits.

8.1 Procedure for processing an application for death benefits

8.1.1 If an insurer receives an application for death benefits the insurer must undertake reasonable steps to obtain information or consent to be joined in an application to ACAT for a payment distribution order, from any dependant of the deceased not included in an application for death benefits. These steps should include:

- identifying all potential dependants of the deceased based on information included in or accompanying the application, or other information the insurer has in their possession;
- making reasonable attempts to contact any potential dependants not covered by the application to establish whether they may be dependants; and
- allowing a dependant up to 28 days to make an application for death benefits after the insurer has given the person a notice about the insurer having received a death benefit application covering other dependants of the deceased.

8.1.2 An insurer should be satisfied that each applicant covered by an application for death benefits is a dependant entitled to a death benefit payment, being a domestic partner, a dependent former domestic partner, or a dependent child of the deceased at the time they died. However, an insurer need not determine this conclusively prior to an application being made to ACAT for a payment order. An insurer should establish that an applicant is a dependant from information and documents provided with an application, and from any additional information requested from an applicant.

8.1.3 An insurer should only accept liability for an application covering multiple applicants for applicants that are entitled to death benefit payments. If the insurer is satisfied that a potential applicant covered by a multiple application is a not a dependant entitled to death benefits then the insurer should indicate liability to pay benefits for the application does not include the potential applicant.

8.2 Information to be given to ACAT for a death benefit payment order

In applying to ACAT for a death benefit payment order an insurer should provide ACAT with:

- a copy of all applications for death benefits in relation to the deceased for which the insurer has accepted liability (confirming a death as a result of a motor accident);
- all documents provided with each application for death benefits;
- any additional information or documents received by an insurer in relation to an application for death benefits;
- the full name of each dependant covered by an application and to be included in a distribution order, the nature of the person's dependency and a summary of information the insurer used to establish each person's entitlement;
- details of any other death benefit applications in relation to the deceased the insurer has received; and
- a copy of any notice for additional information given to any dependant by the insurer that has not been actioned by the dependant, including a notice given to a dependant not covered by an application.

9. FUNERAL EXPENSES (Section 182)

These guidelines make provision for expenses that can be included as funeral expenses.

9.1 What may be included as a funeral expense

Funeral expenses can include:

- transport expenses including the cost of transporting a deceased's remains interstate or overseas;
- the cost of obtaining a certificate of death and any permits;
- funeral director fees;
- expenses of, or associated with, a cremation or burial; and
- expenses of, or associated with, a funeral or memorial ceremony, but not venue hire or catering costs for a wake.

10. ACCEPTING LIABILITY FOR AN APPLICATION (Sections 52, 65 and 66)

These guidelines make provision for information to be given, and actions to be taken, on accepting liability for a defined benefits application. If a relevant insurer does not accept liability for an application, the insurer must give the applicant either a transfer notice or a rejection notice in accordance with section 65 of the MAI Act.

10.1 Defined benefits notice

A defined benefits notice is to include the following information:

- name of the injured or deceased person (in the case of a death benefit application the name of all applicants covered by the given application that the insurer is satisfied are entitled to receive death benefit payments);
- date and time of the motor vehicle accident;
- date of the receipt notice;
- date of acceptance of liability for the application;
- an individual application identifier as provided by the insurer;
- name of and contact details for the case manager for the application; and
- a statement that the notice is an important document and should be retained. The defined benefit notice may be given by electronic means, or by post.

10.2 Information to accompany a defined benefits notice

A defined benefits notice is to be accompanied by a document setting out:

- the key features and benefits available under the MAI scheme;
- the insurer's, and the applicant's, duties in relation to the application (see Division 1.2.4 of the MAI Act); and
- details of complaints and dispute mechanisms available to the applicant under the MAI scheme.

The document may also include other generic additional information, required to be provided with a defined benefit notice under these guidelines.

10.3 Information about treatment and care benefits

A defined benefits notice for an injured person entitled to treatment and care benefits is to be accompanied by the following information:

- details of treatment and care benefits that can be covered by the MAI scheme;
- details of matters that the insurer must consider when deciding whether treatment and care is reasonable and necessary;
- if a recovery plan is, or is likely to be required, information about what the plan will provide for, and when a proposed plan is likely to be given to the person and their treating doctor for consultation or review;
- details about the circumstances in which an insurer may require the person to attend a health practitioner, other than their own doctor, for an assessment of their treatment and care needs;
- the procedure for seeking approval for treatment and care;

- the procedure for seeking reimbursement or payment of approved treatment and care expenses, domestic service expenses and travel expenses; and
- if the application suggests that a person could become a participant in the LTCS scheme under the *Lifetime Care and Support (Catastrophic Injuries) Act 2014,* information about the LTCS scheme.

10.4 Information about income replacement benefits

A defined benefits notice for an injured person entitled to income replacement benefits is to include the following information:

- if an insurer has determined the amount of a weekly payment, how the payment was calculated, when the payment can start, and how the payment can be made; or
- any additional information the insurer requires to determine the amount of a weekly the payment, the amount of any interim payment the insurer can pay, when the interim payment can start, and how this payment can be made.
- the requirements for a fitness for work certificate and work declaration, how this certificate and declaration must be given, and the time frame for providing the certificate and declaration, and the period that a fitness for work certificate may cover; and
- the requirements to notify any change in circumstances, how any change must be notified and the time frame to notify such a change.

10.5 Information about death benefits

A defined benefits notice for an application for death benefits is to also be accompanied by information about the insurer applying for an order for the distribution of death benefits payments to dependants from the ACT Civil and Administrative Tribunal.

10.6 Payment of defined benefits

An insurer must, as soon as practicable, after accepting liability for a defined benefit application approve and pay any outstanding reasonable and necessary treatment and care expenses incurred from the date of the motor accident in accordance with the requirements and timeframes in the treatment and care guidelines. This may include additional pre-application medical and allowable expenses not specified in sections 3.2 and 7.1 of these guidelines and any gap amounts for these expenses.

11. MANAGING CONCURRENT PERSONAL INJURIES APPLICATIONS (Section 487)

These guidelines make provision for information sharing and collaborative arrangements for MAI insurers in managing concurrent personal injuries applications under the MAI scheme. Concurrent applications arise where a person injured in a motor accident already has one or more active applications under the MAI scheme for injuries from earlier motor accidents. These applications may be identified by an insurer through disclosures made about earlier MAI applications on the personal injuries application form. Concurrent applications may continue to be handled separately by each relevant insurer or handled in whole or part by another insurer through an agreement between relevant insurers.

11.1 Insurers obligations in managing concurrent applications

If concurrent applications are identified then each relevant insurer must:

- proactively and regularly share information with other relevant insurers;
- promptly respond to requests from other relevant insurers;
- work collaboratively to ensure a consistent and seamless experience for the applicant; and
- inform the applicant in writing which insurer will handle each part of an application and the reasons why.

11.2 Factors for determining handling arrangements for concurrent applications

The following factors are to be taken into account by each relevant insurer in deciding whether an application or part of an application should be handled by another insurer:

- the nature of the injuries and seriousness of the injuries from each accident and any common or related injuries from each accident;
- whether any applications are being managed or are to be managed under the industry sharing agreement;
- any ongoing treatment and care the injured person has approved under a recovery plan from an earlier accident;
- whether the injured person is receiving income replacement payments from an earlier accident;
- whether the person's injuries from an earlier accident are stable and they are likely to have injuries of a permanent nature; and
- the time period remaining for any defined benefit entitlements from an existing active application.

11.3 Cost arrangements

Any arrangements for another insurer to handle a concurrent application or part of an application may be on a cost recovery, cost sharing or a non-recovery basis, as may be agreed between insurers. A cost sharing agreement may also be put in place between insurers in circumstances where insurers separately manage their own applications. In making cost agreements for concurrent applications insurers must have regard to the materiality of the amounts involved and the administrative costs for the MAI scheme as a whole in implementing a cost agreement.

12. ADMINISTRATIVELY CLOSING DEFINED BENEFITS PERSONAL INJURIES APPLICATION (Section 52)

These guidelines make provision for matters an insurer must consider in deciding to administratively close a defined benefits personal injuries application, the procedure to be followed by the insurer before an application is closed and information to be given to an applicant about closing an application. The closure may be requested by an applicant or initiated by the insurer. An administrative closure does not end the entitlement to defined

benefits. At or after five years an insurer is to close the application if there is no further activity.

12. 1 Matters to be considered before administratively closing an application

An insurer may administratively close a defined benefits personal injuries application prior to five years from the date of an accident if the insurer believes that it is unlikely that the person will need to access further defined benefits, or make a common law claim, under the MAI scheme.

In making this decision the insurer must consider whether the injured person:

- has returned to all their activities of work and daily living at their pre-injury capacity;
- has completed all treatment and care set out in a recovery plan, or does not require a plan / or a further plan;
- requires any other treatment and care outside of a recovery plan;
- has recently incurred any treatment and care expenses or missed any paid work because of their injuries, or made a request for approval or payment of treatment and care; and
- is unlikely to have a permanent impairment from their injuries from the motor accident of 5% or more; has been assessed as having a WPI of less than 5% and the person has accepted or been taken to have accepted the WPI report. Acceptance of a quality of life benefit offer may also be considered.

An application may also be closed if the injured person specifically requests the insurer to close their application, including in circumstances where the person may still require ongoing treatment and care but wishes to access the treatment and care outside of the MAI scheme.

12.2 Procedure to be followed before an application is administratively closed

An insurer must write to an injured person, parent or their guardian before deciding to close an application prior to five years from the date of a motor accident.

An insurer may advise the injured person or their guardian through a courtesy telephone conversation of their intention to close an application. If an insurer chooses not to make a call or is unable to contact the injured person by telephone, an insurer must write to the injured person (through the post or email) advising them of the intention to close their application.

In the written correspondence, an insurer must:

- confirm the courtesy telephone conversation (if made) or advise of the intention to close the application;
- outline the arrangements for the approval, or the payment of, any outstanding treatment and care expenses, and note that these will be paid to the provider or injured person;

- advise the injured person that their application may be re-opened if their circumstances change; and
- provide the details of the Defined Benefits Information Service (DBIS) so that the person may obtain independent information on the proposed account closure.

In all circumstances the insurer must allow the injured person a minimum of 14 calendar days from the date of an email or receipt of a letter, to contact the insurer in response to the email/letter prior to closing an application.

12.3 Information to be provided about ongoing entitlements

An insurer must notify the injured person of the closure of their application in writing. This notification is to include information about defined benefits the person may be entitled to if their circumstances change including treatment and care, income replacement and quality of life benefits.

12.4 Providing information to the Motor Accident Injuries Register

An application is to be recorded as finalised, closed in agreement or lapsed closed due to inactivity, and included as part of the return to the Motor Accident Injuries Register (MAIR) for the month in which the closure occurs.