Financial Sector (Collection of Data) (reporting standard) determination No. 2 of 2021

Reporting Standard GRS 800.2 Claim Data: Public and Product Liability and Professional Indemnity Insurance

Financial Sector (Collection of Data) Act 2001

I, Alison Bliss, delegate of APRA, under paragraph 13(1)(a) of the *Financial Sector (Collection of Data) Act 2001* (the Act) and subsection 33(3) of the *Acts Interpretation Act 1901:*

(a) REVOKE Financial Sector (Collection of Data) (reporting standard) determination No. 17 of 2016, including *Reporting Standard GRS 800.2 Claim Data: Public and Product Liability and Professional Indemnity Insurance* made under that Determination; and

(b) DETERMINE *Reporting Standard GRS 800.2 Claim Data: Public and Product Liability and Professional Indemnity Insurance,* in the form set out in the Schedule, which applies to the financial sector entities to the extent provided in paragraph 3 of the reporting standard.

Under section 15 of the Act, I DECLARE that the reporting standard shall begin to apply to those financial sector entities, and the revoked reporting standard shall cease to apply, on 31 December 2021.

This instrument commences on 31 December 2021.

Dated: 23 March 2021

[Signed]

Alison Bliss
General Manager
Data Analytics and Insights Division

Interpretation

In this Determination:

APRA means the Australian Prudential Regulation Authority.

financial sector entity has the meaning given in section 5 of the Act.

Schedule

Reporting Standard GRS 800.2 Claim Data: Public and Product Liability and Professional Indemnity Insurance comprises the document commencing on the following page.

Reporting Standard GRS 800.2

Claim Data: Public and Product Liability and Professional Indemnity Insurance

Objective of this reporting standard

This Reporting Standard sets out requirements for the provision of information to APRA relating to claims made on insurers' public liability, product liability and professional indemnity insurance policies, and facility business underwritten covering similar risks.

It includes *Reporting Form GRF 800.2 Claim Data: Public and Product Liability and Professional Indemnity Insurance* and the associated instructions.

Authority

1. This Reporting Standard is made under section 13 of the *Financial Sector (Collection of Data) Act 2001*.

Purpose

2. Information collected by *Reporting Form GRF 800.2 Claim Data: Public and Product Liability and Professional Indemnity Insurance* (GRF 800.2) is used by APRA for the purpose of prudential supervision and publication, including publication in the National Claims and Policies Database (NCPD).

Application

3. This Reporting Standard applies to insurers.

Commencement

4. This Reporting Standard applies for reporting periods ending on or after 31 December 2021.

Information required

5. An insurer must provide APRA with the information required by GRF 800.2 for each reporting period and each reportable claim made on the insurer:

   (a) made during the reporting period; and

   (b) originally made before the start of the reporting period and that has not been settled, or was reopened, during the reporting period.

Reporting periods and due dates

6. Subject to paragraph 7 of this Reporting Standard, an insurer to which this Reporting Standard applies must provide the information required by this Reporting Standard in respect of each calendar half-year (i.e. the periods ending 30 June and 31 December each year).

7. APRA may, by notice in writing, change the reporting periods, or specify reporting periods, for a particular insurer to require it to provide the information required by this Reporting Standard more frequently, or less frequently, or in respect of reporting periods based upon the insurer's own accounting financial year, having regard to:

   (a) the particular circumstances of the insurer; and

   (b) the extent to which the information is required for the purposes of the prudential supervision of the insurer.

8. The information required by this Reporting Standard must be provided to APRA by no later than four months after the end of the reporting period.

9. APRA may grant an insurer an extension of a due date in writing, in which case the new due date for the provision of the information will be the date on the notice of extension.

Method of submission

10. Unless a method is notified by APRA, in writing, prior to submission, the information required by this Reporting Standard must be rendered in comma separated values (CSV) format in accordance with the instructions in GRF 800.2, and must be provided electronically through the web site www.ncpd.apra.gov.au, by logging on using the relevant customer identification number and password provided by Fujitsu Australia (as agent of APRA), and following the instructions on that web site.

Quality control

11. The information provided by an insurer under this Reporting Standard must be subject to systems, processes and controls developed by the insurer for the internal review and authorisation of that information. It is the responsibility of the board and senior management of the insurer to ensure that an appropriate set

of policies and procedures for the authorisation of data provided to APRA is in place.

Authorisation

12. Fujitsu Australia (as agent of APRA) will provide each insurer with a customer identification number. If an insurer proposes to submit information required by this Reporting Standard using the method in paragraph 10 (i.e. via the website), the insurer must apply for a password by viewing the web page referred to in paragraph 10, quoting the insurer's customer identification number and following the instructions for applying for a password on that page. Fujitsu Australia will advise the insurer's Chief Financial Officer of the password for the insurer. When information is provided using the method in paragraph 10, the insurer will be required to quote its customer identification number and password. Upon successful validation of the customer identification and password a secure session between the insurer and Fujitsu Australia will be created and information will be encrypted before transmission.

13. Despite paragraph 12, or where APRA has under paragraph 10 notified an alternate method of submission, APRA may also determine in writing that:

    (a) a specified person (who need not be the Principal Executive Officer or Chief Financial Officer of the insurer);

    (b) a person holding a specified position (which need not be the position of Principal Executive Officer or Chief Financial Officer of the insurer); or

    (c) a person authorised by the insurer to use the insurer's customer identification number and password,

    may, or must, authorise (in a manner specified) information provided by the insurer under this Reporting Standard.

Minor alterations to forms and instructions

14. APRA may:

    (a) make minor variations to GRF 800.2 (either generally, or in relation to a class of insurers, or in relation to a particular insurer) to correct technical, programming or logical errors, inconsistencies or anomalies; or

    (b) vary, omit or substitute (either generally, or in relation to a class of insurers, or in relation to a particular insurer) a specification in a Table in GRF 800.2, if APRA forms the view that the specification is inappropriate having regard to the circumstances or business of each relevant insurer and any other relevant considerations.

15. If APRA makes such a variation it must notify affected insurers in writing.

Transition

16. An insurer must report under the old reporting standard in respect of a transitional reporting period. For these purposes:

old reporting standard means the reporting standard revoked by the determination that makes this Reporting Standard (being the reporting standard that this Reporting Standard replaces); and

transitional reporting period means a reporting period under the old reporting standard:

(a) that ended before the date of revocation of the old reporting standard; and

(b) in relation to which the insurer was required, under the old reporting standard, to report by a date on or after the date of revocation of the old reporting standard.

Note: For the avoidance of doubt, if an insurer was required to report under an old reporting standard, and the reporting documents were due before the date of revocation of the old reporting standard, the insurer is still required to provide any overdue reporting documents in accordance with the old reporting standard.

Interpretation

17. In this Reporting Standard:

agent of APRA means a person appointed under section 47 of the *Australian Prudential Regulation Authority Act 1998* to receive data on behalf of APRA.

APRA means the Australian Prudential Regulation Authority established under the *Australian Prudential Regulation Authority Act 1998*.

Chief Financial Officer means the person having the function of chief financial officer of the insurer, by whatever name called, and whether or not he or she is a member of the governing board of the entity, and if there is no such person means a person who performs similar functions to those commonly performed by a chief financial officer.

facility business means business that is closed by bordereau and for which the insurer does not receive individual policy or claims data from the facility manager, and includes business undertaken through an underwriting pool or joint venture arrangement.

Fujitsu Australia means Fujitsu Australia Limited ABN 19 001 011 427.

general insurer has the same meaning as in the *Insurance Act 1973.*

insurer means general insurer.

Principal Executive Officer means the principal executive officer of the insurer for the time being, by whatever name called, and whether or not he or she is a member of the governing board of the entity.

product liability insurance includes policies that provide for compensation for loss and or injury caused by, or as a result of, the use of goods.

professional indemnity insurance includes:

(a) insurance that provides cover for a professional for actions taken against that professional in tort, contract or under statute law in respect of advice or services provided as part of their professional practice, including cover in respect of damages and legal expenses;

(b) directors' and officers' liability insurance and legal expense insurance; and

(c) medical indemnity insurance.

public liability insurance includes:

(a) insurance covering legal liability to the public in respect of bodily injury or property damage arising out of the operation of the insured's business; and

(b) insurance in respect of environmental clean-up costs resulting from pollution where not covered by Fire and Industrial Special Risk policies.

reportable claim means a claim made under a policy of product liability insurance, professional indemnity insurance or public liability insurance that was not finalised or settled by 1 January 2003, not being a claim that relates to:

(a) reinsurance or retrocession cover;

(b) marine insurance;

(c) domestic householder's or owner's insurance, or tenant's liability insurance, sold in conjunction with a building or contents policy; or

(d) an event that could neither occur in Australia nor in relation to an insured resident of Australia.

18. Unless the contrary intention appears, any reference to an Act, Regulation, Prudential Standard, Reporting Standard, Australian Accounting Standard or Auditing Standard is a reference to the instrument as in force or existing from time to time.

19. Where this Reporting Standard provides for APRA to exercise a power or discretion, this power or discretion is to be exercised in writing.

Reporting Form GRF 800.2

Claim Data: Public and Product Liability and Professional Indemnity Insurance

Instruction Guide

These instructions have been prepared for the purpose of defining the claim information required to be submitted by insurers in respect of public and product liability and professional indemnity insurance. This information will contribute to a National Claims and Policy Database (NCPD) in respect of these classes of insurance. The intention is to create a database that holds information in respect of claims and policies for public and product liability and professional indemnity on a national basis. State and Territory Government insurers will also contribute to the NCPD where possible.[1]

Details of requirements in relation to reporting periods, method of submission and authorisation are set out in the Reporting Standard. The data submitted by each insurer will be validated by APRA at each reporting period. The data validation to be performed is outlined in Appendix A.

Record Layouts and Field Specifications

Claim Data Specifications

Claims Data	Data Item	Public & Products	Professional Risk	Field type[1]
1*	Insurer code	M	M	6a
2*	Record type	M	M	1a
3	Status at end of Reporting Period	M	M	1a
4*	Month of End of Reporting Period	M	M	8n
5.1*	Class of Business	M	M	2a
5.2*	Product Type	M	M	3a
6*	Policy Number	M	M	30a/n
7*	Risk Number	M	M	30a/n
8*	Claim Number	M	M	30a/n
9	Date of Loss	M	M	8n
10	Date of Report	M	M	8n
11	Date Finalised	M1	M1	8n

[1] State and Territory insurers are not required to comply with this Reporting Standard *(Reporting Standard GRS 800.2 Claim Data: Public and Product Liability and Professional Indemnity Insurance)*, however, will provide information in accordance with this Reporting Form (GRF 800.2) where possible.

12	Jurisdiction of Claim	M1	M1	3a
13	Deductible/Excess	M	M	12n
14	General Nature of Loss	M1	M1	1a
15	Cause of Loss	M	M	3a
16	Body Functions or Structures Affected	M2	O	1a
17	Severity of Loss	M2	O	1a&1n
18	Litigation Status	M	M	1a
19	Gross Payments in the Reporting Period	M	M	12n
20	Gross Payments to Date	M	M	12n
21	Gross Case Estimate at Start of Reporting Period	M	M	12n
22	Gross Case Estimate at End of Reporting Period	M	M	12n
23	Gross Third Party Recoveries Received	M	O	12n
24	Gross Third Party Recoveries Outstanding	M	O	12n
25.1	Past economic loss	M	M	12n
25.2	Future economic loss	M	M	12n
25.3	Past medical, hospital, caring and related services	M	M	12n
25.4	Future medical, hospital and related services	M	M	12n
25.5	Future caring services	M	M	12n
25.6	General damages	M	M	12n
25.7	Interest	M	M	12n
25.8	Plaintiff legal costs	M	M	12n
25.9	Defendant legal costs	M	M	12n
25.10	Investigation costs	M	M	12n
25.11	Other	M	M	12n

[1]Date must be DDMMYYYY, no delimiter.

Key:

M – mandatory field on all records from 1 July 2004.

M1 – mandatory only if field 3 (Status at end of Reporting Period) = “F”.

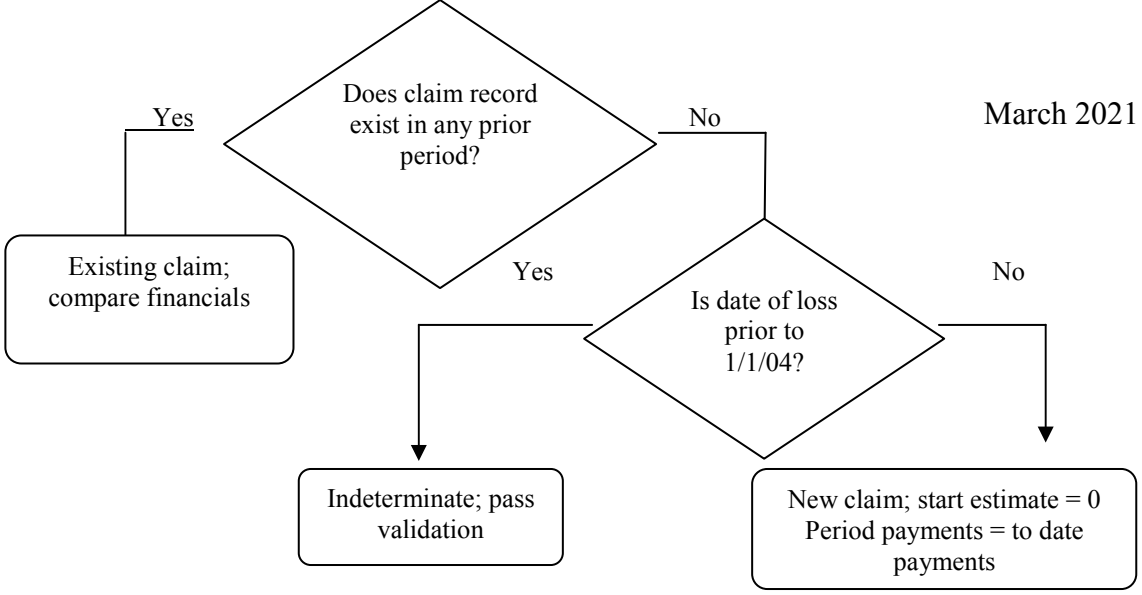
M2 – mandatory only if field 14 (General Nature of Loss) contains a bodily injury component.

O – optional field.

a – alpha.

n – numeric.

* Fields so indicated, as a combination, must be unique.



** A new claim is determined by the following process:

Claims Record Data Field Definitions

1. Insurer code

A unique code assigned by APRA to each contributor.

2. Record type

- C = Claims Record

3. Status at End of Reporting Period

- C = Current
- F = Finalised
- R = Reopened
- S = Structured Settlement

A structured settlement occurs when a claim has been settled and payments are made as annuities over time, rather than in a single payment.

If a claim has been reopened and is closed again in the same period, the status should remain as finalised however there is a need to provide the updated finalised data for such a claim, such as $ paid etc. If a claim has been advised as finalised in a previous submission, has since been reopened AND is still open at the end of the current reporting period, the claim should be recorded as 'Reopened'.

4. Month of End of Reporting Period

The data for each submission will relate to a six month period. Enter as DDMMYYYY the last day of the period being reported, e.g. insert 30062004 for data relating to the six months ending 30 June 2004.

5.1. Class of Business

- PL = Public & Products Liability
- PI = Professional Risk

5.2. Product Type (Table 1)

Class	Public & Products	Professional Risk
Public liability (pure)	PUB	
Products liability (pure) and product recall	PRO	
Mixed public/products cover ('Broadform' liability)	BRD	
Construction liability	CON	
Cyber Insurance	CYB	
Environmental impairment liability	EIL	
Excess Liability	EXL	
Excess Umbrella	EXU	
Umbrella covers	UMB	
Other	PLO	
Professional indemnity (not medical malpractice) and errors & omissions		PII
Association Liability		ASN
Directors' and Officers' liability		D&O
Defamation Insurance		DFI
Employment Practices		EPL
Financial Institutions Policy		FIP
Information & Communication Technology Insurance		ICT
Medical Indemnity/Malpractice		MAL
Management Liability		MAN
Superannuation Trustees		STL
Other		PIO

Note: where business is written as part of a package policy, the "Product type" is to be based on the nature of the cover offered, as set out in the above table. The fact that cover is sold in conjunction with other types of insurance is not collected.

6. Policy Number

A unique policy identifier (which may relate to several separate risk records) by which the exposure and premium information on each individual record can be

identified. Used for matching the policy data in force at date of claim to the claim record. This information is only used for cross-referencing by APRA – it will not be published except in any individual data reports prepared for the insurer concerned.

Where individual claims data is being provided but its associated policy data is being provided in aggregate form in the facility data file, the facility number should be used as the policy number for the claim.

7. Risk Number

A unique risk identifier (which may be the same as the policy number if the policy contains a single risk) by which the exposure and premium information on each individual record can be identified. Used for matching the policy data in force at date of claim to the claim record. This information is only used for cross-referencing by APRA – it will not be published except in any individual data reports prepared for the insurer concerned.

8. Claim Number

A unique identifier of a claim. This information is only used for cross-referencing by APRA – it will not be published except in any individual data reports prepared for the insurer concerned.

9. Date of Loss

Enter as DDMMYYYY the date on which the incident giving rise to the claim is believed to have occurred.

For claims made policies where an actual date of loss is not available, code this field as the date that the claim is notified to the insurer. For losses incurred based (or occurrence based) policies, the Date of Loss should be the date of the event that gave rise to the claim, or the best estimate of the date of that event(s).

10. Date of Report

Enter as DDMMYYYY the date on which the claim was reported (not processed) to the agent or insurer.

11. Date Finalised

Enter as DDMMYYYY the date on which the finalised. This field should only be completed when all payments to the claimant(s) and any third party suppliers are believed to have been made and all recoveries expected from third parties (ignoring reinsurers) have been received. Note that a claim may be recorded as finalised even if recoveries from reinsurers have not been received.

Reopened claims that are still open at the end of the reporting period **must not** have a "date finalised".

12. Jurisdiction of Claim

This is the state (ACT, NSW, NT, QLD, SA, TAS, VIC or WA) where the claim has been decided by a court judgement. If the claim is decided in a federal court, input the

state where the claim was heard. However, if the claim is settled out of court, then input the state where the claim was settled, this would usually be the State or Territory in which the claimant resides.

A claim that never reaches the stage of a writ is an out of court claim.

Where an insurer has multiple claimants under the one claim and payments are made to each claimant, but in different jurisdictions, the jurisdiction of the principle claimant should be used.

If the claim was settled overseas, code the jurisdiction as that of the policy holder's principle address.

This field is mandatory for finalised claims only.

13. Deductible/Excess

Total of all deductibles or excesses applied to this claim in whole dollars. This may differ from the amount shown in field 20 on the related exposure record.

For Liability XOL policies, the relevant attachment point should be reported.

14. General Nature of Loss (Table 3)

General Nature of Loss	**Code**
Bodily injury or death	B
Property damage only	P
Financial loss only (no physical damage or bodily injury)	F
Both property damage and bodily injury	L
Both bodily injury and financial loss	X
Both property damage and financial loss	Y
Property damage, bodily injury and financial loss	Z

If a claim is comprised of more than one general nature of loss field type (i.e. P (property damage) and B (bodily injury)), then a claim may only be coded as L, X, Y or Z if the relevant component is greater than 15% of the claim amount.

15. Cause of loss (Tables 4 & 5)

Code one of the causes shown in the following tables (for appropriate class of business). The most significant contributing factor should be identified. Where a suitable cause of loss was not recorded in respect of a claim that occurred before 30 June 2004, report a hyphen ("-").

APRA Code	**Claim Type – Public & Products Liability (Table 4)**	**Current ISA Code(s)** (for information only)
ABM	Abuse/molestation	L12
ANM	Animal bite/attack/impact	L88,L16, L62

ASB	Asbestos/Dust Diseases	L14
CAT	Catastrophe, e.g. Cyclone, earthquake	
CUS	Care/custody/control	L50
COL	Collapse of building/structure/subsidence/landslide/weakening and or removal of supports/rusting/oxidation/discoloration including concrete cancer	L18, L42, L86, L40
CYF	Cyber – 1st party loss	
CYT	Cyber – 3rd party loss	
DFM	Defamation/slander	L53
DSC	Discrimination/harassment	L54
ELC	Electrocution	L21
ENV	Environmental contamination or pollution/spray/drift/other contamination/exposure to or contact with substance/ Not mould or asbestos	L72, L80, L19, L24
APRA Code	**Claim Type – Public & Products Liability (Table 4)**	**Current ISA Code(s)** (for information only)
EQB	Equipment breakdown and accidental breakage	L22, L11
EXP	Explosion and/or vibration/exposure to sudden or long-term sound or noise/excavation/drilling damage	L23, L56, L43, L65
NEG	Failed or injurious treatment by practitioner or consultant, or negligent advice	L29, L69
FLL	Fall including from height and slip & fall	L25, L41
FPW	Faulty product/faulty workmanship	L51, L59
FIR	Fire including welding	L27, L87
IMP	Impact or damage by object/vehicle/person, including physical assault/trapped by machinery or equipment	L30, L44, L66, L37, L83
LSL	Lease liabilities	L64
LFT	Lifting, carrying or putting down objects/machinery use/repetitive or overuse injury	L63, L66, L77
MLD	Mould	L89
OTH	Other non financial loss i.e. losses with no tangible value attached such as 'Pain and Suffering'	L48
OFN	Other financial loss i.e. losses that are tangible	L26
WTR	Water	L46
WKR	Worker to worker injury	L47

APRA Code	**Claim Type – Professional Risk (Table 5)**
	Non performance or improper, inappropriate, inadequate, incorrect, incomplete, inaccurate, untimely provision of :
AA	Advice
AB	Assault /abuse / mistreatment
AE	Anaesthetic

BC	Breach of confidentiality
BL	Blood Products
BT	Breach of trust / fiduciary duties
CI	Conflict of interest
CO	Consent (incl. no valid consent, failure to warn, acting against patient's wishes)
DA	Documentation/ administration
DE	Defamation
DI	Diagnosis
DS	Design / specification
EQ	Faulty and/or inadequate / inappropriate / inaccurate / contaminated equipment and/or premises
FR	Fraud & dishonesty. Fidelity
HA	Harassment / discrimination
IC	Infection control / prevention
IN	Insolvency
IP	Breach of intellectual property rights
IT	Improper trading / collusive practices /unconscionable conduct
LD	Loss of documents
LE	Legal expense coverage (disciplinary enquiries, investigations, inquests and the like)
ME	Medication
MI	Misleading and/or deceptive advice/conduct (specifically section(s) of federal Trade Practices Act, state Fair Trading Acts and the like)
OR	Other
PM	Project management
PR	Procedural
SE	Services other than specified above
SH	Sexual harassment
SI	Supervision / inspection
APRA Code	**Claim Type – Professional Risk (Table 5)**
TE	Testing
TR	Treatment
UD	Unfair dismissal

16. Body Functions or Structures Affected (Table 6)

Code the most significant body function or structure affecting the claimant as known at the end of the reporting period, for all claims involving bodily injury where claim item 14 (General Nature of Loss) contains a bodily injury component i.e. B, L, X or Z.

APRA Code	Body Functions or Structures Affected
C	Cardiovascular, Haematological, Immunological and Respiratory

D	Death
E	Digestive, Metabolic and Endocrine Systems
G	Genitourinary and Reproductive
M	Mental or Nervous System
N	Neuro-musculoskeletal and Movement-Related
P	Sensory, Pain, Eye, Ear and Related Structures
S	Skin and Related Structures
V	Voice and Speech

17. Severity of loss (Table 7)

Code the severity of the loss underlying the claim for all claims involving bodily injury where claim item 14 (General Nature of Loss) contains a bodily injury component i.e. B, L, X or Z.

APRA code	**Severity of loss**
L1	Minor or mild injury to soft tissue; minor lacerations; bruising; minor psychological harm
L2	Minor or simple fractures; larger lacerations
M1	Moderate injury usually involving nerve or tissue damage; major psychological harm
M2	Serious injury involving loss of tissue, internal bleeding, ruptured tissue or organs; serious and permanent psychological damage
S1	Major injury involving brain injury likely to lead to permanent impairment
S2	Major injury involving spinal cord injury likely to lead to permanent impairment
S3	Quadriplegia
S4	Paraplegia
S5	Other major injury leading to a disability that is likely to permanently reduce the earning capacity or activity in the community of the claimant

18. Litigation Status (Table 8)

Extent to which case has proceeded through the legal system.

APRA Code	**Litigation Status**
O	Claim is not litigated
N	Plaintiff does not have legal representation
U	Plaintiff has legal representation but the claim has not been resolved.
L	Plaintiff has obtained legal advice but settlement was reached by negotiation (whether court proceedings were commenced or subsequent to a judgement but before an appeal court determination)
V	Case was settled by court judgement (whether lower court or appeal court) and defendant
	paid judgement amount (i.e. either case was not appealed or appeal was not upheld)

W	Plaintiff has legal representation and elects to withdraw the claim.
X	Plaintiff has legal representation, but the case is not awarded in plaintiff's favour

19. Gross Payments in the Reporting Period

The amount of payments made since the last reporting period, net of GST in whole dollars, no decimal point. Includes payments made to claimant and to third-party service providers (medical, legal, investigation) that are attributed to the claim.

Note:

1) Data should be provided based on your share only.

2) Income Tax Credits are excluded.

3) The values reported should represent the cost to the insurer however the standard assumes that GST paid out on a claim will be recovered by the insurer. If no recovery is available, then the full value should be reported including GST.

20. Gross Payments to Date

The amount of payments made on this claim since the claim was first reported, net of GST in whole dollars, no decimal point. Includes payments made to claimant and to third-party service providers (medical, legal, investigation) that are attributed to the claim.

21. Gross Case Estimate at Start of Reporting Period

Total of all payments expected to be made in future to the claimant(s) and third party providers at the start of the reporting period, net of GST in whole dollars, no decimal point. Equals field 22 on the corresponding claim record that was submitted for the previous reporting period. Will be zero if this claim was first reported in the current reporting period.

Note:

1) Data should be provided based on your share only.

2) Income Tax Credits are excluded.

3) The values reported should represent the cost to the insurer however the standard assumes that GST paid out on a claim will be recovered by the insurer. If no recovery is available, then the full value should be reported including GST.

22. Gross Case Estimate at End of Reporting Period

Total of all payments expected to be made in future to the claimant(s) and third party providers at the end of the reporting period, net of GST in whole dollars, no decimal point. Will be zero if the claim is finalised.

Note:

1) Data should be provided based on your share only.

2) Income Tax Credits are excluded.

3) The values reported should represent the cost to the insurer however the standard assumes that GST paid out on a claim will be recovered by the insurer. If no recovery is available, then the full value should be reported including GST.

23. Gross Third Party Recoveries Received

Total of all amounts that have been received to date from third parties in respect of the claim, net of GST in whole dollars, no decimal point. Excludes any amounts that have been received under reinsurance contracts.

Salvage should be reported as a third party recovery.

Note: Data should be provided based on your share only.

24. Gross Third Party Recoveries Outstanding

Total of all amounts that are expected to be received after the end of the reporting period from third parties in respect of the claim, net of GST in whole dollars, no decimal point. Excludes any amounts expected to be received under reinsurance contracts. Will be zero if the claim is finalised.

Salvage should be reported as a third party recovery.

Note: Data should be provided based on your share only.

25. Gross Claim Payments by Head of Damage before Third Party Recoveries (This field is not used)

A breakdown of the total settlement amount into the following heads of damage is required for finalised claims only. The total of items 25.1 to 25.11 must equal item 20

– Gross Payments to Date, with any rounding difference included in item 25.11 (Other).

Note:

1) Data should be provided based on your share only.

2) Income Tax Credits are excluded.

3) The values reported should represent the cost to the insurer however the standard assumes that GST paid out on a claim will be recovered by the insurer. If no recovery is available, then the full value should be reported including GST.

A finalised claim is one where field 11 (date finalised) has been recorded and field 22 (gross case estimate at end of reporting period) is zero.

Where a claim is settled out of court, contributors should provide a reasonable estimate as to how the total claim is distributed between the Heads of Damages categories.

25.1. Past economic loss

25.2. Future economic loss

25.3. Past medical, hospital, caring and related services

25.4. Future medical, hospital and related services 25.5. Future caring services

25.6. General damages

25.7. Interest

25.8. Plaintiff legal costs

25.9. Defendant legal costs

25.10. Investigation costs

25.11. Other

Appendix A: Data Validation

As well as unit record validation, overall reasonability checks will be carried out on each insurer's data.

With each half-yearly data submission

Various comparisons between the current reporting period and the previous period will be carried out in order to monitor data reasonability and consistency. These may include:

- Change in the aggregate Gross Earned Premium, split by two digit ANZSIC code or single character occupation code;
- Changes in the total numbers of policies and claims;
- Counts of claims by various measures; causes of loss, severity or litigation status; and
- Changes in the average and total claims paid.

As well, various reasonability checks will be carried out within each period submission, including;

- Overuse of the various 'Other' categories and codes; and
- Comparison of the various premium fields against each other.

Other reasonability checks may be carried out on an ad hoc basis.