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Lodging an insurance claim – Information for GPs and practice owners

Background

This information sheet contains practical information for GPs and practice owners on how to lodge an insurance claim and what to expect throughout the claims process. It also provides guidance on developing an asset register and information on how to seek financial hardship support, where relevant and required.

The information provided in this document is intended to be used as guidance only. Always consult with your insurance provider, legal, and financial advisors for professional advice.

Initiating your insurance claim

Register your claim

The first thing you need to do is to contact your insurer or insurance broker to formally lodge your claim. Your insurer or insurance broker can provide you with your policy details and a copy of your insurance policy if required.

If you have an insurance broker, they can assist you registering your claim and liaise with the insurer on your behalf.

If you do not remember who your insurer is, you can contact the Insurance Council of Australia (ICA) on 1300 728 228 for assistance.

Detail the event

When communicating with your insurer or insurance broker, you will need to provide detailed information about the event, including when and what occurred, how and why it happened, and the resulting consequences.

Providing as much information as possible will help your insurer or broker determine the next course of action.

Document the damage

Documenting the extent of the damage, including the time and the date of the event will provide a clearer picture to your insurer. Where possible:

- take clear photographs and videos of any damaged areas and equipment, and
- create a list of all damaged items including details such as their brand, model and serial number.

Collate essential documentation

Having the necessary paperwork will ensure a smoother and more efficient claims process. There are various financial, business and legal documents you will need to provide to your insurer to support your claim, including:

- police reports,
- details of witnesses to the event,
- receipts for damaged items,
- medical reports for injuries included in the claim,
- financial documents,
- evidence to support loss of income, and
- relevant correspondence and letters.

The ICA has a detailed list of documents and information required to support your insurance claim.

Formalising your claim

To ensure your claim is processed promptly, it is crucial to complete the required forms accurately. Forms may vary from insurer to insurer, but if you have an insurance broker, they can assist you in navigating this process.

Once your insurance claim has been lodged, your insurer will review your claim and identify what actions need to be taken. Depending on the extent of the disaster or emergency, there may be delays in getting your claim settled.

Additional supporting documentation may be required based on the nature of your claim. Should this be the case, your insurer or broker will get in touch with you.

Appointing of assessors and external experts

Your insurer may appoint experts like tradespeople to evaluate the safety of your property, or a loss adjuster to assess the steps needed for your recovery.

In certain cases, it may be necessary for your insurer to obtain expert evaluations or visit the site to inspect the damage. For example, your insurer may engage an engineer to inspect the extent of structural damage to your property.

If your insurer is a signatory to the ICA's Code of Practice, they must inform you of any engagement with loss assessors or loss adjusters within five business days of having done so.

Requesting copies of reports

You can request copies of all reports by loss assessors or adjusters, as well as any external expert reports. If your insurer is a signatory to the ICA's Code of Practice, they should receive expert reports within 12 weeks from the time of engagement. If the external experts are not able to meet this timeframe, your insurer will keep you informed.

Claims review, negotiation and settlement

Once all documentation has been submitted and site inspections completed, your insurer will proceed to review your insurance claim to determine its outcome.

Your insurer will notify you of whether your claim has been accepted or denied. The timeframe for when this occurs is varied and will be determined by the scale of the emergency or disaster.

If your claim is accepted, you will receive a settlement offer. Included in your settlement offer will be a Scope of Work or Statement of Work (SOW). The SOW is a detailed document outlining the specific tasks, repairs, and actions the insurer has agreed to undertake to restore your general practice to its pre-loss condition. It includes a detailed breakdown of the damage caused by the incident, along with an impact assessment.

Cash settlement

Your insurer may offer a cash settlement to cover the cost of repairs or replace any damaged items. If you accept a cash settlement, this means you will need to manage any repair, or restoration works to your buildings and replace any damaged items yourself.

If you are offered a cash settlement for your insurance claim, it is recommended you seek professional legal or financial advice to determine whether the settlement is fair and reasonable.

The Insurance Council of Australia provides a range of information regarding claims and settlement processes.

Rejected claims

If your claim is denied or your insurer does not pay in full, your insurer must inform you in writing of this decision and include:

- the rationale behind the decision,
- the elements of your claim that were not accepted,
- your entitlement to request the information your insurer used to assess your claim, and
- your right to request any assessment reports or external expert reports.

Your insurer must also inform you of their complaints process and your right to make a complaint.

Disputing your insurance claim

If you disagree with your insurer's decision, you can ask for a review. When a review is requested, your insurer is required to undertake an internal review and may appoint an Investigator or Employee to review your claim.

If a review does not resolve your dispute with your insurer, or if the requested review was not completed within 30 calendar days, you can make a complaint to the Australian Financial Complaints Authority (AFCA). This must be done within two years from the date your insurer makes its final decision.

AFCA will require your insurer to respond to your complaint within 21 days of its lodgement with AFCA. During this time, your insurer may contact you in an attempt to resolve the dispute.

More information on AFCA's dispute resolution process is available here.

Additional information

Creating an asset register

It is recommended that all general practices create an asset register to document the physical and digital assets owned by the practice. Ideally this would be available online or a hardcopy kept offsite.

Your asset register could include photos or videos of each listed asset including all medical equipment and infrastructure. You should include details such as the manufacturer/brand, model and serial number, proof of purchase/purchase date, warranty documentation, and any associated fit-out costs. The asset register should be reviewed periodically to ensure that it accurately represents the assets you own. Whenever the asset register is updated, forward a copy to your insurer so that they can revise the value of your contents.

An established asset register can help support any insurance claims you may need to make.

Financial hardship support

If you experience financial hardship when your claim is being processed, you can request support from your insurer. Your insurer is required to have information regarding financial hardship provisions on their website and to provide information on the type of support options available to you.

Once you have successfully demonstrated you are experiencing financial hardship, your insurer may be able to make emergency payments to you within five business days. Your insurer may deduct any advance payments from the total value of your claim.

Alternative funding sources such as government grants and payments may be available to you during this time. The National Emergency Management Agency provides funding to states and territories through the Disaster Recovery Funding Arrangements to provide urgent financial assistance to disaster affected communities.

Delays in claims processing

There may be a delay in processing your claim in the event of an extraordinary catastrophe or disaster. Under the ICA's Code of Practice, an extraordinary catastrophe is defined as a disaster of substantial size or scale, or one that occurs simultaneously with several other disasters. In this case, your insurer must make a decision about your claim within 12 months of receiving it.

However, if you feel that your insurer is unreasonably delaying your claim, you are entitled to make a complaint to your insurer. If you are dissatisfied with your insurer's response, you can lodge a dispute with ICA.

Additional resources

Insurance Council of Australia	https://insurancecouncil.com.au/ 1300 728 228
Australian Financial Complaints Authority	https://www.afca.org.au/ 1800 931 678
General Insurance Code of Practice	https://insurancecouncil.com.au/cop/
Disaster Recovery Funding Arrangements	https://www.nema.gov.au/our-work/disaster-recovery/disaster-recovery-funding-arrangements • ACT • NSW • NT • QLD • SA • TAS • VIC • WA
Information for GPs in disaster-affected areas	https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/naturaldisasters
General practice grants and commissioning	https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/general-practice-grants-and-commissioning
Alternative funding sources for general practice	https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/alternative-funding-sources-for-general-practice