A Guide to Motor Vehicle Accident's post December 2017

To make a claim for compensation you will first need to complete the Application for Personal Injury Benefits Form (APIB). To complete this form the following needs to be obtained if able: -

- Police event number
- Certificate of capacity showing your fitness for work from your general practitioner
- Evidence of your income if you are claiming loss of income
- Accounts/receipts for medical treatment you have incurred

The APIB should be completed within 28 days from the date of the MVA as this will ensure you receive weekly payments (if you have required time off work) from the date you were unable to work.

- The APIB however, can be lodged after 28 days of the date of accident, however, must be done so **within three months of the date of accident**. Once submitted the insurer will then begin payments from the date of receipt. If the claim is lodged late an reasons explaining the delay will need to be lodged.

Once the claim form is processed by the insurer you will be contacted and provided with a claim number and relevant contact details for your claim's consultant. If the insurer accepts the claim, they will commence making weekly payments and medical expenses to you within 14 days.

The first 26 weeks:

Under the MAIA, an individual is entitled to the following benefits for the first 26 weeks following the date of accident regardless of fault. These benefits are as follows:

i. Weekly payments:
   - Your weekly payments are payable by the insurer for the income you have lost. The payments are payable at a percentage of your pre-accident income.
   - The first 13 weeks will be paid at 95% of your weekly income
   - Weeks 14-26 will be 80% of your weekly income

ii. Treatment expenses

iii. Domestic Care & Assistance

iv. Expenses for travel to and from medical appointments

v. Expenses for medical appointments – which are deemed reasonable & necessary

Once the 26-week mark is up post-accident, the insurer will re-assess your claim and make a determination as to whether they will continue your ongoing benefits. The insurer will only do so if the following criteria is met:

1. **They accept liability (fault) for the subject accident**
2. **They classify your injuries as non-minor**

Meaning of a minor injury:

As per the MAIA, the definition of a minor injury is set out. A minor injury is defined as a: **soft tissue injury or a minor psychological or psychiatric injury.** A soft tissue injury is also defined as 'an injury to tissue that connects, supports or surrounds other structures or organs (such as muscles, tendons, ligaments, menisci, cartilage. Fascia, fibrous tissues, fat, blood vessels and synovial membranes), but not an injury to nerves or a complete or partial rupture of tendons, ligaments, menisci or cartilage.' A minor psychological or psychiatric injury is also defined as being an injury that is not a recognized psychiatric illness.

Examples of minor injuries:

- Whiplash, bruising, adjustment disorder, acute distress disorders & stress

Examples of non-minor injuries:

- Injuries to the spinal nerve root that result in radiculopathy, fractures, injury to the nerves, partial or full rupture of cartilage, ligament & tendons, permanent scarring to the body, depression, PTSD, major depressive disorder

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If the insurer accepts that you have sustained a non-minor injury and accepted that you were not at fault for the accident you will be entitled to the following ongoing benefits:

vi. 80% of your weekly income (provided you are unfit to work)
vii. Treatment expenses
viii. Domestic Care & Assistance
ix. Expenses for travel to and from medical appointments
x. Expenses for medical appointments – which are deemed reasonable & necessary
xi. A claim for common law damages ****

Rights of review under the statutory scheme

The internal review process

If the insurer deems your injuries as minor the entitlements to care, treatment, weekly wages & travel will stop. Once a decision has been made, you have 28 DAYS to review the decision by asking the insurer to carry out an internal review. This can be requested via email, phone or letter.

An internal review once received by the insurer will be carried out within 14 DAYS of the date it was requested. The review may affirm the original decision and/or vary it.

What else can be reviewed under an internal review

If the insurer makes a determination that is detrimental to your claim an immediate internal review should be requested. Please note you can review an insurers decision with regards to:

1. A decision regarding your wages
2. A decision regarding your treatment expenses
3. A decision regarding domestic care & assistance
4. A decision regarding travel

After requesting an internal review, the insurer has 14 days to provide a response. If the outcome affirms a decision that is detrimental to the claim an application for review can be lodged with the Dispute Resolution Service (DRS) of SIRA. An application to the DRS must be lodged within 28 days of the date of the internal review decision. The DRS has the ability to assess dispute with regards to whether an injury is minor/non-minor, liability, treatment (and whether it is reasonable), domestic care & assistance and wages.

The DRS once an application has been lodged, will allow the insurer to lodge a reply and from there allocate an Assessor to make a final decision. If a claimant is not happy with the decision of DRS an review application can be lodged (within 30 working days) and/or on the basis of additional clinical evidence.

A DRS application can be lodged early if an insurer fails to provide a internal review outcome 14 days after it has been requested.

If a DRS application is successful, costs are awarded – the maximum regulated costs being $1,616.67 + GST.

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Common Law Damages

If an individual's injuries have been deemed non-minor and the insurer has accepted liability for the subject accident, a claim for common law damages can be lodged. This claim can only be lodged at the 20-month mark post-accident UNLESS the insurer accepts that an individual's injuries will exceed the 10% WPI threshold. The claim for damages is for:

1. Economic Loss – limited to past and future loss of income
2. Non-economic loss – pain and suffering

At the 20-month mark post-accident the Application for Common Law Damages claim form needs to be lodged. Once this is lodged the insurer has 3-months to make another determination on liability. If they accept liability a claim for damages can be made. If not, the matter needs to be referred to the DRS service.

If the insurer fails to make a determination within 3 months, it is deemed that they accept liability.

Once the claim for damages form has been served, a request for the insurer to concede the 10% WPI threshold should be made. At this point the insurer will either concede or will not. If the insurer does not concede a request for an internal review needs to be lodge within 28 days of the date of there decision. The insurer will then provide a review outcome within 14 days of the date of the request.

If an individual is not happy with the review, an application similar to that of the MAS2A needs to be lodged with the DRS to review the issue of WPI:

An application to the DRS must be lodged within 28 days of the date of the internal review decision. The DRS has the ability to assess whether the claimants injuries exceed the 10% WPI threshold. In making the application the claimant MUST submit submissions as to why they believe the claimants exceeds the 10% threshold

The DRS once an application has been lodged, will allow the insurer to lodge a reply and from there allocate an Assessor to make a final decision. If a claimant is not happy with the decision of DRS an review application can be lodged (within 30 working days) and/or on the basis of additional clinical evidence.

As per s 6.25, the claimant is provide the insurer with all relevant particular, so to allow the insurer to make a proper assessment of the claimants' entitlement to damages.

Finalizing the claim

- If liability is accepted and there is a claim for NEL & economic loss, the process would be to write to the insurer and request an ISC.
- If liability is accepted and there is a claim for economic loss but not NEL, the issue process would be to write to the insurer and request an ISC.
- If liability is accepted but there is NEL and/or economic loss – there is nothing that can be claimed

If liability is not accepted and/or the matter does note settle at an ISC, the matter will need to be referred to the DRS service. The DRS can determine disputes and assess damages. There are certain instances in which an exemption certificate can be obtained, those being: the claimant is under legal capacity, the claim involves an action under the Compensation to Relative Act brought on behalf of a person under legal capacity, the claim is brought against a person other than an insurer, the insurer has given notice in writing that the claimant has engaged in fraudulent conduct in contravention of s 6.41