Reporting Standard GRS 800.2

Claim Data: Public and Product Liability and Professional Indemnity Insurance

Objective of this reporting standard

This reporting standard is made under section 13 of the Financial Sector (Collection of Data) Act 2001. It requires general insurers to provide APRA with information on public liability, product liability and professional indemnity policies and facility business, covering similar risks, during a reporting period.

Reporting requirements

1. If, at any time during a reporting period covered by paragraph 2:
   (a) a person makes a reportable claim on the general insurer (insurer); or
   (b) a reportable claim originally made on the insurer before the start of the reporting period has not been settled or is reopened;

   the insurer must report on the claim, in accordance with the Data Specifications, by the time in paragraph 3.

   Note: Reportable claim is defined in paragraph 15.

2. For the purposes of the paragraph 1, the reporting periods are the six month period beginning on 1 January 2005 and ending on 30 June 2005 and each successive 6 month period (ending on a 31 December or a 30 June) after that.

3. A report required by paragraph 1 must be provided:
   (a) if the reporting period ends on 30 June – by no later than the 31 August next following the end of the reporting period; or
   (b) if the reporting period ends on 31 December – by no later than the last day of the month of February next following the end of the reporting period
Variation of reporting periods

4. APRA may, by notice in writing, change the reporting periods for a particular insurer so that it is required to provide reports under this reporting standard in respect of reporting periods based upon the insurer’s own accounting financial year.

5. APRA may, by notice in writing, change the reporting periods for a particular insurer to require it to provide reports under this reporting standard:

(a) more frequently (APRA may require this when, having regard to the particular circumstances of the insurer, APRA considers it necessary or desirable to obtain information more frequently for the purposes of the prudential supervision of the insurer); or

(b) less frequently (APRA may do so when, having regard to the particular circumstances of the insurer and the extent to which it requires prudential supervision, and other relevant considerations, it is unnecessary to require it to provide the information on a 6 monthly basis).

6. If APRA changes a reporting period under paragraph 4 or 5, a report required under this reporting standard in respect of the changed period must be provided by no later than the last day of the second month after the end of the changed period or such later time as APRA may determine in writing.

Method of submission

7. Reports required by this reporting standard must be rendered in comma separated values (CSV) format in accordance with the Data Specifications, and must be provided either:

(a) 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; or

(b) on CD-ROM, which must be sent by post to Fujitsu Australia (as agent of APRA), Level 16, 15 Blue Street, North Sydney, NSW, 2060.

8. Despite paragraph 7, APRA may, in writing, make either or both of the following determinations:

(a) a determination that reports required by this reporting standard must be provided in accordance with alternative information technology requirements specified by APRA in the determination; and
(b) a determination that reports required by this reporting standard must be
provided to APRA or an agent of APRA at an alternative address in
accordance with requirements specified in the determination.

Authorisation

9. Reports provided by an insurer in accordance with this reporting standard must
be the product of processes and controls developed by the insurer for the
internal review and authorisation of the information contained in the reports. 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.

10. Fujitsu Australia (as agent of APRA) will provide each insurer with a customer
identification number. If an insurer proposes to submit reports required by this
reporting standard using the method in paragraph 7(a) (i.e. via the website), the
insurer must apply for a password by viewing the web page referred to in
paragraph 7(a), 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 a report is provided using the method in paragraph 7(a), 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 will be created and the report will be encrypted
before transmission.

11. If a report required by this reporting standard is provided using the method in
paragraph 10(b) (i.e. on CD-ROM), it must be provided under cover of a letter
signed by either:

(a) the Principal Executive Officer of the insurer; or

(b) the Chief Financial Officer of the insurer.

12. Despite paragraphs 10 and 11, where APRA has made a determination under
subparagraph 8(a) or (b) specifying 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

13. APRA may:

(a) make minor variations to the Data Specifications (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; and

(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 the Data Specifications, 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.

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

Interpretation

15. In this reporting standard:

agent of APRA means a person appointed under s 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.

Data Specifications means the Data Specifications in the Schedule.

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; or

(b) marine insurance; or

(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.

16. For the purposes of paragraphs 3 and 6, where a report must be provided by no later than a particular date, the insurer is required to ensure that the report is received by the person to whom it must be provided (whether APRA or an agent of APRA) no later than that date.
Schedule

Data specifications for individual claims for public and product liability and professional indemnity Insurance

Overview

These specifications have been prepared for the purpose of defining the claim information required to be submitted by general 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 general insurer will be validated by APRA each reporting period. The data validation to be performed is outlined in Appendix A.

Record Layouts and Field Specifications

Claim Data Specifications

<table>
<thead>
<tr>
<th>Claims Data</th>
<th>Data Item</th>
<th>Public &amp; Products</th>
<th>Professional Risk</th>
<th>Field type¹</th>
</tr>
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<tbody>
<tr>
<td>1*</td>
<td>Insurer code</td>
<td>M</td>
<td>M</td>
<td>6a</td>
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<tr>
<td>2*</td>
<td>Record type</td>
<td>M</td>
<td>M</td>
<td>1a</td>
</tr>
<tr>
<td>3</td>
<td>Status at end of Reporting Period</td>
<td>M</td>
<td>M</td>
<td>1a</td>
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<tr>
<td>4*</td>
<td>Month of End of Reporting Period</td>
<td>M</td>
<td>M</td>
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<td>M</td>
<td>2a</td>
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<tr>
<td>5,2*</td>
<td>Product Type</td>
<td>M</td>
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<td>9</td>
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<td>8n</td>
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<tr>
<td>10</td>
<td>Date of Report</td>
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<td>M</td>
<td>8n</td>
</tr>
<tr>
<td>11</td>
<td>Date Finalised</td>
<td>M1</td>
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<td>Jurisdiction of Claim</td>
<td>M1</td>
<td>M1</td>
<td>3a</td>
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<td>13</td>
<td>Deductible/Excess</td>
<td>M</td>
<td>M</td>
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<td>General Nature of Loss</td>
<td>M1</td>
<td>M1</td>
<td>1a</td>
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</table>

¹ State and Territory insurers are not required to comply with Reporting Standard GRS 800.2, however will provide information in accordance with this data specification where possible.
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>M</th>
<th>O</th>
<th>a</th>
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<td>16</td>
<td>Body Functions or Structures Affected</td>
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<td>O</td>
<td>1a</td>
</tr>
<tr>
<td>17</td>
<td>Severity of Loss</td>
<td>M2</td>
<td>O</td>
<td>1a&amp;1n</td>
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<td>18</td>
<td>Litigation Status</td>
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<td>19</td>
<td>Gross Payments in the Reporting Period</td>
<td>M</td>
<td>M</td>
<td>12n</td>
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<td>20</td>
<td>Gross Payments to Date</td>
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<tr>
<td>21</td>
<td>Gross Case Estimate at Start of Reporting Period</td>
<td>M</td>
<td>M</td>
<td>12n</td>
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<tr>
<td>22</td>
<td>Gross Case Estimate at End of Reporting Period</td>
<td>M</td>
<td>M</td>
<td>12n</td>
</tr>
<tr>
<td>23</td>
<td>Gross Third Party Recoveries Received</td>
<td>M</td>
<td>O</td>
<td>12n</td>
</tr>
<tr>
<td>24</td>
<td>Gross Third Party Recoveries Outstanding</td>
<td>M</td>
<td>O</td>
<td>12n</td>
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<tr>
<td>25.1</td>
<td>Past economic loss</td>
<td>M</td>
<td>M</td>
<td>12n</td>
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<td>25.2</td>
<td>Future economic loss</td>
<td>M</td>
<td>M</td>
<td>12n</td>
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<tr>
<td>25.3</td>
<td>Past medical, hospital, caring and related services</td>
<td>M</td>
<td>M</td>
<td>12n</td>
</tr>
<tr>
<td>25.4</td>
<td>Future medical, hospital and related services</td>
<td>M</td>
<td>M</td>
<td>12n</td>
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<tr>
<td>25.5</td>
<td>Future caring services</td>
<td>M</td>
<td>M</td>
<td>12n</td>
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<td>25.6</td>
<td>General damages</td>
<td>M</td>
<td>M</td>
<td>12n</td>
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<td>25.7</td>
<td>Interest</td>
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<td>12n</td>
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<td>25.8</td>
<td>Plaintiff legal costs</td>
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<td>Defendant legal costs</td>
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<td>25.10</td>
<td>Investigation costs</td>
<td>M</td>
<td>M</td>
<td>12n</td>
</tr>
<tr>
<td>25.11</td>
<td>Other</td>
<td>M</td>
<td>M</td>
<td>12n</td>
</tr>
</tbody>
</table>

*Date – preference for date is 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:

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)

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

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 claim was 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)

<table>
<thead>
<tr>
<th>General Nature of Loss</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodily injury or death</td>
<td>B</td>
</tr>
<tr>
<td>Property damage only</td>
<td>P</td>
</tr>
<tr>
<td>Financial loss only (no physical damage or bodily injury)</td>
<td>F</td>
</tr>
<tr>
<td>Both property damage and bodily injury</td>
<td>L</td>
</tr>
<tr>
<td>Both bodily injury and financial loss</td>
<td>X</td>
</tr>
<tr>
<td>Both property damage and financial loss</td>
<td>Y</td>
</tr>
<tr>
<td>Property damage, bodily injury and financial loss</td>
<td>Z</td>
</tr>
</tbody>
</table>

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)
--- | --- | ---
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)
--- | ---
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
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.

<table>
<thead>
<tr>
<th>APRA Code</th>
<th>Body Functions or Structures Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Cardiovascular, Haematological, Immunological and Respiratory</td>
</tr>
<tr>
<td>D</td>
<td>Death</td>
</tr>
<tr>
<td>E</td>
<td>Digestive, Metabolic and Endocrine Systems</td>
</tr>
<tr>
<td>G</td>
<td>Genitourinary and Reproductive</td>
</tr>
<tr>
<td>M</td>
<td>Mental or Nervous System</td>
</tr>
<tr>
<td>N</td>
<td>Neuro-musculoskeletal and Movement-Related</td>
</tr>
<tr>
<td>P</td>
<td>Sensory, Pain, Eye, Ear and Related Structures</td>
</tr>
<tr>
<td>S</td>
<td>Skin and Related Structures</td>
</tr>
<tr>
<td>V</td>
<td>Voice and Speech</td>
</tr>
</tbody>
</table>

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.

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

18. **Litigation Status (Table 8)**

Extent to which case has proceeded through the legal system.

<table>
<thead>
<tr>
<th>APRA Code</th>
<th>Litigation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Claim is not litigated</td>
</tr>
<tr>
<td>N</td>
<td>Plaintiff does not have legal representation</td>
</tr>
<tr>
<td>U</td>
<td>Plaintiff has legal representation but the claim has not been resolved.</td>
</tr>
<tr>
<td>L</td>
<td>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)</td>
</tr>
<tr>
<td>V</td>
<td>Case was settled by court judgement (whether lower court or appeal court) and defendant</td>
</tr>
</tbody>
</table>
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.