CTP INSURANCE REGULATOR

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Rules

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Purpose of the Rules

From 30 June 2016 MAC will cease its statutory role as the sole provider of CTP Insurance in South Australia and Approved Insurers will be able to issue Policies to motorists.

The purpose of these Rules is to complement the existing legislative and contractual framework and provide guidance to Approved Insurers as to the operation of the CTP Insurance scheme to ensure fairness, transparency and benefit delivery in service standards, claims management and dispute resolution.

It is a condition of its Approval that an Approved Insurer complies with the Rules. However, the contents provided are not intended to be an exhaustive overview of the CTP Insurance scheme.

All reasonable care has been taken to ensure the information published in these Rules is correct at the time of publication. However, the contents are provided as general information only and are not intended to be exhaustive.

The Rules have been prepared for the use of Approved Insurer staff involved in claims management related tasks. The Rules necessarily contain elements including policy and legal matters which may be subject to alternative interpretation. They are not intended as, nor should they be substituted for, legal advice.

These Rules do not override or substitute an Approved Insurer's obligations under the MV Act, other relevant legislation or applicable common law. In any circumstance where the contents of these Rules are inconsistent with the requirements of governing legislation or applicable common law, those requirements will take precedence. The Rules are not designed to be conclusive on claims management or dispute resolution and the relevant legislation should always be considered when clarifying an Approved Insurer's obligations. It is the responsibility of each Approved Insurer to be aware of and to comply with its legal obligations.

These Rules are subject to continuous review and subsequent updates will be published by the Regulator.

Claimants who take issue with an Approved Insurer should make contact with that insurer before utilising the Complaints process set out at Rule 13.

Definitions

Accident means an accident caused by, or arising out of, the use of a Motor Vehicle;

AHP means an Accredited Health Professional as described in the CLR;

AHP Examination means an examination by an AHP;

Approved Insurer has the meaning given to that term in Part 4 of the MV Act, but excludes MAC;

ARF means an Accident Report Form in such form as may be issued by the Regulator from time to time;

ASIC means the Australian Securities and Investments Commission;

Australian Privacy Principles means the principles described in the *Privacy Act 1988* (Cth), as amended and replaced from time to time;

Business Day means any day except Saturdays, Sundays and declared public holidays in South Australia;

Business Hours means 0900 to 1730 hours Australian Central Standard Time;

Children's Claims means a Claim where the Claimant has not attained the age of 16 years;

CLA means the *Civil Liability Act 1936* (SA), as amended and replaced from time to time;

Claim means a claim for loss or damage:

(a) under, asserted to be under, or capable of being validly made under, a policy of insurance provided under Part 4 of the MV Act; or

(b) a Nominal Defendant Claim;

Claimant means an individual who makes a Claim or on whose behalf a Claim is made, including their properly appointed representative, agent or their solicitor where applicable;

Claimant's Solicitor means a legal practitioner acting in that capacity on behalf of a Claimant in relation to the Claimant's Claim;

Claim Form means a form that facilitates the compliance by Claimants with their Claim reporting obligations under section 126A of the MV Act;

CLR means the *Civil Liability Regulations 2013* (SA), as amended and replaced from time to time;

Complaint means an expression of grievance or dissatisfaction relating to Claims management (but does not include anything relating to offers made by Approved Insurers to resolve a Claim or determinations made by Approved Insurers relating to Claim outcomes) made, either verbally or in writing, to an Approved Insurer that is not resolved to the Complainant's satisfaction;

Complainant means a person who makes a Complaint;

Conciliator means a person approved by the Regulator to be a conciliator or if the Regulator has not approved a person or if that person is unavailable, any other person suitably qualified to be a conciliator;

CTP Insurance means Compulsory Third Party insurance under Part 4 of the MV Act;

CTP Insurance Business means business relating to CTP Insurance;

Customer means a person who holds or intends to hold a Policy with an Approved Insurer;

Data means all hard copy and electronic representation of CTP Insurance scheme information including:

(a) open, closed and archived documents;

(b) accounts, records and all other information relating to Claims made against the CTP Insurance scheme;

(c) document reproduction, document imaging, correspondence and file communication; and

(d) any other storage form directed by the Regulator;

Guardian means a parent of a child, a person who is the legal guardian of the child or has the legal custody of the child or any other person who stands *in loco parentis* to the child and has done so for a significant period of time;

IDR means internal dispute resolution;

Injury means:

(a) bodily injury including mental or nervous shock; or

(b) where the context admits – the death of a person;

insured person has the meaning given to that term in the Part 4 of the MV Act;

Interim Payment means an advance payment of monies the subject of a Claim that would otherwise not be available until settlement of a Claim;

Investigation Provider means an investigator licensed under the *Security and Investigation Industry Act 1995* (SA), as amended and replaced from time to time;

ISV means the injury scale value described in the CLR;

LSA means the Lifetime Support Authority of South Australia established by the LSS Act;

LSS means Lifetime Support Scheme as established by the LSS Act;

LSS Act means *Motor Vehicles (Lifetime Support Scheme) Act 2013* (SA), as amended and replaced from time to time;

MAC means the commission described in the *Motor Accident Commission Act 1992* (SA), as amended and replaced from time to time;

Motor Vehicle has the meaning given to that term in the MV Act;

MV Act means the *Motor Vehicles Act 1959* (SA), as amended and replaced from time to time;

MVR means the *Motor Vehicle (Third Party Insurance) Regulations 2013* (SA), as amended and replaced from time to time;

Nominal Defendant has the meaning given to that term in the MV Act;

Nominal Defendant Claim means a claim for loss or damage:

(a) against, or capable of being validly made against the Nominal Defendant as contemplated by Part 4 of the MV Act; or

(b) in relation to a self-propelled wheelchair or other Motor Vehicle that is taken to be subject to a policy of insurance under Part 4 of the MV Act, as described in section 12A of the MV Act;

Personnel means any employee, contractor or agent of an Approved Insurer who is engaged by the Approved Insurer in conducting the CTP Insurance Business not including Third Party Service Providers or Subcontractors;

Policy and **Policies** have an equivalent meaning to the term "policy of insurance" as used in the MV Act;

Prescribed Authority means a statement authorising the Approved Insurer to access documentary information relevant to the Claim, as required by section 126A(2)(d) of the MV Act and described by Regulation 6 and Schedule 1 of the MVR;

Principal Office means the principal business office of an Approved Insurer located in Australia;

Regulator means the State of South Australia acting through its designated agent;

Return to Work SA means the Return to Work Corporation of South Australia trading as ReturnToWorkSA established pursuant to the *Return to Work Corporation of South Australia Act 1994* (SA), as amended and replaced from time to time;

SAPOL means South Australia Police;

Scheme Stakeholders means Claimants, insured persons, potential Customers of Approved Insurers and any party, aside from an Approved Insurer that may have an interest in and/or provide CTP Insurance Business;

Subcontractor means any subcontractor or agent engaged by an Approved Insurer to fulfil all or part of its obligations to conduct CTP Insurance Business, not including a Third Party Service Provider;

Third Party Service Provider means any person who provides services to an Approved Insurer for the purpose of conducting CTP Insurance Business;

THP means treating health practitioner; and

Treatment, Care and Support Needs has the meaning given to that term in section 127B of the MV Act.

1 The CTP Insurance scheme

1.1 Overview of the CTP Insurance scheme

1.1.1 The MV Act facilitates CTP Insurance which provides compensation for Injury to people injured in road crashes where the driver or owner of a South Australian registered Motor Vehicle is at fault. It may also cover crash victims where a passenger is at fault.

1.1.2 The CTP Insurance scheme is predominantly fault-based meaning:

(a) the injured party must be able to establish negligence against an owner or driver of a Motor Vehicle to obtain compensation; and

(b) owners and drivers of South Australian registered Motor Vehicles are indemnified against liability for an accident causing death or Injury by their Motor Vehicle anywhere in Australia.

1.1.3 No fault compensation is available for:

(a) emergency treatment for all persons injured in Accidents; and

(b) Treatment, Care and Support Needs for those persons who are under the age of 16 at the time of Injury.

1.1.4 Persons otherwise injured as a result of an Accident have no entitlement under the CTP Insurance scheme if:

(a) they were entirely at fault;

(b) they cannot establish fault;

(c) the person at fault was not driving a South Australian registered Motor Vehicle, although if the Motor Vehicle at fault was insured interstate the Claimant may be able to make a Claim against the interstate insurer; or

(d) the claim relates to property damage.

1.2 The role of the Regulator

1.2.1 The Regulator is an independent body responsible for the oversight of the Approved Insurers.

1.3 Conditions on use of these Rules

1.3.1 These Rules have been made available to the general public solely on the basis they are to be used for the good management and efficiency of the CTP Insurance scheme.

1.3.2 These Rules are not to be used for commercial advantage.

2 Market Practice

2.1 Act in good faith with all Customers

2.1.1 Approved Insurers are required to accept all properly identified Motor Vehicles required to be insured under the MV Act presented to them for the issuance of a Policy.

2.1.2 Approved Insurers must avoid marketing techniques that prejudice this obligation in any way.

2.1.3 Approved Insurers are required to give prompt and uniform service to all Customers who approach them for information, irrespective of the risk characteristics of the Motor Vehicle and/or its owner.

2.2 Processes and business practices that do not unfairly discriminate

2.2.1 Approved Insurers and their agents must use processes and business practices that do not unfairly discriminate against individual Customers or Claimants or groups of Customers or Claimants. With the exception of pricing differentiation otherwise expressly permitted under the Rules, Approved Insurers and their agents must treat Customers and Claimants in the same manner irrespective of the risk profile of the Motor Vehicle or Customer or Claimant or the term of the Policy.

2.2.2 Approved Insurers may not pay discounts or incentives linked to Policies to Customers, agents or other intermediaries, whether financial or non-financial. This restriction applies irrespective of whether such discounts or incentives are:

(a) linked directly to the Policy; or

(b) linked to any other product provided to the same Customer or provided separately, but conditional upon or related to:

(i) the issuance of;

(ii) the making of an application for; or

(iii) the holding, renewal or maintenance of,

a Policy.

2.2.3 Approved Insurers and their agents must not encourage Customers to take their business to another Approved Insurer.

2.3 Transparent and practical processes and business practices

2.3.1 An Approved Insurer's communication with the Customer or Claimant must include any information required by the Regulator. The Approved Insurer must ensure that, when required by the Regulator, the Approved Insurers use specific scripts or pro-forma documents.

2.3.2 The Approved Insurer must at all times have sufficient and appropriately skilled Personnel to keep systems, Customer interface and processes required to perform CTP Insurance Business up to date, operational and consistent to all Customers.

3 Approved Insurer obligations

3.1 Guiding principles

3.1.1 When issuing or administering Policies and Claims an Approved Insurer and its agents must:

(a) act in good faith with all Customers;

(b) deal as expeditiously as possible with Claims;

(c) ensure its processes for dealing with Claims are efficient, cost effective and in accordance with law;

(d) encourage early and appropriate treatment and rehabilitation for people who suffer Injuries;

(e) use processes and business practices that do not unfairly discriminate against individual Customers or Claimants or groups of Customers or Claimants;

(f) maintain service standards and business practices consistent to all Customers;

(g) not discriminate against individuals or groups;

(h) engage in processes and business practices that are transparent and practical for the purpose of issuing Policies to Customers;

(i) make Policies readily accessible and available to all Customers;

(j) accept all properly identified Motor Vehicles presented to it for the issuance of a Policy; and

(k) not selectively discourage or de-incentivise Customers from selecting the Approved Insurer, or attempt to do so.

3.1.2 Approved Insurers must not adopt tactics or techniques that prejudice these obligations in any way, irrespective of the risk profile of the Customer, their Motor Vehicle or the Motor Vehicle owner.

3.2 Contact Points

3.2.1 An Approved Insurer must have a Principal Office for providing CTP Insurance Business with staff that are competent and authorised to deal with Claims on the Approved Insurer's behalf.

3.2.2 That Principal Office and any other locations in Australia where the Approved Insurer provides CTP Insurance Business:

(a) must be open for business on every Business Day during Business Hours; and

(b) must be staffed sufficiently to deal with enquiries and provide CTP Insurance Business within a reasonable time frame.

3.3 Other contact requirements

3.3.1 An Approved Insurer must have:

(a) a dedicated telephone line (listed in white pages and yellow pages in hard copy and online) that is available to take telephone calls on every Business Day during Business Hours;

(b) a dedicated facsimile line;

(c) a dedicated email address; and

(d) such other or replacement methods as may be notified by the Regulator as being, in the Regulator's opinion, convenient having regard to changes in communications technology.

3.4 Web site

3.4.1 An Approved Insurer must have a web site in place that:

(a) provides users with the facility to download forms including Claim Forms;

(b) is prominently linked to the Regulator's website;

(c) is up to date and provides relevant and appropriate information for Scheme Stakeholders and members of the public;

(d) provides general contact information for the Approved Insurer;

(e) does not cross-advertise CTP Insurance Business and other Approved Insurer products on the same web page;

(f) contains any other information as directed by the Regulator; and

(g) includes a reference to and provides a hyperlink to any materials the Regulator requires the Approved Insurer to provide,

and the Approved Insurer must enable (or must diligently work towards enabling) Claimants to lodge Claims online through the Approved Insurer's web site.

3.5 Service Levels

3.5.1 Approved Insurers must:

(a) deal with enquiries from Claimants, Customers and their representatives in a professional and courteous manner;

(b) contact insured persons as soon as they become aware of or are notified of an insured person's involvement in an Accident;

(c) provide assistance to Claimants to ensure they are able to comply with Claim lodgement requirements;

(d) provide clear and accurate information as to the making and assessment of Claims;

(e) focus on the early assessment of Claims;

(f) respond to enquiries whether made by telephone, in person or by email as soon as reasonably practicable;

(g) advise Claimants of the progress of their Claim;

(h) discuss and explain to Claimants any decisions they make about their Claim and provide them with the opportunity to provide feedback;

(i) provide information and assistance to Claimants and help them through processing a Claim;

(j) expeditiously advise Claimants if and when additional information may be required;

(k) make fair and reasonable assessments of Claims in accordance with law; and

(l) have a sound and clear process to deal with Complaints.

3.6 Claimant conduct

3.6.1 It is acknowledged Claims will be determined more efficiently when Claimants:

(a) complete the Claim Form to the best of their ability;

(b) comply with any legal requirements and obligations;

(c) give honest and accurate information about their Claim and do not deliberately withhold information or their consent to obtain information;

(d) advise if circumstances change that affect their Claim;

(e) provide information in a timely manner to assist in the decision making process and resolution of their Claim;

(f) commit to optimising their recovery from injuries and mitigating any loss they have suffered; and

(g) abide by relevant laws and ensure their representatives do likewise.

4 Information and privacy

4.1 Compliance with Australian Privacy Principles

4.1.1 In addition to any statutory requirements which apply to Approved Insurers, when performing CTP Insurance Business, Approved Insurers and their Representatives must comply with the Australian Privacy Principles.

4.2 Subcontractor's privacy obligations

4.2.1 An Approved Insurer must ensure any agents, subcontractors and representatives it uses to provide CTP Insurance Business also comply with the Australian Privacy Principles.

4.3 Collection of personal and health information

4.3.1 When an Approved Insurer collects personal and health information about a Claimant, they must take reasonable steps to ensure the Claimant is aware of:

(a) their organisation’s identity and contact details;

(b) the purpose for which the information is collected;

(c) the persons or entities to which information of that kind is usually disclosed;

(d) any law that requires the information to be collected; and

(e) the main consequences, if any, for the person if all or part of the information is not provided.

4.4 Use of Data

4.4.1 Approved Insurers will take all reasonable steps to ensure Data collected through the Claim process, and subsequent Data collected by use of the Prescribed Authority, will remain protected and only be disclosed for the purposes of a function conferred on them to provide CTP Insurance Business or to comply with a legal obligation.

4.4.2 Approved Insurers will take all reasonable steps to ensure third parties engaged by them also comply with these requirements.

4.4.3 Approved Insurers must only use or disclose personal or health information to another person, body or agency for a secondary purpose if:

(a) it is necessary and relevant to perform their Claims management obligations and functions under the MV Act;

(b) they have the individual Claimant's consent;

(c) a Claimant would reasonably expect disclosure;

(d) the use or disclosure is required, authorised or permitted by the MV Act or another law (e.g. court orders, subpoenas, statutory demands by agencies such as Centrelink or the Australian Taxation Office); or

(e) the use or disclosure is necessary for the enforcement of a criminal law, law imposing a financial penalty or the protection of public revenue (e.g. a criminal investigation for providing false or misleading information or to detect and prevent fraud).

4.4.4 This list is not exhaustive and the above uses/disclosures are not mutually exclusive. More than one purpose or exception may be applicable.

4.4.5 Approved Insurers must not allow employees to access personal information they have collected including viewing/browsing of information on a screen or in hard copy, making a record of the information (e.g. printing out material) and/or disclosing the information to third parties, without a reasonable purpose related to Claims management activities.

4.4.6 Unauthorised access or disclosure must immediately be reported to the Regulator. Exceptions to those reporting requirements are:

(a) an employee working on a Claim file identifies and rectifies/removes foreign records from a Claim file;

(b) collecting/viewing another employee's print out/fax in error from a utility room only to realise and return it;

(c) an employee identifying and remedying an incorrect, outdated address or wrong enclosures before sending/posting correspondence; and

(d) an internal check/audit identifying areas or issues for improvement about privacy.

4.5 Disclosure of prescribed information

4.5.1 If the Regulator produces any leaflets, brochures or other publications relating to the CTP Insurance scheme for dissemination to Scheme Stakeholders, the Approved Insurer must:

(a) openly display them to, and make them readily available for collection by, Scheme Stakeholders:

(i) at the Principal Office and any other locations from where CTP Insurance Business is provided from time to time in South Australia;

(ii) on the Approved Insurer's website; and

(iii) in their complete and accurate form, as provided by the Regulator; and

(b) expeditiously forward them to Scheme Stakeholders upon request by those Scheme Stakeholders.

4.6 Requests for information

4.6.1 A request for information related to a Claim may be made by:

(a) a Claimant; or

(b) a person authorised by the Claimant to obtain the information.

4.7 A valid request

4.7.1 A request must be made in writing and clearly describe the information, document or documents being requested.

4.7.2 The request may be made directly to the Approved Insurer that manages the Claim and holds the information or documents requested.

4.7.3 If a request is from an authorised representative of a Claimant it must be accompanied by a current (within 24 months), specific and signed written consent or authority. If there is any doubt the request is not authorised by the Claimant, the Approved Insurer may contact the Claimant to seek confirmation.

4.7.4 Approved Insurers must assist Claimants with the information they require to make a valid request.

4.7.5 Approved Insurers can release information to the Claimant or, if authorised, the Claimant's representative.

4.8 Exemptions from information requests

4.8.1 An Approved Insurer is not required under these Rules to release internal working documents which include documents which may relate to or contain information:

(a) regarding law enforcement;

(b) the subject of legal professional privilege;

(c) about a person that is private;

(d) that is provided in confidence, including information in relation to business or trade secrets;

(e) that may pose a serious threat to life or health; or

(f) regarding internal workings which would include but are not limited to:

(i) internal briefings or memoranda made by the Approved Insurer or the Regulator;

(ii) documents relating to negotiation strategy or future planned activities (for example to conduct surveillance at a future date);

(iii) draft documents; or

(iv) documents that reveal opinion, deliberation or intentions of an Approved Insurer about negotiations with the Claimant that would expose the Approved Insurer to an unreasonable disadvantage.

4.9 Freedom of information

4.9.1 Approved Insurers must provide any assistance required by the Regulator to enable the Regulator to comply with the Regulator's obligations under the *Freedom of Information Act 1991* (SA).

5 Claims management

5.1 Process

5.1.1 Approved Insurers must endeavour to optimise a Claimant's experience in making a Claim by:

(a) providing information and assistance to Claimants and helping them through the process;

(b) being proactive in obtaining sufficient information early to be in a position to assess and resolve the Claim as soon as possible and advising Claimants if and when additional information is required (as detailed in Rule 6);

(c) if there are issues affecting the Claim (such as liability), discussing them with the Claimant, including how they affect their Claim and any entitlement to compensation;

(d) being transparent in the Claim process by advising Claimants what steps are being taken and why, in order to assist in the assessment and management of the Claim;

(e) disclosing when the Prescribed Authority is being used and for what purposes;

(f) subject to Rule 5.1.2, providing the Claimant with a copy of any information obtained using the Prescribed Authority within 21 days of the Approved Insurer receiving such information, unless such disclosure could give rise to a serious and imminent threat to an individual's life, health or safety; or a serious threat to public health or public safety;

(g) in relation to Children's Claims, focusing on paying for Treatment, Care and Support Needs to optimise the Claimant's recovery (subject to liability or other issues) (as detailed in Rule 10); and

(h) in respect of an interstate Motor Vehicle that is uninsured, obtaining proof from the relevant interstate insurer or authority responsible for regulating the relevant interstate compulsory third party insurance scheme, that the interstate Motor Vehicle was uninsured at the time of the Accident.

5.1.2 Nothing in Rule 5.1.1(f) operates to relieve an Approved Insurer of its obligations under section 126A(4) of the MV Act, which obligations prevail over Rule 5.1.1(f) to the extent of any inconsistency.

5.1.3 Approved Insurers must:

(a) have a consistent approach in place to ensure the Claim process is explained to Claimants throughout the Claim lifecycle;

(b) develop and disseminate supporting Claims management information to explain the Claims management process to Claimants; and

(c) ensure Claims management information materials are approved by the Regulator prior to dissemination.

5.2 Making a Claim

5.2.1 Section 126A(1) of the MV Act provides that a person who seeks to make a Claim must provide an Approved Insurer with a Claim Form which must set out or be accompanied by:

(a) a certificate or opinion as to the nature and probable cause of the death or injury (as the case requires) provided by a medical practitioner;

(b) the relevant police report number for any report provided to a police officer under the *Road Traffic Act* 1961 (SA) in connection with the relevant accident;

(c) a Prescribed Authority enabling the Approved Insurer to have access to records and other sources of information relevant to the claim; and

(d) such other report or other information in relation to the Accident or Claim as may be prescribed by the MVR from time to time.

5.3 Time Limits

5.3.1 Regulation 4 of the MVR provides the Claimant is required to submit the Claim Form to the Approved Insurer:

(a) in relation to a Claim against a Nominal Defendant, as soon as reasonably practicable after it becomes apparent that the identity of the relevant Motor Vehicle is not readily ascertainable or the relevant Motor Vehicle uninsured; or

(b) within 6 months of the Accident in any other case.

5.3.2 Failure to comply with the above timeframe may be viewed by an Approved Insurer as a failure to comply with the notice requirements of section 126A(6) of the MV Act meaning that:

(a) an Approved Insurer may decline to consider or deal with the Claim, but this does not effect a Court's ability to determine a Claimant's entitlement to compensation; or

(b) the Claimant is not entitled, until he or she complies with the notification requirements pursuant to section 126A(2)(c) and (d), to commence proceedings or to continue proceedings that have been commenced in respect of the death or Injury.

5.3.3 Pursuant to Regulation 4 of the MVR, section 126A(6) will not operate in relation to a failure to comply with time limits if the failure to give notice of the Claim within the relevant periods was occasioned by:

(a) ignorance or mistake on the part of the Claimant;

(b) absence of the Claimant from South Australia;

(c) inability of the Claimant to lodge within the prescribed timeframe due to Injury or a legal disability; or

(d) any other reasonable cause,

provided the proper assessment of a Claim has not been substantially prejudiced.

5.3.4 Exceptions to the general position above would be:

(a) a Claimant who is only seeking payment of a limited number of medical expenses (i.e. a maximum of 6 treatments);

(b) where a police report has not been provided because such a report is not provided by the police (for example involving buses where no collision has occurred or accidents occurring on driveways or other private property); or

(c) any other exceptions under the MVR.

5.3.5 An Approved Insurer must provide information, support and assistance to Claimants to ensure they are aware of their obligations to comply with the notice requirements in section 126A(2).

5.3.6 Where a non-compliant Claim is submitted, the Claimant must be advised, and provided the opportunity to correct the situation within a reasonable time.

5.4 Photocopies, faxes or scans

5.4.1 Photocopies, faxes or scans of approved forms can be acceptable if all copies contain the appropriately signed authority and are clearly legible.

5.4.2 While it is still recommended the Claimant forwards the original copy of all forms, the Approved Insurer must start the Claim registration and liability process using the photocopied/faxed/scanned forms.

5.4.3 A Claimant may give or serve the Claim Form and related documents on an Approved Insurer and the Approved Insurer must accept those documents by any of the following means:

(a) mail or in person;

(b) electronic methods (if the original signed document is scanned);

(c) facsimile; or

(d) such other or replacement methods as in the opinion of the Regulator are convenient having regard to changes in communications technology.

5.4.4 In order for a Claim to be processed, a Claimant must ensure all pages and sides of the Claim Form are provided and (if applicable) keep the successful facsimile confirmation or email as evidence of transmission.

5.5 Acknowledging a Claim

5.5.1 Upon receipt of a Claim an Approved Insurer must:

(a) ensure Accident and Claim information is accurately recorded;

(b) register all participants and witnesses to the Accident;

(c) assign a unique accident number to each Accident;

(d) assign a unique number to each Claim;

(e) identify and link participants from previous Accidents to the current Claim as facilitated by the Regulator;

(f) link each Claim to an accident number;

(g) ensure a Claim receipt notification letter is sent to the Claimant;

(h) ensure there are reasonable attempts to make early contact via telephone with the:

(i) Claimant individually, or if represented, the Claimant's Solicitor;

(ii) insured person;

(iii) other known parties involved in the Accident; and

(iv) witnesses to the Accident;

(i) assign a claims consultant as the primary contact responsible for the future management of the Claim;

(j) ensure the Claimant and the insured person receive the unique identifier for the Claim; and

(k) comply with any other requirements as directed by the Regulator.

5.6 Contacting Claimants

5.6.1 An Approved Insurer is to contact Claimants directly, or if the Claimant is legally represented, the Claimant's Solicitor, subject to the below exceptions.

5.6.2 The Approved Insurer may send correspondence directly to a Claimant who is legally represented if:

(a) it contains only generic information about making and resolving Claims;

(b) it provides details about an AHP Examination or other medical examination arranged by the Approved Insurer; or

(c) it is in regards to a Claimant's rehabilitation,

provided that a copy is also sent to the Claimant's Solicitor.

5.6.3 An Approved Insurer may contact a Claimant who is legally represented directly if:

(a) requested to do so by the Claimant;

(b) there is no substantive reply from the Claimant's Solicitor to the Approved Insurer's offer of settlement within 10 days and attempt has been made by the Approved Insurer to confirm receipt of the offer of settlement;

(c) there is no substantive reply from the Claimant's Solicitor to the Approved Insurer's correspondence (excluding offers of settlement) within 20 days, and an attempt has been made by the Approved Insurer to confirm receipt of the correspondence; and

(d) in response to a Complaint by the Claimant.

5.7 Enquiries required to make a liability determination

5.7.1 What enquiries an Approved Insurer makes in relation to determining liability will be determined by the facts of each Claim and cannot be specified but may include:

(a) making enquiries appropriate to the Accident circumstances;

(b) conducting a search of the SAPOL system and obtaining a police report of the Accident;

(c) ensuring an ARF is requested from the driver(s), the insured person and the Claimant;

(d) where an ARF is not received from the insured person, ensuring reasonable efforts are made by the claims consultant to contact the insured person and to ascertain and record their version of events;

(e) obtaining witness statements where applicable; and

(f) ensuring where liability is contentious, or the circumstances of the Accident are unclear, further enquiries are conducted and consideration is given to referring the matter to an appropriate investigation provider.

5.8 Determining liability

5.8.1 An Approved Insurer must ensure the liability determinations are:

(a) made appropriately according to the evidence on the Claim file;

(b) made in a timely fashion;

(c) made in accordance with relevant law;

(d) based on sound evidence to support the decision;

(e) with rationale documented on the Claim file; and

(f) promptly notified to the Claimant and the Approved Insurer.

5.8.2 An Approved Insurer must provide written notice to the Claimant in reasonable time advising:

(a) whether the Approved Insurer admits or denies liability for the Claim;

(b) the reasons for the Approved Insurer's decision; and

(c) the evidence that supports those reasons.

5.8.3 Where contributory negligence is a reason for not wholly admitting liability, the Approved Insurer must advise the Claimant of:

(a) the level of contributory negligence attributed to the Claimant;

(b) the reasons for that decision; and

(c) the evidence that supports the contributory negligence alleged.

5.9 Interpreters

5.9.1 An Approved Insurer must provide, at its cost, interpreting services for Claimants to assist them in completing the Claims process.

6 Medical examinations and reports

6.1 Purpose of medical reports

6.1.1 An Approved Insurer may seek a medical report from a Claimant's THP or an AHP in order to:

(a) determine a Claimant's eligibility for initial or ongoing entitlements;

(b) review a Claimant's ongoing medical and health services;

(c) manage a Claimant's rehabilitation; and

(d) determine medical, treatment and Claims liability and entitlement issues, such as an ISV.

6.2 Provision of medical report to Claimant

6.2.1 Subject to Rule 6.2.2, an Approved Insurer must, on receipt of a medical report relevant to a Claim, provide the Claimant to whom the medical report relates with a copy of the report within 21 days, unless such disclosure could give rise to a serious and imminent threat to an individual's life, health or safety; or a serious threat to public health or public safety.

6.2.2 Nothing in Rule 6.2.1 operates to relieve an Approved Insurer of its obligations under section 126A(4) of the MV Act, which obligations prevail over Rule 6.2.1 to the extent of any inconsistency.

6.3 Selection of AHP

6.3.1 When selecting an AHP an Approved Insurer must endeavour to:

(a) match the speciality of the AHP to the Claimant's Injury or the medical treatment or rehabilitation issue to be resolved;

(b) ensure the choice of the AHP is not motivated by the opportunity to obtain an opinion from an AHP who is considered to hold particular views (adverse to Claimants) on specific medical conditions or treatment issues; and

(c) not exert influence on the AHP about the outcome of the examination report.

6.3.2 An Approved Insurer may obtain a report from another medical practitioner who is not an AHP if:

(a) there is no AHP with speciality relevant to the Claimant's Injury or it is otherwise not reasonably practicable to use an AHP;

(b) that medical practitioner has speciality relevant to the Claimant's Injury; and

(c) the Approved Insurer arranges the examination and medical report as if the examiner was an AHP under these Rules.

6.4 Arranging an AHP Examination

6.4.1 In arranging an AHP Examination, an Approved Insurer must:

(a) identify issues that may impact on a Claimant's ability to attend the examination, for example:

(i) if a Claimant has limited ability to use stairs this may make it unsuitable to attend a particular AHP's rooms;

(ii) if a Claimant is from a rural or remote location they may require an afternoon or early evening appointment; or

(iii) cultural or religious issues which may dictate the required gender of the AHP;

(b) if the Claimant is attending the AHP appointment, advise the Claimant at least 7 days prior to the appointment occurring by letter of:

(i) the date, time and location of the appointment;

(ii) the name of the AHP and contact details;

(iii) the speciality of the AHP;

(iv) the reason for attending the AHP appointment;

(v) the need to take medical reports, x-rays and other relevant documentation about the Claimant's Injury, where appropriate, to the appointment;

(vi) any information prescribed by the Regulator for that purpose;

(vii) a map reference or public transport stop for the AHP's rooms;

(viii) their obligation to attend and the fact a failure to do so may adversely affect their Claim; and

(ix) the need to notify the Approved Insurer if they are unable to attend the AHP Examination due to a change in circumstances within 2 Business Days of the AHP Examination occurring or other time so as to avoid any cancellation fee;

(c) send all relevant documentation to an AHP at least 2 Business Days prior to the appointment, which will include but is not limited to:

(i) details about if and when that AHP has previously examined the Claimant;

(ii) Claim Forms and/or ARF's;

(iii) medical certificates (Limited to first and last unless otherwise relevant);

(iv) any relevant medical history, records or notes provided by the Claimant's medical practitioner;

(v) any relevant hospital notes;

(vi) any other medical information so far as it is relevant to the Claim;

(vii) any previous reports from different AHPs, other medical examiners and investigation reports (if relevant);

(viii) details of a Claimant's pre-Injury work capacity, recreational activities and functioning (if available); and

(ix) any documents required by the rules of the Court or practice directions including a copy of Practice Direction 5.4 and Rule 160 *Supreme Court Civil Rules 2006* (SA) or Rule 68 of the *Magistrates Court (Civil) Rules 2013* (SA) as applicable;

(d) only disclose information to an AHP that is relevant to the examination;

(e) not request an AHP to provide an opinion on matters outside their area of medical expertise; and

(f) if an Approved Insurer believes there is a potential safety risk for an AHP in examining a Claimant, the Approved Insurer must discuss security requirements with an AHP before confirming an appointment, implement any security arrangements required or requested by the AHP and allow the AHP the option to decline the referral.

6.4.2 In arranging an AHP Examination, an Approved Insurer must determine whether an interpreter is required. Professional interpreters should be used rather than a Claimant relying upon family members or friends to interpret. If an Approved Insurer is uncertain as to whether an interpreter is required they should make enquiries with the Claimant when arranging the examination.

6.4.3 In addition to the above, when arranging an AHP Examination in Children's Claims, Approved Insurers should endeavour to, wherever possible:

(a) reach agreement with the Claimant's parent or Claimant's representative as to a relevant AHP;

(b) attempt to minimise the need for multiple assessments; and

(c) arrange examinations so as to minimise interference with educational commitments.

6.5 Arranging AHP Examinations through solicitors

6.5.1 If solicitors acting on behalf of an Approved Insurer arrange an AHP Examination the Approved Insurer must ensure they comply with the same Rules.

6.6 Payment for medical examinations

6.6.1 An Approved Insurer must pay for the cost of a medical examination or assessment by an AHP or other health professional and the report on the examination or assessment where the Approved Insurer:

(a) arranged the medical examination or assessment; or

(b) authorised or approved the medical examination or assessment before it was conducted.

6.6.2 If a Claimant fails, without reasonable cause, to attend an examination as required by an Approved Insurer then:

(a) an Approved Insurer may request the Claimant makes payment of any cancellation fees incurred because of the Claimant's non-attendance; and

(b) if a request is made by the Approved Insurer, the Claimant is liable to pay for any fees incurred by the Approved Insurer and the Approved Insurer may set this off against any liability for payment of damages or compensation.

6.6.3 When a cancellation fee is paid by the Approved Insurer the Claimant must be advised that a cancellation fee has been incurred.

6.7 ISV assessments

6.7.1 A Claimant may request in writing that an Approved Insurer arrange an ISV assessment with an AHP and the Approved Insurer must, subject to Rule 6.7.2, arrange that assessment if:

(a) 12 months have passed since the date of Injury;

(b) liability in relation to the Injury or Injuries has been accepted; and

(c) a settlement of damages has not been reached between an Approved Insurer and a Claimant.

6.7.2 If requirements in Rule 6.7.1 are met then an Approved Insurer may only refuse a request if:

(a) it is unlikely a person's Injury or Injuries will score above ISV 7; or

(b) the Claimant's Injury or Injuries are not sufficiently stable for an ISV assessment to occur.

6.7.3 If an Approved Insurer accepts the request under Rule 6.7.1 it must:

(a) expediently arrange the ISV assessment with an AHP in accordance with these Rules;

(b) notify the Claimant of its determination and the details of the ISV assessment; and

(c) pay any costs associated with the ISV assessment.

6.7.4 If an Approved Insurer refuses a request under Rule 6.7.1 then it must:

(a) expediently notify the Claimant;

(b) provide to the Claimant details of the basis of the denial; and

(c) if the denial is a result of insufficient evidence, advise the Claimant as to what further evidence is required.

7 Cost of travel

7.1.1 An Approved Insurer must pay reasonable travel expenses which clearly arise from treatment for the Accident injuries or attendance at an AHP Examination.

7.1.2 Travel by private vehicle is reimbursed on a per kilometre basis at the Return to Work SA gazetted rate but reimbursement for petrol and like expenses will not be considered as this is incorporated in the Return to Work SA rate.

7.1.3 Approved Insurers are not required to reimburse travel in relation to court appearances and appointments with legal representatives, damage or loss of property resulting from travel, and infringements incurred whilst travelling are not claimable.

8 Investigations

8.1.1 The Approved Insurer must only engage an Investigation Provider to conduct any investigation the subject of the *Security and Investigation Industry Act 1995* (SA).

8.1.2 An Approved Insurer must ensure any Investigation Provider engaged by it:

(a) complies with all relevant laws; and

(b) is aware of and complies with any relevant requirements placed on an Approved Insurer by these Rules.

9 Use of service providers

9.1.1 An Approved Insurer must not, without the prior written consent of the Regulator, permit another person to exercise its responsibility for the determination or resolution of Claims by way of assignment, transfer, agency agreement or other similar arrangement.

9.1.2 Such prior approval may be granted by the Regulator by the Regulator's express acceptance of the Approved Insurer's Business Plan containing full details of each relevant service provider and the scope of its proposed role.

9.1.3 Approval of a service provider may be withdrawn by the Regulator at any time at its absolute discretion by notice in writing to the Approved Insurer.

10 Children's Claims

10.1 Children's Claims requirements for Approved Insurers

10.1.1 The Approved Insurer must ensure:

(a) an appropriate claims management strategy is in place which recognises the unique nature of Children's Claims and the effect on families of such Claimants;

(b) evidence is gathered and maintained during the Claim lifecycle;

(c) Children's Claims are actively managed;

(d) Children's Claims are reviewed at regular intervals coinciding with the Claimant's key development milestones;

(e) dedicated specialist personnel assist in achieving optimal health and functional outcomes for Claimants who are children if the number of Children's Claims require it; and

(f) Children's Claims are managed in accordance with any other directions given by the Regulator.

10.2 Assessment of necessary and reasonable treatment in Children's Claims

10.2.1 In establishing whether treatment is necessary and reasonable in Children's Claims, an Approved Insurer must consider the following:

(a) reasonable:

(i) any advice provided to the Claimant by treating practitioners;

(ii) whether the proposed treatment is recognised and appropriate;

(iii) background and medical history of the Claimant;

(iv) the relationship of the treatment to the Injury caused by or arising out of the Accident;

(v) whether evidence exists the proposed treatment is not recommended or against best practice principles; and

(vi) the proposed number and frequency of services; and

(b) necessary:

(i) the expected benefit to the Claimant;

(ii) whether the proposed treatment is effective in improving recovery;

(iii) whether other treatments have been undertaken and the outcome to date; and

(iv) whether refusing funding would result in deterioration in the Claimant's condition and rate of recovery.

10.3 Court Approval in Children's Claims

10.3.1 An Approved Insurer must not settle entitlements under Section 127B of the MV Act without the consent of the Claimant, or, if the Claimant remains a minor as at the date of settlement, the Claimant's Guardian.

10.3.2 An Approved Insurer must not compel the Claimant or the Claimant's Guardian to enter into settlement negotiations with respect to Section 127B of the MV Act entitlements.

10.3.3 In relation to a settlement of section 127B of the MV Act entitlements or damages corresponding to those entitlements, an Approved Insurer must obtain court approval in relation to the settlement of either no fault entitlements or damages (or both) in circumstances where the Claimant remains under the age of 18 years at the date of settlement and is not legally represented.

10.3.4 An Approved Insurer must allow the Claimant to obtain an opinion from independent legal counsel to enable the court to approve or reject the proposed settlement and make orders in relation to the manner in which settlement funds are to be paid.

11 Interim Payments

11.1.1 A Claimant may request in writing that an Approved Insurer make an Interim Payment in respect to their Claim.

11.1.2 An Approved Insurer must only consider making an Interim Payment to a Claimant where:

(a) there is evidence of financial hardship demonstrated by a Claimant's:

(i) incapacity for work;

(ii) inability to pay for necessary and reasonable medical treatment;

(iii) spouse or partner being unable to work;

(iv) inability to focus on their recovery due to financial stress;

(b) fault has been established in relation to the Accident;

(c) there is enough evidence to establish the Claimant's entitlement to damages;

(d) that Interim Payment would not exceed the overall estimated value of the Claim;

(e) there is no suspicion of fraud on the part of the Claimant;

(f) the Claimant has completed a Prescribed Authority which remains valid; and

(g) the treatment requested is necessary and reasonable.

11.1.3 In determining financial hardship an Approved Insurer may take into account and request from a Claimant:

(a) sick certificates;

(b) letters from employers confirming leave taken or the Claimant's inability to work;

(c) particulars of pre- and post-Injury income and expenditure;

(d) outstanding bills, invoices or other requests for payment; and/or

(e) financial records including business activity statements, bank account statements or correspondence with Centrelink.

11.1.4 An Approved Insurer must assess requests received from a Claimant for an Interim Payment within 10 Business Days of receipt of the request.

11.1.5 If, following an Approved Insurer's assessment, the request is approved the Approved Insurer must:

(a) expediently notify the Claimant;

(b) ensure any necessary statutory clearances are obtained (e.g. Centrelink);

(c) ensure the Claimant signs a discharge releasing the Approved Insurer from making future payment of damages in respect to the amount of the Interim Payment; and

(d) upon receipt of a signed discharge and statutory clearances, make Interim Payment to a Claimant within 5 Business Days.

11.1.6 If, following an Approved Insurer's assessment, the request is denied the Approved Insurer must:

(a) expediently notify the Claimant;

(b) provide to the Claimant details of the basis of the denial; and

(c) if the denial is a result of insufficient evidence, advise the Claimant as to what further evidence is required.

12 Lifetime Support Scheme

12.1 Obligations of disclosure

12.1.1 Approved Insurers must disclose and make available information to Claimants who qualify for or may qualify for the LSS as prescribed by the Regulator from time to time.

12.2 Referral of Claimants to the LSS

12.2.1 Approved Insurers must:

(a) not refer Claimants to the LSS without supporting evidence the Claimant will qualify to be a participant in the LSS;

(b) provide early information and assistance regarding the LSS to a Claimant where appropriate and necessary;

(c) use best endeavours to consider whether application to LSA is appropriate; and

(d) provide early notification of possible LSS claims to LSA where appropriate.

12.3 Management of Claimants who may be potential or interim LSS participants

12.3.1 Approved Insurers must not actively encourage or discourage Claimants from making a Claim or continuing to receive benefits pursuant to Section 127B of the MV Act in the event they qualify for participation in the LSS.

12.3.2 Subject to any other eligibility criteria prescribed by legislation, an Approved Insurer must not seek to bar Claimants from receiving compensation pursuant to section 127B of the MV Act solely by reason they were an "interim" participant in the LSS.

12.4 Notification to be given to the Regulator

12.4.1 If an Approved Insurer:

(a) has referred a Claimant to the LSS; or

(b) is involved in a dispute with the LSA or a Claimant regarding a Claimant's participation in the LSS; or

(c) has rejected a Claim for compensation pursuant to section 127B of the MV Act on the basis a Claimant is or has been a participant in the LSS,

it must notify the Regulator.

13 Disputed Claims

13.1 IDR processes

13.1.1 If a Claimant disagrees with a determination made by an Approved Insurer in relation to a Claim, the Claimant may ask to have that decision referred to the relevant Approved Insurer's IDR process.

13.1.2 Approved Insurers must ensure their IDR processes comply with the standards and requirements made or approved by ASIC including:

(a) Australian Standard AS ISO 10002-2006 Customer satisfaction—Rules for complaints handling in organisations; and

(b) ASIC Regulatory Guide 165.

13.1.3 Approved Insurers must obtain approval from the Regulator for their IDR processes.

13.1.4 Approved Insurers must have detailed IDR processes and the IDR processes must be fully explained to Claimants.

13.1.5 Subject to any restriction imposed by law, medical reports, assessor's reports, witness statements, private investigator's reports and anything else obtained by Claimants, Approved Insurers or their legal advisers with respect to a Claim will be exchanged between the Claimant and Approved Insurer as part of the ADR process.

13.2 Conciliation

13.2.1 If a Claimant disagrees with a determination by an Approved Insurer, and the Claimant requests the Approved Insurer conciliate the dispute, the Approved Insurer must agree to conciliate the dispute with a Conciliator if the Claimant's request to conciliate the dispute is made within 30 days of the date of the relevant determination.

13.2.2 If a Claimant requests conciliation an Approved Insurer must arrange conciliation with a Conciliator within 30 days of the request being made.

13.2.3 The Approved Insurer must consider any directions given by the Conciliator.

13.2.4 Approved Insurers must pay the costs of a conciliation conference including the costs of the Conciliator.

13.2.5 A Claimant who attends a conciliation conference is entitled to seek reimbursement from an Approved Insurer for:

(a) reasonable expenses of the Claimant's transport to and from the conciliation up to a maximum of $50; and

(b) loss of income incurred by the Claimant as a result of attending the conciliation up to a maximum of $350.

13.3 Offers of settlement

13.3.1 An Approved Insurer must endeavour to resolve a Claim expeditiously and reduce costs associated with the Claim by making a settlement offer when reasonable to do so or by giving proper consideration to any settlement offer received from a Claimant.

13.3.2 If an Approved Insurer receives a settlement offer from a Claimant, the Approved Insurer must respond to the settlement offer in writing.

13.3.3 Approved Insurers must ensure any offers of settlement to a Claimant in relation to a Claim:

(a) are reasonable and supported by sufficient evidence and clearly state the offer is subject to any statutory repayments and deduction of interim payments and special damages;

(b) comply with the law and/or reflect common law principles;

(c) state all statutory or common law reductions for negligence; and

(d) are made expeditiously, once sufficient supporting evidence is present.

13.4 Settlement Payments

13.4.1 Approved Insurers must ensure settlement payments:

(a) have all statutory repayments, statutory reductions, interim payments, reductions for negligence and credit for special damages taken into account; and

(b) are authorised following the receipt of final statutory and other clearances and notices.

13.5 Notice of Claim (90 day rule)

13.5.1 The Claimant is required to give written notice to Approved Insurers at least 90 days prior to filing proceedings with the Court containing or accompanied by:

(a) an offer to settle the Claim on a basis set out in the notice;

(b) sufficient details of the Claim, and sufficient supporting material, to enable the Approved Insurer to assess the reasonableness of the Claimant's offer of settlement and to make an informed response to that offer; and

(c) if the Claimant is in possession of expert reports relevant to the Claim, copies of the expert reports.

13.5.2 Approved Insurers must, within 60 days after receiving a written notice referred to in Rule 13.5.1, respond in writing to the notice by:

(a) accepting the Claimant's offer of settlement;

(b) making a counter offer which is accompanied by sufficient details and supporting material to enable the Claimant to assess the offer and to make an informed response to it; or

(c) stating that liability is denied and the grounds on which it is denied.

13.5.3 Approved Insurers must endeavour to resolve a Claim within 90 days of receiving written notice of a Claim from a Claimant.

13.6 Receiving a summons or complaint

13.6.1 Approved Insurers must accept service of proceedings on behalf of their insured persons.

13.7 Approved Insurers to pay costs and expenses

13.7.1 Approved Insurers agree costs and expenses which are incurred by those Approved Insurers in the management of a Claim are to be paid solely by the relevant Approved Insurers.

14 Complaints

14.1 Complaints to be initially raised with Approved Insurers

14.1.1 It is expected in the first instance Complaints will be raised with the relevant Approved Insurer as the first point of contact.

14.2 Process for making a Complaint

14.2.1 Approved Insurers must develop and maintain a fair, equitable and non-discriminatory process for addressing Complaints.

14.2.2 The Approved Insurer may adopt a process for addressing Complaints that is approved by the Regulator, but at a minimum, must:

(a) ensure the Complaint is dealt with appropriately by its personnel;

(b) endeavour to resolve all Complaints within 21 days of receiving the Complaint;

(c) provide a final response to the Complaint in writing to the Complainant within 45 days;

(d) ensure a consistent approach is in place for managing and recording Complaints received by Approved Insurers;

(e) ensure Scheme Stakeholders and members of the public are advised of the Complaint management process in a variety of forms of communication, formats and languages appropriate to the needs of Claimants or members of the public;

(f) ensure Complaints are managed efficiently and individual Complaints are promptly responded to;

(g) train personnel involved in the Complaints management process;

(h) ensure their dealings with Complainants are clearly recorded;

(i) investigate Complaints in a timely and effective manner and, where a prolonged investigation is necessary, provide regular feedback to the Complainant;

(j) handle Complaints at no charge; and

(k) record:

(i) the date;

(ii) the name of the Complainant;

(iii) the Complainant's contact details;

(iv) the Claim number;

(v) a brief description of Complaint;

(vi) the action in progress; and

(vii) the resolution of the Complaint.

14.2.3 Approved Insurers must, where appropriate, introduce service improvements to reduce the incidence of Complaints.

15 Motor vehicles registered outside South Australia

15.1.1 Claims in respect of liabilities arising under section 127B of the MV Act which are caused by or arise out of the use of a Motor Vehicle that is registered in a State or Territory other than South Australia, will be allocated by the Regulator to a member of the Approved Insurer Group on a basis to be determined by the Regulator in its discretion, having regard to the Market Share of each Approved Insurer.

15.1.2 Where a Claim is allocated to an Approved Insurer by the Regulator pursuant to item 15.1.1, the Approved Insurer must manage and resolve the Claim:

(a) as if the Claim was made under a Policy for the purposes of the MV Act;

(b) as if the Motor Vehicle that caused the Injury was registered in the State of South Australia; and

without regard to whether a Claimant is entitled to make a claim for compensation or damages for the same Injury under the laws of a place other than South Australia (whether within or outside Australia).