SUBMISSION ON POLICY ISSUES RAISED IN ROUND 6

Submitted By: [redacted]
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Submission for: My Self
Name of other person, business or organisation:
Do you agree to your submission being published: Yes
Do you agree to your full name being published: No
Your submission:
Further to my earlier points in my submission on Insurance; [redacted]

I have posted a submission this morning Your reference number is POL.0006.0001.0195 but I have now seen that the cut and paste didn't work properly on your page. I hadn't reached the limit of characters so I have done it again. I phoned your office and [redacted] said to resend. I apologise for any doubling up. I have a brain injury from the accident.

See Below:

Submission on the processes of third party insurance motor accident claims

Written with assistance

I want victim advocacy to be included in equal representation on the Board and Stakeholders

I don't agree with the policy to have as the CEO of the Insurance Regulator an executive from the Insurance or Banking Industry. I don't think that is correct.

N.B. I was told by a Senior person associated with the Regulator that the Insurance Industry is "very influential" within the Regulator.

Please note the current CEO o[redacted]y has been the subject of some criticism in his role on the [redacted] following the investigations of this Royal Commission into Banking and Financial Services.

I don't agree with the policy to have as the [redacted] insurance executive who also has an extra vote. I don't think that policy is correct.

I believe the CEO needs to be a person of good standing within the community selected for example in the way the Legal Aid Review Committee are selected, people of good standing in the community who have proven understanding of community expectations.

I believe the Board needs to include victim representatives and people of good standing in the community such as are selected on the Legal Aid Review Committee.

I should be provided with a copy of all evidence and statements where that is relied upon to refuse a claim

The Regulator should enforce their own guidelines and forms such as when an insurer refuses to scope investigations within the privacy scope of their statutory declaration the Regulator requires claimants to sign. The claimant should not have to go to the Privacy Commissioner at their own time and cost of another 2 years. And the Regulator should not tell the claimant to make the complaint to the Privacy Commissioner and then threaten a claimant for so doing.

I think the Regulator should provide a State Government CTP Fraud Taskforce for claimants. At present the State Government CTP Fraud Taskforce won't "investigate it's members" and is not interested in fraud committed against claimants by insurers.

I don't think it's correct that an Insurer can do a section 81 notice accept breach of duty of care and deny injury loss and damage and not provide reasons and fully disclose evidence.

I don't think it's correct that the regulator should accept that the statement of the driver at fault (that said there was no injury) was sufficient prima facie evidence to deny injury loss and damage when the insurer had medical and police evidence and reports that states there was injury loss and damage, including to the car of the driver at fault (who refused to give me her details)

The bar of prima facie should be reasonable not spurious and ridiculous

I don't think it's correct to say that because a claimant reported they had a previous injury is prima facie evidence to deny injury in this accident

The insurer should be required to provide reasons and evidence at the time of refusing treatment and injury

For example, the claimant should not have to be the one to test case of fraud or utmost good faith ? or breach of process

The Regulator should be able to make a ruling on whether there was a breach of process and guidelines regardless of whether the decision was reviewed on complaint whereas the Regulator just said, because they wouldn't investigate and I had to go to the Minister and by that time it was too late for my best rehabilitation 2 years after the injury and because the Insurer reviewed their decision (disingenuously) once the Minister became involved, the Regulator simply said in 2012 "I understand, and am sorry for the disruption that was caused by this decision, but as discussed

when we met, this decision had already been reversed by the insurer by the time the MAA intervened as a result of your complaint in 2006" and refused to breach them or even make a finding, in spite of them saying that it affected my rehabilitation. N.B. it was "reversed" disingenuously.

I don't think it's correct that I can't have a support person present at medical assessments whereas at present it is at the doctor's discretion

I don't think it is correct that a doctor can tell a support person to leave during a medical assessment for no good reason and cause distress to a person with PTSD and brain injury.

I think a claimant should be allowed to record medical and other assessments

I think claimant should be allowed to record CARS Hearings – which I wasn't, though I was unrepresented because my lawyer had retired and they had a full legal team they refused.

The Claims process should allow a specialist medical assessor specific to the type of injury and profession occupation they are assessing for example for a pianist who has wrist injuries and there are assessors who have that

They should be more specialised to the injury they are assessing e.g. they had an assessor who does pianists and occupational medical assessments but didn't allow me to be assessed by them and they have a wrist specialist assessor as I damaged my wrists on the bicycle accident the extent of which were not detected till I saw a wrist specialist but they refused to provide a wrist specialist assessor, just a ("run of the mill") upper limb assessor.

The claimant should be able to have a medical specialist specific to the particular specialty and injury

The SIRA should inform the claimant as to which injury or injuries the medical assessor is assessing as they may need to be prepared due to brain injury and PTSD and the complex nature of multiple injuries, for example with bringing x rays and diary notes.

Medical assessors should tell you what they're assessing you for.

The medical assessor should be provided with a list of whatever reports and x rays are being sent to them for them to verify everything is included

The claimant should get a copy of whatever is sent to the medical assessor to verify it is correct and everything is included such as lists of reports and x rays sent to the assessor

I think a claimant should have their disabilities accommodated and be allowed to refer to notes if they have a brain injury and memory problem

An itemized list should be sent with the evidence and a copy provided to ensure all the relevant and available medical evidence is provided

Sufficient time should be allowed during medical assessments to cover all aspects of assessments including accommodating the claimant's disabilities

I don't think it's correct that the claimant and assessor is not given sufficient notice when appointment changes are made

I think it is incorrect that an assessor should raise claims of inconsistencies of video evidence without either specifying or showing the claimant on the DVD itself examples of what he is talking about so that they may respond

Manage expectations

Round 6 submissions

For example:

Conclusions up front. There is a systemic problem within these groups. They use delay threats and intimidation to avoid paying claims and there is no effective recourse.

1. I had the accident - bicycle vs car, I was on bicycle, I'll never play piano again.

police report said car damaged and I was injured, doctors and police said I was injured.

1. I was denied
2. My treating physio complained to Insurer
3. Denied
4. I complained to Regulator
5. Regulator said no use complaining

1. Went to the Minister
2. Insurer said "standard form" admit fault deny injury loss and damage,
3. Regulator found Insurer breached 4 sections of the Act, one repeat offence
4. No penalty

1. Insurer continued to deny treatment.
2. Insurer sought medical information 3-4 years out of time in 2008.
3. Insurer breached Regulator privacy scope
4. Harassed my doctors

1. Major Hospital complained Insurer arguably inappropriate, misleading, misrepresenting me – N.B. use same insurer

and legal firm.

1. Insurer threatened to withdraw my claim
2. Regulator said complain to Privacy Commissioner
3. Insurer said they are an "agent" of the Regulator

1. Insurer lied, committed fraud,

1. They tried to conceal it

1. I complained to [redacted] and each member of the Insurer Board.
2. No response
3. I complained to Regulator

1. Regulator said they don't investigate their own members
2. Regulator said Insurer are supposed to act in good faith
3. Lawyer said Insurer VERY influential within Regulator
4. Regulator no use they will say they are just "insurers being Insurers"
5. I complained to Parliament Enquiry
6. No change

1. Insurer said huge profits due to "unanticipated fall in claims frequencies" "unexpected unexplained unprecedented reductions in claims frequencies"
2. After 10 years of delays I wanted to go to Hearing. Lawyer who used to work for insurance firm, missed court evidence deadlines. He settled against my implied written and verbal instruction in circumstances where he said written consent was required. The lawyer later went back to work for his previous Insurer firm