Australian Government
Services Australia

medicare

Medical Indemnity Request to aggregate payments for the same claim (MO008)

When to use this form

Use this form if you elect to aggregate amounts paid or payable in respect of the same claim in accordance with section 31 (High Cost Claim Indemnity Scheme), section 34ZZBA (Allied Health High Cost Claim Indemnity Scheme) or section 34ZE (Run off Cover Indemnity Scheme) of the *Medical Indemnity Act 2002*.

This form must be completed and signed by an authorised representative of the Medical Indemnity Insurer (MII) and must accompany a Medical Indemnity payment application form.

For more information

Go to **servicesaustralia.gov.au/medicalindemnity**, email us at **medical.indemnity@servicesaustralia.gov.au**, or call **1800 813 167** Monday to Friday, 8:30 am to 5 pm, Australian Eastern Standard Time.

Note: Call charges may apply.
There may be risks with sending personal information through unsecured networks or email channels.

Filling in this form

- **Use black or blue pen.**
- Print in BLOCK LETTERS.

Applicant's details

The applicant is a person authorised on behalf of the MII, named in this form, to sign on their behalf.

1 Applicant's registered business name (and company name if applicable)

2 Australian Business Number (ABN)

3 Position held

Privacy notice

4 The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacy**

Declaration

5 **I declare that:**

- the Medical Indemnity Insurer named in question 1 has paid, or is liable to pay, amounts in relation to the claim against:

  Insured person's family name

  Insured person's first given name

  Claim identification reference (allocated by the applicant)

- the date the Medical Indemnity Insurer was **first notified** of either the claim or incident(s) that gave, or may give, rise to a claim:

  / /

- the information I have provided in this form is complete and correct.
- I am authorised to sign this form on behalf of the Medical Indemnity Insurer.

I authorise:

- Name of Medical Defence Organisation

  who has paid, or is liable to pay, an amount in respect to the same claim, to aggregate the amounts paid or those amounts liable to be paid by it and the above named Medical Indemnity Insurer, for the purposes of applying to Services Australia for a Medical Indemnity payment.

I undertake:

- on behalf of the above named Medical Indemnity Insurer, to provide to the above named Medical Defence Organisation any information requested by the Chief Executive Medicare that is relevant to determining whether a Medical Indemnity payment is payable **and/or** the amount that is payable under a Medical Indemnity scheme.

I understand that:

- giving false or misleading information is a serious offence.

Full name of authorised representative

Signature of authorised representative

On completion, print and sign by hand.

Date / /

Returning your form

Check that all required questions are answered and that the form is signed and dated.

The completed form should be forwarded to the Medical Defence Organisation responsible for assessing this medical practitioner's eligibility under the High Cost Claim Indemnity Scheme, Allied Health High Cost Claim Indemnity Scheme or Run off Cover Indemnity Scheme.

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