PERSONAL INJURIES CLAIMS AND REFUNDS TO PRIVATE HEALTH INSURERS

Most personal injuries cases usually require medical or hospital treatment. This treatment is often paid, in part, by Medicare and/or a private health insurer.

To the extent past treatment expenses have been paid by a private health insurer, it may be a requirement of the insurance policy that if damages or compensation is recovered, then the treatment costs must be refunded to the insurer.

If the claimant has a right to recover damages or compensation in relation to a personal injury, then the claimant must:

* inform their insurer of any such right that exists;
* inform their insurer of any decision to claim for damages;
* include the full amount of all expenses for which benefits are payable in any claim; and
* inform the insurer immediately upon the determination or settlement of the claim.

Where the insurer has paid benefits, whether by way of provisional payments or otherwise, in relation to the claimant’s injury and the claimant receives damages in respect of that injury, the claimant must repay to the insurer the full amount that the insurer paid in relation to the claimant’s injury upon the determination or settlement of the claim.

This obligation to repay may apply regardless of whether:

* the determination or settlement sum includes the full amount that the insurer paid; or
* the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future in respect of which benefits are otherwise payable; or
* the claimant complied with his/her obligations under the insurer’s policy, including the signing of a legally binding undertaking and acknowledgment supplied by the insurer.

If a claimant makes a claim for damages in relation to an injury and fails to comply with any obligation under the insurer’s policy, or fails to include in their claim payments of benefits by the insurer in relation to the claimant’s injury, the insurer may, without prejudice to its rights and in its absolute discretion, take any action permitted by law to:

* assume that all expenses in relation to the injury have been met from the damages payable to or received by the claimant pursuant to the claim; and
* pursue the claimant for repayment of the benefits paid by the insurer in relation to the injury; and
* assume the legal rights of the claimant in respect of all or any parts of the claim.

If a claimant has a right to make a claim for damages in respect of an injury and the insurer reasonably determines that the claimant has chosen not to pursue the claim or has abandoned the claim, then benefits are payable by the insurer if the claimant signs a legally binding undertaking in which the claimant agrees, in consideration for the payment of the benefits by the insurer, not to pursue the claim.

Where a claimant has complied with the insurer’s policy in respect of the claimant’s claim for damages and the insurer has given prior consent to the settlement of the claim for an amount that is less than the total benefits paid, or which would otherwise have been payable by the insurer, the insurer may, at its absolute discretion and subject to any conditions that it considers appropriate, determine that the claimant need not repay any part or the full amount of the benefits paid by the insurer in respect of the claimant’s injury.

Further, the insurer may, at its absolute discretion, pay benefits where:

1. expenses have been incurred as a result of a complication arising from an injury that was the subject of a claim for damages or the provision of service for treatment of an injury that was the subject of a claim for damages; and
2. that claim has been the subject of a determination or settlement, and
3. there is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

In addition to the claimant’s obligations under the insurer’s policy, where a determination or settlement of a claim for damages includes an allocation for future medical expenses in respect of the claimant’s injury, the claimant must use that allocation to pay for treatmentin respect of the injury.

Further, the insurer may refuse to pay benefitsfor such treatment until the allocation is exhausted. Therefore the claimant must provide to the insurer evidence to establish that the allocation has been exhausted and exhausted on treatment for the injury. If the claimantcannot provide such evidence, or the allocation has been exhausted on expenses other than for treatment of the injury, the insurermay refuse to pay benefits for treatment in respect of the injury.

Where it is anticipated that the claimanthas future medical needs in respect of the injury, the claimantmust use reasonable endeavours to procure an award or settlement that includes a specified allocation for future medical expenses.

If the situation arises where, despite the claimant’s reasonable endeavours, a determination or settlement does not include a specified allocation for future medical expenses, the insurermay, again at its absolute discretion, agree to pay benefits for treatmentin respect of the claimant’s injury rendered after the determination or settlement.

It is further worth noting that a claimant’s obligation under the insurer’s policy continues despite any cancellation or termination of the claimant’s policy.

In summary, if a claimant fails to make reasonable enquiries as to any refunds payable to any private health funds, and the claimant fails to include this information in his/her claim for damages, then the claimant may not recover enough money to fairly compensate themselves and to also reimburse his/her insurer for medical expenses stemming from the personal injury, which ultimately may result in the claimant being out of pocket after damages have been awarded.

If you would like more information regarding personal injuries claims, please do not hesitate to contact **Aleisha Turner**, Lawyer, of our office.