3-Year Review of the operation of the Motor Accident Injuries Act 2019 - Financial Aspects

Motor Accident Injuries Scheme

May 2026

finity

1 May 2026

Ms Nicola Clark
MAI Commissioner
Motor Accident Injuries Commission
ACT Government
1 / 220 London Circuit
CANBERRA ACT 2601

Dear Nicola,

3-Year Review of the operation of the Motor Accident Injuries Act 2019 - Financial Aspects

We are pleased to provide our report to assist the Insurance Branch of Chief Minister, Treasury and Economic Development in the completion of the report required under Section 493 of the *Motor Accident Injuries Act 2019*.

We would be pleased to discuss any aspect of this with you.

Yours sincerely

Aaron Cutter
Fellow of the Institute of Actuaries of Australia

Daniel Smith
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Jevon Fulbrook
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3-Year Review of the operation of the Motor Accident Injuries Act 2019 - Financial Aspects

1 Purpose and Scope

The Motor Accident Injuries Commission (MAI Commission) of the ACT on behalf of the Insurance Branch has asked Finity Consulting Pty Ltd (Finity) to assist in the preparation of material to aid the Insurance Branch in completing a review of the operation of the *Motor Accident Injuries Act 2019* (the Act) as required by Section 493 of that Act.

The purpose of this report is to provide an objective and data-driven assessment of the financial performance of the MAI Scheme as at 1 February 2026. It examines key themes such as premium affordability, market competitiveness and claims experience, with the aim of explaining emerging trends and evaluating overall scheme outcomes.

2 Cost Uncertainty

Motor accident injury insurance is a long tail class of insurance business, and it can be many years between an accident occurring and the final cost of a claim being known. The MAI Scheme is still in its relative infancy, with only six years of history, and only a limited number of common law claims finalised to date – as well as having been impacted by the effects of COVID-19.

The experience of the Scheme continues to be shaped by a higher-than-usual level of cost uncertainty. Much of this reflects the typical "honeymoon" period that follows major scheme reform, during which claims activity can appear unusually benign as participants adjust to the new legislative and operational environment. This effect remains evident and continues to influence emerging experience, contributing to uncertainty in interpreting current trends relative to the Ernst & Young (EY) initial costings.

Where references are made to data 'paid to date', this refers to data covering the period 1 February 2020 to 31 January 2026.

The reader's attention is drawn to our full Reliances and Limitations in Section 8.

3 Overview of the Motor Accident Injuries Scheme

Effective 1 February 2020, the scheme covering motor accidents in the ACT was completely overhauled. From this date the Motor Accident Injuries Scheme (MAI Scheme, the New Scheme), governed by the *Motor Accident Injuries Act 2019* (the Act), came into effect. The Act significantly changed the benefits payable to motorists injured in motor vehicle accidents in the ACT.

Under the New Scheme certain Defined Benefits became available to all injured motorists, with at-fault drivers included, with some exclusions for certain benefit types. Those injured parties who are not-at-fault continue to be able to lodge a Common Law claim against the at-fault driver if they are severely injured (or meet certain other minimum requirements). Legal expenses are limited to certain matters.

Catastrophically injured applicants who are eligible receive medical, treatment and care support from the Lifetime Care and Support Scheme (LTCSS) regardless of fault.

ACT motorists who are at-fault for accidents occurring in jurisdictions outside the ACT are covered in accordance with the legislation of that jurisdiction. As such, interstate claim costs are consistent between the old and new schemes. Although at-fault drivers are covered by the MAI insurance policy taken out by the ACT vehicle owner, the benefits payable to injured parties are based on the benefits of the jurisdiction the accident occurs in.

Prior to the introduction of the New Scheme, EY conducted a significant costing analysis of the scheme changes. EY's analysis provided estimates of the cost per policy for passenger vehicles for the various types of payment (Quality of Life, Loss of Earnings etc.), and for the costs associated with the different categories of benefit (Defined Benefits for at-fault and not-at-fault claimants, and Common Law benefits for not-at-fault claimants).This costing exercise was then used by the licensed insurers to price premiums, with all insurers making premium changes in anticipation of the New Scheme commencing.

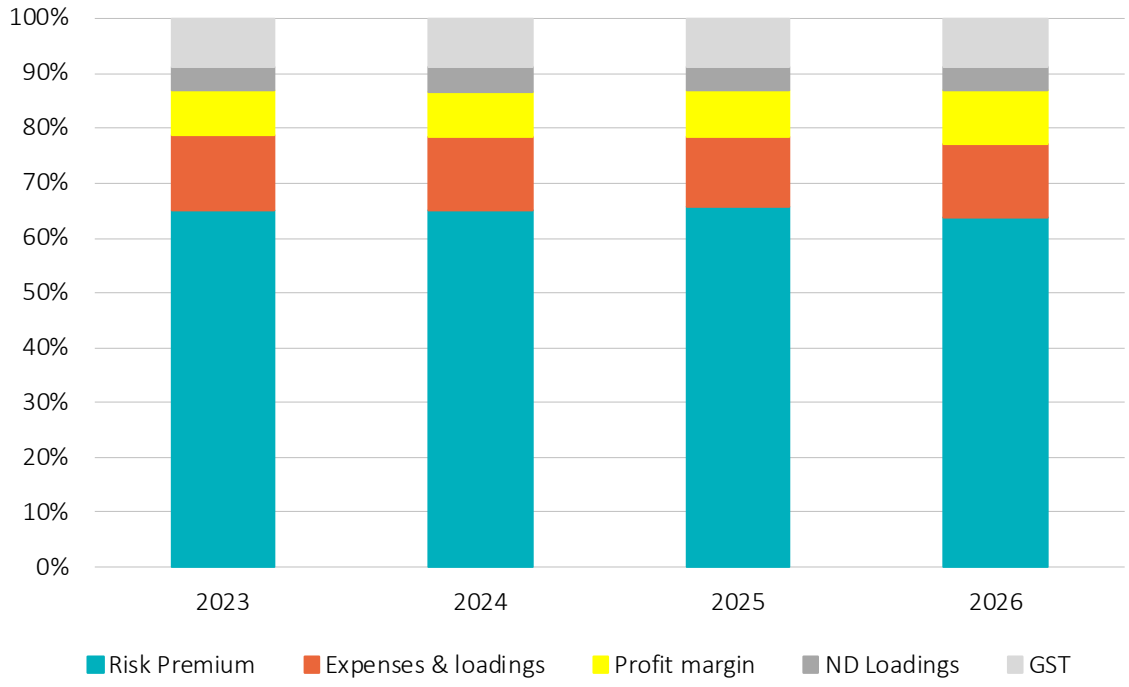
For information on the components of insurance pricing, pricing complexities specific to the MAI Scheme and the role played by the fully funded and not excessive tests required to be applied in assessing premiums, the reader is referred to the report provided by Finity in November 2023. The report is available through the MAI Commission website.

4 Premiums and affordability

The four insurers participating in the MAI Scheme submit annual de novo premium filings (see definition in Glossary), historically commencing on 1 February. The most recent filing, for 2026, was lodged for a 1 April commencement following a change in start date. These filings set out the assumptions and rationale underpinning insurers' prospective premiums. This section summarises selected assumptions at the Scheme level.

Figure 4.1 compares the average proportional breakdown of total premiums across the insurers for each filing.

Figure 4.1 – Components of the de novo premiums



The largest component is the risk premium, i.e. the expected cost of claims allowing for inflation and discounting. Across the 2023 to 2026 de novo filings, the risk premium has remained stable (in percentage terms) at approximately 65% of premiums. This aligns with the experience observed in the 2020 to 2023 period, indicating no material change since the last three-year review. The risk premium is shown further broken down in Figure 4.2.

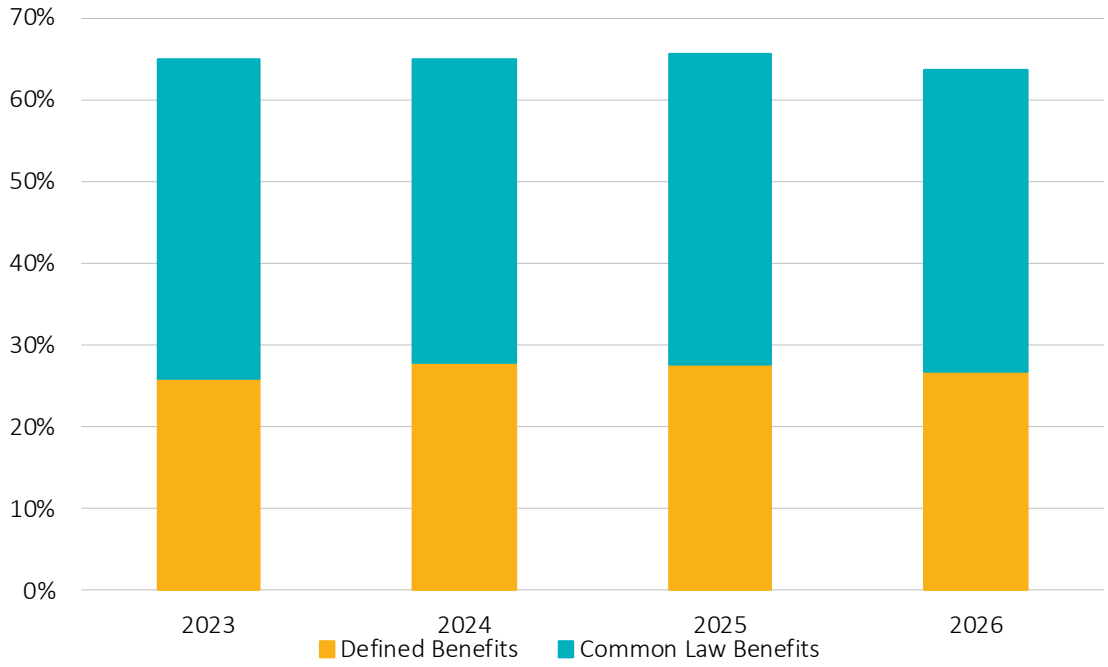
After the risk premium, the next largest element of filed premiums is expenses (13.3%). These represent the costs of marketing and acquisition activities, handling claims and managing any recoveries, managing the business, and business overheads.

GST payable to the Australian Taxation Office represents 8.7% of the premium[1].

The profit margin in the de novo filings has been 8.7% of the total premiums.

The Nominal Defendant Loading is currently 4.4% of premiums. This is how much every registered vehicle is paying on average to cover the costs of injuries arising from uninsured and unidentified vehicles.

Figure 4.2 – Breakdown of the Inflated and Discounted Risk Premium (% total premium)



The largest element of the risk premium is the assumed costs associated with Common Law claims. Given the limited experience available under the new Scheme, this element continues to rely heavily on the pre-Scheme estimates of expected costs. Insurers have made modest year-on-year adjustments to reflect emerging experience and claims cost inflation.

Across the four years, the average Defined Benefits represent around 27% of the total risk premium (including a 2% impact of inflation and discounting), while Common Law accounted for 38% (including a 4% impact of inflation and discounting).

[1] Note: GST is not 9.1% (i.e. equal to 10% of 110%) due to part of the total premium (the Nominal Defendant Loading) being GST exempt.

Figure 4.3 – Weighted average class 1 premiums as a proportion of average weekly earnings (%)

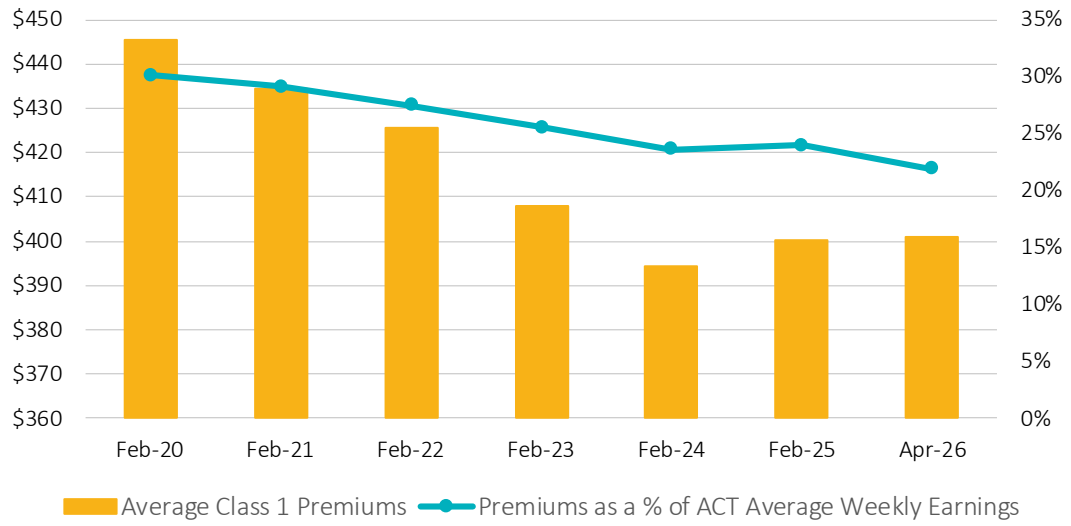


Figure 4.3 presents premiums based on the final premiums submitted by each insurer for Class 1 vehicles at the de novo filings, inclusive of ND loadings and GST, relative to ACT Average Weekly Earnings (AWE). At Scheme inception, premiums represented approximately 30.1% of ACT weekly wages, equivalent to 2.1 days of average earnings. By the latest de novo filings, premiums had fallen to 21.9% of weekly wages, or around 1.5 days of earnings.

The results demonstrate improved premium affordability since the Scheme commenced.

5 Market Share and Competition

Since the inception of the Scheme, insurers have progressed a number of interim[2] filings varying the premium charged for the underwriting year downwards. Particularly notable, several of these premium reductions appear to have been designed primarily in response to competitor pricing, rather than emerging information about the Scheme, and have the effect of lowering the expected profit margin compared to de novo filings.

However, the February 2025 and April 2026 de novo filings show premiums beginning to rise after a period of sustained competitive reductions. In de novo filings insurers commented that claims inflation of prior estimates was a driver of this.

Figure 5.1 shows the GIO and NRMA brands (rival brands making up the bulk of market share in the Territory) competing to charge lower premiums. Of note is that the lowest passenger vehicle premiums have dropped from around $440 at the inception of the Scheme to around $390 currently (an 11% reduction), with some reductions already occurring prior to the Scheme commencing.

[2] These are filings in between de novo filings.

Figure 5.1 – Passenger vehicle premiums by insurer since Scheme introduction

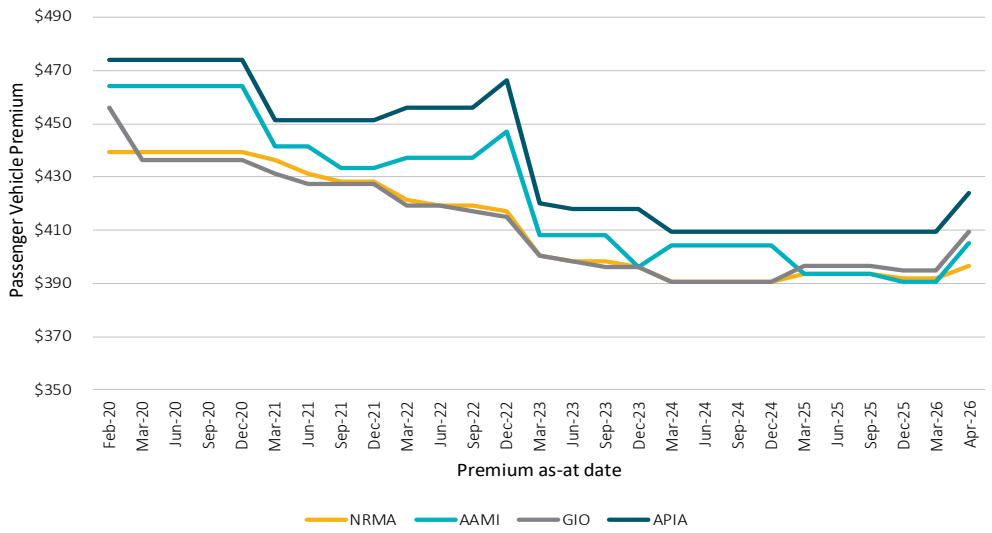
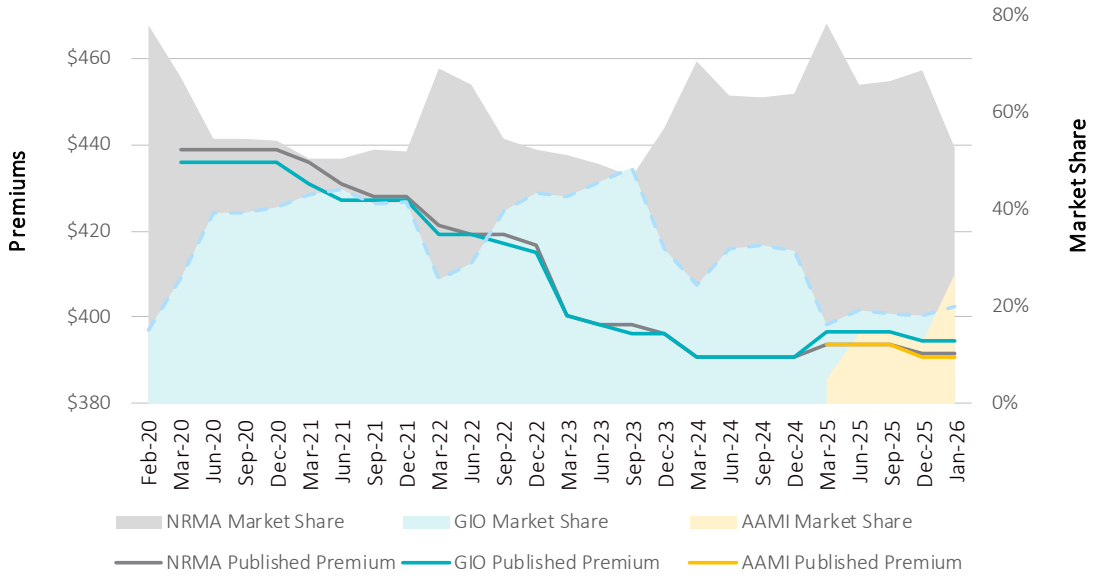


Figure 5.2 illustrates how these competitive dynamics have played out in market share. NRMA wrote the vast majority of CTP policies until early 2015, after which GIO emerged as a strong competitor. By Sep 2023, GIO had reached a comparable market position, overtaking NRMA with a 48.8% share compared to NRMA's 46.8 %. Throughout this period, GIO consistently offered the lowest premiums.

Since June 2025, Suncorp has shifted its competitive strategy by replacing GIO with AAMI as its cheapest priced brand. Following this change, AAMI now holds 26.9% of the market. NRMA remains the market leader at 52.8%, while GIO has reduced to 20.0%. APIA continues to have less than 1% of the market.

Figure 5.2 – Market share of insurers in the ACT



In the past six years, there have been 28 premium filings, comprising 7 de novo submissions and 21 interim filings. Of the interim filings, 19 were price reductions aimed at securing the cheapest Class 1 premium. Across the period, NRMA has held the lowest premium for 11 months, while Suncorp brands have done so for 37 months. For the remaining 27 months, both insurers matched prices, indicating sustained competitive tension.

Analysis of monthly premiums indicates that market share responds to very small, short-term price differentials between insurers, although these effects are typically short-lived. In most months, price differences are small and competitive repricing occurs quickly, with market shares reverting toward longer-run levels.

Periods of more pronounced price advantage are associated with higher shares of new business, particularly where one insurer is materially cheaper than competitors. Smaller price differences tend to result in more limited shifts in market share as summarised in Table 5.1.

Overall, the observed patterns suggest that while relative pricing influences short-term market share, sustained changes are moderated by frequent repricing and the high level of price transparency within the Scheme.

Table 5.1 - Relationship between interim filing premiums and market share

Price Difference	Number of Months	Average Price Difference	IAG Market Share	Suncorp Market Share
IAG cheapest by >$5	5	12.20	73%	27%
IAG cheapest by >$1	2	2.00	70%	30%
Less than $1 Difference	31	0.03	64%	36%
Suncorp cheapest by >$1	34	2.12	54%	46%
Suncorp cheapest by >$5	3	7.53	47%	53%

6 Claim number and payment experience

Number of claims incurred

EY's Model Design Costings Paper [3], a report prepared in 2018 to inform discussion and whilst the MAI Scheme was being developed, estimate total potential Defined Benefit claims (based on a mature scheme) of 1,500 per annum split into 900 not at-fault and 600 at-fault claims. The estimated number of Common Law claims was 100 per annum. The 600 at-fault claims and 100 Common Law estimated annual claims excluded any allowance for interstate claims, which were analysed separately.

Table 6.1 shows the number of claims reported by accident year. Note that 2026 accident year is a partial year (nine months), and further development of claims numbers for all accident years is expected (particularly in relation to Common Law intimations). Intimations are where an insurer has made a case estimate for claims reserving purposes, including that the common law threshold may be met.

[3] Available from: https://yoursayconversations.act.gov.au/download_file/1725/683

Table 6.1 – Number of claims reported to 31 January 2026 (inclusive of interstate claims)

Accident Period ending 31 Mar	Defined Benefit claims reported	Common Law claims reported
2020	76	4
2021	503	40
2022	405	41
2023	519	38
2024	488	36
2025	471	27
2026*	330	24
Total	2,792	215

* 2026 is a partial year running from 1 April 2025 to 31 January 2026.

Honeymoon effect on claims incurred

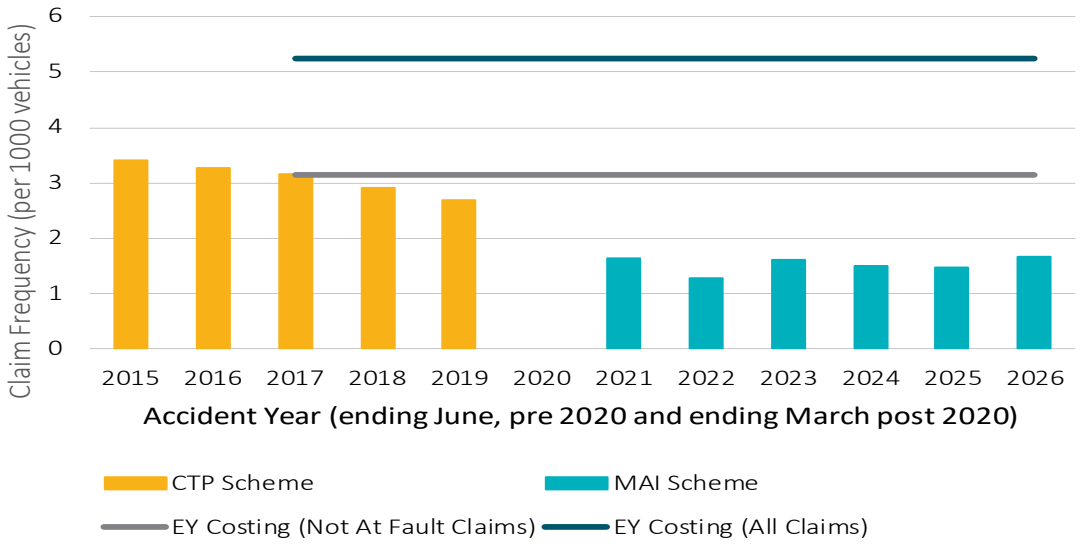
The number of claims incurred by the Scheme to 31 January 2026 has been substantially below anticipated levels. This can be attributed, at least in part, to the significant impacts of the honeymoon period, which is a feature of any scheme reform.

Under the Old Scheme, claim frequency was around 3.15 claims per 1,000 vehicles (excluding trailers). The initial costing for the New Scheme, completed using data up to 2017, assumed a 67% increase in claim frequency due to the expansion of coverage to include at-fault drivers, an overall frequency of 5.26 claims per 1,000 vehicles.

In the final years of the Old Scheme, claim frequency had already begun to decline, falling to 2.90 and 2.69 claims per 1,000 vehicles in 2018 and 2019 respectively. Part of this reduction was influenced by the honeymoon period following the 2017 NSW CTP reforms, which contributed to lower interstate claim volumes.

Despite the expanded coverage under the MAI Scheme, observed claim frequency has remained low, around 1.5 claims per 1,000 vehicles, which is approximately 70% lower than the initial costing assumption (Figure 6.1). It remains too early to determine whether the lower frequency reflects the underlying operation of the Scheme or residual honeymoon effects. At this stage, it appears unlikely that frequency will develop to the levels assumed in the initial costings.

Figure 6.1 – Ultimate claim frequency reported to 31 January 2026 (inclusive of interstate claims)



As a result of the low emerging experience, insurers have generally been decreasing their frequency assumptions for Defined Benefits when setting premiums, not fully allowing for the observed low claim volumes to continue into the future given the high level of uncertainty arising from honeymoon period effects and maturing experience in the NSW Scheme.

COVID-19 impact on claims incurred

The Territory's extended COVID-19 lockdown spanned August to October 2021, with earlier public health restrictions in place from March 2020 onwards. Accordingly, any COVID-19-related impacts would be expected to emerge primarily in accident years 2021 and 2022.

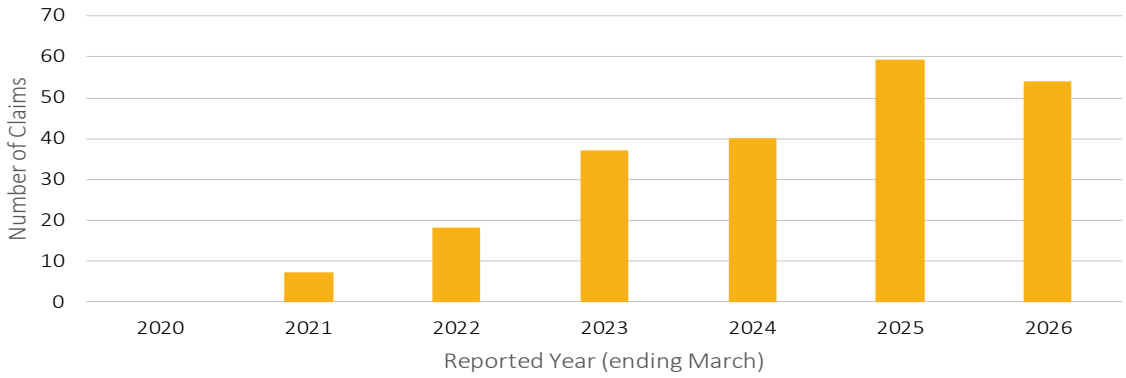
Accident year 2021 ultimate claim frequency was broadly consistent with later years' experience, at 1.63 per 1,000 vehicles compared with an average of 1.50 per 1,000 vehicles, suggesting the 2020 restrictions had little impact on claim frequency. Only a modest COVID-19 effect is, evident in accident year 2022, where frequency fell to 1.27 per 1,000 vehicles.

Common Law claim numbers

It is too early to draw any conclusions regarding Common Law claims as the "oldest" of these applications is now only 6.5 years old. Claimants generally have 5 years from the accident to lodge their Common Law claim and must wait until their injury has stabilised sufficiently to receive a WPI assessment to confirm eligibility[4] (with Common Law claim timing requirements applying once a WPI assessment has been received). We note that following the significant reforms to the NSW Compulsory Third Party (CTP) Scheme in 2018, meaningful volumes of Common Law claims did not emerge for several years after implementation. ACT experience has followed a similar pattern, with Common Law claims only beginning to materialise in the past two years, around five years after Scheme inception (see Figure 6.2 – noting that 2026 represents the 10 months to 31 January 2026).

[4] To be eligible to make a common law claim an injured person must not have been at fault and receives a WPI of 10 per cent or more. Other eligibility criteria can apply in certain circumstances.

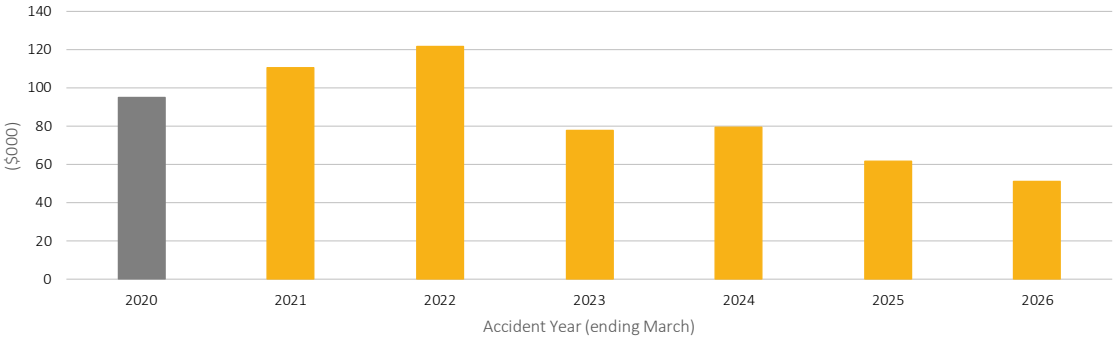
Figure 6.2 – Number of Common Law claims by reported year as at 31 January 2026



Average Claim Size

Figure 6.3 compares the initial costing average claim size assumption of $55,371 per claim, inclusive of Defined Benefits and Common Law, with the experience observed since Scheme commencement. Average claim size is calculated as the ratio of incurred payments to reported claims to date.

Figure 6.3 - Average claim size as of 31 January 2025 (inclusive of interstate claims)



Unlike claim frequency, average claim size has increased well above what was expected based on the EY costing and typical inflation in the years following. The observed decline in incurred claim size simply reflects the immaturity of recent accident years, with further development expected to occur as common law claims are lodged and the incurred costs estimated. For the more developed accident years 2021 and 2022, the incurred average claim size is $102,390 and $111,584 respectively.

Claims Cost Experience

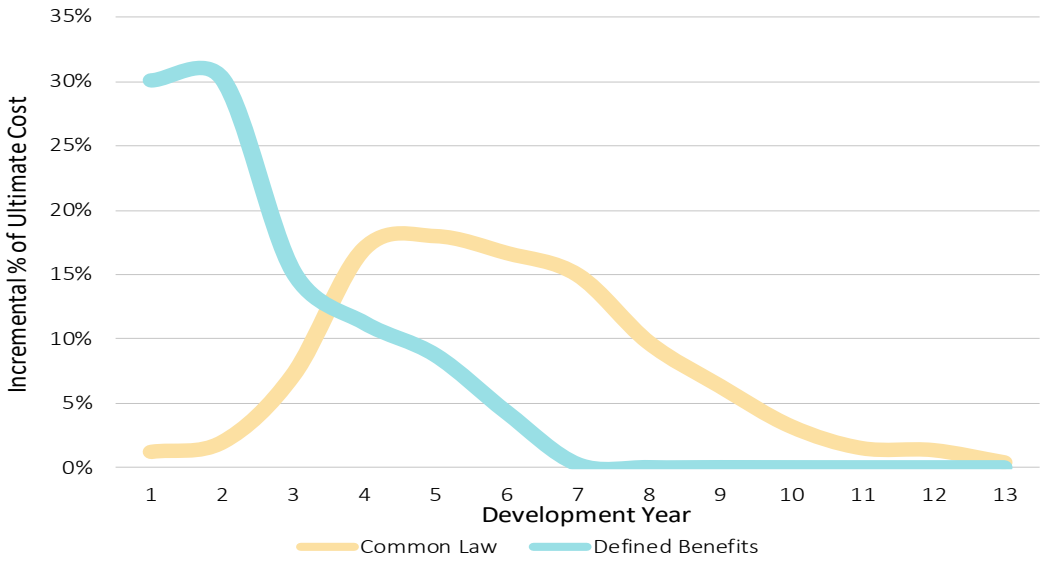
Figure 6.4 presents an indicative payment pattern based on insurer rate filings submitted at the 1 April 2026 de novo filings. Since the first submission prior to Scheme commencement in 2020, the overall shape of the curve has not materially changed. The pattern reflects insurers' expectation of the pattern of claims payments for a single year of accidents over time.

The pattern shows incremental (not cumulative) payments by development year. For example, in Development Year 6 (five years after the end of the year of injury), around 16.7% of the ultimate Common Law costs for that accident year are expected to be paid. The pattern does not represent a typical individual claim, but rather the aggregate payment profile across all claims arising from a year of accidents.

Actual payments in any year depend on claim volumes and claim severity. While insurers adopted different approaches to estimating costs and payment timing, their overall expectations remain broadly aligned, with only modest changes since the previous review:

- Both insurers continue to expect that Defined Benefits are primarily paid in the first three "development years" (i.e. in the first three years post-accident).
- Both insurers have extended their tail assumptions for Defined Benefit payments to be paid by the end of development year 7 (i.e. the 7th year after the year of accident). At the previous 3-year review, the insurers had expected development to cease by year 6.
- Both insurers expect minimal Common Law cost emergence in the accident year, with assumed cost peaks occurring between Development Years 3 and 6.

Figure 6.4 – Indicative payment pattern showing expected payments over time for a year's worth of earned premium



Since the new MAI Scheme began operation in February 2020, only six complete years of development have been observed. Whilst Defined Benefit payment patterns are beginning to materialise, there remains some persistence in the tail, with several payments being made in development year 6. As only one accident-year cohort is close to "maturity", the available experience is not yet sufficient to form a definitive view on the ultimate run-off. Likewise, Common Law payment patterns are only now beginning to emerge. Early indications suggest that payments are starting to follow the anticipated pattern; however, the experience remains too immature to form any definitive conclusions. As discussed in Section 6, the extent to which the observed experience can be relied on to predict future experience is reduced by the effects of a honeymoon period.

While Figure 6.4 represents the pattern of payments for a single accident year, Figure 6.5 presents the indicative cumulative payment pattern (combining Defined Benefits and Common Law) from the commencement of the Scheme alongside the actual cumulative payments observed to date. The emerging pattern suggests that payments are developing broadly in line with expectations with the slightly faster pattern likely to be reflective of the impact of the honeymoon period on a new scheme. As at Payment Year 6 (corresponding to the earliest 2020 cohort), approximately 81% of expected payments have been made.

Figure 6.5 - Actual and expected pattern of cumulative payments from Scheme commencement

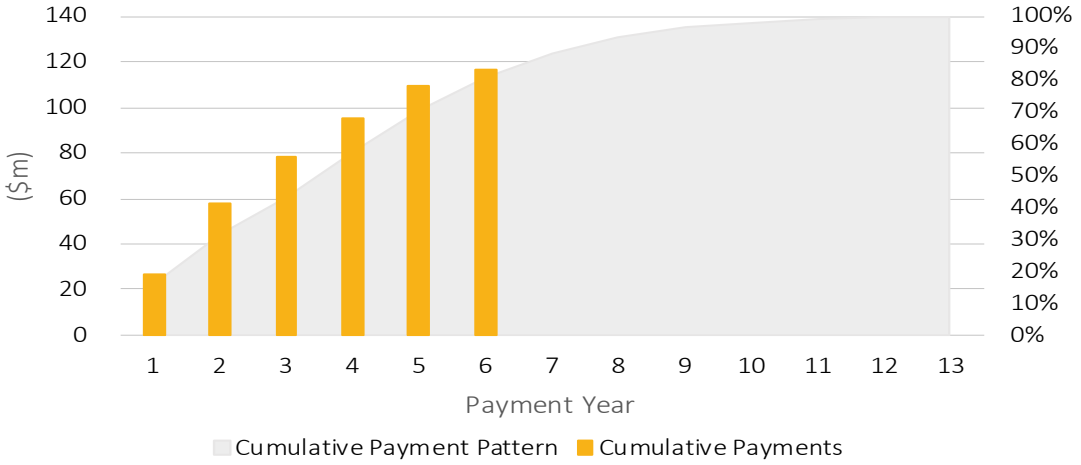
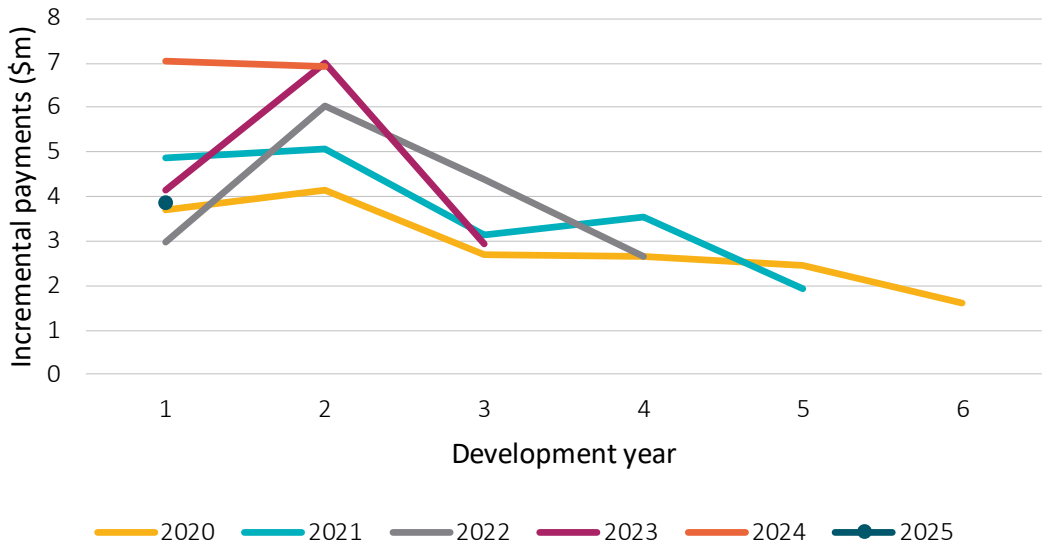


Figure 6.6 and Figure 6.7 show the actual payments made by each accident year and development year, for Defined Benefits and Common Law respectively. Defined Benefits payments made to date outweigh Common Law costs, however this is expected given the later peak in Common Law costs.

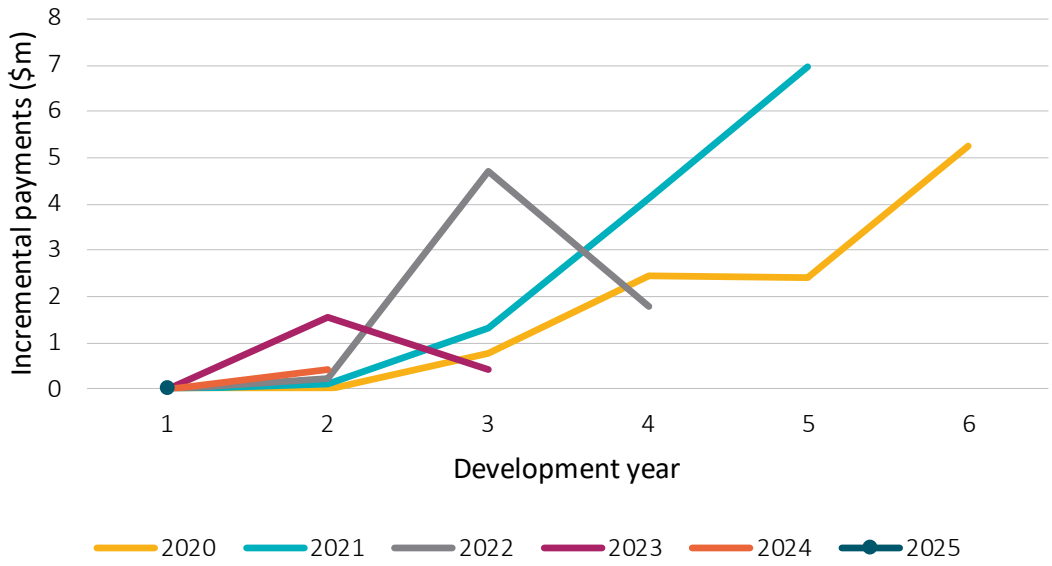
Figure 6.6 – Payment of Defined Benefits over time



Note: Years run from 1 February to 31 January (i.e. 2020 represents 1 February 2020 to 31 January 2021)

Defined Benefits costs peak at Development Year 1 and 2 for all accident years. This "shape" of payments for Defined Benefits to 31 January 2026 is broadly consistent with that envisioned under the costings and subsequent premium filings lodged by insurers, however the tail of payments (development years 5 and 6) are running a bit higher than expected.

Figure 6.7 – Payment of Common Law over time

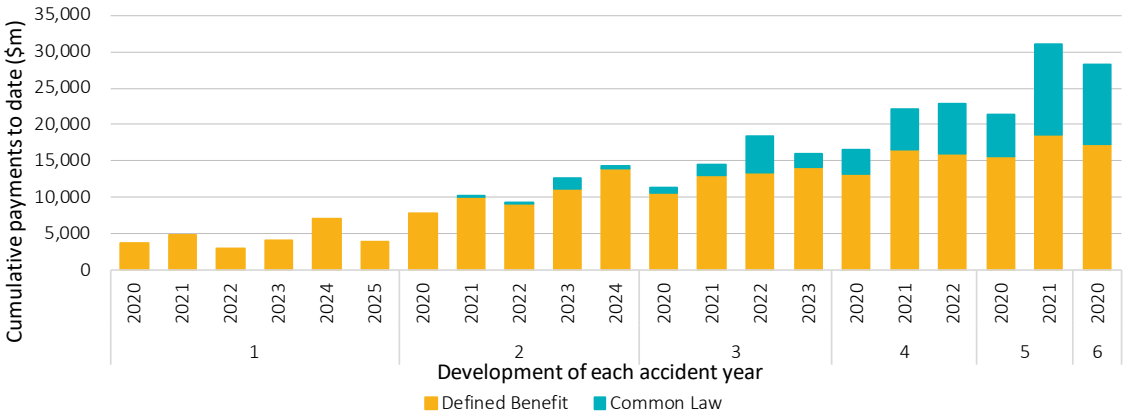


Note: Years run from 1 February to 31 January (i.e. 2020 represents 1 February 2020 to 31 January 2021)

Common Law payments typically peak between development years 3 and 6. Across all accident years, minimal to no payments emerge during the first two years of development, except for 2023. This slower emergence pattern is characteristic of Common Law in other jurisdictions.

Figure 6.8 shows how the total cumulative claim payments for each accident year have developed over time.

Figure 6.8 – Cumulative payments by accident year



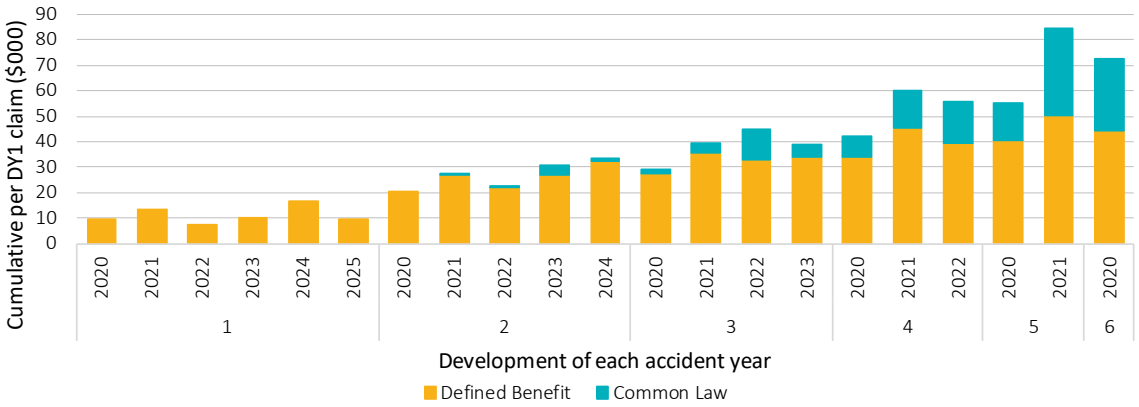
Note: Years run from 1 February to 31 January (i.e. 2020 represents 1 February 2020 to 31 January 2021)

From Figure 6.8 we make the following observations:

- The share of Defined Benefit payments in earlier development periods is substantial. This was anticipated by the reforms as the nature of Defined Benefits is that they are paid as soon as the application is accepted.
- For more mature accident years 2021 and 2022 claims costs consist of approximately one third Common Law and two-thirds Defined Benefits. The proportion will continue to increase for Common Law as accident years develop fully.
- Each accident year has continued to incur both Defined Benefit and Common Law costs and have outstanding case estimates. Therefore, none appear to be "fully developed" to the point where definitive conclusions on ultimate claims costs during the period can be made.

Figure 6.9 shows a variation of Figure 6.8 with absolute payments divided by the number of claims reported in Development Year 1. This adjustment controls for the numbers of claims in each year, and the development of claim reports over time.

Figure 6.9 – Cumulative payments per Defined Benefits claim reported in Development Year 1 by accident year



Note: Years run from 1 February to 31 January (i.e. 2020 represents 1 February 2020 to 31 January 2021)

Continuing payments under the Previous Scheme

In addition to MAI Scheme claim payments, insurers continue to make payments relating to the previous scheme. Table 6.2 shows that material payment volumes remain under the run-off of the Old Scheme, as reported to the MAI Commission. The 2025/26 figures reflect a partial year to 31 January 2026.

Table 6.2 – Old Scheme payments by payment year

Payment Year	Payments ($m)
2020/21	115.4
2021/22	92.0
2022/23	71.7
2023/24	33.3
2024/25	23.6
2025/26*	3.5

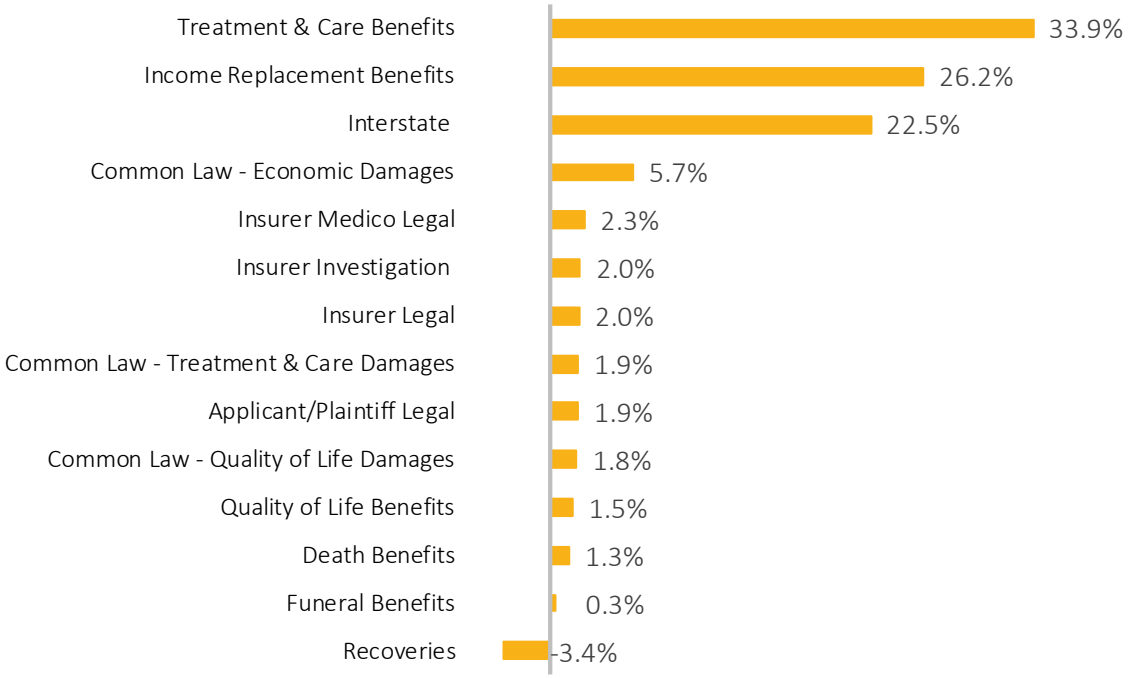
* 2025/26 is a partial year running from 1 July 2025 to 31 January 2026.

While these payments are not directly relevant to the costs, pricing, or profits under the New Scheme; they underscore the inherently long-tail nature of CTP claims; that is costs continue to emerge and develop well beyond the period in which premiums are written.

Payments by benefit type

The benefit type breakdown of benefits paid to 31 December 2025 under the MAI Scheme is shown in Figure 6.10. Note that this reflects the current mix of payment – and with very little Common Law experience to date it is dominated by Defined Benefits. As the Scheme matures, this will further develop. For example, we would expect the Common Law related costs to make up approximately 50% of annual costs.

Figure 6.10 – Benefit type as a proportion of total benefits paid



7 Premiums collected

Data from the MAI Commission shows between $143 million and $156 million in premiums have been collected per annum in each year between 1 February 2020 to 31 January 2026. The data is by “underwriting period” (a breakdown by “earned” year is not available). The underwriting period attaches premiums to when the policy coverage commences; and these premiums are subsequently “earned” over the period of coverage. For example, a 12-month policy commencing on 31 December 2024 would attach to the 2024 MAI written year, even though most coverage applies to (and is earned throughout) the 2025 year. Given the stability in the amounts by underwriting year, we consider this an appropriate metric to compare to costs by accident year.

Table 7.1 – Premiums collected by underwriting year

Underwriting Year	Scheme Premium Collected ($m)
2020	156.0
2021	146.0
2022	146.1
2023	143.7
2024	144.9
2025	146.4

Note: Years run from 1 February to 31 January (i.e. 2020 represents 1 February 2020 to 31 January 2021)

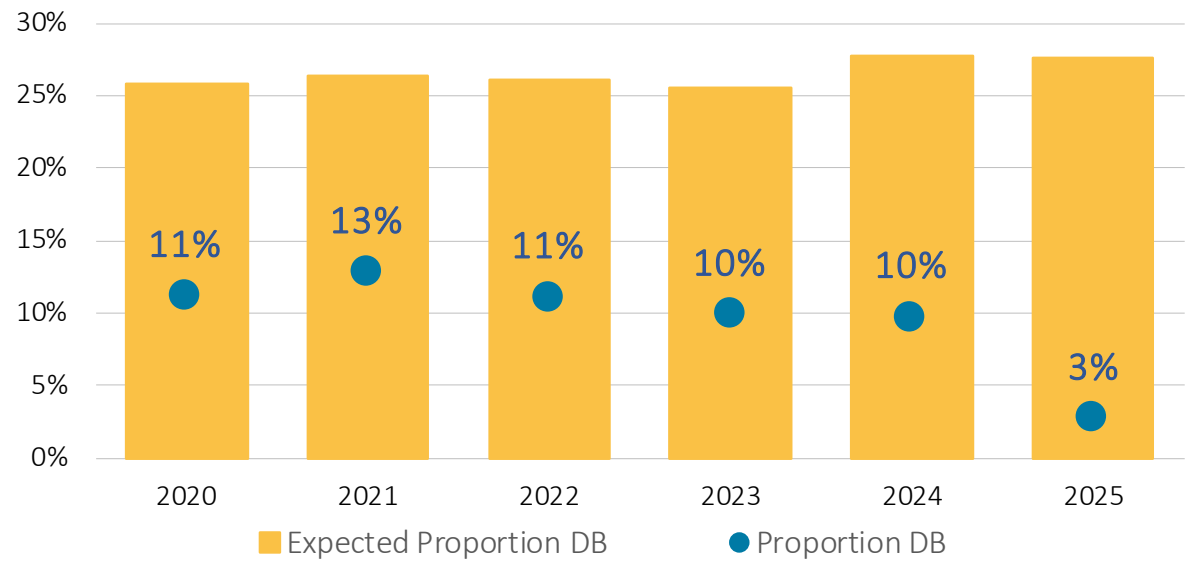
Insurers generally target a risk premium of around 65% of total premium, implying an expected present value of ultimate claims costs of approximately $96 million per annum. This is lower than the total premium collected (as shown in Table 7.1), reflecting the non-claims expense premium components (see Section 4).

The expected claims costs for a single underwriting year emerge over several years (for example, as illustrated in Figure 6.1). Focusing only on payments made in a given year, particularly in the early stages of the Scheme, will materially understate the ultimate cost of accidents occurring in that year and, therefore, the true cost of providing the insurance.

Claims payments as a proportion of premium

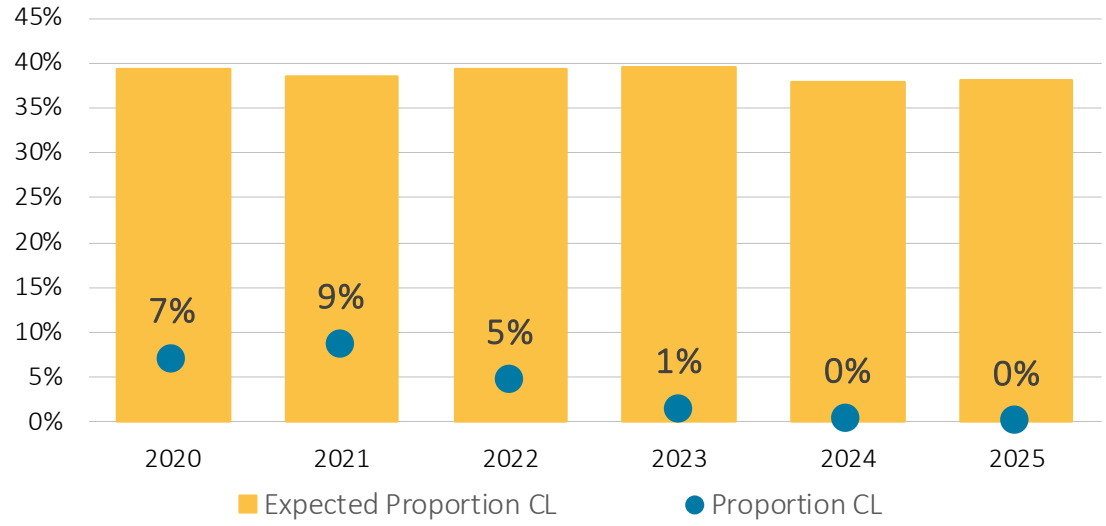
Figure 7.1 and 7.2 show the payments to date of Defined Benefits and Common Law respectively, as a proportion of premiums collected in each underwriting year. Also shown are the ultimate proportions expected from insurer premium filings. As noted in earlier sections of this paper, further payments are expected to be made in each group so the action proportions will increase. The expected proportions align with those shown in Figure 4.2.

Figure 7.1 – Defined Benefits payments, as a proportion of premiums collected



Note: Years run from 1 February to 31 January (i.e. 2020 represents 1 February 2020 to 31 January 2021)

Figure 7.2 – Common Law payments, as a proportion of premiums collected



Note: Years run from 1 February to 31 January (i.e. 2020 represents 1 February 2020 to 31 January 2021)

8 Reliances and Limitations

This report is subject to a number of limitations, reliances and assumptions outlined below.

8.1 Uncertainty

Motor accident injury insurance is a long tail class of insurance business, and it can be many years between an accident occurring and the final cost of a claim being known. The MAI Scheme is still in its relative infancy, with only six years of history, and only a relatively small number of claims finalised to date. This has also amplified the usual "honeymoon" impact that often accompanies scheme reform, where there is often a period of very benign claims activity following significant legislative change, as all parties adjust to the new scheme environment.

There is considerable uncertainty in the projected outcomes of future claims costs, particularly for long tail claims; it is not possible to value or project long tail claims with certainty.

Sources of uncertainty include difficulties caused by limitations of historical information, as well as the fact that outcomes remain dependent on future events, including legislative, social and economic forces, and behaviour by scheme stakeholders such as insurers, claimants and the legal fraternity.

8.2 Reliance on Data and Other Information

We have relied on the accuracy and completeness of the data and other information (qualitative, quantitative, written and verbal) provided to us by the MAI Commission for the purpose of this report. We have not independently verified or audited the data, but we have reviewed the information for general reasonableness and consistency. The reader of this report is relying on the MAI Commission and not Finity for the accuracy and reliability of the data. If any of the data or other information provided is inaccurate or incomplete, our advice may need to be revised and the report amended accordingly.

8.3 Limitations on Use

This report has been prepared for the use of the MAI Commission and to be provided to the Insurance Branch for the purpose stated in Section 1. At the request of the MAI Commission, we have consented to the release of this report, subject to the other reliances and limitations noted herewith.

Third parties, whether authorised or not to receive this report, should recognise that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data contained herein which would result in the creation of any duty or liability by Finity to the third party.

While due care has been taken in preparation of the report Finity accepts no responsibility for any action which may be taken based on its contents.

Finity has performed the work assigned and has prepared this report in conformity with its intended utilisation by a person technically competent in the areas addressed and for the stated purpose only. Judgements about the conclusions drawn in this report should be made only after considering the report in its entirety, as the conclusions reached by a review of a section or sections on an isolated basis may be incorrect.

This report, including all appendices, should be considered as a whole. Finity staff are available to answer any questions, and the reader should seek that advice before drawing conclusions on any issue in doubt.

Any reference to Finity in reference to this analysis in any report, accounts or any other published document or any other verbal report is not authorised without our prior written consent.

Appendices

A Glossary

Accident year	The year in which the injuries occurred, regardless of when the premium was collected, claims were reported or when payments were made.
Annual de novo premium filings'	A mandatory annual submission that all licensed insurers must provide to the MAI Commission, containing comprehensive data and assumptions used in the calculation of premiums.
Case estimate	The estimated cost to settle an individual claim, including both reported and not yet reported expenses, as estimated by the insurer.
Claim frequency	The rate at which claims occur within a period of time, often expressed as the number of claims per exposure unit (such as the number of claims per 1,000 vehicles per year).
Development year	The periods following the accident year in which the cost of claims for the accident year matures and the ultimate cost becomes clearer. Development Year 1 is the year of the accident, Development Year 2 is the year following the accident, and so on.
Discounted (discount rates)	Refers to the process of adjusting future claim payments to their present value using a discount rate. The discount rate reflects the time value of money – the idea that $1 received today is "worth more" than $1 received in one year's time.
Incurred Cost	The total cost of claims associated with a particular period, including both paid claims and reserves for future periods
Nominal Defendant (and associated Levy)	The Nominal Defendant is a last resort insurer in case an at-fault party is not insured or identified. A levy is applied to all insurance policies to fund the Nominal Defendant.
Premium (earned)	The portion of the total written premium that corresponds to the expired part of the policy period.
Premium (written)	The total amount of premiums for policies issued during a particular period. This represents the total revenue expected to be earned over the life of those policies. However, some amount of this premium collected in the most recent underwriting is "unearned" at the balance date – reflecting that it provides coverage following the balance date.
Reported common law claims	Claims that have been assigned a case estimate for which the relevant common law threshold has been met. This includes matters where a formal common law claim has not yet been lodged with an insurer. Interstate claims may be intimated or have a case estimate.
Risk cost (per policy)	The expected cost of *claims* for an individual insurance policy, based on the probability of claim events occurring and their expected cost. This is equivalent to the Risk premium.
Risk premium	See Risk cost.
Ultimate costs	The total cost that an insurer will ultimately pay for all claims related to a particular accident year, including all payments made and to be made in the future. It accounts for both known claims and incurred but not reported (IBNR) claims.