Australian Government
Department of Health, Disability and Ageing

Private Health Insurance Out-of-Round Premium Application Form

Purpose

Private health insurers are required to use this form for out-of-round applications to the Minister for Health and Ageing (the Minister) to request premium approval for one or more of the following circumstances:

- if an insurer proposes to make a new product/product subgroup available (per section 66-8 of the *Private Health Insurance Act 2007* (PHI Act)), either:
  - before (not including) 1 April 2027 or
  - from 1 April 2027 and applied for after 11 November 2026
- if an insurer proposes to change the premium of a complying health insurance product/product subgroup (per paragraph 66-10(1)(a) of the PHI Act), either:
  - before (not including) 1 April 2027 or
  - from 1 April 2027 and applied for after 11 November 2026
- if an insurer proposes to make a designated change (defined in section 66-7 of the PHI Act) to a complying health insurance product (as per paragraph 66-10(1)(b) of the PHI Act):
  - from 2 April 2027 and applied for after 11 November 2026

Insurers are strongly encouraged to submit applications with a proposed date of effect of 1 April 2027 (or 1 April 2027 onward for new products) through the **2027 Premium Round**.

- The 2027 Premium Round application form will be published on 18 September 2026, and applications will be due by 11 November 2026 unless otherwise determined by the Minister (per section 66-6 of the PHI Act).
- As noted in the 2027 Statement of Expectations, the Minister is continuing to use the annual Premium Round process to maintain the value proposition of private health insurance for consumers, and support an appropriate balance of market powers and equitable funding arrangements in the private healthcare industry.

Submissions

Out-of-round premium applications can be submitted via the Department of Health, Disability and Ageing's (the department's) Health Data Portal (the Portal), a cloud-based file transfer system. Access to the Portal has been provided to the nominated users for each insurer. To add or remove users, please provide details to PHIPremiumRound@health.gov.au. Please note that user access to the Portal may take 2-3 business days to process and take effect.

Insurers considering making an out-of-round premium application are encouraged to provide a completed notice-to-department template ("notice template" attached at the end of this document) via PHIPremiumRound@health.gov.au. Provision of a complete notice

template as early as possible ahead of making an application will enable the department to plan its resourcing to enable an efficient assessment process.

The Australian Prudential Regulation Authority (APRA) will have access to the applications and the notices of future intended applications and may engage with contacts on any questions they have. APRA's role in relation to applications is to advise the department whether premium approval requests from private health insurers would result in an adverse prudential outcome for individual insurers.

Please direct any enquiries on the out-of-round premium application form to the department (PHIPremiumRound@health.gov.au) at the earliest opportunity to ensure sufficient time for a response.

Assessment of applications

All out-of-round applications are reviewed by the department and APRA and are subject to approval by the Minister (or delegate).

For applications submitted **outside** the approved application period set at section 66-6 of the PHI Act (i.e. 18 September 2026 to 11 November 2026 inclusive or as otherwise determined under section 66-6 of the PHI Act), the Minister (or delegate) must approve the proposed premiums **if, and only if**, the Minister (or delegate) is satisfied that approving the proposed premiums is in the public interest (per subsections 66-8(6) and 66-10(6) of the PHI Act). If submitted in the approved application period, approval would be given unless considered 'contrary to the public interest' (per subsections 66-8(5) and 66-10(5) of the PHI Act).

The only exception to this is for applications for a decrease in the premium of a product without making a designated change (as defined under section 66-7 of the PHI Act), which must be approved by the Minister (or delegate) without consideration of the public interest.

The Minister (or delegate) may request further information about an application to assist the Minister in considering the application (per section 66-11 of the PHI Act). The Minister may also give notice to the insurer inviting them to further justify their application including through a resubmission (per section 66-12 of the PHI Act).

Confidentiality and Publication

The submitted Out-of-Round premium application forms will be treated as **protected information** as defined by the PHI Act. The department may use or disclose the information provided where authorised or required by law, including Division 323 of the PHI Act and, where relevant, the *Privacy Act 1988*.

Only highly aggregated or non-identifiable information will be made public, such as average premium changes in jurisdictions or by insured groups.

If an application is rejected, the Minister must table the Minister's reasons for refusal in each House of the Parliament no later than 15 sitting days of that House after the refusal.

The Premium Application Form

The PHI Act requires that applications to the Minister for premium approval must be in the approved form (subsections 66-8(2) and 66-10(2)). The approved form for out-of-round premium applications is **comprised of two attachments A and B. Attachment A consists of a written report and Attachment B consists of 2 templates (Templates A and B).** Optional covering letters will also be considered as part of the out-of-round premium application form.

In submitting the premium application form, please note:

- All information should be provided as instructed in this document.
- Data should align with information provided to APRA under the reporting standards.
- Pages should be numbered in the written report.
- The premium application form should **not** be submitted in PDF format.
- Only information that is relevant to the health insurance business is required.[1]
- Insurers are only required to submit information for products that are the subject of the application, but may choose to provide any updated and additional information to support their application on a best-endeavours basis.
    - Per the PHI Act, insurers are **not required** to apply to the Minister to close or terminate a product/product subgroup, to reopen to new members a product/product subgroup previously closed to new members if there is no change to the premium that was approved for the product when it was closed, or if only making a change to an existing product that is not defined as a designated change.
    - However, insurers are encouraged to provide information on any products they have or intend to close or terminate, as well as any changes to products relevant to the application for contextual information (in Template A). For example, a) an increase to benefits may be relevant to a requested premium increase; b) a closed / terminated product information will be relevant to an application for premium approval for a new similar product.
    - Processing of applications may be delayed if insurers do not provide sufficient contextual information, and requests for further information are required.

The department and/or APRA will contact insurers to discuss applications that do not comply with the guidelines and requirements set out in this document.

The written report

The written report is split into questions of relevance for the insurer as a whole and questions relating to the specific product group that the application relates to. If there are multiple product groups in the application, the product group section can be repeated as

[1] Other than Template B where data is collected at a Health Benefits Fund level.

needed. Insurers can cross reference information between questions if appropriate rather than repeating information.

Given the ad hoc nature of an out-of-round premium application, insurers should use their judgement on the level of detail needed to support that the proposed premiums are in the public interest. The insurer should outline changes in actual, projected and target financial performance or any other changes since the previous annual Premium Round application and whether (and if so, how) these changes have influenced them to request the proposed premium and/or product changes.

As a guide, an application which is consistent with the insurer's pricing targets and capital targets is expected to be no more than 20 pages and no more than 10 pages for the actuarial opinion.

Questions

Reference	Question	Guidance
1	Insurer name	Provide the name of the insurer as registered with APRA as at the premium application date.
2	Justification for out-of-round submission	Provide a justification (e.g. operational, financial viability concerns etc.) for why the insurer did not apply through the annual Premium Round process with reference to the proposed date of effect specified in **Template A**. Insurers requesting a date of effect of less than 60 days after the date the application is made are strongly recommended to provide justification for the urgency, and to give the department notice in advance of the application using the notice template included at the end of this document. The department will endeavour to indicate to the insurer if it considers it unlikely that approval will be granted prior to the proposed date of effect.
3	Summary of application	Insurers should provide an overview of proposed changes included in their application, including a summary of new products, designated changes and price changes. Insurers are also asked to provide details on any new planned termination of products for additional context on insurer activity.
4	Public interest rationale	Insurers should provide a high-level public interest rationale for their application as a whole. Individual

Reference	Question	Guidance
		product groups may have their own specific public interest rationales which should also be provided for each individual product/product subgroup. Each application is assessed on its individual merits, and the Minister has broad discretion to consider any relevant matters in relation to the relevant public interest test. In addressing this question, insurers may wish to consider whether the matters outlined in the Minister's Statement of Expectations for the 2026 Premium Round are of relevance to their specific application.
5	Expected overall consumer impact	Insurers should provide the expected overall impact of their application on consumers as well as any specific individual product/product subgroup impacts on consumers. If new product termination and migrations are planned, insurers should detail the number of customers and expected premium impact on consumers, e.g. average $ and % premium increase per SEU.
6	Expected overall insurer impact	Insurers should outline how their application as a whole fit into their overall product portfolio and the expected impact it may have on the insurer's health insurance business, including its risk profile. Insurers should also detail any product/product subgroup-level impacts on the insurer. Where the insurer is aiming to address risks and financial issues, insurers should include key information, such as outline of the current issue, insurer tolerances and how the application will seek to address these issues.
7	Consistency with Act and Rules	Provide a declaration that the proposed premiums are consistent with the *Private Health Insurance Act 2007* and *Private Health Insurance (Prudential Supervision) Act 2015*, and the associated Rules, as at the date submitted.

Reference	Question	Guidance
8	Actuarial opinion	The provision of an actuarial opinion is encouraged, particularly if the application relies on changes to assumptions and forecasts since the previous Premium Round application. It is at the discretion of the insurer whether to provide an actuarial opinion and whether it is provided by the Appointed Actuary. Where provided, the actuarial opinion should specifically comment on any changes to assumptions on future drawing rate growth since the previous Premium Round application. The actuarial opinion may also comment on any matter they deem relevant to the out-of-round premium application process.
9	Contact person	Provide the contact details of a primary contact person, and an alternative contact person. This should include: • name • position title • landline telephone number • mobile phone number E-mail address.

Template A (Products)

- Template A should be completed for **all products where an approval is being sought**. It is at the insurers discretion whether they would like to provide information for other products in their portfolio if useful as contextual information, where providing updates to information for products where an application is not required. This includes information on products that an insurer intends to close or terminate, which insurers are not required to seek approval for.
- For all products where an approval is being sought, insurers must include a proposed date of effect for the proposed premium.
  - When approving a premium, the Minister must specify the date of effect, noting that the date of effect must be a day that is after the day on which the Minister approves the premium (sections 66-8(8) and 66-10(8) of the PHI Act).
  - Note: for proposed new products, the new product may be launched at any point in time on or after the approved date of effect of the approved premium for the proposed new product.
  - However, any newly approved premium for an existing product must take effect on the approved date of effect.
- All products should reflect the name, excesses, and premiums as they will appear in the Private Health Information Statements (PHIS) and Fund Rules from the proposed date of effect**.**
- **Note:** the department acknowledges that product information (including PHIS code and product name) for proposed new products may be subject to further change at the time of the premium application.
- Ambulance Only policies should be included where they are complying health insurance products and included in HRF601.
- Do not include Overseas Visitors Health Cover or Overseas Student Health Cover products.
- Information should be provided for all product subgroups where an approval is being sought, even if some products have the same price (e.g., information should be provided for couple policies even if they are priced the same as family policies).
- Product subgroups listed in all templates should be identified with a unique 'Product Code' identifier. This refers to the PHIS ID for existing products, for new products insurers should nominate a unique 'Product Code' identifier.
- Do not create new categories as a substitute for drop down list options – select only options in the drop-down menu.
- If an insurer provides information on products it intends to terminate products, additional information is requested on the effective price of products that customers are to be migrated to.

Field Descriptions

Field	Data Entry Guidelines	Example
Column A - Insurer	Name of insurer.	
Column B - State	Select from the drop down list the State/Territory in which the product is available. This should be consistent with the risk equalisation jurisdiction for APRA reporting Each State/Territory should be recorded separately (i.e. if the same product is available in multiple states, record in individual rows).	Drop down list: • NSW / ACT • NT • QLD • SA • TAS • VIC • WA
Column C - Product code (PHIS ID)	Enter in full the unique product identification code for the product, exactly as generated in the PHIS by privatehealth.gov.au (i.e. do not truncate by omitting insurer identifier component of code). Every unique PHIS ID should be included in its own row. This includes products that are closed or have zero policies/people. For proposed new products, enter PHIS code if known, otherwise leave blank.	
Column D - Product name as at proposed date of effect	Enter the product name. If the name is duplicated across products, do not leave any rows blank, but instead enter the identical name for each product. This should be consistent with the	Gold Hospital Cover

Field	Data Entry Guidelines	Example
	information recorded in the PHIS for the product. Note: Insurers should provide the names for proposed new products on a best endeavours basis.	
Column E - Product status as of the proposed date of effect	Select from the drop-down list whether the product is: • Open – New Product: New product proposed to be open from or after proposed date of effect. • Open – Existing: Open already existing product as at 1 April 2026 that will continue to be open to new customers upon the proposed date of effect. • Closed – Closing: Product open on 1 April 2026 that the insurer intends to close or has since closed. • Closed – Existing: Product closed as at 1 April 2026. • Terminating: Product planned for termination prior to 1 April 2027, with customers being migrated to alternative products. Note: the product status should be completed on a best endeavours basis based on available information on the date the application is submitted.	Drop down list: • Open – New Product • Open – Existing • Closed – Closing • Closed – Existing • Terminating
Column F – Is the proposed new product intended to replace a	For proposed new products that are intended to replace a closing/terminating product, insurers will need to enter	

Field	Data Entry Guidelines	Example
closing/terminating product? **If yes, provide the PHIS code of the closing/terminating product**	the PHIS code of the closing/terminating product. Otherwise, leave blank.	
Column G – For proposed new products, enter the PHIS code of a comparator product (either the insurers or competitor product).	Enter the PHIS code of a comparator product that is similar to the proposed new product. Comparators may be the insurer's own product or a competitor's product. Insurers should provide a comparator on a best endeavours basis. If no comparator is nominated, insurer will be expected to provide further detail on the product specifications of the proposed new product in the written report.	
Column H - Is a designated change being made (for existing products only)?	Select only from the drop-down list. For products where 'yes' is selected, details relating to the designated change must be completed at a product/product subgroup level in the written report.	Drop down list: • Yes • No
Column I - Proposed date of effect of premium	Enter the date by which the insurer is requesting the proposed premium will have affect from. Note: the date of effect is specified by the Minister in the approval of the proposed	1 July 2027

Field	Data Entry Guidelines	Example
	premium. The date of effect must be a day after the date the Minister approves the proposed premium (i.e. the approval cannot be retrospective). Furthermore, new products may be launched at any point after the approved date of effect. However, approved premiums for existing products must take effect from the approved date of effect.	
Column J - Product Coverage	Select only from the drop-down list.	Drop down list: • Hospital = Hospital treatment only • General = General treatment only • Combined = Combined hospital and general treatment • General - Ambulance = Ambulance only
Column K - Hospital category as at proposed date of effect	Select only from the drop-down list. This should be consistent with the information recorded in the PHIS for the product with that particular unique product identification code. Leave blank for general products.	Drop down list: • Gold • Silver Plus • Silver • Bronze Plus • Bronze • Basic Plus • Basic
Column L - Insured Group	Select only from the drop-down list. Enter information for each product subgroup separately even if different insured	Drop down list: • ChildrenOnly • Couple • ExtendedFamily • ExtendedSingleParentFamily

Field	Data Entry Guidelines	Example
	groups have the same price (e.g. include couples information in a separate row from family's information even if they have the same prices, if they have different PHIS code's).	• Family • Single • SingleParentFamily
Column M - Maximum excess per admission	Enter the maximum excess per admission for the product. For example, where a product has an excess of $0 for same-day admissions and $250 for overnight admissions, the value entered should reflect the maximum excess per admission, i.e., $250. For example, where a product has a maximum excess per admission of $750, this would previously have been entered as $750 for a single and $1,500 for a couple. The excess for this product should be entered as $750 regardless of insured group.	$500
Column N - Annual co-payment from proposed date of effect	Enter the maximum annual total co-payment amount for the product as from the proposed date of effect as a dollar amount or "no cap". A dollar amount should report the **maximum** allowable **annual total** co-payment amount (this is an amount separate to Annual excess – see above). For example, enter $500 if the co-payment is $50 per admission for every	$500 or "no cap"

Field	Data Entry Guidelines	Example
	admission up to a maximum of $500 per year. If no cap exists, enter "no cap".	
Column O – 2025 Monthly premium ($) for products existing on 31 March 2026 **(Leave blank for new products commencing from the proposed date of effect)**	Enter the previously approved 1 April 2025 price per month, regardless of whether this price was applied or not. Enter the price of all products opened between 1 April 2025 and 31 March 2026. This price should reflect the full price and exclude the rebate, LHC loadings, and discounts. For proposed new products, please leave blank.	$100.07
Column P - **1 April 2026 approved monthly premium ($)**	Enter the approved 1 April 2026 price per month, regardless of whether this price has been applied or not or the current price if product was launched after 1 April 2026. This price should reflect the full price and exclude the rebate, LHC loadings, and discounts. For proposed new products, please leave blank.	
Column Q - Proposed Monthly premium ($) as at proposed date of effect	Enter the proposed price per month for the product as at the proposed date of effect, including for new products.	$101.67

Field	Data Entry Guidelines	Example
	This price should reflect the full price and exclude the rebate, LHC loadings, and discounts. Insurers should leave this field blank for existing products if no change to the current price.	
Column R, Cell R2 – APRA quarter-end membership data provided	Enter date of policies and persons data provided. The most recent quarter of APRA data submitted is preferred.	30/09/2026 31/12/2026 31/03/2027 30/06/2027 30/09/2027
Column R - Total number of people covered by this product at [date] **Leave blank for new products commencing from the proposed date of effect**	Enter the total number of people covered by the policies comprising the insured group for the particular product on [date specified at cell R2] (e.g. number of people covered by family policies for the product). Do not record single equivalent units (SEUs). Please leave this as 0 for new products commencing from the proposed date of effect.	2,000
Column S - Total number of policies covered by this product at [date]	Enter the total number of policies comprising the insured group for the particular product on [date specified at cell R2] (e.g. number of couple's policies for the product). Do not record SEUs.	1,000

Field	Data Entry Guidelines	Example
	Please leave this as 0 for new products commencing from the proposed date of effect.	
Column T – 2025 Monthly premium revenue **Apr25 monthly premium x number of policies on [date]**	This is an automated field that calculates the 2025 monthly income from all policies on the product based on 2025 monthly premium [Column O] multiplied by the total number of policies covered by this product [Column S] at [date specified at cell R2]. Because there will be zero policies in Column S for a proposed new product, this field will be zero for all new products.	
Column U **Approved 2026 premium increase ($)**	This is an automated field that calculates the approved premium increase as of 1 April 2026 in dollar terms.	
Column V **Approved 2026 premium increase (%)**	This is an automated field that calculates the approved premium increase as of 1 April 2026 as a percentage.	
Column W **2026 approved monthly premium revenue** **Apr26 monthly premium x number of policies at [date]**	This is an automated field that calculates the 2026 monthly income from all policies on the product based on 2026 monthly premium [Column P] multiplied by the total number of policies covered by this product [Column S] at [date specified at cell R2]. Because there will be zero policies in Column S for a proposed new product,	

Field	Data Entry Guidelines	Example
	this field will be zero for all new products.	
Column X **Proposed premium change on the proposed date of effect from 1 April 2026 approved premiums ($)**	This is an automated field that calculates the dollar value of the premium change between the proposed monthly premium price [Column Q] and the previous approved premium [Column P]. This will be zero for proposed new products.	
Column Y **Proposed premium change on the proposed date of effect from 1 April 2026 approved premiums (%)**	This is an automated field that calculates the percentage premium change between the proposed premium after the proposed date of effect [Column Q] and the previous approved premium [Column P].	
Column Z **Additional monthly premium revenue from the proposed date of effect** **Proposed premium increase x number of policies at [date]**	This is an automated field that calculates the additional monthly premium revenue for all policies on the product based on the proposed increase in the monthly premium [Column X] multiplied by the total number of policies covered by this product [Column S] at [date specified at cell R2]. Because there will be zero policies for a proposed new product, this field will be zero for all new products. For terminating products, this field will be zero as no	

Field	Data Entry Guidelines	Example
	change in premiums is assumed.	
Column AA **Proposed premium increase from 2025 ($)**	This is an automated field that calculates the dollar value of the premium change between the proposed monthly premium price [Column Q] and the 31 March 2026 premium [Column O]. This will be zero for new products and products planned to be terminated.	
Column AB **Proposed premium increase from 2025 (%)**	This is an automated field that calculates the percentage change of the premium change between the monthly premium price after the proposed date of effect [Column Q] and the premium at 31 March 2026 [Column O].	
Column AC **Proposed new 2026 monthly premium revenue** **Based on the proposed premium x number of policies at [date]**	This is an automated field that calculates the proposed monthly premium revenue for all policies on the product based on the proposed monthly premium [Column Q] multiplied by the total number of policies covered by this product [Column S] at [date specified at cell R2]. Because there will be zero policies for a proposed new	

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Field	Data Entry Guidelines	Example
	product, this field will be zero for all new products.	

Template B (Financials)

- Template B reflects the APRA capital and reporting framework effective as of 1 July 2023.
- Insurers are encouraged (but not required) to provide updated information from that submitted in their 2026 Premium Round application, to support their application, particularly if the application relies on changes to assumptions and forecasts since the previous Premium Round application.
- If there are no updates to Template B, the insurer may leave this template blank and instead refer to their 2026 Premium Round application. Please use cell **A4** in Template B to indicate whether the insurer is referring to information from their most recent Premium Round application or whether they have updated the template.
- Please note: the processing of applications may be delayed if insurers do not provide sufficient contextual updating information and requests for further information are required.
- Actual data submitted under Template B must be consistent with actual data submitted under the APRA reporting standards. Notwithstanding this, insurers must note the following differences:
  - Template B requests monthly data whereas the APRA reporting standards request quarterly data.
  - Data must be entered in thousands of dollars ($'000) under Template B (with the exception of Hospital and General Treatment SEUs where the data must be entered in whole numbers). However, under the APRA reporting standards via APRA Connect, data are submitted in whole dollars.
- Data items highlighted in **bold** and *italics* within the tables below are defined in the APRA reporting standards.
- For items relating to balance sheet (APRA basis), HPS 340 insurance liabilities, prescribed capital amount (PCA) and capital base / target capital, insurers are only required to complete the forecasts on a quarterly basis.
- Data must be reported at a Health Benefits Fund level. Where applicable, data items must be aggregated across categories to calculate the amount for a Health Benefits Fund.
- Insurers are only required to complete the **white cells**. Grey cells will automatically calculate.
- The PCA is a formulaic driven line item which accounts for the minimum PCA of $5 million as per Prudential Standard HPS 110 Capital Adequacy (HPS 110) paragraph 24.
- Cells in Template B without a value should have a '0' inserted and not be left blank.
- No additional columns or rows are to be inserted into Template B.

Items under insurance performance and balance sheet – APRA basis

Data item	Definition
Data type	This item identifies whether the information provided reflects actual data, forecast data or a combination of both.
HIB Premium Revenue	This item aligns with ***accrued premium*** reported under *Reporting Standard HRS 101.0 Regulatory Income Statement – Supplementary Information* (HRS 101.0).
Claims Incurred	This item aligns with ***claims incurred amount*** reported under HRS 101.0.
Net Risk Equalisation Special Account Amount	This item aligns with ***net RETF amount*** reported under HRS 101.0.
State Ambulance Levies	This item aligns with ***state ambulance levies*** reported under HRS 101.0.
Other Insurance Business Expenses – HIB	This item aligns with ***other business expenses amount*** for health insurance business (HIB) reported under HRS 101.0.
Gross of reinsurance HRIB Premium Revenue	This item aligns with the ***gross accrued premium*** for health-related insurance business (HRIB) reported under HRS 101.0
HRIB Premium Revenue	This item aligns with the amount calculated after deducting ***reinsurance premiums ceded amount*** from ***gross accrued premium*** for health-related insurance business (HRIB) reported under HRS 101.0
HRIB Insurance Claims	This item aligns with the amount calculated after deducting ***reinsurance recoveries amount*** from ***gross claims incurred amount*** for health-related insurance business reported under HRS 101.0
Other Insurance Business Expenses – HRIB	This item aligns with ***other business expenses amount*** for health-related insurance business reported under HRS 101.0.
Net Other Operational Revenue (Include Health-Related	This item aligns with the amount calculated after deducting ***other business expenses amount*** for health-related business non-insurance from the sum of ***health-related business non-***

Data item	Definition
Business Non-Insurance)	***insurance revenue amount*** and ***net other operational revenue amount***. The relevant data items are reported under HRS 101.0.
Investment Income Amount	This item aligns with ***investment income amount*** reported under HRS 101.0.
Gains/Losses on Investments Amount	This item aligns with ***gains/losses on investments amount*** reported under HRS 101.0.
Hospital SEUs (at months end)	This item aligns with ***Single Equivalent Units (fund) count*** reported under *HRS 115.0 Insurance Risk Charge* (HRS 115.0). These values must be reported in whole numbers.
General treatment SEUs (at month end)	General treatment SEUs reported are to exclude Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment. This should be calculated consistent with that of Hospital SEUs the values must be reported in whole numbers.
Total Assets (Excluding DTAs, Total Intangible Assets And Goodwill, And AASB 17 Insurance And Reinsurance Contracts Asset)	This item aligns with the amount calculated after deducting the following items from ***total assets***: • **Total deferred tax assets;** • **Total intangible assets and goodwill;** • **Insurance contract assets; and** • **Reinsurance contract assets.** The relevant data items are reported under *HRS 300.0 Statement of Financial Position* (HRS 300.0).

Items under capital standards

Data item	Definition
Outstanding Claims Liability At 75th Probability Of Adequacy	This item aligns with ***OCL at 75th probability of adequacy*** calculated under HRS 115.0.

Data item	Definition
Premiums Liability At 75th Probability Of Adequacy (HIB)	This item aligns with ***PL at 75th probability of adequacy*** calculated under HRS 115.0 for health insurance business.
Premiums Liability At 75th Probability Of Adequacy (HRIB)	This item aligns with ***PL at 75th probability of adequacy*** calculated under HRS 115.0 for health-related insurance business.
Risk Equalisation Transfers At 75th Probability Of Adequacy	This item aligns with the amount calculated after deducting ***unbilled gross deficit amount*** from the sum of the following items. • **Unbilled calculated deficit amount;** • **Billed risk equalisation special account liability amount; and** • **Risk margin at 75th POA – risk equalisation transfers amount.** The relevant data items are reported under HRS 115.0.
Individual Other Insurance Liability At 75th Probability Of Adequacy	This item aligns with ***individual other insurance liability at 75th POA amount*** reported under HRS 115.0.
Deferred Claims Liability At 75th Probability Of Adequacy	This item aligns with ***DCL at 75th probability of adequacy (POA) amount*** reported under HRS 115.0
Outstanding Claims Liabilities Risk Charge	This item aligns with ***Outstanding Claims Liabilities Risk Charge*** reported under *HRS 110.0 Prescribed Capital Amount* (HRS 110.0).
Premiums Liabilities Risk Charge	This item aligns with ***Premiums Liabilities Risk Charge*** reported under HRS 110.0.
Risk Equalisation Risk Charge	This item aligns with ***Risk Equalisation Risk Charge*** reported under HRS 110.0.
Other Insurance Liabilities Risk Charge	This item aligns with ***Other Insurance Liabilities Risk Charge*** reported under HRS 110.0.

Data item	Definition
Future Exposure Risk Charge (HIB)	This item aligns with ***Future Exposure Risk Charge (HIB)*** reported under HRS 110.0.
Future Exposure Risk Charge (HRIB)	This item aligns with ***Future Exposure Risk Charge (HRIB)*** reported under HRS 110.0.
Deferred Claims Liability Risk Charge	This item aligns with ***Deferred Claims Liability Risk Charge*** reported under HRS 110.0.
Asset Risk Charge	This item aligns with ***Asset Risk Charge*** reported under HRS 110.0.
Asset Concentration Risk Charge	This item aligns with ***Asset Concentration Risk Charge*** reported under HRS 110.0.
Operational Risk Charge	This item aligns with ***Operational Risk Charge*** reported under HRS 110.0.
Aggregation Benefit	This item aligns with ***aggregation benefit*** reported under HRS 110.0.
Tax Benefits	This item aligns with ***tax benefits*** reported under HRS 110.0.
Adjustments To Prescribed Capital Amount As Approved By APRA	This item aligns with ***adjustments to prescribed capital amount as approved by APRA*** reported under HRS 110.0. Only adjustments approved by APRA should be reported in this data item, consistent with the definition in HRS 110.0. Please do not report the difference between the minimum PCA and the calculated PCA in this item. Insurers electing to participate in the transitional arrangements described in HPS 110 Attachment A should report the adjustment to the PCA under this item.
Capital Base	This item aligns with ***capital base*** calculated under *HRS 112.0 Determination of Capital Base*. Insurers electing to participate in the transitional arrangements described in *Prudential Standard HPS 112 Capital Adequacy: Measurement of Capital* Attachment G should report the capital base after applying the transitional adjustment.

Data item	Definition
Dividends Declared Or Paid	This item aligns with ***dividends declared or paid*** reported under HRS 101.0. Report this item as a positive value.
Retained Earnings Movements Other Than Profit / Loss After Tax and Dividends Declared or Paid	This item is all movements in retained earnings movement within the Health Benefits Fund excluding movements due to the following items reported under HRS 101.0. • **Profit / loss after income tax attributable to members of the company; and** • **Dividends declared or paid.** Please only report those movements that impact the capital base. Report this as a positive value where it would result in an increase in retained earnings. Report this as a negative value where it would result in a decrease in retained earnings.
Share Capital Injections	This item is any share capital injections made into the Health Benefits Fund (e.g. from the parent). Report this item as a positive value.
Share Capital Movements Other Than Share Capital Injections	This item is all movements in share capital movement within the Health Benefits Fund other than share capital injections (e.g. share capital reductions). Please only report those movements that impact the capital base. Report this as a positive value where it would result in an increase in share capital. Report this as a negative value where it would result in a decrease in share capital.
Target Capital – upper bound	Insurers that use a range for its target capital should report the upper bound of the range. Insurers that use a single figure for its target capital should report the figure in the **lower bound** field and zero here.

Data item	Definition
Target Capital – lower bound	This item aligns with ***target capital amount*** reported under *HRS 104.0 Forecasts and Targets*. Insurers that use a range for its target capital should report the lower bound of the range. Insurers that use a single figure for its target capital should report the figure here.

Avoiding Data Issues and Resubmissions

Each year a number of insurers are asked to resubmit their initial applications due to incorrectly completing the approved form or for data issues. To avoid these issues, insurers are asked to be particularly vigilant of data issues that have historically resulted in insurers being asked to resubmit.

To ensure each application does not contain data issues it is requested insurers check the following before submitting:

- The Excel spreadsheet does not contain links to other files.
- Cells surrounding the template are blank. Cells outside of the requested fields do not have checking or verification calculations.
- Cells requesting a number have a number inserted and not text. Similarly, cells with a number have not been formatted to 'text'.
- The formula cells have not been edited by the insurer.
- Data entered by the insurer should be values and not include calculations.
- Compliance checks are routinely carried out to ensure premiums approved by the Minister in the premium round process reflect the corresponding PHIS. Please ensure that accurate PHIS Product IDs are provided along with the new premium price requested for each product.

Australian Government
Department of Health, Disability and Ageing

Notice to department: Out-of-Round Application

Purpose of this notice

Insurers can utilise the template below to provide advance notice to the Department of Health, Disability and Ageing (department) of the insurer's intent to submit an Out-of-Round application. Insurer's may submit this optional notice at any stage of their product development process with the information completed on a best endeavours basis. Provision of a completed notice template as early as possible ahead of making an application will enable the department to plan its resourcing to enable an efficient assessment process. Insurers can use this form to raise questions for discussion with the department.

Question	Insurer Response
Insurer Name	
Intended submission date of application	
Proposed date(s) of effect	
Type of premium change(s) being requested (tick all that apply)	☐New product/product subgroup ☐Designated change ☐Premium change
Short summary of purpose of application	
Any issues/questions for the department?	
Contact person names and email addresses (Please provide 2 contacts)	

This form can be sent to the department via email at PHIPremiumRound@health.gov.au. If you have any questions, please contact the department through the same email address.