Agram GROUP ADRIATIC OSIGURANJE

# KEY INFORMATION FOR THE INJURED PARTY

(in case of damage arising from boat or yacht owner's liability to third parties)

**of the insurer ADRIATIC osiguranje d.d.**

If you find yourself in a situation where you are injured in a maritime accident that occurred in the Republic of Croatia due to the use of a boat or yacht, it is important to be familiar with the claims processing procedure by the insurance company (hereinafter: the Insurer). This guide will provide you with basic information about the key elements of the claims' submission process and claims handling by the Insurer to help you better understand your rights during the claims processing procedure. According to the provisions of the Mandatory Traffic Insurance Act, the owner of a boat or yacht with engine power greater than 15 kW, which must be registered in the register of boats or yachts according to vessel registration regulations, is obliged to conclude a liability insurance contract for damage that may be caused to third parties through the use of the boat or yacht resulting in death, bodily injury, or health impairment. Third parties do not include persons who are on the boat or yacht that caused the damage, persons who are on another boat or yacht, ship, or other floating vessel. Therefore, third parties in terms of mandatory insurance for boat or yacht owners are considered to be swimmers in the sea, people on the beach, and divers at sea.

## A - WHAT TO DO IN CASE OF A MARITIME ACCIDENT?

- A participant in a maritime accident where someone has lost their life or is injured is obligated to provide first aid to the injured, call emergency services, and remain at the maritime accident site unless they themselves need medical attention
- They are obligated to take all measures within their power to eliminate new dangers that may occur at the maritime accident site and ensure that the condition at the accident site remains unchanged
- If possible, document the damage - photograph the accident site and other relevant details
- Notify the police and/or harbour master's office about the maritime accident when required by regulations, especially when there were injuries or fatalities, or if there was another reason why you believe the police or harbour master's office should come to the maritime accident site (another participant leaves the accident site, refuses to provide personal information, in case of an unregistered vessel, in case of operating a vessel without valid license, suspicion that the person operating the vessel is under the influence of alcohol/drugs, etc.).

## B - FILING AN INSURANCE CLAIM

### 1. Where do I submit my claim?

- You submit your claim to the Insurer with whom the boat or yacht of the person responsible for the maritime accident is insured, if this information is known to you. You can verify boat or yacht ownership by entering the registration marks or vessel name on the website: https://eplovilo.pomorstvo.hr. It is recommended to submit the claim as soon as possible.

### 2. Who, how, and where submits the claim?

- The injured party or a person authorized by the injured party can submit a claim:

- in person at the Insurer's offices
- by email at addresses that can be found at: Što u slučaju štete - ADRIATIC osiguranje d.d.

### 3. Documents and information required in the claims processing procedure?

- In case of bodily injury, medical documentation (from first examination to completion of treatment), and in case of death, death certificate, proof of kinship for close relatives who are entitled to compensation (birth certificates, residence certificates) and documentation for funeral and other expenses
- Police report of the maritime accident on-site inspection and/or harbour master's office report
- Account number for payment (IBAN), which is submitted in accordance with GDPR provisions.

### 4. Additional important notes from the Insurer:

- When requesting data, the Insurer will limit itself only to necessary data (for example, contact information, information about the method of compensation payment, medical documentation related to the sustained injury)
- The Insurer may request and direct you to submit additional documentation necessary for resolving the claim which it cannot obtain independently or if you possess it, in order to make the claims processing faster and more efficient
- The Insurer is obligated to communicate in a transparent and understandable manner and provide you with access to information about the progress of the procedure and deadlines for resolving the claim
- The Insurer must not condition the resolution of the claim or the payment of compensation or undisputed part of compensation on, for example, reaching a settlement, nor suggest this as the best or only way to resolve the claim.

### 5. What information can I expect from the insurance company immediately upon filing a claim?

- The Insurer will assign a unique number (case reference) to your claim (damage report), which you will use to track the claim status during the processing procedure at the insurance company
- indicate the date of claim registration (date of claim submission)
- provide information about further procedures for processing the claim
- The Insurer is obligated, upon receiving the claim, to immediately inform you of your rights, as well as the Insurer's obligations, and actively and without delay take necessary actions to fulfil its obligations.

## C - ASSESSMENT AND PROCESSING OF CLAIMS BY THE INSURANCE COMPANY

**1.** The Insurer will assess the amount of damage based on the submitted medical documentation and orientation criteria of the Supreme Court of the Republic of Croatia, and if necessary, will invite you for an examination by our medical assessor.
**2.** Based on the received medical documentation, the Insurer's medical assessor will prepare a findings and opinion report - determining permanent functional deficit (so-called percentage of reduction in life activities), physical pain, fear, and disfigurement.

**3.** The Insurer will communicate with you or with the person you have authorized in the agreed manner to provide information about the claim resolution process.
**4.** You have the right - at your own expense - to engage an independent expert to prepare findings and opinion, and the Insurer will respond to any potentially disputed elements of those findings and opinion.
**5.** Along with the damage assessment, the Insurer also conducts a verification of the claim's validity, i.e., its obligations based on the submitted documentation.

## D - REASONED OFFER, SUBSTANTIATED RESPONSE, AND YOUR RIGHT TO COMPLAINT

**1.** The Insurer has a 60-day deadline from the date of receiving the claim to provide either a written reasoned offer for compensation or a written substantiated response if liability for compensation is disputed or when the amount of damage has not been fully determined.

a) **The reasoned offer must contain:**
- title of the decision, date of its adoption, and function/job title of the decision maker
- date of claim receipt and list of received and obtained documentation
- statement from the responsible Insurer confirming their obligation to pay compensation, and detailed explanation with stated decisive facts and legal basis
- the responsible Insurer must explain in a clear, simple, and understandable manner how they determined the assessed damage amount and the compensation amount to be paid
- statement that they will pay the compensation amount from the reasoned offer within 15 days from the date of sending the reasoned offer, whereby this payment deadline must be within 60 days from the date of receiving the claim
- detailed response to disputed points of the submitted findings and opinion of the independent expert, when submitted
- instructions about the right to file a complaint, the method of filing a complaint against the Insurer's decision, and the 15-day deadline within which the Insurer will respond to that complaint.

b) **The substantiated response must contain:**

▪ when the Insurer has determined they are <u>not liable for compensation</u>:
- title of the decision, date of its adoption, and function/job title of the decision maker
- date of claim receipt and list of received and obtained documentation
- Insurer's statement that they have determined they are not liable and detailed, simple, and understandable explanation with stated decisive facts and legal basis for the reasons of liability exclusion, taking into account all available documentation
- detailed response to disputed points of the submitted findings and opinion of the independent expert related to liability for compensation
- instructions about the method of filing a complaint against the Insurer's decision and the 15-day deadline within which the Insurer will respond to that complaint.

▪ when the responsible Insurer determines they are <u>liable only for partial compensation</u>:
- title of the decision, date of its adoption, and function/job title of the decision maker
- date of claim receipt and list of received and obtained documentation
- Insurer's statement that they have determined they are liable only for partial compensation and detailed explanation with stated decisive facts and legal basis
- the responsible Insurer is obligated to explain in a clear, simple, and understandable manner how they arrived at the determined damage amount and the compensation amount to be paid, and explain any specific factors applied, include a statement that they will pay the undisputed amount from the substantiated response within 15 days from the date of sending the substantiated response, whereby this payment deadline can be shorter as it must be within 60 days from the date of receiving the claim, provide detailed response to disputed points of the submitted findings and opinion of the independent expert, if submitted, and instructions about the method of filing a complaint against the Insurer's decision and the 15-day deadline within which the Insurer will respond to that complaint.

▪ when the responsible Insurer <u>cannot fully determine the amount of damage</u>:
- title of the decision, date of its adoption
- date of claim receipt and list of received and obtained documentation, statement from the responsible Insurer about their liability and that they cannot fully determine the amount of damage, and the reasons why they cannot fully determine the damage amount
- detailed explanation with stated decisive facts and legal basis
- the responsible Insurer is obligated to explain in a clear, simple, and understandable manner the reasons why they could not fully determine the damage amount, and how they arrived at the determined damage amount and compensation amount to be paid, and explain any specific factors applied
- statement that they will pay the undisputed amount within 15 days from the date of sending the substantiated response, whereby this payment deadline can be shorter as it must be within 60 days from the date of receiving the claim
- detailed response to disputed points of the submitted findings and opinion of the independent expert, when submitted
- instructions about the method of filing a complaint against the Insurer's decision and the 15-day deadline within which the Insurer will respond to that complaint.

**2.** If the Insurer does not provide you with a reasoned offer for compensation or a substantiated response without delay, and no later than within 60 days from the date of receiving the claim, and if you cannot resolve the dispute amicably with the Insurer or through the Mediation Centre at the Croatian Insurance Bureau or through other peaceful means https://mpu.gov.hr/mirno-rjesavanje-sporova-medijacija/26978, you may seek protection of your rights through legal channels, i.e., you may file a lawsuit against the Insurer.

**3.** An injured party who is not satisfied with the Insurer's handling of the claims process may contact the Insurance Ombudsman at the Croatian Insurance Bureau and file a complaint with HANFA (Croatian Financial Services Supervisory Agency).