Key Information for Injured Parties (Boat/Yacht Owner Third-Party Liability Claims)

When you find yourself in a situation where you are injured in a maritime accident in the Republic of Croatia that has resulted from the use of a boat/yacht, it is important that you are familiar with the manner in which the insurance company (hereinafter referred to as "the Insurer ") processes claims. This guide provides the basic information regarding the key steps of the Insurer's procedure for filing and processing claims, which will help you get a better understanding of your rights during the claims process.

Pursuant to the provisions of the Act on Compulsory Insurance within the Transport Sector, an owner of a boat/yacht whose total propulsion power exceeds 15kW and which, in accordance with the vessel registration regulations, must be entered in the Boat/Yacht Register, is obligated to conclude a contract of insurance against liability for losses he may cause to third parties by the use of the boat/yacht as a result of death, bodily injury or deterioration in health.

Persons who are on board the boat/yacht which caused the damage and persons on board the other boat/yacht, ship or some other waterborne craft are not considered third parties. Therefore, within the meaning of the compulsory boat/yacht owner insurance, third parties are bathers in the sea, persons on the beach, divers in the sea.

SECTION A – WHAT TO DO IN CASE OF A MARITIME ACCIDENT?

- **Administer first aid** and call an ambulance if there are any injured persons.
- **Report the accident to the police or the port authority**, if required pursuant to the regulations, and particularly if it involves injured persons or fatalities, or:
  - fire or explosion,
  - significant physical damage to the vessel,
  - some other reason which leads you to believe that the police or the port authority should respond to the site of the maritime accident (if the other party involved in the accident leaves the accident site, refuses to provide personal data, if the accident refers to a collision with a non-registered vessel, if the accident involves navigation without a proper licence to operate a vessel, if there is reason to believe that the person operating the vessel might be under the influence of alcohol/narcotics, and similar) and conduct an investigation of the maritime accident.;
- Take all measures possible to reduce or eliminate damage or, where possible, prevent the occurrence of even greater damage.
- Exchange personal information and information about the boats/yachts and insurance companies with other persons involved in the maritime accident.
- If possible, document the damage that has occurred: take photos of the accident site.
- If possible, take photos of the documentation as well (e.g., licence to operate a vessel, boat/yacht registration certificate, etc.).

SECTION B – FILING A CLAIM

1. With whom should I file my claim?
You should file your claim with the Insurer with which the boat/yacht of the person responsible for the maritime accident that has occurred is insured, if you have that information. You can check who owns the relevant boat/yacht by entering its registration number or name on: https://eplovilo.pomorstvo.hr. You are advised to file your claim as soon as possible.

2. Who can file a claim? How and where?
An injured party or a person authorized by the injured party can file a claim via via e-mail prijava.stete@uniqa.hr, or by calling 01/6324-200 or by arriving at the insurer's headquarters, Planinska 13a, Zagreb.
You can find information about all other channels that can be used to file a claim on our official website: www.uniqa.hr.

3. Documents and information required in the claims resolution process
- Number of the account for compensation payment (IBAN),
- Medical records (from the first examination up to the end of the treatment) and, in the event of a bodily injury resulting in death, a death certificate, inheritance decision, birth certificates of the children, certificates of permanent residence and documentation associated with funeral and other expenses,
- Exceptionally, if the police or port authority respond to the accident, the police report and the alcohol test report, or the report by the port authority.

Additional important notes:
- When requesting information, the Insurer will limit his request only to such information which is necessary (e.g., contact information, information regarding the compensation payment method, medical records associated with the injury sustained).
- With the explanation why it is crucial, the Insurer may request from you or advise you to deliver certain additional documentation necessary to resolve your claim, i.e., such that he cannot obtain himself or such that is in your possession, with the aim of ensuring a quicker and more effective claim adjustment process.
- In the aforementioned, the Insurer must not require the injured party to provide documentation that it can obtain independently (for example, police report, harbour master's report, breathalyzer report, inspection documentation, accident site sketch).
- The Insurer is obliged to communicate in a transparent and understandable manner and to provide you with access to information about the progress of the procedure and deadlines for resolving the compensation claim.
- The Insurer must not condition the resolution of the compensation claim or the payment of compensation or the undisputed part of the compensation, for example, by concluding a settlement, nor indicate that this is the best or only way to resolve the compensation claim and that it is necessary to accept the offered amount as final.

4. What information can I expect to receive from the insurance company immediately after filing a claim?
The Insurer will:
- Assign a unique number (case reference) to your notice of loss (claim) based on which you will be able to track the status of your claim during the claim adjustment process conducted by the Insurer,
- Indicate the date on which your claim is entered in the records (claim filing date),
- Provide information on further steps he (the Insurer) intends to take,
- If your treatment is completed, based on the delivered medical records and the Insured's liability for the occurrence of the loss event, the Insurer will determine the compensation for the non-property damage and pay the claim.

Note: The Insurer is obligated to explain all methods of resolving claims in a clear, transparent, and simple manner. By signing a claim settlement declaration or a settlement contract/agreement, you lose the right to seek additional compensation payments. You can refuse the offer to settle and still receive compensation. Settlement contracts are final and binding. If a settlement contract is concluded, the Insurer will not be liable for any payments outside the scope of such contract.

SECTION C – EVALUATION AND PROCESSING OF CLAIMS BY THE INSURANCE COMPANY

1. The Insurer will evaluate the extent of damage based on the medical records delivered to him. If necessary, you will be referred to an examination by our medical censor.
2. Based on the medical records received, the Insurer's medical censor will determine the degree of decrease in activities of daily living ("degree if disability"), pain, fear, disfigurement, which will be outlined in the reasoned offer or reply.
3. The Insurer will communicate with you or with a person you have authorized in an agreed-upon manner (in accordance with usual business communication methods, unless a mandatory communication method is prescribed by law) to provide information about the procedure for resolving the compensation claim.
4. **You have the right to hire, at your own cost, an independent expert to provide their findings and opinion, in which case the Insurer will provide a response in regard to any contested aspects of such findings/opinion.**
5. In addition to the evaluation of damage, based on the documentation delivered to him, the Insurer will also verify the amount claimed and the validity of your claim, i.e., determine the existence and extent of his liability.

SECTION D – REASONED OFFER, REASONABLE RESPONSE AND YOUR RIGHT TO LODGE A COMPLAINT

1. Within 60 days of receiving your claim, the Insurer must provide
   - **a written reasoned offer of compensation for your loss, provided that the Insurer does not dispute its liability and has determined the amount of loss; or**
   - **a written reasoned report if the responsibility for providing you with compensation is disputable or if the amount of loss has not been fully established.**

a. **A reasoned offer** must comprise:
   - decision name, decision date and position/job title
   - of the person who made the decision,
   - claim received date and list of submitted and obtained documents,
   - a declaration of the Insurer about the obligation to pay damages and a detailed explanation with a list of key facts and legal basis (citation of relevant statutory or other relevant provision, terms and conditions of coverage, etc.),
   - a specification of the damage assessment, in which case the Insurer liable to pay for the claim has to elaborate in a clear, simple and understandable way how the value of the claim was evaluated and the amount of compensation was determined and explain any specific factors used (e.g., co-liability, etc.) including the reason for their application and the way their value was determined,
   - **a declaration that the amount of compensation from the reasoned offer will be paid within 15 days from the offer sent date, with the payment due date falling within 60 days from the claim received date,**
   - a detailed statement on disputed information in the independent expert's report,
   - instruction of the right to complain to the Insurer's decision and the complaint procedure and the time period of 15 days the Insurer has to respond to your complaint.

b. **A reasoned response** has to include:
   - **If the Insurer** establishes **it is not liable to pay damages**:
   - decision name, decision date and position/job title
   - of the person who made the decision,
   - claim received date and list of submitted and obtained documents,
   - a declaration of the Insurer about why it has no obligation to pay damages and a clearly understandable explanation with a list of key facts and legal basis (citation of relevant statutory or other relevant provision, terms and conditions of coverage, etc.) why its liability is excluded, taking into account all of the available documents,
   - a detailed statement on disputed information in the independent expert's report and opinion relating to the compensation of damage,
   - instruction of the right to complain to the Insurer's decision and the complaint procedure and the time period of 15 days the Insurer has to respond to your complaint.
   - **If the Insurer** accepts **only obligation of partial payment**:
   - decision name, decision date and position/job title
   - of the person who made the decision,
   - claim received date and list of submitted and obtained documents,
   - declaration of the Insurer about the partial payment of damages and a detailed explanation with a list of key facts and legal basis (citation of relevant statutory or other relevant provision, terms and conditions of coverage, etc.),
   - a specification of the damage assessment, in which case the Insurer liable to pay for the claim has to elaborate in a clear, simple and understandable way how the value of the claim was evaluated and the amount of compensation was determined and explain any specific factors used (e.g., co-liability, etc.) including the reason for their application and the way their value was determined,
   - **a declaration confirming that the Insurer will pay the undisputed amount from the reasoned response within 15 days from its sent date, with the payment term being possibly shorter, as it has to fall within 60 days from the claim received date,**
   - a detailed statement on disputed information in the independent expert's report,
   - instruction of the right to complain to the Insurer's decision and the 15 days the Insurer has to respond to your complaint.
   - **If the Insurer is unable to make a precise damage assessment:**
   - decision name, decision date and position/job title of the person who made the decision,
   - claim received date and list of submitted and obtained documents,
   - a declaration of the Insurer about its liability and inability to make a precise damage assessment and the reasons in support of that,
   - a detailed explanation including the key facts and legal basis (citation of relevant statutory or other relevant provision, terms and conditions of coverage, etc),
   - a specification of the damage assessment, in which case the Insurer liable to pay for the claim has to elaborate in a clear, simple and understandable why the precise damage assessment could not be made and how the amount of compensation was determined and explain any specific factors used (e.g., depreciation, co-liability, etc.) including the reason for their application and the way their value was determined,
   - **a declaration confirming that the Insurer will pay the undisputed amount from the reasoned response within 15 days from its sent date, with the payment term being possibly shorter, as it has to fall within 60 days from the claim received date**,
   - a detailed statement on disputed information in the independent expert's report and opinion and disputed items in the approved service provider's invoice, i.e., offer for damage repair, if it has been issued,
   - instruction of the right to complain to the Insurer's decision and the complaint procedure and the time period of 15 days the Insurer has to respond to your complaint.

2. If the obligation to pay compensation or the undisputed portion thereof within 15 days or 60 days, as the case may be, fails to be performed, the injured party **will be entitled to receive interest accruing as of the claim filing date in addition to the compensation for loss or the undisputed portion thereof.**

3. In case the Insurer without postponement and not later than within 60 days from the day of receiving your claim fails to send you a reasoned offer of compensation, i.e., a reasoned response, and you are unable to come to an agreement with the Insurer through mediation, even in proceedings before the Mediation Centre at the Croatian Insurance Bureau or by some other way of alternative dispute resolution https://mpu.gov.hr/mirno-riesavanje-sporova-medijacija/26978, you can take the matter to court, i.e., file a lawsuit against the Insurer.

4. An injured party who is not satisfied with the Insurer's claim handling can contact the Insurance Ombudsman at the Croatian Insurance Bureau and submit a complaint to the Croatian Financial Services Supervisory Agency (HANFA).