Key Information for Injured Parties (Public Transport Passenger Accident Insurance Claims)

When you find yourself in a situation where you have been injured in an accident as a passenger on public transport in the Republic of Croatia that has resulted from the use of a means of transport, 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, passengers are persons who are on board one of the means of transport designated for public transport for the purpose of traveling on it, regardless of whether they have already purchased a ticket or not, as well as persons within the grounds of a station, port or airport, or in the immediate vicinity of a means of transport prior to boarding or after disembarking, who intended to travel by a particular means of transport or have travelled on it, with the exception of persons employed on such means of transport.

SECTION A – WHAT TO DO IN CASE OF A TRAFFIC ACCIDENT WHERE A PUBLIC TRANSPORT PASSENGER ACCIDENT INSURANCE POLICY HAS BEEN CONCLUDED?

- **Administer first aid** and call an ambulance if there are any injured persons.
- **Report the accident to the police**, if required pursuant to the regulations and particularly if it involves injured persons or fatalities, or:
  - fire or explosion,
  - significant physical damage to the other means of transport,
  - some other reason which leads you to believe that the police should respond to the site of the traffic 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 vehicle, if the accident involves operation of a vehicle without a driver's licence, if there is reason to believe that the driver might be under the influence of alcohol/narcotics, and similar) and conduct an investigation of the traffic accident.
- Take all measures possible to reduce or eliminate damage or, where possible, prevent the occurrence of even greater damage.

SECTION B – FILING A CLAIM

1. With whom should I file my claim?
You should file your **claim with the Insurer with which a public transport passenger accident insurance policy covering the relevant means of transport has been concluded**, if you have that information.
You are advised to file your claim as soon as possible.

2. Who can file a claim? How and where?
The injured party/policyholder or a person authorized by the policyholder can file a claim via an online application available at the link https://www.uniqa.hr/kontakt-i-usluge/prijava-stete/online-prijava-stete/nezgoda/116, by email to the address prijava.stete@uniqa.hr, by calling 01/6324-200, or by visiting the insurer's headquarters at Planinska 13a, Zagreb.

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,
- In the case of police involvement, a police report and a breathalyzer report may exceptionally be requested,
- The ticket or some other evidence confirming that you were a passenger on the means of transport participating in public transport.

Additional important notes:
- When requesting information, the Insurer will limit his request only to such information which is necessary (e.g., in case of property damage – the information contained in the European Accident Statement, identification data, contact information, information regarding the compensation payment method).
- 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 (date of filing the claim),
- Provide information on further steps he (the Insurer) intends to take,
- If your treatment is completed, based on the delivered medical records, the arranged insurance policy, the terms and condition of insurance, and the Disability Table, the Insurer will determine the degree of disability and pay the claim.

Note: The Insurer is obligated, upon receiving the compensation claim, to promptly inform you of your rights, as well as the Insurer's obligations, and to actively and without delay take the necessary actions to fulfill its obligations.
The Insurer is obligated to explain all methods of resolving claims in a clear, transparent, and simple manner. By signing a statement of settlement or a settlement agreement, you lose the right to request additional compensation payments. You can refuse the offer to conclude a settlement and still receive compensation. Settlement agreements are final and binding. In the case of concluding a settlement, the insurer is not responsible for any payments outside that agreement.

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 disability in accordance with the applicable Disability Table, 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 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., 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 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).