KIZO - KEY INFORMATION FOR THE INJURED PARTY

(in case of damage from the liability of the boat or yacht owner towards third parties)

INSURER: SAVA OSIGURANJE, D.D. - BRANCH OFFICE HRVATSKA

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If you find yourself in a situation where you are the injured party in a maritime accident in the Republic of Croatia involving the use of a boat or yacht, it is important to be familiar with the claims handling process by the insurance company (hereinafter: the Insurer). This guide will provide you with basic information about the key elements of submitting a damage claim and the claims processing procedure with the Insurer, so you can better understand your rights during the claims handling process.

PART A - WHAT TO DO IN CASE OF AN ACCIDENT?

Provide first aid and call an ambulance if there are injured persons;

Take all possible measures to reduce or eliminate the damage, or if possible, prevent the occurrence of greater damage;

Exchange personal information and information about vessels and insurance companies with other participants in the maritime accident;

Document the damage, if possible

- Take photos of the scene of the accident, including the position of all involved vessels and damage to the vessels.
- Take photos of other significant marks at the scene of the maritime accident.
- If possible, take photos of relevant documents (navigation license, vessel registration certificate, etc.).

Situations in which you are required to call the police and port authority:

When required by regulations, and especially when there were injuries or fatalities or if there was:

- a fire or explosion;
- major material damage to the vessel;
- there is another reason why you believe that the police or the port authority should go to the scene of the maritime accident (the other participant leaves the scene of the accident, refuses to provide personal information, it is a collision with an unregistered vessel, sailing without a valid license to operate the vessel,
- there is a suspicion that the driver is intoxicated/under the influence of opiates, etc.) and conduct an investigation of the maritime accident;

PART B - FILING A COMPENSATION CLAIM

1 To whom do I submit a compensation claim?

You submit a claim to the insurer with whom the boat or yacht of the person responsible for the maritime accident is insured, if you know this information.

You can check where the vessel is insured by entering the license plate number or name of the boat on the website: https://eplovilo.pomorstvo.hr

2 Who can, how and where submit a compensation claim?

The injured party or a person authorized by the injured party may submit a claim for compensation in person at any office of the Insurer, by e-mail to stete@sava-osiguranje.hr or by phone: 0800-913 023 or 01 66 66 249.

3 Required documents and information for processing a compensation claim?

- It is recommended to provide an account number (IBAN) for payment
- In the case of a physical injury, medical documentation (from the first examination to the end of treatment), and in the case of a fatal physical injury, a death certificate, a decision on inheritance, children's birth certificates, residence certificates and documentation for funeral and other expenses;
- In the case of a departure from the port authority or the police, a police report and a breathalyzer test report or a port authority report;

ADDITIONAL IMPORTANT NOTES:

- The Insurer will only request necessary information (e.g., identification data, all medical documentation, contact information, information on the method of payment of compensation for damage).
- With justification, the Insurer may request additional documents essential for processing the claim that it cannot obtain on its own or that you possess, to facilitate a faster and more efficient process. However, the Insurer cannot request documents it can obtain itself (e. g., police report, breathalyzer results, etc.).

The Insurer must communicate in a transparent and understandable manner and provide access to information about the claim process and resolution timelines.

4 What information can I expect from the Insurer when submitting a compensation claim?

The Insurer will:

- assign a unique reference number for your claim, which will allow you to track its status;
- record the date of claim submission;
- provide information about the next steps.
- if the treatment has been completed based on the submitted medical documentation, the insured's liability for the occurrence of the harmful event has been established, compensation for non-pecuniary damage will be determined and the damage will be paid

Note: **The Insurer must clearly explain all settlement options. By signing a release statement or a settlement agreement, you waive the right to claim additional compensation. You are not obligated to accept a settlement offer and may still receive compensation. Settlement agreements are final and legally binding. In the event of a settlement, the Insurer is not responsible for any payments beyond what is agreed upon in the settlement.**

PART C - DAMAGE ASSESSMENT AND CLAIM PROCESSING BY THE INSURANCE COMPANY

1 The Insurer will determine the amount of compensation based on the submitted medical documentation, and if necessary, will invite you for an examination by our examining physician,

2 Based on the received medical documentation, the Insurer's examining physician will determine the percentage of reduction in life activities (the so-called "percentage of disability"), and this will be described in the reasoned offer or substantiated response.

3 The Insurer shall communicate with you or your authorized representative using agreed-upon standard business communication methods.

4 You have the right to hire an independent expert, at your own expense, to provide a separate assessment and opinion, and the Insurer is required to respond to any disputed elements in the expert's findings.

5 In addition to damage assessment, the Insurer will verify the amount and validity of the compensation claim, i. e., its obligations on the basis of the submitted documentation.

PART D - REASONED OFFER, JUSTIFIED RESPONSE, AND YOUR RIGHT TO APPEAL

1 The Insurer has a **deadline of 60 day from the date of receiving the compensation claim** to provide a written reasoned offer for compensation if liability is not disputed and the damage amount is determined, or a written justified response if liability is disputed or the damage amount is not fully established.

a) A reasoned offer must contain:

- the title of the decision, its date, and the function/title of the decision-maker,
- the date of receipt of the claim and a list of received and obtained documentation,
- a statement from the Insurer confirming liability for compensation and a detailed explanation with key facts and legal basis (relevant laws, insurance terms, etc.)
- a breakdown of the determined amount of damage, whereby the responsible Insurer is obliged to explain in a clear, simple and understandable manner how it arrived at the determined amount of damage and the amount of damage that it will pay, and explain any specific factors applied (e. g. depreciation, co-responsibility, etc.), including the reasons why they were applied and how they were determined,
- a statement that the compensation amount from the offer will be paid within 15 days from the date of sending the reasoned offer, whereby the specified payment deadline must be within 60 days from the date of receipt of the claim,
- a detailed statement on the disputed points of the submitted findings and opinions of the independent expert regarding liability for compensation for damage,
- instructions on the method of submitting an objection to the Insurer's decision and the 15-day period within which the Insurer will respond to that objection.

b) A justified response must contain:

- If the **Insurer determines no liability for compensation:**
- the decision title, date, and function/title of the decision-maker,
- the date of receipt of the claim and a list of received and obtained documentation,
- a statement by the Insurer that it has determined that it is not liable and a detailed, simple and understandable explanation with the stated decisive facts and legal basis (relevant provision of positive regulations, insurance conditions, etc.) on the reasons for the exclusions of liability, taking into account all available documentation,
- a detailed statement on the disputed points of the submitted findings and opinions of the independent expert regarding liability for compensation for damage,
- instructions on how to file an objection to the Insurer's decision and the 15-day period within which the Insurer will respond to that objection.
- If the **Insurer determines partial liability for compensation**:
- the decision title, date, and function/title of the decision-maker,
- the date of receipt of the claim and a list of received and obtained documentation
- a statement from the Insurer that it has determined that it is only liable for part of the compensation for the damage and a detailed explanation with the stated decisive facts and legal basis (relevant provision of positive regulations, insurance conditions, etc.),
- a breakdown of the determined amount of damage, where the responsible Insurer is obliged, in a clear, simple and understandable way explain how the compensation sum was calculated, including any applied factors (e.g., depreciation, shared liability) and reasons for their application,
- a statement that the compensation amount from the offer will be paid within 15 days from sending the reasoned offer, ensuring the payment occurs within the 60-day deadline from the claim receipt,
- a detailed statement on the disputed points of the submitted findings and the opinion of the independent expert, if submitted,
- - instructions on how to submit an objection to the insurer's decision and the 15-day period within which the insurer will respond to that objection.
- If the responsible **Insurer is unable to fully determine the amount of damage:**
- the decision title, date and function/title of the decision-maker,
- the date of receipt of the claim and a list of received and obtained documentation,
- a statement by the responsible Insurer about its liability and that it is unable to fully determined the amount of damage and the reasons for which it is unable to fully determined the amount of damage,
- a detailed explanation with the stated decisive facts and legal basis (relevant provision of positive regulations, insurance conditions, etc.)
- a breakdown of the determined amount of damage, whereby the responsible Insurer is obliged to explain in a clear, simple and understandable manner the reasons for which it was unable to fully determine the amount of damage, and how it arrived at the determined amount of damage and the amount of damage that it will pay, and explain any specific factors applied (e. g., depreciation, co-responsibility, etc.), including the reasons why they were applied and how they were determined,
- a statement that the compensation amount from the offer will be paid within 15 days from sending the reasoned offer, whereby the stated payment deadline may be shorter because it must be within 60 days of the date of receipt of the claim,
- a detailed statement on the disputed points of the submitted findings and opinion of the independent expert and the disputed items of the invoice or offer for repair of the damage from the authorized provider services, when delivered,
- instructions on how to file a complaint against the Insurer's decision and the 15-day period within which the Insurer will respond to that complain.

2 In the event of non-fulfillment of the obligation to pay damages or an undisputed amount of damages within 15 days, or within a period of 60 days, the injured person has the right to pay interest in addition to the due amount of damages, i.e., in addition to the due amount of damages, from the date of submitting the claim for damages.

3 If the Insurer does not provide you with a reasoned offer for compensation for damages or a substantiated response without delay, or at the latest within 60 days from the date of receipt of the claim, and you are unable to resolve the dispute amicably with the Insurer or before the Mediation Center at the Croatian Insurance Bureau or in another amicable manner (https://mpu.gov.hr/mirno-rjesavanje-sporova-medijacija/26978), you may seek protection of your rights in court, or you may file a lawsuit against the Insurer.

4 An injured party who is not satisfied with the insurer's conduct in the process of resolving a claim may contact the Insurance Ombudsman at the Croatian Insurance Office and submit a complaint to HANFA.

Compulsory Traffic Insurance Act

IMPORTANT INFORMATION: Please note that each Insurer may adapt the process of resolving claims described here to each specific case, but in accordance with applicable legislation. Also, the information in Part A of this document is prescribed in detail by the Compulsory Traffic Insurance Act and its implementation and supervision are the responsibility of police officers or the ministry responsible for internal affairs.