KIIP - Key Information for the Injured Party (insurance of passengers in public transport against the consequences of an accident) with the Insurer Generali osiguranje d.d.

If you are the injured party in a traffic accident in the Republic of Croatia, it is important to be familiar with the processing of compensation claims for death, bodily injury, or health impairment carried out by the insurance company (hereinafter referred to as: the Insurer). This guide provides essential information about the key elements of the procedure of filing a compensation claim and the claims processing procedure with the Insurer so that you can better understand your rights and the steps involved during the compensation claims process.

SECTION A – WHAT TO DO IN THE EVENT OF AN ACCIDENT?

What to do in case of a bodily injury or death:

- Call the police or the harbour master's office, and an ambulance if there are injured persons
- Exchange personal information, vehicle/vessel details, and compulsory vehicle/vessel insurance policy information
- Take photographs of the accident scene and the damages to the vehicle/vessel.

SECTION B – FILING A COMPENSATION CLAIM

1. Where to file a compensation claim?

In the event of a traffic accident, a compensation claim is filed with the insurance company (hereinafter referred to as: the Insurer) that covers the means of transport with a personal accident insurance policy for public transport, if this information is known to you.
It is recommended that a compensation claim be filed as soon as possible.

2. Who can file a compensation claim, how and where?

The injured party or a person authorised by the owner can file a compensation claim in person at any branch of the Insurer, online via the link https:// www.generali.hr/prijava-stete Accident insurance, or by e-mail:stete.hr@generali.hr or by post to the address Generali osiguranje d.d., Slavonska avenija 1b, Zagreb.

3. Documents and information required in the compensation claim procedure?

- Medical documentation in the event of physical injury,
- Death certificate, autopsy report, and birth certificates of close family members,
- An account number for compensation payment (IBAN) is recommended,
- Only exceptionally, and in case of police arrival, the police report,
- Transport ticket or other written evidence confirming that you were a passenger in the public transport vehicle.

ADDITIONAL IMPORTANT NOTES FROM THE INSURER:

When requesting information from the injured party, limit the inquiry to necessary data (identification details, contact information, and preferred method of compensation payment).

- After explaining its necessity, the Insurer may request and direct the submission of additional documentation required to resolve the compensation claim. The Insurer may not request documentation from the injured party that it can obtain independently (e.g., police report, breathalyzer report).
- The Insurer is obligated to communicate in a transparent and understandable manner and provide access to information about the progress and deadlines for resolving the compensation claim.
- The Insurer may not make the resolution or payment of the compensation claim, or the undisputed portion thereof, conditional on actions such as entering into a settlement agreement. Nor should the Insurer suggest that such an agreement is the best or only way to resolve the claim. The Insurer must clarify the available options for resolving the claim.

4. What information can I expect from the insurance company when filing a compensation claim?

The Insurer will do the following:

- Assign a unique reference number (case number) to your claim, allowing you to track its status throughout the processing period at the insurance company,
- Indicate the date of claim registration (when the compensation claim was filed).
- Provide information on the subsequent procedures to be undertaken by the Insurer.

Upon receipt of the compensation claim, the Insurer is obligated to promptly inform you of your rights as well as the obligations of the Insurer, and to actively and without undue delay take the necessary actions to fulfil its obligations.

Note: The Insurer is obligated to clearly and thoroughly explain all methods of resolving the claim. By signing a statement of settlement or a settlement agreement, you waive the right to request additional compensation for the claim. You have the right to reject a settlement offer and still receive compensation for your claim. Settlement agreements are final and binding. Once a settlement is reached, the Insurer is not liable for any payments beyond those specified in the settlement agreement

.

SECTION C – ASSESSMENT AND PROCESSING OF COMPENSATION CLAIMS BY THE INSURANCE COMPANY

1. The Insurer will assess the extent of the damage based on the provided medical documentation and/or an examination by the Insurer's appointed medical examiner when the circumstances of the case require it.
   Based on the report and opinion of the Insurer's appointed medical examiner, as well as the insurance policy, insurance conditions, and disability tables, the Insurer will determine the percentage of disability and proceed with the compensation payment.
2. The Insurer will communicate with you or your appointed representative in the agreed manner, whether by phone, app, email, or postal mail, to provide information on the claim resolution process.
3. **You have the right, at your own expense, to engage an independent expert to prepare a report and opinion, especially if you disagree with the Insurer's assessment, in which case the Insurer must provide a detailed response to all elements of that report and opinion.**
4. **In addition to the damage assessment, the Insurer will also verify the validity and amount of the compensation claim, i.e., its obligations based on the provided documentation.**

SECTION D – DETAILED OFFER, REASONED RESPONSE, AND YOUR RIGHT TO APPEAL

1. The Insurer shall have 60 days from the receipt of the compensation claim to provide:
   – **a written detailed offer for compensation payment, or**
   – **a written reasoned response if liability for compensation is disputed or if the extent of the damage has not been fully determined.**
   a. **The detailed offer** referred to in paragraph 1 of this article must include:
   - The title of the decision from paragraph 1 of this Article, the date it was adopted, and the name, surname, and function/title of the decision-maker,
   - The date of receipt of the compensation claim and a list of the received and obtained documentation,
   - The liable Insurer's statement declaring that it has established its obligation to compensate for damages, along with a detailed explanation that includes the relevant facts and legal grounds (applicable provisions of positive regulations, insurance conditions, etc.), followed by a specification of the determined amount of damage and the compensation amount to be paid, including the specific factors applied, and taking into account all available documentation. This explanation should be presented in a clear, simple and understandable manner, outlining how the Insurer determined the amount of damages and the amount of compensation to be paid, and to explain any specific factors applied, including the reasons for their application and the method of their determination,
   - **a statement that the compensation amount specified in the detailed offer will be paid within 15 days from the date the detailed offer is sent, with the payment deadline falling within 60 days from the day of receipt of the compensation claim.**

- A detailed response to all points of the provided report and opinion of the independent expert, as well as the invoice or repair offer from an authorized service provider, when submitted,
- Instructions regarding the right to file an appeal and the procedure for submitting an appeal against the Insurer's decision, along with the 15-day period within which the insurer will respond to the appeal, in accordance with Article 378, paragraph 2 of the Insurance Act.

b. A **reasoned response** from paragraph 1 of this Article must include the following:

• If the Insurer has established **that it is not liable for compensation:**

- The title of the decision from paragraph 1 of this Article, the date of its adoption, and the name, surname, and function/title of the decision-maker,
- The date of receipt of the compensation claim and a list of the received and obtained documentation, - a statement from the Insurer confirming that it has determined it is not liable, and a detailed explanation of the decisive facts and legal grounds (relevant provisions of positive regulations, insurance conditions, etc.) for excluding liability, taking into account all available documentation, This explanation should be presented in a clear,
- simple and understandable manner, outlining how the Insurer concluded it is not liable,
- a detailed response to all points in the report and opinion of the independent expert and the repair offer or invoice from the authorized service provider, when submitted,
- Instructions on how to file an appeal against the Insurer's decision and the 15-day period within which the Insurer will respond to the appeal, in accordance with Article 378, paragraph 2 of the Insurance Act.

- When the liable Insurer determines **that it is liable only for a part of the damage compensation**: - The title of the decision from paragraph 1 of this Article, the date of its adoption, and the name, surname, and function/title of the decision-maker,
- the date of receipt of the compensation claim and a list of the received and obtained documentation, - The Insurer's statement declaring that it has established its liability only for part of the compensation, and a detailed explanation of the decisive facts and legal grounds (relevant provision of positive regulations, insurance conditions, etc.), the specification of the determined amount of damage and the compensation amount, or the undisputed portion, including the specific factors applied, taking into account all available documentation. This explanation should be presented in a clear, simple and understandable manner, outlining how the Insurer determined the amount of damages and the amount of compensation to be paid, and to explain any specific factors applied, including the reasons for their application and the method of their determination;
- **The statement that it will pay the undisputed amount from the reasoned response within 15 days of sending the reasoned response, whereby the specified payment period may be shorter since it must be within 60 days from the date of receipt of the compensation claim;**
- A detailed response to all points of the report and opinion of the independent expert and the repair offer or invoice from the authorized service provider, if submitted,
- The instruction on the method of submitting an objection to the Insurer's decision and the 15-day deadline by which the Insurer will respond to that objection, in accordance with Article 378, paragraph 2 of the Insurance Act.

- If the liable Insurer **is unable to fully establish the amount of damages:**
- The title of the decision from paragraph 1 of this Article, the date it was adopted, and the name, surname, and function/title of the decision-maker,
- the date of receipt of the compensation claim and a list of the received and obtained documentation, - A statement from the liable Insurer regarding its liability and that it is unable
- to fully determine the extent of the damage, along with the reasons for being unable to fully determine the damage amount;
- A detailed explanation with the specified decisive facts and legal grounds (relevant provision of positive regulations, insurance conditions, etc.), followed by a specification of the established amount of damages and the amount of compensation to be paid, including the specific factors applied, and taking into account all available documentation, whereby the liable Insurer is required to explain this in a clear, simple, and understandable manner
- the reasons why it was unable to fully determine the extent of the damage, how it arrived at the determined amount of damage and the compensation to be paid, and provide reasoning for any specific factors applied, including the reasons why they were applied and how they were determined;
- **A statement that it will pay the undisputed amount within 15 days of sending the reasoned response, whereby the specified payment period may be shorter since it must be within 60 days from the date of receipt of the compensation claim;**
- A detailed response to all points of the report and opinion of the independent expert and the repair offer or invoice from the authorized service provider, if submitted,
- The instruction on the method of submitting an objection to the Insurer's decision and the 15-day deadline by which the Insurer will respond to that objection, in accordance with Article 378, paragraph 2 of the Insurance Act.

2. In the event of a failure to pay the damage compensation or the undisputed compensation amount within 15 days or the 60-day period, the injured party, in addition to the due damage compensation or the due undisputed compensation amount, **is entitled to the payment of interest, starting from the date of submission of the compensation claim**.

3. If the Insurer does not provide a detailed offer for damage compensation or a reasoned response without delay, and no later than 60 days from the receipt of the compensation claim, and if you are unable to resolve the dispute amicably with the Insurer or before the Mediation Centre at the Croatian Insurance Office or by other peaceful means (https://mpu.gov.hr/mirno-rjesavanje-sporova-medijacija/26978), you may seek legal protection of your rights through the courts, i.e., you may file a lawsuit against the Insurer.

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