Code of Conduct for Handling Personal Injury Claims

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Background of this Code
A severe accident has a significant impact on the life of the victim. If the one who caused the accident is liable, the financial damages are usually compensated by his insurance. The insurance company and the victim, who is often aided by a representative, then get to work to determine the amount of the compensation the victim is entitled to, according to the law (full compensation). If these parties are unable to reach an agreement, the matter is put before a judge.

This method of handling a personal injury claim is complicated and time-consuming. It has to occur when the victim really needs to devote all of his attention to his physical and mental recovery and overly complicated procedures to get what he is due can quickly seem like a maze with no exit. If the dialogue with the insurance company grinds to a halt, this can quickly become a second disaster in the life of the victim.

This Code of Conduct for the Handling of Personal Injury Claims has been drawn up to avoid such disasters. It describes how personal injury claims can be handled as smoothly and quickly as possible.

Who is the code aimed at?
Anyone involved in dealing with cases of severe injury, stemming from traffic and other accidents. The victim is the main focus of this code. It was written with his ability to understand the procedures better in mind. A Guide provides him with further explanations. Another significant party is the liability insurer, who can use this code as a guideline when developing internal procedures and as a touchstone for quality control. The code is also aimed at representatives, medical advisors and all others who, in the course of their profession, assist parties in handling the claim.

What does the code encompass?
The code outlines proper practice in dealing with injury claims in 20 Principles. The first principle contains the core values of handling personal injury claims. Each principle is expanded into concrete rules for good practice, succinctly formulated. Those in need of more information can refer to the clarification. The symbol denotes items still in development.

Who created the code, and by what method?
Victims, insurers, and their organisations have looked for a method of dealing with injury claims that is less taxing, time-consuming, and adversarial for a long time now. The need for such a method has become more immediate due to media attention and political pressure. Research has shown the types of problems that are encountered and the possible avenues for improvement. Starting in September 2003, an ever-increasing group of people from the field has worked on these improvements. The bottlenecks were identified in 11 “expert meetings”, which were open to anyone interested. Good solutions were selected by study groups. The University of Tilburg (Centre for Liability Law) provided oversight and reporting.
Important organisations in the liability field have consistently supported this project by providing manpower, ideas, and comments. The main Dutch consultative body in the field, the National Platform Personenschade (National Platform Physical Injuries) held extensive discussions of the code. Not everyone agrees on all aspects of the code, but generally, it is quite well supported.

**How can this code be used?**

With consideration and feeling. The code describes the best practices in handling personal injury claims that the field was able to come up with. Whoever follows it, can be confident that the proceedings yield satisfying results. Those who ignore it, should have good reasons. This code has the same shortcomings as any other protocol. Not all possibilities can be covered. Desirable behaviour cannot be completely described. Do you doubt whether something in your particular case is as it should be? The principle is more important than the particulars of an individual case. Core values take precedence over the principles.

**Should you expect others to adhere to the code?**

The code is not a law. So why should it be adhered to? The people and organisations involved in drawing up the code, came up with the following “enforcement philosophy”.

People who want to do well at their jobs, benefit from good practice. And who would not want to do a good job? Oversight from third parties can be the incentive to invest that little bit of extra effort. The code can help the victim in assessing the work of those people who are professionally involved in his case, who can in turn assess the work of each other and, more importantly, reward good practice. The code requires parties to regularly consult with each other, to plan, and to evaluate. These are opportunities to make adjustments.

This Code of Conduct will be followed by other improvements. As it stands now, having problems resolved by a judge can take years. It will be possible in the future to call on a neutral person before matters get completely out of hand (Principle 15-17). This person will of course try to determine where things went wrong.

Furthermore, a Permanent Organisation stimulates adherence to the code. Insurers and other parties can publicly declare through the organisation that they agree in principle with the code. In the event that the code is ignored, the Permanent Organisation can step in to take action. For now, only by asking questions and making suggestions. Should this not be enough, the different means of enforcement can be explored.
**Principle 1:**

These are the core values of the claim handling procedure: the emphasis should be on the victim, interaction should always be respectful, clarity, creating and furthering trust, harmonious consultation, swiftness, resolving problems in concert, and mutual correction.

1. **Emphasis on the Victim.** His situation, cares, needs, and desires are the main focus. Professional parties show understanding for and recognition of his situation towards the victim. They respect his right of self-determination. He is completely involved in the handling of his case, except when he expresses unwillingness or inability to be so involved.

2. **Interaction should always be respectful.** Professional parties show courtesy, openness, and integrity in their communications with and concerning the victim. The professionals also show respect towards each other, and assume equality.

3. **Clarity.** The process of resolving the personal injury claim is made clear and understandable for the victim.

4. **Creating and strengthening trust.** Parties create an atmosphere of trust by approaching each other openly and neutrally and by living up to the expectations of the other parties. They strengthen that trust by communicating regularly, making sure that agreements are met, and through open discussion of problems.

5. **Harmonious consultation.** The claim handling procedure is dealt with constructively, no matter the differences in opinion. The parties cooperate with the aim of resolving the issue. Good communication is a basic requirement.

6. **Swiftness.** Parties work as quickly as possible and as the situation allows. Joint coordination ensures a more speedy resolution and avoids unnecessary delays in settling the claim.
7. **Resolving problems in concert.** Parties are aware that problems may occur. They agree on what to do in the event of such problems. Parties look for solutions to problems together and, if necessary, seek outside aid. *However, putting the case before a court is always an option.*

8. **Mutual correction.** Parties hold each other to the core values as described in this code of conduct. They offer suggestions for improvements to the claim handling procedures, and are themselves open to such suggestions. They inform the Permanent Organisation of improvements of and additions to the code.
**Principle 2:**

All those involved are aware of the importance of a positive relationship and strive to keep it so. The relationship offers guarantees to the victim.

A good relationship between parties and others involved has a positive effect on dealing with the claim handling proceedings, whereas a bad relationship has a disturbing effect. *Respect towards each other* is the basis.

**Examples of good practice:**

a. **The victim** is *personally involved* in the procedure, unless he expresses unwillingness or inability to be involved. His choice to decline involvement, or to limit his involvement, is respected and recorded (*Principle 7*).

b. **Involvement** can be effectuated, for example, through *three-way conversations*. In principle, these conversations take place to align the procedures for the claim (*Principle 7*) and to agree on an amount for the damages (*Principle 13*).

c. **Three-way conversations** have the following aims: getting to know each other; creating mutual trust; giving the victim an opportunity to relate his story; listening to his concerns, wishes, and needs; explaining the claim handling procedures and the code; agreement; exchanging information; status updates; finalising the arrangements.

d. **During verbal and written communication** with (and concerning) the victim, the professionally involved parties adhere to the following guarantees.

e. **Communication with the victim** only occurs in the presence of, or through, his representative. The victim can involve *a person from his personal circle whom he trusts* as support.

f. **They ensure** that communication with (and concerning) the victim happens in a *safe atmosphere*, is *understandable*, and has a *neutral and pleasant tone*. The purpose of the communication is made clear to the *victim*. 
g. The victim and his representative prepare for the three-way conversation. During the conversation, they have the opportunity for private consultation. A report is made of the three-way conversation. Parties have a two-week window after receiving the report in which they can make corrections to it.

h. The victim’s representative provides him with a copy of all written communications between the representative and the insurer.

i. Except when the representative feels that the tone or contents of the communication is hurtful for the victim. In such a case, the representative immediately informs the insurer of the reason why no copy was sent. The insurer then has the option of amending his communication. If he is unwilling to do so, the representative informs the victim of the letter and of his reasons not to forward it.

j. An insurer who receives no response to his letter, asks the representative to clarify. Should a response not be forthcoming, the insurer can decide to ask the victim in writing to contact his representative.

k. In their communications, parties make use of rapid forms of communication whenever possible, unless there is a pressing reason not to do so.

Possible causes of disturbed communication:
Failure to listen; failure to take the other side seriously; a negative mode of communication (“harsh” language, recriminations, accusations, and threats); stubborn refusal to amend an opinion; unwillingness to see things from the others’ perspective.
**Principle 3:**

**Parties consult constructively. One good method is (a form of) problem solving negotiation.**

This code bases itself on a constructive method of handling the personal injury claim. Parties can turn to a form of problem solving negotiation to achieve this.

Examples of good practice:

a. **Parties cooperate** in handling the case. They regard reaching a satisfying result as a mutual responsibility. Problems are resolved in unison.

b. **Parties remain businesslike** with regards to the subject matter. They take a constructive approach towards the claim handling procedure. Their interaction is conducted with friendliness and empathy.

c. **The mutual interests take a central role** in the negotiations, primarily the needs of the victim.

d. **In the event of conflicting interests**, parties make a list of objective criteria to aid in reaching an agreement.

e. They **creatively look for solutions**, as opposed to rigidly working towards one possible result.

f. **Parties explain their position** in light of the interests and indicate how this position matches with the objective criteria.

g. **Lines of communication remain open**, even in the event of conflicting interests or problems. Should the other party fail to cooperate, this is no reason to abandon a constructive approach as well. This should avoid escalation.

**Bottlenecks that may occur:**

What should be done if one of the parties takes a hostile approach? This could delay resolution of the case and lead to higher costs. Even in such an event, the other party has options. A cooperative, open, and constructive approach invites the other party to do the same. In this way, it becomes clear to the victim, and any neutral parties who are called upon as mediators, what causes the problem.
Principle 4:

De handling of the personal injury claim takes a forward-looking approach. Fitting solutions for the victim, in his personal and professional life, have primacy.

Repairing his health comes first. Repairing or adjusting his living- and work situation comes second. Compensating the costs of these adjustments and any other damages comes third.

Examples of good practice:

a. Parties work together to find fitting solutions. These solutions are tailored to the victim, his recovery, his limitations, and his living situation.

b. The victim chooses those solutions that fit him best, at a time of his choosing (right to self-determination). The insurer supports the victim whenever necessary.

c. The insurer and the representative ensure that the victim knows when his decisions affect the amount of compensation awarded to him (obligation to avoid damage).

d. The insurer assumes good faith in the victim.

e. The guideline for finding fitting solutions are the common practices of treatment and support.

f. The victim should inform the insurer of the treatment and support he receives, so that the insurer knows that treatment and support are provided properly.

g. Approximately 2 months after the accident, parties review the situation of the victim. Should there be no improvement, the parties consider whether extra support is necessary, for example calling on an expert.

h. Rehabilitation into normal working life is of paramount importance. This rehabilitation is shaped by the victim, the employer, and/or the institution responsible for the benefits. The insurer monitors, stimulates, and supports where necessary.

i. The insurer avoids pressuring the victim. He does not demand that the victim goes along with a solution, if the victim can explain why he is not yet ready for it. The insurer shows restraint in assessing the willingness of a victim to cooperate.
Principle 5:

Each phase in handling the personal injury claim is resolved promptly and briskly. Parties strive to settle the procedure within two years after the accident. Should they be unable to resolve matters within this timeframe, the situation is evaluated every year and appropriate steps are taken.

Clear timeframes are a good aid to ensure everything proceeds smoothly. Therefore, the code outlines target times for settling four important parts and the most common activities within these parts. The parts can be settled parallel to each other.

Examples of good practice:

a. Parties avoid unnecessary suspensions of the proceedings.

b. They use short response times.

c. They agree on handling deadlines in the plan of action (see Principle 7).

d. They adhere to the following target times:
   - For the part establishing the liability: 12 weeks, counted from the first reporting of the injury.
   - For the medical advice and expertise procedure: 20 weeks, counted from the moment the injuries are stable. Before that time, parties can proceed with matters concerning the hypothetical situation.
   - For establishing the amount of the damages: 16 weeks, counted from the moment all information has been gathered.
   - For resolving a conflict with the aid of a neutral person: 12 weeks.

e. Four-week timeframes are in force for the most common steps in each part.

f. In the event of unexpected delays or a pressing need to amend a timeframe, parties contact each other. New agreements are established.

g. Parties guarantee that any outside aid adheres to the agreed-upon timeframes in the plan of action and the code.

h. 2 years after the accident, parties evaluate the claim handling procedure and implement necessary steps. This is done on a yearly basis from then on.
i. **Parties** can agree on postponing the final settlement, mainly when both parties prefer payment in instalments.

j. If **parties are unable to agree** on timeframes, they adhere to *Principles 15-17*.

Timetable: entire claim handling procedure, including possible extensions (see l.):

![Diagram showing the claim handling procedure with timeframes]

k. All **parts** include the time needed to gather all information in that part.

l. **Justified reasons for extending the timeframes** are:
   - Waiting for the injuries to stabilise;
   - Resolving one or more disputes;
   - Delays in gathering information from third parties, needed for establishing liability, provided all efforts have been made to acquire the information.

m. **Parties avoid overruns** in handling the claim that have no clear reason, without mutual agreement, or evaluation.

**Possible bottlenecks that can have an influence on the total time needed for handling the claim:**

Unclear timeframes, or failure to adhere to timeframes without prior consultation. Unnecessary suspensions of handling the claim because the “final medical situation” needs to be waited for. Proactive settlement of the damages by looking for fitting solutions at an early stage is more effective, supports the victim in his recovery, and avoids high costs in completing the process.
**Principle 6:**

**During first contact with the victim, emphasis should be placed on recognition, attention, and care. No agreements are made that bind the victim.**

The first contact between the insurer and the victim is an important moment. It sets the tone for the whole process of handling the personal injury claim.

**Examples of good practice:**

a. **After the injury has been reported,** the insurer contacts the victim by phone. If he is aware that a representative has been brought in, the insurer confers with him on how best to express interest in the victim.

b. **If the victim personally initiates contact,** the insurer makes time for it. Should this come at an inconvenient time, the insurer makes an appointment for a conversation, within 2 days at most.

c. **The insurer** actively listens to the victim’s story and *shows understanding.* He inquires as to how the victim is doing, and whether he receives proper care.

d. **The insurer provides concise information** on how the personal injury claim is to be handled. He mentions that more extensive information shall be sent at a later date.

e. **This more extensive information** always includes information on a contact person. Furthermore, he sends the leaflet and Guide that accompany this code, or equally extensive information.

f. **The insurer asks only for objective information on the victim** that is required. The insurer may mention that more information will be needed in the future. He agrees with the victim on a convenient moment to ask for that information.

g. **The insurer makes the victim aware of options for help.** He always mentions the option of calling on a representative, explaining that reasonable costs due to a representative are reimbursed, should liability be decided.

h. **The insurer makes no judgements** concerning the situation of the victim, or his experiences.

i. **The insurer** comes to no agreements that are binding to the victim.
Principle 7:

Handling the personal injury claim proceeds according to a plan and by mutual agreement. A plan of action can be helpful.

Cases involving personal injury claims are often complex. A well-structured, agreed-upon, and planned approach has shown to be the best way to proceed. It also helps the victim in understanding the processes of handling his claim.

Examples of good practice:

a. The insurer, the representative, and the victim agree on how the claim will be handled: who does what, and at what time? For the level of involvement of the victim, see Principle 2.

b. Plans are made for, among others, the gathering of information (Principle 8), a possible medical advice or expertise (Principle 12), their consultation on the amount of the damages (Principle 13), and for the resolution of disputes that may arise (Principle 15-17).

c. A plan of action for handling the claim can be helpful. Parties draw up such a plan during a three-way conversation.

d. This plan also forms the central forum where parties can show the progress of their handling of the claim, for themselves, for the other party, and for any third parties who may be involved in handling the claim.

e. The plan of action also contains all information that is exchanged between the parties. Parties note points of agreement and work arrangements. They also make note of points of contention, as well as clear agreements on how to resolve these issues. Parties include a joint assessment of the damages in the plan of action.

f. Parties draft a plan of action as soon as it is shown that the victim will not be free of limitations within six months after the accident.

Bottlenecks that can occur when the plan of action has not been sufficiently established.

Lack of insight and trust on the part of the victim. Failure to coordinate and wasting time. Chances are that points of contention will take a central place, instead of possible solutions. Difficulties may arise in distinguishing between main and side issues.
Principle 8: Exchange of Information

Parties critically review which pieces of information are essential. They delineate tasks in the gathering of information. Exchanging information remains separate from consultation on the possible results of that information.

Asking for information is easy, gathering information is difficult because it requires an investment of time and money, and is often taxing for the victim. Nevertheless, the situation sometimes calls for it.

Examples of good practice:

a. Parties agree on what information is necessary and who is responsible for gathering it. They need to make it possible for themselves and for each other to take those decisions that are essential for the handling the claim.

b. They use the checklists that have been drawn up for that purpose as a guideline.

c. Ask for what you need, explain why, and be aware of the work that the other party needs to do.

d. Information on the accident itself, and on what the situation would be had the accident not occurred, can be gathered quickly. Information on the recovery and the prognosis gradually becomes available.

e. Try to keep the information objective: who, what, where, when, and how. Information can be supplemented and corrected.

f. In the event of opposing viewpoints, allow for different versions of the facts and views on the situation. Make no judgements on the behaviour, descriptions, or views of the other.

g. Gathering of information remains separate from interpreting and assessing that information. The latter happens in consultation and only after all needed information has been gathered. See Principle 13.

h. Parties respect the privacy of the victim.
i. If someone feels he has a good reason to ignore a request for information, he explains that reason.

j. If parties are unable to agree on the exchange of information, they adhere to Principles 15-17.

Bottlenecks:
People have different views and experiences. These differences often colour the information. Parties can interpret information to their own advantage, which easily leads to bickering.
The insurer exercises restraint in asking for information on the health and personal situation of the victim. He interprets the information with care and respect.

The insurer wants to ascertain what damages are a result of the accident. Medical and personal matters are often a sensitive subject for the victim. The insurer can harm the victim by focussing on these areas to argue for a compensation that is as low as possible. Therefore, the insurer needs to be aware of that and show care and respect in his communications with the victim, to ensure that the victim’s trust is justified.

Examples of good practice:

a. The medical advisor of the insurer indicates what information he needs, and why.

b. In principle, he asks specific questions, in writing.

c. He does not ask for the patients’ file without a special reason to do so. In the event of such a reason, a more severe burden to motivate is in force. He mentions how he plans to deal with this information in his request.

d. A possible special reason is when the victim asks for compensation of loss of income for a significant number of years, combined with considerable absence before the accident, or absence that occurred some time after the accident.

e. A “more severe burden to motivate” is also in effect if information is requested that pertains to:
   - A period of time more than two years before the accident;
   - Injuries and sickness that occurred a significant period of time after the accident.

f. The insurer shows restraint in asking about events that may occur in everyone’s life, such as divorces and deaths, and that normally can be coped with.

g. The victim decides whether or not to divulge information. The insurer and the representative ensure that the victim is aware of the possible consequences when the basic assumptions of determining the damages are drafted.

h. Medical data is open only to the victim, his representative, and medical advisors.

i. If parties are unable to agree on the exchange of information, they adhere to Principles 15-17.
Parties make sure that liability is made clear early on. If liability is denied, the victim receives a respectful and understandable explanation.

Examples of good practice:

a. The insurer views being notified of the injury as a liability claim.
b. He confirms receipt of the notification in writing to the victim.
c. After being notified, the insurer actively investigates the liability. The victim cooperates with that investigation.
d. Parties consult with each other on what aspects of dealing with the claim can be begun, except when liability appears to be a remote possibility.
e. The insurer reaches a decision as soon as possible. When the insurer denies liability, he does so in writing and with respect.
f. He can reach a provisional decision based on available information, especially when necessary information from other parties is delayed.
g. Should the insurer appeal to culpability on the part of the victim, he takes into account the effect this has on the victim. He carefully structures his motivation and empathises with the victim.
h. In the event of substantial differences of opinion, parties do not procrastinate in resolving these issues. They adhere to Principles 15-17.

Bottlenecks:
Delays in reaching a decision on liability are harmful for the victim. The victim and his representative can be hesitant to spend money for resolving the case. This can lead to delays and puts strain on the relationship.
When the insurer accepts liability, he makes advance payments and pays out the undisputed parts of the compensation.

The victim incurs costs during the handling of his claim and he possibly misses income. This creates a need for advance payments. These advance payments are meant not only to compensate damages that the victim already suffered, but also damages in the (near) future that can not yet be clearly determined.

Examples of good practice:

a. **After accepting liability**, the insurer pays out an *advance* for all damages that likely have been suffered, or that will be suffered. Undisputed damages are compensated.

b. **Unless the insurer denies liability**, he looks *favourably* at any other requests for an advance. Parties work together to form an image of the victim’s situation and his needs for advance payments.

c. **This also holds** for *advances for extrajudicial costs*.

d. **Paying an advance** does not imply *acceptance of liability*.

e. **The victim provides the insurer** with a *breakdown* of the costs when asking for an advance.

f. **The insurer explains his reasons to deny an advance payment**. He specifically mentions what he needs before being willing to pay an advance.

g. **The insures** does not make paying an advance *dependant* on concessions in other areas.

h. **In the course of handling the claim**, parties regularly consult on the *paying of advances*. They set agreements to that effect down in the plan of action.

i. **An advance covers, in principle, 100% of the item of loss**. In the event of culpability on the part of the victim, the advance is adjusted by an equal percentage.

j. **The insurer indicates what item of loss** the advance covers. All parties make a record of this.

k. **The insurer can recover an advance**, especially in the event of fraud or when liability is later shown to be absent.
Principle 12:

If a medical advice or expertise is necessary, parties minimise its stress on the victim. They strive for speed, objectiveness, and dialogue.

Medical advice or expertise can provide insight in the physical and mental limitations stemming from the accident. Sometimes, more insight is needed into the limitations that already existed at the time of the accident, and limitations that would have occurred even without the accident. Still, a medical procedure is costly and time-consuming, partly because consultation is required between a larger number of people.

Timetable medical advice and expertise procedure:

Examples of good practice:

a. Each party has a medical advisor.

b. Parties and their medical advisors respect the perception of the victim of his situation and his symptoms.

c. The aim of the medical advice and expertise procedure is to gather objective data on these symptoms and their resulting limitations (evidence based advice). Medical advisors give notice of the absence of (sufficient) objective data. This not necessarily points to the absence of limitations, but it does mean that these limitations need to be determined through other methods, or need to be estimated.

d. At an early stage, parties lay down control-agreements. Their medical advisors consult directly with each other, except when the needed trust is absent.
e. Parties present their medical advisors with the same questions as much as possible.

f. Preferably, medical advisors determine the limitations together, based on the available data. They make note of the points of doubt or disagreement.

g. Medical advice is provided in writing.

h. Parties consult with each other on the possible legal significance of the medical advisors' report (see Principles 13 and 14).

i. Parties call on a medical expert only in the event of a continuing difference of opinion, or when the medical advisors need specific medical expertise.

j. Parties together call on one expert. Parties agree on how the question is framed.

k. Copies of the medical advice of the medical advisors and the expert's report are made available to the other party, unless the victim objects (right to confidentiality).

l. If parties continue to disagree on the medical advice and expertise procedure, they adhere to Principle 15-17.
**Principle 13:**

After sufficient information has been exchanged and the injuries have been stabilised, parties consult in person and strive to reach the outlines of the final result.

Exchange of information comes first, followed by establishing the damages. This is covered by the principle of full compensation as laid down in Dutch law. The victim is present in person at these consultations, unless he is unable or unwilling to. Less contentious items of loss can be discussed by parties through the plan of action, via e-mail, or over the phone.

**Examples of good practice:**

a. **Parties work together** to create a summary (assessment of the damages) of the costs incurred by the victim for fitting solutions (Principle 4) and of the other damages (items of loss), see Principle 7.

b. **The insurer** already has compensated the acknowledged items of loss (Principle 11).

c. **The items remaining to be discussed** are those that were previously disputed, and items that continue into the future.

d. **For these items**, parties first agree on points of departure, and then on calculations (Principle 14).

e. **Parties determine the amount of compensation** based on objective criteria. Possible sources are the law, case law, or other norms applicable to the practice of injury claims. Should these not yet exist, parties present each other with suggestions for criteria that could be generally valid for cases such as the present one.

f. **The results** of the consultation are recorded by the parties.

g. **After receiving the record**, the victim is allowed 2 weeks time to consider. Within that timeframe, the victim can ask for more time to consider, provided he presents reasons for his request.
Bottlenecks:

Parties sometimes calculate to their own advantage and then refuse to diverge from that amount. Asking for too much or offering too little can damage trust and sour relations. The same is true for tactics such as procrastination, postponing, or pressuring the other party with a “final offer” or short deadlines for decisions.
**Principle 14:**

If circumstances are difficult to determine objectively, parties consult on possible outcomes (scenarios). They determine the likelihood of the different scenarios. Compensation is established in relation to these likelihoods.

It is not always possible to gather “hard” data on circumstances, for example in relation to the future situation of the victim, without taking the accident into account, or in relation to future developments in the life of the victim after the accident. This uncertainty can lead to disagreements.

**Examples of good practice:**

a. **Parties consult on the points of departure** for calculating the damages. Examples are the (expected) career path of the victim and the periods when he will be or should have been working.

b. **Parties choose realistic points of departure.** Whoever presents a point of departure without a *beginning of realization*, provides an explanation.

c. **In principle, the insurer draws no consequences** from events that can occur in everyone’s life, and that can normally be dealt with, such as divorce or the death of someone close.

d. **Parties calculate the amount of the damages** only after the points of departure have been determined.

e. **If they are unable to agree** on points of departure, these calculations are based both on the own points of departure, and on those of the other party (*each other’s scenarios*).

f. **If the level of trust between parties allows for it,** they can choose to calculate based on a *variety of scenarios* they establish together.

g. **The future is never certain.** In the event of a dispute, parties strive to talk about the *likelihood* of various scenarios (expressed as a percentage).

h. **A neutral person** is called on if necessary (*Principle 17*).
Principle 15:

If consultations fail, parties identify the problem and look for avenues to resume negotiations. They strive to avoid escalation of the problem.

Impasses can occur in any claim handling procedure. Constructive handling of the claim according to this code, also means that parties resolve the problems together.

Examples of good practice:

a. Parties strive to prevent conflicts. They set out agreements to that effect at the start of the procedure (Principle 7).

b. If one of the parties feels that the negotiations are at an impasse, they personally contact the other party.

c. Parties then schedule a face-to-face talk to discuss the problem.

d. Each party explains his view of the problem in that conversation. They use neutral terminology, without assigning blame.

e. Parties then try to determine the problem together. Does the issue concern the contents, the procedure, or the tone of the cooperation?

f. They discuss possible options to surmount the impasse.

g. These options are set down in the plan of action.

h. If it proves impossible to resolve the issues among themselves, parties call on a neutral person (Principle 16).

i. The option to put the issue before a judge always remains open.
Things to prevent:
Avoiding each other, or waiting for the impasse to disappear by itself. Postponing resolution of a problem, or allowing smaller problems to stack up. Submitting to avoid argument.
Principle 16:

Should consultation fail to yield the desired results, parties diagnose the conflict and call on a suitable neutral person. This is done in consultation, if at all possible.

Examples of good practice:

a. Parties do not break off negotiation. Handling the claim proceeds.

b. Parties define the problem together ("conflict diagnosis"). If reaching a common diagnosis of the problem proves to be impossible, then each party describes the problem in neutral terms.

c. These descriptions are written down, accompanied by any points where parties do agree (Principle 7).

d. Parties can call on a different person from their own organisation. This person might offer fresh insights on the matter, or completely take over the proceedings.

e. If not, they together choose an intervention, a procedure, and the neutral person who handles them. The 'Selection menu' helps parties with determining the most suitable intervention and procedure.

f. Should parties fail to reach an agreement on the intervention, procedure, or neutral person, then each party can approach the Office of Dispute Resolution for advice on the matter.

g. If a party indicates this beforehand, the advice from the Office of Dispute Resolution is binding to that party.

h. If a party disagrees with the advice, they ask the Office of Dispute Resolution for a second opinion, based on a more extensive investigation. They can elect to precede this with suggesting an alternative intervention, procedure, or person to the other party.

i. The option to put the issue before a judge always remains open.

Things to prevent:

Declining to ask for help, or arguing over the method of dispute resolution. Allowing personal relations to deteriorate.
**Principle 17:**

Disputes are resolved constructively, based on the plan of action, aimed at the present dispute, within a short timeframe, and at predictable costs.

After the parties have chosen the intervention, the procedure, and the neutral person, dispute resolution begins.

**Examples of good practice:**

a. *The neutral person focuses on the impasse at hand.* He consults with parties to find a solution that allows parties to proceed.

b. *Parties take a constructive approach,* even when they feel that the other party does not.

c. *They allow access to the claim handling procedure* for the neutral person (the plan of action and any documents pertaining to the dispute that were previously exchanged). They avoid creating *supplementary documents* for the time being.

d. *Concrete proposals to settle* need not be presented.

e. *The neutral person* arranges for a talk to take place.

f. *The talk covers the following items:* the diagnosis, the interests, the relevant opinions of parties, possible solutions, and objective criteria for these solutions.

g. *Supplementary information is gathered* by mutual agreement.

h. *The neutral person* offers *the intervention* to parties that they have chosen, or that was proposed by the Dispute office.

i. *The neutral person* can offer *feedback* to parties concerning their attitudes.

j. *Parties record the outcome.* Should a party refuse to (fully) accept the outcome, if the outcome is not binding to that party, parties consult on how to proceed. In any case, they avoid suspensions of the claim handling proceedings.

k. *Parties and the neutral person strive to minimise the costs* of resolving the dispute. Costs cannot be allowed to form an obstacle for the victim, unless he is *disproportionate in his appeals* to conflict resolution.
Principle 18: Limiting Costs and the Emotional Burden

Parties control the financial and emotional burden. Discussions on the compensation of extrajudicial costs have no influence on the claim handling proceedings and are resolved quickly and efficiently.

Limiting costs, loss of time, and emotional burdens is important to both the victim and the insurer. Sufficient compensation for their efforts is important to those who are professionally involved.

Examples of good practice:

a. **Parties are aware of the costs** that their stance in the proceedings incurs for the other party.

b. **Parties plan the extrajudicial costs:** *How much? When?* They agree on when payments should occur and on whether the representative guarantees any amounts that are overpaid.

c. **Should something arise** on one side that causes diverging from the plan, the other party is notified.

d. **When determining the amount and moment of payments,** they base themselves on *objective criteria*.

e. **The victim and his representative specify** the declaration. The insurer offers *them a specification* of which items are compensated and which are not.

f. **If the insurer chooses to decline compensation for an item,** he specifies exactly what data he would need to reverse his decision. Should he feel an item to be *unreasonable,* he specifies exactly what objective criteria he uses to determine whether to compensate items such as this.

g. **If parties are unable to reach an agreement,** then the insurer provisionally compensates the extrajudicial costs as far as he feels them to be reasonable, taking into account the *average compensation in similar cases,* until parties are able to reach an agreement.
h. The claim handling proceedings are not hindered by discussions between the representative and the insurer concerning extrajudicial costs. They call on a neutral person should they be unable to reach agreement.

i. Compensating extrajudicial costs cannot be made dependant on agreement with certain proposals, or vice versa.

**Bottlenecks:** Double work and inefficient consultation between parties leads to needlessly high costs.
Parties use this code as a guideline. They stimulate each other and any other involved persons to work according to basic values, principles, and good practice. They offer suggestions for improvements and amendments to the Permanent Organisation.

Handling a claim where opposing interests are at stake, is always difficult. Even if parties take a constructive approach and intend to reach a satisfactory conclusion in unison.

Examples of good practice:

a. First ask the other party what motivates them to ignore this code or other guidelines. If necessary, ask them whether they would be willing to change their opinion.

b. Positive feedback works better than negative feedback.

c. Show appreciation for the positive contribution of the other party. Go along with the good practices of the other party.

d. Remain open to suggestions for improving methods, even when these require changes in the own organisation.

e. Parties measure satisfaction. They regularly evaluate the claim handling proceedings and their cooperation. If necessary, they make course corrections.

f. Parties vouch for the methods of any other organisations or persons they may call on.

g. This code of conduct is not “finished”. It turned out to be quite difficult to formulate good practices for some bottlenecks. Much progress remains to be made. Parties pass on other good practices they already use or develop to the Permanent Organisation.

Bottlenecks:

Demanding that the other party thinks and acts the same as oneself. Differences are the best way to learn from each other.
The Permanent Organisation supervises proper claim handling proceedings. The effects of this code of conduct are regularly reviewed. The code is constantly amended. Victim’s organisations and the field are involved in these amendments.

A code of conduct alone is not enough to ensure proper proceedings. Workers in the field will have to organise this themselves, aided by the government if necessary. These are identified here as the tasks of the Permanent Organisation, inspired by the thought that there should be an organisation that oversees claim handling procedures.

Functions of the Permanent Organisation:

a. It ensures good practice in the handling of personal injury claims. It organises whatever is necessary to ensure that good practice. The code serves as an aid here.

b. It stimulates adherence to the code. One of the means here is providing education. Furthermore, it offers suggestions for improving methods and procedures in the field.

c. It maintains and improves the code, and any provisions tied to it. These are, among others, the Guide, the plan of action, dispute resolutions, and the Office of Dispute Resolution.

d. It collects complaints as a signal of bottlenecks, and is able to report on these. Possibly, it has an active role in the resolution of and deciding on these bottlenecks.

e. It makes public which persons and organisations explicitly adhere to the code of conduct, and to what extent they do so.

f. It furthers certification of persons and organisations who guarantee good claim handling procedures.

g. It gathers data on how claims are resolved under the code.

h. It organises a helpdesk for users of the code.
Quality standards which the Permanent Organisation lives up to:
A high level of neutrality, representation, and expertise. A good and forceful representation, also on the side of the victims. Flexibility, decisiveness, and transparency. It regularly gives account. It sees itself as having an enabling role.