# INTERNAL PROCEDURES FOR HANDLING OF CLAIMS AND COMPLAINTS ON INSURANCE CONTRACTS

With these rules are defined the procedures for handling of insurance claims lodged on the basis of concluded Individual and group life insurance contracts with IJSC Sogelife Bulgaria (further called Insurer or the Company).
The process of handling of a life assurance claim starts on the date of lodging of an insurance claim and lasts to the date of its full and final settlement by the company.

## I. REGISTRATION OF A CLAIM

1.1 In order to lodge a claim the Claimant must fill in a claim form in a form of the Insurer including full and detailed information about the bank account on which the payments on the side of the Insurer to be done and to use the appropriate one according to a certain insurance contract.

1.2 Each beneficiary fills in a separate claim form. In cases of more than one claim for the same Claimant, different claim forms must be filled in for each separate claim.

1.3 The claimant can lodge a claim at the headquarters of the Insurer on the following address: fl.4, Crystal building, Osogovo str. 38-40, Vazrajdane region, Sofia, Bulgaria or at any other office of the company by supplying the claim form and all required documents according to section II below.
The claimant might lodge a claim as well as to all brokers and agents which have the right to receive and collect documents on claims on behalf of the Insurer. All claims forms and required documents must be sent to the Insurer by a registered post with a return coupon.

1.4 The initial notification of a claim might be done by fax, telephone or e-mail, but the claimant is obliged to send all the original documents as soon as possible after that.

1.5 The claim might be handled only on the basis of all received original documents by the claimant.

1.6 In cases when the claim is lodged in the headquarters of the Insurer, the claimant must produce an ID card and to sign a claim form in a front of an employee from Claims Department.

1.7 The insurer accepts a notification of a claim by the way of an incoming registration number, including the date of receiving of the claim (it must be the same date as the date of actual receiving of a claim form).

1.8 An employee from Claims Department checks if the claim form was filled in properly and in the cases of submission of a claim at the headquarters asks instantly the claimant to fill in the missing data.

1.9 In cases when the claim form was submitted by post, fax or e-mail, the requirement for fulfillment of missing data will be done in writing with a letter with outgoing registration number and by the registered post.

## II. DOCUMENTS REQUIRED FOR ASSESSEMNT OF VALIDITY AND AMOUNT OF A CLAIM

2.1 Lodging of an insurance claim the claimant is obliged to attach all necessary documents according to the requirements of an insurance agreement or the General Conditions for each type of product. According to the Insurance Code the Insurer registers the date of each lodged claim as well as the date of receiving of any subsequent document on it and certifies each of those circumstances separately or with a list in a front of the person who lodged the claim.

2.2 While lodging a claim the claimant is obliged to present full and detailed data for the bank account on which the payments by the Insurer to be done.

2.3 In case of death alongside with the claim form including full and detailed information about the bank account on which the payments on the side of the Insurer to be done form the following documents must be presented to the Insurer:

- Original insurance policy or original insurance membership certificate in cases of group policy with which the claimant proves their right to lodge a claim;
- All annexes to the original insurance contract if there are any;
- The copy-extract of death certificate;
- Notification for death completed by the doctor certifying death indicating the cause of death, which certificate could be sent to the Insurer's medical adviser in a sealed envelope;
- Other documents, proving the date, cause/es and consequences of the insurance event; for the accidental death guarantee, the evidence of the accident as cause of the death;
- Any other document that the Insurer may deem necessary as history of the disease, Personal Medical File (LAK), police report, any medical expertises as chemical expertise, and other documents according to art. 106 of the Code of Insurance;
- Certificate for heirs if there are no beneficiaries shown in the policy.

2.4 In case of Total and Irreversible Loss of Autonomy (TILA) or Permanent Total Disability (PTD) the documents required by the Insurer are:

- Claim form including full and detailed information about the bank account on which the payments on the side of the Insurer to be done;
- Original insurance policy or original insurance membership certificate in cases of group policy, with which the claimant proves their right to lodge a claim;
- All annexes to the original insurance contract;
- A medical certificate addressed in a sealed envelope to the Insurer's medical adviser using the model provided by the Insurer, completed by the doctor providing treatment and which shows the nature of the injuries or illness, the resultant permanent impairment and the date of consolidation – TELK/NELK decision if available;
- For the PTDA guarantee and TILA as result of an accident guarantee, the evidence of the accident as cause of the PTD or TILA state;
- For the PTD or PTDA guarantees, the evidence that the insured person was carrying an officially registered occupation both on the date of his application for membership and on the commencement of his/her total disability;
- In cases of accident - data about the circumstances of occurrence of the accident (place and date of the accident, full description of the accident); name of a doctor, performed medical examination after the accident and who defined or performed necessary medical treatment; conclusion of the doctor about the nature and the degree of physical injuries as well as eventual consequences, information about pre-existing conditions and illnesses, injuries existing before the date of the accident; existing medical documents about definitely found medical conditions with the aim of defining the final percentage of disability;
- Any other document that the Insurer may deem necessary according to art. 106 of the Insurance Code.

2.5 In case of Temporary Disability the documents required by the Insurer are:

- Claim form including full and detailed information about the bank account on which the payments on the side of the Insurer to be done;
- Original insurance policy or original insurance membership certificate in cases of group policy, with which the claimant proves their right to lodge a claim;
- All annexes to the original insurance contract;
- Sick leave certificates;
- Any other documents that the Insurer may deem necessary according to art. 106 of the Insurance Code.

2.6 In case of survival on the end date of the insurance contract:

- Claim form including full and detailed information about the bank account on which the payments on the side of the Insurer to be done;
- Evidence of having right to claim the payment if not evident from the policy /certificate for heirs if they are beneficiaries but are not named in the policy;
- The ID card of the life assured or declaration sighed in a front of a notary by the insured that they are alive on the end date of the insurance contract, if the life assured does not appear personally to receive the sum assured.

2.7 If the original insurance policy or original insurance membership certificate is missing or lost this is not a reason for a refusal of the claim.

2.8 If the claimant needs the original documents back, the employee from Claims Department must make copies, to certify them with a stamp “Identical with the original”, to put their signature and to return back the originals to the claimant.

## III. COLLECTION OF PROOF FOR ASSESSEMNT OF VALIDITY AND AMOUNT OF A CLAIM

3.1 An employee from Claims Department opens an individual file for each separate claim and for each separate beneficiary, including the following information:

- Consecutive number of the claim (unique individual number) and the date of registration of the claim. The employee gives this data to the claimant in order to allow them to have the reference number in their further communication;
- If at lodging of a claim not all required documents are attached, an employee handling the case must inform the claimant in written asking for missing documents and explaining that they should be received in the company as soon as possible as it is not possible to handle the claim without them.

3.2 When the user of an insurance service is a party to the insurance contract the Insurer notifies him/her about the additional proofs on the claim later 45 days from presenting of the proofs stipulated in the agreement and the rules on art. 104 and which proofs were not foreseen in the insurance contract at its conclusion and which are necessary for assessment of the ground and amount of the insurance claim.

3.3 The final term for lodging of a claim is 5 years from the occurrence of an insurance event.

3.4 In cases of an excess which directly results from an insurance event the prescription period is 5 years from the date of occurrence or learning about the excess but not more than the prescription towards the responsible for the damages person when the damages are a result of an illegal damage. Excess is any deterioration of the health sate of the damaged person which is in direct result and is in direct connection with the occurred insurance event.

3.5 The prescription regarding the receivings of the damaged person under the direct claim aginst the insurer as well as of the insured person or the beneficiary stops to be in effect from the date of lodging of the claim in a front of the insurer up to the date of receiving of the decision of the Insurer according to art. 108, par. 1 of the Insurance Code respectively up to the expiry of the maximum term for taking of a decision according to art. 108, par. 2,3 and 5 of the Insurance Code.

3.6 All the costs for collection of information and documents for proof of validity and amount of a claim are for the claimant themselves.

3.7 The insurer has the right of access to any medical data at appropriate institutions, which have it at their disposal as hospitals, medical establishments and any other medical institutions, for which an insured person gave their consent on an application form and subject to strict observation of Data Protection Act.

3.8 According to the Insurance Code for the aims of assessment of the insurance event and the damages as a result of it the Insurer has the right to receive the necessary information archived by the bodies of the Minisrtry of Internal Affairs, investigation bodies, other state bodies, general practitioner, health and medical establishments and the persons who have the right to certify occurrence of the circumstances as well as certified copies of documents. In cases when the required information is a part of the materials of a pre-court investigation the prosecutor allows an access to it.

3.9 In cases when the information according to points 3.7 and 3.8 above represents protected by the law secret at giving of such information to the Insurer in writing and against the signature it is explained to the Insurer its obligations not to widespread this information as well as consequences of the information’s unallowed widespreading.

3.10 The Insure has no right to ask for information and documents which the Insured cannot receive because of existing legal obstacles or legal way for its receiving as well as such evidence which has no connection with the claim's assessment and aim its unreasonable delay.

## IV. ASSESSEMNT OF THE DEGREE OF A CLAIM

4.1 The insurer prepares the basis for assessment of the insurance claim, grounds and procedures for defining of the amount of an insurance payment on the basis of collected required document as shown above.

4.2 Claims Department assesses medical consequences as a result of occurred insurance event on the basis of received medical documents.

4.3 In cases of assessment of Permanent Total Disability or Total and Irreversible Loss of Autonomy (TILA) the degree of disability is assesses by a doctor appointed by the Insurer. Sogelife Bulgaria reserves the right to cause the Insured's state of health to be verified by any authorized person designated by it. From that time payments shall be suspended until the medical report is received by the Consulting Physician of Sogelife Bulgaria. The state of PTD is determined by a doctor designated (appointed) by the Insurer based on received medical documents, including TELK/NELK decision in 15 working days from receiving of all required documents.
For insurance contracts concluded according to General Conditions for Accident at work compulsory insurance the state and percentage of Permanent Total Disability (PTD) as a result of an accident at work is defined by TELK/NELK commission. Insurance payment on PTD risk as a result of an accident at work is defined as a percentage of the sum assured equal to the percentage of disability of the Insured person defined by the respective competent body for assessment of medical expertise to work.

4.4 In cases when the disability claim notification is delayed with more than 4 months and unless the Insured can prove he/she was unable to make the notification of a claim, then the Insurer reserves the right, in view of the prejudice caused by the inability to verify the degree of disability, to set the day of disability at the date of declaration to the Insurer.

4.5 Any retention of information or intentionally false declaration on the part of the claimant or the production of inexact or falsified documents purporting to show the date, circumstances or consequences of the loss will result in forfeiture of any cover for the claim in question.

4.6 At a proposal of the doctor appointed by the company, the life insured might be called for a medical examination. A notification for a medical examination must be sent showing the place and date of examination. On the basis of conducted medical examination and according to the wordings of a certain type of product, the doctor appointed proposes in written a percentage of lost ability to work.

4.7 Any doctor authorised by the Insurer must be able to have access to the Insured suffering from disability, at any time on any working day up till 8pm at the place where he/she is undergoing treatment or at his/her home so as to be able to check on the seriousness of his/her state of health, failing which insurance cover may be denied.

4.8 In determining the amount of payment for incapacity caused by an insured event, except in cases of loss of limbs or other human organs, the insurer may provide for a period of stabilization of incapacity, which may not exceed one year from the date of occurrence of the insured event.
In this case, the insurer determined and paid preliminary amount within the period according the Insurance Code, which amount may not be less than the minimum undisputed amount of the payment.

## V. DEFINITION OF THE AMOUNT OF INSURANCE PAYMENT

The amount of insurance payment depends on the definitions and procedures as specified in the insurance contract or General Condition by type of product and per type of risk covered.

5.1 In case of an insurable event a sum insured will be paid as it was defined at the inception of insurance cover. It might be a lump sum or part of it. In the latter case the partial payment is based on the percentage of defined disability by the Insurer's appointed doctor or for insurances concluded according to the General Conditions for compulsory Accident at work insurance – the

percentage of Permanent Total Disability (PTD) as a result of an accident at work is defined by TELK/NELK commission.

5.2 Insurance payment might depend on the cause of death – sickness or accident according to the insurance contract (there might be double payment in case of accident).

5.3 The Insurer has the right to subtract all non-paid premiums form the insurance payment as well as any taxes or legal obligations that the Insurer is obliged to subtract by law.

## VI. INSURANCE PAYMENT

6.1 The Insurer will take one of the following decisions in 15 working days form receiving of all necessary documents required as per part II or additionally required by the Insurer:

- to accept a claim as a valid one and to pay the insurance indemnity;
- to refuse to pay a claim.

6.2 All insurance payment must be done in 15-days period form receiving of all necessary documents on a bank account of the beneficiary/ies shown in the claim form.

6.3 In case when all proofs according to art. 106 of the Insurance Code are not presented (Part II) the Insurer will take one of the above-mentioned decisions not later than 6 months from the date of lodging of the claim.

6.4 The insurer is obliged to send a written notification to the claimant with a registered post showing the amount of insurance payment, ground for payment (death, disability etc.) as well as subtracted amounts, if any. The notification for payment must indicate if the insurance payment is a lump sum and if this terminates the insurance cover.

6.5 The claim is payable in the original currency of the risk (the currency of sum insured and premiums payable) unless the insured person wishes to receive the payment in BGN. In this case the exchange rate will be the official exchange rate of National Central Bank on date of payment.

6.6 The Insurer makes payment of the insurance indemnity on the bank account presented at the beginning independently if the amount of the indemnity is assessed by the Insurer or under the court procedure. The change of the bank account is binding for the Insurer only after he has officially informed in writing before the execution of the payment including cases of court cases.

6.7 If under the insurance contract there are a few Beneficiaries they have equal rights except in cases when otherwise is stipulated in the insurance agreement. If a beneficiary refuses to receive or didn't receive his/her part of the insurance indemnity his/her part will be added to the part of the other beneficiaries. If a beneficiary up to the expiry of the prescription period didn't claim his/her part of the sum assured the Insurer will divide it proportionally between the rest of the beneficiaries. In cases under third sentence in one-year period of expiry of the prescription period the beneficiary didn't receive the additional part it remains for the insurer.

6.8 If the Beneficiary dies before the insured person and there are no other beneficiaries appointed under the insurance contract in case of occurrence of an insurance event the payment of the sum assured under the insurance agreement will be done to the insured person or his/her legal heirs except otherwise agreed. The first sentence is also applicable in case of cancellation of a legal entity in cases when the legal entity is a beneficiary. If at the moment of an occurrence of the insured event there is no any person who has the right to receive the payment than it stays at a disposal of the insurer after the expiry of the prescription period.

6.9 In cases where the Insurer on the basis of the documents and information supplied decides that the claim is unjustified and therefore no insurance payment will be done, they inform the claimant in written. Notification about refusal concludes all data for identification of a claim (number of the claim, date of occurrence of the insured event etc.) as well as the reason for refusal of payment.

## VII. PROCEDURE FOR HANDLING OF COMPLAINTS

7.1 General Provisions

Timely and effective management of complaints is a key constitutive element of operational risk management and customer relationship management.

Any complaint received must strictly abide by the rules and timelines set out by in the Complaint Management Procedure.

The procedure for handling of complaints is in compliance with Sogelife's Complaints management procedure as well as the following normative documents:

- Law for Consumer Protection;
- Insurance Code;
- EIOPA's (European Insurance and Occupational Pensions Authority) Guidelines on Complaints-Handling by Insurance Undertakings (EIOPA-BoS- 12/069);
- Report on Best Practices by Insurance Undertakings in handling complaints of EIOPA's (European Insurance and Occupational Pensions Authority) (EIOPA-BoS-12/070).

**Definitions:**

Complaint

A complaint is a statement of dissatisfaction, made either verbally or in writing, about the standard of service, actions or lack of action by the Sogelife or its staff, affecting an individual customer or group of customers.

Complainant

Complainant is a person who is presumed to be eligible to have a complaint considered by Sogelife and has already lodged a complaint e.g. a policyholder, insured person, beneficiary or their lawyers.

7.2 Registration of a complaint

7.2.1 The process for registration of the complaints is described in Sogelife's Complaints Management Procedure. Complaints can be submitted in the following ways: throughout the distributor network, FSC or other Regulator, or directly by the following means: phone, fax, e-mail, letter or verbal communication.
If not sent or communicated directly to Sogelife, all original complaints should be submitted at the headquarters of the Insurer at fl.4, Crystal building, Osogovo str. 38-40, Vazrajdane region, , Sofia, Bulgaria. Following a verbal complaint, the Insurer will advise the clients for the process to be followed and the means to submit a written complaint.

7.2.2 Complaint must be written in a plain language and contain the following minimum information: the name of the claimant, address of the person as well as telephone number for contacting them, reasons for the complaint, name of the insured person, number of insurance policy (when applicable), signature of the claimant and date of submission of the complaint (except for verbal complaints).

7.2.3 Complaint registration is proved by putting of an incoming number and date from Sogelife's Complaints register.

**7.3 Assessment of validity of the complaint**

7.3.1 The complaint is assessed on the basis of all collected documents as well as any other additionally received documents and/or information.

7.3.2 In cases of a complaint, amicable means shall be applied following the steps described below:

- Each party appoints a medical expert to act on their behalf;
- If the claimant contests in writing the opinion of Sogelife Bulgaria, he/she has the right to choose and appoint a counter expert at his/her expense. Written opinion of the counter expert must be subsequently forwarded to Sogelife Bulgaria;
- Should disagreement persist, a third party expert appraisal must take place at costs shared between the parties. The two experts shall designate by common consent a third physician in order to settle the matter;
- The report issued by the third expert can be accepted or rejected by each of the parties. It is not binding and cannot prejudice any subsequent court decision;
- The costs and fees incurred for the first two medical experts are borne by the party which appointed the expert. Those incurred for a third expert will be split fifty/fifty between the Insurer and the claimant.

7.3.3 All decisions of the insurer taken on the basis of the conclusions of the appointed doctor will be notified to the insured by registered letter. The claimant can challenge them by providing a

detailed medical certificate. Any such objections must be addressed to the insured by a registered letter.

7.3.4 The procedure for handling of complaints must be quick, objective as well as it is necessary to comply with legal requirements, insurance practice and the rights of the claimants.

7.3.5 The procedure for reviewing of complaints will end up with issuing of a decision in a form of a written answer showing the grounds for the decision taken. . In a case of a complaint by the user of insurance services related to the assessment of the amount of the indemnity the Insurer is obliged in 7-days term in written to present to the user the factual and legal grounds for the decision taken.
For all other cases the Insurer is obliged to register, review and answer to all complaints in one-month term from the date of receiving of the complaint. The Insurer is obliged to analyze the received complaints and to take measured for removing of weaknesses in its activity detected on the complaints basis.
However, the employees responsible should make all efforts possible to answer clients within 5 working days.
In case that is needed more than 30 days for the final treating of the complaint the Compliance Officer sends informative letter to the client for the progress of the complaint treatment , inform the complainant about the causes of delay and set out when the investigation is likely to be completed.
All decisions by the insurer on complaints shall be notified to the claimant by registered letter, signed by the CEO or another authorized employee, unless the client has specifically requested to receive a reply by e-mail or by fax.
The answer is written in a plain language and must include the legal basis for the decision as well as the legal rights of the claimant if they are not satisfied by the decision. The possibilities outlined must include the option for an out-of-court settlement of a dispute in the first place, including hiring of independent parties as experts.

7.3.6 When providing a final decision that does not fully satisfy the complainant's demand, include a thorough explanation of the SOGELIFE's position on the complaint and set out the complainant's option to maintain the complaint e.g. the availability of Alternative Dispute Resolution (ADR) mechanism, national competent authorities, etc.

7.3.7 If the parties do not reach an agreement, judicial means will be used to settle the dispute.

## VIII. CONFIDENTIALITY

8.1 The data in a claim form and attached medical documents will be treated with strict confidentiality. A claims handler (employee of Claims Department), who handles the claim as well as all the other employees, who have access to that information, observe the rules for confidentiality and internal rules of the Company with the aim of prevention of use of those information by unauthorized persons during the period of claims handling as well as after its closing. The persons, who have access to the documents, related to the insurance claim are policyholder, life assured, beneficiaries, legal heirs of the policyholder/life assured or other legally authorized person or a person, who has access to the information in question by operation of law.

8.2 Information might be given to persons who have legal right of access to the information only on the basis of their written request and submission of a document proving their legal right to have access to it.

8.3 Employees can give the original documents to competent government bodies in case when the original documents are necessary in the process of conducting an investigation. In these cases Claims Department gives all original documents and makes photocopies, which remain in the Company. Alongside with the copies be prepared a report, which shows the location of original documents. Giving of the original documents is performed by a written statement signed by the both parties. All documents which are copies and which Claims Department uses in the process of handling of claims be marked with a stamp "True with the original" and this be certified with a signature.

## IX. FINAL PROVISIONS

These Rules have been accepted according to art.104, par. 1 of the Code of Insurance.

These Rules were accepted with the decision of the Board of Directors of , which is mentioned in the Minutes No 05 dated 02.10.2008, amended with the decision of the Board of Directors held on 04.12.2008, mentioned in Minutes N 06 dated 04.12.2008, amended with the decision of the Board of Directors held on 31.05.2013, mentioned in the Minutes N 35 dated 31.05.2013 and amended with the decision of the Board of Directors held on 29.1.2016 mentioned in the Minutes № 53 dated 29.1.2016.