INTERNAL REGULATIONS FOR CLAIMS HANDLING PROCEDURES

1.Notification of occurred insurance event

The Company receives claim notifications in its Head office at address: Sofia, 75 Bulgaria Blvd. The notification is submitted as Claim Notification - Form №1 approved by the Company. The form may be obtained at the Company Head office, from the respective agency managing the policy or downloaded from this web site. The notification is completed and submitted by:

- Insured /Policy Owner;
- Beneficiary;

Above persons could find assistance for filling in the form from their Agent or the Agency secretary.

The documents available to the claimant shall be attached to and duly described in the notification.

In accordance with policy provisions, *Notification of claim* has to be submitted as follows:

- Death claims: within 7 days considered from date of death (Basic Policy) and within 5 days for accidental death (Rider PA or PA insurance).
- For other insurance coverage – within 7 days from the date of event (Permanent Invalidity, Daily Benefits, Surgical Benefit).

2. Each notification is registered by an employee dealing with evaluation of insurance claims, is entered into a special Company Register and obtains a unique number. The unique number is announced to the person who submitted the notification by the same way as the notification was received by the Company.
3. Upon receiving of a notification, the Company opens a file for the damage, which is given the above unique number. All documents sent/ received by the Company with respect to the declared insurance event are kept in this file. The entire Company correspondence regarding the declared insurance event refers to the respective file number (as well as the sent/ received date).
4. The Costumer Services Department:
    - Judges, on the basis of the originally submitted information in the Notification, the policies/ coverage under which payment of benefit may be due, depending on the nature of the described insurance event;
    - evaluates the probable amount of payment that would be due against submission of the respective evidence for the damage occurred;
    - and forms a reserve

5. Within 4 working days after the date of receiving the Notification, the Company performs an initial assessment of the information included in it and provides to the beneficiaries information concerning:
    - the insurance coverage that may apply for the declared insurance event;
    - the documents (evidence) necessary to assess the justification and amount of the claim for each of the insurance coverage.

The information is provided directly – through a letter to the beneficiary or through the insurance agent (broker) who manages the policy.

DOCUMENTS REQUIRED

The standard Claim documents required are listed below:

A. In case of death claim:

- *Death Claim Form – form 2.*

This form must be filled out by Beneficiary. If there is more than one Beneficiary, a separate form will be filled in by each. In case the claimant is under age 18, the form must be filled out by the claimant's legal representative.

- *Death Claim Form - Physician's Statement for the death– form 2A.*

This form must be filled out by Physician who attended the deceased during his last illness or the medical institution where the Insured is treated.

- Authorized copy of Death Certificate.
- Authorized copy of Birth Certificate of the Insured (Proof of Age).
- Documents to identify the beneficiaries: Identity Card of the Beneficiary; if the beneficiaries are Legal heirs - Certificate of Legal Heirs; or in case of beneficiary under age 18 - Guardianship certificate, if needed.
- Original Policy with all issued endorsements
- Authorized copy of Autopsy report.

B. In case of claims for permanent disability, Surgical Benefit, Daily Benefit, fractures, serious disease or other type of benefits the following documents are also requested, depending on the coverage on which the claim is based:

- *Physician's Statement – Claim for permanent disability – form 3*
- *Statement of Insured – only Accidental Claim Form – form 4.*
- *Physician's Statement – only Accidental Claim Form – form 4A.*
- *Physician's Statement - Hospital/Surgical Claim Form – form 5*

In case of policies with coverage Permanent disability or Waiver of premium, when the conditions of the policy regarding payment of such types of benefit are fulfilled, the insured shall also submit the Claim form for Permanent disability or Waiver of premium – Form 6.

According to the explicit authorization of the insured/owner or beneficiary of the policy, the Company can carry on from third parties related to and required for the clarification of the circumstances of the insurance event and defining the grounds and amount of the claim. The Company obligates not to request from the third parties information and documents not related to and not required for the clarification of the circumstances of the insurance event and defining the grounds and amount of the claim.

6. If the circumstances of the insurance event need clarification in regards to the proofs of loss and the amount of the benefit (death or other covered insurance event) the following documents could be requested (and other documents, in case that the beneficiary or the insured/owner of the policy is able to provide them (e. g. there is a legal right and no any legal restrictions for that) as well:

    - Medical documents – epicrisis from hospitalizations, personal medical record, medical card, sick leaves, toxicological report, X-rays,

Certificates for permanent disability from State committee, lab tests results.

- Report from the National Social Security Institute about an accident at work and declaration for accident at work – these are requested for policies, in case the policy provides for different benefits in case of accident at work and accidents out of work.
- Police deeds and statements of the Ministry of Inner Affairs concerning the claim in case there were made investigations or undertaken any actions.
- Police deeds and statements of the Prosecution or Penalty Court concerning the claim in case there were undertaken any legal actions.
- A court order in case the Insured is missing or there is no possibility to identify the corpse.
- Statement of the coroner on duty or a penal deed under the Road Traffic Act) in case of correspondence under the circumstances includes road accident.
- Other documents, referring to the correspondence facts

Regarding the requested documentation, the company can accept a copy, certified by Notary or the respective issuing Institution. In cases when the due benefit does not exceed 1000 BGN, the copies can be certified by the claimer and after verification with the original documentation by the company employee, the script is sent back to the claimer.

7. Within 45 days after receiving the Claim Form with the respective documents, the Company performs an assessment of the facts and evidence submitted and, in case a reasonable and objective need of additional information arises for clarification of the circumstances related to the insurance event and defining the grounds and amount of the claim, the Company sends a request in writing with detailed and clear instructions as to the necessary additional documents and information. In the cases when the policy provisions foresee the expiry of a certain time period in order for the insurance event to be deemed as occurred (e. g. the one-year period required in order the permanent disability state to be acknowledged), the above period starts after expiry of the respective period. If necessary the Company carries on its own correspondence with institutions, including health institutions, physicians etc., in order to collect the necessary data and evidence. The Company may also carry out its own investigation.
8. When one and the same insurance event becomes the basis for successive claims under different insurance coverage (e. g. hospitalization coverage followed by such for disability or death), a separate Claim Form is submitted for each of the events. The periods for review and assessment of the documents, for request of additional information and documents, and for judgment on the claim, shall run independently from each other. A separate sub-file is opened for each of the separate claims within the file for the respective insurance claim. Each sub-file is

given a separate number and the entire correspondence in respect of the separate claim, should includes the respect No of the sub-file.

9. The **review of proofs of loss and claim assessment process** as a whole includes:
    1) Verify the Insured
    2) Verify the loss
    3) Verify if the respective insurance event is covered by the policy and if the policy had been in force at the moment of its occurrence and if the other conditions for benefit payment foreseen in the policy are fulfilled
    4) Define the amount of the payable benefit or decide for well-grounded decline of the claim.

    The submitted medical and other documents are reviewed by the insurance-medical committee, which consists of a trusted physician and a claims examiner both consulting the company. The amount of the payable benefit is defined, according to the terms of the relevant Insurance policy, based on the Physician consultant statement about the availability of covered events under the policy and the concrete amount of the due benefit with a view to the proved characteristics of the insurance event.(for example: availability of covered damages, Temporary or Permanent Disability/status, continuance, proved medical expenses, etc)
10. After submission of the additional data and documents required by the Company, the claim is reviewed again by the insurance-medical committee. The committee assesses and defines the amount of the payable benefit in accordance to the policy provisions or decides for a justified decline of the claim. Within the legitimate 15-days term the Company sends a rejection letter or respectively informs the beneficiaries/Insured for its decision to pay insurance benefit. The letter informing of the decline of the claim shall clearly state the motifs of the Company for the decline, as well as the facts and policy provisions on which the decline is based. The letter informing of a positive decision for benefit payment shall state for each separate insurance coverage (if benefit is due under more than one coverage): the amount of the benefit that the Company accepts to pay, and if part of the insurance amount is concerned – the motifs for defining the specific amount of the benefit. In case payment is declined for parts of the coverage subject of the claim, while payment is accepted under other parts, the letter of the Company shall contain respective justification for both cases.
11. The payment of policy benefits is made in the currency, stated in the policy. It is possible to pay the equivalent in BGN of a benefit due in foreign currency (using the exchange rate of the Bulgarian national bank of the day), if the beneficiary/ insured requests so in writing. Payment could be made in cash (up to 300 BGN) or by bank transfer to the bank account provided by the respective beneficiary. The payment is effected within 15 days, in keeping with the Insurance code and under the condition that the beneficiary has provided in writing a bank account for payment of the benefit (except when the latter is payable in cash according to these rules).
12. The procedures for review of client appeals are attached as Annex A to these rules.