INTERNAL RULES
WITH REGARD TO OPERATIONS FOR THE SETTLEMENT OF CLAIMS UNDER INSURANCE CONTRACTS

1. BASIC PROVISIONS

1.1. These Internal Rules for the activity of settling insurance claims under insurance contracts, called for short "Internal Rules" of Inter Partner Assistance S.A. based in Brussels, Avenue Louise 166 b1, 1050, part of the AXA group, were adopted on the grounds of Art. 104 of the Insurance Code.

1.2. The internal rules regulate the procedures by which the insurer accepts the claims under the insurance contracts, collects the evidence for establishing their grounds and amount, assesses the damages, determines the amount of indemnities, makes payments to consumers and considers complaints filed by them.

1.3. The rules are public and aim to guarantee consumers' rights to a quick, transparent and fair settlement of their claims.

1.4. The policy of the Insurer in settling the claims is determined by the principles of correctness, legality, liquidity, security and justice.

1.5. The relations for the provision of insurance services between the Insurer and its Insured persons are settling through insurance contracts and General terms and conditions that meet the requirements of the Bulgarian legislation.

2. OBLIGATION TO NOTIFY THE INSURER IN THE EVENT OF AN INSURED EVENT

2.1. The insured or beneficiaries are obliged to notify the insurer of the occurrence of an insurance event within the period specified in the General Terms and Conditions for the respective type of insurance, in the Insurance Code or in a normative act regulating the respective type of insurance.

2.2. The notification must be made in writing by post, e-mail or telephone, specified in the General Terms and Conditions or the insurance policy.

2.3. The Insurer has the right to refuse payment if the Insured has not fulfilled its obligations within the terms under item 2.1., in order to prevent the Insurer from establishing the circumstances under which the event occurred, or if the failure has made it impossible for the Insurer to establish them.

3. SUBMISSION AND ACCEPTANCE OF CLAIMS UNDER INSURANCE CONTRACTS

3.1. The claim is filed by electronic notification, by phone or by filling out a claim form, complete with accurate bank account details and documents establishing the occurrence of the event, damages and the right of the claimant to receive compensation. A separate claim is submitted for each insurance event and by each beneficiary. When there are more than one user, only one of the claims is completed with the necessary documents.

3.2. The claim is submitted personally by the entitled person (insured / beneficiary), his authorized representative or insurance broker, when the insured has assigned it to him. In case the entitled person is a minor or incapacitated, the claim shall be submitted by his / her legal representative, who shall prove this capacity through written documents.

3.3. The documents establishing the occurrence of the event and the claim shall be submitted at the seat of the Insurer or by mail to the address of the Insurer: CORIS Assistance, 1A Yakov Kraikov Str., Sofia 1606, Bulgaria, or electronically to e-mail address: operations@coris.bg.

3.4. The submission of claims is made within the terms provided in the General Terms and Conditions of the respective insurances, but not later than the limitation period.

3.5. The claims are registered with a unique number in the information system of the Insurer.

3.6. Upon acceptance of the claim, the respective representative of the Insurer shall check whether the following requirements are met:

a. The Insured must have a valid insurance policy;
b. he insurance premiums provided for in the policy to be paid within the established terms and amount;
c. the insurance event has occurred during the period of validity and in the territorial scope of the policy;
d. the event that caused the claimed damages is a covered risk according to the concluded insurance contract.

4. EVIDENCE OF ESTABLISHING THE GROUNDS AND AMOUNT OF THE CLAIMS

4.1. In order to prove the occurrence of an insurance event and the amount of the indemnity, the insured is obliged:
4.1.1. to present to the insurer the documents required by the General Terms and Conditions for the respective type of insurance and / or specified in the insurance contract and / or in another normative act;
4.1.2. to present additionally the documents requested by the insurer, directly related to the occurrence of the event and the amount of damages;
4.1.3. to present all the information necessary for the insurer to establish the basis and the amount of the indemnity in full and truthfully.
4.2. if necessary, the insurer has the right to access all medical documentation in connection with the health condition of the insured person and may request it from all persons storing such information.
4.3. The Insurer, no later than 45 days from the submission of the evidence specified in the insurance contract, notifies the claimant of the necessary additional evidence that could not have been included in the insurance contract at the time of concluding or filing the claim, but are directly related. with the event and are necessary to establish the basis and amount of the claim.
4.4. It is not allowed to require evidence which the claimant cannot obtain due to existing regulatory obstacles or due to the lack of legal possibility to provide them, as well as those for which a reasonable assessment can be made that they are not essential for establishing the grounds and the amount of the claim and aim at unjustified delay and prolongation of the procedure for settling the claim.
4.5. The documents and evidence are provided to the Insurer:
4.5.1. in original - financial documents (invoices, fiscal vouchers for medical and other expenses incurred by the insured, which he claims to be reimbursed);
4.5.2. original or copy of all other documents.
4.6.1. All evidence and documents shall be submitted at the Insurer's registered office or by mail to the Insurer's address: CORIS Assistance, 1A Yakov Kraikov Str., Sofia 1606, Bulgaria or electronically to the e-mail address: operations@coris.bg. Receiving is certified with a date and incoming number by an employee of the insurer.
4.6.2. If the documents and evidence are in a foreign language other than Bulgarian, they must be accompanied by an official translation into Bulgarian.
4.6.3. If the insured provides copies of documents, they must be certified by the insured person or his authorized representative or his legal representative for authenticity with the original.
4.7. The terms provided under Art. 108, para. 1 of the Insurance Code, shall begin to run after the submission of all required documents.

5. DOCUMENTS REQUIRED TO ESTABLISH THE GROUNDS AND AMOUNT OF CLAIMS

5.1. Evidence for establishing the grounds and amount of the claim are described in the General Terms and Conditions for the respective type of insurance. Depending on the nature of the insured event, documents related to the occurrence of the event, the amount of compensation and the identification of the beneficiaries shall be submitted together with the submission of the claim.
5.2. The insured person is obliged to present the necessary documents for proving an insurance event.
5.3. To assess the damages, the Insurer conducts an inspection of the damaged property.The inspection is performed by a representative of the Insurer and the Insured or his proxy. If special knowledge is required, an expert, who is nominated by the Insurer, shall be included in the inspection of the property. In cases where the damage is caused by a third party and it is known, if possible, the presence of that person or his representative.
5.4. The facts and circumstances that are established during the inspection shall be entered in a statement of findings for inspection of the damage. The report shall be prepared during the inspection according to the sample of the Insurer.
5.5. The statement of findings for the inspection shall be signed by all participants in two copies, one of which shall be provided to the Insured. In case the Insured does not agree with the findings made in the minutes, this may be noted in the protocol and the same is signed by the Insured with a special opinion.

6. DETERMING THE AMOUNT OF INSURANCE INDEMNITY

6.1. The insurance indemnity is determined by the Insurer within the limits of the sum insured determined by the insurance contract and in compliance the norms of the Insurance Code. The limit of the insurance coverage under the insurance for each event is determined by the policy.

6.2. The Insurer determines the due indemnity according to the amount of the sum insured, the type of the insured event, its consequences and the presented evidence for establishing the grounds and the amount of the indemnity.

6.3. The Insurer shall provide the insurance indemnity in money or in kind as agreed in the insurance contract.

6.4. When filing a claim for payment of expenses incurred, the amount of compensation is determined by the amount of expenses actually incurred by the insured in accordance with the coverage of the insurance policy. The compensation is proved on the basis of submitted medical and financial documents.

7. COMPLETION AND DETERMINATION OF THE GROUNDS OF THE CLAIM

7.1. Each claim is completed by an employee of the insurer and includes:

7.1.1. Claim form, submitted by the insured person, except in cases where the claim is submitted by electronic notification;

7.1.2. documents and opinions received from the insured and the competent authorities in connection with the insured event;

7.1.3. decision for payment of compensation or motivated proposal for refusal to pay compensation.

7.1.4. Compensation is determined in compliance with the following principles:

7.1.5. when preparing the decision under item 7.1.3. the competent employee of the insurer is obliged to make sure that the claim is proved on the grounds and amount, namely that:

7.1.6. the insurance contract is valid as of the date of occurrence of the event;

7.1.7. the insurance event has occurred as a result of the occurrence of a risk covered by the terms of the insurance contract;

7.1.8. there is no breach of obligations under the contract by the insured person.

8. PAYMENT OF SUM INSURED AND INSURANCE INDEMNITIES

8.1. Sum insured and insurance indemnities shall be paid within the period specified in the relevant policy or the General Terms and Conditions, but not later than 15 working days from the submission of all necessary evidence and documents.

8.2. The payment of the sum insured or insurance indemnity is made by bank transfer to a bank account specified by the claimant, and the responsibility for the correct indication of the information lies with the claimant.

8.3. In the cases when the Insurer has paid indemnity under an insurance contract for property damage caused by a third party, it enters into the rights of the Insured against the third party up to the amount of the paid insurance indemnity and the incurred expenses. The waiver of the Insured's rights against the third party, guilty of causing the damage, is invalid against the Insurer.

8.4. When paying indemnity, the General Terms and Conditions for the respective type of policy, as well as these Rules apply.

9. REFUSAL TO PAY INSURANCE INDEMNITIES

9.1. Refusal to pay compensation is made in the presence of one or more of the following circumstances:

9.1.1. the insurance contract was not in force on the date of the event;

9.1.2. the event did not occur as a result of the occurrence of a risk covered by the terms of the contract or due to an excluded risk;

9.1.3. upon non-fulfilment by the insured person of an obligation under the insurance contract, which is material with a view to thebinsurer's interest, which has been provided for in a law or in the insurance contract and which has led to the occurrence of the insured event. ;

9.1.4. the insured or the third party beneficiary has not provided the documents necessary to prove the grounds for payment of compensation, which have been requested by the insurer;

9.1.5. the insured or the third party beneficiary has presented documents with false content, false, forged or false documents or otherwise tried to deceive or deceive the insurer;

9.1.6. the insured or the third party beneficiary prevents the insurer from receiving information about the health condition of the insured or the performed treatment from the treating doctors, hospitals or from the employer, necessary for clarification of the grounds and the amount of the claim.

9.2. In case of refusal to pay insurance indemnity or part of it, upon a written claim, the insurer shall notify the claimant in writing, stating the reasons for the decision within a period specified in the policy, but not later than 15 working days from submission of all necessary evidence.

9.3. In the absence of evidence regarding the grounds or amount of the claim, the insurer is obliged to rule out no later than 6 months from the date of filing the claim.

10. EXAMINATION OF COMPLAINTS

10.1. Complaints on submitted claims are accepted at the Insurer's registered office or by mail at the Insurer's address: CORIS Assistance, 1A Yakov Kraikov Str., Sofia 1606, Bulgaria or electronically at the e-mail address: operations@coris.bg. New written evidence, which has not been submitted and is relevant to the insured event, the reasons for its occurrence, the grounds and the amount of the insurance indemnity, may be attached to the complaint.

10.2. A register is kept for all complaints received by the company.

10.3. If in the process of reviewing the complaint it is necessary to obtain additional information related to the application, the Insurer shall inform the Insured in writing.

10.4. The Insurer shall submit in writing within 7 days from the date of receipt of the complaint the factual and legal grounds of the decision for payment of compensation. To comply with this deadline, it is sufficient for the reply to be sent before its expiry.

10.5. The statement of the Insurer is sent to the address of the Insured, unless the Insured has asked to send the answer by e-mail - then the answer is sent electronically to the specified e-mail address.

10.6. If the statement does not satisfy the Insured, then he can file his claim in court. Disputes are resolved by the competent court in accordance with the legislation of the Republic of Bulgaria.

10.7. If the dispute cannot be resolved after a complaint addressed directly to the insurer, then the Insured:

10.7.1. may apply to the Sectoral Conciliation Commission of the Consumer Protection Comission for resolving disputes in the field of insurance and insurance mediation, and may submit a complaint to the Consumer Protection Commission in accordance with the provisions of the Consumer Protection Act.

10.7.2. may apply for assistance from a qualified mediator in accordance with the provisions of the Consumer Protection Act.

10.7.3. may submit a complaint to the Financial Supervision Commission in accordance with the provisions of Article 290, paragraph 1 of the Insurance Code.

10.8. Complaints re-lodged on a matter on which there is a decision shall not be considered unless they are related to the execution of the decision or are based on new facts and circumstances.

10.9. Complaints that are not considered shall be returned to the sender, who shall be informed of the reasons for this.

These internal rules are adopted by the Board of Directors of Inter Partner Assistance S.A. based in Brussels, Avenue Louise 166 b1, 1050, part of the AXA group, on 23rd of November 2020.