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Prof. emeritus dr Mirko S. Vasiljević[1]

ZAKON O PRIVREDNIM DRUŠTVIMA I AKCIONARSKA DRUŠTVA ZA OSIGURANJE/REOSIGURANJE

ORIGINALNI NAUČNI RAD

Apstrakt:

Specijalizovana privredna društva koja obavljaju delatnosti koje su po pravilu u režimu dozvole osnivanja i dozvole za rad nadležnih tela najčešće se regulišu sumarno, posebnim zakonima. To je slučaj i sa osiguravajućim društvima uopšte i naročito sa akcionarskim društvom za osiguranje. Ta tehnika regulative primenjuje se prvenstveno stoga što u svim zemljama, a tako je i u Srbiji, postoji opšti zakon koji reguliše sva privredna društva i koji se primenjuje, bilo „shodno", bilo direktno (neposredno), i na specijalizovana društva, pa i na osiguravajuća društva, i time i na akcionarsko društvo za osiguranje u onim pitanjima i institutima za koje ne postoje posebne norme u specijalizovanom zakonu, konkretno zakonu koji reguliše osiguranje.

U ovom radu razmatraju se pitanja odnosa zakona koji uređuje privredna društva i zakona koji uređuje osiguranje, s posebnim akcentom na akcionarska društva za osiguranje. Reč je o odnosu opšteg zakona (Zakon o privrednim društvima) i posebnog zakona (Zakon o osiguranju), koji je uređen maksimom *lex specialis derogat lege generali* (posebni zakon ukida opšti zakon). Interesantno je da je Zakon o osiguranju između dve opcije te primene, „shodne primene" i direktne (neposredne) primene, optirao za direktnu primenu Zakona o privrednim društvima kada ne sadrži posebnu normu koja svoj osnov nalazi u specifičnosti delatnosti osiguranja u odnosu na druge delatnosti pokrivene u smislu regulative Zakonom o privrednim društvima. U radu se posebno analiziraju pitanja vezana za status akcionarskog društva i njegovih organa (korporativno upravljanje) za koja ne postoje posebne norme koje sadrži zakon koji reguliše

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osiguranje, a na koja se ipak ne može direktno primeniti zakon koji reguliše privredna društva, već bi se tada moralo pribeći pravilu koje je bliže prirodi „shodne primene".

Ključne reči: osiguravajuća društva, akcionarsko društvo za osiguranje, modeli uprave društava kapitala, adekvatnost kapitala, grupe društava za osiguranje.

I Umesto uvoda

Statusni aspekt osiguravajućih društava nije, kako bi se očekivalo, uređen posebnim zakonom koji uređuje oblast osiguranja, već generalnim zakonom koji uređuje privredna društva. Posebni zakon koji uređuje delatnost osiguranja u Srbiji, ipak, rezervisao je za sebe pravo uređenja nekih odstupanja od opštih odredaba zakona koji za svoju vokaciju ima uređenje statusnih aspekata privrednih društava u Srbiji, bez obzira na delatnost. Tako se ta odstupanja koja po prirodi imaju poziciju posebnih odredaba primenjuju, kada postoje, umesto opštih pravila statusa privrednih društava – *lex specialis derogat lege generali*. U tom smislu je specijalizovani Zakon o osiguranju[2] propisao da se na „društvo za osiguranje, društvo za reosiguranje, društvo za posredovanje u osiguranju i zastupnika u osiguranju primenjuje zakon koji uređuje privredna društva,[3] osim ako ovim zakonom nije drukčije propisano". Taj iskaz specijalnog zakona istovremeno znači da ove primene nema kad je u pitanju „društvo za uzajamno osiguranje", s obzirom na to da opšti zakon koji uređuje privredna društva nema takvu pravnu formu organizovanja koja bi kao opšta važila za obavljanje bilo koje privredne delatnosti, već takva forma postoji samo u oblasti osiguranja, te je onda i logično da je samim tim uređuje samo zakon koji kao posebni uređuje delatnost osiguranja, uključujući i ovu statusnu formu.

Društvo za osiguranje osniva se kao akcionarsko društvo ili društvo za uzajamno osiguranje, a društvo za reosiguranje samo kao akcionarsko društvo za reosiguranje uz primenu pravila koja važe za ovu formu društva koje obavlja poslove osiguranja. Društvo za posredovanje u osiguranju osniva se kao akcionarsko društvo ili kao društvo s ograničenom odgovornošću. Društvo za zastupanje u osiguranju osniva se takođe kao akcionarsko društvo ili kao društvo s ograničenom odgovornošću, a ove poslove može obavljati i fizičko lice sa statusom preduzetnika u smislu zakona koji uređuje privredna društva. U ovom radu biće reči samo o specifičnostima akcionarskog društva za osiguranje (koje shodno važe i za akcionarsko društvo za reosiguranje) u odnosu na opšta pravila koja važe za akcionarsko društvo koje pokriva zakon koji uređuje privredna društva, s obzirom na to da kod ove forme društva postoje posebno izražene specifičnosti, dok takve specifičnosti ili posebno

[2] Zakon o osiguranju - ZO, *Službeni glasnik RS*, br. 139/14 i 44/21, čl. 18.
[3] Zakon o privrednim društvima - ZOPD, *Službeni glasnik RS,* br. 36/2011-3, 99/11-14, 83/14-15 – dr. zakon, 5/15-3, 44/18-27, 95/18-335, 91/19-61, 109/21-15.

izražene specifičnosti ne postoje kod društva za osiguranje u formi društva s ograničenom odgovornošću (neke naravno postoje, poput sistema dozvole za osnivanje, minimalnog osnovnog kapitala, nadzora nad radom i poslovanjem i slično), te o ovoj formi društva za osiguranje neće biti reči, kao što neće biti reči ni o društvu za uzajamno osiguranje koje ne postoji kao opšta statusna forma u zakonu koji uređuje privredna društva, već samo kao specijalizovana forma društva u delatnosti osiguranja pokrivena posebnim zakonom koji uređuje ovu delatnost i ovu statusnu formu za njeno obavljanje.[4]

II Posebnosti akcionarskog društva za osiguranje/reosiguranje

1. Poslovno ime i osnovni kapital

Akcionarsko društvo za osiguranje/reosiguranje obavlja delatnost finansijske prirode, te analogno posebnom režimu koji uređuje poseban zakon koji reguliše banke organizovane kao akcionarska društva i zakon koji uređuje osiguranje sadrži niz specifičnosti statusa ovih društava za obavljanje delatnosti osiguranja/reosiguranja u odnosu na društva iste pravne forme organizovanja i osnivanja koja ne obavljaju ovu delatnost. Logično je da je prva takva specifičnost posebnost poslovnog imena, radi distinktivnosti od drugih društava ove forme koja ne obavljaju ovu delatnost – poslovno ime koje se registruje mora biti u skraćenoj formi „a.d.o." (akcionarsko društvo za osiguranje). Takođe, samo to društvo može obavljati i registrovati obavljanje delatnosti osiguranja ili reosiguranja (princip alternativnosti, ne kumulativnosti).

Ključne specifičnosti, s obzirom na to da je priroda obavljanja delatnosti osiguranja i reosiguranja u osnovi finansijska, za ova društva postoje kod uređenja brojnih pitanja vezanih za osnovni kapital ovog društva. Najpre, propisani minimalni osnovni kapital obavezno je u novčanom obliku i daleko višeg iznosa od osnovnog kapitala društava koja obavljaju druge komercijalne delatnosti nefinansijske prirode (visina zavisi od toga koje vrste životnog ili neživotnog osiguranja obavlja ovo društvo, kao i da li se bavi delatnošću osiguranja ili reosiguranja).[5] Zatim, propisan je princip održanja te forme osnovnog kapitala u toj visini i tokom trajanja poslovanja i života društva, što kod društava koja obavljaju delatnost nefinansijske prirode u principu ne postoji.[6] Najzad, pored određenja pojmova „značajno" i „kontrolno" kapital učešće, u osnovi na istovetan način kao i zakon koji uređuje privredna društva, zakon koji uređuje osiguranje sadrži i određenje pojma „kvalifikovano kapital

[4] Više: Nataša Petrović Tomić, *Pravo osiguranja – Sistem,* Službeni glasnik, Beograd, 2019, str. 185–212, 242–275.

[5] ZO, čl. 27; ZOPD, čl. 293.

[6] Više: Mirko Vasiljević, *Komentar Zakona o privrednim društvima*, Službeni glasnik, Beograd, 2023, str. 611–662.

učešće" (neposredno ili posredno preko drugog lica u svoje ime a za račun tog lica kapital učešće u nekom licu sa 10% ili više vlasništva ili glasačkih prava). U vezi s tim institutima postoji i niz dopunskih podinstituta koji teren specifičnosti ovih društava čine kompletnijim: prvo, zabrana uzajamnih kapital učešća svih formi društava koje uređuje Zakon o osiguranju; drugo, prethodna saglasnost Narodne banke Srbije – NBS (kao nadzornog organa nad osiguravajućim društvima) za sticanje ili uvećanje sticanja značajnog (20%) ili kontrolnog (50%) kapital učešća ili glasačkih prava u ovom društvu; treće, propisivanje posebnih uslova za sticanje ili uvećanje kvalifikovanog kapital učešća (time i značajnog ili kontrolnog): dobra poslovna reputacija, odgovarajuće iskustvo, finansijsko stanje, utvrđivanje izvora sredstava, utvrđivanje razloga sticanja ili uvećanja; četvrto, propisivanje obaveze prethodnog pismenog obaveštenja NBS kod otuđenja ili umanjenja kvalifikovanog kapital učešća (time i značajnog i kontrolnog); najzad, peto, propisivanje pravnih posledica nedozvoljenog sticanja ili uvećanja kvalifikovanog (time i značajnog i kontrolnog) kapital učešća: nalaganje od strane NBS otuđenja stečenog ili tako uvećanog kapitala, i to u određenom roku, suspenzija u međuvremenu do otuđenja glasačkih i imovinskih prava, ništavost pravnog posla takvog sticanja u slučaju neotuđenja ili nesmanjenja nedozvoljeno stečenog kapital učešća u ostavljenom roku.

Posebna specifičnost kad je reč o osnovnom kapitalu akcionarskih društava za osiguranje/reosiguranje predstavlja *institut adekvatnosti kapitala*. Društvo za osiguranje/reosiguranje je dužno da, radi trajnog izvršavanja obaveza i podnošenja rizika u poslovanju, formira *tzv. garantnu rezervu* u skladu sa zakonom koji uređuje osiguranje. Garantnu rezervu čini *tzv. primarni kapital* (koji čine elementi definisani ovim Zakonom) *i dopunski kapital* (koji takođe čine elementi određeni ovim zakonom), uz umanjenje za odbitne stavke definisane ovim zakonom. Zakon koji uređuje osiguranje utvrđuje posebnu, *tzv. marginu solventnosti* za osiguravajuća društva koja vrše životno osiguranje i posebnu marginu solventnosti za osiguravajuća društva koja vrše neživotno osiguranje. Društvo za osiguranje/reosiguranje dužno je da obezbedi tzv. *raspoloživu marginu solventnosti*, u zavisnosti od toga da li se bavi životnim ili neživotnim osiguranjima, a ova margina se smatra obezbeđenom ako društva imaju propisanu garantnu rezervu u skladu sa zakonom koji reguliše oblast osiguranja. Za razliku od tzv. garantne rezerve, zakon koji reguliše osiguranje/reosiguranje poznaje i institut *tzv. garantnog kapitala*, koji predstavlja deo garantne rezerve utvrđene u skladu s ovim zakonom, a koji iznosi najmanje jednu trećinu zahtevane margine solventnosti zavisno od grupe osiguranja koje društvo za osiguranje obavlja. Garantni kapital društva za osiguranje ne sme biti manji od iznosa propisanih tim zakonom, u zavisnosti od grupe osiguranja koje društvo za osiguranje obavlja, u skladu sa izdatom dozvolom za rad. Društvo za osiguranje ispunjava uslove za adekvatnost kapitala ako zadovoljava kriterijume raspoložive margine solventnosti i garantnog kapitala, u skladu sa zakonom koji reguliše osiguranje. Ako društvo za osiguranje

prestane da ispunjava zahtevane uslove adekvatnosti kapitala, dužno je da Narodnoj banci Srbije u propisanom roku dostavi *program mera za ponovno ispunjenje tih uslova*, odnosno solventnosti društva, i to u periodu od najduže tri meseca od utvrđivanja prestanka ispunjenosti tih uslova. NBS može od društva za osiguranje tražiti da izmeni i/ili dopuni program tih mera, a ako to ne zahteva, smatra se da se saglasila sa sprovođenjem predloženih mera. Radi obezbeđenja trajne solventnosti društva za osiguranje, NBS može od tog društva tražiti da joj, u periodu sprovođenja programa mera ispunjenosti uslova solventnosti, dostavi *dugoročni plan finansijske konsolidacije*.[7]

2. Osnivanje

Osiguravajuća/reosiguravajuća društva osnivaju se, za razliku od režima osnivanja društava po pravilima zakona koji uređuje privredna društva gde važi sistem slobodnog osnivanja, po sistemu dozvole, koju izdaje NBS u zakonom definisanom upravnom postupku uz priloženu propisanu dokumentaciju. Zakon koji uređuje osiguranje reguliše takođe i mogućnost odbijanja zahteva za izdavanje dozvole, kao i osnove prestanka važenja izdate dozvole za rad.

Akcionarska društva koja se osnivaju po režimu zakona koji reguliše privredna društva mogu biti zatvorena (osnivaju se bez javnog upisa akcija) i otvorena (osnivaju se sa javnim upisom akcija). Taj zakon, međutim, ni kod otvorenih društava ne poznaje institut osnivačke skupštine, što sugeriše da zakonodavac i ne očekuje osnivanje ovog društva javnim putem već praktično osnivanje samo nejavnim putem od strane samih osnivača (zatvoreno društvo), te se ovo društvo nakon osnivanja i registracije u proceduri definisanoj zakonom koji uređuje tržište kapitala može pretvoriti u otvoreno (javno) društvo novom javnom emisijom akcija ili konverzijom osnivačke (nejavne) emisije akcija u javnu emisiju primenom propisane procedure pred Komisijom za hartije od vrednosti. S druge strane, zakon koji uređuje osiguranje ne govori o vrstama akcionarskih društava za osiguranje/reosiguranje, ali reguliše institut osnivačke skupštine ovog društva, koja se mora održati u propisanom roku nakon dobijanja dozvole (za rad) od strane NBS, po propisno podnetom zahtevu od strane osnivača (uz prilaganje propisane dokumentacije). Interesantno je da zakon koji uređuje osiguranje propisuje da osnivači na osnivačkoj skupštini imaju pravo glasa „srazmerno visini svog uloga", iako je reč o osnivačkoj fazi u kojoj osnivači nastupaju kao ugovorne strane koje su zaključile ugovor o osiguranju akcionarskog društva za osiguranje/reosiguranje, a ne kao akcionari društva koje treba da nastane i stekne subjektivitet tek nakon donošenja propisanih akata na ovoj skupštini i posledične registracije društva koje ima prirodu društva kapitala u kome akcionari sa akcijama s pravom glasa imaju pravo glasa srazmerno kapital učešću. U svakom slučaju, osnivači

[7] O ovim institutima adekvatnosti kapitala društva za osiguranje: ZO, čl. 124–130.

ovog društva kvalifikovanom većinom (2/3) glasova donose statut društva, biraju prvi nadzorni odbor društva, utvrđuju poslovnu politiku i poslovni plan društva, donose opšte akte društva i akte njegove poslovne politike i druge akte značajne za početak rada i poslovanja društva, utvrđuju najveći iznos troškova osnivanja kad ti troškovi padaju na teret društva, prihvataju procenu vrednosti nenovčanih uloga. Te usvojene akte osnivači dostavljaju NBS u propisanom roku i propisanom registru (Agencija za privredne registre – APR), radi registracije i sticanja pravnog subjektiviteta.[8]

III Organi akcionarskog društva za osiguranje/reosiguranje

3.1. Modeli upravljanja (uprave)[9]

3.1.1. Jednodomni model

Prvi sistem (tzv. jednodomni model – one-tier system) jeste originalno sistem anglosaksonskog prava, koji je usvojen i u znatnom broju zemalja kontinentalnog prava (Francuska, Švajcarska, Italija).[10] To je sistem u kome je funkcija upravljanja u rukama jednog ili više lica (Švajcarska, Engleska, SAD), odnosno odbora direktora – upravni odbor, koji bira skupština akcionara (upravni odbor – *board of directors*).[11] Po ovom sistemu, upravni odbor iz reda svojih članova (*executive directors*) ili delom iz reda onih što nisu članovi ili od lica stalno zaposlenih u društvu bira jednog ili više izvršnih direktora za operativno vođenje poslova društva.[12] Najčešće je sam predsednik odbora direktora (koga bira ovaj odbor) i predsednik društva i prvi izvršni direktor (*chairman-chief executive officer, president-directeur* général). Članovi upravnog odbora mogu biti, s raznim varijacijama, stalno zaposleni u društvu (*executive directors*) ili lica koja nisu zaposlena u društvu (*non executive directors*). Dakle, po ovom sistemu, funkcija upravnog odbora (odbora direktora) ostvaruje se delom na

[8] ZO, čl. 48–49.

[9] Više: Mirko Vasiljević, Tatjana Jevremović Petrović, Jelena Lepetić, *Kompanijsko pravo – pravo privrednih društava,* Službeni glasnik, Beograd, 2023, str. 537–542.

[10] Francuski *La loi sur les sociétés commerciales* (br. 66-537), čl. 89. (dalje: FTZ…), Švajcarski zakonik o obligacijama, čl. 89–117; (1911, 1936, 1984, dalje: ŠZO…), čl. 707–726. Pravno-teorijsku obradu instituta upravnog odbora vidi naročito: Pierre Gilles Gourlay, *Le conseil d' administration de la sociétés anonymes,* thèse, Paris, 1971.

[11] ŠZO ..., čl. 707, 712. i 714; FTZ..., čl. 89, 110. i 115; u Engleskoj akcionarska društva s javnim upisom akcija imaju bar dva direktora, a društva bez javnog upisa akcija imaju bar jednog direktora – John Charlesworth (ed. Geoffrey Morse), *Company Law,* London, 1995, str. 312–315.

[12] Vidi: Joseph Hamel, Gaston Lagarde, Alfred Jauffret, *Droit commercial,* Paris, 1980, str. 357–402; René Rodière, *Droit commercial*, Pariz 1980, str. 193–212; Maurice Cozian, Alain Viandier, *Droit des sociétés,* Paris, 1998, str. 235–272; Robert Pennington, *Company Law*, London 1995, str. 768–778; John Birds *et al.*, *Company Law,* London, 1995, str. 415–430; Paul L. Cannu, *La société anonyme à directoire*, Paris, 1979; Robert Hamilton, *The Law of Corporations,* Minnesota, 1991, str. 218–249.

kolegijalnoj osnovi (sednice, kolektivno zastupanja), a delom i na inokosnoj osnovi (izvršna funkcija predsednika, izvršna funkcija generalnog direktora, izvršna funkcija direktora, izvršni direktori). U tom sistemu *nadzorni odbor nije obavezan organ* u akcionarskom društvu (kontrolnu funkciju vrše spoljni nezavisni revizori, delom i interni revizori ili specijalni revizori).

Jednodomni model korporativnog upravljanja razvio se u sledećem okruženju: 1) dominacija disperzovanih akcionara – uglavnom fizičkih lica, 2) dobra zakonska i sudska zaštita akcionara, 3) ograničeno akcionarstvo banaka i drugih institucionalnih investitora, 4) postojanje pravila „jedna akcija jedan glas", 5) likvidno i razvijeno tržište kapitala, 6) veoma razvijeno neprijateljsko preuzimanje, 7) slaba moć sindikata, 8) slabo razvijena državna socijalna politika, 9) slab sistem socijalne demokratije i 10) razvijeno radničko akcionarstvo kroz poreske podsticaje.

Jednodomni model korporativnog upravljanja razvio se u uslovima tzv. *akcionarskog kapitalizma*. Taj model ranije je karakterisan kao menadžerski (profitno) orijentisan model, a sada se sve više označava kao akcionarski orijentisan model. Osnovne odlike tog modela su: 1) konkurencija u svim oblastima, 2) dominacija privatnog (interes akcionara) nad javnim u upravljanju, 3) potiskivanje uloge moćnih privatnih institucionalnih investitora i forsiranje javne emisije akcija kao glavnog izvora finansiranja, 4) uređivanje korporativnog upravljanja dispozitivnim normama, čime se podstiče tržište, 5) kompletno odvajanje upravljanja od vlasništva, te akcionari nemaju pravo da direktno upravljaju aktivnostima društva, već to u njihovo ime čini odbor direktora i menadžera, s fiducijarnom dužnošću prema kompaniji (dominiraju po pravilu otvorene kompanije), 6) izuzetno laka mogućnost za akcionare da pokreću sudske postupke protiv neposlovnih i štetnih odluka uprave društva, 7) motivisanje uprave preko ugovora koji naknadu za njih vezuje za uspeh kompanije, 8) razvijena javna kontrola kvaliteta upravljanja, pogotovo preko specijalizovanih medija i razvijenog tržišnog rejtinga menadžera, 9) razvijena sudska praksa s precedentima korporativnog upravljanja koji su svojevrsna lekcija za dobro upravljanje.

Ekonomska teorija kao ključne prednosti akcionarski orijentisanog kapitalizma navodi: 1) prednost kod započinjanja biznisa i uvođenja nove tehnologije, 2) podsticaj inicijativnosto, individualnosti i inovativnosti, 3) politička neutralnost, 4) podsticaj profesionalizaciji menadžera, 5) diverzifikacija rizika (javna emisija akcija – *IPO*), 6) relativno visoki prinosi od ulaganja u akcije. S druge strane, kao ključni nedostaci ovog sistema kapitalizma navode se: 1) maksimiranje rezultata na kratak rok zapostavlja strategiju na dugi rok, 2) cena akcija bazira se na kratkoročnoj strategiji, što onemogućuje strategiju istraživanja i razvoja, 3) slaba kontrola uprave od strane disperzovanih akcionara (*model jaki menadžeri slabi akcionari*), 4) relativno slabe akcionarske skupštine i relativno moćni upravni odbori, 5) vezivanje naknade upravi za uspeh kompanije (cena akcija) vodi zloupotrebama uprave kod „naduvavanja bilansa", 6) slaba zaštita drugih interesa u kompaniji (osim akcionarskih).

3.1.2. Dvodomni model

Drugi sistem (tzv. dvodomni model – two-tier system), sistem nemačkog prava, koji alternativno s prvim sistemom usvaja i novije francusko zakonodavstvo, sastoji se u tome što u akcionarskom društvu u principu (izuzetno u malim društvima funkciju upravnog odbora može vršiti i jedno lice) postoje dva odbora: upravni odbor u užem smislu (*Vorstand* – direktorijum) i nadzorni odbor (*Aufsichtsrat*).[13] Upravni odbor u užem smislu vrši svoje funkcije upravljanja i poslovođenja delom na kolektivnoj osnovi (donošenje odluka na sednicama, kolektivno zastupanje), a delom na individualnoj osnovi (individualno zastupanje, individualno izvršenje na sednicama donetih odluka).[14] Izuzetno u akcionarskim društvima s manjim kapitalom (zakonom propisanim) funkciju upravnog odbora može vršiti i jedno lice – jedini generalni direktor. U tom sistemu članove nadzornog odbora bira (i razrešava) skupština, a nadzorni odbor bira (i razrešava) članove upravnog odbora. Taj sistem usvaja i Hrvatska.[15] Naravno, i u tom sistemu kontrolnu funkciju pored nadzornog odbora vrši i spoljni nezavisni revizor, a može i unutrašnji revizor i ponekad specijalni revizor.

Dvodomni model uprave razvio se u sledećem okruženju: 1) dominacija banaka kao akcionara u upravljanju kompanijama kao akcionara ili kroz sistem punomoćja, ili pak ugovora o vršenju glasačkih prava, 2) spoj uloge poverioca, značajnog akcionara i kontrolora preko vršenja glasačkih prava, 3) koncentrisano akcionarstvo, 4) zakonsko saodlučivanje (kohezija rada i kapitala), 5) retko zasedanje nadzornog odbora da bi se umanjila uloga zaposlenih u saodlučivanju i da se ne bi pokretala odgovornost uprave za štetne odluke i time i odgovornost samog nadzornog odbora zbog propusta u nadzoru, 6) relativno nerazvijeno tržište kapitala, 7) relativno nerazvijeno neprijateljsko preuzimanje, 8) relativno zanemarljiva uloga malih akcionara, 9) jaki sindikati i 10) razvijena socijalna politika i socijalna demokratija.

Dvodomni model uprave u Nemačkoj razvio se u uslovima *tzv. radnički orijentisanog modela kapitalizma (model socijalne demokratije)*. Osnovne odlike tog modela su: 1) nedovoljno izražena odvojenost vlasništva od upravljanja u uslovima koncentrisanog akcionarstva (po pravilu dominiraju zatvorena društva), 2) uprava je oslobođena od uspeha na kratak rok i po pravilu dominira dugoročna strategija, 3) razvijenost socijalne demokratije (distributivna pravda) i saodlučivanja vrši pritisak na menadžere da pored interesa akcionara uvažavaju i druge interese (*društvena odgovornost kompanija*), 4) politička determinisanost modela, 5) kvalitet uprave ne zavisi toliko od tržišta koliko od procene uspešnosti od strane glavnih akcionara (po pravilu banke), 6) koncentrisano akcionarstvo i slaba disperzija slabi prava akcionara, ali uvećava sigurnost radnih mesta (socijalna sigurnost), 7) razvijena diskreciona

[13] Nemački Aktiengesellschaft (1965…, dalje: NDZ), čl. 76-117; FTZ ... , čl. 118-150.
[14] Tako: J. Hamel, G. Lagarde *et. al*., str. 420. Detaljnije o direktorijumu: P. Le Cannu, str. 33–122.
[15] Hrvatski Zakon o izmenama i dopunama Zakona o trgovačkim društvima (HTZ: 1993, 2003), čl. 244.

moć kontrolnog akcionara, 8) slaba zaštita manjinskih akcionara i nerazvijena praksa akcionarskih tužbi (derivativne tužbe).

Ekonomska teorija kao ključne slabosti tog modela kapitalizma (izvorno pripada Nemačkoj, ali i Japan ima u osnovi njegove odlike, sa određenim specifičnostima) navodi: 1) nedovoljno razvijena konkurencija i tržište (pogotovo tržište kapitala zbog ograničenja u transferu akcija i tržište rada zbog socijalne demokratije), 2) netransparentno upravljanje i potencijalni sukob interesa dominantnog akcionara i dužnosti njegove lojalnosti prema kompaniji, 3) slaba zaštita interesa malih akcionara (često visoki kapital cenzusi za korišćenje prava manjinskih akcionara), 4) potencijalni sukob interesa akcionara i uprave (slabo korišćenje modela učešća uprave u vlasništvu), zbog dužnosti uprave da u uslovima socijalne demokratije i saodlučivanja radi posebno i u interesu zaposlenih, 5) heterogenost interesa predstavnika kapitala u upravi i predstavnika zaposlenih te potencijalna nekvalitetnost odluka uprave, pogotovo sa stanovišta konkurentnosti (stalne tenzije između interesa kapitala i interesa rada).

Prednosti uloge banaka, s druge strane, kao ključnih akcionara (u nemačko-japanskom modelu uprave) u osnovi su sledeće: 1) cena kredita u principu je jevtinija u odnosu na cenu u SAD, gde se odnosi banke i kompanije postavljaju na tržišnu osnovu, 2) sukob interesa kredita i kapitala se lakše rešava, 3) u odnosu na male disperzovane akcionare, banke kao poverioci ili kao akcionari u principu uživaju bolju sudsku zaštitu. S druge strane, slabosti uloge banaka, kao ključnih akcionara (u nemačko-japanskom modelu) su sledeće: 1) zbog bliskih odnosa s kompanijama (značajni akcionari), banke često daju subvencije ili niže kamate na kredite, uz višu cenu za bankarske usluge, 2) kad nema ograničenja na plasmane, akcije banke mogu se preinvestirati u akcije umesto u kreditni kapital, 3) dugogodišnje vlasništvo u kompanijama vodi zbližavanju sa upravom i gubitku profesionalnog odnosa.

3.1.3. Japanski jednodomni model – mešavina anglosaksonskog i nemačkog

Japanski model uprave u osnovi je jednodomni, ali i kao takav ipak ima odlike američko-britanskog jednodomnog i nemačkog dvodomnog modela: 1) velika uloga banaka kao kontrolnih akcionara i monitora, 2) zanemarljiva uloga ostalih malih akcionara, 3) neograničeno ukršteno akcionarstvo, *cross-shareholding*, 4) slabo razvijeno neprijateljsko preuzimanje, 5) sistem doživotnog zaposlenja – humani kapitalizam, 6) unutrašnje-zatvoreno tržište izbora zaposlenih i menadžera, 7) kontinuirane konsultacije zaposlenih i menadžera, 8) razvijeni korporativni sindikalizam a ne nacionalni, 9) umesto nadzornog odbora, uloga nadzora jedino je spoljna od strane revizora i 10) upravni odbor (odbor direktora), koji je redovno veoma brojan (po pravilu bez spoljnih – nezavisnih članova), radi u interesu kompanije i ne trpi pritisak akcionara.

Japanski model uprave razvio se u osnovi u istom okruženju kao i nemački model uprave, sa određenim specifičnostima koje se odnose na smanjenu ulogu nacionalnih sindikata (time i saodlučivanja), ali i pojačanu ulogu tradicije i kulture (humani kapitalizam) i države. Otuda se japanski model kapitalizma označava kao *državno orijentisani model* (izvesno vreme ovaj model je pokušavala da primenjuje i Francuska).

3.1.4. Mešoviti model – sloboda izbora modela

Najzad, *treći sistem*, koji usvaja Statut Evropske kompanije, prema kom u akcionarskom društvu može postojati (*sistem slobode izbora*) ili *tzv. jednostepeni (jednodomni) model* – izvršni (upravni) odbor direktora koji bira skupština akcionara ili *tzv. dvostepeni (dvodomni) model* – upravni odbor i nadzorni odbor, gde nadzorni odbor bira skupština, a on zatim bira upravni odbor (ostavljena je ipak mogućnost da države članice predvide da ga bira takođe i skupština).[16] Taj sistem je u osnovi *mešavina prvog i drugog modela* i prihvaćen je u Francuskoj (alternativno s jednodomnim modelom), u varijanti izbora oba organa od skupštine akcionara (uz mogućnost da se i razdvoje funkcije predsednika upravnog odbora i generalnog direktora, kada se želi razdvajanje menadžmenta i njegova jača kontrola preko upravnog odbora, kada se govori uslovno o *tzv. trećem modelu uprave* u Francuskoj), Srbiji, Crnoj Gori, Makedoniji, Sloveniji.[17] Za sistem slobodne opcije akcionarskog društva između tzv. jednodomnog sistema i dvodomnog sistema organizacije organa uprave u akcionarskim društvima zalaže se i *The High level group of company law experts on a modern regulatory framework for company law in Europe*.[18]

3.1.5. Zakon o osiguranju – dvodomni model uprave

Prirodu modela upravljanja akcionarskim društvom ne određuje postojanje skupštine društva kao obaveznog organa u svakom ovom društvu, pa ni u jednočlanom društvu. Razlog je prirodan i logičan – skupštinu čine akcionari društva koji imaju vlasnička prava koja proizlaze iz vrste posedovanih akcija. Prirodu modela upravljanja ovim društvom određuje zakonsko određenje postojanja drugih obaveznih organa.

[16] Statut Evropske kompanije, *Council regulation (EC),* No. 2157/2001, čl. 38-51.

[17] FTZ..., čl. 90. i 120. U literaturi se navodi da je, za razliku od klasičnog sistema sa upravnim odborom, novi sistem s nadzornim odborom i direktorijumom u Francuskoj nepopularan budući da je dvadesetak godina od uvođenja prihvaćen samo u oko 2,61% društava kapitala – vidi: M. Cozian, A. Viandier, str. 291; srpski ZOPD, čl. 198 (društvo s ograničenom odgovornošću), čl. 326, 383, 417 (akcionarsko društvo); slovenački Zakon o gospodarskih družbah (STZ: *Uradni list RS*, br. 30-1298/93 i 45-2548/2001), čl. 250; makedonski Zakonot za trgovskite društva (2002. dalje: MTZ...), čl. 301.

[18] Vidi: *Report of the High Level Group on Company Law Experts on a Modern Regulatory Framework for Company Law in Europe*, Brisel, 2004.

Kako srpski zakon koji uređuje osiguranje određuje da su, pored skupštine, obavezni organi ovog društva nadzorni odbor (koji bira skupština) i izvršni odbor (koji bira nadzorni odbor), to sledi nedvosmislen zaključak da je obavezni model organizacije upravljanja ovim društvom dvodomni model – postoje dakle dva kolektivna organa: nadzorni odbor i izvršni odbor, koje zakon skupno označava jedinstvenim imenom – uprava društva. Dakle, *ex lege*, akcionarska društva za osiguranje moraju imati dvodomni model uprave, bez mogućnosti izbora jednodomnog modela uprave ili mogućnosti opcije između jednodomnog i dvodomnog modela upravljanja društvom. U svakom slučaju, kod uređenja organa ovog društva za osiguranje/reosiguranje srpski zakon ponavlja opštu normu iz opšteg dela zakona da se na ova društva, ako nema posebnih pravila u ovom posebnom zakonu, primenjuju pravila koja uređuju privredna društva (opšta koja važe za sve forme privrednih društava i posebna koja se odnose na istu formu organizovanja društva), što dakle važi i za organe društva (što bi inače važilo i da ova norma nije ponovljena kod organa društva jer je sadržana u opštem delu zakona koji uređuje osiguranje).[19]

Suštinski, dakle, dvodomni model uprave razlikuje se od jednodomnog modela uprave po postojanju drugog organa s nadzornim funkcijama u društvu (nadzor nad radom izvršnih direktora i nadzor nad sprovođenjem usvojene poslovne strategije društva) – nadzorni odbor, čiju funkciju u jednodomnom modelu uprave treba da, bar delom, obavljaju neizvršni direktori i nezavisni direktori (kod javnih akcionarskih društava). Jednodomni model je model koji je karakterističan za anglosaksonske zemlje i zemlje koje svoju regulativu modeliraju po ugledu na ove zemlje, dok je model dvodomnog upravljanja akcionarskim društvom karakterističan za germanske zemlje i zemlje koje svoje zakonodavstvo donose po ugledu na regulativu ovih zemalja.

Sve reforme korporativnog upravljanja jednodomnog modela pokazale su u suštini njegovu slabost i ranjivost. Otuda se dvodomni model pokazao stabilnim i otpornijim na izazove ekonomskih kriza. To je u velikoj meri zasluga postojanja drugog kolektivnog organa u ovom modelu upravljanja društvom – nadzornog odbora kao organa društva, uz neke ostale institute reformisanog jednodomnog modela upravljanja, jer je reč o organu koji nadzire rad „izvršne sfere vlasti u društvu" i ima brojna nadzorna ovlašćenja izdvojena iz nadležnosti izvršnog odbora (odnosno odbora direktora kod jednodomnog modela uprave), te je tako u mogućnosti da vrši stvarni nadzor nad tom sferom i nadzor koji je vitalniji, pravovremeniji i koji na vreme akcionarima daje signalne lampice za pretresanje rada izvršnih direktora i izvršnog odbora, što u jednodomnom modelu uprave ipak, iz mnogih razloga, ne mogu efikasno da čine neizvršni i nezavisni direktori (ili delom i skupština).

[19] ZO, čl. 18. i 50.

IV Organi akcionarskog društva za osiguranje/reosiguranje[20]

4.1. Skupština – posebna pravila

Skupština akcionarskog društva za osiguranje u osnovi je uređena na identičan način kao i skupština akcionarskog društva koje funkcioniše primenom zakona koji uređuje privredna društva. Otuda se i na skupštinu tog društva primenjuju sledeća pravila ovog zakona: sastav skupštine i prava akcionara, sazivači, poziv za sednicu (klasični, elektronski, internet objava), vrste sednice (redovne, vanredne i posebne za klasu akcionara s preferencijalnim akcijama), mesto održavanja skupštine, dan akcionara, predsednik skupštine, poslovnik, dnevni red (pravo predlaganja i utvrđivanja, pravo manjinskih akcionara na dopunu, dopuna po nalogu suda kad se ne prihvati zahtev manjinskih akcionara za dopunu), održavanje sednice po nalogu suda (kad se ne prihvati njeno održavanje po zahtevu manjinskih akcionara), način održavanja (fizička i nefizička sednica), pravo postavljanja pitanja i obaveza davanja odgovora (davanje odgovora po nalogu suda), glasanje (direktno, glasanje u odsustvu, učešće u radu skupštine elektronskim putem ili preko punomoćnika – punomoćje za glasanje, ko može biti punomoćnik, punomoćje za više akcionara, posebna pravila za punomoćnika koje predlaže društvo, posebna pravila za banke koje vode zbirne ili kastodi račune, izmena i opoziv punomoćja za glasanje), pristupanje na sednicu, sednice – kvorum za prvu i ponovljenu sednicu sa istim dnevnim redom, komisija za glasanje, većina za odlučivanje – obična, apsolutna i kvalifikovana, rezultat glasanja, način glasanja – javno ili tajno, pravo glasa na osnovu založenih akcija, glasanje posebnih klasa akcija, ugovori o glasanju, isključenje prava glasa i sukob interesa, zapisnik, izjava o primeni kodeksa korporativnog upravljanja, materijali za sednicu, objava godišnjih izveštaja o poslovanju društva, usvajanje finansijskih i drugih izveštaja, ništavost i pobijanje odluka (pravo na pobijanje, posledice tužbe za pobijanje, postupak po pobojnoj tužbi (*actio Pauliana*), posledice odluke suda kojom se poništava odluka, posebno pravilo za pobijanje odluke o usvajanju godišnjih finansijskih izveštaja, pravilo kada odluka neće biti poništena).[21]

Posebna pravila zakona koji uređuje osiguranje kad je reč o institutu skupštine akcionarskog društva za osiguranje/reosiguranje u osnovi su vezana za činjenicu posebne nadzorne uloge NBS u odnosu na osiguravajuće organizacije: obaveza obaveštavanja NBS o sednici i mogućnost prisustvovanja njenog predstavnika sednici, mogućnost NBS da zahteva da se određena pitanja uvrste u dnevni red skupštine. Van toga postoji posebno pravilo o pravu akcionara koji poseduje najmanje 1% kapital učešća s pravom glasa da neposredno ostvaruje pravo glasa i isključenje mogućnosti isključenja tog prava statutom društva (kod društava koja su

[20] Vid. N. Petrović Tomić (2019), str. 203–212.
[21] ZOPD, čl. 377–381.

u režimu zakona koji uređuje privredna društva postoji autonomno pravo društva da na osnovu zakona svojim statutom dâ takvo pravo ličnog učešća u radu skupštine akcionaru koji poseduje 0,1% „ukupnog broja akcija odgovarajuće klase").[22] Konačno, zakon koji uređuje osiguranje reguliše posebnom odredbom i delokrug, manje više po istom principu kao i zakon koji reguliše privredna društva (uz izričitu normu zabrane delegiranja zakonske nadležnosti na druge organe društva), kao i sednice skupštine (u kontekstu odnosa sa NBS).

4.2. Nadzorni odbor – posebna pravila

Po istom maniru po kom uređuje skupštinu akcionarskog društva za osiguranje/reosiguranje (kao i izvršni odbor), zakon koji reguliše osiguranje uređuje i nadzorni odbor ovog društva. Dakle, sumarno i sa samo nekoliko odredaba kojima daje prirodu posebnih i koje se primenjuju pre opštih normi koje se odnose na ovaj organ u dvodomnom modelu uprave koji je prihvaćen u društvima za osiguranje/reosiguranje, a koje su sadržane u zakonu koji uređuje privredna društva. Najpre, zakon koji reguliše osiguranje normira minimalni broj članova tog organa (maksimalni utvrđuje statut društva) – tri člana (uključujući i predsednika) i, što je naročito važno, propisuje da *„najmanje jednu trećinu" njegovih članova čine nezavisni članovi* u smislu zakona koji uređuje privredna društva (kod društava kod kojih se primenjuje ovaj zakon inače postoji obaveza postojanja najmanje jednog nezavisnog člana, i to samo kod javnih – otvorenih akcionarskih društava), dok ostali članovi ovog organa moraju biti *neizvršni članovi* (nisu zaposleni u tom društvu čiji je nadzorni odbor u pitanju – reč je o bilo kojoj formi ugovora o radu jer zakon ne insistira samo na ugovoru o radu s punim radnim vremenom). Zatim, zakon koji reguliše osiguranje uređuje posebnom normom i delokrug (nadležnost) nadzornog odbora, koja je u osnovi istovetna delokrugu nadzornog odbora akcionarskih društava s dvodomnim upravljanjem a na koje se primenjuje zakon koji uređuje privredna društva, dok je smisao posebne norme u specifičnosti nekih poslova iz delokruga ovog organa koji proizlaze iz posebnosti delatnosti osiguranja (imenovanje i razrešenje ovlašćenog aktuara, uspostava sistema interne kontrole i utvrđivanje strategija za upravljanje rizicima, usvajanje plana interne revizije i slično) i posebno nadzorne funkcije NBS u odnosu na osiguravajuća društva (obaveštavanje o utvrđenim nepravilnostima u radu društva, razmatranje nalaza NBS u postupku nadzora nad obavljanjem delatnosti osiguranja i slično), što ne postoji kod društava za koje važi zakon koji uređuje privredna društva.[23] Najzad, kao posebnu normu zakon koji reguliše osiguranje sadrži

[22] ZO, čl. 51, st. 3; ZOPD, čl. 328, st. 3.

[23] Upor. ZOPD, čl. 441; ZO, čl. 55. Poslovi iz nadležnosti nadzornog odbora: 1) ne mogu se preneti na izvršne direktore društva (ovaj model „uprave" nema neizvršne direktore); 2) mogu se preneti u nadležnost skupštine društva samo odlukom nadzornog odbora (delegacija nadležnosti), ako statutom nije

i pitanje sednica nadzornog odbora, naročito sa stanovišta potrebe komunikacije sa NBS (najmanje jedna sednica u tri meseca, obaveza obaveštavanja NBS o zakazivanju sednice radi mogućeg prisustva njenog predstavnika i eventualno obraćanja članovima nadzornog odbora, mogućnost zahtevanja od strane NBS održavanja sednice ovog organa, obaveznost godišnjeg podnošenja izveštaja o radu nadzornog odbora NBS koji uključuje i broj održanih sednica).

Van pitanja koja uređuje zakon koji reguliše osiguranje u vezi s nadzornim odborom (minimalni broj članova, nezavisni članovi, delokrug, sednice) s primenom režima ovog zakona kao posebnog režima, sva ostala pitanja u vezi s ovim organom detaljno se uređuju zakonom koji reguliše privredna društva. U ta pitanja spadaju i instituti koje taj zakon reguliše jedinstveno i za nadzorni i za izvršni odbor („uprava društva"), poput: prethodne saglasnosti NBS za obavljanje funkcije člana uprave ili odbijanja davanja te saglasnosti i oduzimanja date saglasnosti, uslova za obavljanje funkcija člana uprave, obaveštavanja skupštine društva o „prihodima člana uprave", obaveza i odgovornosti člana uprave. Pitanja pak koja su u vezi s tim organom a koja ne reguliše zakon koji uređuje osiguranje, nisu otvorena jer se na njih voljom ovog zakona direktno „primenjuje" (ne shodno) zakon koji reguliše privredna društva.

U smislu rečenog, dakle, na nadzorni odbor akcionarskog društva za osiguranje/reosiguranje „primenjuju se" (direktno, ne shodno)[24] sledeći instituti koje uređuje zakon koji reguliše privredna društva u vezi s ovim organom kod dvodomnog upravljanja društvom: uslovi i ograničenja članstva u nadzornom odboru (osuđivanost za određena krivična dela dok traju pravne posledice osude, izrečena određena mera bezbednosti dok traje ta mera, član izvršnog odbora ili nadzornog odbora u više od pet društava, lice koje je zaposleno u tom društvu – zabrana ne važi za lice zaposleno u povezanom društvu – tzv. neizvršni članovi, koji moraju ispunjavati ovaj uslov nezavisnosti ali ne i druge uslove koji se traže za nezavisnog člana);[25] sastav (ne mogu biti izvršni direktori društva niti prokuristi – ovo je posledica potrebe nezavisnosti članova ovog organa u odnosu na lica čiji rad nadziru, što im je jedna od važnih nadležnosti – razdvajanje izvršnih tj. poslovodnih i zastupničkih funkcija i nadzornih funkcija – izvršni direktori su i zastupnici društva, a i prokuristi zastupaju društvo i imaju u tom smislu odgovarajuća ovlašćenja, zavisno od vrste prokure, te se *nadziranje izvršnih direktora odnosi i na prokuriste*; mogu biti *kako fizička tako i pravna lica* – preko zastupnika pravnog lica; članovi nadzornog odbora *ne mogu imati zamenike* – naglašeno lično svojstvo člana i individualizacija odgovornosti; mogu biti domaća i strana lica; članovi odbora upisuju se u registar, obavezan je

drugačije određeno (isključenost prenosa, limitiranje pitanja za koje je dozvoljena delegacija, saglasnost i skupštine društva na delegaciju i slično). Upravo tu delagaciju nadležnosti zakon ima u vidu kada govori o nadležnosti skupštine akcionarskog društva predviđanjem odlučivanja o „drugim pitanjima koja su u skladu s ovim zakonom stavljena na dnevni red sednice skupštine".

[24] ZO, čl. 50, st. 2.

[25] ZOPD, čl. 432 u vezi sa čl. 382 i 391.

neparan broj),[26] imenovanje (predlog kandidata – postojeći nadzorni odbor, komisija za imenovanje ako postoji, akcionari koji imaju pravo predlaganja dnevnog reda – akcionari sa najmanje 5% akcija s pravom glasa),[27] mandat (pretpostavljeni maksimalni četiri godine a statutom ili odlukom skupštine može se odrediti i kraći, postoji mogućnost reimenovanja bez ograničenja broja puta),[28] postoji mogućnost kooptacije nedostajućih članova od strane samog odbora (najviše do dva člana);[29] postojanje nezavisnih članova (najmanje 1/3) uz ispunjavanje propisanih uslova nezavisnosti: 1) u odnosu na društvo u kome je član nadzornog odbora, 2) u odnosu na izvršne direktore tog društva i 3) u odnosu na povezana lica s tim društvom i tim direktorima[30] (radnopravne, svojinske-kapitalske, imovinske, funkcijske);[31] naknada za rad članova (način utvrđivanja predloga i donošenja odluka, fiksna i varijabilna – s tim da ne može biti određena kao učešće u dobiti društva, utvrđivanje politike naknada, izveštaj o naknadama – transparentnost, glasanje o politici naknada i o izveštaju o naknadama);[32] prestanak mandata pre isteka vremena imenovanja i razrešenje (prestanak ispunjavanja uslova, neusvajanje godišnjih finansijskih izveštaja društva na redovnoj skupštini, mogućnost razrešenja i bez navođenja razloga);[33] ostavka (mogućnost podnošenja ostalim članovima organa u svako doba, dejstvo od trenutka podnošenja – osim ako je u njoj označen neki kasniji datum, upis u registar);[34] obaveza izveštavanja skupštine (o računovodstvenoj praksi i praksi finansijskog izveštavanja, usklađenosti poslovanja sa zakonom i drugim propisima, kvalifikovanosti i nezavisnosti revizora u odnosu na društvo, ugovorima zaključenim između društva i članova ovog organa i povezanim licima);[35] predsednik odbora (izbor od strane odbora, nadležnost, mogućnost razrešenja u svako doba i bez navođenja razloga, u slučaju odsutnosti mogućnost zakazivanja sednice od strane bilo kog člana, upis u registar);[36] način rada odbora (uređivanje statutom i poslovnikom o radu koji donosi odbor) i sednice odbora (sazivanje i rok sazivanja, kvorum za održavanje i način održavanja, prisustvo drugih lica sednici, odlučivanje i većina za donošenje odluka, mogućnost odlučujućeg glasa predsednika kod jednake podele glasova, zapisnik sa sednice i njegovo dostavljanje članovima odbora);[37] komisije odbora – *komisije nadzornog odbora u svakom slučaju nisu organi društva već su radna tela* nadzornog

[26] ZOPD, čl. 433.
[27] ZOPD, čl. 434 u vezi sa čl. 337.
[28] ZOPD, čl. 435 u vezi sa čl. 385.
[29] ZOPD, čl. 436 u vezi sa čl. 386.
[30] ZOPD, čl. 391–392.
[31] ZOPD, čl. 437 u vezi sa čl. 392.
[32] ZOPD, čl. 438 u vezi sa čl. 393 i 463a-463v; ZO, čl. 60.
[33] ZOPD, čl. 439 u vezi sa čl. 394 i 395.
[34] ZOPD, čl. 440.
[35] ZOPd, čl. 442 u vezi sa čl. 399.
[36] ZOPD, čl. 443 u vezi sa čl. 400.
[37] ZOPD, čl. 445 u vezi sa čl. 402–407.

odbora koja se obrazuju njegovom odlukom i *ne mogu odlučivati o pitanjima iz nadležnosti nadzornog odbora* (obaveznost komisije za reviziju i mogućnost komisije za imenovanja, komisije za naknade i drugih komisija odbora – ako se ove fakultativne komisije ne obrazuju, njihovu nadležnost vrši nadzorni odbor, sastav komisija – u komisiji za reviziju obavezno jedan nezavisni član odbora i koji je predsednik komisije te takođe jedan ovlašćeni revizor, nadležnost komisija odbora, način rada komisija i donošenje odluka većinom glasova uz odlučujući glas predsednika komisije u slučaju jednake podele glasova);[38] odgovornost članova odbora za štetu društvu za svoje odluke (odgovornost članova koji su glasali za odluku, istovetna odgovornost članova koji su glasali uzdržano, istovetna odgovornost odsutnih članova ili članova koji nisu glasali za odluku ako se u određenom roku od njenog donošenja ne usprotive toj odluci, zastarelost zahteva društva za naknadu štete, mogućnost i nemogućnost odricanja društva od zahteva za naknadu štete društvu).[39]

Dodatno, Zakon o privrednim društvima propisuje *shodnu primenu niza instituta jednodomnog upravljanja* akcionarskim društvom vezanih za direktore, odnosno odbor direktora, i za nadzorni odbor akcionarskog društva kod dvodomnog upravljanja, što po istoj logici posebnog zakona važi i za nadzorni odbor akcionarskog društva za osiguranje. To naročito čini i kad je reč o odgovornosti (imovinskoj u ovom slučaju, a isto je to učinio i kod statusne odgovornosti – razrešenje)[40] direktora jednodomnog modela upravljanja (shodna primena na članove nadzornog odbora dovodomnog modela upravljanja akcionarskog društva).

Imovinska odgovornost direktora akcionarskog društva proizlazi iz vršenja poslova iz nadležnosti direktora i odbora direktora. Takođe, i imovinska odgovornost članova nadzornog odbora mora da proizlazi iz vršenja poslova iz nadležnosti ovog organa, a ne kao posledica propusta u vršenju nadležnosti izvršnih direktora i izvršnog odbora dvodomnog modela uprave (čija je odgovornost takođe uređena shodno odgovornosti direktora i članova odbora direktora jednodomnog modela upravljanja).[41]

Članovi nadzornog odbora su, kao i direktori (zastupnici i prokuristi i specifično za potrebe likvidacije društva likvidacioni upravnik), takođe *lica sa zakonom propisanim dužnostima prema društvu*, pa i posebne dužnosti pažnje (pažnje dobrog privrednika i/ili prema okolnostima slučaja i pažnje dobrog stručnjaka), zbog čije povrede, u skladu sa zakonom, mogu odgovarati za štetu društvu po osnovu tužbe društva ili akcionara s propisanim kapital cenzusom za derivativnu tužbu za društvo (i/ili akcionarima društva – individualna ili kolektivna tužba). Odgovornost članova nadzornog odbora i u smislu shodne primene pravila o odgovornosti direktora (jednodomnog ili dvodomnog modela upravljanja) na odgovornost članova nadzornog

[38] ZOPD, čl. 408–414.
[39] ZOPD, čl. 447 u vezi sa čl. 415.
[40] ZOPD, čl. 439.
[41] ZOPD, čl. 427 i čl. 430, u vezi sa čl. 415.

odbora može se zasnivati samo na povredi propisane dužnosti pažnje i s tim u vezi nepostupanja „u najboljem interesu društva" pri izvršavanju poslova iz svoje nadležnosti, a koji obuhvataju i „nadzor nad radom izvršnih direktora," kao i brojne druge dužnosti iz sfere nadležnosti ovog organa utvrđene zakonom, statutom i odlukama skupštine društva. Uvek je dakle reč o odgovornosti za prouzrokovanu štetu društvu (i/ili akcionarima društva) *svojim radnjama ili neradnjama*, što uključuje i povredu dužne pažnje *u vršenju i ovog nadzora – odgovornost za svoju „krivicu"* (a ne za same nezakonite i/ili štetne odluke drugih organa društva). Upravo zbog prirode svoje funkcije i svojih nadležnosti članovi nadzornog odbora često su u poziciji da mogu skupštini društva skrenuti pažnju na neku odluku izvršnih direktora ili izvršnog odbora (koji čine izvršni direktori) kojom se može prouzrokovati šteta privrednom društvu (i/ili akcionarima), te u slučaju kada to ne učine i kada postoji povreda propisane dužnosti pažnje, oni takođe odgovaraju za štetu nastalu iz izvršenja takve odluke (*delimična odgovornost za „tuđu krivicu"*). Pri tome, potrebno je odrediti koliki je deo štete u uzročnoj vezi s krivicom drugog organa, a koliki deo u uzročnoj vezi s povredom dužne pažnje članova nadzornog odbora.

Shodna primena pravila imovinske odgovornosti direktora i članova odbora direktora jednodomnog modela upravljanja i na imovinsku odgovornost članova nadzornog odbora i izvršne direktore (pojedinačno ili kao članove izvršnog odbora i odluke izvršnog odbora) dvodomnog modela upravljanja akcionarskog društva, javnog ili nejavnog, obuhvata isti princip odgovornosti, postojanje istih pretpostavki, aktivno legitimisana lica za pokretanje postupka i podnošenje tužbe, pasivno legitimisana lica, odgovornost članova koji su glasali za odluku i članova koji nisu prisustvovali sednici, ali se u zakonom propisanom roku nisu pismenim putem usprotivili odluci, odgovornost članova koji su glasali uzdržano, zastarelost, mogućnost oslobođenja od odgovornosti odgovarajućom odlukom skupštine društva, solidarnu odgovornost prema društvu i/ili akcionarima uz mogućnost regresa – specifičnost u pogledu kruga subjekata solidarne odgovornosti u odnosu na odgovornost direktora jednodomnog modela upravljanja zbog postojanja upravo nadzornog odbora kod dvodomnog modela upravljanja). Isto važi i za odgovornost prema trećim licima, pored odgovornosti društva kao pravnog lica, po osnovu prihvatanja u kompanijskom pravu i direktne odgovornosti članova organa društva (specifičan „proboj pravne ličnosti").[42]

4.3. Izvršni odbor – posebna pravila

Zakon o osiguranju reguliše samo minimum statusnih pitanja vezanih za izvršni odbor akcionarskog društva za osiguranje/reosiguranje, kod pitanja koja smatra da treba da odstupaju kao posebna pravila od primene i na ovaj organ

[42] Vid. ŠZO, art. 754–761; vid. i: Genevieve Viney, *La responsabilité civile*, Paris, 1982, str. 555; Ph. Merle, A. Fauchon, str. 494–495; M. Cozian, A. Viandier, F. Deboissy, str. 286.

u ostalom delu zakona koji uređuje privredna društva. Prvo, sastav: sastoji se od najmanje dva člana a maksimalan broj utvrđuje se statutom društva (uključujući i predsednika izvršnog odbora koji po samom zakonu predstavlja i zastupa društvo, koji je u svakom slučaju dužan da pri zastupanju obezbedi supotpis još jednog člana ovog organa). Akcionarska društva na koja se primenjuje zakon koji uređuje privredna društva imaju obavezni izvršni odbor od najmanje tri člana (maksimalan broj utvrđuju statutom) ako su javna (otvorena) društva i ako imaju tri ili više izvršnih direktora kod dvodomnog upravljanja društvom, a ako imaju jednog ili dva izvršna direktora, nemaju izvršni odbor. *Supotpis (zajedničko zastupanje)* kod tih društava nije obavezan, a može se utvrditi statutom, kada se upisuje u registar i ima dejstvo prema trećim licima (ovakvo dejstvo važi i za akcionarsko društvo za osiguranje jer nema posebne norme u zakonu koji reguliše osiguranje).[43] Zajedničko je zakonsko rešenje i za to društvo kad se primenjuje zakon koji uređuje privredna društva ili zakon koji uređuje osiguranje da član izvršnog odbora (ili izvršni direktori) ne može imati zamenika *(priroda ličnog karaktera statusa)*, kao i rešenje da nadzorni odbor imenuje izvršni odbor društva (ili izvršne direktore – *dvodomni model nema neizvršne direktore i nema nezavisnog direktora u izvršnom odboru*) i obaveza upisa članova ovog odbora u registar (kao i prestanka mandata i ostavke). Takođe, i delokrug (nadležnost), s logičnim specifičnostima koje proizlaze iz posebnosti delatnosti osiguranja, izvršnog odbora (uključujući i delokrug izvršnih direktora) u oba zakona regulisana je u osnovi na istovetan način.[44]

Opšte norme zakona koji uređuje privredna društva koje se odnose na izvršne direktore, odnosno izvršni odbor, kad ne postoji posebno pravilo koje postavlja zakon koji uređuje osiguranje, primenjuju se i na izvršni odbor akcionarskog društva za osiguranje/reosiguranje. To važi za sledeće institute zakona koji uređuje privredna društva: smetnje (zabrane) za imenovanje članova izvršnog odbora koje nisu pokrivene smetnjama koje propisuje zakon koji uređuje osiguranje (osuđivanost za propisana krivična dela dok traju pravne posledice osude, izrečena mera bezbednosti zabrane obavljanja delatnosti dok traje ta mera, višestruko članstvo u nadzornom ili izvršnom odboru drugih društava – preko pet);[45] predlog za imenovanje (komisija nadzornog odbora za imenovanje ako postoji, a ako ne postoji, svaki član nadzornog odbora)[46] – a po našem mišljenju, to bi moglo i drugo lice utvrđeno statutom društva (npr. svaki akcionar ili akcionar s određenim procentnom kapital učešća); mandat direktora (analogno mandatu člana nadzornog odbora – pretpostavljeni najduži zakonski ili kraći statutarni, mogućnost reimenovanja);[47] nadležnost izvršnog odbora i nadležnost

[43] ZOPD, čl. 419-420 i 33; ZO, član 57.
[44] ZOPD, čl. 422 i 427; ZO, čl. 58.
[45] ZOPD, čl.418 u vezi sa čl. 382.
[46] ZOPD, čl. 420.
[47] ZOPD, čl. 421 u vezi sa čl. 385.

izvršnih direktora kao članova odbora (ukoliko eventualno postoji neko pitanje koje nije uređeno u zakonu koji reguliše osiguranje kao nadležnost izvršnog odbora, a uređeno je zakonom koji reguliše privredna društva – npr. neke nadležnosti izvršnog odbora za poslove za koje je potrebna saglasnost nadzornog odbora)[48] – zakon koji uređuje osiguranje pak uvodi *pretpostavku nadležnosti izvršnog odbora* (odlučuje o svim pitanjima o kojima ne odlučuje po zakonu i eventualno statutu društva skupština i nadzorni odbor), a s druge strane zakon koji uređuje privredna društva cementira pravilo koje važi i za osiguravajuća akcionarska društva da se „pitanja iz nadležnosti izvršnog odbora ne mogu preneti na nadzorni odbor":[49] način rada izvršnog odbora (u vođenju poslova društva izvršni odbor postupa samostalno i po pravilu odlučuje i postupa van sednica, a ako ne postoji saglasnost izvršnih direktora kao članova, predsednik izvršnog odbora „može sazvati sednicu" radi donošenja odluke većinom glasova, a u slučaju jednake podele glasova glas predsednika odbora je odlučujući – to je i razlog što zakon koji uređuje osiguranje ne reguliše posebnom normom sednice ovog organa društva, a s druge strane reguliše institut sednica nadzornog odbora);[50] ovlašćenja predsednika izvršnog odbora koga imenuje nadzorni odbor (primena pravila koje sadrži zakon koji uređuje privredna društva u vezi sa institutom generalnog direktora društva kao prvog izvršnog direktora, uz isključenje individualnog zastupanja zbog obaveze supotpisa jednog člana izvršnog odbora);[51] naknade za rad članova izvršnog odbora – izvršnih direktora (fiksna naknada i varijabilne naknade, ali bez mogućnosti određenja u formi učešća u dobiti društva, što može zavisiti od poslovnih rezultata društva; politika naknada, izveštaj o naknadama – transparentnost naknada, glasanje u skupštini društva o politici naknada i o izveštaju o naknadama);[52] prestanak mandata i razrešenje (analogno pravilima koja važe za članove nadzornog odbora, ali uz isključenost mogućnosti kooptacije od strane samog izvršnog odbora);[53] ostavka (analogno pravilima koja važe za ostavku članova nadzornog odbora, ali bez mogućnosti kooptacije i u tom slučaju);[54] mogućnost postavljanja privremenog zastupnika od strane suda ako društvo nema nijednog izvršnog direktora upisanog u registar u propisanom roku (zbog obaveze supotpisa iz zakona koji reguliše osiguranje mislimo da bi se morala imenovati dva privremena zastupnika);[55] društvo sa dva izvršna direktora (uključujući i predsednika – primena odredaba o izvršnom odboru, osim odredaba o sednicama odbora);[56] izveštaji izvršnih

[48] ZO, čl. 58 i ZOPD, čl. 422.
[49] ZO, čl. 58, st. 2, t. 13; ZOPD, čl. 427, st. 2.
[50] ZO, čl. 56; ZOPD, čl. 429.
[51] ZOPD, čl. 423.
[52] ZOPD, čl. 424, 393, 463a-v.
[53] ZOPD, čl. 425.
[54] ZOPD, čl. 426, st. 1–3.
[55] ZOPD, čl. 426, st. 3–6.
[56] ZOPD, čl. 428.

direktora kao opšte pravilo zakona koji uređuje privredna društva uz primenu i posebnog pravila zakona koji uređuje osiguranje o izveštavanju skupštine društva od strane izvršnog odbora;[57] odgovornost (imovinska prema društvu ili prema akcionarima) izvršnih direktora kao članova izvršnog odbora (analogno pravilima koja važe za takvu odgovornost članova nadzornog odbora imajući u vidu nadležnost jednog i drugog organa društva).[58]

Imovinska odgovornost izvršnih direktora (odnosno izvršnog odbora) kod dvodomnog upravljanja društvom, *za štetu* iz svojih poslovnih odluka prouzrokovanu *društvu, kao i akcionarima društva* (individualna tužba, kolektivna tužba), *izuzetno trećim licima*, uređuje se shodnom primenom pravila koja važe za direktore, odnosno odbor direktora jednodomnog upravljanja društvom.[59] Tako ostaje da se i na odgovornost izvršnog odbora za kolektivno donete odluke (glasanje protiv odluke, uzdržano glasanje, odgovornost člana koji nije prisustvovao sednici na kojoj je određena odluka doneta, solidarna odgovornost, aktivno i pasivno legitimisana lica, zastarelost, mogućnost oslobođenja od odgovornosti odlukom skupštine i slično) shodno primenjuju odredbe o odgovornosti članova odbora direktora jednodomnog modela uprave.[60]

4.4. Uprava akcionarskog društva za osiguranje

Za razliku od zakona koji uređuje društva koji ne poznaje pojam „uprave društva", zakon koji uređuje osiguranje utvrđuje ovaj pojam i izričito određuje da se pod „upravom akcionarskog društva za osiguranje/reosiguranje podrazumeva nadzorni i izvršni odbor". Ustanovljenje tog pojma omogućilo je zakonodavcu iz oblasti osiguranja da ustanovi neke zajedničke institute koji se primenjuju na članove i jednog i drugog organa (nadzorni i izvršni odbor).

Prvo, regulisanje pozitivnih uslova za imenovanje za člana ovih organa (dobra poslovna reputacija, odgovarajuća stručna kvalifikacija, potrebno znanje i iskustvo utvrđeno statutom društva), kao i regulisanje negativnih uslova (zabrane, smetnje) koji diskvalifikuju neko lice da bude član uprave ovog društva (osuđivanost za ovim zakonom imenovana krivična dela, i to na široj osnovi nego što to čini zakon koji uređuje privredna društva, izrečena određena zaštitna mera, oduzimanje dozvole za rad društvu u kome je to lice u tom trenutku ili određeno vreme pre toga bilo član uprave, otvaranje stečaja ili prinudne likvidacije nad društvom u kome je neko lice u tom trenutku ili određeno vreme pre toga bilo član uprave, lice kome je u poslednje tri godine izrečena mera oduzimanja saglasnosti da bude član uprave,

[57] ZOPD, čl. 431 u vezi sa čl. 416; ZO, čl. 60.
[58] ZOPD, čl. 430 u vezi sa čl. 415.
[59] ZOPD, čl. 63–64. i 415.
[60] Više: N. Petrović Tomić (2019), str. 209–212.

lice koje je razrešeno dužnosti člana uprave po nalogu NBS u skladu sa zakonom; lice koje po zakonu koji reguliše privredna društva ima zabrane imenovanja za člana ovih organa, lice koje je povezano s pravnim licem u kome akcionarsko društvo za osiguranje ima određeni procenat kapital učešća ili prava glasa, lice koje je član uprave ili prokurista u nekom drugom akcionarskom društvu za osiguranje/reosiguranje) i, najzad, regulisanje i dodatnih uslova za imenovanje zakonom (aktivno znanje srpskog jezika, prebivalište ili boravište u Srbiji, zaključenje ugovora o radu s punim radnim vremenom u društvu – izvršni direktori – *dvodomni model nema neizvršne direktore i nema nezavisnog direktora u izvršnom odboru*) i posebnim propisom NBS.

Drugo, sistem prethodne saglasnosti NBS za imenovanje za člana uprave akcionarskog društva za osiguranje/reosiguranje (sa propisivanjem osnova uskraćivanja takve saglasnosti i nemogućnosti podnošenja novog zahteva u takvom slučaju godinu dana od dana takvog uskraćivanja). Za razliku od ovog, postoji i mogućnost oduzimanja već date saglasnosti za imenovanje za člana uprave tih društava u slučaju utvrđenja da postoje takvi osnovi propisani zakonom (uz nemogućnost davanja nove saglasnosti za takvo imenovanje tri godine od donošenja rešenja NBS o oduzimanju takve saglasnosti).

Treće, propisivanje zakonom koji reguliše osiguranje posebnih pravila za obaveze i odgovornosti člana uprave u odnosu na takva pravila za članove organa akcionarskih društava na koje se primenjuje zakon koji uređuje privredna društva. Ta pravila po svojoj prirodi su dvojaka: najpre, ustanovljenje jednog opšteg pravila – članovi uprave akcionarskih društava za osiguranje/reosiguranje dužni su da „preduzimaju mere radi sprečavanja nezakonitih ili neprimerenih radnji i uticaja koji su štetni ili nisu u najboljem interesu akcionarskog društva za osiguranje i njegovih akcionara, a koje vrše lica blisko povezana s tim društvom – radi zaštite korisnika usluga osiguranja“,[61] i to u skladu s „propisima, pravilima struke i dobrim poslovnim običajima“.[62] To pravilo unekoliko modifikuje pravilo odgovornosti članova organa akcionarskog društva na koje se primenjuje zakon koji uređuje privredna društva, a koje je poznato pod nazivom „pravilo poslovne procene“ (*Business Judgment Rule*).[63] To opšte pravilo odgovornosti članova uprave akcionarskog društva za osiguranje/reosiguranje praćeno je i sa nekoliko posebnih pravila koja konkretizuju osnove ove odgovornosti, a koja se svode na obavezu informisanja po liniji izvršni odbor – nadzorni odbor i nadzorni odbor – NBS. Naime, u prvom slučaju, izvršni odbor je dužan da odmah obavesti nadzorni odbor u tri slučaja: ugroženost likvidnosti, odnosno solventnosti društva, nastupanje razloga prestanka važenja dozvole za rad društva,

[61] ZO, čl. 59, sta. 2 .

[62] Pod pojmom „korisnik osiguranja“ podrazumeva se „osiguranik, ugovarač osiguranja, korisnik osiguranja i treća oštećena lica“: ZO, član 15 stav 1. Vid. Nataša Petrović Tomić, *Zaštita potrošača usluga osiguranja,* Beograd, 2015, str. 47–137.

[63] Vid. Mirko Vasiljević, „Civil Law and Business Judgment Rule“, *Anali Pravnog fakulteta Univerziteta u Beogradu*, br. 3/2012, str. 7–38.

ili nastupanje razloga za oduzimanje takve dozvole, ili razloga za prestanak obavljanja pojedinih vrsta osiguranja, nastupanje neadekvatnosti osnovnog kapitala društva. U drugom slučaju, nadzorni odbor po prijemu ovih informacija od izvršnog odbora dužan je takođe da odmah o tome obavesti NBS. Po svim tim osnovima povrede zakona, opštim i posebnim, može nastati šteta akcionarskom društvu za osiguranje/reosiguranje za koje odgovara član uprave primenom zakona koji uređuje privredna društva, s obzirom na to da nema daljih posebnih rešenja u zakonu koji reguliše osiguranje.[64]

Najzad, četvrto, zakon koji uređuje osiguranje sadrži i posebno zajedničko pravilo za informisanje skupštine društva o prihodima članova uprave (izvršnog i nadzornog odbora).[65] Naime, skupština akcionarskog društva za osiguranje/reosiguranje najmanje jednom godišnje razmatra pismeni izveštaj uprave društva o svim detaljima zarada, naknada i drugih primanja članova, kao i o svim ugovorima zaključenim između društva i tih lica i lica povezanih s tim licima,[66] a čija je posledica imovinska korist za ova lica, kao i predlog nadzornog odbora o zaradama, naknadama i drugoj imovinskoj koristi tih lica za narednu godinu.[67]

V Sistem upravljanja poslovanjem u akcionarskom društvu za osiguranje

Za razliku od privrednih društava na koje se primenjuju zakon koji uređuje ova društva kao komercijalna (profitna) društva, kod kojih je sa stanovišta dužnosti i odgovornosti (imovinske po osnovu donetih poslovnih odluka) uprave društva prema društvu zaštitni subjekt samo društvo (eventualno i drugi nosioci rizika poslovanja društva, pogotovo akcionari i članovi društva), akcionarska društva za osiguranje/reosiguranje (kao i druga osiguravajuća društva) obavljaju specifičnu privrednu delatnost za čije uspešno obavljanje imaju posebnu dužnost i imovinsku odgovornost članovi uprave društva (nadzorni i izvršni odbor), ali ne samo prema društvu i članovima društva (u smislu zakona koji uređuje privredna društva), već i prema drugim zaštitnim subjektima – osiguranicima, ugovaračima osiguranja, trećim oštećenim licima i korisnicima osiguranja (uopšte). Ta činjenica zahtevala je od zakonodavca osiguranja da konstituiše poseban institut u osiguranju – sistem upravljanja društvom. Taj sistem obuhvata: 1) upravljanje rizikom, 2) sistem internih kontrola, 3) internu reviziju i 4) aktuarstvo.

Sistem upravljanja rizikom, kao segment upravljanja akcionarskim društvom za osiguranje/reosiguranje obuhvata: preuzimanje rizika u osiguranju i rezervisanje, upravljanje imovinom i obavezama, investicije, likvidnost i upravljanje koncentracijom

[64] ZOPD, čl. 415 i 447.
[65] ZO, čl. 60.
[66] Pojam povezanog lica u smislu zakona koji reguliše osiguranje: ZO, čl. 30.
[67] ZO, čl. 60.

rizika, upravljanje operativnim rizikom, reosiguranje i druge načine umanjenja rizika. Radi obezbeđenja efikasnog sistema upravljanja rizikom, zakon koji uređuje osiguranje reguliše pravila o upravljanju rizikom i način upravljanja rizikom.[68] Zakon o osiguranju detaljno uređuje i druge segmente celovitog sistema upravljanja društvom: *sistem interne kontrole, sistem interne revizije i aktuarstvo*.[69] Bliža pravila o svim tim sistemima donosi NBS.

VI Grupa društava i grupa društava za osiguranje – posebna pravila

Zakon koji reguliše osiguranje za statusno poimanje osiguravajućih društava sadrži i određenje opšteg pojma „grupa društava", kao i posebnog pojma „grupa društava za osiguranje". U smislu tog zakona grupa društava je grupa koju čine matično društvo, njegova zavisna društva i pravna lica u kojima to matično društvo, odnosno njegova zavisna društva imaju udeo u kapitalu (kapital učešće), kao i društva koja su međusobno povezana zajedničkim upravljanjem. *Matično društvo* pravnog lica je društvo koje ima kontrolno učešće u tom pravnom licu. *Zavisno društvo* pravnog lica je društvo u kome to pravno lice ima kontrolno učešće. *Društva povezana zajedničkim upravljanjem* jesu društva koja nisu povezana odnosom matičnog i zavisnog društva ni udelom u kapitalu, a koja obuhvataju: 1) društva u kojima se upravlja na jedinstven način u skladu s ugovorom zaključenim između tih društava ili odredbama osnivačkih akta ili statuta tih društava (*ugovor o upravljanju*) ili 2) društva kod kojih ista lica čine većinu članova organa upravljanja ili nadzora (*personalna unija*). Reč je o pojmovnom određenju koje u sadržinskom smislu odgovara određenju grupe društava, holdinga, društava sa uzajamnim učešćem u kapitalu i ugovora o kontroli i upravljanju u zakonu koji uređuje privredna društva.[70]

Grupa društava za osiguranje je grupa društava iz pojmovnog određenja takve grupe u zakonu koji uređuje osiguranje u kojoj je *društvo za osiguranje*, odnosno društvo za reosiguranje *najznačajnije društvo u toj grupi*. Najznačajnijim društvom u grupi društava u smislu ovog zakona smatra se *krajnje matično društvo* u grupi ili društvo koje ima značajno ili kontrolno učešće u drugom licu ili efektivno vrši uticaj na upravljanje tim licem (značajni imalac), ili društvo sa većom bilansnom sumom ako dva ili više društava u grupi ispunjavaju kriterijume značajnog imaoca.[71]

[68] ZO, čl. 149 i 150.
[69] ZO, čl. 151–174.
[70] Upor. ZO, čl. 218, st. 1–4. i ZOPD, čl. 551–554.
[71] ZO, čl. 218, st. 5–6.

VII Umesto zaključka

Analiza prirode odnosa zakona koji uređuje privredna društva uopšte (generalni zakon) i zakona koji uređuje osiguranje (poseban zakon), iako je reč o odnosu posebnog i opšteg, kada posebno ima prednost nad opštim, i pored činjenice da se ovaj posebni zakon opredeljuje, za slučaj kad nije iskoristio mogućnost da konstituiše posebnu normu, za direktnu (neposrednu) primenu ovog generalnog zakona iskazom „primenjuje se", i to na dva mesta (kod formi posebnih društava i zajedničkih instituta društava i kod organa društava), isključujući time drugu moguću opciju – „shodnu primenu", pokazuje da u nizu neregulisanih pitanja posebnom normom nije moguća takva primena i da se mora posegnuti za „shodnom primenom". U protivnom, došlo bi se u situaciju da se obesmišljavaju i neke inače postojeće norme posebnog zakona, čija posebnost ima svoj *ratio.*

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COMPANY LAW AND JOINT STOCK COMPANIES FOR INSURANCE/REINSURANCE

SCIENTIFIC PAPER

Abstract

Specialized companies that perform activities typically requiring establishment permits and operational permits from competent bodies are most often regulated summarily, by special laws. This is also the case with insurance companies in general, and particularly with joint-stock insurance companies. This technique of regulation is primarily applied because, in all countries, including Serbia, there is a general law that regulates all companies. This general law is applied either "accordingly" or directly to specialized companies, including insurance companies, and thus to joint-stock insurance companies for issues and institutes for which there are no specific provisions in the specialized law, i.e. the insurance law.

This paper discusses the relationship between the law regulating companies and the law regulating insurance, with a particular emphasis on joint-stock insurance companies. The relationship in question is between the general law (the Company Law) and the special law (the Insurance Law), which is governed by the maxim *lex specialis derogat lege generali* (special law repeals the general law). It is interesting that the Insurance Law, between the two options of that application, "according application" and direct application, opted for the direct application of the Company Law when it does not contain specific provisions based on the specificity of the insurance activity as compared to other activities covered by the regulatory framework of the Company Law. The paper specifically analyzes issues related to the status of joint-stock companies and their bodies (corporate governance) for which

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there are no special provisions in the law regulating insurance, and to which the law regulating companies cannot be directly applied; instead, it would be necessary to resort to a rule closer to the nature of "according application".

Keywords: *insurance companies, joint-stock insurance companies, corporate governance models, capital adequacy, groups of insurance companies.*

I Instead of an Introduction

The status aspect of insurance companies is not regulated, as one might expect, by the special law governing the insurance activity, but rather by the general law governing companies. However, the special law regulating the insurance activity in Serbia reserves the right to regulate certain deviations from the general provisions of the law that govern the status aspects of companies in Serbia, regardless of their activities. Thus, these deviations, which are inherently considered special provisions, are applied, when there are ones, instead of the general rules on the status of companies – *lex specialis derogat lege generali*. In this sense, the specialized Insurance Law[2] stipulates that the Company Law[3] shall apply to "insurance companies, reinsurance companies, insurance brokerage companies, and insurance agencies, unless otherwise prescribed by this law." This statement of the special law also indicates that this application does not extend to "mutual insurance companies" given that the general law governing companies does not encompass such a legal form of organization that would be generally valid for performing any economic activity, instead, this form exists only in the field of insurance, therefore, it is logical to be regulated solely by the law that specifically regulates the insurance activity, including this status form.

An insurance company is incorporated as a joint-stock or mutual insurance company, while a reinsurance company is incorporated only as a joint-stock reinsurance company, adhering to the rules applicable to this form of company that conducts insurance activities. An insurance brokerage company is incorporated as a joint-stock company or as a limited liability company. An insurance agency company is also incorporated as a joint-stock or as a limited liability company, and these activities can also be performed by a physical person with the status of an entrepreneur in accordance with the law governing companies. This paper will focus only on the specificities of a joint-stock insurance company (which also apply accordingly to a joint-stock reinsurance company) in relation to the general rules that apply to a joint-stock company governed by the law regulating companies, considering that there are particularly pronounced specificities of this form of company which are

[2] Insurance Law - IL, *Official Gazette of the Republic of Serbia*, No. 139/14 and 44/21, art.18.
[3] Company Law - CL, *Official Gazette of the Republic of Serbia*, No. 36/2011-3, 99/11-14, 83/14-15 – other law, 5/15-3, 44/18-27, 95/18-335, 91/19-61, 109/21-15.

not present in insurance companies organized as limited liability companies (some do exist, of course, such as the system of establishment permits, minimum capital requirements, supervision of work and operations, and so on). Therefore, neither this type of insurance company nor mutual insurance companies will be discussed, as they do not exist as a general status form under the law governing companies, but only as a specialized form within the insurance sector, regulated by the special law that governs this activity and this status form for its performance.[4]

II Specificities of Joint-Stock Insurance/Reinsurance Company

1. Business Name and Capital

A joint-stock insurance/reinsurance company engages in financial activities and, corresponding to the special regime governing banks organized as joint-stock companies and the Insurance Law, contains a number of specificities related to the status of these companies for conducting insurance/reinsurance activities, distinguishing them from companies of the same legal form that do not engage in these activities. It is logical that one such specificity is the uniqueness of the business name to distinguish it from other companies of this form that do not engage in this activity. The business name must be registered in the abbreviated form "a.d.o." (joint-stock insurance company). Additionally, only this type of company can perform and register insurance or reinsurance activities (principle of exclusivity, not cumulativeness).

Given that the nature of insurance and reinsurance activities is fundamentally financial, there are key specificities for these companies regarding the regulation of various issues related to their capital. First, the prescribed minimum capital must be in cash and is significantly higher than the capital required for companies engaged in other non-financial commercial activities (the amount depends on the type of life or non-life insurance the company provides and whether it engages in insurance or reinsurance activities).[5] Additionally, there is a requirement to maintain this form of capital at the prescribed level throughout the duration of the company's operations and life, a requirement that is generally not applicable to companies involved in non-financial activities.[6] Finally, in addition to defining the terms "significant" and "controlling" capital participation, similar to the law governing companies, the Insurance Law also defines "qualified capital participation" (directly or indirectly through another person in their own name but on behalf of that person, with a capital stake of 10% or more in ownership or voting rights). In relation to these concepts there

[4] For more details: Nataša Petrović Tomić, *Pravo osiguranja – Sistem,* Belgrade, 2019, pp. 185–212, pp. 242–275.

[5] CL, art. 27; CL, art. 293.

[6] For more details: Mirko Vasiljević, *Komentar Zakona o privrednim društvima*, Belgrade, 2023, pp. 611–662.

is a number of supplementary sub-institutes that further detail the specificities of these companies: firstly, a prohibition on reciprocal capital participation among all forms of companies regulated by Insurance Law; secondly, the requirement for prior approval from the National Bank of Serbia (NBS) as the supervisory authority for insurance companies for acquiring or increasing significant (20%) or controlling (50%) capital participation or voting rights in the company; thirdly, stipulation of specific conditions for acquiring or increasing qualified capital participation (and thus significant or controlling): good business reputation, relevant experience, financial condition, verification of source of funds, and reasons for acquiring or increasing; fourthly, the requirement for prior written notification to the NBS in the case of the disposal or reduction of qualified capital participation (including significant and controlling); and finally, the specification of legal consequences for unauthorized acquisition or increase of qualified (and thus substantial and controlling) capital participation: orders from the NBS to dispose of the acquired or increased capital within a specified period, suspension of voting and property rights until disposal, and nullification of the legal transaction in case of non-disposal or failure to reduce unauthorized capital within the allotted time frame.

A particular specificity regarding the capital of joint-stock insurance/reinsurance companies is *the institute of capital adequacy*. An insurance/reinsurance company is obliged to establish a so-called *guarantee reserve*, in accordance with the Insurance Law, to ensure the continuous fulfillment of obligations and risk management in its operations. The guarantee reserve consists of so-called *primary capital* (comprising elements defined by this Law) and *supplementary capital* (also comprising elements specified by this law), reduced by deductible items defined by the law. The Insurance Law establishes a special *solvency margin* for insurance companies engaged in life insurance, and a special solvency margin for those engaged in non-life insurance. An insurance/reinsurance company is obliged to secure *an available solvency margin*, depending on whether it engages in life or non-life insurance, and this margin is considered secured if the companies have the prescribed guarantee reserve in accordance with the Insurance Law. Unlike the guarantee reserve, the insurance law also recognizes the institute of so-called *guarantee capital*, which is part of the guarantee reserve defined by this law and amounts to at least one-third of the required solvency margin, depending on the insurance group the company is engaged in. The guarantee capital of an insurance company must not be less than the amounts prescribed by this Law, depending on the insurance group in which the company operates, as per the issued operating license. An insurance company meets the conditions for capital adequacy if it satisfies the criteria for the available solvency margin and guarantees capital, in accordance with the insurance law. If an insurance company ceases to meet the required capital adequacy conditions, it must submit *a program of measures* to the National Bank of Serbia within

a prescribed period *to re-establish these conditions*, i.e., the company's solvency, within a maximum period of three months from the determination of the non-fulfillment of these conditions. The NBS may request the insurance company to amend and/or supplement the program of measures, and if no such request is made, it is considered that the proposed measures are approved. To ensure the continuous solvency of the insurance company, the NBS may require the company to submit a *long-term financial consolidation plan*[7] during the implementation of the solvency condition compliance program.

2. Incorporation

Insurance/reinsurance companies are incorporated under a licensing system, as opposed to the free establishment regime which applies to companies under the law regulating Company Law, where the license is issued by the National Bank of Serbia (NBS) through a legally defined administrative procedure, which includes the submission of prescribed documentation. The Insurance Law also regulates the possibility of rejecting the request for a license application, as well as the grounds for the termination of an issued license.

Joint-stock companies incorporated under the Company Law can be either closed (formed without public subscription of shares) or open (formed with public subscription of shares). However, even for open companies, this Law does not recognize the institute of the founding assembly, implying that the legislator does not anticipate the public establishment of these companies, but rather their private formation by the founders (closed company). Such a company can transform into an open (public) company after incorporation and registration by following the procedure defined by the capital market law, through a new public share issuance or the conversion of the initial (private) share issuance into a public issuance, subject to the procedures set by the Securities Commission. On the other hand, the Insurance Law does not differentiate types of joint-stock insurance/reinsurance companies but regulates the institute of the founding meeting. This assembly must be held within a prescribed period after obtaining a license from the NBS, based on a duly submitted application by the founders (with the required documentation). It is interesting that the Insurance Law stipulates that founders have voting rights at the founding assembly "proportionate to their contributions" even though, at this stage, they act as contractual parties who have signed an agreement to incorporate the insurance/reinsurance joint-stock company, and not as shareholders. The company will acquire legal personality only after the prescribed acts are adopted at this assembly and the subsequent registration of the company, which will then have the nature of a capital

[7] Regarding these institutes of capital adequacy for insurance companies: IL, arts. 124–130.

company where shareholders with voting shares have voting rights proportional to their capital contributions. In any case, the founders of this company vote by a qualified majority (2/3), adopt the company's statute, elect the first supervisory board, determine the company's business policy and business plan, adopt the company's general acts and business policy acts, and other acts significant for the commencement of activities and company operations. They also determine the maximum amount of funding expenses to be borne by the company and approve the valuation of non-cash contributions. These adopted acts are then submitted by the founders to the NBS within the prescribed period and to the prescribed register (Business Registers Agency - BRA) for registration and acquiring legal personality.[8]

III Governance Bodies of Insurance/Reinsurance Joint-Stock Company

3.1. Management Models (Boards)[9]

3.1.1. One-Tier Model

The first system (the so-called one-tier model) originates from Anglo-Saxon law which has been adopted by many continental law countries (France, Switzerland, Italy).[10] In this system, the management function is in the hands of one or more individuals (Switzerland, England, the USA), or a board of directors - supervisory board, which is elected by the shareholders' assembly *(*supervisory board - *board of directors*).[11] According to this system, the board of directors elects one or more executive directors from among its members (*executive directors*) or partly from among those who are not members, or from individuals who are permanently employed in the company, for the operational management of the company's operations.[12] Most often, the chairman of the board of directors (elected by the board) is also the

[8] IL, arts. 48-49.

[9] For more details: Mirko Vasiljević, Tatjana Jevremović Petrović, Jelena Lepetić, *Kompanijsko pravo – pravo privrednih društava*, Belgrade, 2023, pp. 537–542.

[10] The French Commercial Companies Act (No. 66-537), art. 89 (hereinafter: FCC...), the Swiss Code of Obligations, arts. 89–117; (1911, 1936, 1984, hereinafter: SCO...), arts. 707–726. For a theoretical legal analysis of the board of directors, See generally Pierre Gilles Gourlay, *Le conseil d' administration de la sociétés anonymes*, thesis, Paris, 1971.

[11] SCO..., arts. 707, 712, and 714; FCC..., arts. 89, 110, and 115. In England, joint-stock companies with public share issuance must have at least two directors, while companies without public share issuance must have at least one director – John Charlesworth (ed. Geoffrey Morse), *Company Law*, London, 1995, pp. 312–315.

[12] See Joseph Hamel, Gaston Lagarde, Alfred Jauffret, *Droit commercial*, Paris 1980, pp. 357–402; René Rodière, *Droit commercia*l, Paris, 1980, pp. 193–212; Maurice Cozian, Alain Viandier, *Droit des sociétés*, Paris, 1998, pp. 235–272; Robert Pennington, *Company Law*, London, 1995, pp. 768–778; John Birds *et*

president of the company and the chief executive officer (*chairman-chief executive officer, president-directeur général*). Members of the board of directors can be, with a range of variations, either full-time employees of the company (*executive directors*) or individuals not employed by the company (*non-executive directors*). Thus, in this system, the function of the board of directors is carried out partly on a collegial basis (meetings, collective representation) and partly on an individual basis (executive functions of the chairman, executive functions of the general manager, executive functions of directors, executive directors). In this system, *the supervisory board is not a mandatory body* in a joint-stock company (the control function is performed by external independent auditors, partly by internal auditors, or special auditors).

The one-tier corporate governance model was developed in the following environment: 1) the dominance of dispersed shareholders — mainly physical persons, 2) strong legal and judicial protection of shareholders, 3) limited shareholding by banks and other institutional investors, 4) the existence of the "one share, one vote" rule, 5) a liquid and developed capital market, 6) a highly developed hostile takeover market, 7) weak union power, 8) poorly developed state social policies, 9) a weak system of social democracy, and 10) developed employee shareholding through tax incentives.

The one-tier corporate governance model developed under the conditions of so-called *shareholder capitalism*. This model was previously characterized as a managerial (profit-oriented) model but is now more frequently referred to as a shareholder-oriented model. The main features of this model are: 1) competition in all areas, 2) dominance of private interest over public interest in management, 3) reducing the role of powerful private institutional investors and promoting public share issuance as the main source of financing, 4) regulating corporate governance with default rules, thereby encouraging market activities, 5) complete separation of management from ownership, so that shareholders do not have the right to directly manage the company's activities, but instead, this is done on their behalf by the board of directors and managers, who have a fiduciary duty to the company (open companies typically predominate), 6) an exceptionally easy ability for shareholders to initiate legal proceedings against non-businesslike and harmful decisions made by the company's management, 7) incentivizing management through contracts tied to company success: linking managers' compensation to the company's performance, 8) developed public oversight of management quality, especially through specialized media and advanced market ratings of managers, 9) developed judicial practice with corporate governance precedents that provides valuable lessons for effective management.

Economic theory cites the following key advantages of shareholder-oriented capitalism: 1) an advantage in starting businesses and introducing new technology,

al., *Company Law*, London, 1995, pp. 415–430; Paul L. Cannu, *La société anonyme à directoire*, Paris, 1979; Robert Hamilton, *The Law of Corporations*, Minnesota, 1991, pp. 218–249.

2) encourages initiative, individuality, and innovation, 3) political neutrality, 4) promotes the professionalization of managers, 5) risk diversification (public issuance of shares – *IPO*), and 6) relatively high returns on stock investments. On the other hand, the key disadvantages of this system of capitalism include: 1) maximizing short-term results at the expense of long-term strategy, 2) the share prices are based on short-term strategies, hindering R&D strategies, 3) weak management oversight by dispersed shareholders (*strong managers, weak shareholders model*), 4) relatively weak shareholder assemblies and relatively powerful boards of directors, 5) linking executive compensation to company performance (share prices) leads to management abuses in "inflating balance sheets" and 6) weak protection of other interests within the company (beyond those of shareholders).

3.1.2. Two-Tier Model

The second system (the so-called two-tier model) is the system of the German law, which is, as an alternative to the one-tier system, also incorporated into the most recent French legislation. In a joint-stock company, this model generally (except in small companies where the function of the management board can be performed by one person) consists of two boards: the management board (*Vorstand*) and the supervisory board (*Aufsichtsrat*).[13] The management board performs its management and operational functions partly on a collective basis (decision-making at meetings, collective representation) and partly on an individual basis (individual representation, individual execution of decisions made at meetings). Exceptionally, in joint-stock companies with smaller capital (as prescribed by the Law), the function of the management board can be performed by a single person – the sole general manager. The management board, in the narrower sense, performs its management and operational functions partly on a collective basis (making decisions at meetings, collective representation) and partly on an individual basis (individual representation, individual execution of decisions made at meetings).[14] In this system, the members of the supervisory board are elected (and dismissed) by the assembly, while the supervisory board elects (and dismisses) the members of the management board. This system is also adopted in Croatia.[15] Naturally, in this system, the control function is performed not only by the supervisory board but also by an external independent auditor, and it can also be performed by an internal auditor and sometimes a special auditor.

The two-tier management model was developed in the following environment: 1) domination of banks as shareholders in company management, either directly as shareholders or through a proxy system or agreements on exercising

[13] German Aktiengesellschaft (1965..., hereinafter: NDZ), arts. 76-117; FTZ..., arts. 118-150.
[14] *Thus* J. Hamel, G. Lagarde *et al.*, p. 420. For more details on the directorate: P. Le Cannu, pp. 33-122.
[15] Croatian Companies Act (HTZ: 1993, 2003), art. 244.

voting rights, 2) a combination of the roles of creditor, significant shareholder, and controller through the exercise of voting rights, 3) concentrated shareholding, 4) legal co-determination (cohesion of labor and capital), 5) infrequent meetings of the supervisory board to minimize the role of employees in co-determination in order to avoid triggering management liability for harmful decisions, thus also protecting the supervisory board from supervisory negligence, 6) a relatively underdeveloped capital market, 7) relatively underdeveloped hostile takeovers, 8) a relatively negligible role of small shareholders, 9) strong unions, and 10) a developed social policy and social democracy.

The two-tier management model in Germany was developed under conditions of *the so-called worker-oriented capitalism model (social democracy model)*. The main characteristics of this model are: 1) insufficient separation of ownership from management in conditions of concentrated shareholding (usually dominated by closed companies), 2) management is relieved from short-term success pressures, typically focusing on long-term strategy, 3) the development of social democracy (distributive justice) and co-determination pressures managers to consider other interests other than those of shareholders (corporate social responsibility), 4) political determination of the model, 5) the quality of management depends more on the assessment of success by major shareholders (usually banks) than on the market, 6) concentrated shareholding and weak dispersion weaken shareholder rights but increase job security (social security), 7) developed discretionary power of controlling shareholders, 8) weak protection of minority shareholders and an underdeveloped practice of shareholder lawsuits (derivative lawsuits).

Economic theory identifies the following key weaknesses of this model of capitalism (originally belonging to Germany, but also fundamentally present in Japan, with certain specificities): 1) insufficiently developed competition and market (particularly the capital market due to restrictions on the transfer of shares, and the labor market due to social democracy), 2) non-transparent management and potential conflicts of interest between the dominant shareholder and their duty of loyalty to the company, 3) weak protection of the interests of small shareholders (often due to high capital thresholds for exercising minority shareholders' rights), 4) potential conflict of interests between shareholders and management (limited use of management ownership participation) due to management's duty to work particularly in the interest of employees under conditions of social democracy and co-determination, 5) heterogeneity of interests between capital representatives in management and employee representatives, leading to potentially poor-quality management decisions, especially from the standpoint of competitiveness (constant tensions between capital interest and labor interest).

The advantages of the role of banks, on the other hand, as key shareholders (in the German-Japanese management model) are fundamentally as follows: 1) the cost

of credit is generally cheaper compared to the cost in the USA, where bank-company relationships are market-based, 2) conflicts of interest between credit and capital are more easily resolved, 3) compared to small dispersed shareholders, banks as creditors or shareholders generally enjoy better legal protection. On the other hand, the weaknesses of the role of banks as key shareholders (in the German-Japanese management model) are as follows: 1) due to close relationships with companies (significant shareholders), banks often provide subsidies or lower interest rates on loans, resulting in higher costs for banking services, 2) when there are no restrictions on placements, bank funds may be over-invested in shares instead of credit capital, 3) long-term ownership in companies leads to close ties with management and the loss of a professional relationship.

3.1.3. The Japanese One-Tier Model – Combination of Anglo-Saxon and German

The Japanese model of corporate governance is primarily one-tier model, yet it incorporates characteristics of both the American-British one-tier model and the German two-tier model: 1) significant role of banks, i.e. banks act as controlling shareholders and monitors, 2) negligible role of other small shareholders, 3) unlimited *cross-shareholding*, 4) underdeveloped hostile takeover, 5) lifetime employment system - known as humane capitalism, 6) closed internal labor market - the recruitment and selection of employees and managers are conducted within the company, 7) continuous consultation between employees and managers, 8) developed corporate unionism rather than national unionism, 9) external oversight where instead of a supervisory board, external auditors perform the oversight function, 10) executive board (board of directors) which is typically large and operates in the company's interest without external (independent) members and without pressure from shareholders.

The Japanese corporate governance model was developed primarily in the same environment as the German governance model, with certain specificities. These include a reduced role for national labor unions (and thus co-determination), but also an increased role for tradition and culture (humane capitalism) and the state. Therefore, the Japanese model of capitalism is referred to as *a state-oriented model* (for some time, France also attempted to implement this model).

3.1.4. Mixed Model – Freedom to Choose

Lastly, the third system, adopted by the Statute of the European Company, allows a joint stock company to choose (*system of freedom of choice*) either a so-called *one-tier model* (*monistic*) — an executive (management) board of directors elected by the general assembly of shareholders, or a so-called *two-tier (dual) model* — a management board and a supervisory board, where the supervisory board is elected

by the general assembly, which then elects the management board (although the possibility is still left for member states to stipulate that the supervisory board can also be elected by the general assembly of shareholders).[16] That system is essentially *a combination of the first and second models* and has been adopted in France (as an alternative to the unitary model), in the variant where both bodies are elected by the general assembly of shareholders (with the possibility to separate the functions of the chairman of the board of directors and the general director, when the aim is to separate management and provide stronger control through the board of directors, which is conditionally referred to as the "third model of governance" in France, Serbia, Montenegro, North Macedonia, and Slovenia.[17] *The High-level group of company law experts on a modern regulatory framework for Company Law in Europe* also advocates for the system of free choice for joint-stock companies i.e. allowing the choice between the so-called unitary system and the two-tier system of corporate governance bodies in joint-stock companies.[18]

3.1.5. Insurance Law – Two-tier Management Model

The nature of the governance model of a joint-stock company is not determined by the existence of the general assembly as a mandatory body in every such company, not even in a single-member company. The reason is natural and sensible: the assembly consists of the shareholders who hold ownership rights arising from the types of shares they possess. The nature of the governance model for such a company is determined by the legal stipulations regarding the existence of other mandatory bodies. Since Serbian law regulating insurance mandates that, in addition to the general assembly, the mandatory bodies of such a company include the supervisory board (elected by the general assembly) and the executive board (elected by the supervisory board), it follows unambiguously that the mandatory governance model for such a company is a two-tier model. Therefore, there are two collective bodies: the supervisory board and the executive board, which the law collectively refers to with a single term - the company's management. Thus, *ex lege*, joint-stock insurance companies must adopt a two-tier management model, without the option to choose a one-tier management model or an alternative between

[16] Council Regulation (EC) No. 2157/2001, arts. 38-51.

[17] FTZ..., arts. 90 and 120. In the literature, it is noted that, unlike the classic system with a board of directors, the new system with a supervisory board and directorate in France is unpopular, as twenty years after its introduction, it has been adopted in only about 2.61% of capital companies - See M. Cozian, A. Viandier, p. 291; Serbian Company Law, art. 198 (limited liability company), arts. 326, 383, 417 (joint-stock company); Slovenian Companies Act (STZ: *Official Gazette of the Republic of Slovenia*, 30-1298/93 and 45-2548/2001), art. 250; Macedonian Companies Act (2002, hereinafter: MTZ...), art. 301.

[18] See Report of the High Level Group of Company Law Experts on a Modern Regulatory Framework for Company Law in Europe, Brussels 2004.

one-tier and two-tier governance models. In any case, concerning the organization of bodies within such an insurance/reinsurance company, Serbian law reiterates the general norm from the general part of the law, stating that in the absence of specific rules in this special law, the rules governing commercial companies apply (both general rules valid for all forms of commercial companies and specific rules related to the same form of company organization). This also applies to the company's governing bodies (which would apply even if this norm were not reiterated in the section on the company's governing bodies, as it is included in the general part of the insurance law).[19]

Essentially, the two-tier management model differs from the one-tier management model by having a second body with supervisory functions within the company (supervision of the work of executive directors and oversight of the implementation of the company's adopted business strategy). In the one-tier model, these supervisory functions should, at least in part, be performed by non-executive directors and independent directors (in the case of public joint-stock companies). The one-tier model is characteristic of Anglo-Saxon countries and those that base their regulations on these countries. In contrast, the two-tier management model is typical of Germanic countries and those that structure their legislation based on the regulations of these countries.

Reforms of the one-tier corporate governance model have fundamentally highlighted its weaknesses and vulnerabilities. Consequently, the two-tier model has proven to be more stable and resilient in the face of economic crises. This stability is largely due to the presence of a second collective body within this management model—the supervisory board, which, along with other reformed elements of the one-tier model, plays a crucial role. The supervisory board monitors the work of the "executive sphere of authority within the company" and has numerous supervisory powers distinct from those of the executive board (or board of directors in the one-tier model). As a result, it can provide effective and timely oversight, offering shareholders early warning signals to review the performance of executive directors and the executive board - something that non-executive and independent directors (or partly the general assembly) in the one-tier model cannot do efficiently for various reasons.

IV Bodies of the Joint-Stock Insurance/Reinsurance Company[20]

4.1. General Assembly – Special Rules

The general assembly of a joint-stock insurance company is essentially regulated in the same manner as the general assembly of a joint-stock company

[19] IL, arts. 18 and 50.

[20] See Nataša Petrović Tomić (2019), pp. 203–212.

governed by the Company Law. Therefore, the following rules of this Law apply on the assembly of such a company: composition of the assembly and shareholders' rights, conveners, notice of meeting (traditional, electronic, internet publication), types of meetings (regular, extraordinary, and special meetings for preferential shareholders), location of the assembly, the shareholders' day, the president of the assembly, rules of procedure, agenda (the right to propose and determine the agenda, minority shareholders' rights to supplement the agenda, and court-ordered additions if minority shareholders' requests are not accepted), holding a meeting by court order (when it is not held in response to a request by minority shareholders), meeting formats (physical and non-physical (virtual) meetings), the right to ask questions and obligation to respond (providing answers as ordered by the court), voting (direct voting, absentee voting, participation via electronic means or proxies — rules regarding proxy voting, who can be a proxy, proxy voting for multiple shareholders, special rules for proxies proposed by the company, and special rules for banks managing collective or custodian accounts, as well as rules for changing and revoking proxy voting), access to the meeting, quorum for the first and repeated meetings with the same agenda, voting committee, majority for decision-making(-simple, absolute, and qualified), voting results, method of voting (public or secret), voting rights based on pledged shares, voting of special classes of shares, voting agreements, exclusion of voting rights and conflict of interest, minutes, statement on the application of the corporate governance code, meeting materials, publication of annual reports, approval of financial and other reports, nullity and challenging of decisions (the right to challenge decisions, consequences of challenge, proceedings for challenges, consequences of court ruling, special rule for challenging the approval of annual financial statements, and rules for when a decision will not be invalidated).[21]

Special rules of the Insurance Law concerning the shareholders' assembly of an insurance/reinsurance joint-stock company are primarily related to the specific supervisory role of the National Bank of Serbia (NBS) over insurance organizations. These include the obligation to notify the NBS about the meeting and the possibility for an NBS representative to attend the meeting, as well as the ability of the NBS to request that certain issues be included in the assembly's agenda. Additionally, there is a special rule granting shareholders who hold at least 1% of the voting capital the right to directly exercise their voting rights, and this right cannot be excluded by the company's statute (in contrast, for companies governed by the company law, there is an autonomous right for the company to grant such direct participation rights in the shareholders' assembly to shareholders holding 0.1% of the "total number of shares of the relevant class").[22] Ultimately, the Insurance Law regulates the scope of authority and the conduct of meetings of the general assembly in a manner similar

[21] CL, arts. pp. 377–381.

[22] IL, art. 51, para. 3; CL, art. 328. para. 3.

to the Company Law, with an explicit prohibition on delegating statutory authority to other bodies within the company, as well as specific provisions regarding meetings of the assembly in the context of relations with the National Bank of Serbia (NBS).

4.2. Supervisory Board – Special Rules

Similarly to how the Insurance Law regulates the general assembly of a joint-stock insurance/reinsurance company (as well as the executive board), it also governs the supervisory board of this company. In summary, there are only a few provisions that grant the supervisory board a special nature, which apply prior to the general norms referring to this body within the two-tier management model accepted in insurance/reinsurance companies. These specific provisions are encompassed in the company law. First, the insurance law stipulates the minimum number of members for the supervisory board (the maximum number is determined by the company's statute)—three members (including the chairman). Notably, it requires that *"at least one-third" of its members be independent* in the sense defined by the Company Law (while Company Law generally requires at least one independent member, and this applies only to public joint-stock companies). The remaining members of the supervisory board must be *non-executive members* (i.e., not employed by the company, under any form of employment contract, as the law does not specifically require full-time employment). Furthermore, the Insurance Law specifically regulates the scope of authority of the supervisory board. This scope is fundamentally similar to that of the supervisory boards of joint-stock companies with a two-tier management system under the Company Law. The purpose of this specific regulation lies in the peculiarities of certain duties within the supervisory board's scope that arise from the unique nature of the insurance business (e.g. appointing and dismissing the authorized actuary, establishing an internal control system, determining risk management strategies, adopting the internal audit plan, etc.), as well as the specific supervisory role of the National Bank of Serbia (NBS) over insurance companies (e.g. reporting identified irregularities in the company's operations, reviewing the findings of NBS during the supervision of insurance activities, etc.), which do not apply to companies governed by the company law.[23] Lastly, the insurance law includes special provisions regarding supervisory board meetings, particularly from the standpoint of the need

[23] *Cf.* CL, art. 441; IL, art. 55. Duties within the jurisdiction of the supervisory board: 1) cannot be transferred to the company's executive directors (this management model does not include non-executive directors); 2) can be transferred to the jurisdiction of the general assembly only by a decision of the supervisory board (delegation of authority), unless otherwise specified by the statute (exclusion of transfer, limitation of issues for which delegation is allowed, consent of the general assembly to the delegation, etc.). This delegation of authority is precisely what the Law refers to when it mentions the jurisdiction of the general assembly of a joint-stock company by stipulating decisions on "other matters that are in accordance with this law placed on the agenda of the general assembly meeting".

for communication with the National Bank of Serbia (NBS). This includes requirements for at least one meeting every three months, the obligation to notify the NBS of scheduled meetings to enable the possible attendance of its representative and potential addressing to the supervisory board members, the possibility for the NBS to request meetings of this body, and the annual obligation to submit a report to the NBS on the supervisory board's activities, including the number of meetings held.

Aside from the issues regulated by the Insurance Law concerning the supervisory board (such as the minimum number of members, independent members, scope of authority, and meetings) under the specific regime of this Law, all other matters concerning this body are thoroughly regulated by the Company Law. This includes provisions that the Company Law regulates uniformly for both the supervisory and executive boards ("management of the company"), such as requirements for prior approval from the NBS to serve as a board member, the conditions and qualifications necessary for serving as a board member, the obligation to inform the company's assembly about the "income of a board member", and the duties and responsibilities of a board member. Issues related to this body that are not covered by the Insurance Law are not left unresolved, as they are directly governed by the Company Law as mandated by this legislation.

In this context, the following provisions from the Company Law governing joint-stock insurance/reinsurance companies "apply" (directly, rather than accordingly)[24] to the supervisory board of such entities under the two-tier management system: conditions and restrictions for membership on the supervisory board (such as criminal convictions for certain offenses, while the legal consequences of the conviction are in effect, any imposed security measures, as long as such measures remain in force; serving as a member of the executive or supervisory board in more than five companies; employment within the company, with the exception of individuals employed in a related company - such employees are considered non-executive members and must meet the independence criteria but are not required to satisfy the additional criteria for independent member);[25] composition (executive directors of the company or procurators cannot be members of the supervisory board - this is due to the need for the board members' independence from those whose work they oversee, which is one of their key responsibilities). Executive directors and procurators represent the company and have corresponding powers, which implies separation between executive/management functions and supervisory functions - executive directors also act as representatives of the company, and procurators represent the company and have corresponding powers, thus, *the oversight of executive directors extends to procurators* as well; members can be both *physical and legal persons,* the latter through their representatives; supervisory board members *cannot have*

[24] IL, art. 50 para. 2.

[25] CL, art. 432 in relation to arts. 382 and 391.

substitutes, emphasizing personal responsibility and accountability; members can be domestic or foreign individuals; members of the board must be registered, and an odd number is required);[26] appointment (candidates may be proposed by the existing supervisory board, a nomination committee (if one exists), or shareholders holding at least 5% of voting shares);[27] term (the term is generally four years, though statutes or general meetings may specify a shorter term, reappointment is possible without limitation on the number of terms);[28] the board may co-opt up to two missing members;[29] independent members (at least one-third) of the board must be independent, meeting specified criteria for independence 1) in relation to the company in which the individual is a member of the supervisory board, 2) in relation to the executive directors of the company, and 3) in relation to affiliated persons with that company and those directors[30] (including employment, ownership, property, and functional relationships);[31] remuneration for board members (procedures for establishing proposals and making decisions, including fixed and variable components (but not profit-sharing), establishing and defining the remuneration policy, ensuring transparency in reporting on remuneration policy, which must be made available for review, voting on the remuneration policy and the remuneration report);[32] termination of mandate prior to the end of the appointed period and removal (termination of fulfilling conditions, non-approval of annual financial statements at the regular assembly, removal without stated reasons);[33] resignation (members can resign at any time, the resignation takes is effective immediately unless a later date is specified, resignation must be registered);[34] reporting to the assembly (the obligation to report on accounting practices, financial statements, legal compliance, auditor qualifications, and contracts concluded between the company and members of the governing body, as well as with affiliated entities);[35] the chairman of the board (the chairman is elected by the board and holds specific responsibilities and powers as defined by the board; the chairman can be removed at any time without specifying reasons; in the event of the chairman's absence, any board member has the authority to schedule meetings; registering);[36] board operations (regulated by the statute and the rules of procedure adopted by the board) and board meetings

[26] CL, art. 433.
[27] CL, art. 434 in relation to art. 337.
[28] CL, art. 435 in relation to art. 385.
[29] CL, art. 436 in relation to art. 386.
[30] CL, arts. 391–392.
[31] CL, art. 437 in relation to art. 392.
[32] CL, art. 438 in relation to arts. 393 and 463a-463v.; IL, art.60.
[33] CL, art. 439 in relation to arts. 394 and 395.
[34] CL, art. 440.
[35] CL, art. 442 in relation to art. 399.
[36] CL, art. 443 in relation to art. 400.

(calling and notice period, quorum for holding and conducting meetings, attendance of other persons at the meeting, decision-making processes, the majority required for decision-making, including the chairman's deciding vote in case of a tie, preparation of minutes from the meetings and their distribution to board members);[37] board committees - *committees of the supervisory board are not decision-making bodies of the company but are working bodies* established by the supervisory board's decision. *They cannot make decisions on matters within the supervisory board's jurisdiction* (the obligation of the audit committee and the possibility of the nomination committee, compensation committee, and other board committees - if these optional committees are not established, their functions are performed by the supervisory board; composition of committees - the audit committee must include one independent board member who serves as the chair of the committee, as well as one authorized auditor; committees operate and make decisions by majority vote, with the committee chair having a deciding vote in the event of a tie);[38] board members are liable to the company for the damage resulting from their decisions (this liability extends to members who voted in favor of a decision, equivalent liability of members who abstained from, or equivalent liability of members who did not vote for the decision if they did not oppose it within a statutory period after its adoption; there is a statute of limitations for the company's claims for damages, the company may or may not waive its right to claim damages).[39]

Additionally, the Company Law stipulates *the analogous application of several provisions* related to the management board (i.e. directors or board of directors) and the supervisory board *of a joint-stock company with the one-tier management system*. These provisions also apply to the supervisory board of a joint-stock insurance company in a two-tier management system, in accordance with the specific law. This includes, in particular, liability (property liability and status liability in cases of removal)[40] for directors in the one-tier management model, which accordingly applies to members of the supervisory board in the two-tier management model of joint-stock companies.

The property liability of directors in a joint-stock company arises from the performance of duties within the jurisdiction of the directors and the board of directors. Similarly, the property liability of members of the supervisory board must stem from the performance of duties within the scope of this body's jurisdiction, rather than as a result of failures in the performance of the duties of executive directors and the executive board in the two-tier management model (whose liability is also regulated in accordance with the liability of directors and members of the board of directors in the one-tier management model).[41]

[37] CL, art. 445 in relation to arts. 402–407.
[38] CL, arts. 408–414.
[39] CL, art. 447 in relation to art. 415.
[40] CL, art. 439.
[41] CL, art. 427 and art. 430 in relation to art. 415.

Members of *the supervisory board*, just like directors (including legal representatives and procurators, and the liquidator for the company's liquidation), *are also individuals with legally prescribed duties towards the company*. This includes special duties of care (such as the care of a prudent businessman and/or expert). In accordance with the Law, for breaches of these duties, they can be liable for damages to the company based on a lawsuit filed by the company or shareholders with the prescribed capital threshold for derivative actions on behalf of the company (and/or to the shareholders of the company – individual or collective lawsuits). The liability of supervisory board members, and in terms of the according application of the rules governing the liability of directors (in the one-tier or the two-tier management systems), can be based solely on a breach of the prescribed duty of care and failing to act "in the best interest of the company" while performing their duties within their jurisdiction. This includes the "supervision of the work of executive directors" as well as numerous other duties within the scope of this body's jurisdiction as defined by law, the company statute, and the decisions of the shareholders' assembly. Therefore, it is always a matter of liability for damage caused to the company (and/or its shareholders) *by their actions or non-actions*, which includes a breach of the duty of care *in the performance of this supervision – liability for their own "fault"* (and not for the unlawful and/or harmful decisions of other company bodies). Due to the nature of their function and duties, members of the supervisory board are often in a position to bring attention to a decision by the executive directors or the executive board (comprising executive directors) that could cause harm to the company (and/or its shareholders). If they fail to do so and there is a breach of the prescribed duty of care, they are also liable for the damage resulting from the execution of such a decision (*partial liability for the "fault of others"*). It is necessary to determine the extent of the damage causally linked to the fault of the other body and the extent linked to the breach of the duty of care by the supervisory board members.

The according application of the rules regarding the property liability of directors and members of the board of directors in the one-tier management model, and on the property liability of supervisory board members and executive directors (individually or as members of the executive board and decisions of the executive board) in the two-tier management model of a joint-stock company, whether public or private, encompasses the same principles of liability. This involves the same underlying principles, the active legitimacy of individuals to initiate proceedings and file lawsuits, the passive legitimacy of individuals, the liability of members who voted for the decision and those who were absent from the meeting but did not oppose the decision in writing within the legally prescribed period, the liability of members who abstained from voting, the statute of limitations, the possibility of release from liability through a decision of the company assembly, and joint liability to the company and/or shareholders with the possibility of recourse - a specificity

regarding the circle of subjects of joint liability concerning the liability of directors in the one-tier management model due to the presence of the supervisory board in the two-tier management model. The same applies to liability towards third parties, in addition to the liability of the company as a legal entity, based on acceptance in corporate law and the direct liability of members of company bodies (a specific "piercing of corporate veil").[42]

4.3. Executive Board – Special Rules

The Insurance Law regulates only the minimum status-related issues concerning the executive board of a joint-stock insurance/reinsurance company, specifically addressing matters that deviate as special rules from the application from the application of this body under the general provisions of the Company Law. Firstly, regarding composition: the executive board consists of at least two members, with the maximum number determined by the company's statute (including the president of the executive board, who, by law, represents and acts on behalf of the company and is required to ensure the co-signature of another board member when representing the company). Joint-stock companies that are subject to the Company Law are required to have an executive board of at least three members (the maximum number is determined by the statute) if they are public (open) companies and have three or more executive directors in a two-tier management system. If they have one or two executive directors, they do not have an executive board. *Co-signature (joint representation)* is not compulsory for these companies but can be established by the statute, and it takes effect when registered and against third parties (the same applies to insurance companies as there are no specific provisions in the Insurance Law).[43] It is a common legal solution under both Company Law and Insurance Law, stipulating that a member of the executive board (or executive directors) cannot have a deputy *(due to the personal nature of the status),* as well as the provision that the supervisory board appoints the executive board of the company (or executive directors - *the two-tier model does not have non-executive directors or independent directors in the executive board*) and is obligated to register the members of this board (as well as the termination of mandate and resignations). Additionally, the scope of duties (jurisdiction), with logical specificities arising from the nature of insurance activities, of the executive board (including the scope of executive directors) is fundamentally regulated in the same manner under both laws.[44]

When there is no specific rule established by the Insurance law, the general provisions of the Company law that apply to executive directors and the executive

[42] See FCC, arts.754–761; *see also* G. Viney, *La responsabilité civile*, Paris, 1982, p. 555; Ph. Merle, A. Fauchon, pp. 494–495; M. Cozian, A. Viandier, F. Deboissy, p. 286.
[43] CL, arts. 419-420 and 33; IL, art. 57.
[44] CL, arts. 422 and 427; IL, art. 58.

board are also applicable to the executive board of a joint-stock insurance/reinsurance company. This applies to the following institutes governed by the Company Law: restrictions on the appointment of executive board members not covered by the restrictions specified by the Insurance Law (e.g. convictions for specified offenses while the legal consequences of the conviction are still in effect, security measures prohibiting business activities while such measures are in force, and multiple memberships (over five) on supervisory or executive boards of other companies - over five);[45] Proposal for appointment (by the nomination committee of the supervisory board if it exists, or, if not, by any member of the supervisory board[46] – in our opinion, it could also be another individual designated by the company's bylaws (e.g. any shareholder or a shareholder with a specified percentage of capital participation); mandate of directors (analogous to the mandate of supervisory board members – the presumed maximum statutory term or a shorter statutory term, with the possibility of reappointment);[47] the jurisdiction of the executive board and the jurisdiction of executive directors as members of the board (if there are any issues not regulated by the insurance law but regulated by the Company Law – e.g. certain executive board responsibilities requiring supervisory board approval)[48] – the Insurance Law introduces *the presumption of the executive board's jurisdiction* (deciding on all issues not decided by the general assembly and the supervisory board under the law and possibly the statute of the company), while the Company Law establishes the rule for insurance joint-stock companies that "issues within the jurisdiction of the executive board cannot be transferred to the supervisory board"[49]: the working method of the executive board (in managing the company's affairs, the executive board acts independently and generally makes decisions and takes actions outside of meetings. If there is no agreement among the executive directors as members, the president of the executive board "may call a meeting" to make decisions by a majority vote, with the president's vote being decisive in case of a tie – this is why the insurance law does not specifically regulate meetings of this company body, while it does regulate the institution of supervisory board meetings);[50] authorities of the president of the executive board appointed by the supervisory board (application of rules contained in the Company Law concerning the institute of the general director as the first executive officer, with the exclusion of individual representation due to the requirement for co-signature by one member of the executive board);[51] remuneration for members of the executive board – executive directors (fixed and

[45] CL, art. 418 in relation to art. 382.
[46] CL, art. 420.
[47] CL, art. 421 in relation to art. 385.
[48] IL, art. 58 and CL, art. 422.
[49] IL, art. 58 para. 2 item 13; CL, art. 427 item 2.
[50] IL, art. 56; CL, art. 429.
[51] CL, art. 423.

variable remuneration, but not in the form of participation in the company's profits, which may depend on the company's business results; remuneration policy, report on remuneration – transparency of remuneration, voting at the general assembly of the company on the remuneration policy and the report on remuneration);[52] termination of mandate and dismissal (according to the rules applicable to members of the supervisory board, but excluding the possibility of co-option by the executive board itself);[53] resignation (according to the rules applicable to the resignation of supervisory board members, but without the possibility of co-option in this case);[54] possibility of appointing a temporary representative by the court if the company has no executive director registered within the prescribed period (due to the co-signature obligation regulated by the Insurance Law, we believe two temporary representatives should be appointed);[55] company with two executive directors (including the president – provisions on the executive board apply except for provisions on board meetings);[56] reports by executive directors as a general rule under Company Law, with specific provisions from Insurance Law regarding the executive board's reporting to the company's assembly;[57] liability (property liability to the company or to shareholders) of executive directors as members of the executive board (according to the rules governing such liability for members of the supervisory board, considering the jurisdiction of both bodies within the company).[58]

The property liability of executive directors (or the executive board) in a two-tier management system *for damages* caused *to the company* by their business decisions, as well as *to the company's shareholders* (individual or collective lawsuits), and exceptionally *to third parties*, is governed accordingly by the rules that apply to directors and the board of directors in a one-tier management system.[59] Thus, the provisions regarding the liability of the board of directors in one-tier management model (including rules on collective decision-making, voting against a decision, abstaining from voting, the liability of non-attending members, joint liability, actively and passively legitimized parties, the statute of limitations, the possibility of relief from liability by decision of the assembly and similar) are accordingly applied to the executive board in a two-tier management system.[60]

[52] CL, art. 424, 393, 463a-v.
[53] CL, art. 425.
[54] CL, art. 426 items 1–3.
[55] CL, art. 426 items 3–6.
[56] CL, art. 428.
[57] CL, art. 431 in relation to art. 416.
[58] CL, art. 430 in relation to art. 415.
[59] CL, arts. 63–64 and 415.
[60] For more details, see N. Petrović Tomić (2019), pp. 209–212.

4.4. Joint-Stock Insurance Company Management

Unlike the law governing companies, which does not recognize the concept of "company management", the Insurance Law establishes this concept and explicitly defines that "management of a joint-stock insurance/reinsurance company includes both the supervisory board and the executive board." The establishment of this concept has enabled the insurance legislator to introduce some common principles that apply to the members of both bodies (the supervisory and executive boards).

First, the regulation of positive conditions for the appointment of members of these bodies (good business reputation, appropriate professional qualifications, necessary knowledge and experience as determined by the company's statute), as well as the regulation of negative conditions (prohibitions, impediments) that prevent an individual from being appointed to the management of such a company (convictions for criminal offenses specified by this Law, and on a broader basis than Company Law, certain protective measures imposed, revocation of a company's license to operate while the individual was a member of its management at that time or for a certain period prior, initiation of bankruptcy or forced liquidation proceedings against a company while the individual was a member of its management at that time or for a certain period prior, individuals who have had their consent to be a member of the management revoked by the NBS in the last three years, individuals dismissed from their management duties by NBS order in accordance with the law; individuals who are prohibited by the company law from being appointed as a member of these bodies, individuals connected with a legal entity in which the insurance joint-stock company holds a certain percentage of capital or voting rights, individuals who are members of the management or procurators in another insurance/reinsurance joint-stock company). Finally, it is also necessary to regulate additional appointment conditions by law (such as active knowledge of the Serbian language, residence or domicile in Serbia, full-time employment contract with the company for executive directors – *the two-tier model does not have non-executive directors, and not have independent directors in the executive board*) and by special NBS regulation.

Second, the system of prior approval by the National Bank of Serbia (NBS) for the appointment of members to the management of insurance/reinsurance companies (including the grounds for withholding such approval and the prohibition on submitting a new request for a period of one year from the date of such withholding). In contrast, there is also the possibility of revoking previously granted approval for such appointments if it is determined that there are legal grounds for such revocation (with a prohibition on granting new approval for such appointments for three years from the date of the NBS decision to revoke the approval).

Third, the Insurance Law prescribes specific rules for the duties and responsibilities of members of the management board of insurance and reinsurance

companies compared to the rules for members of the governing bodies of joint-stock companies regulated by the company law. These rules are dual: first, the establishment of a general rule – members of the management board of insurance/reinsurance companies are required to "take measures to prevent unlawful or inappropriate actions and influences that are harmful or not in the best interests of the insurance company and its shareholders, carried out by persons closely related to the company – for the protection of insurance service users",[61] in accordance with "regulations, professional rules, and good business practices."[62] This rule slightly modifies the general rule of liability for members of the governing bodies of joint-stock companies, known as the "Business Judgment Rule".[63] This general rule of liability for members of the management board of insurance and reinsurance companies is accompanied by several specific rules that clarify the grounds for this liability, focusing on the obligation to report along the lines of the executive board – supervisory board, and supervisory board – NBS. Specifically, in the first instance, the executive board is required to immediately inform the supervisory board in three cases: liquidity or solvency issues of the company, reasons for the revocation of the company's operating license, or reasons for discontinuing certain types of insurance, or inadequacy of the company's core capital. In the second instance, upon receiving this information from the executive board, the supervisory board is also required to immediately notify the NBS. For all these grounds of legal violations, both general and specific, damages may arise to the insurance/reinsurance company for which the management member is liable under the company law, given that there are no further specific provisions in the inusurance law.[64]

Finally, fourthly, the Insurance Law includes a specific common rule for informing the company's assembly about the remuneration of management members (both executive and supervisory boards).[65] Specifically, the assembly of the joint-stock insurance/reinsurance company must review, at least once a year, a written report from the management detailing all earnings, remunerations, and other earnings of the members, as well as all contracts concluded between the company and these individuals or their related parties,[66] which result in financial benefit for these individuals, as well as the supervisory board's proposal regarding the salaries, remunerations, and other financial benefits for these individuals for the upcoming year.[67]

[61] IL, art. 59 item 2.

[62] Under the term "insurance user" it denotes "insured, policyholder, insurance beneficiary, and third-party injured parties": IL, art. 15, para. 1. See Nataša Petrović Tomić, *Zaštita potrošača usluga osiguranja*, Belgrade, 2015, pp. 47–137.

[63] See Mirko Vasiljević, "Civil Law and Business Judgment Rule", *Anali Pravnog fakulteta Univerziteta u Beogradu*, No. 3/2012, pp. 7–38.

[64] CL, art. 415 and 447.

[65] IL, art. 60.

[66] The term "related party" as defined by the Insurance Law: IL, art. 30.

[67] IL, art. 60.

V Business Management System in Insurance Joint-Stock Company

Unlike commercial (profit-oriented) companies regulated by laws applicable to such enterprises, where the protective subject of the company's duties and liability (including financial liability for business decisions) is typically limited to the company itself (and potentially other risk-bearers like shareholders and company members), insurance/reinsurance joint-stock companies (as well as other insurance entities) engage in a specific economic activity for which the management of the company (both supervisory and executive boards) has particular duties and financial liability. These duties extend not only to the company and its members (as per the company law) but also to other protective subjects - insureds, policyholders, third-party injured parties, and insurance beneficiaries in general. This fact required that insurance legislation establish a distinct institute in insurance management - the company management system. This system includes 1) risk management, 2) internal control systems, 3) internal audit, and 4) actuarial practices.

The risk management system, as a segment of managing a joint-stock insurance/reinsurance company, encompasses: risk underwriting and reserving, asset and liability management, investments, liquidity and risk concentration management, operational risk management, reinsurance, and other risk mitigation methods. To ensure an effective risk management system, insurance legislation regulates the rules for risk management and the methods of managing risk.[68] The Insurance Law also provides detailed regulations for other segments of the comprehensive company management system: *internal control system, internal audit system, and actuarial practices*.[69] The National Bank of Serbia (NBS) establishes more detailed rules for all these systems.

VI Groups of Companies and Groups of Insurance Companies – Special Rules

The Insurance Law defines both the general concept of "group of companies" and the specific concept of "group of insurance companies". According to this Law, a group of companies consists of the parent company, its subsidiaries, and legal entities in which the parent company or its subsidiaries hold a capital share (capital participation), as well as companies that are interconnected through joint management. *A parent company* is a legal entity that holds a controlling interest in another legal entity. *A subsidiary* is a legal entity in which the parent company

[68] IL, arts. 149 and 150.
[69] IL, arts. 151–174.

holds a controlling interest. *Companies connected through joint management* are those that are not related as parent and subsidiary companies or through capital participation but are characterized by 1) managing in a unified manner according to an agreement between these companies or provisions of their founding acts or statutes (*management agreement*), or 2) having the same individuals as the majority members of the governing or supervisory bodies (*personal union*). This conceptual definition corresponds substantively to the definition of a group of companies, holding companies, companies with reciprocal capital participation, and control and management agreements as defined in the Company Law.[70]

A group of insurance companies is a group of companies as defined by the insurance law in which *an insurance company*, or a reinsurance company, is *the most significant entity within that group*. The most significant company in the group, according to this law, is considered to be *the ultimate parent company* within the group or the company that holds a substantial or controlling capital participation in another entity or effectively influences the management of that entity (significant holder), or the company with the largest balance sheet total if two or more companies within the group meet the criteria of a significant holder.[71]

VII Instead of a Conclusion

Analysis of the nature of the relationship between the law governing companies in general (general law) and the law governing insurance (special law), even though this concerns the relationship between special and general laws, where the special law takes precedence over the general law, and despite the fact that this special law opts, in cases where it has not provided a specific norm, for direct application of the general law by stating "applies," and this in two places (regarding the forms of special companies and common company institutions and company organs), thereby excluding the other possible option—"appropriate application"—shows that for a range of issues not regulated by the special norm, such application is not feasible and that "appropriate application" must be sought. Otherwise, it could result in undermining the purpose of certain existing norms within the special law, whose specificity has its own *ratio*.

[70] *Cf.* IL, art. 218(1–4) and CL, Articles 551–554.
[71] IL, art. 218. pp. 5–6.

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PRAVCI RAZVOJA TRŽIŠTA OSIGURANJA

ORIGINALNI NAUČNI RAD

Apstrakt

Globalno tržište osiguranja važan je deo svetske ekonomije i na njegov razvoj utiču makroekonomski faktori, intenziviranje postojećih rizika i pojava novih, promene regulative, globalizacija, liberalizacija itd. Pandemija koronavirusa (COVID-19), prirodne katastrofe ogromnih razmera, inflacija i geopolitički događaji, uticali su, u najvećoj meri, na pad ili usporavanje rasta globalne ekonomije i svetskog tržišta osiguranja. Došlo je do blagog pada globalne premije osiguranja u 2022. godini u odnosu na 2021. godinu, a prema preliminarnim rezultatima, 2023. nastupio je blagi porast premije osiguranja u odnosu na 2022. godinu. Promene su se dogodile u ponudi usluga osiguranja, tražnji za njima i poslovanju osiguravača. Predmet rada je analiza pravaca razvoja svetskog tržišta osiguranja. Cilj rada je da se istakne stepen razvijenosti osiguranja u svetu i ukaže na spremnost svetskog tržišta osiguranja da se odupre negativnim pojavama i iskoristi savremene izazove za rast i poboljšanje performansi.

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Rad prihvaćen: 19.8.2024.

Ključne reči: *tržište osiguranja, životno osiguranje, neživotno osiguranje, pravci razvoja, COVID-19, prirodne katastrofe, inflacija, digitalizacija.*

I Uvod

Obezbeđujući stabilnost funkcionisanja vitalnih procesa, osiguranje doprinosi stvaranju preduslova za ekonomski rast društva. Usporavanje globalnog ekonomskog rasta u etapama, visoka inflacija i geopolitička neizvesnost imaju ogroman uticaj na svetsko tržište osiguranja. Analiza prethodno navedenih promena veoma je važna za definisanje mogućnosti prilagođavanja i strategije razvoja tržišta osiguranja. U radu će biti analizirani pravci razvoja i savremeni izazovi na svetskom tržištu osiguranja.

II Pokazatelji razvijenosti svetskog tržišta osiguranja

Svet je izložen sve većem broju makroekonomskih šokova već dugi niz godina, i to od svetske finansijske krize 2008/2009. godine, krize evra, sve do krize izazvane pandemijom COVID-19[5] i razornih geopolitičkih sukoba. Uprkos negativnim dejstvima prethodno navedenih šokova, ispoljena je relativna otpornost globalnog tržišta osiguranja. Ekonomski šokovi mogu da utiču negativno na premiju osiguranja, obim odštetnih zahteva, kao i na rezultate investiranja sredstava.[6] U 2023. godini, procena je da su prihodi od globalne premije osiguranja iznosili oko 7100 milijardi $, što predstavlja blagi porast globalne premije osiguranja u odnosu na 2022. godinu, kada je ona iznosila oko 6782 milijarde $ (i u 2024. godini se očekuje realni rast od 1,7% u odnosu na 2023. godinu, ali su ovi rezultati ispod desetogodišnjeg proseka (2012–2021. godina) od 2,6%). Taj blagi rast nastupa nakon pada globalne premije osiguranja od 1,1% u 2022. u odnosu na 2021. godinu. U 2022. globalna premija neživotnog osiguranja iznosila oko 3969 milijardi $ (58,52% svetske premije osiguranja), a globalna premija životnog osiguranja je dosegla oko 2813 milijardi $ (41,48% svetske premije osiguranja).[7] Tri tržišta osiguranja, u 2022. godini, s najvišim iznosima premije osiguranja (nominalno) bila su: tržište osiguranja SAD (2960 mlrd $), Kine (698 mlrd $) i Velike Britanije (363 mlrd $).[8] Udeo premije osiguranja SAD u ukupnoj

[5] Svetska zdravstvena organizacija je proglasila pandemiju COVID-19 11. 3. 2020. godine, a 5. 5. 2023. godine proglašen je kraj pandemije (oko 765 miliona obolelih i oko 6,9 miliona preminulih osoba u svetu od posledica COVID-19), Tatjana Rakonjac-Antić, *Penzijsko i zdravstveno osiguranje*, Ekonomski fakultet Univerziteta u Beogradu, 2024, str. 223, prema www.who.int.

[6] Allianz Research, „Allianz Global Insurance Report 2023: Anchor in turbulent times", 2023, *https://www.allianz.com/en/economic_research/insights/publications/specials_fmo/global-insurance-report.html*, pristupljeno 10. 7. 2024, str. 18.

[7] Swiss Re Institute, „World insurance: stirred, and not shaken", *Sigma,* No. 3/2023, Zürich, 2023, str. 19–42.

[8] U 2021. godini japansko tržište osiguranja bilo je na trećem mestu s premijom osiguranja od 398 mlrd $, a britansko tržište osiguranja na četvrtom mestu sa premijom osiguranja od 374 mlrd $.

svetskoj premiji osiguranja porastao je 2022. u odnosu na 2021. godinu sa oko 40% na oko 44% kao posledica rasta premija glavnih vrsta osiguranja i aprecijacije dolara u odnosu na skoro sve glavne valute u svetu. Kinesko tržište osiguranja zadržalo je istovetno učešće premije osiguranja u ukupnoj svetskoj premiji osiguranja sa 10,3%, a učešće premije osiguranja tržišta Velike Britanije u ukupnoj svetskoj premiji osiguranja iznosilo je 5,4% (videti detaljnije informacije prikazane u okviru Tabele 1).

Tabela 1. Premija osiguranja (nominalno) na deset najvećih tržišta osiguranja u svetu

Država (tržište)	Ukupna premija u mlrd $ u 2022. godini	Ukupna premija u mlrd $ u 2021. godini	% promene	Globalno tržišno učešće u 2022. godini	Globalno tržišno učešće u 2021. godini
SAD	2960	2725	8,6%	43,7%	40,3%
Kina	698	696	0,2%	10,3%	10,3%
Velika Britanija	363	374	-2,8%	5,4%	5,5%
Japan	338	398	-15,1%	5,0%	5,9%
Francuska	261	293	-10,7%	3,9%	4,5%
Nemačka	242	272	-11,3%	3,6%	4,0%
Južna Koreja	183	193	-5,3%	2,7%	2,9%
Kanada	171	166	2,8%	2,5%	2,5%
Italija	160	192	-16,5%	2,4%	2,8%
Indija	131	123	6,5%	1,9%	1,8%

Izvor: Pripremljeno prema Swiss Re Institute, „World insurance: stirred, and not shaken", *Sigma,* No. 3/2023, Zürich, 2023, str. 40.

Učešće ukupne premije osiguranja pet najvećih tržišta osiguranja (SAD, Kina, Velika Britanija, Japan, Francuska) u ukupnoj svetskoj premiji osiguranja povećalo se u 2022. godini (68,3%) u odnosu na 2021. godinu (66,5%). Među dvadeset najvećih tržišta osiguranja u 2022. godini bilo je pozicionirano sedam tržišta osiguranja država Azije (Kina, Japan, Južna Koreja, Indija, Tajvan, Hongkong, Singapur) sa učešćem premije osiguranja u globalnoj premiji osiguranja od 22,9%. Prosečna realna godišnja stopa rasta premije osiguranja u Kini od 2009. do 2018. godine iznosila je 13,4%.[9] Ako bi se nastavila takva tendencija, izvesno je da bi Kina, zajedno sa ostalim azijskim državama, koje se po veličini premije osiguranja nalaze u prvih dvadeset država sveta, predstavljala važan pokretač razvoja i u narednom periodu. Procena je da će Kina biti jedan od ključnih učesnika u globalnoj ekonomiji i na strani proizvodnje i na strani

[9] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Koprivica, Predrag Šulejić, *Osiguranje u teoriji i praksi*, Ekonomski fakultet Univerziteta u Beogradu, 2021, str. 433.

potrošnje.[10] Indijsko tržište osiguranja jedno je od najbrže rastućih tržišta osiguranja na svetu (sa globalnim tržišnim učešćem u 2022. godini od oko 1,9%). U 2022. u odnosu na 2021. godinu premija na ovom tržištu osiguranja porasla je za 6,5%. Predviđanja su da će, ako se rast nastavi ovim tempom, indijsko tržište osiguranja do 2032. godine biti šesto tržište osiguranja po veličini ukupne globalne premije osiguranja.[11]

Tabela 2. Deset najbolje rangiranih država prema ukupnim premijama osiguranja *per capita* i % GDP-a, 2022. godina

Rang	Država	Ukupna premija osiguranja *per capita* ($)	Rang	Država	Ukupna premija osiguranja kao % GDP-a
1.	Kajmanska ostrva	20.834	1.	Kajmanska ostrva	23,2
2.	Hongkong	9159	2.	Makao	20,9
3.	SAD	8885	3.	Hongkong	19,0
4.	Singapur	7563	4.	SAD	11,6
5.	Danska	7320	5.	Tajvan	11,4
6.	Makao	6605	6.	Južnoafrička Republika	11,3
7.	Švajcarska	6364	7.	Južna Koreja	11,1
8.	Irska	5438	8.	Danska	10,9
9.	Švedska	5180	9.	Ujedinjeno Kraljevstvo	10,5
10.	Finska	5036	10.	Finska	10,0
	Svet (ukupno)	853		Svet (ukupno)	6,8

Izvor: Pripremljeno prema Swiss Re Institute, „World insurance: stirred, and not shaken", *Sigma,* No. 3/2023, Zürich, 2023.

Ukupna premija osiguranja *per capita* u svetu je u 2022. godini iznosila 853 $ i 6,8% GDP-a (videti detaljnije informacije po državama u Tabeli 2).

III Globalne promene u poslovanju osiguravača

Pored već postojećih, poslednjih godina, intenziviraju se novi digitalni, socijalni, ekonomski, zdravstveni, klimatski, geopolitički i drugi rizici koji utiču na poslovanje osiguravača i ponudu usluga osiguranja.[12] Najviše pod uticajem

[10] Allianz Research, str. 10.
[11] Swiss Re Institute, „World insurance: inflation risks front and centre", *Sigma,* No. 4/2022, Zürich, 2022, str. 15.
[12] Kennedys Law, „2022 insurance industry forecast: trends and future risks", *https://kennedyslaw.com/en/thought-leadership/reports/trends-and-future-risks*, pristupljeno 6. 7. 2024, str. 2–14.

COVIDa-19, ubrzan je proces automatizacije i digitalizacije na tržištu osiguranja i ovo iskustvo omogućilo je bolje uslove za njegovu adekvatnu pripremu za eventualne buduće pandemije. Prethodno navedena pandemija, klimatske promene, katastrofalni prirodni događaji, inflacija, promene na tržištu rada, zahtevi osiguranika, promena regulative, pojava konkurentskih institucija, novih tehnoloških i finansijskih usluga itd. uslovili su i globalne promene u poslovanju osiguravača. Klimatske promene se ubrzavaju uz ekstremna ispoljavanja poslednjih godina, što zahteva brzu reakciju osiguravača.[13] Za bolje upravljanje rizicima klimatskih promena potrebno je i jačanje javno privatnih partnerstava.[14] U 2023. godini evidentirana je 291 mlrd $ ekonomskih šteta od prirodnih katastrofa, što prevazilazi desetogodišnji prosek od 235 mlrd $. Osiguravači su isplatili 108 mlrd $ naknada šteta od prirodnih katastrofa nastalih u 2023. godini, što ovu godinu čini jednom od godina s najvećim isplaćenim naknadama šteta u istoriji. Već četvrtu godinu za redom, osigurane štete usled prirodnih katastrofa na globalnom nivou prevazišle su 100 mlrd $, i očekuje se da će u dugom roku nastaviti da rastu po stopi od 5 do 7% godišnje.[15]

Svetski makroekonomski ambijent je iz godine u godinu sve složeniji. U uslovima inflacije smanjuje se kupovna moć osiguranika i potencijalnih osiguranika, povećavaju se troškovi u vezi s nadoknadom šteta (pogotovo u sektoru zdravstvenog i imovinskog osiguranja), uvećava se rizik od nedostizanja odgovarajućeg prinosa na investirana sredstva premija osiguranja itd.[16] Mere monetarne politike koje se primenjuju s ciljem stabilizovanja inflacije mogu uticati na recesiju itd. Razvija se gig ekonomija u okviru koje poslodavci s radnicima zaključuju ugovore za kratkoročne poslove. To je nov oblik zapošljavanja koji menja tradicionalni odnos poslodavca i zaposlenog. Fleksibilno je radno vreme, zadaci su uglavnom kratkoročni i mnogi radnici rade na daljinu. Novi oblici zapošljavanja utiču i na skiciranje novih usluga osiguranja. Regulativa u vezi sa solventnošću je rigoroznija, s ciljem da obezbedi uslove za nesmetano poslovanje osiguravača i, pre svega, za zaštitu korisnika osiguranja.

Osnovni pokretači četvrte industrijske revolucije su veštačka inteligencija[17], »big data«, tj. analitika velikih podataka, mašinsko učenje, internet stvari, robotika, »blockchain«, autonomna vozila, 3-D štampa, nanotehnologija, biotehnologija itd. Primenom prethodno navedenih tehnologija omogućava se opstanak i razvoj osiguravača u digitalnom svetu.[18] „Big data" (analitika velikih podataka) se odnosi

[13] International Association of Insurance Supervisors, Global Insurance Market Report, Basel, 2023, str. 41–56.
[14] Miloš Pjanić, Milica Inđić, Vera Zelenović, Mirela Mitrašević, „Insurance industry: opportunities and challenges" in Engineering management and competitiveness (2024) (EMC 2024), str. 225-230.
[15] Swiss Re Institute, „Natural catastrophes and inflation in 2023: gearing up for today's and tomorrow's weather risks", *Sigma,* No. 1/2024, Zürich, 2024.
[16] Eduardo D'Alma, August Majer, Global Insurance Market Pulse 2023/2024, Wavestone, 2023, str. 6.
[17] Karl Hersch, James Colaco, Michelle Canaan, 2024 global insurance outlook, Deloitte Center for Financial Services, 2024, str. 12-15.
[18] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Koprivica, Predrag Šulejić, *Osiguranje u teoriji i praksi*, Ekonomski fakultet Univerziteta u Beogradu, 2021, str. 444-448, prema, Schwab K., Davis N. "Shaping the Fourth Industrial Revolution", World Economic Forum, Geneva, 2018, str. 7.

na ogromne skupove podata kojima osiguravači mogu da pristupe ili su ih sami sakupili, a koje mogu da analiziraju radi dobijanja informacija o rizicima osiguranika, rizicima poslovanja itd. Dostupnost prethodno navedenih podataka osiguravačima daje konkurentsku prednost u odnosu na druge subjekte koji nemaju pristup datim podacima.[19] Digitalizacijom u osiguranju se uspostavljaju novi načini komunikacije sa osiguranicima, novi načini realizovanja poslovnih procesa, ali se stvaraju i novi rizici. Najvažniji efekti digitalizacije na sektor osiguranja su: poboljšanje iskustva osiguranika, unapređenje poslovnih procesa, razvoj novih proizvoda (usluga).[20]

„Insurtech" kompanije su novi učesnici na tržištu osiguranja koji koriste prednosti novih tehnologija da obezbede osiguravajuće pokriće za digitalno pismene osiguranike. U ponudi imaju personalizovane usluge i rade u uslovima potpune automatizacije poslovnih procesa. Te kompanije su usmerene na neiskorišćene segmente tržišta osiguranja i na pojedinačne usluge (npr. telematičko osiguranje). Poboljšanje iskustva osiguranika, unapređenje poslovnih procesa osiguravača, razvoj novih usluga osiguranja predstavljaju najznačajnije efekte digitalizacije na ovaj sektor. Osiguravači radi pravovremenog pružanja relevantnih informacija osiguranicima i potencijalnim osiguranicima u vezi sa osiguranjem koriste: veb-sajtove, aplikacije za mobilne uređaje, robotske savetnike, društvene mreže (npr. *Facebook*), video platforme (npr. *YouTube*) itd. Uz tradicionalne kanale prodaje (direktna prodaja, prodaja preko zastupnika i posrednika), raste i udeo alternativnih digitalnih kanala prodaje osiguranja putem interneta, društvenih medija i mobilnih aplikacija.[21] Tendencija koncentracije i centralizacije kapitala takođe su karakteristike svetskog tržišta osiguranja. Glavni pokretači konsolidacije u osiguranju su sve učestaliji katastrofalni rizici, regulatorne promene i tehnološki progres. Ukrupnjavanje kapitala proizlazi iz potrebe za osiguranjem od krupnih rizika, rastućih solventnosnih kapitalnih zahteva i nastojanja da se kroz spajanja i pripajanja sa inovativnim kompanijama tehnološkim liderima olakša digitalna transformacija tradicionalnih osiguravača.[22] Za savremeno tržište osiguranja, katastrofalni rizici predstavljaju izazov koji preti da ugrozi performanse osiguravača, ali istovremeno i priliku za dalju ekspanziju i razvoj sektora, naročito u zemljama u razvoju, gde je stepen pokrivenosti katastrofalnih šteta osiguranjem nizak.[23]

[19] Dino Wilkinson, Alec Christie, Anthony A Tarr, Juli-Anne Tarr, "Big Data, Artificial Intelligence and Insurance. In The Global Insurance Market and Change, 2024., Chapter 2.

[20] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Koprivica, Predrag Šulejić, *Osiguranje u teoriji i praksi*, Ekonomski fakultet Univerziteta u Beogradu, 2021, str. 444-448, prema, Eling M., Lehman M. "The Impact of Digitalization on the Insurance Value Chain and the Insurability of Risks", Geneva Papers on Risk and Insurance - Issues and Practice, 43(3), 2018, str. 363.

[21] J. Kočović, T. Rakonjac-Antić, M. Koprivica, P. Šulejić, (2021). str. 444-448.

[22] Jelena Kočović, Marija Koprivica, Željko Jović, „Sustainable Developments of Insurance in Crisis Conditions", Contemporary Challenges and Sustainability of the Insurance Industry (editors Jelena Kočović, Biljana Jovanović Gavrilović, Branislav Boričić, Marija Koprivica), University of Belgrade, Faculty of Economics, Belgrade, 2021, str. 137–157.

23 Jelena Kočović, Marija Koprivica, Gorana Krstić, „Catastrophic risks and contemporary insurance market", Challenges and tendencies in contemporary insurance market (editors Jelena Kočović,

IV Savremeni trendovi na tržištu neživotnog i životnog osiguranja u svetu

Globalna premija neživotnog osiguranja je u 2022. godini u odnosu na 2021. godinu porasla za 0,5% (realno), a procena je da je u 2023. ostvareno povećanje od 1,4% u odnosu na 2022. godinu (videti Grafikon 1). Predviđa se da će osnovni pokretač daljeg rasta globalne premije neživotnog osiguranja biti jačanje privrednih aktivnosti. Osiguravači su, generalno, povećavali premije osiguranja radi obezbeđenja sredstava za pokriće rastućih troškova po osnovu šteta usled inflacije.[24] Najviše je ostvarena premija osiguranja u zdravstvenom osiguranju, 49% od ukupne premije neživotnog osiguranja.[25] SAD, kao najznačajnije svetsko tržište zdravstvenog osiguranja, prema prvim preliminarnim rezultatima, imalo je pad premije zdravstvenog osiguranja od 1,4% (realno) u 2023. godini usled smanjenja tražnje nakon pandemije COVIDa-19. Za razliku od razvijenih država Evrope na čijem tržištu nisu na vidiku značajne promene, na azijskom tržištu očekuje se nastavak rasta premije zdravstvenog osiguranja. Za 2023. godinu procenjen je rast od 8,9% koji je potpomognut državnim medicinskim pokrićima i digitalizacijom. Procena je da je globalna premija zdravstvenog osiguranja smanjena za 0,6% u 2023. godini, a da će doći do blagog povećanja u 2024. godini. U osiguranju motornih vozila ostvareno je oko 21% ukupne globalne premije neživotnog osiguranja, a procenjuje se, prema preliminarnim rezultatima, da je u 2023. godini ostvaren rast premije ove vrste osiguranja od 2,8% (realno). Za 2024. godinu očekuje se rast od 2,2% kao posledica jačanja ekonomskih uslova i realizovanja ranije potražnje za motornim vozilima nakon odblokiranja zastoja u lancu snabdevanja. Premija osiguranja imovine u globalnoj premiji neživotnog osiguranja u 2022. godini učestvovala je sa 14%. Značajan rast premija osiguranja od odgovornosti bio je u 2021. godini, 12,3%, a u 2022. godini rast je iznosio samo 1,6% (realno).[26] Očekuje se dalji rast premije osiguranja kredita i osiguranja jemstva koje već dugi niz godina rastu za oko 5,1% (nominalno) na godišnjem nivou.[27]

Branislav Boričić, Biljana Jovanović Gavrilović, Martin Balleer), University of Belgrade, Faculty of Economics, Belgrade, 2017, str. 3-31.

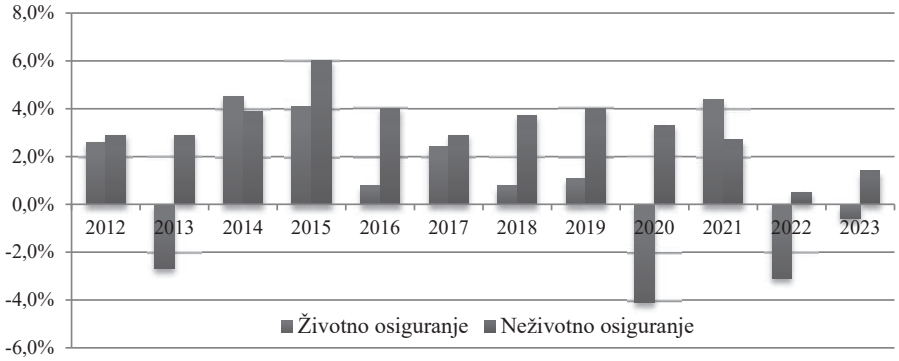
[24] www.swissre.com.

[25] Ukoliko se tržište neživotnog osiguranja podeli na zdravstveno osiguranje, personalno (individualno) osiguranje i komercijalno osiguranje (pravna lica zaključuju ugovore o osiguranju), u 2022. godini premija zdravstvenog osiguranja u okviru globalne premije neživotnog osiguranja učestvovala je sa 49%, u okviru personalnog osiguranja ostvareno je bilo 25%, a u okviru komercijalnog osiguranja 26% globalne premije neživotnog osiguranja.

[26] U svim regionima sveta rast je bio skroman osim u Aziji.

[27] Swiss Re Institute, „World insurance: stirred, and not shaken", *Sigma,* No. 3/2023, Zürich, 2023, str. 16–26.

Grafikon 1. Realne godišnje stope rasta premije životnog i neživotnog osiguranja u svetu (2012–2023. godina)



Izvor: Pripremljeno prema https://www.sigma-explorer.com/

Globalna stopa rasta premije životnih osiguranja u svetu u 2020. godini bila je negativna (-4,4%). U prethodnom desetogodišnjem periodu zabeležen je realan rast (po stopi od 1,7% prosečno godišnje).[28] Procena je da je nakon smanjenja globalne premije životnog osiguranja u 2022. godini za 3,1% u odnosu na 2021. godinu došlo do povećanja premije životnog osiguranja od 0,7% (realno) u 2023. godini. Taj rast je posledica povećanja izdvajanja za štednju stanovništva, rasta premija osiguranja po pojedinačnim ugovorima o osiguranju, porasta kamatnih stopa[29] itd. Rast premija osiguranja je brži kod zemalja u razvoju i zemalja Azije u odnosu na visokorazvijene zemlje.[30] Usled porasta prihoda od ulaganja sredstava i smanjenja odštetnih zahteva po osnovu COVIDa-19, došlo je do povećanja profitabilnosti osiguravača na globalnom tržištu životnog osiguranja.[31] Radi povećanja otpornosti poslovanja životnih osiguravača na pandemiju COVIDa-19, potrebno je bilo sprovođenje proaktivnog upravljanja rizikom.[32]

[28] Jelena Kočović, „Contemporary challenges and perspecives of insurance market development", Development of Modern Insurance Market: Constraints and Possibilities (editors Jelena Kočović, Biljana Jovanović Gavrilović, Žaklina Stojanović, Zorica Mladenović, Dejan Trifunović, Marija Koprivica), University of Belgrade, Faculty of Economics, Belgrade, 2022, str. 3–20.

[29] Swiss Re Institute, „Life insurance in the higher interest rate era: asset-savvy is the new asset-light", *Sigma,* No. 2/2024, Zürich, 2024, str. 15.

[30] Swiss Re Institute, „World insurance: stirred, and not shaken", *Sigma,* No. 3/2023, Zürich, 2023, str. 26.

[31] Swiss Re Institute, „Economic stress reprices risk: global economic and insurance market outlook 2023/24", *Sigma,* No. 6/2022, Zürich, 2022, str. 32.

[32] Maria Carannante, Valeria D'Amato, Paola Fersini, Salvatore Forte, Giuseppe Melisi, „Disruption of Life Insurance Profitability in the Aftermath of the COVID-19 Pandemic", Risks, 10:40, *https://doi.org/10.3390/risks10020040*, str. 13.

V Pravci razvoja tržišta osiguranja u Srbiji

Na tržištu osiguranja u Srbiji još od 2018. godine posluje 16 društava za osiguranje. Ukupna premija osiguranja u 2022. godini iznosila je oko 1,2 mlrd $. Od prethodno navedenog iznosa 78,6% je ostvareno premije u neživotnom osiguranju, a 21,4% u životnom osiguranju (videti podatke prikazane u okviru Tabele 3). Među osnovne pokazatelje stepena razvijenosti tržišta osiguranja, a i važne indikatore ekonomske razvijenosti države, svrstavaju se premija osiguranja *per capita* (gustina osiguranja) i procentualno učešće premije osiguranja u bruto domaćem proizvodu (penetracija osiguranja).

Tabela 3. Pokazatelji razvijenosti tržišta osiguranja Srbije (2012-2022.)

Pokaz./ God.	2012.	2013.	2014.	2015.	2016.	2017.	2018.	2019.	2020.	2021.	2022.
Br. osig. komp.	24	24	21	20	19	17	16	16	16	16	16
Ukupna premija osig. u mil $	713	770	698	727	761	939	966	1,024	1,067	1,200	1,200
Bilansna suma osig. sektora u finans. sektoru (%)	4,5	4,8	5,2	5,8	6,1	6,3	6,7	6,6	6,0	6,0	5,6
Premija *per capita* ($)	96	104	111	105	114	123	140	150	154	176	179
Premija u BDPu (%)	1,8	1,8	1,9	2,0	2,0	2,1	2,0	2,0	2,0	1,9	1,9
Premija životnog osig. (% od ukupne premije osig.)	19,3	22	23,1	23,9	25,9	24,4	23,8	23,3	23,8	22,7	21,4
Premija neživotn. osig. (% od ukupne premije osig.)	80,7	78	76,9	76,1	74,1	75,6	76,2	76,7	76,2	77,3	78,6

Izvor: Kočović, str. 15. prema www.nbs.rs i www.institute.swissre.com

Relativno stabilno učešće ukupne premije osiguranja u bruto domaćem proizvodu ukazuje na uravnoteženo kretanje dva parametra tokom vremena, što predstavlja posledicu uzajamne uslovljenosti ekonomskog razvoja i razvoja tržišta osiguranja.[33] Prema vrednosti tog pokazatelja od 1,9% u 2022. godini, Srbija se svrstala na 65. mesto u svetu, dok je isti indikator u zemljama EU iznosio 6,4%. Premija osiguranja *per capita* u 2022. godini u Srbiji je iznosila 177 $, što je petostruko više u poređenju sa 2002. godinom (33 $). Prema tom indikatoru, srpsko tržište osiguranja je u 2022. godini bilo rangirano na 63. mestu u svetu. Na prvom mestu su se nalazila Kajmanska ostrva sa 20.834 $ premije osiguranja *per capita* (videti podatke prikazane u okviru Tabele 2). Slovenija je, sa 1396 $ premije osiguranja *per capita*, bila rangira na 30. mestu u svetu. Hrvatska je sa 456 $ premije osiguranja *per capita* u istoj godini bila rangirana na 43. poziciji u svetu. Prosečna premija osiguranja *per capita* u zemljama članicama EU iznosila je 2377 $ u 2022. godini.[34] Najveće učešće u ukupnoj premiji osiguranja u Srbiji od 29,1% u 2022. godini ostvarilo je osiguranje od odgovornosti zbog upotrebe motornih vozila, kao obavezna vrsta osiguranja. Učešće premije životnih osiguranja tokom poslednjih godina je relativno stabilno. U 2022. godini je iznosilo 22,7% od ukupne premije osiguranja.[35]

Razvoj srpskog tržišta osiguranja uslovljen je prvenstveno kretanjima u makroekonomskom ambijentu. Od primarnog značaja su povećanje zaposlenosti i životnog standarda stanovništva, jačanje privrednih aktivnosti, stabilnost nacionalne valute, razvoj finansijskog tržišta itd. Za funkcionisanje osiguranja, obezbeđenje sredstava za isplatu osiguranih suma i naknade šteta kao i realizaciju finansijsko akumulatorske funkcije osiguranja, između ostalog, važna je i razvijenost tržišta novca i tržišta kapitala. Na kraju 2021. godine usvojena je Strategija razvoja tržišta kapitala za period 2021-2026. godina sa ciljem stvaranja adekvatnih uslova za ulaganje sredstava za sve učesnike, među kojima su i osiguravači.[36] Budući da regulatorni okvir u velikoj meri utiče na razvoja tržišta osiguranja, tokom poslednje decenije sprovedeno je nekoliko važnih promena u regulativi koja se odnosi na poslovanje društava za osiguranje u Srbiji po ugledu na pravna rešenja u ekonomski razvijenim zemljama (primena elemenata Solventnosti II). Razvoj kvalitetne i potpune statistike osiguranja na nacionalnom nivou preduslov je za tačnost aktuarskih obračuna i baza

[33] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Jović, „Effects of privatization model of insurance market in transition economies", From Global Crisis to Economic Growth Which Way to Take? Vol. I, Economics (editors Miomir Jakšić, Božidar Cerović, Aleksandra Praščević), University of Belgrade, Faculty of Economics, Belgrade, 2012, str. 486.

[34] Swiss Re Institute, „World insurance: stirred, and not shaken", *Sigma,* No. 3/2023, Zürich, 2023.

[35] Narodna banka Srbije, Sektor osiguranja u Republici Srbiji: Izveštaj za 2022, Beograd, 2023, str. 13.

[36] Miloš Petrović, "Brief overview of particular elements of the capital market development strategy (2021): adjustment of insurance industry to European union standards", Tokovi osiguranja, 4/2022, str. 110-111., prema, Strategija za razvoj tržišta kapitala za period 2021. do 2026. godine („Službeni glasnik RS", br. 102/2021).

zdravog rasta tržišta u budućnosti.[37] U uslovima ubrzanih tehnoloških promena, važno je da osiguravači prepoznaju i iskoriste mogućnosti koje pruža digitalizacija za poboljšanje iskustva osiguranika, unapređenje poslovnih procesa i obezbeđenje novih usluga. Konstantno je neophodno ulaganje napora za osnaživanje i unapređenje međusobnog poverenja između učesnika na tržištu osiguranja i jačanje poslovne etike i društveno odgovornog poslovanja osiguravača.[38]

V Zaključak

Pod uticajem usporavanja rasta globalne ekonomije, inflatornih pritisaka, geopolitičkih događaja, prirodnih katastrofa, pandemije COVIDa-19, pooštravanja regulative, ispoljavanja starih i pojave novih rizika, globalizacije, liberalizacije itd., došlo je do promena u poslovanju osiguravača i u ponudi usluga osiguranja. Intenziviran je proces ukrupnjavanja kapitala, konsolidacije u osiguranju, digitalizacije i automatizacije poslovnih procesa. Pored korišćenja tradicionalnih kanala prodaje (direktna prodaja, prodaja preko zastupnika i posrednika), povećan je i udeo alternativnih digitalnih kanala prodaje osiguranja putem interneta, društvenih medija i mobilnih aplikacija. U 2022. godini zabeležen je blagi pad globalne premije osiguranja u odnosu na 2021. godinu, što ukazuje na to da je tržište osiguranja pokazalo priličnu otpornost na makroekonomske šokove izazvane pandemijom COVIDa-19 i sukobom u Ukrajini. Prema preliminarnim rezultatima, u 2023. godini ostvaren je mali rast ukupne svetske premije osiguranja u odnosu na 2022. godinu. U 2022. globalna premija neživotnog osiguranja je iznosila 58,52% svetske premije osiguranja, a globalna premija životnog osiguranja iznosila je 41,48% svetske premije osiguranja. Tržišta osiguranja s najvišim iznosima premije osiguranja, u 2022. godini, bila su tržišta osiguranja SAD (globalno tržišno učešće oko 44%), Kine (globalno tržišno učešće oko 10%) i Velike Britanije (globalno tržišno učešće oko 5%). U Srbiji je u 2022. godini 78,6% od ukupne premije osiguranja akumulirano u neživotnom osiguranju, a 21,4% u životnom osiguranju. Najveće učešće u ukupnoj premiji osiguranja, od 29,1%, imalo je osiguranje od odgovornosti za upotrebu motornih vozila (obavezno osiguranje). Prema vrednosti pokazatelja učešća premije u bruto domaćem proizvodu od 1,9% u 2021. godini, Srbija se nalazila na 65. mestu u svetu, a prema pokazatelju premija osiguranja per capita od 176 $, bila je pozicionirana na 62. mestu na svetu. Za razvoj srpskog tržišta osiguranja od izuzetne važnosti je razvoj privrede, povećanje nivoa zaposlenosti i životnog standarda stanovništva, primena unapređenih regulatornih okvira, razvoj finansijskog tržišta itd.

[37] J. Kočović, M. Koprivica, G. Krstić, str. 12.
[38] Ivana Soković, „Značaj osiguranja i perspektive razvoja u Srbiji", Tokovi osiguranja, 2/2024, str. 277-278.

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TRENDS IN INSURANCE MARKET DEVELOPMENT

Abstract

The global insurance market is a crucial part of the world economy and its development is influenced by macroeconomic factors, the intensification of existing risks and the emergence of new ones, regulatory changes, globalization, liberalization, and more. The COVID-19 pandemic, large-scale natural disasters, inflation, and geopolitical events have significantly impacted the decline or slowdown in the growth of the global economy and the world insurance market. There was a slight decrease in global insurance premiums in 2022 compared to 2021, and preliminary results suggest a slight increase in insurance premiums in 2023 compared to 2022. Changes have occurred in the provision of insurance services, demand for them, and insurers' operations. The focus of this paper is the analysis of the trends in the development of the global insurance market. The goal is to highlight the degree of insurance development worldwide and to assess the global insurance market's readiness to withstand negative phenomena and leverage contemporary challenges for growth and performance improvement.

Keywords: *insurance market, life insurance, non-life insurance, development trends, COVID-19, natural disasters, inflation, digitalization.*

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I. Introduction

By ensuring the stability of vital processes, insurance contributes to creating conditions for the economic growth of society. The phased slowdown in global economic growth, high inflation, and geopolitical uncertainty have a tremendous impact on the global insurance market. Analyzing these changes is crucial for defining the possibilities for adaptation and market development strategies. This paper will analyze the trends and contemporary challenges in the global insurance market.

II Indicators of the Development of the Global Insurance Market

The world has been exposed to an increasing number of macroeconomic shocks for many years, starting from the global financial crisis of 2008/2009, followed by the euro crisis, to the crisis triggered by the COVID-19 pandemic[5], as well as devastating geopolitical conflicts. Despite the negative impacts of these shocks, the global insurance market has demonstrated relative resilience. Economic shocks can negatively affect insurance premiums, the volume of claims, and investment results.[6] In 2023, it is estimated that global insurance premiums amounted to approximately $7,100 billion, representing a slight increase compared to 2022, when they amounted to around $6,782 billion (and a real growth of 1.7% is expected in 2024 compared to 2023, although these results are below the ten-year average (2012–2021) of 2.6%). This slight growth follows a 1.1% decline in global insurance premiums in 2022 compared to 2021. In 2022, global non-life insurance premiums reached about $3,969 billion (58.52% of global insurance premiums), while global life insurance premiums reached around $2,813 billion (41.48% of global insurance premiums).[7] The three insurance markets with the highest nominal insurance premiums in 2022 were: the US insurance market ($2,960 billion), China ($698 billion), and the UK ($363 billion).[8] The share of US insurance premiums in the total global insurance premiums increased from about 40% in 2021 to around 44% in 2022 due to the growth in premiums of major insurance types and the appreciation of the dollar against nearly all major currencies worldwide. The Chinese insurance market

[5] The World Health Organization declared the COVID-19 pandemic on March 11, 2020, and declared its end on May 5, 2023 (approximately 765 million cases and around 6.9 million deaths worldwide due to COVID-19), Tatjana Rakonjac-Antić, *Penzijsko i zdravstveno osiguranje*, Faculty of Economics, University of Belgrade, 2024, p. 223, according to *www.who.int.*

[6] Allianz Research, "Allianz Global Insurance Report 2023: Anchor in turbulent times," 2023, *https://www.allianz.com/en/economic_research/insights/publications/specials_fmo/global-insurance-report.html*, accessed on: 10. 7. 2024, p. 18.

[7] Swiss Re Institute, "World insurance: stirred, and not shaken," *Sigma*, No. 3/2023, Zurich, 2023, pp. 19–42.

[8] In 2021, the Japanese insurance market was in third place with premiums of $398 billion, and the UK insurance market was in fourth place with premiums of $374 billion.

maintained its share of 10.3% of total global insurance premiums, while the share of the UK insurance market in total global insurance premiums was 5.4% (see detailed information in Table 1). The share of total insurance premiums of the five largest insurance markets (US, China, UK, Japan, France) in total global insurance premiums increased in 2022 (68.3%) compared to 2021 (66.5%).

Table 1. Insurance premiums (nominal) in the ten largest insurance markets worldwide

Country (market)	Total Premium in $ Billion in 2022	Total Premium in $ Billion in 2021	% change	Global Market Share in 2022	Global Market Share in 2021
USA	2960	2725	8,6%	43,7%	40,3%
China	698	696	0,2%	10,3%	10,3%
United Kingdom	363	374	-2,8%	5,4%	5,5%
Japan	338	398	-15,1%	5,0%	5,9%
France	261	293	-10,7%	3,9%	4,5%
Germany	242	272	-11,3%	3,6%	4,0%
South Korea	183	193	-5,3%	2,7%	2,9%
Canada	171	166	2,8%	2,5%	2,5%
Italy	160	192	-16,5%	2,4%	2,8%
India	131	123	6,5%	1,9%	1,8%

Source: Prepared according to Swiss Re Institute, "World insurance: stirred, and not shaken," *Sigma*, No. 3/2023, Zurich, 2023, p. 40.

Among the twenty largest insurance markets in 2022, seven were Asian markets (China, Japan, South Korea, India, Taiwan, Hong Kong, Singapore) with a share of 22.9% in the global insurance premiums. The average real annual growth rate of insurance premiums in China from 2009 to 2018 was 13.4%.[9] If this trend continues, it is likely that China, along with other Asian countries that rank among the top twenty global insurance markets by premium size, will remain a significant driver of development in the future. It is estimated that China will be one of the key participants in the global economy both in terms of production and consumption.[10] The Indian insurance market is one of the fastest-growing insurance markets in the world (with a global market share of approximately 1.9% in 2022). In 2022, compared

[9] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Koprivica, Predrag Šulejić, *Osiguranje u teoriji i praksi*, Faculty of Economics, University of Belgrade, 2021, p. 433.
[10] Allianz Research, p. 10.

to 2021, premiums in India increased by 6.5%. Forecasts suggest that if this growth continues, the Indian insurance market could become the sixth-largest insurance market by total global premiums by 2032.[11]

Table 2. Top ten countries by total insurance premiums *per capita* and % of GDP, 2022

Rank	Country	Total insurance premiums *per capita* ($)	Rank	Country	Total insurance premiums as % of GDP
1.	Cayman Islands	20.834	1.	Cayman Islands	23,2
2.	Hong Kong	9159	2.	Macau	20,9
3.	USA	8885	3.	Hong Kong	19,0
4.	Singapore	7563	4.	USA	11,6
5.	Denmark	7320	5.	Taiwan	11,4
6.	Macau	6605	6.	South Africa	11,3
7.	Switzerland	6364	7.	South Korea	11,1
8.	Ireland	5438	8.	Denmark	10,9
9.	Sweden	5180	9.	United Kingdom	10,5
10.	Finland	5036	10.	Finland	10,0
	World (Total)	853		World (Total)	6,8

Source: Prepared according to Swiss Re Institute, "World Insurance: Stirred, and Not Shaken", *Sigma*, No. 3/2023, Zurich, 2023.

The total insurance premium *per capita* worldwide in 2022 amounted to $853, representing 6.8% of GDP (see detailed information by country in Table 2).

III Global Changes in Insurance Operations

In addition to existing challenges, recent years have seen an intensification of new digital, social, economic, health, climate, geopolitical, and other risks that affect the operations of insurers and the range of insurance services offered.[12] The impact of COVID-19 has accelerated the process of automation and digitalization in the insurance market, providing better conditions for adequate preparation for potential future pandemics. This pandemic, along with climate change, catastrophic natural events, inflation, labor market changes, policyholders' demands, regulatory changes, the emergence of competitive institutions, and new technological and financial services, etc., have all contributed to global changes in the operations of

[11] Swiss Re Institute, "World insurance: inflation risks front and centre," *Sigma*, No. 4/2022, Zurich, 2022, p. 15.
[12] Kennedys Law, "2022 Insurance Industry Forecast: Trends and Future Risks," accessed on: 6. 7. 2024, *https://kennedyslaw.com/en/thought-leadership/reports/trends-and-future-risks*, pp. 2-14.

insurers. Climate change is accelerating, with extreme manifestations in recent years, requiring a swift response from insurers.[13] For better management of climate change risks, it is necessary to strengthen public-private partnerships.[14] In 2023, economic losses from natural disasters were recorded at $291 billion, exceeding the ten-year average of $235 billion. Insurers paid out $108 billion in claims for natural disaster-related damages in 2023, making it one of the highest years for claims payouts in history. For the fourth consecutive year, insured losses from natural disasters on a global scale surpassed $100 billion, and they are expected to continue growing at an annual rate of 5% to 7% in the long term.[15] The global macroeconomic environment is becoming increasingly complex year by year. Under inflationary conditions, the purchasing power of policyholders and potential policyholders decreases, costs related to claims compensation rise (especially in the health and property insurance sectors), and the risk of not achieving adequate returns on invested insurance premiums increases, among other factors.[16] Monetary policy measures aimed at stabilizing inflation can also lead to recession, among other consequences. The gig economy is developing, where employers engage workers for short-term tasks. This is a new form of employment that is changing the traditional employer-employee relationship. Working hours are flexible, tasks are mostly short-term, and many workers are working remotely. These new forms of employment are influencing the design of new insurance services. Regulations regarding the solvency of insurers are becoming more stringent, with the goal of ensuring smooth operations for insurers and, above all, protecting insurance consumers.

The primary drivers of the fourth industrial revolution are artificial intelligence[17], »big data«, i.e. big data analytics, machine learning, the Internet of Things, robotics, »blockchain«, autonomous vehicles, 3D printing, nanotechnology, biotechnology, and more. The application of these technologies enables insurers to survive and thrive in the digital world.[18] "Big data" (big data analytics) refers to the massive data sets that insurers can access or have collected themselves, which they can analyze to obtain information about policyholder risks, business risks, etc. The availability of these data gives insurers a competitive advantage over other entities

[13] International Association of Insurance Supervisors, Global Insurance Market Report, Basel, 2023, pp. 41-56.
[14] Miloš Pjanić, Milica Inđić, Vera Zelenović, Mirela Mitrašević, "Insurance industry: opportunities and challenges" in Engineering management and competitiveness (2024) (EMC 2024), pp. 225-230.
[15] Swiss Re Institute, "Natural Catastrophes and Inflation in 2023: Gearing Up for Today's and Tomorrow's Weather Risks," *Sigma*, No. 1/2024, Zurich, 2024.
[16] Eduardo D'Alma, August Majer, Global Insurance Market Pulse 2023/2024, Wavestone, 2023, p. 6.
[17] Karl Hersch, James Colaco, Michelle Canaan, 2024 global insurance outlook, Deloitte Center for Financial Services, 2024, pp. 12-15.
[18] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Koprivica, Predrag Šulejić, *Insurance in theory and practice*, Faculty of Economics, University of Belgrade, 2021, pp. 444-448, according to Schwab K., Davis N. "Shaping the Fourth Industrial Revolution", World Economic Forum, Geneva, 2018, p. 7.

that do not have access to such information.[19] Digitalization in insurance establishes new ways of communicating with policyholders, new ways of implementing business processes, but also creates new risks. The most significant effects of digitalization on the insurance sector include: improving the policyholder experience, enhancing business processes, and developing new products (services).[20]

"Insurtech" companies are new competitors in the insurance market, leveraging new technologies to provide insurance coverage for digitally literate policyholders. They offer personalized services and operate under fully automated business processes. These companies focus on untapped segments of the insurance market and specific services (e.g., telematics insurance). The most significant effects of digitalization in this sector include improving the customer experience, enhancing insurers' business processes, and developing new insurance services. Insurers use websites, mobile applications, robo-advisors, social networks (e.g. *Facebook*), video platforms (e.g. *YouTube*), etc. to provide timely and relevant information to policyholders and potential policyholders. Alongside traditional sales channels (direct sales, sales through agents and brokers), the share of alternative digital sales channels via the internet, social media, and mobile apps is also growing.[21] The trend of capital concentration and centralization is also a characteristic of the global insurance market. The main drivers of consolidation in insurance are the increasing frequency of catastrophic risks, regulatory changes, and technological progress. The accumulation of capital stems from the need to insure against major risks, growing solvency capital requirements, and the efforts to facilitate the digital transformation of traditional insurers through mergers and acquisitions with innovative, technologically leading companies.[22] For the modern insurance market, catastrophic risks pose a challenge that threatens the performance of insurers but also presents an opportunity for further expansion and development of the sector, particularly in developing countries where the level of insurance coverage for catastrophic damages is low.[23]

[19] Dino Wilkinson, Alec Christie, Anthony A Tarr, Juli-Anne Tarr, "Big Data, Artificial Intelligence and Insurance." In The Global Insurance Market and Change, 2024., Chapter 2.

[20] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Koprivica, Predrag Šulejić, *Insurance in theory and practice*, Faculty of Economics, University of Belgrade, 2021, pp. 444-448, according to Eling M., Lehman M. "The Impact of Digitalization on the Insurance Value Chain and the Insurability of Risks", Geneva Papers on Risk and Insurance - Issues and Practice, 43(3), 2018, p. 363.

[21] Kočović, Rakonjac-Antić, Koprivica, Šulejić, pp. 444-448.

[22] Jelena Kočović, Marija Koprivica, Željko Jović, "Sustainable Developments of Insurance in Crisis Conditions", Contemporary Challenges and Sustainability of the Insurance Industry (editors Jelena Kočović, Biljana Jovanović Gavrilović, Branislav Boričić, Marija Koprivica), University of Belgrade, Faculty of Economics, Belgrade, 2021, pp. 137-157.

[23] Jelena Kočović, Marija Koprivica, Gorana Krstić, "Catastrophic risks and contemporary insurance market", Challenges and tendencies in the contemporary insurance market (editors Jelena Kočović, Branislav Boričić, Biljana Jovanović Gavrilović, Martin Balleer), University of Belgrade, Faculty of Economics, Belgrade, 2017, pp. 3-31.

IV Contemporary Trends in the Global Non-Life and Life Insurance Markets

The global non-life insurance premium grew by 0.5% in real terms in 2022 compared to 2021, with an estimated increase of 1.4% in 2023 compared to 2022 (see Graph 1). The primary driver of future growth in the global non-life insurance premium is expected to be the strengthening of economic activities. Insurers have generally increased insurance premiums to secure funds for covering rising claim costs due to inflation.[24] The highest insurance premium was recorded in health insurance, accounting for 49% of the total non-life insurance premium.[25] The U.S., as the world's largest health insurance market, experienced a real decline of 1.4% in health insurance premiums in 2023 according to preliminary results, due to reduced demand following the COVID-19 pandemic. Unlike developed European countries, where no significant changes are anticipated, the Asian market is expected to continue growing in health insurance premiums. For 2023, an increase of 8.9% is projected, supported by state medical coverage and digitalization. It is estimated that the global health insurance premium decreased by 0.6% in 2023, with a slight increase expected in 2024. In motor vehicle insurance, approximately 21% of the total global non-life insurance premium was achieved, and preliminary results estimated a 2.8% real growth in this type of insurance premium for 2023. For 2024, a 2.2% increase is expected due to strengthening economic conditions and the realization of previously unmet demand for motor vehicles following the resolution of supply chain disruptions. Property insurance accounted for 14% of the global non-life insurance premium in 2022. Significant growth in liability insurance premiums was recorded in 2021 at 12.3%, but in 2022, the growth slowed to just 1.6% (real).[26] Further growth is expected in credit and surety insurance premiums, which have been increasing, for many years, by approximately 5.1% (nominally) annually.[27]

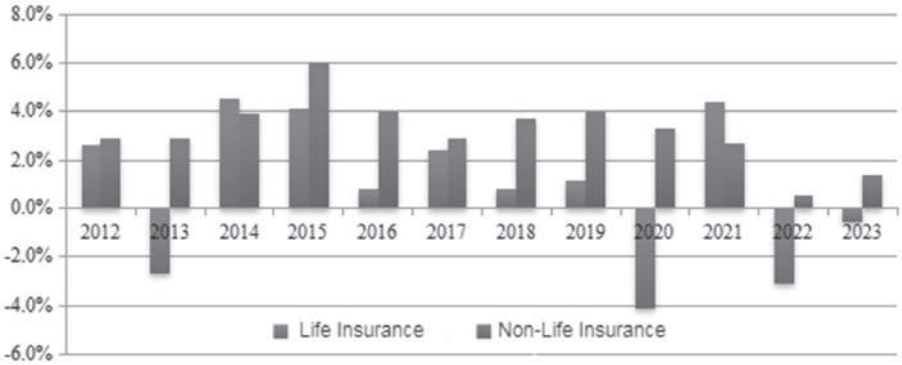
[24] *www.swissre.com*.

[25] If the non-life insurance market is divided into health insurance, personal (individual) insurance, and commercial insurance (where legal entities enter into insurance contracts), in 2022, health insurance premiums accounted for 49% of the global non-life insurance premium, personal insurance contributed 25%, and commercial insurance made up 26% of the global non-life insurance premium.

[26] Growth was modest in all regions of the world except for Asia.

[27] Swiss Re Institute, "World insurance: stirred, and not shaken", *Sigma*, No. 3/2023, Zürich, 2023, pp. 16–26.

Graph 1. Real annual growth rates of life and non-life insurance premiums worldwide (2012-2023)



Source: Prepared according to *https://www.sigma-explorer.com/*

The global growth rate of life insurance premiums in 2020 was negative (-4.4%). In the previous decade, real growth was recorded (at an average annual rate of 1.7%).[28] It is estimated that after a decrease in global life insurance premiums by 3.1% in 2022 compared to 2021, there was an increase in life insurance premiums of 0.7% (real growth) in 2023. This growth is attributed to the increase in savings allocations by the population, growth in insurance premiums under individual insurance contracts, and the rise in interest rates, among other factors.[29] The growth of insurance premiums is faster in developing countries and Asian nations compared to highly developed countries.[30] Due to increased investment income and reduced claims related to COVID-19, there has been an increase in the profitability of insurers in the global life insurance market.[31] To increase the resilience of life insurers' operations against the COVID-19 pandemic, proactive risk management was necessary.[32]

[28] Jelena Kočović, "Contemporary challenges and perspectives of insurance market development", Development of Modern Insurance Market: Constraints and Possibilities (editors Jelena Kočović, Biljana Jovanović Gavrilović, Žaklina Stojanović, Zorica Mladenović, Dejan Trifunović, Marija Koprivica), University of Belgrade, Faculty of Economics, Belgrade, 2022, pp. 3–20

[29] Swiss Re Institute, "Life insurance in the higher interest rate era: asset-savvy is the new asset-light", *Sigma*, No. 2/2024, Zürich, 2024, p. 15.

[30] Swiss Re Institute, "World insurance: stirred, and not shaken", *Sigma*, No. 3/2023, Zürich, 2023, p. 26.

[31] Swiss Re Institute, "Economic stress reprices risk: global economic and insurance market outlook 2023/24", *Sigma*, No. 6/2022, Zürich, 2022, p. 32.

[32] Maria Carannante, Valeria D'Amato, Paola Fersini, Salvatore Forte, Giuseppe Melisi, "Disruption of Life Insurance Profitability in the Aftermath of the COVID-19 Pandemic", Risks, 10:40, *https://doi.org/10.3390/risks10020040*, p. 13.

V Directions for the Development of the Insurance Market in Serbia

Since 2018, 16 insurance companies have been operating in the Serbian insurance market. In 2022, the total insurance premium amounted to approximately $1.2 billion. Of this amount, 78.6% was generated from non-life insurance premiums, while 21.4% came from life insurance premiums (see data in Table 3). Key indicators of the development level of the insurance market, and important indicators of a country's economic development, include insurance premiums *per capita* (insurance density) and the percentage of insurance premiums in gross domestic product (insurance penetration).

Table 3. Indicators of the Development of the Serbian Insurance Market (2012-2022)

Indicator/ Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Number of Insurance Companies	24	24	21	20	19	17	16	16	16	16	16
Total Insurance Premiums (in mil $)	713	770	698	727	761	939	966	1,024	1,067	1,200	1,200
Balance Sheet Total of the Insurance Sector in the Financial Sector (%)	4,5	4,8	5,2	5,8	6,1	6,3	6,7	6,6	6,0	6,0	5,6
Premium *per capita* ($)	96	104	111	105	114	123	140	150	154	176	179
Premium as a % of GDP	1,8	1,8	1,9	2,0	2,0	2,1	2,0	2,0	2,0	1,9	1,9
Life Insurance Premium (% of Total Premiums)	19,3	22	23,1	23,9	25,9	24,4	23,8	23,3	23,8	22,7	21,4
Non-Life Insurance Premium (% of Total Premiums)	80,7	78	76,9	76,1	74,1	75,6	76,2	76,7	76,2	77,3	78,6

Source: Kočović, p. 15, according to www.nbs.rs and www.institute.swissre.com

The relatively stable share of total insurance premiums in the gross domestic product (GDP) indicates a balanced movement of these two parameters over time, which represents the consequence of the mutual interdependence between economic development and the development of the insurance market.[33] According to the value of this indicator, which was 1.9% in 2022, Serbia ranked 65th in the world, while the same indicator in EU countries was 6.4%. The insurance premium *per capita* in Serbia in 2022 was $177, which is five times higher compared to 2002 ($33). According to this indicator, the Serbian insurance market was ranked 63rd in the world in 2022. The Cayman Islands held the first position with $20,834 in insurance premiums *per capita* (see data presented in Table 2). Slovenia, with $1,396 in insurance premiums *per capita*, was ranked 30th in the world. Croatia, with $456 in insurance premiums *per capita* in the same year, was ranked 43rd in the world. The average insurance premium *per capita* in EU member states was $2,377 in 2022.[34] The largest share of total insurance premiums in Serbia in 2022 was from motor vehicle liability insurance, a compulsory type of insurance, accounting for 29.1%. The share of life insurance premiums has remained relatively stable over recent years, constituting 22.7% of total insurance premiums in 2022. The share of life insurance premiums has been relatively stable in recent years. In 2022, it accounted for 22.7% of the total insurance premium.[35]

The development of the Serbian insurance market is primarily conditioned by trends in the macroeconomic environment. Key factors include increasing employment and living standards, strengthening economic activities, stability of the national currency, the development of the financial market, etc. For the functioning of insurance, securing funds for the payment of insured sums and damage compensation, as well as the realization of the financial accumulation function of insurance, among other things, the development of the money market and the capital market is also important. At the end of 2021, the Capital Market Development Strategy for the period 2021-2026 was adopted with the aim of creating adequate conditions for investment by all participants, including insurers.[36] Since the regulatory framework significantly influences the development of the insurance market, several important regulatory changes related to the operations of insurance

[33] Jelena Kočović, Tatjana Rakonjac-Antić, Marija Jović, "Effects of privatization model of insurance market in transition economies", From Global Crisis to Economic Growth Which Way to Take? Vol. I, Economics (editors Miomir Jakšić, Božidar Cerović, Aleksandra Praščević), University of Belgrade, Faculty of Economics, Belgrade, 2012, p. 486.

[34] Swiss Re Institute, "World insurance: stirred, and not shaken", *Sigma,* No. 3/2023, Zürich, 2023.

[35] National Bank of Serbia, Insurance Sector in the Republic of Serbia: Report for 2022, Belgrade, 2023, p. 13.

[36] Miloš Petrović, "Brief Overview of Particular Elements of the Capital Market Development Strategy (2021): adjustment of the Insurance Industry to European Union Standards," *Insurance Trends*, 4/2022, pp. 110-111, according to *Capital Market Development Strategy for the Period 2021 to 2026* ("Official Gazette of the RS," No. 102/2021).

companies in Serbia have been implemented over the past decade, modeled after legal solutions in economically developed countries (application of elements of Solvency II). The development of high-quality and comprehensive insurance statistics at the national level is a prerequisite for accurate actuarial calculations and a foundation for healthy market growth in the future.[37] In the era of rapid technological changes, it is important for insurers to recognize and leverage the opportunities offered by digitalization to enhance customer experience, improve business processes, and provide new services. Constant efforts are necessary to strengthen and enhance mutual trust among participants in the insurance market and to improve business ethics and socially responsible business of insurers.[38]

V Conclusion

Under the influence of slowing global economic growth, inflationary pressures, geopolitical events, natural disasters, the COVID-19 pandemic, tightening regulations, the manifestation of old and emergence of new risks, globalization, liberalization, etc., there have been changes in the operations of insurers and the insurance service offerings. The process of capital consolidation, insurance consolidation, digitalization, and automation of business processes has intensified. In addition to traditional sales channels (direct sales, sales through agents and brokers), the share of alternative digital sales channels through the internet, social media, and mobile apps has increased. In 2022, there was a slight decrease in global insurance premiums compared to 2021, indicating that the insurance market demonstrated considerable resilience to macroeconomic shocks caused by the COVID-19 pandemic and the conflict in Ukraine. According to preliminary results, in 2023 there was a small growth in the total global insurance premium compared to 2022. In 2022, global non-life insurance premiums accounted for 58.52% of global insurance premiums, while global life insurance premiums was 41.48% of global insurance premiums. The insurance markets with the highest premium amounts in 2022 were the markets of the United States (with a global market share of about 44%), China (with a global market share of about 10%), and the United Kingdom (with a global market share of about 5%). In Serbia, in 2022, 78.6% of the total insurance premium was accumulated in non-life insurance, while 21.4% was in life insurance. The largest share of the total insurance premium, at 29.1%, was for motor vehicle liability insurance (compulsory insurance). According to the value of the indicator for the insurance premium's share of gross domestic product, which was 1.9% in 2021, Serbia was ranked 65th in the world, and with the insurance premium *per capita* of $176, it was ranked 62nd in the

[37] Kočović, Koprivica, Krstić, p. 12.
[38] Ivana Soković, "Importance of Insurance and Prospects of Development in Serbia", *Insurance Trends*, 2/2024, pp. 277-278.

world. For the development of the Serbian insurance market, it is crucial to advance the economy, increase employment and living standard, implement improved regulatory frameworks, and develop the financial market, among other things.

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OSIGURANJE OD FINANSIJSKIH GUBITAKA ZBOG PREKIDA OBAVLJANJA DELATNOSTI

PREGLEDNI RAD

Apstrakt

Osiguranje od finansijskih gubitaka usled prekida rada (šomažno osiguranje) zaključuje se kao dopunsko osiguranje, uz osiguranje od osnovnih rizika vezanih za stvari ili objekte. Kod šomažnog osiguranja, osiguravač je u obavezi da isplati naknadu za posrednu štetu koja nastane nemogućnošću korišćenja stvari, mašina ili objekata. To znači da između realizacije osnovnih rizika i nastanka posredne štete mora postojati uzročna veza. Tu vrstu osiguranja zaključuju, pre svega, lica koja se bave određenom delatnošću, bez obzira na to da li se radi o pravnim licima ili preduzetnicima. No, šteta koja nastane usled prekida rada mora biti uzrokovana spoljnim okolnostima i ne može se vezivati za poslovanje samog subjekta. Jedno od najvažnijih pitanja kod šomažnog osiguranja vezuje se za obračun naknade, odnosno određivanje izgubljene dobiti i troškova. Autor u radu govori i o upravljanju i predviđanju rizika u privrednim subjektima. Takođe, posvećuje se pažnja i najbitnijim elementima posebnih uslova osiguranja u ovoj oblasti.

Ključne reči: *gubici, prekid rada,* šomažno *osiguranje, dopunsko osiguranje, osnovni rizici, posredna šteta, izgubljena dobit, troškovi poslovanja.*

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Rad prihvaćen: 21. 8. 2024.

I Uvodni deo

Osiguranje od finansijskih gubitaka usled prekida obavljanja delatnosti zbog ostvarenja različitih vrsta rizika, odnosno opasnosti i događaja značajno je kako bi se pokrili troškovi uzrokovani prekidom rada. Osim troškova, ta vrsta osiguranja omogućava i naknadu profita za vreme dok privredni subjekt ili drugo lice ne obavlja delatnost. Tu vrstu osiguranja nazivamo i šomažno. Sama reč šomaž (*chômage*) je francuskog porekla i označava zastoj, mirovanje. Osiguranje od prekida rada zaključuje se kao dopunsko, ali samo ako se kod istog osiguravača zaključuje osiguranje osnovnih sredstava u subjektu, kao i nenovčanih obrtnih sredstava. Što se tiče obaveze naknade štete, ona će postojati samo ako je ugovoreno da je osiguravač dužan da naknadi navedenu štetu nakon nastanka osiguranog slučaja. Samim tim, ako ugovor o osnovnom osiguranju prestane da važi, prestaje da važi i ugovor o osiguranju od prekida rada, to jest šomažno osiguranje.[2]

Da bi šomažno osiguranje imalo dejstvo, šteta mora nastati usled: – požara ili udara groma; – eksplozije; – oluje; – grada; – udara sopstvenog motornog vozila ili pokretne radne mašine u osigurani građevinski objekat; – pada vazduhoplova; – manifestacija i demonstracija. Obaveza na naknadu po osnovu šomažnog osiguranja postoji onda kada postoji obaveza da se naknadi šteta po osnovu osiguranja od osnovnih rizika, kao što su rizik od požara ili drugih štetnih događaja. Osiguranik, da bi mogao zahtevati naknadu po šomažnom osiguranju, mora da ostvaruje prihod, odnosno da utvrđuje i raspoređuje dohodak. Osim toga, on mora zaključiti šomažno osiguranje za sve organizacione jedinice na istoj lokaciji, bez obzira na to da li se nalaze u jedinstvenom ili odvojenom riziku. Ako to ne bude tako, tada će se kod osiguranog slučaja, prilikom utvrđivanja iznosa naknade štete primeniti proporcija koje se osiguranik može osloboditi ako ranije plati doplatu na osnovnu premiju.[3]

Takođe, moramo imati u vidu da se ovim osiguranjem ne pokriva insolventnost subjekta koja je nastala usled nemogućnosti izvršenja obaveza prema poveriocima, već se pokriva nemogućnost obavljanja delatnosti jer subjekt ne može da upotrebljava sredstva i prostor za rad (objekte).

U svakom slučaju, prekid rada mora predstavljati osigurljiv rizik, iako se naknađuje posredna šteta, kao posledica realizacije osnovnih rizika. Predmet osiguranja od prekida rada od svih rizika predstavlja gubitak osiguranika i njegovog osiguranog interesa, odnosno dobitka koji se mogao očekivati, a čije ostvarivanje je onemogućeno nastankom osiguranog slučaja. Naknada iz osiguranja za prekid rada može biti ugovorena kao nadoknada bruto dobiti ili fiksnih troškova i neto dobiti koja predstavlja iznos koji nije zarađen zbog smanjenja poslovnih prihoda

[2] Boris Marović, Vladimir Njegomir, „Poslovanje osiguravajućih i reosiguravajućih društava u korelaciji sa energetikom i energetskim izvorima", *34. susret osiguravača i reosiguravača*, Sarajevo 2023, str. 61.

[3] B. Marović, V. Njegomir, str. 62.

i povećanja troškova rada. Suma osiguranja koja se može ugovoriti za prekid rada ne može biti manja od godišnje bruto dobiti ako se ugovara osiguranje bruto dobiti, odnosno od neto dobiti i navedenih fiksnih troškova.[4]

II Nastanak šomažnog osiguranja

Šomažno osiguranje postoji veoma dugo, skoro tri i po veka. Kratko ćemo se osvrnuti na razvoj ove vrste osiguravajuće zaštite. Naime, prvo pokriće indirektnih šteta kao dopunsko osiguranje vezujemo za engleskog osiguravača *Minerva Universal* 1707. godine. Zatim, u Hamburgu, slična polisa osiguranja zaključena je 1817. godine kod društva *Cassa Generale Incendio*. U Francuskoj se 1857. godine javlja pokriće pod nazivom *chomage*. Sve navedene polise odnosile su se na paušalnu odštetu za posredne troškove u obliku procenta od štete od osnovnog rizika. Kasnije je *Lloyd* prihvatio navedeno osiguranje kao *percentage of fire loss*. U pitanju su, dakle, bile paušalne sume osiguranja, budući da u to vreme računovodstva, u okviru kompanija, nisu bila pouzdani izvor podataka o dobiti i gubicima osiguranika, pa nije bilo moguće utvrditi tačan iznos posrednih, indirektnih šteta. Naravno, navedeno je kasnije postalo moguće razvojem knjigovodstvenih standarda, tako da je 1899. godine ponuđena polisa za pokriće posrednih troškova pod nazivom *Loss of profit*, koja je bila vezana za osnovni rizik za određeni period. Za nastanak te vrste pokrića najviše je zaslužan škotski broker Mac Lellan Man. Inače, ta vrste pokrića imala je i svoje protivnike među osiguravačima koji su smatrali da se radi o nemoralnim poslovima koji omogućavaju nedozvoljeno bogaćenje osiguranika. No, praksa je zahtevala zaključenje ove vrste osiguranja, tako da su polise u ovoj oblasti zaključene 1911. u Nemačkoj, da bi 1955. godine šomažno osiguranje postalo autonomna vrsta osiguranja sa sopstvenom tarifom premija. U Francuskoj je osiguravači prihvataju pod nazivom *pertes d' exploitation* – gubici aktivnosti.[5]

III Osiguranje od gubitaka

Ugovor o osiguranju od gubitaka usled prekida poslovanja predstavlja ugovor o obeštećenju. Tim pokrićem se obezbeđuje povratak ekonomske pozicije koja omogućava nastavak rada, tj. koja je postojala ranije, pre nastanka osiguranog slučaja. Šomažnim osiguranjem se nadoknađuje izgubljeni novčani tok poslovanja i dodatni troškovi nastali zbog nemogućnosti poslovanja ili uništenih osiguranih

[4] Milovan Jovanović, „Osiguranje od svih rizika na tržištu osiguranja u Srbiji", *Evropska revija za pravo osiguranja*, br.4/2012, Beograd 2012, str. 72.

[5] Marijan Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)" 13. 5. 2024.; https://www.osiguranje.hr/ClanakDetalji.aspx?22746, pristup: 10.7.2024.

sredstava rada.[6] Osiguranje gubitaka usled prekida poslovanja proizlazi iz upotrebe imovine i, da bi šteta mogla biti isplaćena, potrebno je da se ispuni pet kriterijuma koji su međusobno povezani. Pre svega, mora postojati fizičko oštećenje na stvarima. Zatim, te stvari moraju biti osigurane, kao i da se radi o ostvarenim rizicima koji su pokriveni tim osiguranjem. Takođe, šteta mora da rezultira merljivim gubitkom zbog prekida poslovanja, i to za određeni period koji je potreban za nabavku drugih sredstava rada, kao i preduzimanja drugih radnji kako bi se nastavilo poslovanje. Radi se o pet uslova koji su u neprekidnom lancu i prekid u bilo kom delu doprineo bi nemogućnosti naknade štete.[7] Osiguranje gubitaka usled prekida rada ne obuhvata samo imovinu u fizičkom smislu već i interes osiguranika odnosno potencijalnu zaradu (koja nije ostvarena). O tome se mora voditi računa kada subjekt obavlja svoju delatnost na nekoliko lokacija koje su međusobno povezane, što znači da interes mora biti vezan za sva mesta u kojima osiguranik obavlja posao, to jest da njegovu imovinu treba shvatiti kao integrisanu celinu.[8]

1. Upravljanje rizicima od strane subjekata koji obavljaju određenu delatnost

Osvrnućemo se i na upravljanje rizicima od strane subjekata koji vrše određenu privrednu ili bilo koju drugu delatnost. Postoji više načina za upravljanje rizikom u okviru jednog takvog subjekta. Koji način će biti izabran, zavisi od delatnosti kojom se privredni subjekt bavi, zatim od veličine tog subjekta, broja radnika, sredstava kojima raspolaže, kao i od mnogih drugih činjenica koje čine jedan privredni subjekt. Izdvojićemo četiri načina upravljanja rizikom, napominjući da se mogu definisati i drugi, kao i da se, pri upravljanju rizikom, može kombinovati više načina. Ti načini su sledeći: 1) Predvidljivost i kontrola šteta; 2) Finansiranje šteta; 3) Smanjenje mogućnosti nastanka šteta;[9] i 4) Nadzor nad radom u privrednom subjektu.[10] Najčešći način kontrole rizika u okviru privrednog subjekta jeste transfer rizika na osiguravajuće društvo. Privredni subjekt mora da proceni da li je uputno izdvajanje sredstava za plaćanje premije osiguranja. Činjenica je da je transfer rizika najpovoljniji ne samo kada je u pitanju transfer rizika na osiguravajuće društvo već i kada se radi o prodaji dela preduzeća, prodaji akcija, spajanju ili pripajanju subjekata.[11] Velike kompanije

[6] David A. Borghesi, „Business Interruption Insurance--A Business Perspective", *Nova Law Review* vol. 17-1993, str. 1147–1148.

[7] D. A. Borghesi, str. 1151.

[8] Alan G. Miller, „Business Interruption Insurance, A Legal Primer", *Drake Law Review*, vol.24 – December 1975, str. 801.

[9] Svetlana Ivanović, „Upravljanje rizikom i osiguranje", *Industrija* br.1-2/2003, str. 72.

[10] Vladimir Čolović, „Upravljanje rizikom u privrednim društvima", *EMC Review* – časopis za ekonomiju i tržišne komunikacije, 10(2)/2015, str. 242.

[11] V. Čolović (2015), str. 239.

moraju da vode računa i o umnožavanju rizika, ali i o umreženim rizicima, koji mogu izazvati gubitke u nekoliko poslovnih linija osiguranja ili gubitke na neočekivanim mestima, ili na više geografskih tržišta zbog međusobne povezanosti poslovnim vezama (poplave u Tajlandu izazivale su gubitke i putem prekida rada na tržištu SAD).[12]

IV Karakteristike šomažnog osiguranja

Šomažno osiguranje je, pre svega, dopunsko osiguranje. Dopunska osiguranja su ona koja se ugovaraju uz osnovne rizike i nije ih moguće ugovoriti drugačije. Znači, da bi šomažno osiguranje moglo da se zaključi, potrebno je da postoji osiguravajuće pokriće za osnovne rizike čija realizacija može dovesti i do posredne, indirektne štete. U uslovima osiguranja, ali i u samoj polisi, mora biti definisano koji rizici se pokrivaju dopunskim osiguranjem. Takođe, dopunska osiguranja svrstavamo u dobrovoljna osiguranja, što znači da sami osiguranici odlučuju ne samo da li će zaključiti ovu vrstu osiguranja, već određuju i koji će rizici biti pokriveni. S druge strane, ako govorimo o dodatnom osiguranju, ono predstavlja osiguranje od rizika koje nije povezano sa osiguranjem od osnovnih rizika. Šomažno osiguranje se, pre svega, odnosi na preduzeća, odnosno na industriju, ali ovu vrstu osiguranja mogu zaključiti i ostali osiguranici, npr. zbog štete na iznajmljenom objektu usled nemogućnosti korišćenja zakupnine, zatim zbog nemogućnosti upotrebe određenog objekta, zbog troškova najma drugog objekta itd. Kod te vrste osiguranja primenjuju se i specifični osiguravajući uslovi, koji sadrže i odredbe koje ograničavaju obavezu osiguravača, kao što su vreme pokrića, vrste troškova, potrebu vođenja knjigovodstva, utvrđivanje opravdanosti troškova putem veštačenja itd.[13]

Neki autori smatraju da je šomažno osiguranje posebno, odnosno da se ono zaključuje uz zaključenje polise od požara.[14] Ne možemo reći da je šomažno osiguranje posebno, jer da jeste, ne bi bilo vezano za osiguranje osnovnog rizika, već bi moglo samostalno da se zaključi. S obzirom na to da je ta vrsta osiguranja jasno određena i da je vezana za oštećenje ili uništenje neke stvari ili objekta, usled čega privredni ili neki drugi subjekt ne može da obavlja svoju delatnost, ono se i zaključuje samo uz osiguranje osnovnog rizika.

Osiguranik na čijim je stvarima nastala šteta neće imati pravo na pokriće gubitaka ako osiguranjem nisu obuhvaćeni ti rizici. Tom vrstom osiguranja se ne mogu sanirati posledice lošeg poslovanja, postojanje velikih dugova prema poveriocima, loš plasman robe na tržištu, gubici u proizvodnji koji su posledica loše realizacije poslovnog plana itd.

[12] Marija Kerkez, Ivan Ivanović, „Katastrofalni rizici i osiguranje", *Megatrend revija*, vol.13, no.2, 2016, str. 25-26

[13] M. Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", 13. 5. 2024.

[14] Andrej Pak, *Zaključenje i prestanak ugovora o osiguranju*, doktorska disertacija, Univerzitet Edukons, Fakultet za evropske pravno-političke studije, Novi Sad 2016, str. 79.

Takođe, smatra se da šomažno osiguranje spada u osiguranje stvari isto kao i osiguranje od požara, od provalne krađe i razbojništva, mašina od loma, kasko osiguranje, osiguranje useva i plodova.[15] Ne bismo mogli u potpunosti da se složimo s navedenim. Naime, činjenica je da ono spada u imovinsko osiguranje zato što je vezano za osiguranje imovine. Ali, bilo bi uputnije izdvojiti tu vrstu osiguranja, budući da ono može ali ne mora biti realizovano iako je osnovni rizik realizovan. Da li će osiguravač po zaključenom šomažnom osiguranju biti obavezan, zavisi od posledica koje mogu ali ne moraju nastati. Ako posledice nastanu, znači da su nastali gubici i tada je osiguravač dužan da isplati naknadu. Ako ne nastanu, tada osiguravač neće biti ni u kakvoj obavezi.

1. Šomažno osiguranje u domaćem zakonodavstvu

Zakon o osiguranju Republike Srbije (dalje: ZO)[16] reguliše osiguranje finansijskih gubitaka. No, moramo reći da ZO ovu vrstu osiguranja definiše malo nespretno, imajući u vidu da se iz njegove odredbe ne vidi da li se finansijski gubici osiguravaju sami za sebe ili su vezani za neki štetni događaj, to jest da su njegova posledica. Naime, ZO definiše da ovo osiguranje pokriva gubitke zbog gubitka zaposlenja, nedovoljnih prihoda, lošeg vremena, izgubljene dobiti, neplaniranih opštih troškova, neplaniranih troškova poslovanja, gubitka tržišne vrednosti, gubitka zakupnine odnosno prihoda, posrednih poslovnih gubitaka, kao i ostalih neposlovnih i finansijskih gubitaka.

1.1. Šomažno osiguranje u posebnim uslovima osiguranja

Regulisanje šomažnog osiguranja u posebnim uslovima osiguranja proizlazi iz karakteristika ove vrste osiguravajuće zaštite. Posvetićemo pažnju nekim odredbama koje se nalazi u Posebnim uslovima za osiguranje od prekida rada usled požara i nekih drugih opasnosti jednog osiguravajućeg društva,[17] slučajevima isključenja iz osiguranja. To su situacije: 1) kada šteta nastane usled vanrednih događaja, a koje se odnose na makroekonomske promene, neosigurane opasnosti itd. 2) ako je šteta nastala kao posledica ograničenja organa vlasti pri popravci oštećenih stvari; 3) kada nedostaju finansijska sredstva za opravku ili nabavku oštećenih ili uništenih stvari; 4) ako su uzroci štete nastali kod drugih subjekata s kojima je osiguranik u poslovnim odnosima; 5) ako je šteta nastala zbog uništenja novca, hartija od vrednosti, plano-

[15] Nataša Petrović Tomić, „Aktuelnost razlikovanja prava na naknadu štete i prava na osiguranu sumu u delu Mihaila Konstantinovića: klasični instituti i moderno pravo osiguranja", *Anali Pravnog fakulteta u Beogradu,/Poseban broj u čast profesora Mihaila Konstantinovića*, Beograd 2022, str. 567, fn. 6.

[16] Zakon o osiguranju, ZO, *Službeni glasnik Republike Srbije,* br. 139/2014 i 44/2021.

[17] Posebni uslovi za osiguranje od opasnosti prekida rada usled požara i nekih drugih opasnosti, Sava osiguranje; https://www.sava-osiguranje.rs/sr-rs/uslovi-osiguranja/, pristup: 11. 7. 2024.

va, poslovnih knjiga i sl. 6) ako je šteta nastala usled gubitka posla, otkaza zakupa, licence, u tačno određenim slučajevima.[18]

Isti Uslovi definišu i koje će gubitke pokriti osiguranje. Pre svega, radi se o bruto dobiti zbog smanjenja prometa, kada se obračunava razlika između standardnog prometa i stvarnog prometa u momentu prekida rada, koji treba da bude pomnožen sa stepenom bruto dobiti. Isto tako, isplatiće se iznos pri povećanju poslovnih troškova, kao dodatni izdaci koji su potrebni za opravdanje ili smanjenje gubitka prometa dok prekid traje.[19]

Izdvojili smo odredbe ovih uslova o isključenju iz osiguranja, kao i o obračunu gubitaka, kako bismo predstavili specifičnosti šomažnog osiguranja, zatim vezanost ovog osiguranja za osnovni rizik i obavezu nastanka gubitka, koji se odnosi na gubitak profita i povećanje troškova u periodu prekida rada.

2. Osigurani slučaj kod šomažnog osiguranja

Nakon nastanka neposredne opasnosti, kao i kada ona počne neposredno da se ostvaruje, osiguranik je dužan odmah, bez odlaganja, odnosno istog dana, da obavesti osiguravača usmeno, odnosno pismeno narednog dana. Ukoliko se obaveštenje ne učini na navedeni način, osiguravač može da utvrdi finansijski efekat neprijavljivanja nastanka opasnosti i da srazmerno tome umanji iznos naknade štete. Naravno, osiguranik je dužan da, u slučaju prekida rada, preduzme potrebne mere za otklanjanje ili smanjenje štete, odnosno da preduzima mere koje će smanjiti vreme trajanja prekida, kao i da se pridržava uputstava osiguravača, u tom smislu.[20] Ako osiguranik, nakon prekida rada, koji je trajao kraće od ugovorenog, želi da obnovi pokriće za ceo garantni rok, tada treba da zaključi dopunski ugovor o šomažnom osiguranju. I u tom ugovoru se premija snižava srazmerno neiskorišćenom garantnom roku iz prethodnog ugovora.

U vezi s navedenim, kod šomažnog osiguranja, budući da ono ne pokriva štetu na stvarima, postavlja se pitanje kada je nastao osigurani slučaj, s obzirom na to da gubici pokriveni osiguranjem nastaju nakon nastanka štetnog događaja, a već nastale novčane štete često su uzrok daljih ovakvih šteta. Ako bi se prihvatilo da je osigurani slučaj vezan za gubitke usled prestanka rada nastao kad i sam osigurani slučaj vezan za realizaciju osnovnog rizika, tada bi sam rizik nemogućnosti obavljanja delatnosti teško mogao da se proceni. Ovde se može postaviti pitanje da li se može prihvatiti da je osigurani slučaj vezan za rizik prekida rada nastao kada je nastala prva šteta pokrivena ovim osiguranjem u seriji šteta koje su uzročno posledično povezane.[21]

[18] Član 3, st. 6 Posebnih uslova.
[19] Član 4 Posebnih uslova.
[20] B. Marović, V. Njegomir, str. 63.
[21] Jasna Pak, *Pravo osiguranja,* Univerzitet Singidunum, Beograd 2011, *str.* 198.

Možemo odgovoriti pozitivno. U svakom slučaju, prekid rada mora nastati kao posledica realizacije osnovnog rizika. Da li će doći do prekida rada, iako je osnovni rizik realizovan, drugo je pitanje. No, ako do njega dođe, kao trenutak nastanka osiguranog slučaja određuje se momenat nastanka štetnog događaja vezanog za osnovni rizik. U svakom slučaju, nastankom osiguranog slučaja koji su vezani za požar, poplavu, kvar i uništenje mašina, nastaje i obaveza osiguravača da naknadi štetu.[22]

Zatim, može se dogoditi da gubitak usled prekida rada nastane zbog više uzroka. Naravno, radi se o tome da do oštećenja ili uništenja stvari ili objekta dođe usled više različitih uzroka. Neki od tih uzroka, odnosno ostvarenih rizika mogu biti pokriveni osiguranjem, a neki ne. Pomenućemo jedan primer iz prakse SAD, koji se ticao tržnog centra čiji je krov uništio uragan. No, nakon nastanka štete, postavilo se pitanje da li je krov izrađen u skladu sa standardima, odnosno da li je korišćen odgovarajući materijal, da li je krov odgovarao standardima u projektovanju itd. Naravno, ti uzroci nisu bili pokriveni osiguranjem. Predstavnik osiguravača je tvrdio da je do urušavanja krova došlo i usled lošeg projektovanja i neodgovarajuće konstrukcije. Ovde moramo imati u vidu i činjenicu da je potrebno utvrditi koji je uzrok doveo do štete. U vezi s tim, mora se utvrditi da li je drugi uzrok doprineo efikasnosti prvog uzroka. Utvrđeno je da pre uragana nije postojala opasnost od urušavanja krova, tako da je odlučeno u korist osiguranika.[23] Kod takvih slučajeva, može se postaviti i pitanje koji je uzrok doveo do veće štete, odnosno da li se može utvrditi, procentualno ili na drugi način, koliko je jedan, a koliko je drugi rizik doprineo nastanku štete. S druge strane, ovde se može govoriti i o nesavesnoj, neadekvatnoj gradnji, odnosno neadekvatnom materijalu koji je i doveo do opasnosti za objekat. Isto tako, spoljni uzroci su ti koji su pokriveni osiguranjem, dok su unutrašnji uzroci vezani za odgovornost osiguranika.

3. Naknada po osnovu šomažnog osiguranja

Kada se ostvari rizik na osiguranoj stvari, nastaje neposredna, direktna šteta. Ali osiguranik može pretrpeti i nepokrivenu štetu koja je u uzročnoj vezi sa osiguranom stvari. Takva šteta predstavlja finansijsku posledicu osiguranog slučaja koja nastaje bez obzira na to što je osiguranik već dobio naknadu za oštećenje ili uništenje stvari. Takva posredna ili indirektna šteta može biti i veća od direktne, odnosno one koja je proizašla iz rizika koji predstavlja osnovni. Naime, ovde se radi o nemogućnosti bavljenja određenom delatnošću u određenom vremenskom rasponu u kome je potrebno da se saniraju sve posledice nastanka osnovnog rizika. Naravno, u tom

[22] M. Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", 13. 5. 2024.

[23] Paul M. Hummer, „Basics of Business Interruption Insurance: The Ins and Outs of Tricky Coverage", *Defense Counsel Journal*, July 2022, str. 310.

periodu osiguranik ima i određene fiksne troškove koje je morao da snosi, iako mu je delatnost u zastoju ili prekidu. Dakle, ovde s jedne strane govorimo o indirektnoj šteti prouzrokovanoj nemogućnošću obavljanja delatnosti, a s druge strane o troškovima koje osiguranik ima u periodu u kome ne može da obavlja svoj rad.[24]

Kod šomažnog osiguranja, naknada iz osiguranja se obračunava po posebnim merilima u zavisnosti od toga da li je nastupio prekid rada i da li je taj prekid rada uticao na nastanak gubitaka. Upravo zbog toga, moramo imati u vidu eventualnu uzročnu vezu, ako je došlo do prekida rada, zatim nastanak posredne (indirektne) štete, kao i šta će činiti naknadu.

Šta pokriva osiguranje od prekida poslovanja? Kod obračuna iznosa mora se poći od bruto zarade, kao i od poslovnih prihoda. Kad govorimo o šteti usled prekida rada, ona obuhvata iznos dohotka koji osiguranik, u periodu dok je prekid trajao, nije mogao da ostvari, kao i nepokriveni iznos osiguranih troškova koji su nastali u tom periodu. Osiguravač mora naknaditi štetu za ugovoreni period trajanja isplate, ali najviše do 12 meseci od dana nastanka osiguranog slučaja. Taj rok može biti i drugačije ugovoren. Ali, ako je prekid rada trajao tri dana ili manje, tada osiguravač nije u navedenoj obavezi. Osiguranje će prestati kada osiguranik iskoristi pravo iz celog garantnog roka zbog jednog ili nekoliko prekida rada. Vrlo često je obavezno i učešće osiguranika u šteti, odnosno franšiza. Utvrđivanje visine naknade određuje se prema dohotku, koji bi osiguranik ostvario i osiguranim troškovima, koji bi nastali da nije bilo prekida rada. Navedeno se utvrđuje na osnovu podataka o ostvarenim dohocima i troškovima u tekućoj godini ili nekoliko prethodnih godina poslovanja. Svako odstupanje od tako utvrđenog dohotka, kao i utvrđenih troškova, osiguranik mora da dokaže određenom dokumentacijom. Može se ugovoriti i fiksna obaveza osiguravača, što se odnosi i na dohodak i na troškove. Fiksna naknada se utvrđuje na prethodno navedeni način. Osim toga, poslovni prihodi se odnose na neto prihod koji bi osiguranik zaradio, a na koji se dodaju fiksni troškovi, kao što su plate i porezi. Iznos gubitaka usled prekida rada treba da bude isti u okviru oba oblika.[25]

3.1. Posredna (indirektna) šteta; izgubljena dobit

Posvetićemo se najbitnijim elementima naknade po šomažnom osiguranju, naknadi posredne štete i izgubljenoj dobiti.[26] Posredna šteta definiše se i kao posledica druge štete.[27] Kad će se smatrati da postoji uzročna veza koja je neophodna da bi se

[24] M. Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", 13. 5. 2024.
[25] Chris French, „The Aftermath of Catastrophes: Valuing Business Interruption Insurance Losses", *Georgia State University Law Review*, vol. 30:2/2014, str. 69–470.
[26] Obren Stanković, „Pojam i vrste štete", *Anali Pravnog fakulteta u Beogradu*, vol. 25, br. 3/1977, str. 306.
[27] Jakov Radišić, *Obligaciono pravo*, opšti deo, Centar za publikacije Pravnog fakulteta u Nišu 2023, str. 223.

odredila indirektna šteta? Postoje dve teorije: teorija ekvivalentne uzročnosti i teorija adekvatne uzročnosti, pa se u zavisnosti od toga koja se od njih usvoji, razlikuju i definicije direktne i indirektne štete. Postoje, naravno, i različite varijante ove dve teorije. Po jednoj, direktna šteta je ona koja se neposredno nadovezuje na štetnu radnju, a indirektna ona koja se nadovezuje na direktnu. Po drugoj, direktna je svaka šteta koja je bila nužna i neizbežna. Po trećoj, to je šteta koja je tipična posledica štetne radnje. Po četvrtoj, direktna je ona kojoj je štetna radnja izvor, a indirektna ona kojoj je štetna radnja samo povod. Pritom, ne samo što svaka od ovih definicija ima svojie pristalice nego se pomoću iste definicije često vrše različite kvalifikacije.[28] Znači, o indirektnoj šteti govorimo ako su finansijski gubici nastali usled kvara ili uništenja sredstava, odnosno objekta za rad. Osim toga, preovlađuje stav da i za direktnu i za indirektnu štetu mora biti odgovoran isti štetnik.[29]

Kad je u pitanju izgubljena dobit, osiguravač ili sud (u zavisnosti od toga ko i u kom postupku obračunava štetu) mora imati u vidu da u naknadu za oštećenu ili uništenu stvar ulazi i naknada izgubljene dobiti, ako se, inače, može ostvariti korišćenjem te stvari.[30] Izgubljena dobit se definiše i kao izgubljena zarada koju je oštećeni ostvarivao preprodajom tuđih stvari.[31] Lice koje je trebalo da zadovolji neku svoju potrebu kupovinom stvari od očekivane dobiti koja mu je izmakla štetnikovom krivicom ili nekim drugim štetnim događajem nije ništa manje pogođeno od onoga ko je tu istu potrebu trebalo da zadovolji upotrebom stvari koju poseduje, odnosno kupovinom takve stvari za gotov novac (već ostvarenu zaradu), pa je u tome onemogućen uništenjem stvari, usled nastanka određenog štetnog događaja.[32] Izgubljena dobit predstavlja negativnu štetu, koja se manifestuje kao neostvarena imovinska vrednost, odnosno kao sprečeno povećanje imovine oštećenog usled štetne radnje.[33] Takođe, Zakon o obligacionim odnosima (dalje: ZOO)[34] definiše izgubljenu dobit kao sprečavanje povećanja dobiti.[35] Pri utvrđivanju iznosa štete, izgubljena dobit će se uzeti u obzir samo ako je to ugovoreno.[36] Izgubljena dobit se ocenjuje na način da se uzima u obzir dobitak koji je mogao da se očekuje na osnovu svih osnovanih okolnosti, prema redovnim tokovima ili po posebnim okolnostima, a čije je ostvarenje sprečeno radnjom štetnika ili njegovim propuštanjem.[37] Izgubljenu

[28] O. Stanković, str.307.
[29] J. Radišić, str.224.
[30] O. Stanković, str. 289.
[31] *Ibidem*.
[32] O. Stanković, str. 290.
[33] J. Radišić, str.221.
[34] Zakon o obligacionim odnosima, ZOO, *Sl.list SFRJ* br. 29/78, 39/85, 45/89 i 57/89, *Sl. list SRJ* br. 31/93, *Sl.list SCG* br. 1/2003 – Ustavna povelja i *Sl.glasnik RS* br. 18/2020.
[35] Član 155 ZOO.
[36] Član 925, st. 5 ZOO.
[37] Član 189 ZOO.

dobit možemo definisati i kao očekivano uvećanje imovine.[38] Ali nije merodavno ono što sam oštećeni očekuje, već objektivna mogućnost sticanja dobiti, što znači da se radi o dobitku koji se osnovano mogao očekivati po redovnom toku stvari ili po posebnim okolnostima. Isto tako, nije neophodno da se utvrdi potpuno ostvarenje dobiti, već određeni stepen verovatnoće.[39] U svakom slučaju, izgubljena dobit će se kod šomažnog osiguranja isplatiti samo ako je posebno ugovorena, to jest ako je plaćena premija ili premijski dodatak na osnovnu premiju. O izgubljenoj dobiti govorimo i u slučaju gubitka zakupnine, požara na objektima, šteta kod osiguranja useva i plodova itd.[40]

3.2. Pojedini aspekti i problemi vezani za obračun naknade iz osiguranja

Kada se utvrdi osigurani slučaj, kao i potrebni elementi kod ove vrste osiguranja, sámo vrednovanje prekida poslovanja može da bude veoma složen zadatak. Od čega treba poći da bi se mogao utvrditi iznos koji će se platiti oštećenom? Pre svega, stvarni pretrpljeni gubitak, zatim, period prekida poslovanja, troškovi koji su nastali kako bi se ublažili gubici, ali koji su kontinuirani u odnosu na nestalne troškove. Moramo istaći da je utvrđivanje navedenog iznosa za naknadu mnogo složenije u oblasti proizvodnje nego u oblasti trgovine.[41]

Izuzetno važno pitanje za obračun naknade jeste i trajanje perioda u kome subjekt nije mogao da obavlja svoju delatnost. Trajanje tog perioda može zavisiti od mnogo faktora. Glavni faktor predstavljaju posledice koje je izazvao osigurani slučaj, to jest realizovana opasnost koja ne mora da ošteti samo osigurani subjekt. Da li će osiguranik biti u mogućnosti da osposobi svoja sredstva kako bi mogao da nastavi s radom, zavisi i od mogućnosti koje mu stoje na raspolaganju.[42] Obračun gubitka, odnosno naknade će biti složeni i kada je trajanje prekida tačno određeno. Postoji nekoliko smernica za utvrđivanje naknade. Poslovanje je retko statično tako da eksterni uslovi i revidiranje programa rada osiguranika mogu da utiču na taj iznos. Osiguranik može dokazivati da bi došlo do povećanja zarade (da rad nije prekinut), ako bi se dokazala potencijalna efikasnost programa obavljanja delatnosti. Isto tako, moraju se uzeti u obzir i tendencije opadanja u poslovanju, koje mogu da utiču i na pad zarada. Kada se radi o proizvodnom preduzeću kao osiguraniku, tada će gubitak zavisiti od gubitaka u proizvodnji, a ne od gubitaka u prodaji.[43] Kod osiguranika koji se bave proizvodnjom, dobit od gotovih proizvoda koji su pretrpeli

[38] J. Radišić, str. 221.
[39] J. Radišić, str. 222.
[40] J. Pak, str. 234.
[41] D. A. Borghesi, p.1152–1153.
[42] A. G. Miller, p. 804.
[43] A. G. Miller, p. 805.

štetu od osigurane opasnosti nadoknađuje se u iznosu koji bi bio naplaćen posle ugovorenog perioda obeštećenja, pri čemu taj iznos mora biti osiguran na posebnu sumu iskazanu u polisi osiguranja.[44] Na isti način možemo da odredimo i gubitke ako je osiguranik trgovinska kompanija.

Moramo pomenuti i nekoliko problema koji mogu nastati u postupku utvrđivanja iznosa za naknadu. Prvo, obračun štete usled prekida poslovanja zasniva se na obračunu zarada pre oporezivanja dohotka. Ako kompanija osigurava imovinu koja se nalazi u drugim zemljama, treba uzeti u obzir razlike u stopama poreza na dohodak, odnosno to da li ta činjenica predstavlja značajan rizik od gubitka u zavisnosti od toga gde se uplaćuje prihod od osiguranja. Zatim, nisu svi troškovi iznad uobičajenih nadoknadivi. Može se utvrditi da su određeni troškovi razumni i realni. Ali može se desiti da neki troškovi nisu nastali u cilju smanjenja gubitaka i vraćanja poslovanja u normalu. Troškovi pripreme zahteva za naknadu štete, zatim honorari konsultanata, putni troškovi uglavnom nisu pokriveni. Sledeće, izgubljene kamate na potraživanja isključene su iz obračuna gubitaka usled prekida rada.[45]

Najzad, vrednost prekida rada, odnosno iznos koji predstavlja izgubljenu dobit utvrđuje se knjigovodstvenom evidencijom ili drugim dokazima o neto gubitku tokom perioda prekida obavljanja delatnosti. No mora se voditi računa i o mogućnosti da se osiguranik na taj način neopravdano obogati. Npr. preduzeće koje je i pre nastanka osiguranog slučaja poslovalo s gubicima možda neće biti u poziciji da nastavi svoju delatnost, uprkos naknadi od strane osiguravača. Osim toga, osiguranik neće imati pravo na naknadu ako ne može dokazati da je prekid rada prouzrokovao gubitak u proizvodnji ili prodaji.[46]

4. Uslovi za realizaciju šomažnog osiguranja

Već smo rekli da je šomažno osiguranje specifično. Ipak, na osnovu navedenih karakteristika te vrste osiguranja, možemo izdvojiti uslove za njegovu realizaciju. Ti uslovi su sledeći:

1. Rizik kod šomažnog osiguranja nije poseban, već je vezan za osnovni rizik, to jest njegovo ostvarenje;
2. Šomažno osiguranje je dopunsko osiguranje, kod kojeg se plaća veća premija, što znači da mora biti ugovoreno odgovarajuće pokriće;
3. Šomažno osiguranje nije posebno osiguranje, jer nije samostalno;
4. Obaveza po šomažnom osiguranju nastaje samo ako su nastale posledice, to jest gubici usled prekida obavljanja delatnosti;
5. Ova vrsta osiguranja nije vezana za uspešno ili neuspešno poslovanje, pa samim tim ne može biti vezana ni za insolventnost;

[44] M. Jovanović, str. 72.
[45] D. A. Borghesi, p. 1164.
[46] P. M. Hummer, p. 311.

6. I druge vrste osiguranja se mogu ugovarati zbog opasnosti nastanka od gubitaka, kao što je osiguranje od odgovornosti, kasko osiguranje, klasično osiguranje imovine, ali šomažno osiguranje je šire sa stanovišta obuhvata različitih vrsta gubitaka i nastalih troškova; i
7. Gubici mogu biti obračunati samo ako postoje jasne knjigovodstvene vrednosti za odgovarajući prethodni period.

Više puta smo pomenuli da se šomažno osiguranje ne može odnositi na insolventnost osiguranika, odnosno ne može pokrivati gubitke subjekta u tom smislu, kao ni njegove dugove prema poveriocima. No ovde ćemo, ipak, pomenuti pitanje insolventnosti određenog subjekta u vezi sa momentom nastanka takvog stanja. Naime, ako duže traje prekid rada, privredni ili drugi subjekt može doći u situaciju da nije u stanju izvršavati svoje obaveze. Tada se postavlja pitanje da li tada, uopšte, možemo govoriti o stečajnom postupku, kao i u situaciji kada je insolventnost nastala pre realizacije osnovnog rizika. Dakle, mogu nastati situacije kod kojih moramo razlikovati stečajne razloge na one koji su nastali u vezi s poslovanjem i postupanjem jednog subjekta (pre nastupanja osiguranog slučaja) i na one koji su uzrokovani nekom situacijom za koju taj subjekt nije odgovoran.[47] Bez obzira na to kada je nastao stečajni razlog, odnosno kada je nastupila insolventnost, ne možemo govoriti o šomažnom osiguranju, imajući u vidu karaktertistike i uslove za realizaciju te vrste osiguranja.

V Šomažno osiguranje danas

U zadnjih nekoliko godina, šomažno osiguranje se često pominje, imajući u vidu pandemiju koja je doprinela da mnogi privredni i drugi subjekti prekinu rad. Prema podacima OECD, za vreme pandemije kovida 19 mesec dana stroge zatvorenosti dovelo je do približno 1,7 biliona dolara gubitka prihoda preduzeća u različitim oblastima.[48] Podaci Nacionalne asocijacije osiguranja SAD govore da je 2020. godine u skoro osam milijardi komercijalnih polisa osiguranja uključeno i pokriće prekida poslovanja.[49] Takođe, u SAD je pandemija izazvala dramatične padove potrošnje i najviši nivo nezaposlenosti još od velike depresije. Ta kriza je podstakla brzu akciju Kongresa i Federalnih rezervi tako što je odobreno povećanje od 600 dolara na ime beneficija za nezaposlene preko Saveznog programa kompenzacije za nezaposlene usled pandemije. U međuvremenu, brojne državne i lokalne samouprave u SAD, kao

[47] Vladimir Čolović, „Uticaj pandemije na pokretanje i vođenje stečajnog postupka", *Zbornik Pandemija kovida 19: pravni izazovi i odgovori,* Institut za uporedno pravo, Beograd 2021, str. 140.
[48] Piotr Tereszkiewicz, „Business interruption insurance as a means of spreading pandemic – related losses", *The Geneva Papers on Risk and Insurance – Issues and Practice,* vol.48, 2023, str. 714.
[49] David L. Eckles, Robert E. Hoyt, Johannes C. Marais, „The History and Development of Business Interruption Insurance", *Journal of Insurance Regulation* 2022, article 7, str. 5.

i savezne agencije, uvele su moratorijume na izvršenja, kao i druge mere.[50] I u nama susednoj Hrvatskoj uvedene su određene mere koje su se odnosile na uticaj prekida rada na finansijsku stabilnost privrednih subjekata. Naime, ako je insolventnost nastala u vreme pandemije i uzrok je tog stanja, nije se pokretao nijedan postupak koji bi doveo do gašenja subjekta. U Hrvatskoj su donete odluke čija je važnost produžavana u zavisnosti od trajanja posledica koje je izazvala pandemija. Slična situacija je bila i u drugim zemljama regiona.[51]

Ono što danas predstavlja problem u vezi sa šomažnim osiguranjem jeste činjenica da je ono ograničeno, jer je vezano za osnovno osiguranje i može se zaključiti samo kod osiguravača kod kojeg je osiguran i osnovni rizik. Znači, činjenica da se radi o dopunskom osiguranju, predstavlja ograničenje koje se ogleda i u prisutnosti na tržištu. Pomenućemo samo podatak sa hrvatskog tržišta osiguranja, gde je u 2022. godini zabeležena premija u iznosu od 26.515.000 evra, što je predstavljalo samo 1,58% ukupne zaračunate bruto premije, odnosno samo 2,03% ukupno zaračunate bruto premije neživotnih osiguranja.[52]

Osim toga, u Hrvatskoj su osiguravači i za mala i srednja preduzeća kreirali posebne pakete osiguranja. Na primer, preduzetnički paket osiguranja omogućava malim i srednjim preduzećima da jednom polisom osiguraju svoju kompletnu imovinu. Jednom polisom može se ugovoriti osiguranje od požarnih rizika, osiguranje od rizika zemljotresa, loma mašina, provalne krađe i razbojništva, loma stakla, prekida rada usled požarnih rizika, od prekida rada usled zemljotresa, osiguranja od opšte i profesionalne odgovornosti, kasko osiguranja, kao i osiguranja od nezgode.[53] Možda je taj način jedna od šansi da se poveća broj ugovora o šomažnom osiguranju u narednom periodu.

VI Zaključak

Ono što moramo prvo istaći jeste da je šomažno osiguranje zavisno od realizacije osnovnog rizika. Mora se voditi računa o tome šta obuhvata pokriće, na šta se ono odnosi. Kad govorimo o ovoj vrsti osiguranja, moramo imati na umu da će se, pre svega, uzimati u obzir spoljni uzroci, na koje osiguranik nije mogao da vrši uticaj. Šomažno osiguranje se ne može samostalno zaključiti. To znači da između realizacije osnovnih rizika i nastalih posledica po delatnost osiguranika mora postojati

[50] Jialan Wang Jeyul Yang Benjamin Iverson Raymond Kluender, „Bankruptcy and the COVID-19 Crisis", Harvard Business School, Working Paper 21-041, September 2020, str. 2.

[51] „Covid-19 coronavirus measures impacting insolvency proceedings and enforcement", Allen&Overy, 24 June 2020, str. 7;
file:///C:/Users/Vlada/Downloads/Covid-19%20Insolvency%20map%20updated%2024%20June%202020%20(10).pdf; V. Čolović (2021), str. 135.

[52] M. Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", 13. 5. 2024.

[53] M. Jovanović, str. 74.

uzročna veza. Takođe, rekli smo da insolventnost ne može biti pokrivena ovom vrstom osiguranja, s obzirom na posledice koje ona proizvodi u smislu eventualnog gašenja subjekta ili njegove reorganizacije.

Ovde moramo postaviti pitanje koje se odnosi na činjenicu da bi šomažno osiguranje trebalo svesti samo na osiguranje od prekida rada usled požara ili uništenja ili kvara sredstava za rad (mašina). Mnogo je širi spektar rizika čije ostvarenje može dovesti do stvaranja finansijskih gubitaka u dužem ili kraćem periodu. Naravno, osiguravači navedeno moraju da imaju u vidu, kako bi šomažno osiguranje bilo prihvatljivije za privredne i druge subjekte. S druge strane, posledice koje može izazvati realizacija osnovnih rizika mogu biti nesagledive sa stanovišta poslovanja određenog subjekta, što može proizvesti velike troškove, kao i gubitak profita. Iako je period prekida, sa stanovišta osiguravača, ograničen, moramo imati u vidu da kod mnogih osiguranih slučajeva ove vrste, pojedini osiguravači neće biti u stanju da naknade štetu. Zato se moraju definisati jasni programi osiguranja u ovoj oblasti koji će biti prilagodljivi kako osiguravačima tako i budućim osiguranicima, privrednim i drugim subjektima. Ti programi ne treba da se odnose samo na projektovanu premiju, pa samim tim i iznos štete, u vezi s nastankom gubitka i periodom prekida rada, već i na jasne modele upravljanja rizikom od strane budućih osiguranika, kao i na programe disperzije rizika između više osiguravača, ali i reosiguravača.

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INSURANCE AGAINST FINANCIAL LOSSES DUE TO BUSINESS INTERRUPTION

REVIEW ARTICLE

Abstract

Insurance against financial losses due to business interruption (loss profit insurance) is concluded as supplementary insurance, along with insurance for basic risks related to property or assets. In business interruption insurance, the insurer is obligated to pay compensation for indirect damage caused by the inability to use property, machinery, or facilities. This means that there must be a causal connection between the realization of the basic risks and the occurrence of indirect damage. This type of insurance is primarily concluded by individuals engaged in certain activities, regardless of whether they are legal entities or entrepreneurs. However, the damage that occurs due to business interruption must be caused by external circumstances and cannot be related to the business of the insured entity itself. One of the most important issues in business interruption insurance is related to the calculation of compensation, that is, the determination of lost profits and costs. In the paper, the author also discusses risk management and forecasting in business entities, with particular attention to the most important elements of the special terms and conditions of insurance in this field.

Keywords: *losses, business interruption, loss profit insurance, supplementary insurance, basic risks, indirect damage, lost profit, business costs.*

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I Introductory

Insurance against financial losses due to business interruption caused by various types of risks, hazards, or events is important for covering the costs incurred during the interruption of business activities. In addition to covering these costs, this type of insurance also provides compensation for lost profits during the period when the business entity or other party is unable to conduct its activities. This type of insurance is also known as "chômage" insurance. The word *chômage* is of French origin and denotes a stoppage or inactivity. Business interruption insurance is concluded as supplementary insurance, but only if the same insurer also provides insurance for the basic assets of the entity, as well as for non-monetary working capital. As for the obligation to compensate for damage, it will only exist if it is agreed that the insurer is obliged to pay for the specified damage following the occurrence of the insured event. Consequently, if the basic insurance contract ceases to be valid, the business interruption insurance contract, i.e. the "chômage" insurance, also ceases to be valid.[2]

To ensure the effectiveness of business interruption insurance, the damage must result from: – fire or lightning strike; – explosion; – storm; – hail; – collision of the insured building by the insured's motor vehicle or mobile work machine; – aircraft crash; – manifestations and demonstrations. The obligation to compensate under business interruption insurance exists only when there is an obligation to pay for damage under insurance against basic risks, such as the risk of fire or other harmful events. To be eligible for compensation under business interruption insurance, the insured must generate income or determine and allocate earnings. In addition, they must conclude business interruption insurance for all organizational units at the same location, regardless of whether they are exposed to a single or separate risk. If this is not done, in the event of an insured incident, the proportionate rule will be applied when determining the amount of compensation. However, the insured can be exempt from this rule if they pay an additional premium in advance.[3]

We must also bear in mind that this insurance does not cover the insolvency of an entity resulting from the inability to meet obligations to creditors; rather, it covers the inability to conduct business because the entity cannot use its assets and work space (facilities).

Nevertheless, the business interruption must represent an insurable risk, even though it compensates for indirect damage as a consequence of the realization of basic risks. The subject of business interruption insurance against all risks is the loss of the insured party and their insured interest, meaning the profit that could have been expected but was prevented from being realized due to the occurrence

[2] Boris Marović, Vladimir Njegomir, „Poslovanje osiguravajućih i reosiguravajućih društava u korelaciji sa energetikom i energetskim izvorima", *34th Meeting of Insurers and Reinsurers*, Sarajevo 2023, p. 61.

[3] B. Marović, V. Njegomir, p. 62.

of the insured event. Compensation under business interruption insurance can be agreed upon as compensation for gross profit or fixed costs and net profit, which represents the amount that was not earned due to a reduction in business income and an increase in employment costs. The sum insured that can be agreed upon for business interruption cannot be less than the annual gross profit if gross profit insurance is contracted, or less than the net profit and the aforementioned fixed costs.[4]

II The History of Business Interruption Insurance

Business interruption insurance has existed for a very long time, nearly three and a half centuries. We will briefly review the development of this type of insurance protection. The first coverage for indirect damages as supplementary insurance is attributed to the English insurer Minerva Universal in 1707. Subsequently, in Hamburg, a similar insurance policy was issued in 1817 by the company *Cassa Generale Incendio*. In France, coverage under the name *chômage* emerged in 1857. All these policies provided lump-sum compensation for indirect costs as a percentage of the damage from the basic risk. Later, *Lloyd* adopted this insurance as a *percentage of fire loss*. These were, therefore, lump-sum insurance amounts, as accounting practices within companies at that time were not reliable sources of data on the profits and losses of the insured, hence, it was impossible to determine the exact amount of indirect damages. Naturally, this became possible later with the development of accounting standards, leading to the introduction of a policy in 1899 covering indirect costs under the name *Loss of Profit*, which was tied to the basic risk for a specific period. The Scottish broker Mac Lellan Man played a significant role in the emergence of this type of coverage. However, this type of coverage faced criticism from some insurers, who believed it involved unethical business practices that enabled the insured to gain unjust enrichment. Nevertheless, the demand for this type of insurance led to policies being issued in this area in Germany in 1911, and by 1955, business interruption insurance had evolved into an autonomous type of insurance with its own premium rates. In France, insurers adopted it under the name *pertes d'exploitation* – operational losses.[5]

III Insurance Against Losses

A contract for insurance against losses due to business interruption is a contract of indemnity. This coverage ensures the reinstatement of the economic

[4] Milovan Jovanović, „Osiguranje od svih rizika na tržištu osiguranja u Srbiji", *European Insurance Law Review*, No. 4/2012, Belgrade 2012, p. 72.

[5] Marijan Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)" 13. 5. 2024.; *https://www.osiguranje.hr/ClanakDetalji.aspx?22746*, accessed on: 10.7.2024.

position that allows for the continuation of business activities, i.e. the position that existed prior to the occurrence of the insured event. Business interruption insurance compensates for lost cash flow and additional costs incurred due to the inability to operate or the destruction of insured assets.[6] Insurance for losses due to business interruption results from the use of property, and for a claim to be paid, five interrelated criteria must be met. First, there must be physical damage to the property. Then, the damaged property must be insured, and the risks must be incurred risks covered by that insurance. Additionally, the damage must result in a measurable loss due to the business interruption, and this must be for a specific period needed to procure other means of production and take other actions to continue business activities. These five conditions are interconnected, and a break in any part of this chain would prevent compensation for the damage.[7] Insurance against losses due to business interruption encompasses not only the physical assets but also the insured's interest, particularly the potential profit that was not earned. This must be considered when the business operates across multiple interconnected locations, meaning that the insured's interest must extend to all places where the insured conducts business, i.e. their property should be considered as an integrated whole.[8]

1. Risk Management by Entities Engaged in Certain Activities

We will also address risk management by entities engaged in economic or other activities. There are several methods for managing risk within such an entity. The choice of method depends on the nature of the business, the size of the entity, the number of employees, available resources, and many other factors that define the business entity. We will highlight four methods of risk management, noting that other methods can also be defined and that multiple methods can be combined in risk management. These methods are as follows: 1) Predictability and damage control; 2) Financing of damages; 3) Reducing the likelihood of damages;[9] and 4) Supervision of business activities within the business entity.[10] The most common risk control method within a business entity is the risk transfer to an insurance company. The business entity must assess whether it is advisable to allocate funds for paying insurance premiums. The fact is that risk transfer is most beneficial not only when transferring risk to an insurance company but also in the context of selling part of

[6] David A. Borghesi, „Business Interruption Insurance--A Business Perspective", *Nova Law Review* vol. 17-1993, pp. 1147–1148.
[7] D. A. Borghesi, p. 1151.
[8] Alan G. Miller, „Business Interruption Insurance, A Legal Primer", *Drake Law Review*, vol.24 – December 1975, p. 801.
[9] Svetlana Ivanović, „Upravljanje rizikom i osiguranje", *Industrija,* No.1-2/2003, p. 72.
[10] Vladimir Čolović, „Upravljanje rizikom u privrednim društvima", *EMC Review* – Journal of Economics and Market Communications, 10(2)/2015, p. 242.

the business, selling shares, merging, or acquiring other entities.[11] Large companies must also be aware of risk multiplication and interconnected risks, which can result in losses across multiple insurance lines or losses in unexpected areas, including various geographical markets, due to interlinked business relationships (for example, floods in Thailand led to business interruption losses in the U.S. market).[12]

IV Characteristics of Business Interruption Insurance

Business interruption insurance is primarily supplementary insurance. Supplementary insurances are those that are contracted alongside basic risks and cannot be agreed upon separately. This means that in order to conclude business interruption insurance, there must be insurance coverage for basic risks whose occurrence can also lead to consequential, indirect damage. The conditions of the insurance, as well as the policy itself, must define which risks are covered by the supplementary insurance. Furthermore, supplementary insurance is classified as voluntary insurance, meaning that policyholders themselves decide not only whether they will purchase this type of insurance, but also which risks will be covered. On the other hand, supplementary insurance refers to coverage for risks that are not related to the insurance of basic risks. Business interruption insurance primarily pertains to companies and industries. However, other insured parties may also conclude this type of insurance, for example, to cover losses related to leased property due to the inability to collect rent, the inability to use a specific property, rental costs for another property, etc. This type of insurance applies specific terms and conditions, which include provisions that limit insurer's obligations, such as coverage duration, types of costs covered, requirements for proper accounting, determining the legitimacy of expenses through expert evaluation, etc.[13]

Some authors argue that business interruption insurance is a distinct type of insurance, typically purchased alongside fire insurance policy.[14] However, we cannot classify business interruption insurance as entirely distinct because, if it were, it would not be linked to basic risk insurance and could be contracted independently. Given that this type of insurance is clearly defined and linked to the damage or destruction of an asset or property, which prevents a business or another entity from carrying out its activities, it is only available in conjunction with basic risk insurance.

An insured party whose property has been damaged will not be entitled to coverage for losses if those risks are not included in the insurance policy. This type

[11] V. Čolović (2015), p. 239.
[12] Marija Kerkez, Ivan Ivanović, „Katastrofalni rizici i osiguranje", *Megatrend revija*, Vol.13, No.2, 2016, p. 25-26.
[13] M. Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", 13. 5. 2024.
[14] Andrej Pak, *Zaključenje i prestanak ugovora o osiguranju*, doctoral dissertation, Educons University, Faculty of European Legal and Political Studies, Novi Sad, 2016, p. 79.

of insurance cannot mitigate the consequences of poor business performance, large debts to creditors, poor market placement of goods, production losses due to poorly executed business plans, and so on.

Additionally, business interruption insurance is often categorized alongside property insurance, such as fire insurance, burglary and robbery insurance, machinery breakdown insurance, comprehensive car insurance, and crop and yield insurance.[15] However, we cannot fully agree with this classification. While it is true that business interruption insurance is categorized as property insurance because it is linked to the insurance of assets, it would be more appropriate to consider it separately. This is because the realization of business interruption insurance may or may not occur, even if the basic risk has occurred. Whether the insurer is obligated to pay out under a business interruption insurance policy depends on whether the consequences, which may or may not occur, actually do arise. If consequences do arise, it means that losses have been sustained, and the insurer is obligated to provide compensation. If they do not, the insurer will not have any obligation to pay.

1. Business Interruption Insurance in Domestic Legislation

The Insurance Law of the Republic of Serbia (hereinafter: IL)[16] regulates the financial loss insurance. However, it should be noted that the IL defines this type of insurance somewhat imprecisely, as its provisions do not clearly indicate whether financial losses are covered independently or if they are related to a harmful event, i.e. as a consequence of such an event. Specifically, the IL stipulates that this insurance covers losses due to unemployment, insufficient income, adverse weather conditions, lost profits, unexpected general expenses, unplanned operating costs, loss of market value, loss of rent or income, indirect business losses, as well as other non-business and financial losses.

1.1. Business Interruption Insurance in Specific Insurance Conditions

The regulation of business interruption insurance within specific insurance conditions stems from the specific characteristics of this type of insurance coverage. We will focus on certain provisions found in the Special Conditions for insurance against business interruption due to fire and other perils, issued by one insurance company[17],

[15] Nataša Petrović Tomić, „Aktuelnost razlikovanja prava na naknadu štete i prava na osiguranu sumu u delu Mihaila Konstantinovića: klasični instituti i moderno pravo osiguranja", *Annals of the Faculty of Law in Belgrade*, Special Issue in Honor of Professor Mihailo Konstantinović, Belgrade 2022, p. 567, fn. 6.

[16] Insurance Law, IL, *Official Gazette of the Republic of Serbia*, No. 139/2014 and 44/2021.

[17] Special Conditions for Insurance Against Business Interruption Due to Fire and Certain Other Hazards, Sava Insurance; *https://www.sava-osiguranje.rs/sr-rs/uslovi-osiguranja/*, accessed: July 11, 2024.

particularly regarding cases of exclusions from coverage. These situations includes: 1) when the damage results from extraordinary events related to macroeconomic changes, uninsured risks, etc.; 2) if the damage is a consequence of restrictions imposed by government authorities on the repair of damaged property; 3) when there is a lack of financial resources for the repair or replacement of damaged or destroyed property; 4) if the causes of damage originate from other entities with whom the insured has business relations; 5) if the damage is due to the destruction of money, securities, plans, business records, and similar items; 6) if the damage occurs due to job loss, lease termination, or license revocation in specifically defined situations.[18]

The same conditions also define the types of losses that the insurance will cover. Primarily, this includes gross profit losses due to a reduction in revenue, calculated as the difference between standard revenue and actual revenue at the time of the business interruption, which is then multiplied by the gross profit margin. Additionally, the insurance will cover increased operating expenses, as these are the additional costs necessary to mitigate or reduce the loss of revenue during the interruption period.[19]

We have highlighted the provisions regarding exclusions from insurance coverage, as well as the calculation of losses, to illustrate the specificities of business interruption insurance. These provisions emphasize the connection of this insurance to the basic risk and the requirement that a loss must occur, specifically in relation to profit loss and increased expenses during the period of business interruption.

2. Insured Event in Business Interruption Insurance

Upon the occurrence of an immediate peril or when it begins to manifest, the insured is obligated to promptly notify the insurer, without delay, on the same day orally, and then in writing by the following day. If the insured fails to notify the insurer in the specified manner, the insurer may determine the financial impact of the failure to report the occurrence of the peril and proportionately reduce the compensation amount. Naturally, in the event of a business interruption, the insured is also required to take the necessary measures to eliminate or reduce the damage, that is, to take actions that will shorten the duration of the interruption, and to follow the insurer's instructions.[20] If the insured experiences a business interruption that lasts shorter than the agreed period and wishes to renew coverage for the entire guarantee period, a supplementary agreement for business interruption insurance must be concluded. In such a case, the premium is reduced proportionally to the unused guarantee period from the previous contract.

[18] Article 3, Paragraph 6 of the Special Conditions.
[19] Article 4 of the Special Conditions.
[20] B. Marović, V. Njegomir, p. 63.

In the context of business interruption insurance, since it does not cover property damage, a question arises as to when the insured event occurs. This is particularly pertinent given that losses covered by the insurance occur after the damaging event, and already incurred financial losses often lead to further such damages. If we were to accept that the insured event related to losses due to business interruption occurs simultaneously with the realization of the basic risk event, then the risk of the inability to conduct business would be difficult to assess. It can be questioned whether the insured event related to business interruption can be accepted as occurring when the first covered damage in a series of causally related damages arises.[21] We can provide a positive response to this. In any case, the business interruption must result from the realization of the basic risk. Whether or not a business interruption will actually occur, despite the basic risk being realized, is another matter. However, if it does occur, the moment of the insured event is determined by the moment of the damaging event associated with the basic risk. In any case, upon the occurrence of an insured event related to risks such as fire, flood, machinery breakdown, or destruction, the insurer's obligation to provide compensation for the damage arises.[22]

Then, it may happen that a business interruption loss arises due to multiple causes. Specifically, this refers to damage or destruction of property or an object resulting from several different causes. Some of these causes, or realized risks, may be covered by insurance, while others may not. We will mention an example from U.S. practice, which involved a shopping mall whose roof was destroyed by a hurricane. After the damage occurred, the question arose as to whether the roof was constructed according to standards, whether appropriate materials were used, and whether it met design specifications, etc. Naturally, these causes were not covered by insurance. The insurer's representative argued that the roof collapse was also due to poor design and inadequate construction. In such cases, it is crucial to establish the cause of the damage. In this regard, it must be determined whether the secondary cause contributed to the effectiveness of the basic cause. For instance, it was found that before the hurricane, there was no danger of the roof collapsing, so the decision was made in favor of the insured.[23] In such cases, the question may also arise as to which cause led to greater damage, or whether it is possible to determine, either percentage-wise or otherwise, how much each risk contributed to the damage. On the other hand, there may be issues related to negligent or inadequate construction or the use of substandard materials that contributed to the risk to the property.

[21] Jasna Pak, Insurance Law, Singidunum University, Belgrade 2011, p. 198.

[22] M. Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", May 13, 2024.

[23] Paul M. Hummer, „Basics of Business Interruption Insurance: The Ins and Outs of Tricky Coverage", *Defense Counsel Journal*, July 2022., p. 310.

Likewise, external causes are typically covered by insurance, while internal causes related to the insured's responsibility are not.

3. Compensation under Business Interruption Insurance

When a risk materializes on the insured property, consequential, direct damage occurs. However, the insured may also suffer uncovered damage that is causally related to the insured property. Such damage represents the financial consequence of the insured event that arises regardless of whether the insured has already received compensation for the damage or destruction of the property. This indirect or consequential damage can be greater than the direct damage resulting from the basic risk. Here, this pertains to the inability to conduct a particular business activity during a period necessary to address all consequences arising from the basic risk. During this period, the insured incurs certain fixed costs that must be borne even though the business activity is at a standstill or interrupted. Thus, on one hand, we are discussing indirect damage caused by the inability to conduct business, and on the other hand, we are addressing the costs incurred by the insured during the period of business interruption.[24]

In business interruption insurance, the compensation is calculated based on specific criteria depending on whether the business interruption occurred and how it impacted the resulting losses. Consequently, it is crucial to consider the potential causal relationship if there has been a business interruption, the occurrence of indirect (consequential) damage, as well as what will determine the compensation.

What does business interruption insurance cover? In calculating the amount of compensation, the starting point must be the gross profit and business revenues. When discussing damage due to business interruption, it includes the amount of income that the insured was unable to earn during the period of interruption, as well as the insured expenses incurred during that time. The insurer is obligated to compensate for the losses for the agreed period of indemnity, but not exceeding 12 months from the date of the insured event. This period may be different if specified in the policy. If the interruption lasted three days or less, the insurer is not obligated to provide compensation. Insurance coverage will cease when the insured has utilized the coverage for the entire guarantee period due to one or multiple interruptions. It is often required that the insured participates in the loss, i.e. a deductible applies. The amount of compensation is determined based on the income that the insured would have earned and the insured expenses that would have been incurred if there had been no business interruption. This is determined based on data from the current year or several previous years of business activities. Any deviations from

[24] M. Ćurković, „Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", May 13, 2024.

the determined income or expenses must be substantiated by the insured with appropriate documentation. A fixed sum of compensation for the insurer may also be agreed upon, which applies both income and expenses. This fixed compensation is determined as previously described. Additionally, business revenues refer to the net income the insured would have earned, with fixed costs such as salaries and taxes added. The amount of loss due to business interruption should be consistent in both forms of compensation.[25]

3.1. Indirect (Consequential) Damage; Lost Profit

In this section, we will focus on the key elements of compensation under business interruption insurance, specifically indirect damage and lost profit.[26] Indirect damage is defined as the consequence of another form of damage.[27] When is it considered that a causal connection exists, which is necessary to determine indirect damage? There are two theories: the theory of equivalent causation and the theory of adequate causation. The choice of theory affects the definitions of direct and indirect damage. There are also variations of these theories. According to one, direct damage is seen as that which directly follows the harmful action, while indirect damage follows from this direct damage. According to another theory, direct damage is any harm that was necessary and unavoidable. According to a third theory, direct damage is the typical consequence of the harmful action. According to a fourth theory, direct damage results directly from the harmful action, while indirect damage is merely initiated by it Not only does each of these definitions have its supporters, but the same definition is often used to make different qualifications.[28] Thus, indirect damage refers to financial losses that occur due to the malfunction or destruction of operational means or objects. It is generally accepted that for both direct and indirect damage, the same liable party must be accountable.[29]

When it comes to lost profit, under business interruption insurance, the insurer or the court (depending on who is calculating the damage and in what procedure) must consider that compensation for damaged or destroyed property includes compensation for lost profit if it could otherwise have been achieved by using that property.[30] Lost profit is also defined as the profit that the injured party would have earned from reselling someone else's property.[31] A person who intended to fulfill a

[25] Chris French, „The Aftermath of Catastrophes: Valuing Business Interruption Insurance Losses", *Georgia State University Law Review*, vol. 30:2/2014, pp.69–470.
[26] Obren Stanković, „Pojam i vrste štete", *Annals of the Faculty of Law in Belgrade*, Vol. 25, No. 3/1977, p. 306
[27] Jakov Radišić, *Obligatory Law*, General Part, Center for Publications of the Faculty of Law in Niš, 2023, p. 223.
[28] O. Stanković, p. 307.
[29] J. Radišić, p. 224.
[30] O. Stanković, p. 289.
[31] *Ibidem*.

need by purchasing property with anticipated profit that was lost due to the fault of the wrongdoer or another harmful event is no less affected than someone who needed to fulfill the same need by using their own property or by purchasing such property for cash (already earned profit), and who is hindered by the destruction of the property due to a harmful event.[32] Lost profit represents a form of negative damage, which manifests as unrealized property value or a prevented increase in the injured party's assets due to the harmful act.[33] Additionally, the Law of Contract and Torts (hereinafter: LCT)[34] defines lost profit as the prevention of the increase in profit.[35] When determining the amount of damage, lost profit will be considered only if it is stipulated in the contract.[36] Lost profit is assessed by considering the profit that could have been expected based on all reasonable circumstances, according to regular course of events or specific circumstances, and which was prevented by the wrongdoer's actions or omissions.[37] Lost profit can also be defined as the expected increase in assets.[38] However, what the injured party expects is not applicable; instead, it is the objective possibility of profit acquisition, meaning the profit that could reasonably have been expected based on the regular course of events or specific circumstances. Likewise, it is not necessary to determine complete realization of profit, but a certain degree of probability.[39] In any case, lost profit under business interruption insurance will be compensated if it is specifically agreed upon, meaning if the premium or a premium supplement to the base premium has been paid. Lost profit is also discussed in cases of rental loss, property fire, crop insurance losses, and similar situations.[40]

3.2. Specific Aspects and Challenges in Insurance Compensation Calculation

When determining an insured event and the necessary elements of this type of insurance, the valuation of business interruption can be a highly complex task. What should be the starting point for determining the amount to be paid to the injured party? Primarily, the actual incurred loss, the duration of business interruption, and the costs incurred to mitigate losses, which are continuous compared

[32] O. Stanković, p. 290.
[33] J. Radišić, p. 221.
[34] Law of Contract and Torts, LCT, *Official Gazette of SFRY*, No. 29/78, 39/85, 45/89, and 57/89, *Official Gazette of FRY*, No. 31/93, *Official Gazette of SCG*, No. 1/2003 – Constitutional Charter, and *Official Gazette of RS*, No. 18/2020.
[35] Article 155 LCT.
[36] Article 925, para. 5 LCT.
[37] Article 189 LCT.
[38] J. Radišić, p. 221.
[39] J. Radišić, p. 222.
[40] J. Pak, p. 234.

to variable costs. It is important to note that calculating this compensation amount is significantly more complex in the manufacturing sector than in the retail sector.[41]

A crucial issue in calculating compensation is the duration of the business interruption, during which the entity was unable to conduct its business activities. The duration of this period can depend on numerous factors. The basic factor is the consequences of the insured event, i.e. the realized risk, which may not only affect the insured entity. Whether the policyholder can restore their assets to resume operations also depends on the resources available to them.[42] Calculating the loss, or the corresponding compensation, will be complex even when the interruption period is precisely defined. There are several guidelines for determining compensation. Business operations are rarely static, so external conditions and revisions to the policyholder's operational program can influence the compensation amount. The policyholder may argue that there would have been an increase in earnings (had the interruption not occurred), if the potential efficiency of the business operation program could be demonstrated. Similarly, any declining business trends that could lead to reduced earnings must also be considered. For a manufacturing company, the loss depends on production losses rather than sales losses.[43] In the case of a policyholder engaged in manufacturing, the profit from finished products that suffered damage from the insured risk is compensated based on the amount that would have been earned after the agreed indemnity period, with this amount needing to be covered by a specific sum specified in the insurance policy.[44] We can apply similar approach to trading companies.

We must also address several issues that may arise during the process of determining the amount of compensation. Firstly, damage calculation due to business interruption is based on pre-tax earnings. If the company insures property located in other countries, differences in income tax rates must be considered, particularly if these differences pose a significant risk to the insurance revenue. Furthermore, not all expenses above the usual are compensable. It can be determined that certain expenses are reasonable and realistic. However, some costs may not have been incurred with the intent of mitigating losses and restoring business to normal. Costs related to preparing compensation claims, consulting fees, and travel expenses are generally not covered. Additionally, lost interest on claims is excluded from the calculation of losses due to business interruption.[45]

Finally, the value of the business interruption, or the amount representing lost profit, is determined based on accounting records or other evidence of net loss

[41] D. A. Borghesi, p.1152–1153.
[42] A. G. Miller, p. 804.
[43] A. G. Miller, p. 805.
[44] M. Jovanović, p. 72.
[45] D. A. Borghesi, p. 1164.

during the period of business interruption. However, it must be ensured that the insured does not unjustly enrich themselves in this manner. For instance, a company that was already operating at a loss before the occurrence of the insured event might not be in a position to continue its operations, despite compensation from the insurer. Moreover, compensation will not be granted if the insured cannot prove that the business interruption led to a loss in production or sales.[46]

4. Conditions for the Implementation of Business Interruption Insurance

As previously noted, business interruption insurance is specific in nature. However, based on the primary characteristics of this type of insurance, we can identify the conditions necessary for its implementation. These conditions are as follows:

1. The risk in business interruption insurance is not separate, it is directly linked to the realization of the basic risk event;
2. Business interruption insurance is supplemental, which involves paying a higher premium, meaning that appropriate coverage must be contracted;
3. Business interruption insurance is not a standalone policy, as it is not an independent;
4. Obligation under business interruption insurance arises only if there are consequences, i.e. losses due to the interruption of business operations;
5. This type of insurance does not address successful or unsuccessful business operations, and therefore, it is not connected to insolvency issues;
6. Other types of insurance can be contracted to cover risks of losses, such as liability insurance, comprehensive coverage, and traditional property insurance. However, business interruption insurance is broader in terms of coverage for various types of losses and incurred costs;
7. Losses can be calculated only if clear accounting values from the relevant prior period are available.

We have mentioned several times that business interruption insurance cannot address insolvency of the insured party, nor can it cover losses of the entity in this sense, including its debts to creditors. However, we will still discuss the issue of insolvency a particular entity in relation to the moment such a condition arises. Specifically, if the interruption of business operations persists for an extended period, a business or other entity may find itself unable to meet its obligations. This raises the question of whether we can even discuss bankruptcy proceedings in such situations, especially when insolvency occurs before the basic risk event materializes.

Therefore, there may be situations where we need to differentiate between insolvency reasons that arise from the business activities and actions of the entity

[46] P. M. Hummer, p. 311.

(before the insured event occurs) and those caused by situations for which the entity is not liable.[47] Regardless of when insolvency occurs or its causes, business interruption insurance cannot be applied in these situations due to the specific conditions and characteristics of this type of insurance.

V Business Interruption Insurance Today

In recent years, business interruption insurance has gained significant attention, particularly due to the pandemic, which led many commercial and other entities to halt their business activities. According to OECD data, a month of stringent lockdowns during the COVID-19 pandemic resulted in approximately $1.7 trillion in lost revenue for businesses across various sectors.[48] The National Association of Insurance Commissioners (NAIC) in the U.S. reports that, in 2020, nearly eight billion commercial insurance policies included coverage for business interruption.[49] Moreover, the pandemic caused dramatic declines in consumer spending and the highest unemployment levels in the U.S. since the Great Depression. This crisis prompted swift action from Congress and the Federal Reserve, including the approval of a $600 increase in unemployment benefits through the Federal Pandemic Unemployment Compensation program. Meanwhile, numerous state and local governments in the U.S., along with federal agencies, implemented moratoriums on various relief measures.[50] In neighboring Croatia, similar measures were also introduced to mitigate the impact of business interruptions on the financial stability of economic entities. Specifically, if insolvency occurred during the pandemic and was the cause of such a condition, no proceedings were initiated to dissolve the entity. Decisions made in Croatia extended their relevance based on the duration of the pandemic's effects. A similar situation was observed in other countries within the region.[51]

One current issue with business interruption insurance is its limitation, as it is tied to the basic insurance, and it can only be contracted with insurers who also cover the basic risk. Thus, the fact that it is a supplementary insurance, presents a limitation which reflects in its market presence. For instance, we will mention the data in the Croatian insurance market, where the premium for business interruption insurance

[47] Vladimir Čolović, „Uticaj pandemije na pokretanje i vođenje stečajnog postupka", *Zbornik Pandemija kovida 19: pravni izazovi i odgovori,* Institute for Comparative Law, Belgrade 2021, p. 140.

[48] Piotr Tereszkiewicz, „Business interruption insurance as a means of spreading pandemic – related losses", *The Geneva Papers on Risk and Insurance – Issues and Practice,* vol.48, 2023, p.714.

[49] David L. Eckles, Robert E. Hoyt, Johannes C. Marais, „The History and Development of Business Interruption Insurance", *Journal of Insurance Regulation* 2022, article 7, p. 5.

[50] Jialan Wang Jeyul Yang Benjamin Iverson Raymond Kluender, „Bankruptcy and the COVID-19 Crisis", Harvard Business School, Working Paper 21-041, September 2020, p.2.

[51] „Covid-19 coronavirus measures impacting insolvency proceedings and enforcement", Allen & Overy, 24 June 2020, p. 7;
file:///C:/Users/Vlada/Downloads/Covid-19%20Insolvency%20map%20updated%2024%20June%202020%20(10).pdf; V. Čolović (2021), p. 135.

in 2022 amounted to €26,515,000, which represented only 1.58% of the total gross premium written, or just 2.03% of the total gross premium for non-life insurance.[52]

Additionally, in Croatia, insurers have developed specialized insurance packages for small and medium-sized enterprises (SMEs). For example, an entrepreneurial insurance package allows SMEs to insure their entire property under a single policy. This policy can cover risks such as fire, earthquake, machinery breakdowns, burglary and robbery, glass breakage, business interruption due to fire, business interruption due to earthquake, general and professional liability, comprehensive vehicle insurance, and accident insurance.[53] This approach might be one of the opportunities to increase the number of business interruption insurance contracts in the future.

VI Conclusion

What we must first emphasize is that business interruption insurance depends on the realization of the basic risk. It is essential to understand the scope of coverage and what it encompasses. When discussing this type of insurance, it is important to remember that external causes, over which the insured could not have influence, will primarily be considered. Business interruption insurance cannot be purchased independently. This means that there must be a causal link between the occurrence of the basic risks and the resulting impact on the insured's business. Moreover, we have established that insolvency cannot be covered by this type of insurance due to its implications in terms of potential business closure or reorganization.

We must also address the fact that business interruption insurance should not be limited solely to coverage for interruptions caused by fire, destruction, or breakdown of equipment (machinery). A broader range of risks could result in financial losses over varying periods. Insurers need to take this into account to make business interruption insurance more attractive to businesses and other entities. On the other hand, the consequences of basic risks can be unforeseeable from the perspective of a particular business, potentially leading to significant costs and profit loss. Although the period of interruption is limited from the insurer's standpoint, it is important to recognize that, in many cases, insurers may not be able to compensate for the damage. Therefore, clear insurance programs in this area must be defined, and adaptable to both insurers and future insured parties, including businesses and other entities. These programs should not only address the projected premiums and damage amount in relation to the occurrence of loss and interruption period, but also include clear risk management models for future insured parties and risk dispersion strategies among multiple insurers and reinsurers.

[52] M. Ćurković, "Osiguranje financijskih gubitaka nastalih zbog prekida djelatnosti uslijed nastanka osiguranog slučaja (šomažna osiguranja)", 13. 5. 2024.
[53] M. Jovanović, p. 74.

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POSEBAN REŽIM STEČAJA DRUŠTAVA ZA OSIGURANJE

ORIGINALNI NAUČNI RAD

Apstrakt

U ovom radu autorka analizira pravni režim stečaja društava za osiguranje u srpskom pravu. Na početku rada predstavljeni su domaći i strani pravni izvori relevantni za ovu temu. Ukazano je na to da je primena posebnog pravnog režima stečaja na društva za osiguranje opravdana i uobičajena u uporednom pravu. Autorka navodi da terminologija koja je korišćena u domaćim zakonima nije adekvatna i da upravo pogrešna terminologija dovodi do dilema u pogledu određenja subjekata posebnog režima stečaja, čemu je posvećen sledeći deo rada. Što se tiče dileme da li se poseban pravni režim odnosi i na društva za reosiguranje, autorka daje potvrdan odgovor. Nakon prikaza statističkih podataka koji jasno govore da je pravni okvir potrebno unaprediti, analizirana su rešenja u vezi s vršenjem funkcije stečajnog upravnika u stečajnim postupcima nad društvima za osiguranje. Na kraju rada date su preporuke o tome na koji način se može unaprediti važeće rešenje o obavljanju te funkcije.

Ključne reči: stečaj, društva za osiguranje, društva za reosiguranje,Agencija za osiguranje depozita.

I Uvod

Stečaj finansijskih institucija, uključujući i društva za osiguranje, predstavlja važnu temu u okviru stečajnog prava, koja je često neopravdano zapostavljana. Naime, stečaj finansijskih institucija može imati negativan uticaj na čitavu privredu i, kada je reč o društvima za osiguranje, narušiti poverenje osiguranika i korisnika

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osiguranja u pružaoce usluga, ali i u vršioce nadzora u oblasti osiguranja. Upravo sistemski rizik koji se vezuje za te institucije opravdava poseban pravni režim stečaja tih subjekata. Uopšteno govoreći, reč je o riziku, odnosno mogućnosti da posrnuće finansijske institucije ili šok na tržištu prouzrokuju masovne gubitke ili neizvesnost, uz značajan uticaj na koštanje i dostupnost kapitala.[2] U tom kontekstu, značajno je napomenuti da je gotovo nemoguće predvideti i isključiti sistemsko posrnuće.[3]

Imajući u vidu da se ne može isključiti takva mogućnost, pad finansijskih institucija mora biti bezbedan za okruženje.[4] Zbog toga, stečaj društava za osiguranje i drugih finansijskih institucija, bar u određenom delu, regulišu posebna pravila u odnosu na opšti pravni režim. Ta pravila mogu biti deo opšteg propisa u konkretnoj oblasti ili mogu biti sadržana u posebnom zakonu, ili pak biti deo opšteg propisa kojim je regulisan stečaj.

Na nivou Evropske unije, stečaj društava za osiguranje regulisan je Direktivom EZ br. 138/2009 o osnivanju i obavljanju delatnosti osiguranja i reosiguranja (Solventnost II).[5] Deo IV te direktive odnosi se ne samo na stečaj već i na reorganizaciju, kao i na druge postupke koji ne podrazumevaju insolventnost društva, bez obzira na to da li je reč o prinudnim ili dobrovoljnim postupcima.[6] U modernom stečajnom pravu akcenat je upravo na prevenciji i ranoj intervenciji, što se odnosi i na društva za osiguranje. U tom kontekstu, značajno je istaći da se uskoro očekuje usvajanje Predloga direktive za uspostavljanje okvira za oporavak i restrukturiranje društava za osiguranje i društava za reosiguranje iz 2021. godine.[7] Imajući u vidu da je Srbija kandidat za članstvo u Evropskoj uniji, mogu se očekivati i novine u srpskom pravu kada je reč o stečaju društava za osiguranje.

[2] Ben Klaber, „Bankruptcy Insurance: A Modular Approach to Systemic Risk", *University of Pittsburgh Law Review*, Vol 74, No. 2/2012, str. 335.

[3] Vid. *ibid*., str. 333.

[4] *Ibid*.

[5] Direktiva EZ br. 138/2009 o osnivanju i obavljanju delatnosti osiguranja i reosiguranja (Solventnost II) – dalje u tekstu i fusnotama Direktiva Solventnost II (Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II) (Recast), *OJ L* 335/2009, 17. 12. 2009, p. 1–155.

[6] Vid. Gabriel Moss, Ryan Perkins, „Commentary on Title IV of Directive 2009/138/EC on the Taking Up and Pursuit of the Business of Insurance and Reinsurance (Solvency II)", *EU Banking and Insurance Insolvency* (eds. Gabriel Moss, Bob Wessels, Matthias Haentjens), Oxford, 2017, str. 145.
Direktiva Solventnost II definiše mere reorganizacije kao „mere koje podrazumevaju bilo koje delovanje nadležnih tela koje su namenjene očuvanju ili ponovnom uspostavljanju finansijske stabilnosti u društvu za osiguranje i koje utiču na stečena prava lica, osim tog društva za osiguranje, što uključuje, ali nije ograničeno na mere koje podrazumevaju mogućnost obustavljanja plaćanja, odlaganje izvršenja ili smanjenje potraživanja". Vid. Direktivu Solventnost II, čl. 268 (1) (c).

[7] European Commission, Proposal for a Directive establishing a framework for the recovery and resolution of insurance and reinsurance undertakings and amending Directives 2002/47/EC, 2004/25/EC, 2009/138/EC, (EU) 2017/1132 and Regulations (EU) No. 1094/2010 and (EU) No. 648/2019, Brussels, 22.9.2021 COM(2021) 582 final, 2021/0296 (COD).

U domaćem pravu, stečaj društava za osiguranje regulisan je Zakonom o stečaju i likvidaciji banaka i društava za osiguranje.[8] Važno je istaći da je tim zakonom predviđeno da se odredbe o reorganizaciji iz Zakona o stečaju ne primenjuju u postupku stečaja nad društvima za osiguranje.[9] Pored toga, nad društvom za osiguranje ne može se sprovesti ni finansijsko restrukturiranje.[10] S druge strane, reorganizacija koja nije stečajna u pozitivnopravnom smislu, ili bar mere reorganizacije u širem smislu predviđene su Zakonom o osiguranju.[11] Zbog obima ovog rada, analiza će dalje biti ograničena isključivo na stečaj društava za osiguranje, što znači da neće obuhvatiti postupke reorganizacije (koja nije stečajna u kontekstu domaćeg prava), kao ni restrukturiranja i oporavka društava za osiguranje u finansijskim teškoćama. Iz istog razloga, a imajući u vidu da postoje brojna pravila posebnog režima stečaja društava za osiguranje koja se razlikuju od opštih pravila stečaja, u radu će biti obrađena samo posebna pravila koja se odnose na stečajnog upravnika u postupku stečaja nad društvom za osiguranje, ali ne i druga posebna pravila.

Struktura rada je sledeća: nakon uvoda su predstavljeni izvori prava značajni za stečaj društava za osiguranje. Zatim je ukazano na probleme u vezi sa određenjem stečajnog dužnika u našem pravu koji su u najvećoj meri prouzrokovani pogrešnom i nepotpunom terminologijom u pravnim izvorima. Nakon toga, predstavljeni su statistički podaci u vezi sa sprovođenjem stečajnih postupaka nad društvima za osiguranje koji pokazuju da je neophodno unaprediti pravni okvir. Potom su analizirane specifičnosti obavljanja funkcije stečajnog upravnika u tim postupcima. Na kraju rada nalazi se zaključak.

II Izvori prava

Uopšteno govoreći, potrebu postojanja posebnih pravila u poslovnom pravu diktiraju specifičnosti delatnosti koju privredni subjekti obavljaju. U kontekstu kompanijskog prava, to se odnosi na osnivanje tih subjekata, na pravila o korporativnom upravljanju, kao i na njihov prestanak. Naime, pojedine delatnosti, kao što je delatnost osiguranja, zahtevaju poseban nadzor države, uključujući i nadzor u vezi s prestankom postojanja tih subjekata. Jedan on načina na koji društva za osiguranje mogu

[8] Zakon o stečaju i likvidaciji banaka i društava za osiguranje – ZSLBDO, *Službeni glasnik RS*, br. 14/2015 i 44/2018 – dr. zakon.

[9] Vid. ZSLBDO, čl. 22. Prema Zakonu o stečaju, reorganizacija predstavlja namirenje poverilaca prema usvojenom planu reorganizacije redefinisanjem dužničko-poverilačkih odnosa, statusnim promenama ili na drugi način koji je predviđen planom reorganizacije. Vid. Zakon o stečaju – ZS, *Službeni glasnik RS*, br. 104/2009, 99/2011 – dr. zakon, 71/2012 – odluka RS, 83/2014, 113/2017, 44/2018 i 95/2018, čl. 1, st. 4.

[10] Vid. Zakon o sporazumnom finansijskom restrukturiranju, *Službeni glasnik RS*, br. 89/2015, čl. 2, tač. 1.

[11] Vid. Predrag Šulejić, „Neka pitanja stečaja i likvidacije društava za osiguranje s posebnim osvrtom na dejstva u pogledu dvostranoteretnih ugovora", *Pravo i privreda*, br. 5-8/2009, str. 176; Zakon o osiguranju – ZO, *Službeni glasnik RS*, br. 139/2014 i 44/2021.

prestati da postoje jeste stečaj. Reč je o sudskom postupku kolektivnog namirenja poverilaca ostvarivanjem najveće moguće vrednosti stečajnog dužnika, odnosno njegove imovine.[12] Prema opštim pravilima, taj postupak se sprovodi bankrotstvom ili reorganizacijom. Značaj regulisanja stečaja društava za osiguranje prepoznao je i evropski zakonodavac, budući da je stečaj društava za osiguranje regulisan u pravu Evropske unije. Stečaj društava za osiguranje obično je regulisan posebnim pravilima i u uporednim pravima, uključujući i američko pravo.

1. Domaće pravo

U našoj državi, stečaj društava za osiguranje regulisan je posebnim zakonom (*lex specialis*). Opredeljenost Srbije da posebnim zakonom reguliše stečaj društava za osiguranje nije novina. Naime, pre stupanja na snagu Zakona o stečaju i likvidaciji banaka i društava za osiguranje, stečaj društava za osiguranje bio je regulisan istoimenim zakonom iz 2005. godine.[13] Pre donošenja tog zakona, situacija je bila drugačija. Naime, Zakon o osiguranju iz 2004. godine predviđao je da se na postupak stečaja društva za osiguranje primenjuje zakon kojim se uređuje likvidacija i stečaj, ako Zakonom o osiguranju određena pitanja nisu drugačije rešena.[14] Isto je predviđao i Zakon o osiguranju imovine i lica iz 1996. godine.[15] Dakle, do 2005. godine, odredbe o stečaju društava za osiguranje nalazile su se u zakonu koji uređuje osiguranje. Obe koncepcije regulisanja stečaja društava za osiguranje su prihvatljive, odnosno nije značajno da li su odredbe o stečaju predviđene posebnim propisom ili zakonom kojim je uređena oblast osiguranja. Na primer, hrvatski Zakon o osiguranju sadrži odredbe o stečaju.[16] Isti je slučaj i u Bugarskoj – stečaj društava za osiguranje predviđen je Zakonikom o osiguranju.[17] Koncepcija prema kojoj se odredbe o stečaju nalaze u materijalnom zakonu za oblast osiguranja omogućava da se sva ili gotova sva posebna pravila koja se odnose na društvo za osiguranje u finansijskim teškoćama nađu u istom zakonu. Ipak, naš zakonodavac se nije opredelio za taj model. U svakom slučaju, bez obzira na mesto nalaženja određenih normi, bitno je da li se na stečaj društva za osiguranje primenjuju opšta ili posebna pravila o stečaju.

Imajući u vidu da je u našem pravu stečajni postupak nad društvom za osiguranje uređen posebnim propisom, ovaj postupak spada u posebne stečajne

[12] Mirko Vasiljević, Tatjana Jevremović Petrović, Jelena Lepetić, *Kompanijsko pravo – Pravo privrednih društava*, Beograd, 2023, str. 883.

[13] Zakon o stečaju i likvidaciji banaka i društava za osiguranje, *Službeni glasnik RS*, br. 61/2005, 116/2008 i 91/2010.

[14] Vid. Zakon o osiguranju, *Službeni glasnik RS*, br. 55/04 i 70/04, čl. 208.

[15] Vid. Zakon o osiguranju imovine i lica, *Službeni list SRJ*, br. 30/96, 57/98, 53/99 i 55/99, čl. 137.

[16] Vid. hrvatski Zakon o osiguranju, *Narodne novine*, br. 30/2015, 112/2018, 63/2020, 133/2020 i 151/2022, odeljak IX.

[17] Deloitte Legal, *A guide to pre-insolvency and insolvency proceedings across Europe*, July 2023, str. 9.

postupke.[18] Još preciznije, reč je o posebnom postupku zato što se na njega primenjuju posebna pravila. Pritom, odredbe Zakona o stečaju (*lex generalis*) primenjuju se na pitanja koja nisu regulisana posebnim propisom.[19] Iako je većina pravila o stečaju društava za osiguranje sadržana u propisima kojima je regulisan stečaj (*lex specialis* i *lex generalis*), određena pravila nalaze se i u drugim propisima. Tako u izvore prava za stečaj društva za osiguranje spadaju i Zakon o obligacionom odnosima i Zakon o obaveznom osiguranju u saobraćaju.[20] Oba zakona sadrže posebna pravila o posledicama otvaranja stečajnog postupka, pri čemu Zakon o obaveznom osiguranju u saobraćaju sadrži i posebno pravilo o prijavi potraživanja u stečajnom postupku.

Kada je reč o podzakonskim aktima, treba istaći da se u stečajnom postupku nad društvom za osiguranje ne primenjuju nacionalni standardi za upravljanje stečajnom masom.[21] Prema opštem pravnom režimu, primenjuje se ukupno osam nacionalnih standarda.[22] Umesto toga, u slučaju stečaja društva za osiguranje primenjuje se Pravilnik o unovčavanju imovine finansijskih institucija u stečaju ili likvidaciji kojim je detaljnije regulisan postupak prodaje imovine stečajnog dužnika. Pravilnik je donela Agencija za osiguranje depozita 2018. godine.[23] Primena tog pravilnika je neophodna imajući u vidu da su pravila o prodaji imovine koja su predviđena Zakonom o stečaju prilično uopštena.[24]

2. Pravo EU

Već je pomenuto da je ključni izvor prava Evropske unije za stečaj društava za osiguranje Direktiva Solventnost II.[25] Stečaj je jedan od postupaka koji je regulisan u delu IV ove direktive. Ipak, treba imati u vidu da Direktivom Solventnost II nisu harmonizovana stečajnopravna pravila – Direktiva sadrži pravila koja omogućavaju

[18] Vid. Vuk Radović, *Osnovi stečajnog prava*, Beograd, 2020, str. 253.
[19] Vid. ZSLBDO, čl. 22.
[20] Zakon o obligacionim odnosima, *Službeni list SFRJ*, br. 29/78, 39/85, 45/89 – Odluka USJ i 57/89, *Službeni list SRJ*, br. 31/93, *Službeni list SCG*, br. 1/2003 – Ustavna povelja i *Službeni glasnik RS*, br. 18/2020; Zakon o obaveznom osiguranju u saobraćaju, *Službeni glasnik RS*, br. 51/2009, 78/2011, 101/2011, 93/2012 i 7/2013 – odluka US.
[21] Vid. Odgovori i pitanja Privrednih sudova koji su utvrđeni na sednici Odeljenja za privredne sporove Privrednog apelacionog suda održanoj 19. 11. i 20. 11. 2019. i na sednici Odeljenja za privredne prestupe održanoj 20. 11. 2019. godine.
[22] Vid. Pravilnik o utvrđivanju nacionalnih standarda za upravljanje stečajnom masom, *Službeni glasnik RS*, br. 62/2918. Nacionalni standardi su deo ovog pravilnika.
[23] Pravilnik o unovčavanju imovine finansijskih institucija u stečaju ili likvidaciji, jul 2018. godine. Pravilnik je dostupan na sajtu Agencije za osiguranje depozita: *www.aod.rs*, 18. 7. 2024.
[24] Vid. *ibid*.
[25] Detaljnije o Direktivi Solventnost II i srpskom pravu vid. Milo Marković, „Izazovi tržišta osiguranja u Srbiji na putu ka Solventnosti II", *Tokovi osiguranja*, br. 2/2024, str. 333-361.

razumevanje i saradnju između država članica.[26] Naime, reč je o instrumentu međunarodnog privatnog prava. Ranije je ista materija, gotovo na identičan način, bila regulisana Direktivom EZ br. 17/2001 o reorganizaciji i likvidaciji društava za osiguranje.[27] Dakle, stečaj društava za osiguranje je već odranije regulisan posebnim pravilima. U vezi s tim, treba istaći i da Uredba o stečajnim postupcima (važeća iz 2015. godine, kao i ranija iz 2000. godine) sadrži komplementarno rešenje prema kojem su društva za osiguranje isključena iz primene te uredbe.[28]

3. Pravo Sjedinjenih Američkih Država

Dok se u pravnoj teoriji isključenje društava za osiguranje iz opšteg stečajnog režima ne dovodi u pitanje kada je reč o Evropi, postoje mišljenja da je njihova isključenost kao subjekata stečaja iz američkog saveznog stečajnog prava neopravdana. Naime, na stečaj društava za osiguranje ne primenjuje se američki Stečajni zakonik (*U. S. Bankruptcy Code*), pa za sprovođenje stečaja nisu nadležni savezni stečajni sudovi.[29] Ipak, treba imati u vidu da su postojanje različitih državnih pravila i nadležnosti sudova tih država razlozi zbog kojih je postojanje posebnog pravnog režima za stečaj društava za osiguranje kritikovano u američkoj pravnoj teoriji.[30] Drugačije rečeno, ne osporava se da je reč o subjektima čiji prestanak zahteva primenu posebnih pravila, već je kritikovan važeći režim u celini. Propisi kojima države uređuju stečaj razlikuju se međusobno budući da se zasnivaju na jednom od dva dostupna model-zakona. Reč je o Jednoobraznom zakonu o likvidaciji osiguravača (*Uniform Insurers Liquidation Act*), koji je donela Nacionalna konferencija poverenika (*National Conference of Commissioners*), i Model-zakonu o oporavku i likvidaciji (*Rehabilitation and Liquidation Model Act*), koji je sačinilo Nacionalno udruženje stečajnih poverenika (*National Association of Insurance Commissioners*).[31]

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[26] Kyriaki Noussia, Peter Underwood, Stergios Frastanlis, „Restructuring, Winding-Up & Portfolio Transfer of Insurance Companies in Distress", *The Governance of Insurance Undertakings – Corporate Law and Insurance Regulation* (eds. Pierpaolo Marano, Kyriaki Noussia), Sham, 2022, str. 186 i 189.

[27] Directive 2001/17/EC of the European Parliament and of the Council of 19 March 2001 on the reorganization and winding up of insurance undertakings, OJ L 110/2001, 20.4.2001, p. 28-39. Direktiva je prestala da važi 2015. godine. Vid. G. Moss, R. Perkins, str. 122.

[28] Vid. Uredbu EU br. 848/2015 o stečajnim postupcima (Regulation (EU) 2015/848 of the European Parliament and of the Council of 20 May 2015 on insolvency proceedings (recast), *OJ L* 141, 5. 6. 2015, p. 19–72), čl. 1 (2) (a) i Uredbu EZ, br. 1346/2000 o stečajnim postupcima (Council regulation (EC) No 1346/2000 of 29 May 2000 on insolvency proceedings, *OJ L* 160, 30. 6. 2000, p. 1–18), čl. 1 (2).

[29] Američki stečajni zakonik se ne primenjuje na domaća društva za osiguranje. Vid. Američki zakonik, deo 11, poglavlje 1, ¶ 109 (b) (2).

[30] Vid., na primer, Laura S. McAlister, „The Inefficiencies of Exclusion: The Importance of Including Insurance Companies in the Bankruptcy Code", *Emory Bankruptcy Developments Journal*, Vol. 24, No. 1/2008, str. 129 i Wm. Carlisle Herbert, „When Jurisdictions Collide: Determining Judicial Roles When Bankruptcy Court and Insurance Receivership Court Responsibilities Overlap", *Tort Trial & Insurance Practice Law Journal*, Vol. 42, No. 4/2007, str. 941.

[31] Vid. L. S. McAlister, str. 131.

III Subjekti posebnog režima stečaja

Zakon o stečaju koristi neadekvatan termin za označavanje subjekata iz oblasti osiguranja u pogledu isključenja primene tog zakona na određene subjekte. Konkretno, primena Zakona o stečaju isključena je u odnosu na određene subjekte, uključujući i „osiguravajuće organizacije", osim kada je reč o pitanjima koja nisu uređena posebnim propisom.[32] Termin „osiguravajuće organizacije" širi je od pojma društava za osiguranje, pa bi mogao obuhvatiti i društva za reosiguranje, ali i društva koja obavljaju poslove posredovanja i zastupanja u osiguranju.

1. Društva za osiguranje

Zakon o stečaju i likvidaciji banaka i društava za osiguranje uređuje uslove i postupak stečaja ovih društva, ali ih ne definiše. Definiciju društava za osiguranje sadrži važeći Zakon o osiguranju. Društva za osiguranje su njime definisana kao pravna lica koja imaju sedište u Republici Srbiji i obavljaju delatnost osiguranja, a za čije je osnivanje neophodna dozvola Narodne banke Srbije.[33] Pritom, društvo za osiguranje može biti osnovano kao akcionarsko društvo ili društvo za uzajamno osiguranje.[34] Da je reč upravo o tim vrstama društava za osiguranje kao subjektima posebnog režima stečaja, jasno je vidljivo iz odredbe o isplatnim redovima iz Zakona o stečaju i likvidaciji banaka i društava za osiguranje. Naime, u poslednjem isplatnom redu nalaze se potraživanja poverilaca koji su akcionari akcionarskog društva za osiguranje i članova, odnosno osiguranika uzajamnog društva za osiguranje.[35] Dakle, stečajni subjekti na koje se primenjuje *lex specialis* su društva za osiguranje bez obzira na to u kojoj su formi osnovana.

Društvo za uzajamno osiguranje predstavlja pravno lice sa sedištem u Republici Srbiji koje može obavljati sve poslove osiguranja osim reosiguranja, a koje se osniva u formi društva sa ograničenom odgovornošću na osnovu dozvole Narodne banke Srbije.[36] Za razliku od domaćeg prava, prema kojem se poseban režim stečaja odnosi na sva društva za uzajamno osiguranje, obuhvat Direktive Solventnost II je nešto uži. Konkretno, Direktiva Solventnost II se ne odnosi na ona društva za uzajamno osiguranje koja obavljaju delatnost neživotnog osiguranja, a koja su s drugim društvima za uzajamno osiguranje zaključila ugovor o potpunom reosiguranju polisa osiguranja koje su izdala ta društva ili na osnovu kojeg se to drugo društvo obavezalo da preuzme obaveze koje proizlaze iz izdatih polisa.[37]

[32] ZS, čl. 14, st. 2.
[33] ZO, čl. 3, st. 1.
[34] ZO, čl. 20, st. 4.
[35] ZSLBDO, čl. 21, tač. 7.
[36] Vid. ZO, čl. 70.
[37] Vid. Direktivu Solventnost II, čl. 7.

Ta razlika nema praktičan značaj u kontekstu domaćeg prava jer ta forma društava za osiguranje u praksi nije uhvatila korena. Naime, trenutno nema aktivnih društava za uzajamno osiguranje koja su registrovana na teritoriji Srbije.[38]

2. Društva za reosiguranje

Društva za reosiguranje predstavljaju pravna lica sa sedištem u Republici Srbiji koja se osnivaju upisom u registar na osnovu dozvole Narodne banke Srbije.[39] Za razliku od društava za osiguranje, društva za reosiguranje se osnivaju za obavljanje poslova reosiguranja, pri čemu mogu biti osnovana isključivo u formi akcionarskog društva.[40] Zakon o stečaju i likvidaciji banaka i društava za osiguranje ne pominje društva za reosiguranje. Društva za reosiguranje se ne pominju ni u Zakonu o Agenciji za osiguranje depozita. Zbog toga mora se utvrditi da li je reč o propustu zakonodavca ili zakonodavac nije imao nameru da predvidi društva za reosiguranje kao subjekte posebnog režima stečaja. Razrešenje dileme u pogledu toga da li se na društva za reosiguranje primenjuje opšti ili poseban režim stečaja ima i praktični značaj budući da u Srbiji trenutno posluju četiri takva društva.[41] Za razliku od domaćeg rešenja, koje ostavlja mesta dilemama, hrvatski zakonodavac je jasno naveo da se odredbe Zakona o osiguranju koje se odnose na stečaj društava za osiguranje na odgovarajući način primenjuju i na društva za reosiguranje.[42]

S druge strane, naš zakonodavac nije u potpunosti zanemario reosiguranje u Zakonu o stečaju i likvidaciji banaka i društava za osiguranje, što dodatno čini nejasnim status društava za reosiguranje kao subjekata stečaja. Naime, Zakonom su privilegovani poverioci iz ugovora o reosiguranju u slučaju stečaja društva za osiguranje. Drugačije rečeno, potraživanja reosiguravača su dobila povlašćen tretman zajedno s drugim potraživanjima u vezi sa osiguranjem u odnosu na ostala potraživanja poverilaca društva za osiguranje koja nisu u vezi s poslovima osiguranja.

Važno je istaći da društva za osiguranje ne obuhvataju društva za reosiguranje, odnosno da društva za osiguranje nisu u tom smislu šiti pojam. Naime, pravni režim društava za osiguranje i društava za reosiguranja uređen je odredbama glave II Zakona o osiguranju, čiji se odeljak 2 odnosi na akcionarska društva za osiguranje/reosiguranje. Budući da se obe vrste društva pominju zajedno, jasno je da nije reč o užem i širem pojmu. Pritom, društva za reosiguranje se ne pominju u odredbi

[38] Na sajtu Agencije za privredne registre dostupna je informacija da je Društvo za uzajamno osiguranje MG Beograd, koje je osnovano 1998. godine za obavljanje delatnosti životnog osiguranja, prestalo da postoji 2005. godine nakon uspešno sprovedenog postupka likvidacije. Vid. *www.apr.gov.rs*, 17. 7. 2024.

[39] Vid. ZO, čl. 3, st. 2.

[40] Vid. ZO, čl. 3, st. 2 i čl. 20, st. 4.

[41] Reč je o broju subjekata prema stanju dostupnom na sajtu Agencije za privredne registre na dan 17. 7. 2024. godine. Vid. *www.apr.gov.rs*, 17. 7. 2024.

[42] Vid. hrvatski Zakon o osiguranju, čl. 284, st. 3.

Zakona o osiguranju koja se odnosi na primenu odredaba o stečaju i likvidaciji. Naime, Zakonom je predviđeno da se stečaj društava za osiguranje sprovodi u skladu sa zakonom kojim je uređen stečaj i likvidacija banaka i društava za osiguranje, dok se na stečaj društava za posredovanje i zastupanje u osiguranju primenjuje zakon kojim je uređen stečaj.[43] S druge strane, naslov glave XI u kojoj su sadržane navedene odredbe glasi: „Prestanak rada, likvidacija i stečaj subjekata nadzora". Iz toga se može zaključiti da se odredbe te glave primenjuju i na društva za reosiguranje, budući da su i ona subjekti nadzora koji vrši Narodna banka Srbije.[44] Što je još važnije, Zakonom o osiguranju predviđeno je da se odredbe koje se odnose na društvo za osiguranje shodno primenjuju na društvo za reosiguranje.[45] Iako je naslov tog člana „shodna primena zakona na poslovanje akcionarskog društva za reosiguranje", što može dovesti u pitanje primenu odredbe na prestanak društva, iz njenog sadržaja se ne može izvući takav zaključak. Tumačenjem Zakona o osiguranju, može se zaključiti da se poseban pravni režim primenjuje i na društva za reosiguranje. Isto se može zaključiti i na osnovu odredbe Zakona o stečaju koji isključuje primenu odredaba tog Zakona na „osiguravajuće organizacije". Termin „osiguravajuće organizacije" bi svakako mogao da obuhvati i društva za reosiguranje.

Uopšteno govoreći, postoji više argumenata u prilog tome da i društva za reosiguranje treba da budu uključena u poseban režim stečaja. Naime, stečaj društva za reosiguranje može negativno uticati na sektor osiguranja generalno. Uopšteno govoreći, rizik reosiguranja se smatra velikim rizikom u pogledu njegovog pravnog režima u pravu Evropske unije.[46] Takođe, budući da je reč o specifičnoj delatnosti, stečajni upravnici u stečajnom postupku nad društvom za reosiguranje trebalo bi da imaju posebna znanja o oblasti reosiguranja. S druge strane, argument protiv primene posebnog režima može da bude to što se stečaj društava za reosiguranje može direktno preliti samo na društva za osiguranje. Naime, stečaj društva za reosiguranje ne mora uticati na druge učesnike na tržištu, izuzev društava za osiguranje sa kojima je zaključen ugovor o reosiguranju. Naime, ugovor o reosiguranju zaključuju privredna društva – osiguravač i reosiguravač, dok ugovor o osiguranju zaključuju osiguravači s pojedincima, privrednim društvima i drugim organizacijama koje se ne bave delatnošću osiguranja.[47] Pritom, deo IV Direktive Solventnost II ne primenjuje se na društva za reosiguranje.[48] Jedini izuzetak se odnosi na slučajeve kada je društvo za reosiguranje registrovano i za obavljanje poslova osiguranja.[49]

[43] Vid. ZO, čl. 221.
[44] Vid. ZO, čl. 187, st. 1.
[45] Vid. ZO, čl. 69.
[46] Nataša Petrović Tomić, *Pravo osiguranja – Sistem*, Knjiga I, Beograd, 2019, str. 727.
[47] Vid. *ibid*.
[48] Vid. Direktivu Solventnost II, čl. 1 (3) i 2 (1), drugi paragraf.
[49] G. Moss, R. Perkins, 129.

Imajući u vidu rešenja Zakona o osiguranju u vezi sa shodnom primenom pravila o društvima za osiguranje na društva za reosiguranje i terminologiju Zakona o stečaju, kao i argumente u prilog uključenja društva za reosiguranje u poseban režim stečaja generalno, može se zaključiti da se u domaćem pravu na društva za reosiguranje primenjuju odredbe o stečaju koje predviđa Zakon o stečaju i likvidaciji banaka i društava za osiguranje. Naime, nepominjanje društava za reosiguranje u tom zakonu, kao i u Zakonu o Agenciji za osiguranje depozita, treba smatrati previdom, a ne namerom zakonodavca da ta društva isključi iz posebnog režima stečaja. Radi otklanjanja svih dilema, u Zakonu o stečaju i likvidaciji banaka i društava za osiguranje treba jasno navesti i društva za reosiguranje kao stečajne subjekte na koje se taj zakon primenjuje. Takođe, treba izmeniti i Zakon o stečaju tako da se umesto termina „osiguravajuće organizacije" navedu društva za osiguranje i društva za reosiguranje kao subjekti koji su isključeni iz opšteg režima stečaja.

3. Isključenost društava koja obavljaju delatnost posredovanja i zastupanja u osiguranju iz specijalnog režima stečaja

Zakon o osiguranju reguliše ne samo osnivanje i poslovanje društva za osiguranje i reosiguranje, već, između ostalog, i obavljanje poslova posredovanja i zastupanja u osiguranju.[50] U domaćoj literaturi postoje mišljenja da zakonski termin društva za osiguranje treba promeniti u osiguravajuća društva. Naime, termin osiguravajuća društva se koristi u praksi za označavanje društava koja se bave delatnošću osiguranja, dok se terminu društva za osiguranje zamera to što on može da obuhvati i društva koja se bave delatnošću zastupanja i posredovanja u osiguranju.[51] Zbog toga, može se javiti dilema da li se poseban režim stečaja koji je predviđen Zakonom o stečaju i likvidaciji banaka i društava za osiguranje odnosi i na ta društva.

Tumačenjem odredaba Zakona o stečaju i likvidaciji banaka i društava za osiguranje i Zakona o osiguranju može se izvesti nedvosmislen zaključak da se poseban pravni režim na ta društva na primenjuje. Naime, ne samo što se u Zakonu o stečaju i likvidaciji banaka i društava za osiguranje ne pominju društva koja obavljaju delatnost posredovanja i zastupanja u osiguranju, već se u odredbi Zakona o osiguranju koja se odnosi na stečaj društava za posredovanje u osiguranju i društava za zastupanje u osiguranju navodi da se stečajni postupak nad tim subjektima sprovodi u skladu sa zakonom koji uređuje stečaj.[52] Takođe, ni deo IV Direktive Solventnost II se ne odnosi na ta društva, već samo na društva za osiguranje i ogranke društava za osiguranje trećih država koji se nalaze na teritoriji Zajednice.[53]

[50] Vid. ZO, čl. 1.

[51] Vid. Vladimir Čolović, Zdravko Petrović, „Sporna pitanja regulisanja stečaja osiguravajućih društava u Srbiji i usklađivanje sa Direktivom 2001/17/EZ", *Evropska revija za pravo osiguranja*, br. 4/2015, str. 31.

[52] ZO, čl. 221, st. 2.

[53] Vid. Direktivu Solventnost II, čl. 267.

IV Trajanje posebnih stečajnih postupaka nad društvima za osiguranje – neusaglašenost sa načelom hitnosti

Da bi se sagledao značaj teme posebnog režima stečaja društava za osiguranje, treba imati u vidu i relevantne statističke podatke u vezi sa stečajnim postupcima nad tim društvima koji su sprovedeni u Srbiji. Prema javno dostupnim podacima sa sajta Agencije za osiguranje depozita, u periodu od 2004. do 2024. godine vođeno je sedam stečajnih postupaka nad akcionarskim društvima za osiguranje, od kojih je u tri slučaja prvo vođen postupak likvidacije, pa tek onda postupak stečaja.[54] Stečajni postupci su u proseku trajali *više od osam godina* (ne računajući trajanje postupaka likvidacije).[55] Poređenjem prosečne dužine trajanja tih postupaka s prosečnom dužinom trajanja stečajnih postupaka na koje se primenjuje opšti režim stečaja, može se zaključiti da posebni stečajni postupci nad društvima za osiguranje traju nedopustivo dugo. Naime, prema podacima dostupnim na sajtu Agencije za licenciranje stečajnih upravnika, na dan 1. 7. 2024. godine, prosečno vreme trajanja 9389 stečajnih postupaka je tri godine, dva meseca i šest dana.[56] Prosek je još kraći kada se uzme u obzir trajanje postupaka koji su pokrenuti po važećem zakonu o stečaju. Konkretno, ukupno 7812 postupaka koji su pokrenuti po važećem zakonu trajali su u proseku dve godine, 10 meseci i sedam dana.[57] Uzimajući u obzir trajanje ukupnog broja opštih i posebnih stečajnih postupaka, može se zaključiti da su posebni stečajni postupci trajali više nego dvostruko duže u odnosu na opšte.

Iako, na prvi pogled, može delovati da je broj stečajnih postupaka vođenih nad društvima za osiguranje mali, treba imati u vidu da se delatnošću osiguranja bavi samo određen broj subjekata na tržištu, kao i da je značaj obavljanje te delatnosti veliki imajući u vidu podatke o njenom učešću u BDP-u. Konkretno, prema podacima Nacionalnog zavoda za statistiku, delatnost osiguranja, reosiguranja i penzijskih fondova je imala 0,5 % učešća u BDP-u u 2021. godini i 0,4% u 2022. godini.[58] Pritom, treba imati u vidu da su sve finansijske delatnosti, uključujući delatnost osiguranja, imale 3,2% učešća u BDP-u i u 2021. i u 2022. godini.[59]

U svakom slučaju, podaci o trajanju stečajnih postupaka nad društvima za osiguranje ukazuju na to da je u cilju promovisanja principa hitnosti koji važi u stečajnom pravu potrebno poboljšati zakonski okvir kojim je regulisan poseban stečajni postupak nad ovim društvima.[60] Zbog toga, posebno treba imati u vidu

[54] Vid. podatke dostupne na: *www.aod.gov.rs*, 19. 7. 2024. Napomena: autorka je izračunala prosečan broj godina trajanja postupka na osnovu podataka o stečajnim postupcima koji su dostupni na sajtu.
[55] Vid. *ibid*.
[56] Vid. *www.alsu.gov.rs*, 19. 7 . 2024.
[57] Vid. *ibid*.
[58] Podaci su dostupni na: *www.stat.gov.rs*, 20. 7. 2024.
[59] *Ibid*.
[60] Vid. ZS, čl. 8.

razlike između pravila koja se primenjuju na te postupke. Postoje brojna značajna odstupanja u pogledu sprovođenja i dinamike postupka stečaja nad društvima za osiguranje u odnosu na opšti pravni režim. Između ostalog, sud ne vodi prethodni stečajni postupak zbog značajne uloge koje ima Narodna banka Srbije u vezi sa stečajem društava za osiguranje. Za razliku opštih pravnih pravila, stečajni postupak se ne može sprovesti reorganizacijom, pri čemu se ni imovina ne može unovčiti prodajom stečajnog dužnika kao pravnog lica. Primenjuju se i posebna pravila o troškovima i isplatnim redovima. Takođe, značajna odstupanja se odnose na organe stečajnog postupka. Konkretno, broj organa je manji, dok funkciju stečajnog upravnika sprovodi pravno lice – Agencija za osiguranje depozita. Dalje će biti reči samo o tom organu, kao početnoj tački istraživanja i otkrivanja mogućih razloga zbog kojih je prosečno trajanje stečajnih postupaka nad društvima za osiguranje neuporedivo duže nego prosečno trajanje opštih stečajnih postupaka.

V Agencija za osiguranje depozita kao stečajni upravnik

Prema posebnom pravnom režimu stečaja koji se primenjuje na društva za osiguranje, stečajni organi su stečajni sudija, stečajni upravnik i odbor poverilaca, dok su to stečajni sudija, stečajni upravnik, skupština poverilaca i odbor poverilaca prema opštem režimu. U odnosu na opšta pravila o stečajnim organima, Zakon o stečaju i likvidaciji banaka i društava za osiguranje predviđa tri ključna izuzetka. Prvi se odnosi na obavljanje funkcije stečajnog upravnika, drugi na broj poverilačkih stečajnih organa, a treći na nadležnosti stečajnih organa.

1. Posebna znanja (ne)potrebna za obavljanje funkcije stečajnog upravnika

U domaćem pravu, funkciju stečajnog upravnika u postupku stečaja društva za osiguranje obavlja Agencija za osiguranje depozita, dok posao stečajnog upravnika obavljaju imenovani poverenici Agencije. Konkretno, poverenike imenuje i razrešava Odbor direktora uz saglasnost Upravnog odbora ili na inicijativu Upravnog odbora Agencije za osiguranje depozita.[61] Pored funkcije stečajnog upravnika, Agencija za osiguranje depozita obavlja i poslove obaveznog osiguranja depozita i isplate osiguranih iznosa, upravlja imovinom prenetom u postupku restrukturiranja banaka i obavlja druge poslove u vezi s tim postupkom i organizuje fond za zaštitu investitora.[62] Treba istaći da ona obavlja funkciju stečajnog upravnika i u drugim posebnim stečajnim postupcima. Naime, Agencija za osiguranje depozita obavlja tu funkciju i u stečajnim postupcima koji se sprovode nad bankama i davaocima lizinga. Prema posebnom pravnom režimu stečaja nad društvima za osiguranje, poverenik

[61] Vid. Statut Agencije za osiguranje depozita, *Službeni glasnik RS*, br. 59/2015 i 49/2016, čl. 13, tač. 12.
[62] Vid. Zakon o Agenciji za osiguranje depozita, *Službeni glasnik RS*, br. 14/2015 i 51/2017, čl. 2.

Agencije za osiguranje depozita ne mora da položi stručni ispit i stekne posebna znanja koja su mu potrebna da bi valjano obavljao funkciju stečajnog upravnika. Naime, u domaćem pravu poverenik ne mora imati licencu stečajnog upravnika.

Prema opštim pravilima, funkciju stečajnog upravnika obavlja fizičko lice koje ima licencu za obavljanje poslova stečajnog upravnika. Pritom, stečajnog upravnika imenuje stečajni sudija metodom slučajnog odabira s liste aktivnih stečajnih upravnika za područje nadležnosti suda. Da bi dobilo licencu, fizičko lice, između ostalog, mora da položi stručni ispit. Za dobijanje licence za obavljanje poslova stečajnog upravnika potrebno je i znanje o posebnim stečajnim postupcima. Prema Pravilniku o programu i načinu polaganja stručnog ispita za obavljanje poslova stečajnog upravnika, poznavanje te oblasti mora biti detaljno (relevantni izvori su Zakon o stečaju i likvidaciji banaka i društava za osiguranje, Zakon o Agenciji za osiguranje depozita i Zakon o osiguranju), pri čemu se, između ostalog, zahteva i dobro poznavanje ugovora o osiguranju.[63] Imajući u vidu to da licencirani stečajni upravnici ne obavljaju funkciju stečajnog upravnika u posebnim stečajnim postupcima, nije jasno zbog čega je neophodno da detaljno poznaju oblast stečajnog prava koja se odnosi na posebne stečajne postupke. Moguće objašnjenje bilo bi to da se na stečaj društava za reosiguranje primenjuje opšti pravni režim, ali za to nema dovoljno argumenata. Naime, stečajni upravnici moraju da imaju detaljan nivo znanja i o stečaju banaka, iako nema dileme u pogledu toga da Agencija za osiguranje depozita obavlja funkciju stečajnog upravnika u tim postupcima.

Odstupanje od opštih pravila u vezi sa stečajnim upravnikom ne vezuje se samo za stečajne postupke nad finansijskim institucijama, uključujući i društva za osiguranje. Naime, u domaćem pravu funkciju stečajnog upravnika obavlja pravno lice i u stečajnim postupcima nad pravnim licima s većinskim javnim ili društvenim kapitalom, kao i u slučajevima u kojima u toku stečajnog postupka stečajni dužnik postane pravno lice s većinskim javnim kapitalom. U tim slučajevima, funkciju stečajnog upravnika obavlja Agencija za licenciranje stečajnih upravnika.[64]

Poveravanje obavljanja funkcije stečajnog upravnika određenoj organizaciji nije nepoznanica ni u uporednim pravima. Primera radi, upravljanje društvom za osiguranje u stečaju se u američkom pravu poverava nadzornom telu za oblast osiguranja. Naime, ukoliko je društvo za osiguranje u finansijskim teškoćama (engl. *impaired*), nadležno nadzorno telo, odnosno poverenik (svaka država ima svoje nadzorno telo) podnosi zahtev sudu za određivanje mere posebnog upravljanja (engl. *receivership*), pri čemu mora odrediti da li društvo treba reorganizovati ili likvidirati.[65] Kada sud odobri taj postupak, nadzorno telo upravlja društvom za osiguranje.[66]

[63] Vid. Pravilnik o programu i načinu polaganja stručnog ispita za obavljanje poslova stečajnog upravnika, *Službeni glasnik RS*, br. 47/2010, čl. 4.
[64] Vid. M. Vasiljević, T. Jevremović Petrović, J. Lepetić, str. 890. Vid. ZS, čl. 22.
[65] Vid. L. S. McAlister, str. 130–131.
[66] Vid. *ibid*., str. 131.

S druge strane, postoje i rešenja prema kojima odstupanja od opšteg pravnog režima u pogledu obavljanja funkcije stečajnog upravnika u postupcima stečaja nad društvima za osiguranje nisu velika. Na primer, u hrvatskom pravu stečajni upravnik u postupcima stečaja nad društvima za osiguranje je fizičko lice – licencirani stečajni upravnik. Konkretno, stečajni upravnik može biti lice koje osim uslova koji se zahtevaju za imenovanje stečajnog upravnika ima znanje i iskustvo iz oblasti osiguranja, pri čemu se sud konsultuje sa Hrvatskom agencijom za nadzor finansijskih usluga u pogledu imenovanju tog lica.[67] U tom smislu, korisno je sačiniti i posebnu listu stečajnih upravnika koji imaju znanje i iskustvo iz oblasti osiguranja. Pojedini domaći autori zalažu se za usvajanje takvog rešenja u našem pravu.[68]

Uopšteno govoreći, nije značajno da li je vršenje funkcije stečajnog upravnika načelno povereno određenom pravnom licu, na primer određenoj agenciji, kao što je slučaj u našem pravu, ili je pak ono povereno licenciranim stečajnim upravnicima. Ono što jeste značajno je da lica koja obavljaju konkretan posao imaju dovoljno znanja da to učine na najbolji mogući način. U tom smislu, opravdano je predvideti posebne uslove koje poverenici Agencije za osiguranje depozita moraju ispuniti kako bi mogli da obavljaju funkciju stečajnog upravnika u posebnom stečajnom postupku. Postojeće rešenje prema kojem poverenici ne moraju da polože stručni ispit i steknu potrebna znanja za obavljanje funkcije stečajnog upravnika u posebnim stečajnim postupcima nije valjano, pogotovo kada se ima u vidu da se detaljno poznavanje posebnih stečajnih postupaka zahteva od licenciranih stečajnih upravnika koji tu funkciju u njima ne obavljaju.

Ukoliko domaći zakonodavac ne namerava da menja važeće rešenje prema kojem funkciju stečajnog upravnika u stečajnim postupcima nad društvima za osiguranje obavlja Agencija za osiguranje depozita, poverenici Agencije treba da prođu odgovarajuću obuku i polože stručni ispit koji bi zbog toga bili organizovani. Ukoliko bi pak zakonodavac promenio pristup i obavljanje funkcije stečajnog upravnika poverio licenciranim stečajnim upravnicima, određen broj licenciranih stečajnih upravnika trebalo bi da se specijalizuje za posebne stečajne postupke ukoliko nemaju prethodno iskustvo iz odgovarajućih oblasti. Specijalizacija bi mogla da se odnosi samo na oblast osiguranja ili na više oblasti za koje se vezuju posebni stečajni postupci. Imajući u vidu ukupan broj stečajnih postupaka koji je vođen nad društvima za osiguranje u poslednjih dvadeset godina, broj licenciranih stečajnih upravnika koji bi bili specijalizovani za oblast osiguranja ne bi morao da bude veliki.

[67] Vid. hrvatski Zakon o osiguranju, čl. 286.
[68] Vid. Vladimir Čolović, „Osnovne pretpostavke za regulisanje stečaja osiguravajućih društava", *Godišnjak Fakulteta pravnih nauka*, br. 9/2019, str. 18.

2. Dužnosti stečajnog upravnika prema posebnom pravnom režimu

Značajne razlike u odnosu na opšti režim stečaja odnose se i na nadležnosti stečajnog upravnika. Budući da u postupku stečaja nad društvom za osiguranje ne postoji skupština poverilaca, već samo jedan poverilački organ – odbor poverilaca, imenovanje poverilaca koji će biti članovi tog organa dobija poseban značaj. Agenciji za osiguranje depozita poverena je nadležnost da daje predloge u vezi sa imenovanjem i razrešenjem članova odbora poverilaca. Naime, stečajni sudija na predlog Agencije bira i razrešava članove odbora poverilaca vodeći se kriterijumom visine potraživanja.[69] Iako je nesporno da se sudija mora voditi tim kriterijumom prilikom imenovanja članova odbora poverilaca, važno je istaći da to nije jedini niti presudan kriterijum u pogledu izbora, kako bi se to pogrešno moglo zaključiti jezičkim tumačenjem relevantne odredbe Zakona o stečaju i likvidaciji banaka i društava za osiguranje. Naime, sudija mora da vodi računa o opštim pravilima o tome ko uopšte može da bude član odbora poverilaca.[70] Takođe, prilikom razrešenja članova odbora poverilaca sudija ne vodi računa o visini potraživanja poverioca koji je član odbora poverilaca, već mora voditi računa o razlozima za razrešenje. Agencija ima još jednu nadležnost i u vezi s tim organom. Konkretno, odbor poverilaca ima pet članova, ali ih može imati i više na obrazloženi predlog Agencije. Dakle, uloga Agencije za osiguranje depozita veoma je važna iz aspekta uticaja poverilaca na tok stečajnog postupka. Njene nadležnosti se u tom smislu razlikuju od nadležnosti stečajnog upravnika prema opštim pravilima stečajnog prava.

Pored nadležnosti u vezi s odborom poverilaca, Agencija za osiguranje depozita ima i specifične dužnosti u vezi s postupkom prenosa portfelja osiguranja koje ne postoje u opštem pravnom režimu stečaja.[71] Portfelj osiguranja predstavlja prava i obaveze društva za osiguranje po osnovu ugovora o osiguranju, pa se njegovim prenosom omogućava održavanje tih ugovora na snazi.[72] Odredbe o prenosu portfelja osiguranja ne predviđaju posebna pravila za pojedine vrste osiguranja, već se taj postupak sprovodi saglasno raspoloživim novčanim sredstvima stečajnog dužnika i isplatnim redovima, što je kritikovano u pravnoj teoriji.[73] Odredbe o prenosu portfelja iz Zakona o osiguranju shodno se primenjuju na prenos portfelja osiguranja društva za osiguranje u stečaju. Može se pretpostaviti da je sprovođenje tog postupka jedan

[69] Vid. ZSLBDO, čl. 8, st. 3.

[70] Odgovori na pitanja privrednih sudova, utvrđeni na sednici Odeljenja za privredne sporove Privrednog apelacionog suda od 8. 11. 2018. i 9. 11. 2018, i na sednici Odeljenja za privredne prestupe održanoj 5. 12. 2018. godine.

[71] Vid. ZSLBDO, čl. 13.

[72] Vladimir Čolović, Magdalena Makiela, „Isplatni redovi u stečajnom postupku protiv osiguravajućih društava", *Prouzrokovanje štete, naknada štete i osiguranje* (ur. Zdravko Petrović, Vladimir Čolović), Beograd-Valjevo, 2019, str. 438.

[73] V. Čolović, Z. Petrović, str. 33.

od razloga odugovlačenja stečajnog postupka nad društvima za osiguranje. U tom smislu, treba istaći da u postupku prenosa portfelja osiguranja značajnu ulogu ima i Narodna banka Srbije. Naime, upravo je Narodna banka ta koja daje saglasnost na izbor društva za osiguranje koje preuzima portfelj osiguranja. S druge strane, stečajni sudija nema ovlašćenja u vezi s prenosom portfelja. Takvo rešenje je uobičajeno u državama čiji je pravni sistem kontinentalnog tipa, dok je za anglosaksonski pravni sistem karakteristično to što je ta nadležnost poverena sudu, a ne upravnim telima.[74]

Zakon o stečaju i likvidaciji banaka i društava za osiguranje predviđa i druga posebna pravila o nadležnostima Agencije za osiguranje depozita. Tako Agencija može odlučiti da troškove stečajnog postupka privremeno obezbedi iz sopstvenih sredstava, pri čemu će imati pravo na povraćaj nakon formiranja stečajne mase.[75] Ta odluka je diskreciona i u potpunosti u rukama Agencije jer Zakonom nisu predviđeni bilo kakvi uslovi i smernice u vezi s tom mogućnošću. Takođe, Zakon predviđa i posebne rokove za izvršenje obaveza Agencije za osiguranje depozita koje se odnose na popis imovine i sačinjavanje početnog stečajnog bilansa, uključujući i izveštaj koji sadrži podatke o aktivi i pasivi stečajnog dužnika, značajnim transakcijama koje je stečajni dužnik zaključio u periodu od 180 dana pre dana nastupanja posledica pokretanja stečajnog postupka, kao i poslovima koje je stečajni dužnik obavljao u ime i za račun drugih pravnih lica. Popis imovine i početni stečajni bilans Agencija mora sačiniti u roku od 60 dana od dana nastupanja posledica pokretanja stečajnog postupka, odnosno od dana preuzimanja imovine i prava stečajnog dužnika, dok prema opštim pravilima rok za izradu početnog stečajnog bilansa koji sadrži podatke o aktivi i pasivi iznosi 30 dana (može biti produžen najduže za pet dana), pri čemu počinje da teče od dana preuzimanja imovine i prava stečajnog dužnika.[76] Takođe, prema opštim pravilima, stečajni upravnik mora započeti popisivanje imovine u roku od 10 dana od dana imenovanja i okončati ga u roku od 30 dana od dana imenovanja.[77] Agencija za osiguranje depozita dužna je da izveštaj o stanju stečajne mase i toku postupka kvartalno ažurira i objavljuje na svojoj internet stranici. Uputstvo za izradu kvartalnog izveštaja o stanju stečajne/likvidacione mase dužnika i toku postupka Agencija je sačinila 2015. godine.[78]

Zakonom je predviđena i obaveza Agencije da u roku od šest meseci od dana isteka roka za prijavu potraživanja utvrdi njihovu osnovanost i visinu.[79] Rok za prijavu potraživanja ne može biti kraći od 30 ni duži od 90 dana od dana objavljivanja obaveštenja o pokretanju postupka stečaja nad društvom za osiguranje

[74] K. Noussia, P. Underwood, S. Frastanlis, str. 184–185.
[75] Vid. ZSLBDO, čl. 18.
[76] Upor. ZSLBDO, čl. 16, st. 1 i ZS, čl. 109, st. 1 i 2.
[77] Vid. ZS, čl. 27, st. 1, tač. 3.
[78] Uputstvo za izradu kvartalnog izveštaja o stanju stečajne/likvidacione mase dužnika i toku postupka dostupno je na sajtu Agencije za osiguranje depozita: *www.aod.rs*, 17. 7. 2024. godine.
[79] Vid. ZSLBDO, čl. 17, st. 1.

u *Službenom glasniku Republike Srbije*.[80] Ispitno ročište se održava najkasnije u roku od 60 dana od dana isteka roka u kojem Agencija ima obavezu da utvrdi osnovanost i visinu prijavljenih potraživanja.[81] Prema opštim pravilima, stečajni upravnik mora najkasnije deset dana pre dana održavanja ispitnog ročišta da dostavi listu potraživanja stečajnom sudiji.[82] Ispitno ročište održava se u roku koji nije kraći od 30 dana ni duži od 60 dana od dana isteka roka koji je određen za prijavu potraživanja.[83] Rok za prijavu potraživanja ne može biti kraći od 30 dana ni duži od 120 dana od dana objavljivanja oglasa o otvaranju stečajnog postupka u *Službenom glasniku Republike Srbije*.[84] Imajući u vidu rokove koji su predviđeni posebnim režimom a koji se odnose na ispitivanje potraživanja i ulogu Agencije za osiguranje depozita u tom postupku, može se zaključiti da zakonska rešenja u pogledu dinamike stečajnog postupka ne mogu bitno uticati na njegovo trajanje, odnosno biti razlog dužeg trajanja postupka stečaja nad društvom za osiguranje u poređenju sa stečajnim postupkom koji se sprovodi po opštem pravnom režimu.

Na kraju, Zakonom je predviđeno i da Agencija može pobijati pravne poslove i radnje kojima je stečajni dužnik pogodovao poverioce. Reč je o poslovima i radnjama izvršenim u roku od šest meseci od dana nastupanja pravnih posledica pokretanja postupka stečaja, odnosno u roku od godinu dana kada su ti poslovi izvršeni s povezanim licima u značenju koje je određeno Zakonom o osiguranju.[85] U tom slučaju nije reč o posebnim nadležnostima, jer stečajni upravnici mogu da pobijaju pravne radnje stečajnog dužnika prema opštim pravilima ukoliko su ispunjeni zakonom predviđeni uslovi.

U pogledu razlika između nadležnosti stečajnih upravnika prema opštem i posebnom režimu, značajno je istaći i da Agencija za osiguranje depozita nema određene nadležnosti koje stečajni upravnici imaju prema opštem pravnom režimu stečaja. Reč je o razlikama koje su rezultat toga što se određena pravila primenjuju samo ako se stečajni postupak sprovodi prema opštem pravnom režimu. Na primer, Agencija nema nadležnosti u vezi s reorganizacijom jer se stečaj društva za osiguranje ne može sprovesti na taj način.

Može se zaključiti da je postojeći pravni okvir u pogledu nadležnosti Agencije za osiguranje depozita moguće neznatno unaprediti preciziranjem pojedinih normi (na primer, one koja se odnosi na obezbeđivanje troškova stečajnog postupka), ali da su pravila načelno valjana. Isto tako, evidentno je da neznatne razlike u pogledu određenja rokova za sprovođenje radnji između opšteg i posebnog pravnog režima ne mogu dovesti do značajnog odugovlačenja stečajnog postupka nad društvom za osiguranje.

[80] Vid. ZSLBDO, čl. 7.
[81] Vid. ZSLBDO, čl. 17, st. 2.
[82] Vid. ZS, čl. 113, st. 4.
[83] Vid. ZS, čl. 72, st. 2.
[84] Vid. ZS, čl. 70, st. 1, tač. 5.
[85] Vid. ZSLBDO, čl. 14, st. 1, 2 i 4.

VI Zaključak

U Srbiji je postupak stečaja društava za osiguranje regulisan Zakonom o stečaju i likvidaciji banaka i društava za osiguranje, dok se pojedina pravila nalaze i u drugim propisima. Postojanje posebnog režima stečaja društava za osiguranje generalno se smatra opravdanim. Zbog toga, ono je uobičajeno i u uporednom pravu. U našem pravu, poseban režim stečaja se odnosi ne samo na društva za osiguranje, već i na društva za reosiguranje, ali se ne odnosi na društva koja obavljaju poslove zastupanja i posredovanja u osiguranju. Iako je zakonodavac učinio propust budući da nije pomenuo društva za reosiguranje u Zakonu o stečaju i likvidaciji banaka i društava za osiguranje kao stečajne subjekte, tumačenjem Zakona o osiguranju i Zakona o stečaju može se zaključiti da se poseban pravni režim stečaja primenjuje i na njih. Radi preciznosti, u Zakonu o stečaju i likvidaciji banaka i društava za osiguranje treba jasno navesti da se on primenjuje i na ta društva. Takođe, termin „osiguravajuće organizacije" koji se koristi u Zakonu o stečaju treba zameniti terminima društva za osiguranje i društva za reosiguranje, čime će sve nedoumice u vezi sa određenjem subjekata posebnog režima stečaja biti otklonjene.

Problemi koji se odnose na stečaj društava za osiguranje nisu vezani samo za određenje stečajnog dužnika. Naime, statistički podaci u vezi sa sprovođenjem stečajnih postupaka nad društvima za osiguranje svedoče o tome da se ti postupci ne sprovode u skladu s načelom hitnosti, koje je jedno od stečajnih načela prema opštim pravnim pravilima. Razlozi odugovlačenja stečajnih postupaka društava za osiguranje koji u proseku traju više nego dvostruko duže u odnosu na stečajne postupke koji se sprovode prema opštem pravnom režimu treba tražiti u specifičnostima posebnog pravnog režima. Zakonom o stečaju i likvidaciji banaka i društava za osiguranje precizirano je koje se odredbe Zakona o stečaju ne primenjuju u stečajnim postupcima nad društvima za osiguranje. Naime, određena pravila se ne primenjuju zbog specifičnosti subjekata nad kojima se sprovodi stečajni postupak, kao i zbog uloge Narodne banke Srbije koja vrši nadzor nad poslovanjem društava za osiguranje.

Jedna od ključnih razlika između opšteg i posebnog režima stečaja odnosi se na vršenje funkcije stečajnog upravnika. Budući da tu funkciju u stečajnim postupcima nad društvima za osiguranje vrši Agencija za osiguranje depozita, poverenici Agencije koji obavljaju taj posao treba da imaju znanja neophodna za valjano obavljanje tog posla. Oni treba da prođu odgovarajuću obuku i polože stručni ispit. Ukoliko bi zakonodavac promenio pristup i odabrao opciju da funkciju stečajnih upravnika obavljaju licencirani stečajni upravnici, za uključenje na posebnu listu ili liste koje se odnose na posebne stečajne postupke trebalo bi zahtevati produbljeno znanje o odgovarajućoj oblasti ili oblastima ukoliko nemaju prethodno iskustvo. S druge strane, za dobijanje licence stečajnih upravnika ne bi trebalo zahtevati detaljno poznavanje posebnih stečajnih postupaka, već samo osnovno ili eventualno dobro.

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SPECIAL BANKRUPTCY REGIME FOR INSURANCE COMPANIES

SCIENTIFIC PAPER

Abstract

In this paper, the author analyzes the legal regime of bankruptcy for insurance companies under Serbian law. At the beginning of the paper, domestic and foreign legal sources relevant to this topic are presented. It highlights that the application of a special legal regime for bankruptcy of insurance companies is justified and common in comparative law. The author notes that the terminology used in domestic laws is inadequate and that incorrect terminology leads to dilemmas regarding the determination of subjects under the special bankruptcy regime, which is addressed in the following section of the paper. Regarding the dilemma of whether the special legal regime also applies to reinsurance companies, the author provides an affirmative answer. After presenting statistical data that clearly indicate the need for improvement in the legal framework, the paper analyzes solutions related to the function of the bankruptcy administrator in bankruptcy proceedings involving insurance companies. The paper concludes with recommendations on how to improve the current solution for performing this function.

Keywords: *bankruptcy, insurance companies, reinsurance companies, Deposit Insurance Agency.*

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I Introduction

The bankruptcy of financial institutions, including insurance companies, is an important topic within bankruptcy law that is often unjustifiably overlooked. The bankruptcy of financial institutions can have a negative impact on the entire economy and, in the case of insurance companies, can undermine the trust of policyholders and insurance beneficiaries in service providers as well as in the regulatory authorities overseeing the insurance sector. The systemic risk associated with these institutions justifies the special legal regime for their bankruptcy. Generally speaking, this refers to the risk or possibility that the failure of a financial institution or a market shock could cause widespread losses or uncertainty, significantly affecting the cost and availability of capital.[2] In this context, it is important to note that it is almost impossible to predict and eliminate systemic failure.[3]

Given that such a possibility cannot be excluded, the collapse of financial institutions must be safe for the surrounding environment.[4] Therefore, the bankruptcy of insurance companies and other financial institutions is, at least in part, regulated by special rules compared to the general legal regime. These rules may be part of general legislation in the specific field, or they may be contained in a special law, or be part of the general legislation regulating bankruptcy.

At the European Union level, the bankruptcy of insurance companies is regulated by Directive 2009/138/EC on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II).[5] Title IV of this Directive pertains not only to bankruptcy but also to reorganization and other procedures that do not involve the insolvency of a company, regardless of whether they are compulsory or voluntary procedures.[6] In modern bankruptcy law, the emphasis is precisely on prevention and early intervention, which also applies to insurance companies. In this context, it is significant to note that the adoption of the Proposal for a Directive establishing

[2] Ben Klaber, "Bankruptcy Insurance: A Modular Approach to Systemic Risk," *University of Pittsburgh Law Review,* Vol. 74, No. 2/2012, p. 335.

[3] See *ibid.*, p. 333.

[4] *Ibid.*

[5] Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II) (Recast), OJ L 335/2009, 17.12.2009, pp. 1–155.

[6] See Gabriel Moss, Ryan Perkins, "Commentary on Title IV of Directive 2009/138/EC on the Taking Up and Pursuit of the Business of Insurance and Reinsurance (Solvency II)," *EU Banking and Insurance Insolvency* (eds. Gabriel Moss, Bob Wessels, Matthias Haentjens), Oxford, 2017, p. 145.The Solvency II Directive defines reorganization measures as "involving any intervention by the competent authorities which are intended to preserve or restore the financial situation of an insurance undertaking and which affect pre-existing rights of parties other than the insurance undertaking itself, including but not limited to measures involving the possibility of a suspension of payments, suspension of enforcement measures or reduction of claims." See Solvency II Directive, Article 268(1) (c).

a framework for the recovery and resolution of insurance and reinsurance undertakings from 2021 is expected soon.[7] Given that Serbia is a candidate for European Union membership, changes in Serbian law regarding the bankruptcy of insurance companies can also be expected.

In domestic law, the bankruptcy of insurance companies is regulated by the Law on Bankruptcy and Liquidation of Banks and Insurance Companies.[8] It is important to note that this Law stipulates that the provisions on reorganization from the Bankruptcy Law do not apply to the bankruptcy proceedings of insurance companies.[9] Additionally, financial restructuring cannot be conducted over an insurance company.[10] On the other hand, a reorganization outside of bankruptcy in the strict legal sense, or at least reorganization measures in a broader sense, are provided for by the Insurance Law.[11] Due to the scope of this paper, the analysis will henceforth be limited exclusively to the bankruptcy of insurance companies, which means it will not cover reorganization (which does not refer to bankruptcy in the context of domestic law), nor the restructuring and recovery of insurance companies in financial distress. For the same reason, and considering that there are numerous specific rules governing the bankruptcy of insurance companies that differ from the general bankruptcy rules, this paper will focus solely on the specific rules related to the bankruptcy administrator in the bankruptcy proceedings of an insurance company, excluding other special rules.

The structure of the paper is as follows: after the introduction, the sources of law relevant to the bankruptcy of insurance companies are presented. Next, the paper highlights the issues related to the determination of the bankruptcy debtor in our legal system, which are largely caused by incorrect and incomplete terminology in legal sources. Following this, statistical data related to the implementation of bankruptcy proceedings for insurance companies are presented, indicating the

[7] European Commission, Proposal for a Directive establishing a framework for the recovery and resolution of insurance and reinsurance undertakings and amending Directives 2002/47/EC, 2004/25/EC, 2009/138/EC, (EU) 2017/1132 and Regulations (EU) No. 1094/2010 and (EU) No. 648/2019, Brussels, 22.9.2021 COM(2021) 582 final, 2021/0296 (COD).

[8] Law on Bankruptcy and Liquidation of Banks and Insurance Companies – LBLBIC, *Official Gazette of the Republic of Serbia*, Nos. 14/2015 and 44/2018 – other law.

[9] See LBLBIC, Art. 22. According to the Bankruptcy Law, reorganization represents the settlement of creditors according to an approved reorganization plan by redefining debtor-creditor relations, through changes in the company's legal status, or in another manner provided by the reorganization plan. See Bankruptcy Law – BL, *Official Gazette of the Republic of Serbia*, Nos. 104/2009, 99/2011 – other law, 71/2012 – Constitutional Court decision, 83/2014, 113/2017, 44/2018, and 95/2018, Art. 1, Para. 4.

[10] See Law on Consensual Financial Restructuring, *Official Gazette of the Republic of Serbia*, No. 89/2015, Art. 2, Item 1.

[11] See Predrag Šulejić, „Neka pitanja stečaja i likvidacije društava za osiguranje s posebnim osvrtom na dejstva u pogledu dvostranoteretnih ugovora", *Pravo i privreda*, Nos. 5-8/2009, p. 176; Insurance Law – IL, *Official Gazette of the Republic of Serbia*, Nos. 139/2014 and 44/2021.

necessity to improve the legal framework. The paper then analyzes the specificities of performing the function of the bankruptcy administrator in these proceedings. Finally, the conclusion is provided.

II Legal Sources

Generally speaking, the need for special rules in business law is dictated by the specificities of the activities carried out by business entities. In the context of company law, this applies to the establishment of these entities, rules on corporate governance, as well as their dissolution. Certain industries, such as the insurance industry, require special state oversight, including supervision related to the dissolution of these entities. One of the ways in which insurance companies can cease to exist is through bankruptcy. This refers to a judicial proceeding of collective settlement of creditors by achieving the highest possible value of the bankruptcy debtor or their assets.[12] According to general rules, this proceeding is conducted through liquidation or reorganization. The importance of regulating the bankruptcy of insurance companies has also been recognized by European legislators, as the bankruptcy of insurance companies is regulated under European Union law. The bankruptcy of insurance companies is typically governed by special rules in comparative law, including U.S. law.

1. Domestic Law

In our country, the bankruptcy of insurance companies is regulated by a special law (*lex specialis*). Serbia's decision to regulate the bankruptcy of insurance companies through a special law is not an innovation. Before the current Law on the Bankruptcy and Liquidation of Banks and Insurance Companies came into force, the bankruptcy of insurance companies was regulated by a Law of the same name from 2005.[13] Prior to the adoption of this Law, the situation was different. Namely, the Insurance Law of 2004 stipulated that the law regulating liquidation and bankruptcy would apply to the bankruptcy proceedings of insurance companies unless specific issues were otherwise addressed by the Insurance Law.[14] The same was stipulated by the Property and Personal Insurance Law of 1996.[15] Thus, until 2005, the provisions

[12] Mirko Vasiljević, Tatjana Jevremović Petrović, Jelena Lepetić, *Kompanijsko pravo – Pravo privrednih društava*, Beograd, 2023, p. 883.
[13] Law on the Bankruptcy and Liquidation of Banks and Insurance Companies, *Official Gazette of the Republic of Serbia*, Nos. 61/2005, 116/2008, and 91/2010.
[14] See the 2004 Insurance Law, *Official Gazette of the Republic of Serbia*, Nos. 55/04 and 70/04, art. 208.
[15] See the Law on Property and Personal Insurance, *Official Gazette of the FRY*, Nos. 30/96, 57/98, 53/99, and 55/99, art. 137.

regarding the bankruptcy of insurance companies were included in the law governing insurance. Both approaches to regulating the bankruptcy of insurance companies are acceptable, meaning that it does not particularly matter whether the bankruptcy provisions are stipulated in a special law or in the law governing the insurance sector. For example, the Croatian Insurance Law contains provisions on bankruptcy.[16] The same case is in Bulgaria, where the bankruptcy of insurance companies is governed by the Insurance Code.[17] The approach of including bankruptcy provisions within the substantive law for the insurance sector allows for all or nearly all special rules related to insurance companies in financial distress to be found within the same law. Nevertheless, our legislator has not opted for this model. In any case, regardless of where certain norms are found, the key issue is whether the general or special bankruptcy rules apply to the bankruptcy of an insurance company.

Considering that in our legal system, the bankruptcy proceedings for insurance companies are regulated by a special law, this process falls under the category of special bankruptcy proceedings.[18] More precisely, it is viewed as a special proceeding because it is governed by specific rules. Meanwhile, the provisions of the Bankruptcy Law (*lex generalis*) apply to issues not regulated by the special law.[19] Although most of the rules regarding the bankruptcy of insurance companies are contained in the regulations governing bankruptcy (*lex specialis* and *lex generalis*), certain rules can also be found in other regulations. Therefore, the legal sources for the bankruptcy of insurance companies also include the Law of Contract and Torts and the Law on Compulsory Traffic Insurance.[20] Both laws contain specific rules regarding the consequences of initiating bankruptcy proceedings, while the Law on Compulsory Traffic Insurance also includes a special rule on the filing of claims in bankruptcy proceedings.

When it comes to secondary legislation, it is important to highlight that the national standards for managing the bankruptcy estate do not apply in bankruptcy proceedings involving insurance companies.[21] According to the general legal regime, a total of eight national standards are typically applied.[22] Instead, in the case of an

[16] See the Croatian Insurance Law, *Official Gazette*, Nos. 30/2015, 112/2018, 63/2020, 133/2020, and 151/2022, section IX.

[17] Deloitte Legal, *A guide to pre-insolvency and insolvency proceedings across Europe*, July 2023, p. 9.

[18] See Vuk Radović, *Osnovi stečajnog prava*, Belgrade, 2020, p. 253.

[19] See LBLBIC, Art. 22.

[20] Law of Contract and Torts, *Official Gazette of the SFRY,* No. 29/78, 39/85, 45/89 – Decision of the Constitutional Court, and 57/89, *Official Gazette of the FRY*, No. 31/93, *Official Gazette of SCG*, No. 1/2003 – Constitutional Charter, and *Official Gazette of RS*, No. 18/2020; Law on Compulsory Traffic Insurance, *Official Gazette of RS*, No. 51/2009, 78/2011, 101/2011, 93/2012, and 7/2013 – Constitutional Court Decision.

[21] See the Answers and Questions of Commercial Courts established at the session of the Commercial Appellate Court's Department for Commercial Disputes held on November 19 and 20, 2019, and at the session of the Department for Economic Offenses held on November 20, 2019.

[22] See the Rulebook on Establishing National Standards for Bankruptcy Estate Management, *Official Gazette of the Republic of Serbia*, No. 62/2018. The national standards are part of this Rulebook.

insurance company bankruptcy, the Regulation on the Liquidation of Assets of Financial Institutions in Bankruptcy or Liquidation, which provides more detailed rules on the sale of the debtor's assets, is applied. This Regulation was issued by the Deposit Insurance Agency in 2018.[23] The application of this Regulation is necessary given that the rules on asset sales stipulated by the Bankruptcy Law are relatively general.[24]

2. EU Law

As previously mentioned, the key legal source of the European Union for the insolvency of insurance companies is the Solvency II Directive.[25] Insolvency is one of the processes regulated under Title IV of this Directive. However, it is important to note that the Solvency II Directive does not harmonize insolvency law rules—it contains provisions that facilitate understanding and cooperation between member states.[26] Essentially, it functions as an instrument of private international law. Previously, this matter was regulated in nearly the same manner by Directive 2001/17/EC on the reorganization and winding up of insurance undertakings.[27] Therefore, the insolvency of insurance companies has long been governed by specific rules. In this context, it should also be noted that the Regulation on Insolvency Proceedings (in effect since 2015, and previously in 2000) provides a complementary solution, excluding insurance companies from its scope of application.[28]

3. U.S. Law

While the exclusion of insurance companies from the general bankruptcy regime is widely accepted in European legal theory, there are opinions that their exclusion as bankruptcy subjects under U.S. federal bankruptcy law is unjustified. Specifically, U.S. Bankruptcy Code does not apply to insurance companies, and federal

[23] Rulebook on the Liquidation of Assets of Financial Institutions in Bankruptcy or Liquidation, July 2018. The rulebook is available on the Deposit Insurance Agency's website: *www.aod.rs*, 18. 7. 2024.

[24] See *ibid*.

[25] For more information on Solvency II Directive and Serbian law, see Milo Marković, „Izazovi tržišta osiguranja u Srbiji na putu ka Solventnosti II", *Tokovi osiguranja*, No. 2/2024, pp. 333-361.

[26] Kyriaki Noussia, Peter Underwood, Stergios Frastanlis, „Restructuring, Winding-Up & Portfolio Transfer of Insurance Companies in Distress", *The Governance of Insurance Undertakings – Corporate Law and Insurance Regulation* (eds. Pierpaolo Marano, Kyriaki Noussia), Sham, 2022, pp. 186 and 189.

[27] Directive 2001/17/EC of the European Parliament and of the Council of 19 March 2001 on the reorganization and winding up of insurance undertakings, OJ L 110/2001, 20.4.2001, p. 28-39. The directive ceased to be in force in 2015. See G. Moss, R. Perkins, p. 122.

[28] See Regulation (EU) No 848/2015 on insolvency proceedings (Regulation (EU) 2015/848 of the European Parliament and of the Council of 20 May 2015 on insolvency proceedings (recast), *OJ L* 141, 5.6.2015, pp. 19–72), Article 1(2)(a), and Regulation (EC) No 1346/2000 on insolvency proceedings (Council Regulation (EC) No 1346/2000 of 29 May 2000 on insolvency proceedings, *OJ L* 160, 30.6.2000, pp. 1–18), Article 1(2).

bankruptcy courts do not have jurisdiction over their bankruptcies.[29] However, it should be noted that the existence of varying state rules and court jurisdictions is one of the reasons why the special legal regime for insurance company bankruptcies has been criticized in U.S. legal theory.[30] In other words, while it is not disputed that these entities require a special set of rules for their dissolution, the current regime itself is subject to criticism. The regulations governing bankruptcy differ among states because they are based on one of two available model acts: the Uniform Insurers Liquidation Act, adopted by the National Conference of Commissioners, and the Rehabilitation and Liquidation Model Act, developed by the National Association of Insurance Commissioners.[31]

III Entities Subject to Special Bankruptcy Regime

The Bankruptcy Law uses an inadequate term to denote entities in the insurance sector concerning the exclusion of certain entities from the application of this Law. Specifically, the application of the Bankruptcy Law is excluded for certain entities, including "insurance organizations," except in matters not regulated by special legislation.[32] The term "insurance organizations" is broader than the term "insurance companies" and could potentially encompass reinsurance companies as well as companies engaged in insurance brokerage and agency activities.

1. Insurance Companies

The Law on Bankruptcy and Liquidation of Banks and Insurance Companies regulates the conditions and procedures for the bankruptcy of these companies, but it does not define them. The definition of insurance companies is provided in the current Insurance Law. According to this Law, insurance companies are defined as legal entities with headquarters in the Republic of Serbia that conduct insurance activities, for which the approval of the National Bank of Serbia is required.[33] Additionally, an insurance company may be established either as a joint-stock company

[29] The U.S. Bankruptcy Code does not apply to domestic insurance companies. See U.S. Code, Title 11, Chapter 1, § 109(b) (2).

[30] See, for example, Laura S. McAlister, "The Inefficiencies of Exclusion: The Importance of Including Insurance Companies in the Bankruptcy Code," *Emory Bankruptcy Developments Journal*, Vol. 24, No. 1/2008, p. 129, and Wm. Carlisle Herbert, "When Jurisdictions Collide: Determining Judicial Roles When Bankruptcy Court and Insurance Receivership Court Responsibilities Overlap," *Tort Trial & Insurance Practice Law Journal*, Vol. 42, No. 4/2007, p. 941.

[31] See L. S. McAlister, p. 131.

[32] BL, Article 14, Paragraph 2.

[33] IL, Article 3, Paragraph 1.

or as a mutual insurance company.[34] It is evident from the provision regarding the order of payments in the Law on Bankruptcy and Liquidation of Banks and Insurance Companies that these specific types of insurance companies are subject to a special bankruptcy regime. Namely, in the last rank of bankruptcy claims, there are the claims of creditors who are shareholders of a joint-stock insurance company and members, or insured persons of a mutual insurance company.[35] Thus, the bankruptcy entities to which the *lex specialis* applies are insurance companies, regardless of their form of establishment.

A mutual insurance company is a legal entity headquartered in the Republic of Serbia that can conduct all insurance activities except reinsurance and is established as a limited liability company based on the approval of the National Bank of Serbia.[36] Unlike domestic law, where the special bankruptcy regime applies to all mutual insurance companies, the scope of the Solvency II Directive is somewhat narrower. Specifically, the Solvency II Directive does not apply to those mutual insurance companies that engage in non-life insurance activities and have entered into an agreement with another mutual insurance company for the full reinsurance of the insurance policies they have issued, or where the other company has committed to assuming the obligations arising from the issued policies.[37] This difference has no practical significance in the context of domestic law, as this form of insurance company has not taken root in practice. Currently, there are no active mutual insurance companies registered in Serbia.[38]

2. Reinsurance Companies

Reinsurance companies are legal entities based in the Republic of Serbia that are established by registration in the registry upon obtaining a permit from the National Bank of Serbia.[39] Unlike insurance companies, reinsurance companies are established for the purpose of conducting reinsurance activities and can only be established in the form of a joint-stock company.[40] The Law on Bankruptcy and Liquidation of Banks and Insurance Companies does not mention reinsurance companies. Reinsurance companies are also not mentioned in the Law on the Deposit Insurance Agency. Therefore, it must be determined whether this omission is a legislative oversight

[34] IL, Article 20, Paragraph 4.
[35] Law on Bankruptcy and Liquidation of Banks and Insurance Companies, Article 21, Point 7.
[36] See IL, Article 70.
[37] See Solvency II Directive, Article 7.
[38] Information available on the website of the Business Registers Agency indicates that the Mutual Insurance Company MG Beograd, established in 1998 for life insurance activities, ceased to exist in 2005 following a successful liquidation process. See www.apr.gov.rs, 17. 7. 2024.
[39] See IL, Art. 3, para. 2.
[40] See IL, Art. 3, para. 2 and art. 20, para. 4.

or if the legislator did not intend to include reinsurance companies as subjects of a special bankruptcy regime. Resolving the issue of whether reinsurance companies are subject to general or special bankruptcy regimes has practical significance, as there are currently four such companies operating in Serbia.[41] Unlike the domestic solution, which leaves room for doubts, Croatian legislation explicitly states that the provisions of the Insurance Act related to the bankruptcy of insurance companies apply accordingly to reinsurance companies.[42]

On the other hand, our legislator has not entirely neglected reinsurance in the Law on Bankruptcy and Liquidation of Banks and Insurance Companies, which further obscures the status of reinsurance companies as bankruptcy subjects. Specifically, the Law grants priority to creditors from reinsurance contracts in the event of an insurance company's bankruptcy. In other words, the claims of reinsurers receive preferential treatment, along with other insurance-related claims, compared to other claims of insurance company creditors that are not related to insurance activities.

It is important to note that insurance companies do not include reinsurance companies, meaning that insurance companies are not a broader term in this sense. The legal regime for insurance companies and reinsurance companies is regulated by the provisions of Chapter II of the Insurance Law, with Section 2 referring to joint-stock insurance/reinsurance companies. Since both types of companies are mentioned together, it is clear that there is no narrower or broader term. Moreover, reinsurance companies are not mentioned in the provision of the Insurance Law concerning the application of provisions on bankruptcy and liquidation. Specifically, the Law stipulates that the bankruptcy of insurance companies is conducted in accordance with the law governing the bankruptcy and liquidation of banks and insurance companies, while the bankruptcy of insurance brokerage and agency companies is governed by the bankruptcy law.[43] On the other hand, the title of Chapter XI, which contains the mentioned provisions, is: "Termination of operations, liquidation, and bankruptcy of supervised entities." From this, it can be concluded that the provisions of this chapter also apply to reinsurance companies, as they are also supervised entities under the National Bank of Serbia.[44] Moreover, the Insurance Law stipulates that provisions related to insurance companies apply accordingly to reinsurance companies.[45] Although the title of this article is "Accordingly Application of the Law to the Operations of a Joint-Stock Reinsurance Company," which may raise questions about the application of the provision to the dissolution of the company, such

[41] This number is based on information available on the website of the Business Registers Agency as of July 17, 2024. See *www.apr.gov.rs*, 17. 7. 2024.
[42] See Croatian Insurance Law, Art. 284, para. 3.
[43] See IL, Article 221.
[44] See IL, Article 187, paragraph 1.
[45] See IL, Article 69.

a conclusion cannot be drawn from its content. Interpretation of the Insurance Law concludes that the special legal regime also applies to reinsurance companies. The same can be concluded from the provision of the Bankruptcy Law, which excludes the application of its provisions to "insurance organizations". The term "insurance organizations" could certainly include reinsurance companies.

Generally speaking, there are several arguments in favor of including reinsurance companies in the special bankruptcy regime. Specifically, the bankruptcy of a reinsurance company could negatively impact the insurance sector as a whole. Reinsurance risk is considered a significant risk regarding its legal regime under European Union law.[46] Additionally, since reinsurance is a specialized activity, bankruptcy administrators in bankruptcy proceedings managing a reinsurance company should have specific expertise in the field of reinsurance. On the other hand, an argument against applying a special regime might be that the bankruptcy of a reinsurance company could directly affect only insurance companies. Specifically, the bankruptcy of a reinsurance company does not necessarily impact other market participants, except for the insurance companies with which it has entered into a reinsurance agreement. Reinsurance agreements are concluded between commercial entities – the insurer and the reinsurer, while insurance agreements are made between insurers and individuals, commercial entities, and other organizations not engaged in insurance activities.[47] Moreover, Title IV of the Solvency II Directive does not apply to reinsurance companies.[48] The only exception pertains to cases where a reinsurance company is also registered for insurance activities.[49]

Considering the provisions of the Insurance Law regarding the accordingly application of rules for insurance companies to reinsurance companies, the terminology of the Bankruptcy Law, as well as the arguments for including reinsurance companies in a special bankruptcy regime in general, it can be concluded that domestic law applies the bankruptcy provisions of the Bankruptcy and Liquidation of Banks and Insurance Companies Law to reinsurance companies. Specifically, the omission of reinsurance companies in that Law, as well as in the Deposit Insurance Agency Law, should be considered an oversight rather than an intention by the legislator to exclude these companies from the special bankruptcy regime. To eliminate all doubts, the Bankruptcy and Liquidation of Banks and Insurance Companies Law should explicitly list reinsurance companies as bankruptcy subjects to which the Law applies. Additionally, the Bankruptcy Law should be amended to replace the term "insurance organizations" with "insurance companies" and "reinsurance companies" as subjects excluded from the general bankruptcy regime.

[46] Nataša Petrović Tomić, *Pravo osiguranja – Sistem*, Volume I, Belgrade, 2019, p. 727.
[47] See *Ibid.*
[48] See Solvency II Directive, Article 1(3) and 2(1), second paragraph.
[49] G. Moss, R. Perkins, p. 129.

3. Exclusion of Insurance Brokerage and Agency from the Special Bankruptcy Regime

The Insurance Law regulates not only the establishment and operation of insurance and reinsurance companies but also, among other things, the activities of insurance brokerage and agency.[50] In domestic literature, there are opinions suggesting that the legal term "insurance companies" should be changed to "insurance undertakings." Specifically, the term "insurance undertakings" is used in practice to denote companies engaged in insurance activities, while the term "insurance companies" is criticized for potentially including firms engaged in insurance brokerage and agency.[51] Therefore, a dilemma may arise as to whether the special bankruptcy regime provided by the Law on Bankruptcy and Liquidation of Banks and Insurance Companies also applies to those companies.

By interpreting the provisions of the Law on Bankruptcy and Liquidation of Banks and Insurance Companies and the Insurance Law, it can be unequivocally concluded that the special legal regime does not apply to these companies. Specifically, not only are insurance brokerage and agency companies not mentioned in the Law on Bankruptcy and Liquidation of Banks and Insurance Companies, but the Insurance Law also specifies that the bankruptcy proceedings for insurance brokerage and agency companies are conducted in accordance with the law governing bankruptcy.[52] Additionally, Title IV of the Solvency II Directive does not apply to these companies, but only to insurance companies and branches of insurance companies from third countries that are located within the Community's territory.[53]

IV Duration of Special Bankruptcy Proceedings for Insurance Companies – Inconsistency with the Principle of Urgency

To fully understand the significance of special bankruptcy regimes for insurance companies, it is essential to consider relevant statistical data concerning bankruptcy proceedings conducted for these companies in Serbia. According to publicly available data from the Deposit Insurance Agency's website, between, 2004 to, 2024, seven bankruptcy proceedings were conducted over joint-stock insurance companies, three of which involved liquidation proceedings followed by bankruptcy proceedings.[54] On average, these bankruptcy proceedings lasted *more than eight*

[50] See IL, Article 1.

[51] See Vladimir Čolović, Zdravko Petrović, „Sporna pitanja regulisanja stečaja osiguravajućih društava u Srbiji i usklađivanje sa Direktivom 2001/17/EZ", *Evropska revija za pravo osiguranja*, No. 4/2015, p. 31.

[52] See IL, Art. 221, para. 2.

[53] See Solvency II Directive, Art. 267.

[54] See data available at: *www.aod.gov.rs*, 19. 7. 2024. Note: The author calculated the average duration of the proceedings based on the data on bankruptcy proceedings available on the website.

years (excluding the duration of liquidation proceedings).[55] When comparing the average duration of these proceedings with the average duration of bankruptcy proceedings under the general bankruptcy regime, it can be concluded that the special bankruptcy proceedings for insurance companies take an unacceptably long time. Specifically, according to data available on the website of the Bankruptcy Supervision Agency, as of July 1, 2024, the average duration of 9,389 bankruptcy proceedings was three years, two months, and six days.[56] The average duration is even shorter for proceedings initiated under the Bankruptcy Law in force. Specifically, a total of 7,812 proceedings initiated under this Law lasted, on average, two years, ten months, and seven days.[57] Considering the duration of both general and special bankruptcy proceedings, it can be concluded that special bankruptcy proceedings lasted more than twice as long as general ones.

Although, at first glance, the number of bankruptcy proceedings conducted against insurance companies may seem small, it should be noted that only a limited number of entities operate in the insurance market, and the significance of this activity is considerable given its contribution to GDP. Specifically, according to data from the National Statistical Office, the insurance, reinsurance, and pension funds sector accounted for 0.5% of GDP in 2021 and 0.4% in 2022.[58] Furthermore, all financial activities, including insurance, contributed 3.2% to GDP in both 2021 and 2022.[59]

In any case, the data on the duration of bankruptcy proceedings against insurance companies indicates that, in order to promote the principle of urgency that applies in bankruptcy law, it is necessary to improve the legal framework governing special bankruptcy proceedings for these companies.[60] Therefore, it is particularly important to consider the differences between the rules applied to these proceedings. There are numerous significant deviations in the implementation and dynamics of bankruptcy proceedings against insurance companies compared to the general legal regime. Among other things, the court does not conduct a preliminary bankruptcy procedure due to the significant role played by the National Bank of Serbia in relation to the bankruptcy of insurance companies. Unlike the general legal rules, bankruptcy proceedings cannot be carried out through reorganization, and the assets cannot be liquidated through the sale of the debtor as a legal person. Special rules regarding costs and payment priorities are also applied. Additionally, significant deviations pertain to the bodies involved in the bankruptcy procedure. Specifically, the number of bankruptcy bodies is smaller, and the function of the bankruptcy administrator is carried out by a legal person – the Deposit Insurance

[55] See *ibid*.
[56] See *www.alsu.gov.rs*, 19. 7. 2024.
[57] See *ibid*.
[58] Data available at: *www.stat.gov.rs*, 20. 7. 2024.
[59] *Ibid*.
[60] See BL, Art. 8.

Agency. The following discussion will focus solely on this body as a starting point for investigating and uncovering possible reasons why the average duration of bankruptcy proceedings against insurance companies is disproportionately longer than the average duration of general bankruptcy proceedings.

V Deposit Insurance Agency as Bankruptcy Administrator

Under the special legal regime of bankruptcy that applies to insurance companies, the bankruptcy bodies are the bankruptcy judge, the bankruptcy administrator, and the creditors' committee. In contrast, under the general regime, the bodies include the bankruptcy judge, the bankruptcy administrator, the creditors' assembly, and the creditors' committee. Compared to the general rules regarding bankruptcy bodies, the Law on Bankruptcy and Liquidation of Banks and Insurance Companies prescribes three key exceptions. The first concerns the performance of the bankruptcy administrator's duties, the second pertains to the number of creditor bankruptcy bodies, and the third involves the powers of the bankruptcy bodies.

1. Special Knowledge (Not) Required for Performing the Function of Bankruptcy Administrator

In domestic law, the Deposit Insurance Agency performs the function of the bankruptcy administrator in the bankruptcy proceedings of insurance companies, while the duties of the bankruptcy administrator are carried out by the Agency's appointed commissioners. Specifically, commissioners are appointed and dismissed by the Board of Directors with the approval of the Managing Board or at the initiative of the Managing Board of the Deposit Insurance Agency.[61] In addition to its function as a bankruptcy administrator, the Deposit Insurance Agency also handles mandatory deposit insurance and the payout of insured amounts, manages assets transferred during the restructuring of banks, and performs other related tasks, including organizing the Investor Protection Fund.[62] It is important to note that the Agency also fulfills the function of bankruptcy administrator in other special bankruptcy proceedings. Namely, the Deposit Insurance Agency serves this function in bankruptcy proceedings conducted against banks and leasing companies. Under the special legal regime governing the bankruptcy of insurance companies, a commissioner appointed by the Deposit Insurance Agency is not required to pass a professional exam or acquire special knowledge needed to properly fulfill the role

[61] See the Statute of the Deposit Insurance Agency, *Official Gazette of the RS*, No. 59/2015 and 49/2016, Article 13, Point 12.

[62] See the Law on the Deposit Insurance Agency, *Official Gazette of the RS*, No. 14/2015 and 51/2017, Article 2.

of bankruptcy administrator. Specifically, under domestic law, the commissioner is not required to hold a bankruptcy administrator license.

According to general rules, the function of the bankruptcy administrator is performed by a natural person who holds a license to carry out the duties of a bankruptcy administrator. The bankruptcy administrator is appointed by the bankruptcy judge through a random selection method from a list of active bankruptcy administrators within the court's jurisdiction. To obtain a license, a natural person must, among other requirements, pass a professional exam. Knowledge of special bankruptcy proceedings is also required to obtain a license for performing bankruptcy administrator duties. According to the Regulation on the program and method of taking the professional exam to perform the duties of a bankruptcy administrator, knowledge in this area must be detailed (relevant sources include the Law on Bankruptcy and Liquidation of Banks and Insurance Companies, the Law on the Deposit Insurance Agency, and the Insurance Law), and among other things, a good understanding of insurance contracts is required.[63] Considering that licensed bankruptcy administrators do not perform the function of a bankruptcy administrator in special bankruptcy proceedings, it is unclear why it is necessary for them to have detailed knowledge in the area of bankruptcy law related to special bankruptcy proceedings. A possible explanation might be that the general legal regime applies to the bankruptcy of reinsurance companies, but there are not enough arguments to support this. Namely, bankruptcy administrators must have detailed knowledge about the bankruptcy of banks, even though there is no doubt that the Deposit Insurance Agency performs the function of bankruptcy administrator in those proceedings.

The deviation from general rules concerning the bankruptcy administrator is not limited only to bankruptcy proceedings involving financial institutions, including insurance companies. In domestic law, the function of the bankruptcy administrator is also performed by a legal person in bankruptcy proceedings involving majority socially-owned or state-owned legal entities, as well as in cases where the bankruptcy debtor becomes a majority state-owned legal entity during the bankruptcy proceeding. In these cases, the function of the bankruptcy administrator is performed by the Bankruptcy Supervision Agency.[64]

Assigning the role of bankruptcy administrator to a specific organization is not uncommon in comparative law. For example, in U.S. law, the management of an insurance company in bankruptcy is entrusted to the relevant supervisory authority for insurance. Specifically, if an insurance company is in financial distress (impaired), the competent supervisory authority or commissioner (each state has its supervisory authority) files a petition with the court to impose a receivership, deciding whether

[63] See Regulation on the Program and Method of Passing the Professional Examination for Performing the Duties of a Bankruptcy Administrator, *Official Gazette of RS*, No. 47/2010, Art. 4.

[64] See M. Vasiljević, T. Jevremović Petrović, J. Lepetić, p. 890. See BL, Art. 22.

the company should be reorganized or liquidated.[65] Once the court approves this process, the supervisory authority manages the insurance company.[66]

On the other hand, there are solutions where deviations from the general legal regime regarding the function of the bankruptcy administrator in the bankruptcy proceedings of insurance companies are minimal. For instance, under Croatian law, the bankruptcy administrator in such proceedings is a natural person — a licensed bankruptcy administrator. Specifically, the bankruptcy administrator can be a person who, in addition to meeting the requirements for appointment as a bankruptcy administrator, has knowledge and experience in the field of insurance, with the court consulting the Croatian Financial Services Supervisory Agency regarding the appointment of this individual.[67] In this context, it would be useful to create a specific list of bankruptcy administrators who have knowledge and expertise in the field of insurance. Some domestic authors advocate for the adoption of such a solution in our legal system.[68]

Generally speaking, it is not significant whether the function of the bankruptcy administrator is primarily assigned to a specific legal person, such as an agency, as is the case in our law, or to licensed bankruptcy administrators. What is essential is that those persons, who perform specific duties, have sufficient knowledge to do so in the best possible manner. In this regard, it is justified to set specific conditions that the commissioners of the Deposit Insurance Agency must meet to perform the duties of a bankruptcy administrator in special bankruptcy proceedings. The current solution, where commissioners are not required to pass a professional exam or acquire the necessary knowledge to fulfill the role of a bankruptcy administrator in special proceedings, is inadequate, especially considering that detailed knowledge of special bankruptcy proceedings is required of licensed bankruptcy administrator who do not perform this function in those proceedings.

If the domestic legislator does not intend to change the current arrangement, under which the Deposit Insurance Agency performs the role of bankruptcy administrator in bankruptcy proceedings involving insurance companies, then the Agency's commissioners should undergo appropriate training and pass a professional exam that would need to be organized for this purpose. However, if the legislator changes its approach and assigns the role of bankruptcy administrator to licensed bankruptcy administrators, a certain number of licensed bankruptcy administrators would need to specialize in specific bankruptcy proceedings if they do not have prior experience in the relevant areas. Specialization could focus solely on the insurance sector or

[65] See L. S. McAlister, pp. 130–131.
[66] See *ibid*., p. 131.
[67] See Croatian Insurance Act, Article 286.
[68] See Vladimir Čolović, „Osnovne pretpostavke za regulisanje stečaja osiguravajućih društava", *Godišnjak Fakulteta pravnih nauka*, No. 9/2019, p. 18.

cover multiple areas associated with specific bankruptcy proceedings. Considering the total number of bankruptcy proceedings involving insurance companies over the past twenty years, the number of licensed bankruptcy administrators specialized in the insurance sector would not need to be large.

2. Duties of the Bankruptcy Administrator under the Special Legal Regime

Significant differences from the general bankruptcy regime also pertain to the powers of the bankruptcy administrator. Since there is no creditors' assembly in bankruptcy proceedings against an insurance company, but only one creditors' body — the creditors' committee — the appointment of creditors who will be members of this body becomes particularly important. The Deposit Insurance Agency is entrusted with the authority to propose the appointment and dismissal of members of the creditors' committee. Specifically, the bankruptcy judge, based on the Agency's proposal, selects and dismisses members of the creditors' committee according to the amount of claims.[69] Although it is undisputed that the judge must use this criterion when appointing members of the creditors' committee, it is important to note that this is not the only or decisive criterion in the selection process, as might be incorrectly concluded from a language interpretation of the relevant provisions of the Law on Bankruptcy and Liquidation of Banks and Insurance Companies. The judge must also consider the general rules regarding who may be a member of the creditors' committee.[70] Additionally, when dismissing members of the creditors' committee, the judge does not consider the extent of claim held by the creditor who is a member of the committee but must take into account the reasons for the dismissal. The Agency also has another authority related to this body. Specifically, the creditors' committee consists of five members but can have more on the Agency's reasoned proposal. Thus, the role of the Deposit Insurance Agency is very significant in terms of influencing the course of the bankruptcy proceedings. Its powers, in this regard, differ from the powers of the bankruptcy administrator under the general rules of bankruptcy law.

In addition to its duty concerning the creditors' committee, the Deposit Insurance Agency also has specific powers related to the process of transferring the insurance portfolio, which are not present in the general bankruptcy regime.[71] The insurance portfolio represents the rights and obligations of the insurance company under insurance contracts, and transferring it allows these contracts to remain in

[69] See LBLBIC, Article 8, Paragraph 3.

[70] See Responses to Questions from Commercial Courts, as established in the session of the Department for Commercial Disputes of the Commercial Appellate Court on November 8, 2018, and November 9, 2018, and in the session of the Department for Economic Offenses held on December 5, 2018.

[71] See LBLBIC, Article 13.

force.[72] The provisions regarding the transfer of the insurance portfolio do not stipulate special rules for specific types of insurance; rather, the process is conducted in accordance with the available financial resources of the bankruptcy debtor and the ranking of bankruptcy claims, which has been criticized in legal theory.[73] The provisions on portfolio transfer from the Insurance Law apply similarly to the transfer of the insurance portfolio of a company in bankruptcy. It can be assumed that the implementation of this process is one of the reasons for the delay of bankruptcy proceedings against insurance companies. In this context, it should be noted that the National Bank of Serbia also plays a significant role in the portfolio transfer process. Specifically, it is the National Bank that approves the choice of the insurance company that will take over the insurance portfolio. On the other hand, the bankruptcy judge does not have authority regarding the portfolio transfer. This arrangement is typical in countries with a civil law system, whereas, in common law systems, such authority is usually entrusted to the court rather than administrative bodies.[74]

The Law on Bankruptcy and Liquidation of Banks and Insurance Companies also stipulates additional special rules regarding the powers of the Deposit Insurance Agency. For instance, the Agency may decide to temporarily cover the costs of the bankruptcy proceedings from its own funds, with the right to reimbursement after the bankruptcy estate is established.[75] This decision is discretionary and entirely within the Agency's powers, as the Law does not prescribe any conditions or guidelines concerning this possibility. Additionally, the Law provides specific deadlines for the Deposit Insurance Agency's obligations related to asset inventory and the preparation of the initial bankruptcy balance sheet, including a report containing data on the assets and liabilities of the bankruptcy debtor, significant transactions conducted by the debtor in the 180-day period prior to the onset of the consequences of the bankruptcy proceedings, and activities carried out by the debtor on behalf of other legal persons. The Agency must complete the asset inventory and initial bankruptcy balance sheet within 60 days from the onset of the bankruptcy proceedings or from the date of assuming control of the debtor's assets and rights. In contrast, according to general rules, the deadline for preparing the initial bankruptcy balance sheet, which includes data on assets and liabilities, is 30 days (which can be extended by up to five days), starting from the date of taking over of the debtor's assets and rights.[76] Additionally, under general rules, the bankruptcy administrator must start the inventory of assets within 10 days of appointment and complete it within 30 days

[72] Vladimir Čolović, Magdalena Makiela, „Isplatni redovi u stečajnom postupku protiv osiguravajućih društava", *Prouzrokovanje štete, naknada štete i osiguranje* (ed. Zdravko Petrović, Vladimir Čolović), Belgrade-Valjevo, 2019, p. 438.
[73] V. Čolović, Z. Petrović, p. 33.
[74] K. Noussia, P. Underwood, S. Frastanlis, p. 184–185.
[75] See LBLBIC, Article 18.
[76] Compare LBLBIC, Article 16, Paragraph 1, and BL, Article 109, Paragraphs 1 and 2.

of appointment.[77] The Deposit Insurance Agency is required to update and publish a report on the status of the bankruptcy estate and the progress of the proceedings quarterly on its website. The guidelines for preparing the quarterly report on the status of the bankruptcy/liquidation estate and the progress of the proceedings were issued by the Agency in 2015.[78]

The law also requires the Agency to determine the validity and amount of claims within six months from the expiration of the claims submission deadline.[79] The deadline for submitting claims cannot be shorter than 30 days or longer than 90 days from the date of publication of the notice of the initiation of bankruptcy proceedings against the insurance company in the *Official Gazette of the Republic of Serbia*.[80] The hearing at which the claims are examined must be held no later than 60 days after the expiration of the deadline within which the Agency must determine the validity and amount of the submitted claims.[81] According to general rules, the bankruptcy administrator must submit the list of claims to the bankruptcy judge no later than ten days before the date of the hearing at which the claims are examined.[82] This hearing is held within a period of no less than 30 days and no more than 60 days from the expiration of the deadline for submitting claims.[83] The deadline for submitting claims cannot be shorter than 30 days or longer than 120 days from the date of publication of the notice of the opening of bankruptcy proceedings in the *Official Gazette of the Republic of Serbia*.[84] Considering the deadlines provided by the special regime related to the examination of claims and the role of the Deposit Insurance Agency in this process, it can be concluded that the legal provisions regarding the dynamics of the bankruptcy procedure cannot significantly affect its duration, nor be a reason for a longer duration of bankruptcy proceedings against an insurance company compared to bankruptcy proceedings conducted under the general legal regime.

Finally, the Law provides that avoidance proceedings may be commenced by the Agency regarding the debtor's legal acts which are preferential to certain creditors. This concerns transactions and other legal acts carried out within six months from the day of the occurrence of legal consequences of the initiation of bankruptcy proceedings, or within one year if these legal acts were conducted with

[77] See BL, Article 27, Paragraph 1, Item 3.
[78] The guidelines for preparing the quarterly report on the status of the bankruptcy/liquidation estate and the progress of the proceedings are available on the Deposit Insurance Agency's website: *www.aod.rs*, 17. 7. 2024.
[79] See LBLBIC, Article 17, Paragraph 1.
[80] See LBLBIC, Article 7.
[81] See LBLBIC, Article 17, Paragraph 2.
[82] See BL, Article 113, Paragraph 4.
[83] See BL, Article 72, Paragraph 2.
[84] See BL, Article 70, Paragraph 1, Item 5.

related parties as defined by the Insurance Law.[85] In this case, it does not involve specific powers of the Agency, as bankruptcy administrators can commence avoidance proceedings regarding the debtor's legal acts under general rules if the conditions specified by law are met.

Regarding the differences between the powers of bankruptcy administrators under the general and special regimes, it is significant to note that the Deposit Insurance Agency does not have certain powers that bankruptcy administrators have under the general legal regime of bankruptcy. These differences arise from the fact that certain rules apply only if the bankruptcy procedure is conducted under the general legal regime. For example, the Agency does not have powers related to reorganization, as insolvency proceedings of an insurance company cannot be conducted in that manner.

It can be concluded that the existing legal framework regarding the powers of the Deposit Insurance Agency could be slightly improved by clarifying certain provisions (for example, those related to covering bankruptcy procedure costs), but that the rules are well grounded. Similarly, it is clear that minor differences in terms of the deadlines for conducting actions between the general and special legal regimes cannot lead to significant delays in bankruptcy proceedings against an insurance company.

VI Conclusion

In Serbia, the bankruptcy proceedings for insurance companies are regulated by the Law on Bankruptcy and Liquidation of Banks and Insurance Companies, with certain rules also found in other regulations. The existence of a special bankruptcy regime for insurance companies is generally considered justified. Therefore, it is common in comparative law as well. In our law, the special bankruptcy regime applies not only to insurance companies but also to reinsurance companies. However, it does not apply to companies engaged in insurance brokerage and agency activities.

Although the legislator made an oversight by not mentioning reinsurance companies in the Law on Bankruptcy and Liquidation of Banks and Insurance Companies as subjects of bankruptcy, an interpretation of the Insurance Law and the Bankruptcy Law leads to the conclusion that the special legal regime of bankruptcy also applies to them. For the sake of precision, the Law on Bankruptcy and Liquidation of Banks and Insurance Companies should clearly state that it applies to these companies as well. Additionally, the term "insurance organizations" used in the Bankruptcy Law should be replaced with the terms insurance companies and reinsurance companies, thereby eliminating any ambiguities regarding the designation of entities subject to the special bankruptcy regime.

[85] See LBLBIC, Article 14, Paragraphs 1, 2, and 4.

The problems related to the bankruptcy of insurance companies are not only tied to the determination of the bankruptcy debtor. Statistical data regarding the implementation of bankruptcy proceedings over insurance companies indicate that these proceedings are not conducted in accordance with the principle of urgency, which is one of the key principles of bankruptcy according to general legal rules. The reasons for the delay of bankruptcy proceedings for insurance companies, which on average last more than twice as long as those conducted under the general legal regime, should be sought in the specificities of the special legal regime. The Law on Bankruptcy and Liquidation of Banks and Insurance Companies specifies which provisions of the Bankruptcy Law do not apply in bankruptcy proceedings involving insurance companies. Namely, certain rules are not applicable due to the specific nature of the entities undergoing bankruptcy proceedings, as well as due to the role of the National Bank of Serbia, which supervises the operations of insurance companies.

One of the key differences between the general and special bankruptcy regimes concerns the function of the bankruptcy administrator. Since this function in bankruptcy proceedings over insurance companies is performed by the Deposit Insurance Agency, the commissioners of the Agency who carry out this work must have the knowledge necessary for the proper execution of their duties. They should undergo appropriate training and pass a professional exam. If the legislator were to change the approach and opt for licensed bankruptcy administrators to perform this role, inclusion on a special list or lists related to special bankruptcy proceedings should require thorough knowledge of the relevant field or fields if they do not have prior experience. On the other hand, obtaining a license as a bankruptcy administrator should not require detailed knowledge of special bankruptcy proceedings but only basic or potentially good knowledge.

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SUBROGACIJSKI ZAHTJEVI INOZEMNIH NOSILACA SOCIJALNOG OSIGURANJA PREMA DOMAĆIM OSIGURATELJIMA OD AUTOODGOVORNOSTI

ORIGINALNI NAUČNI RAD

Apstrakt

U ekonomski snažnijim zemljama Europe uspostavljeni su kvalitetni mehanizmi socijalnog osiguranja koji, u slučaju tjelesnih povreda ili smrti u prekograničnim saobraćajnim nezgodama, njihovim osiguranicima omogućavaju različite vrste naknada u cilju bržeg oporavka i lakšeg snošenja posljedica nemilih događaja. Po isplati naknada, inozemni nosioci zdravstvenog i penzionog osiguranja potražuju refundaciju isplaćenih davanja putem instituta zakonske subrogacije prema domaćem društvu za osiguranje kod kojega je zaključen ugovor o obaveznom osiguranju od odgovornosti štetnika za štete pričinjene trećim osobama. S obzirom na to da se radi o zahtjevima s međunarodnim elementom, u radu će se najprije analizirati mjerodavno pravo za aktivnu legitimaciju i utvrđivanje sadržaja prava inozemnog nosioca. Imajući u vidu da je obim obaveze osiguratelja od autoodgovornosti definiran ugovorom o osiguranju zaključenom u skladu s odredbama Zakona o obaveznim osiguranjima u saobraćaju, dat će se odgovor na pitanje ima li inozemni nosilac socijalnog osiguranja pravo na potpunu naknadu isplaćenih iznosa u skladu s propisima države svoga sjedišta ili u granicama ugovora o osiguranju od autoodgovornosti štetnika.

Ključne riječi: *subrogacija, zdravstveno osiguranje, penziono osiguranje, inozemni nosilac, osiguranje od autoodgovornosti*

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I Pojam subrogacije u osiguranju

Kad osigurani slučaj kod imovinskih osiguranja nastane uslijed građanskopravne vanugovorne odgovornosti štetnika, osiguranik ima pravo potraživati naknadu štete po dva osnova: od štetnika prema pravilima o građanskopravnoj vanugovornoj odgovornosti ili od osiguratelja po osnovu sklopljenog ugovora o osiguranju (ugovorna odgovornost). Zabrana kumuliranja zahtjeva znači da osiguranik ne može istovremeno ostvarivati prava po obadva osnova u punom iznosu, odnosno da ne može iz obaju osnova dobiti više nego što iznosi šteta koju je pretrpio.[2] Iz toga proizlazi jedna od temeljnih karakteristika imovinskih osiguranja, a to je primjena odštetnog načela (načela obeštećenja) po kojem naknadu štete može ostvariti samo osoba koja zbog nastanka osiguranog slučaja trpi materijalni gubitak i po kojem ta osoba ne može ostvariti veći iznos naknade iz osiguranja od iznosa štete koju je pretrpjela ostvarenjem osiguranog slučaja.

Međutim, to ne znači da ispunjenjem obaveze osiguratelja iz ugovora o osiguranju štetnik ostaje neodgovoran. Naprotiv, uspostavljanjem **prava subrogacije osiguratelja** onemogućava se izbjegavanje odgovornosti štetnika za prouzročenu štetu.[3] Subrogacija u osiguranju je utemeljena na zakonu, što podrazumijeva da nastupa *ex lege* isplatom naknade iz osiguranja i predstavlja prijelaz prava osiguranika prema osobi koja je po bilo kojem osnovu odgovorna za štetu, do visine isplaćene štete.[4] Budući da radi o prijelazu, a ne o stjecanju vlastitog prava, pravo subrogacije osiguratelja smatra se izvedenim pravom prema osobi odgovornoj za štetu. Postoje dvije pretpostavke za nastanak zakonske subrogacije osiguratelja. Prva je da je isplaćena naknada iz osiguranja osiguraniku ili oštećenoj osobi, pri čemu osiguratelj snosi teret dokaza da je isplata izvršena.[5] Druga pretpostavka je da postoji pravo osiguranika na naknadu štete od osobe odgovorne za štetu. Svrha te pretpostavke je da odgovorna osoba treba snositi teret naknade štete koju je osiguraniku prouzročila.

Budući da personalna subrogacija u obligacionom odnosu podrazumijeva zamjenu jednog vjerovnika drugim, na osiguratelja kao vjerovnika mogu prijeći

[2] Nataša Petrović Tomić, *Osnovi prava osiguranja*, 1. izdanje, Beograd, 2021, str. 192.

[3] Berislav Matijević, „Pravo subrogacije osiguratelja", *Zbornik XXV Međunarodne naučne konferencije „Prouzrokovanje štete, naknada štete i osiguranje" (ur. Zdravko Petrović i dr.),* Beograd – Valjevo, 2022, str. 387.

[4] Zakon o obligacionim odnosima – ZOO, *Sl. list RBiH,* br. 2/92, 13/93, 13/94; *Službene novine FBiH,* br. 29/03; *Sl. glasnik RS*, br. 17/93, 3/96, 39/03 i 74/04, čl. 939.

[5] U presudi Kantonalnog suda u Mostaru br. 58 0 Mals 194895 20 Pž odbijen je tužbeni zahtjev kasko osiguratelja protiv osiguratelja od autoodgovornosti zbog toga što nije dokazao valjanost i zakonitost prijelaza prava prema odgovornom osiguratelju. Prema obrazloženju suda, kasko osiguratelj nije dostavio dokaz o plaćenoj premiji kasko osiguranja. Naime, kao dokaz aktivne legitimacije priložen je ispis police kasko osiguranja iz baze podataka kasko osiguratelja. Na polici su sadržane informacije o ugovaratelju, osiguraniku i osiguratelju, predmet osiguranja (vozilo s naznačenom markom i tipom i brojem šasije) zatim osigurani rizici, period pokrića i iznos premije. Navedeno je da je premija plaćena u cijelosti prilikom ugovaranja police, međutim po stavu suda aktivna legitimacija nije dokazana.

samo ona prava koja osiguranik ima prema odgovornoj osobi ili njegovom osiguratelju od odgovornosti.[6] Isplatom naknade iz osiguranja prelaze na osiguratelja sva osiguranikova prava prema osobi koja je po bilo kojoj osnovi odgovorna za štetu (zakonska subrogacija), po zakonu do visine isplaćene naknade, a slijedom čega je potrebno utvrditi je li osiguranik odgovoran za nastanak štetnog događaja i štetu koju je njime pretrpio oštećenik.[7]

Kratko ćemo se podsjetiti na to da ZOO prihvaća dualističku koncepciju podjele ugovora o osiguranju prema predmetu osiguranja na osiguranje imovine (u koje spada i osiguranje od odgovornosti) i osiguranje osoba. Obaveza osiguratelja kod osiguranja imovine jest naknada štete po pravilima odštetnog prava i uz primjenu ranije spomenutog odštetnog načela. Nasuprot tome, kod osiguranja osoba činidba osiguratelja sastoji se u isplati unaprijed ugovorene osigurane svote koja nema karakter naknade štete, te je kumulacija zahtjeva dozvoljena. Iz toga slijedi kogentna zakonska odredba da kod osiguranja osoba subrogacija nije dozvoljena,[8] tako da su ranije izložena pravila o zakonskoj subrogaciji predviđena samo za imovinska osiguranja. Upravo je sadržaj prava osiguranika po ugovoru o osiguranju imovine i osoba, kao i zabrana subrogacije kod osiguranja osoba značajan za definiranje sadržaja obaveze osiguratelja od autoodgovornosti kod subrogacijskih zahtjeva inozemnih ustanova socijalnog osiguranja, o čemu se govori u nastavku rada.

II Subrogacijski zahtjevi inozemnih nositelja socijalnog osiguranja

Prelazak državne granice u poslovne, turističke i druge svrhe je svakodnevica za sve veći broj osoba. Osim toga, migracije stanovništva regije Zapadnog Balkana iz ekonomskih i/ili političkih razloga također su utjecale na porast prekograničnog cestovnog saobraćaja, što posljedično dovodi do sve većeg broja saobraćajnih nezgoda u kojima učestvuju vozači i putnici iz različitih država. Pitanje subrogacije u osiguranju posebno izaziva nedoumice kad se na strani vjerovnika pojavljuje ustanova socijalnog osiguranja sa sjedištem u jednoj državi, a potražuje refundaciju isplaćenih davanja nastalih kao posljedica saobraćajne nezgode nastale u drugoj državi. Takvi zahtjevi, vidimo, u sebi sadrže inozemni element, te se kod utvrđivanja obaveze subrogacijskog dužnika – najčešće osiguratelja od autoodgovornosti - postavlja pitanje određivanja mjerodavnog prava za utvrđivanje postojanja obaveze i obima te obaveze.[9]

[6] Nataša Petrović Tomić, *Pravo osiguranja – Sistem*, Knjiga I, Beograd, 2019, str. 485.

[7] Jadranka Nižić Peroš, „Personalna subrogacija u odnosu prema pravu regresa osiguratelja i ustupanju tražbine – cesiji", *Oeconomica Jadertina*, br. 1/2021, str. 81.

[8] ZOO, čl. 948.

[9] Sve veći broj saobraćajnih nezgoda u kojima učestvuju vozači i putnici iz različitih država dovodi i do sve većeg broja sudskih sporova. O značaju vansudskog postupka za naknadu štete kod obveznog

Oštećene osobe s prebivalištem ili uobičajenim boravištem u nekoj od razvijenih europskih zemalja, ili u slučaju smrti njihovi srodnici, ostvaruju različite benefite koje im isplaćuju inozemni nosioci penzionog i zdravstvenog osiguranja kojima uplaćuju obavezne doprinose. U praksi osiguravajućih društava u BiH i regiji subrogacijski zahtjevi takvih ustanova se pojavljuju često, u pravilu su izrazito visoki, a ponekad sadrže različite vrste potraživanja koja naše zakonodavstvo ne poznaje.[10]

Na primjer, austrijski nosioci zdravstvenog osiguranja isplaćuju svojim osiguranicima tzv. *„Krankengeld"* (naknadu za lječenje) u dnevnim iznosima za vrijeme procijenjenog trajanja liječenja uslijed povreda nastalih u saobraćajnoj nezgodi. Prema austrijskom Zakonu o socijalnom osiguranju, ako osobe kojima pripadaju davanja imaju prava da naknadu štete nastale osiguranim slučajem ostvaruju na osnovu drugih zakonskih propisa, pravo na naknadu prelazi na nosioca osiguranja u onoj mjeri u kojoj je ovaj dužan da pruži davanja.[11] Međutim, u tom slučaju se ne radi o refundaciji stvarnih troškova medicinskih usluga i lijekova po računima izdatim od strane zdravstvenih ustanova, već o paušalnim davanjima na ime liječenja. Navedenu vrstu naknade ne poznaje domaće zakonodavstvo, te se davanje paušalnih dnevnih iznosa na ime *„Krankengelda"* ne može smatrati stvarnom štetom na koju oštećeni ima pravo u smislu odredaba Zakona o obligacionim odnosima[12] i Zakona o obaveznim osiguranjima u prometu FBiH.[13] Nesporno je da je to vid naknade koju priznaje austrijski pravni sistem svojim građanima kao vid kompenzacije za ublažavanje tegoba proisteklih uslijed povrjeđivanja, ali navedena davanja nemaju odštetni karakter već predstavljaju socijalna prava osiguranika obaveznog osiguranja u Austriji.

Pošto u Bosni i Hercegovini žrtve saobraćajne nezgode nemaju pravo na *„Krankengeld"* prema domaćim propisima, pa samim tim ni domaće ustanove zdravstvenog i socijalnog osiguranja ne mogu potraživati regres isplaćenih takvih davanja, zapitat ćemo se može li se to isto pravo priznati inozemnim ustanovama. Ako može, jesu li te ustanove privilegirane u odnosu na domaće ustanove koje pružaju obavezno osiguranje utemeljeno na načelima međugeneracijske solidarnosti?

Drugi veoma čest primjer koji izaziva nedoumice u praksi osiguravajućih društava i sudova predstavljaju subrogacijski zahtjevi nositelja njemačkog penzionog

osiguranja od autoodgovornosti vidi: Slobodan Ilijić, „Vansudski postupak za naknadu štete u obaveznom auto-osiguranju", *Tokovi osiguranja*, br. 2/2012, str. 39-56.

[10] Dino Torlak, „Mjerodavno pravo za rješavanje zahtjeva za naknadu štete iz saobraćajnih nezgoda s posebnim osvrtom na subrogaciju", *Anali Pravnog fakulteta u Zenici*, br. 20, god. 10, str. 195.

[11] Vidi Josef Schörghuber, „Pravo regresa nosilaca socijalnog osiguranja nakon saobraćajne nezgode prema osiguravaču obaveznog osiguranja odgovornosti, s posebnim osvrtom na austrijsko pravo", *Revija za pravo osiguranja*, Beograd, br. 3, 2007, str. 3.

[12] ZOO, čl. 195.

[13] Zakon o obaveznim osiguranjima u saobraćaju FBiH - ZOOS, *Službene novine FBiH,* br. 57/2020 sadrži Okvirne kriterije za utvrđivanje odštete u slučaju povrede fizičkog ili psihičkog integriteta, odnosno smrti (u daljem tekstu: Kriterijumi). U Kriterijima su utvrđena pravila za određivanje visine naknade materijalne i nematerijalne štete po pojedinim vidovima.

osiguranja koji plaćaju tzv. udovičke rente, odnosno penzije udovicama i djeci smrtno stradalih osiguranika u saobraćajnim nezgodama u drugim državama.[14] Kad je takav zahtjev postavljen osiguratelju od autoodgovornosti štetnika, postavlja se pitanje je li osiguratelj dužan podmiriti isti u cijelosti ili u granicama preuzetim ugovorom o osiguranju.

III Određivanje mjerodavnog prava za subrogacijske zahtjeve inozemnih nositelja socijalnog osiguranja

Sudska praksa u Bosni i Hercegovini, Srbiji i Hrvatskoj je raznolika i kreće se od potpunog priznavanja do potpunog odbijanja tužbenih zahtjeva inozemnih ustanova prema domaćim osiguratelјima od autoodgovornosti. U nauci također ne postoji jedinstven stav o pravnoj prirodi obligacionog odnosa između inozemne ustanove socijalnog osiguranja i štetnika, odnosno njegovog osiguratelja od autoodgovornosti. Neki autori su stava da se odgovornost štetnika u takvim slučajevima promatra kao ugovorna odgovornost, što bi značilo da je za utvrđivanje obaveze kod subrogacijskog zahtjeva ustanove socijalnog osiguranja mjerodavan ugovorni statut, odnosno pravo države u kojoj je socijalno osiguranje zasnovano.[15]

Kritika ovome stavu može se uputiti zbog toga što između ustanove socijalnog osiguranja i štetnika, kao i osiguravajućeg društva kod kojeg je osigurana odgovornost štetnika, ne postoji nikakav raniji ugovor, pa stoga zaključujemo da primjena mjerodavnog prava za ugovor nije opravdana. Argument kojim se može potkrijepiti ta tvrdnja jest i to da pravo na subrogaciju nije izvorno već izvedeno pravo, koje ustanova socijalnog osiguranja stječe nakon što isplati naknadu svome osiguraniku. Nosilac socijalnog osiguranja po isplati naknade svom osiguraniku ima pravo na direktan zahtjev protiv osobe koja je odgovorna za štetu i taj zahtjev ne proizlazi direktno iz njegovog odnosa sa štetnikom, već se radi o pravu koje je izvedeno iz prava njegovog osiguranika prema odgovornoj osobi.[16] To podrazumi-

[14] Denis Lauc, „Regresni zahtjevi njemačkih nositelja socijalnog osiguranja", *Anali Pravnog fakulteta u Zenici*, br. 17, 2016, 385-397, str. 386.

[15] Starija sudska praksa u Republici Srbiji podržava takav stav. Na primjer, u Presudi Vrhovnog suda Srbije u sporu po tužbi njemačkog socijalnog osiguranja, utvrđeno je da su privredni sudovi pravilno primijenili materijalno pravo kada su visinu štete koja se sastoji od isplaćenih naknada za liječenje, bolovanje, hranarine, prijevoz, rente (privremene penzije) i druga davanja iz socijalnog, zdravstvenog i penzijskog osiguranja utvrdili prema iznosu stvarno isplaćenih troškova prema propisima SR Njemačke u kojoj je vršena isplata. Ovo sa razloga što štetu za tužioca predstavlja sve ono što je on morao da isplati svom osiguraniku prema propisima svoje zemlje. Otuda je pravilno stanovište nižestepenih sudova kada su utvrdili da tužioci imaju pravo na visinu one štete koju su isplatili osiguraniku po propisima SR Nemačke, jer osiguranik ostvaruje prava iz zdravstvenog i penzijskog osiguranja po propisima zemlje u kojoj je radio. Dakle, osiguraniku tužioca pripadaju sva prava koja mu priznaju propisi SR Nemačke, bez obzira da li ta prava postoje po jugoslavenskim propisima. Vidi: Presuda Prev. 28/94 od 28. 6. 1995. godine, Sudska praksa privrednih sudova br. 1/1996, str. 109., citirano prema Petar Đundić, „Regresna potraživanja stranih fondova socijalnog osiguranja i neka pitanja međunarodnog privatnog prava", *Zbornik Pravnog fakulteta u Novom Sadu*, 2007, vol. 41, br. 1-2, str. 315

[16] Predrag Šulejić, *Pravo osiguranja*, Novi Sad, 4. izdanje, 1997, str. 319.

jeva da je za oba zahtjeva, odnosno zahtjeva direktnog oštećenika, tj. osiguranika inozemne ustanove socijalnog osiguranja za naknadu štete prema osiguratelju od autoodgovornosti, kao i subrogacijskog zahtjeva koji postavi ta ustanova, osnov potraživanja isti, a sastoji se u građanskopravnoj izvanugovornoj odgovornosti štetnika, odnosno njegovog osiguratelja. Dakle, mjerodavno pravo po kojem se utvrđuje obaveza štetnika jest pravo na koje ukazuje koliziona norma za građanski delikt i bilo bi protivno javnom poretku da se za više zahtjeva proisteklih iz istog građanskopravnog odnosa primjenjuje različito pravo.

1. Mjesto nastanka štete kod saobraćajne nezgode

Za utvrđivanje mjerodavnog prava za naknadu štete iz saobraćajne nezgode osnovni propis jest Haška konvencija o mjerodavnom pravu za saobraćajne nezgode[17] koju su u svoje pravne poretke preuzele sve države nastale raspadom Jugoslavije. Međutim, iz polja primjene *rationae materiae* ove Konvencije isključeni su regresni (subrogacijski) zahtjevi.[18] Stoga se mjerodavno pravo za subrogacijske zahtjeve treba utvrđivati primjenom domaćeg propisa iz oblasti međunarodnog privatnog prava, a to je u Bosni i Hercegovini Zakon o rješavanju sukoba zakona s propisima drugih zemalja[19] koji za izvanugovornu odgovornost za štetu propisuje primjenu prava mjesta gdje je izvršena štetna radnja ili gdje je nastupila štetna posljedica, ovisno o tome što je povoljnije za oštećenika.[20]

Iako subrogacijski zahtjevi ne potpadaju pod odredbe Haške konvencije, haška konvencija može poslužiti za tumačenje pojma mjesta nastanka štete kod saobraćajne nezgode s inozemnim elementom. Naime, prilikom utvrđivanja temeljnog pravila Haške konvencije *lex loci delicti commissi*, donosioci Haške konvencije su istaknuli glavnu prednost primjene poveznice mjesta nastanka nezgode, a to je da određivanje mjesta nastanka saobraćajne nezgode rijetko izaziva poteškoće i nesporazume. Mjesto štetne radnje je gotovo uvijek i mjesto gdje je posljedica nastupila, te samo u iznimnim slučajevima ova dva mjesta se razlikuju (npr. nezgode koje se dogode na graničnom području, tj. cesti ili drugoj javnoj površini koja pripada dvjema državama).[21]

[17] Konvencija o mjerodavnom pravu za saobraćajne nezgode - Haška konvencija, *Službeni list SFRJ* dodatak broj: 26/1976. Ova konvencija je doneta 1971. godine, stupila snagu 03.06.1975. godine, a BiH je postala članica ove konvencije temeljem sukcesije.

[18] Haška konvencija, čl. 2.

[19] Zakon o rješavanju sukoba zakona sa propisima drugih zemalja - ZRSZ, *Sl.list SFRJ*, br. 43/082 i 72/82 – 1645, *Sl. list RBiH*, br. 2/92-5,13/94-189. Isti propis je još uvijek na snazi i u Srbiji, *Sl. list SRJ* 46/96, *Sl. glasnik RS* , br. 46/2006.

[20] ZRSZ, čl. 28.

[21] Essén, Eric W., *Rapport explicatif*, u: Conférence de la Haye de droit international privé, Actes et documents de la onzième session, 7 au 26 Octobre 1968, Tome III, Accidents de la circulation routière (Eksplanatorno izvješće Haške konvencije), str. 14.

ZRSZ ne sadrži posebno koliziono pravilo za subrogacijske zahtjeve, te bi se, u nedostatku izričite odredbe, trebalo primjeniti pravo koje je mjerodavno za osnovnu obavezu, upravo iz razloga što subrogacija nastaje kad kada osiguratelj isplati naknadu svom osiguraniku i tad na njega prelaze, do visine isplaćenog iznosa, sva osiguranikova prava prema licu koje je odgovorno za štetu.[22]

Iz svega navedenog proizlazi da je mjerodavno pravo za subrogacijske zahtjeve inozemnih ustanova socijalnog osiguranja prema osiguratelju od autoodgovornosti pravo mjesta nastanka saobraćajne nezgode. U prilog tome idu i novija shvaćanja Suda EU pri tumačenju Uredbe Rim II o mjerodavnom pravu za izvanugovorne obaveze u pogledu odredaba o mjerodavnom pravu za subrogacijske zahtjeve.[23] Radilo se o zahtjevu za prethodno odlučivanje u sporu koji je vođen pred francuskim sudom između Garantnog fonda Francuske, koji je isplatio naknadu oštećeniku iz nezgode prouzročene upotrebom brodice na motorni pogon u Portugalu, i portugalskog osiguratelja od odgovornosti. Sud je utvrdio da pravo koje je mjerodavno za tužbu treće osobe na koju su subrogirana prava oštećenika protiv počinitelja štete i koje određuje, između ostalog, pravila o zastari, **u načelu pravo države u kojoj je ta šteta nastala**. Dakle, iako je Garantni fond insistirao na primjeni francuskog prava kao mjerodavnog, Sud je iznio stav da bi takvo tumačenje imalo za posljedicu to da bi dužnik, zbog toga što je protiv njega tužbu podnijela subrogirana treća osoba, a ne oštećenik, bio stavljen u drugi položaj, koji je, ovisno o slučaju, manje povoljan od položaja u kojem bi se nalazio da taj vjerovnik ostvaruje svoja prava osobno i direktno protiv njega.[24]

2. Međunarodni ugovori - sporazumi o socijalnom osiguranju i pitanje subrogacije

Zahvaljujući intenzivnim migracijama stanovništva šezdesetih i sedamdesetih godina prošlog stoljeća, u bivšoj Jugoslaviji zaključeni su dvostrani međunarodni ugovori o socijalnom osiguranju s velikim brojem država Europe i svijeta, kao instrumenti koordinacije koji omogućavaju usklađenu primjenu nacionalnih zakonodavstava država ugovornica u oblasti socijalnog osiguranja. Dio tih ugovora je preuzet sukcesijom u pravne poretke novonastalih država, a neke su iste države zaključile nakon svoga osamostaljenja.[25] Inozemne ustanove socijalnih osiguranja

[22] Jasmina Alihodžić, Anita Duraković, „Assessment of Damage and Recourse Actions in 1971 Hague Convention, Rome II Regulation and Bosnian PIL Act: What is Wrong with Respective Case Law in Bosnia and Herzegovina?" *South East European Law Journal*, Vol. 1, No. 2 (2014), str. 75.

[23] Uredba (EZ) br. 864/2007 Europskog parlamenta i Vijeća od 11. srpnja 2007. o pravu koje se primjenjuje na izvanugovorne obveze („Rim II"), *Službeni list Europske unije*, L 199/40, 2007.

[24] Sud pravde Europske unije, Presuda u predmetu C-264/22, *Fonds de Garantie des Victimes des Actes de Terrorisme et d'Autres Infractions (FGTI) v. Victoria Seguros*, ECLI:EU:C:2023:417, *https://eur-lex.europa.eu/legal-content/HR/TXT/PDF/?uri=CELEX:62022CJ0264*, pristupljeno: 09.07.2024. godine.

[25] Spisak bilateralnih sporazuma o socijalnom osiguranju koje je Bosna i Hercegovina potpisala s drugim državama i koje je preuzela sporazumom o sukcesiji dostupan je na: https://zzofbih.ba/ino-osiguranje /,pristupljeno: 09.07.2024.

se u subrogacijskim zahtjevima upućenim osigurateljima od autoodgovornosti pozivaju na navedene sporazume o socijalnom osiguranju i potražuju refundaciju svih isplaćenih davanja svojim osiguranicima, i to na odredbu kojom je propisano da, *ako osoba koja prema pravnim propisima jedne države ugovornice treba da dobije naknadu za štetu nastalu na području druge države ugovornice, a prema njenim propisima ima pravo na naknadu štete od treće osobe, ovo pravo na naknadu prelazi na nosioca prava države ugovornice prema pravnim propisima koji važe za njega.*[26]

Kao što je ranije istaknuto, sudska praksa u BiH i državama regije nema jedinstven stav o pitanju subrogacije inozemnih ustanova socijalnog osiguranja. Postoje odluke gdje sudovi nosiocima socijalnog osiguranja jedne države ugovornice dosuđuju refundaciju isplaćenih iznosa za štetu nastalu na području druge države ugovornice prema pravnim propisima države nosioca osiguranja, bez obzira na to što se šteta dogodila u drugoj zemlji, tj. bez utvrđivanja mjerodavnog prava. Nažalost, to nije slučaj samo kod subrogacijskih zahtjeva. Naime, unatoč načelnoj imperativnosti kolizionih normi, općenito se ističe problem rasprostranjene pojave u sudskoj praksi da sudije primjenjuju domaće pravo, nastojeći pritom po svaku cijenu izbjeći primjenu stranog prava.[27]

U nekim presudama su iznesena pravna shvaćanja da se sporazumi o socijalnom osiguranju odnose na oblast socijalnog osiguranja, na propise o zdravstvenom i penzionom osiguranju, osiguranju za slučaj povrede na radu i profesionalne bolesti, osiguranju za slučaj nezaposlenosti i na naknadu u vezi materinstva i dodatka na djecu, ali ne i na oblast ugovora o obaveznom osiguranju u saobraćaju. Ranija sudska praksa je po automatizmu dosuđivala stranim ustanovama socijalnog osiguranja refundaciju isplaćenih iznosa u cijelosti, pozivajući se na osnovne odredbe sporazuma o socijalnom osiguranju u kojima je navedeno da se isti odnose na penziono, zdravstveno, invalidsko osiguranje i drugo, a prijelaz prava – subrogaciju su temeljili na domaćem ZOO-u, ne preispitujući odredbe o naknadi štete sadržane u navedenim sporazumima.[28]

Međutim, novija praksa u velikoj mjeri je posvećena problematici utvrđivanja mjerodavnog prava kod ovakvih zahtjeva. U suštini, sudovi polaze od činjenice da su međunarodni sporazumi o socijalnom osiguranju mjerodavni samo za prijelaz

[26] Svi Sporazumi o socijalnom osiguranju imaju sličan tekst. Odredba o naknadi štete propisana je u čl. 33. sporazuma.

[27] Maja Stanivuković, Mirko Živković, *Međunarodno privatno pravo – opšti deo*, VIII izdanje, Beograd, 2023, str. 245.

[28] Presuda Kantonalnog suda u Sarajevu broj: 65 0 Ps 040370 12 Pž od 08.12.2015. godine, potvrđena presudom Vrhovnog suda FBiH broj: 65 0 Ps 040370 16 Rev 21.02.2017. godine. U obrazloženju je navedeno: Članom 2. stav 1. navedenog sporazuma je propisano da se isti odnosi, između ostalog, i na zdravstveno i penzijsko osiguranje. Kako se u konkretnom slučaju radi o regresnom zahtjevu stranog osiguravatelja za iznose isplaćene po osnovu obiteljske mirovine, protiv domaće osiguravajuće organizacije koja odgovara po osnovu obaveznog osiguranja od odgovornosti u prometu (pitanje subrogacije član 939. ZOO), to isplatom naknade iz osiguranja, po samom zakonu, do visine isplaćene naknade, na osiguravača prelaze sva osiguranikova prava prema licu koje je po ma kom osnovu odgovorno za štetu.

prava (subrogaciju), dok se sadržaj prava inozemne ustanove, odnosno obim obaveza osiguratelja od autoodgovornosti utvrđuju primjenom domaćeg prava po načelu *lex loci delicti commissi*.[29] Pritom ne ulaze u pitanje naknade štete definirano citiranom odredbom člana 33. sporazuma o socijalnom osiguranju, već na temelju polja primjene sporazuma *rationae materiae* ustanovljavaju da isti nije primjenjiv na obavezna osiguranja u prometu.

Pojedini sudovi detaljnije analiziraju pitanje mjerodavnog prava, te se referiraju upravo na citiranu odredbu čl. 33. sporazuma o socijalnom osiguranju, a posebno na sintagmu *„a prema njenim propisima ima pravo na naknadu štete od treće osobe."* Jedan takav predmet je subrogacijski spor između njemačke institucije penzionog osiguranja i hrvatskog osiguratelja od autoodgovornosti za isplaćene penzije povodom smrti stradalog osiguranika u nezgodi u Hrvatskoj. Sud je utvrdio da je prema hrvatskim propisima *potrebno utvrditi ima li osoba, koja je primalac benefita iz socijalnog osiguranja u Njemačkoj pravo na naknadu štete od štetnikovog osiguranja od autoodgovornosti*. Pritom sud zaključuje da je sporazum o socijalnom osiguranju mjerodavan samo za prijelaz prava na njemačku ustanovu socijalnog osiguranja, tj. za aktivnu legitimaciju, a za sva ostala pitanja osnovanosti i visine zahtjeva mjerodavni su hrvatski propisi.[30]

Subrogacijsko pravo ustanove socijalnog osiguranja spram osiguratelja od autoodgovornosti u prekograničnoj prometnoj nezgodi bilo je predmet razmatranja i pred Sudom pravde EU u predmetu *Kordel i drugi* u kojem je zauzet stav da je za prijelaz prava (subrogaciju) mjerodavno pravo države u kojoj je ustanova registrirana, ali da se sadržaj prava određuje prema pravu mjesta nastanka nezgode. Također, u predmetnoj presudi definirano je da pravo na subrogaciju nositelja socijalnog osiguranja iz jedne države članice ne može nadmašiti pravo koje ima žrtva u drugoj državi članici u kojoj se nezgoda dogodila.[31]

Možemo se složiti s navedenim mišljenjem jer u odnosu ustanova socijalnog osiguranja – osiguratelj prvenstveno je potrebno utvrditi koja prava ima žrtva nezgode ili njegov bliski srodnik prema mjerodavnom materijalnom pravu, te da se nakon toga ima provjeriti, da li su i u kojoj mjeri ta prava prešla na nositelja socijalnog osiguranja. Iz toga proizlazi da nositelj socijalnog osiguranja ne može ostvariti više prava nego što ih je imala sama žrtva, neposredno ozlijeđeni, odnosno članovi uže obitelji smrtno stradale osobe.[32]

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[29] Presuda Kantonalnog suda u Sarajevu, br. 65 0 Ps 446900 18 Pž od 08.04.2021. godine

[30] Presuda Vrhovnog suda Republike Hrvatske, VSRH Rev x 97/2014-2 od 14.05.2014. Isti stav je zauzet i u Presudi Općinskog suda u Splitu, P-455/09, pravomoćna 25.11.2014. godine, kao i u jednoj novijoj Presudi Visokog trgovačkog suda u Zagrebu br. 11 Pž-2634/2023-2.

[31] Sud pravde Europske unije, Presuda u predmetu C-397/96, *Kordell i dr.,* presuda od 21.09.1999. godine, ECR 1999 p. I-5959, ECLI:EU:C:1999:432, *https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:61996CJ0397*, pristupljeno: 09.07.2024. godine.

[32] J. Schorghuber, str. 23.

3. Uredba 883/2004 o koordinaciji sustava socijalne sigurnosti

Radi ostvarenja slobode kretanja radnika kao jedne od temeljnih sloboda na kojima se zasniva zajedničko tržište Europske unije, bilo je nužno regulirati pravo na starosnu penziju na europskoj razini i na taj način omogućiti radnicima slobodu kretanja i rada u državi čiji nisu državljani.[33] Unatoč regulatornoj autonomiji nacionalnih zakonodavstava, bilo je potrebno uspostaviti pravni okvir koji će omogućiti mobilnom radniku ostvarenje prava na starosnu penziju i druge vidove socijalne zaštite u drugoj državi članici. Pitanja socijalne sigurnosti koja su prethodno bila regulirana međunarodnim sporazumima bilo je potrebno harmonizirati jedinstvenim europskim propisom koji će biti direktno primjenjiv u državama članicama, te je u tu svrhu donešena Uredba 883/2004 o koordinaciji sustava socijalne sigurnosti.[34]

Uredba 883/2004 sadrži pravila koja se odnose na subrogacijska prava ustanova socijalne zaštite, a koja su predmetom različitog tumačenja od strane sudova država članica. Naime, odredba kojom su regulirana prava ustanova predviđa dvije obaveze svih država članica. Prva je da priznaju pravo subrogacije kao izvedeno pravo ustanove koja izvrši plaćanje svom osiguraniku, odnosno da omogući prijelaz prava osiguranika prema odgovornoj osobi na ustanovu koja je izvršila plaćanje na temelju propisa primjenjivih za tu ustanovu. Druga obaveza je da države članice priznaju pravo regresa kao direktno pravo ustanove prema odgovornoj osobi.[35] Citiranom odredbom određeno je samo pravo koje će se koristiti pri ocjeni prijenosa prava s neposrednog oštećenika na nositelja socijalnog osiguranja, a ne i pravo koje je mjerodavno za sadržaj obaveze odgovorne osobe prema nositelju socijalnog osiguranja.

To potvrđuje i Viši sud u Ljubljani u presudi u postupku austrijskog penzionog osiguranja protiv slovenskog osiguravajućeg društva, za isplaćene invalidske naknade i penzije iz saobraćajne nezgode koja se dogodila u Sloveniji. Sud obrazlaže da se u pogledu prijenosa prava s neposrednog oštećenika na nositelja socijalnog osiguranja, primjenjuje se pravo mjesta sjedišta nositelja socijalnog osiguranja, u konkretnom slučaju primjenjuje se austrijsko pravo prema sjedištu tužitelja, dok sadržaj prava i protiv koga ta prava postoje (pasivna stvarna legitimacija) prosuđuje prema slovenskom pravu. Opseg naknada koje je tuženik kao odgovorno osiguravajuće društvo dužan podmiriti određen je Zakonom o obaveznim osiguranjima u saobraćaju koji je *lex specialis* u odnosu na Zakone o mirovinskom i invalidskom osiguranju.[36]

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[33] Tomislav Sokol, „Pravo na starosnu mirovinu mobilnih radnika temeljem Uredbe o koordinaciji sustava socijalne sigurnosti Europske unije", *Europske studije*, 2015, broj 1, str. 86.

[34] Uredba (EZ) br. 883/2004 Europskog parlamenta i Vijeća od 29. travnja 2004. 883/2004 o koordinaciji sustava socijalne sigurnosti – Uredba 883/2004, Službeni list Europske unije, SL L 166, 30.4.2004, p. 1–123. Uredba zamjenjuje sve konvencije o socijalnoj sigurnosti koje se primjenjuju među državama članicama i koje se odnose na isto područje primjene (čl. 8. st. 1. Uredbe 883/2004).

[35] Uredba 883/2004, čl. 85. st. 1.

[36] Presuda Višeg suda u Ljubljani, br. VSL I Cpg 533/2017 od 22.11.2018. godine

Iz izložene analize kolizionopravnih propisa za subrogacijske zahtjeve, kao i brojnih primjera iz novije sudske prakse domaćih sudova i Suda EU, ponovno apostrofiramo da međunarodni sporazumi o socijalnom osiguranju, kao i Uredba 883/2004, omogućavaju prijelaz prava s direktnog oštećenika na nositelja socijalnog osiguranja i obavezuju države članice da međusobno priznaju subrogacijske zahtjeve, ali navedeni akti ne sadrže odredbe o sadržaju obaveze štetnika, odnosno njegovog osiguratelja od odgovornosti koji je najčešći obaveznik plaćanja takvih zahtjeva. Utvrđivanje postojanja obaveze i visine obaveze osiguratelja na temelju zaključenog ugovora o osiguranju za štete nastale upotrebom motornog vozila vrši se primjenom odgovarajućeg zakona o obaveznim osiguranjima u saobraćaju.[37] Sud EU je također dosljedan u pogledu tumačenja da su države članice slobodne u svojim propisima regulirati pravila i kriterije za naknadu štete nastale upotrebom motornog vozila različite od onih koji se primjenjuju na ostale izvanugovorne odnose naknade štete,[38] te da direktive iz oblasti osiguranja od autoodgovornosti nalažu da građanskopravna odgovornost za štetu pričinjenu trećim osobama treba biti pokrivena obaveznim osiguranjem, ali obim naknade štete je predmet regulacije nacionalnog zakonodavstva. Stoga su države članice slobodne samostalno urediti svoj sistem odgovornosti koji se primjenjuje na naknadu štete nastale upotrebom motornog vozila.[39]

IV Utvrđivanje obima naknade kod subrogacijskih zahtjeva nositelja inozemnih socijalnih osiguranja primjenom prava mjesta nastanka nezgode

Kod subrogacijskih zahtjeva inozemnih nosilaca penzionog i zdravstvenog osiguranja prema domaćim osiguratelјima od autoodgovornosti, s obzirom na to da se radi o pravnom odnosu s inozemnim elementom gdje koliziona odredba upućuje na primjenu prava mjesta nastanka nezgode, postavlja se pitanje po kojem domaćem propisu se utvrđuje obaveza, odnosno obim prava takvih ustanova. Analizom međunarodnih sporazuma o socijalnom osiguranju utvrdili smo da isti propisuju mogućnost podnošenja subrogacijskog zahtjeva inozemnom nosiocu spram domaćeg

[37] Više o tome: Loris Belanić, „Redefiniranje obveze osiguratelja od automobilske odgovornosti s obzirom na upotrebu vozila u kontekstu prakse Suda EU", *Godišnjak Akademije pravnih znanosti Hrvatske*, vol. XII, 1/2021, str. 346. Jasmina Đokić, „Kriteriji za odmjeravanje naknade nematerijalne štete nastale upotrebom motornog vozila u praksi Suda EU i Ustavnog suda BiH", *Zbornik 34. Susreta osiguravača i reosiguravača*, Sarajevo, 2023, str. 118.

[38] Sud pravde Europske unije, Presuda u predmetu C-577/21, LM and NO v HUK-COBURG-Allgemeine Versicherung AG, ECLI:EU:C:2022:992, *https://eur-lex.europa.eu/legal-content/HR/TXT/PDF/?uri=CELEX:62021CJ0577*, pristupljeno: 09.07.2024. godine.

[39] Sud pravde Europske unije, Presuda u predmetu C- 371/12 *Petillo v. Unipol SAI*, ECLI:EU:C:2014:26, *https://curia.europa.eu/juris/document/document.jsf?text=&docid=146690&pageIndex=0&doclang=en&mode=lst&dir=&occ=first&part=1&cid=113289*, pristupljeno: 09.07.2024. godine.

štetnika, odnosno njegovog osiguratelja od građanskopravne odgovornosti. U nastavku ćemo vidjeti da je obim prava inozemnih nosilaca osiguranja područje koje uopće nije normirano našim zakonodavstvom, što znači da se radi o pravnoj praznini. U teoriji prava zastupljen je stav da je pravna praznina područje koje zakonodavac, iz određenih razloga,[40] nije regulirao. Za popunjavanje pravnih praznina koristi se više sredstava, a osnovni način je tumačenje putem **analogije**, što podrazumijeva da se na konkretan slučaj primjeni pravna norma predviđena za drugi slučaj koji je njim sličan i to baš zbog te sličnosti.[41] Analizirat ćemo na koji način nam analogno tumačenje može pomoći pri rješavanju subrogacijskih zahtjeva inozemnih nosilaca zdravstvenog i socijalnog osiguranja.

1. Subrogacijski zahtjevi ustanova zdravstvenog osiguranja

Kao što je već rečeno, opseg osiguravajućeg pokrića po ugovoru o obaveznom osiguranju od autoodgovornosti reguliran je odredbama Zakona o obaveznim osiguranjima u saobraćaju. U Federaciji BiH propisana je obaveza osiguratelja na nadoknadu stvarne štete nadležnom Zavodu zdravstvenog osiguranja,[42] a u Republici Srpskoj to pravo pripada Fondu zdravstvenog osiguranja RS.[43] Primjećujemo da obadva entitetska zakona koriste pogrešan termin „regresni zahtjev" iako se radi o subrogacijskom zahtjevu. Razlika nije samo terminološka već sadržajna.[44] Naime, iako se u osiguranjnoj terminologiji regresni zahtjev poistovjećuje sa subrogacijskim, u nauci je načelno zauzet stav da regres u osiguranju predstavlja izvorno pravo osiguratelja prema svom osiguraniku čiju građanskopravnu odgovornost pokriva, ukoliko je upravljao vozilom u nekim okolnostima (npr. pod utjecajem alkohola u nedozvoljenoj koncentraciji i sl.) zbog kojih osiguratelj ima pravo na djelimičan ili potpun povrat isplaćenog iznosa naknade štete. [45]

[40] Nikola Visković, *Država i pravo*, Zagreb, 1997, str. 218-220. Prof. Visković navodi dva osnovna uzroka pojave pravnih praznina: prvo, kad normotvorci novog pravnog poretka nakon prevrata, revolucije i slično ne stvore odmah pravne norme umjesto onih koje su ukinute, tako da neki odnosi ostanu neregulirani, a drugi uzrok je pojava društveno važnih konfliktnih odnosa koje zakonodavac kao takve nije prepoznao i nije ih na vrijeme regulirao.)

[41] Hrvoje Kačer, Blanka Ivančić Kačer, „O rješavanju antinomija i pravnih praznina (posebno) na primjeru odnosa Zakona o sportu i Zakona o obveznim odnosima" *Zbornik radova Pravnog fakulteta u Splitu*, god. 54, 2/2017, str. 410.

[42] U Federaciji BiH područje zdravstvenog osiguranja i zdravstvene zaštite provodi se na nivou deset kantona. Okvirni propis je Zakon o zdravstvenom osiguranju FBiH, *Službene novine FBiH,* br. 30/1997, 7/2002, 70/2008, 48/2011, 100/2014 - odluka US, 36/2018 i 61/2022, te isti propisuje obavezu osnivanja Zavoda zdravstvenog osiguranja u svakom kantonu u cilju ostvarenja prava i obezbjeđenja sredstava iz obaveznog zdravstvenog osiguranja.

[43] Zakon o obaveznim osiguranjima u saobraćaju Republike Srpske, *Sl. glasnik RS*, br. 82/15, 78/20, 1/24, čl. 31.

[44] O razlici između subrogacionog i regresnog zahtjeva vidi: Predrag Šulejić, „Subrogacija i regres u zakonu i sudskoj praksi pravni položaj garantnog fonda", *Tokovi osiguranja,* br. 1/2014, str. 17 i dalje.

[45] Više o tome: B. Matijević, str. 387.; Slobodan Stanišić, „Regres i zakonska subrogacija u osiguranju od autoodgovornosti", *Godišnjak Fakulteta pravnih nauka Apeiron*, Banja Luka, 5/2015, str. 85.

U oba entiteta društvo za osiguranje nadoknađuje stvarnu štetu u okviru odgovornosti svog osiguranika i u granicama obaveza preuzetih ugovorom o osiguranju.[46] Stvarnom štetom smatraju se troškovi liječenja i drugi nužni troškovi oštećenika u skladu s propisima o zdravstvenom osiguranju.[47] Recipročna odredba sadržana je i u Zakonu o zdravstvenom osiguranju FBiH po kojoj kantonalni Zavodi zdravstvenog osiguranja imaju pravo na direktni zahtjev za naknadu štete prema osiguratelju od autoodgovornosti štetnika ukoliko se radi o šteti prouzrokovanoj upotrebom motornog vozila.[48]

Entitetski zakoni o obaveznim osiguranjima u saobraćaju uopće ne normiraju pravo inozemnih nosioca zdravstvenog i penzionog osiguranja, već navedeno pravo daju isključivo domaćim izričito nominiranim institucijama koje provode obavezno zdravstveno osiguranje na razini entiteta.

Aktivna legitimacija inozemnih nosilaca zdravstvenog osiguranja najčešće se zasniva na međunarodnom ugovoru – sporazumu o socijalnom osiguranju. Pošto sadržaj prava takvih nosilaca našim zakonodavstvom nije normiran, analognom primjenom odredaba ZOOS-a i Zakona o zdravstvenom osiguranju dolazimo do zaključka da im pripada stvarna šteta koju predstavljaju troškovi liječenja i drugi nužni troškovi koji su priznati domaćim propisima o zdravstvenom osiguranju. Izraz „drugi nužni troškovi" može se protumačiti kao drugi vidovi stvarne štete kao posljedice tjelesnog ozljeđivanja ili smrti u što, *inter alia,* možemo svrstati troškove prijevoza, repatrijacije i sl, a ne i paušalna davanja u vidu dnevnih iznosa za troškove liječenja koja ne predstavljaju stvarnu štetu, a u sklopu prava iz zdravstvenog osiguranja priznaju ih zakonodavstva pojedinih europskih država.

2. Subrogacijski zahtjevi ustanova penzionog i invalidskog osiguranja

U Zakonu o penzionom i invalidskom osiguranju FBiH pravo na regres nosioca penzionog i invalidskog osiguranja uvjetovano je time da šteta mora biti prouzrokovana namjerno ili krajnjom nepažnjom, a kao i kod zdravstvenog osiguranja, nosioci imaju pravo na neposredan zahtjev prema osiguratelju od autoodgovornosti ukoliko je šteta nastala upotrebom motornog vozila.[49] U Republici Srpskoj je na snazi samo načelna odredba po kojoj je Fond penzionog osiguranja obavezan tražiti naknadu štete od štetnika, tj. od osobe koja je prouzročila invalidnost ili smrt osiguranika.[50] lako se ciljanim tumačenjem može zaključiti da pasivna legitimacija postoji na strani

[46] Zakon o obaveznim osiguranjima u prometu - ZOOP, *FBiH Službene novine FBiH*, br. 57/2020, čl. 28. st. 1.
[47] ZOOP FBiH, čl. 28. st. 2.
[48] Zakon o zdravstvenom osiguranju - Zakon o zdravstvenom osiguranju, *Službene novine FBiH,* br. 30/1997, 7/2002, 70/2008, 48/2011, 100/2014 - odluka US, 36/2018 i 61/2022 , čl. 70.
[49] Zakon o penzijskom i invalidskom osiguranju - Zakon o PIO FBiH, *Sl. novine FBiH*, br. 13/18, 93/19., čl. 132. i 135.
[50] Zakon o penzionom i invalidskom osiguranju Republike Srpske, *Sl. glasnik RS*, br. 134/2011 s izmjenama do 43/2023., čl. 164.

štetnikovog osiguratelja, zakonom u RS nije normirana mogućnost podnošenja direktnog zahtjeva prema osiguratelju od odgovornosti.

ZOOS i Zakon o obaveznim osiguranjima u saobraćaju Republike Srpske je, kako smo već istakli, pravo podnošenja subrogacijskog zahtjeva direktno prema osiguratelju od autoodgovornosti, omogućio samo domaćim ustanovama zdravstvenog osiguranja, a ne i ustanovama penzionog i invalidskog osiguranja.

Vidimo da entitetski zakoni o PIO i ZOOS na različit način reguliraju ista pitanja, odnosno subrogacijske zahtjeve nosilaca penzionog i invalidskog osiguranja, s tim da nijedan od navedenih propisa ne spominje inozemne nosioce. Imajući u vidu vremenski okvir donošenja ovih dvaju propisa, tj. da je Zakon o PIO FBiH donesen 2018. godine, a ZOOS 2020. godine, dolazimo do tumačenja po načelu *lex posterior derogat legi priori*, što bi u konačnici značilo isključivu primjenu ZOOS-a po kojem bi pravo tih nosilaca bilo u cijelosti osporeno jer ZOOS uopće ne normira subrogacijske zahtjeve nosilaca penzionog i invalidskog osiguranja, već to pravo daje samo izričito kantonalnim Zavodima zdravstvenog osiguranja.

Jednako kao i za zahtjeve iz zdravstvenog osiguranja, i za subrogacijske zahtjeve inozemnih ustanova penzionog osiguranja aktivna legitimacija je utemeljena međunarodnim sporazumima o socijalnom osiguranju, a sadržaj prava se može utvrditi analognom primjenom Zakona o PIO FBiH. Shodno važećoj odredbi Zakona o PIO FBiH, takav zahtjev je osnovan samo ako je tjelesno oštećenje, invalidnost ili smrt osiguranika prouzrokovana namjerno ili krajnjom nepažnjom. Visina štete se obračunava prema visini priznate penzije, odnosno novčane naknade za tjelesno oštećenje, kao i prema očekivanom prosječnom vremenu korišćenja tog prava.[51] Dakle, obaveza domaćeg osiguratelja od autoodgovornosti prema inozemnom nosiocu penzionog osiguranja postoji ako je šteta prouzrokovana namjerno ili krajnjom nepažnjom, a obim obaveze utvrđuje se u jednokratnom iznosu, ovisno o iznosu priznate penzije ili naknade za invalidnost i prosječnog vremena korištenja tog prava.

Da bi se izbjegle nedoumice i primjena analogije, poželjno bi bilo u entitetska zakonodavstva u BiH iz oblasti obaveznih osiguranja u saobraćaju normirati subrogacijske zahtjeve nosilaca penzionog i invalidskog osiguranja. Pri tome bi uzor mogli pronaći u važećim Zakonima o obaveznim osiguranjima u prometu Republike Hrvatske i Republike Srbije koji detaljno propisuju prava navedenih nosilaca i način obračuna iznosa koji im pripada kao stvarne štete nastale uslijed isplate penzije ili naknade za invalidnost kao posljedice upotrebe motornog vozila, te ne ograničavaju navedena prava samo na domaće nosioce osiguranja.

U nedavnoj presudi Vrhovnog suda Republike Hrvatske u sporu između austrijskog nosioca penzionog osiguranja i hrvatskog osiguratelja od autoodgovornosti povodom subrogacijskog zahtjeva za isplatu invalidskih penzija utvrđeno je da se na konkretan odnos tužitelja i tuženika u pogledu utvrđivanja visine i obima

[51] Zakona o PiO FBiH, čl. 133.

i obaveze tuženika kao osiguratelja primjenjuje materijalno pravo koje regulira konkretan ugovor o osiguranju, a to su odredbe ZOOS-a. Zanimljiv je stav izrečen u obrazloženju citirane presude po kojem potraživanje tužitelja ne može prijeći okvire propisane ZOOS-om jer bi u protivnom tužitelj kao strani fond penzionog osiguranja, s obzirom na primjenu hrvatskog prava, bio doveden u povoljniji pravni položaj u odnosu na tuženika od pravnog položaja domaćeg (hrvatskog) fonda penzionog osiguranja, a što bi uostalom bilo protivno i javnom poretku, ali i Ugovoru o socijalnom osiguranju između Hrvatske i Austrije.[52]

V Zaključak

Rješavanje subrogacijskih zahtjeva nosilaca zdravstvenog i penzionog osiguranja sa sjedištem u inozemstvu predstavlja izazov ne samo domaćim osiguravajućim društvima iz osnova osiguranja od autoodgovornosti koji su najčešći obaveznici plaćanja, već i sudovima koji, najčešće zbog ignoriranja inozemnog elementa i kolizionopravne regulacije, različito tumače opseg prava navedenih institucija. Iz analize propisa i sudske prakse možemo zaključiti da Sporazumi o socijalnom osiguranju kao dvostrani međunarodni ugovori sklopljeni su u cilju lakšeg ostvarenja socijalnih prava, kao i Uredba 883/2004, omogućavaju prijelaz prava (subrogaciju) s osiguranika na nosioca osiguranja, ali se za utvrđivanje obaveze osiguratelja od autoodgovornosti i obima te obaveze primjenjuju odredbe nacionalnog prava države u kojoj je nastao osigurani slučaj upotrebom motornog vozila. To podrazumijeva primjenu Zakona o obaveznim osiguranjima u saobraćaju kojim su ustanovljene granice odgovornosti osiguratelja u pogledu subrogacijskih zahtjeva inozemnih nosilaca socijalnog osiguranja. Entitetski Zakoni o obaveznim osiguranjima u saobraćaju FBiH i RS propisuju samo subrogaciju domaćih institucija zdravstvenog osiguranja, ali se putem analogije iste odredbe mogu primijeniti i na inozemne nosioce zdravstvenog osiguranja. U nedostatku odredaba o subrogaciji inozemnih nosilaca penzionog osiguranja, opseg obaveze osiguratelja od autoodgovornosti kod zahtjeva inozemnih nosilaca penzionog osiguranja treba utvrđivati primjenom relevantnih domaćih propisa iz oblasti penzionog osiguranja, ali u svakom slučaju ugovorom o osiguranju od autoodgovornosti postavljene su granice obaveze osiguratelja po postavljenom zahtjevu.

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[52] Presuda Vrhovnog suda Republike Hrvatske, br. Rev 1005/2020-2 od 27.02.2024. godine

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SUBROGATION CLAIMS BY FOREIGN SOCIAL SECURITY INSURERS AGAINST DOMESTIC MOTOR LIABILITY INSURERS

Abstract

In economically stronger European countries, quality social insurance mechanisms have been established, providing various types of compensation to their insured individuals in cases of bodily injury or death resulting from cross-border traffic accidents. These mechanisms aim to facilitate quicker recovery and mitigate the impact of unfortunate events. Upon the payment of compensation, foreign health and pension insurers claim reimbursement of the paid amounts through the legal subrogation process from the domestic insurance company with which the compulsory liability insurance contract was concluded for damages caused to third parties by tortfeasor. Given that these claims involve an international element, this paper will first analyze the applicable law concerning active standing and the determination of the rights of the foreign insurer. Considering that the extent of the motor liability insurer's obligation is defined by the insurance contract concluded in accordance with the provisions of the Law on Compulsory Traffic Insurance, this paper will examine whether the foreign social security insurer is entitled to full reimbursement of the paid amounts in accordance with the regulations of its home country or within the limits of the motor liability insurance contract of the tortfeasor.

Keywords*: subrogation, health insurance, pension insurance, foreign insurer, motor liability insurance*

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I Concept of Subrogation in Insurance

When an insured event in property insurance occurs due to the civil liability of a tortfeasor, the insured party has the right to claim damages on two grounds: from the tortfeasor according to the rules of civil liability, or from the insurer based on the insurance contract (contractual liability). The prohibition of accumulation of claims means that the insured cannot simultaneously pursue rights on both grounds in full, nor can they receive more from both sources than the amount of damage they have suffered.[2] This leads to one of the fundamental characteristics of property insurance, which is the application of the principle of indemnity (compensatory principle). According to this principle, compensation for damage can be obtained only by the person who suffers a material loss due to the occurrence of the insured event, and that person cannot obtain an amount greater than the damage suffered.

However, this does not mean that by fulfilling the insurer's obligation under the insurance contract, the tortfeasor remains unaccountable. On the contrary, by establishing **the insurer's right of subrogation**, the tortfeasor's liability for the damage caused is prevented from being avoided.[3] Subrogation in insurance is based on statutory law, which means it arises *ex lege* upon the payment of insurance compensation and represents the transfer of the insured's rights to a person who is liable for the damage, up to the amount of the paid damage.[4] Since it involves a transfer rather than the acquisition of a new right, the insurer's right of subrogation is considered a derived right against the person liable for the damage. There are two conditions for the occurrence of legal subrogation by the insurer. The first is that the insurance compensation has been paid to the insured or the injured party, with the insurer bearing the burden of proof for the payment made.[5] The second condition is that there is a right of the insured to claim damages from the person liable for the damage. The purpose of this condition is to ensure that the liable party bears the burden of compensating the damage caused to the insured.

[2] Nataša Petrović Tomić, *Osnovi prava osiguranja*, 1st ed., Belgrade, 2021. p. 192.

[3] B. Matijević, „Pravo subrogacije osiguratelja", *Zbornik XXV Međunarodne naučne konferencije „Prouzrokovanje štete, naknada štete i osiguranje"(eds. Zdravko Petrović et al.),* Beograd – Valjevo, 2022, p. 387.

[4] The Law of Contract and Torts – LCT *(Official Gazette of the RBiH*, No. 2/92, 13/93, 13/94; *Official Gazette of the FBiH*, No. 29/03; *Official Gazette RS*, No. 17/93, 3/96, 39/03, and 74/04), Article 939.

[5] In the judgment of the Cantonal Court in Mostar, No. 58 0 Mals 194895 20 Pž, the claim of the comprehensive insurer against the auto liability insurer was rejected because it did not prove the validity and legality of the transfer of rights to the liable insurer. According to the court's reasoning, the comprehensive insurer did not provide proof of the payment of the comprehensive insurance premium. The only evidence of active standing submitted was an extract from the comprehensive insurer's database showing details of the policy, including information about the policyholder, insured, insurer, the subject of insurance (vehicle with specified make, type, and chassis number), covered risks, coverage period, and premium amount. Although it was stated that the premium was paid in full at the time of the policy's issuance, the court held that active standing was not proven.

Since personal subrogation in an obligatory relationship involves the substitution of one creditor for another, the insurer, as the creditor, can only acquire those rights that the insured has against the responsible party or their liability insurer.[6] Upon the payment of insurance compensation, all of the insured's rights against the person liable for the damage (legal subrogation) are transferred to the insurer, up to the amount of the compensation paid. Consequently, it is necessary to determine whether the insured is liable for the occurrence of the harmful event and the damage suffered by the injured party.[7]

We will briefly recall that the Law of Contract and Torts (LCT) adopts a dualistic concept of dividing insurance contracts based on the subject of insurance into property insurance (which includes liability insurance) and personal insurance. The insurer's obligation in property insurance is to compensate for damages according to the rules of indemnity law and with the application of the previously mentioned indemnity principle. In contrast, in personal insurance, the insurer's performance consists of paying a pre-agreed sum which does not constitute damage compensation, and therefore, the accumulation of claims is permitted. This leads to a mandatory legal provision that subrogation is not allowed in personal insurance.[8] Consequently, the rules on legal subrogation discussed earlier apply only to property insurance. The content of the insured's rights under property and personal insurance contracts, as well as the prohibition of subrogation in personal insurance, is significant for defining the content of the motor liability insurer's obligations in subrogation claims by foreign social insurance institutions, which will be discussed further in this paper.

II Subrogation Claims by Foreign Social Security Insurers

Crossing national borders for business, tourism, and other purposes has become a routine part of life for an increasing number of people. Additionally, migration within the Western Balkan region for economic and/or political reasons has also contributed to a rise in cross-border road traffic, which consequently leads to more traffic accidents involving drivers and passengers from different countries. The issue of subrogation in insurance particularly raises concerns when a social insurance institution based in one country seeks reimbursement for benefits paid out as a result of a traffic accident occurring in another country. Such claims, as observed, involve an international element, and determining the obligation of the subrogation debtor — typically a motor liability insurer — requires addressing the issue of applicable law to establish the existence and extent of that obligation.

[6] Nataša Petrović Tomić, *Pravo osiguranja – Sistem*, Knjiga I, Beograd, 2019, p. 485.

[7] Jadranka Nižić Peroš, „Personalna subrogacija u odnosu prema pravu regresa osiguratelja i ustupanju tražbine – cesiji", *Oeconomica Jadertina*, No. 1/2021, pp. 79-90, 81.

[8] LCT, Article 948.

People who are residents or usually reside in one of the developed European countries, or their relatives in the case of death, receive various benefits paid out by foreign pension and health insurance institutions to whom they pay mandatory contributions. In practice, insurance companies in Bosnia and Herzegovina and the region frequently encounter subrogation claims from such institutions. These claims are typically very high and sometimes include types of demands not recognized by our legislation.[9]

For example, Austrian health insurance institutions pay their insured persons a benefit known as *"Krankengeld"* (sickness benefit) in daily amounts during the estimated duration of treatment resulting from injuries sustained in a traffic accident. According to the Austrian Social Insurance Act, if the persons entitled to these benefits have the right to claim compensation for the damage caused by the insured event under other legal provisions, the right to compensation transfers to the insurance provider to the extent that it is obligated to provide benefits.[10] However, in such cases, this is not a reimbursement of actual medical service and medication costs based on invoices issued by healthcare institutions, but rather a lump-sum payment for treatment. This type of compensation is not recognized under domestic law, and the provision of lump-sum daily amounts as *"Krankengeld"* cannot be considered as actual damages to which the injured party is entitled under the provisions of the Law of Contract and Torts[11] and the Law on Compulsory Traffic Insurance of the Federation of Bosnia and Herzegovina (FBiH).[12] It is undisputed that this is a form of compensation recognized by the Austrian legal system for its citizens as a way to alleviate the difficulties resulting from injury, but these benefits do not have a compensatory nature. Instead, they represent social rights of the insured under the compulsory insurance system in Austria.

Since in Bosnia and Herzegovina, victims of traffic accidents do not have the right to *"Krankengeld"* under domestic regulations, and therefore domestic health and social insurance institutions cannot claim reimbursement for such payments, the question arises whether the same right can be recognized for foreign institutions. If it can, are these institutions privileged compared to domestic institutions that provide compulsory insurance based on the principles of intergenerational solidarity?

[9] Dino Torlak, „Mjerodavno pravo za rješavanje zahtjeva za naknadu štete iz saobraćajnih nezgoda s posebnim osvrtom na subrogaciju", *Anali Pravnog fakulteta u Zenici*, No. 20., vol. 10., p. 195.

[10] See Josef Schörghuber, „Pravo regresa nosilaca socijalnog osiguranja nakon saobraćajne nezgode prema osiguravaču obaveznog osiguranja odgovornosti, s posebnim osvrtom na austrijsko pravo", *Revija za pravo osiguranja*, Beograd, No. 3, 2007.,3.

[11] LCT, Article 195.

[12] The Law on Compulsory Traffic Insurance of the Federation of Bosnia and Herzegovina (FBiH) - LCTI, *Official Gazette of FBiH*, No. 57/2020. This law includes the Framework Criteria for determining compensation in cases of injury to physical or psychological integrity, or death. The Criteria establish the rules for determining the amount of compensation for both material and non-material damages in specific cases.

Another very common example that causes confusion in the practice of insurance companies and courts involves subrogation claims by German pension insurance providers who pay so-called widow's pensions, i.e. pensions to widows and children of insured persons who died in traffic accidents in other countries.[13] When such a claim is made against the motor liability insurer of the at-fault party, the question arises whether the insurer is obligated to settle the claim in full or only up to the limits prescribed in the insurance contract.

III Determining the Applicable Law for Subrogation Claims by Foreign Social Security Institutions

Case law in Bosnia and Herzegovina, Serbia, and Croatia is varied, ranging from full recognition to complete dismissal of claims by foreign institutions against domestic motor liability insurers. Similarly, there is no consensus in legal scholarship regarding the nature of the obligation between the foreign social insurance institution and the at-fault party, or their motor liability insurer. Some authors argue that the liability of the at-fault party in such cases is viewed as contractual liability, which would imply that the applicable law for determining the obligation in a subrogation claim by a social insurance institution is governed by the contractual statute, i.e. the law of the country where the social security is established.[14]

Criticism of this viewpoint can be directed at the fact that there is no prior agreement between the social insurance institution and the liable party, or the insurance company with which the liable party is insured, and therefore the application of the applicable law for the contract is not justified. An argument supporting this claim is that the right to subrogation is not an original but a derived right that

[13] Denis Lauc, „Regresni zahtjevi njemačkih nositelja socijalnog osiguranja", *Anali Pravnog fakulteta u Zenici*, No. 17, 2016., pp. 385-397, 386.

[14] Older case law in the Republic of Serbia supports this view. For example, in a decision by the Supreme Court of Serbia in a case brought by German social insurance, it was determined that the commercial courts correctly applied the substantive law when assessing the amount of damage, which included payments for treatment, sick leave, subsistence allowances, transportation, pensions (temporary pensions), and other benefits from social, health, and pension insurance, according to the amount of actual costs incurred under the regulations of the Federal Republic of Germany where the payments were made. This is because the damage to the plaintiff represents all that they had to pay to their insured under the regulations of their own country. Therefore, the lower courts correctly concluded that the plaintiffs were entitled to compensation for the amount of damage they paid to their insured according to the regulations of the Federal Republic of Germany, as the insured person is entitled to benefits from health and pension insurance according to the regulations of the country where they worked. Thus, the insured party is entitled to all rights granted by the regulations of the Federal Republic of Germany, regardless of whether such rights exist under Yugoslav regulations. See: Judgment Prev. 28/94 dated June 28, 1995, Judicial Practice of Commercial Courts No. 1/1996, p. 109., cited according to Petar Đundić, „Regresna potraživanja stranih fondova socijalnog osiguranja i neka pitanja međunarodnog privatnog prava", *Zbornik Pravnog fakulteta u Novom Sadu,* 2007, vol. 41, No. 1-2, p. 315.

the social insurance institution acquires after paying compensation to its insured. Upon payment of compensation to its insured, the social insurance institution has the right to a direct claim against the party liable for the damage, and this claim does not directly arise from its relationship with the liable party but is derived from the rights of its insured against the liable party.[15] This implies that for both types of claims — the claim of the direct injured party, i.e. the insured of the foreign social security institution for damages against the motor liability insurer, and the subrogation claim made by that institution — the basis of the claim is the same and consists of civil tort liability of the liable party or their insurer. Therefore, the applicable law for determining the liability of the responsible party is the law indicated by the conflict of laws rule for civil liability, and it would be contrary to public policy to apply different laws to multiple claims arising from the same civil liability relationship.

1. Location of Damage in Traffic Accidents

To determine the applicable law for compensation claims arising from traffic accidents, the primary regulation is the Hague Convention on the Law Applicable to Traffic Accidents[16] adopted by all states formed after the breakup of Yugoslavia. However, claims for recourse (subrogation) are excluded from the scope of *ratione materia*e of this Convention.[17] Therefore, the applicable law for subrogation claims should be determined according to domestic regulations in the field of private international law, specifically in Bosnia and Herzegovina, the Law on the Resolution of Conflicts of Laws with Regulations of other countries,[18] which stipulates that for non-contractual liability for damage, the law of the place where the harmful act was performed or where the harmful consequence occurred should apply, depending on which is more favorable for the injured party.[19]

Although subrogation claims are excluded from the provisions of the Hague Convention, the Convention can be useful in interpreting the concept of the location of damage in road traffic accidents with a foreign element. When establishing the basic rule of the Convention, *lex loci delicti commissi*, the drafters of the Convention emphasized the main advantage of applying the connecting factor of the place where the accident occurred. This approach is beneficial because determining the

[15] Predrag Šulejić, *Pravo osiguranja*, Novi Sad, 4th edition, 1997., p. 319.

[16] Hague Convention on the Law Applicable to Traffic Accidents, 1971, entered into force on June 3, 1975, Bosnia and Herzegovina a member through succession; text published in "*Official Gazette of the SFRY*", Supplement No. 26/1976.

[17] Hague Convention on the Law Applicable to Traffic Accidents, Article 2.

[18] Law on the Resolution of Conflicts of Laws with Regulations of Other Countries - LRCL, *Official Gazette of the SFRY, No.* 43/82 and 72/82 – 1645, *Official Gazette of RBiH*, No. 2/92-5, 13/94-189. The same regulation is still in force in Serbia, *Official Gazette of the FRY, No.* 46/96, *Official Gazette of RS, No.* 46/2006.

[19] LRCL, Article 28.

location of the road traffic accident is generally straightforward and rarely leads to difficulties or misunderstandings. The place of the harmful act is almost always the location where the consequences occurred, and only in exceptional cases do these two places differ (e.g. accidents that occur in border areas, i.e. roads or other public areas belonging to two states).[20]

The LRCL does not contain a specific conflict rule for subrogation claims. In the absence of an explicit provision, the law applicable to the underlying obligation should be applied, precisely because subrogation occurs when the insurer indemnifies its insured, thereby acquiring all the insured's rights against the party liable for the damage, up to the amount of the indemnity paid.[21]

From this, it follows that the applicable law for subrogation claims by foreign social insurance institutions against the motor liability insurer is the law of the place where the traffic accident occurred. This view is supported by the recent interpretations of the EU Court of Justice when interpreting the Rome II Regulation on the law applicable to non-contractual obligations concerning the provisions on the applicable law for subrogation claims.[22]

The case involved a request for a preliminary ruling in a dispute before a French court between the French Guarantee Fund, which indemnified an injured party of an accident caused by the use of a motorboat in Portugal, and the Portuguese liability insurer. The Court determined that the law applicable to a claim by a third party to whom the injured party's rights have been subrogated against the perpetrator of the damage, including rules on prescription, is, in principle, the law of the state where the damage occurred. Therefore, although the Guarantee Fund insisted on applying French law as the governing law, the Court expressed the view that such an interpretation would result in the debtor being placed in a different position because the claim was brought against him by a subrogated third party rather than the injured party. This position could, depending on the case, be less favorable than if the creditor were to exercise their rights personally and directly against him.[23]

[20] Essén, Eric W., *Rapport explicatif*, in: Conférence de la Haye de droit international privé, Actes et documents de la onzième session, 7 au 26 Octobre 1968, Tome III, Accidents de la circulation routière (Explanatory Report of the Hague Convention), p. 14.

[21] Jasmina Alihodžić, Anita Duraković, Assessment of Damage and Recourse Actions in 1971 Hague Convention, Rome II Regulation and Bosnian PIL Act: What is Wrong with Respective Case Law in Bosnia and Herzegovina? South East European Law Journal, Vol. 1, No. 2 (2014), p. 75.

[22] Regulation (EC) No. 864/2007 of the European Parliament and of the Council of 11 July 2007 on the law applicable to non-contractual obligations ("Rome II") (OJ 2007, L 199).

[23] Judgment in Case C-264/22, *Fonds de Garantie des Victimes des Actes de Terrorisme et d'Autres Infractions (FGTI) v. Victoria Seguros,* ECLI:EU:C:2023:417.

2. International Agreements - Social Security Agreements and the Issue of Subrogation

Due to the intense migrations of people during the 1960s and 1970s, bilateral international agreements on social insurance were concluded in the former Yugoslavia with a large number of countries in Europe and around the world. These agreements served as coordination instruments, allowing harmonized application of the national legislations of the contracting states in the field of social security. Some of these agreements were carried over into the legal systems of the newly formed states through succession, while others were concluded by these states after gaining independence.[24] Foreign social insurance institutions, in their subrogation claims against motor liability insurers, refer to these Agreements on social security and seek reimbursement for all benefits paid to their insured individuals. They ground their claims on a provision stipulating that *if a person, under the laws of one contracting state, is entitled to compensation for damage incurred in the territory of another contracting state, and according to the latter's regulations has the right to compensation from a third party, this right to compensation is transferred to the institution of the first contracting state in accordance with its applicable legal regulations*.[25]

As previously noted, the case law in Bosnia and Herzegovina and neighboring countries does not have a consistent stance on the issue of subrogation for foreign social security institutions. There are rulings where courts have awarded social security institutions of one contracting state reimbursement for amounts paid in compensation for damages incurred in the territory of another contracting state, according to the legal provisions of the state where the insurance institution is based, even though the damage occurred in another country, i.e. without determining the applicable law. Unfortunately, this issue extends beyond just subrogation claims. Despite the general principle that conflict-of-law norms are mandatory, it is widely acknowledged that in practice, judges often apply domestic law, deliberately avoiding the application of foreign law at all costs. [26]

In some rulings, legal interpretations have been presented stating that Agreements on social security pertain specifically to the field of social security, including regulations on health and pension insurance, insurance for work-related injuries and occupational diseases, unemployment insurance, and maternity and child benefits, but not to the area of compulsory traffic insurance contracts. Earlier

[24] A list of bilateral social security agreements signed by Bosnia and Herzegovina with other countries and adopted by the succession agreement is available at: https://zzofbih.ba/ino-osiguranje/, accessed on: 09.07.2024.

[25] All Social Security Agreements contain similar wording. The provision on compensation is stipulated in Article 33 of the Agreement.

[26] Maja Stanivuković, Mirko Živković, *Međunarodno privatno pravo – opšti deo*, VIII Edition, Belgrade, 2023, p. 245.

case law automatically granted foreign social security institutions full reimbursement for amounts paid out, citing the basic provisions of the Agreements, which state that they apply to pension, health, disability insurance, and other related areas. The transfer of rights, i.e. subrogation was based on the domestic the Law of Contract and Torts (LCT) without scrutinizing the compensation provisions contained in these agreements.[27]

However, more recent case law has been largely focused on the issue of determining the applicable law for such claims. Essentially, courts start from the premise that international social security agreements are relevant only for the transfer of rights (subrogation), while the content of the foreign institution's rights, as well as the extent of the obligations of the motor liability insurer, are determined by applying domestic law under the principle of *lex loci delicti commissi*.[28] In doing so, they do not address the issue of compensation as defined by the cited provision of Article 33 of the Agreement but rather establish that, based on the scope of the Agreement's application *ratione materiae*, it does not apply to compulsory traffic insurance.

Some courts conduct a more detailed analysis of the issue of applicable law, specifically referring to the cited provision of Article 33 of the Social Security Agreement, particularly the phrase *"and according to its regulations has the right to compensation from a third party."* One such case involves a subrogation dispute between a German pension insurance institution and a Croatian motor liability insurer regarding pensions paid following the death of an insured individual in an accident in Croatia. The court determined that, under Croatian law, *it is necessary to establish whether the person receiving social security benefits in Germany has the right to claim compensation from the liable party's motor liability insurance*. The court concluded that the Social Security Agreement is only applicable to the transfer of rights to the German social security institution, i.e. for the purpose of establishing active legitimacy, while all other questions concerning the validity and amount of the claim are governed by Croatian law.[29]

[27] Judgment of the Cantonal Court in Sarajevo No. 65 0 Ps 040370 12 Pž dated 08.12.2015, confirmed by the Supreme Court of the Federation of Bosnia and Herzegovina Judgment No. 65 0 Ps 040370 16 Rev dated 21.02.2017. The reasoning stated: Article 2, paragraph 1, of the mentioned agreement stipulates that it applies, among other things, to health and pension insurance. In this particular case, the matter involves a recourse claim by a foreign insurer for amounts paid based on family pension, against a domestic insurance company responsible under mandatory liability insurance in traffic (subrogation issue Article 939 of the LCT). Therefore, by law, upon the payment of the insurance compensation, all the insured's rights against the party liable for the damage, for any reason, are transferred to the insurer up to the amount paid.

[28] Judgment of the Cantonal Court in Sarajevo, No. 65 0 Ps 446900 18 Pž dated 08.04.2021.

[29] Judgment of the Supreme Court of the Republic of Croatia, VSRH Rev x 97/2014-2 from 14.05.2014. The same position was taken in the Judgment of the Municipal Court in Split, P-455/09, final on 25.11.2014., as well as in a recent Judgment of the High Commercial Court in Zagreb, No. 11 Pž-2634/2023-2.

The subrogation right of a social security institution against a motor liability insurer in a cross-border traffic accident was also considered by the Court of Justice of the EU in the case of *Kordell and others*. The Court held that the law applicable to the transfer of rights (subrogation) is the law of the state in which the institution is registered, but the content of those rights is determined by the law of the place where the accident happened. In addition, the ruling clarified that the subrogation right of a social security institution from one member state cannot exceed the rights of the victim in another member state where the accident took place.[30]

We can agree with this opinion because, in the relationship between social security institutions and insures, it is first necessary to determine the rights of the accident victim or their close relative according to the applicable substantive law. Following that, it must be verified whether, and to what extent, these rights have been transferred to the social security institution. Therefore, the social security institution cannot claim more rights than those held by the victim, the directly injured party, or the immediate family members of the deceased person.[31]

3. Regulation 883/2004 on the Coordination of Social Security Systems

In order to achieve the freedom of movement for workers, one of the fundamental freedoms on which the common market of the European Union is based, it was necessary to regulate the right to an old-age pension at the European level, thus enabling workers the freedom to move and work in a country of which they are not citizens.[32] Despite the regulatory autonomy of national legislations, it was necessary to establish a legal framework that would enable mobile workers to exercise their right to an old-age pension and other forms of social protection in another member state. Issues of social security that were previously regulated by international agreements needed to be harmonized through a unified European regulation that would be directly applicable in the member states. To this end, Regulation 883/2004 on the coordination of social security systems was enacted.[33]

This Regulation contains rules regarding the subrogation rights of social protection institutions, which have been subject to varying interpretations by the courts of member states. Namely, the provision regulating the rights of institutions specifies two obligations on all member states. The first obligation is to recognize

[30] Judgment of 21.09.1999., in case C-397/96, Kordell et al., ECR 1999 p. I-5959, ECLI:EU:C:1999:432.

[31] Josef Schorghuber, p. 23.

[32] Tomislav Sokol,„Pravo na starosnu mirovinu mobilnih radnika temeljem Uredbe o koordinaciji sustava socijalne sigurnosti Europske unije", *European Studies*, 2015, 1, pp. 81-106, 86.

[33] Regulation (EC) No. 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, OJ L 166, 30.4.2004, p. 1–123. The Regulation replaces all social security conventions applicable between member states that relate to the same scope (Article 8. para. 1 of the Regulation).

the right of subrogation as a derived right of the institution that makes a payment to its insured person, meaning that the insured person's rights against the liable party are transferred to the institution that made the payment under the applicable regulations for that institution. The second obligation is for member states to acknowledge the right of recourse as a direct right of the institution against the liable party.[34] The cited provision only determines the law that will be used in assessing the transfer of rights from the immediate injured to the social security institution, but not the law applicable to the content of the obligation of the liable party towards the social security institution.

This is confirmed by the Higher Court in Ljubljana in its judgment in the case of Austrian pension insurance against a Slovenian insurance company for disability benefits and pensions related to a traffic accident that occurred in Slovenia. The court explains that for the transfer of rights from the immediate injured to the social security institution, the law of the seat of the social security institution is applied — in this case, Austrian law according to the claimant's seat — while the content of the rights and the applicable law regarding those rights (passive standing) is judged according to Slovenian law. The scope of the compensation that the defendant is required to pay, as the liable insurance company, is determined by the Law on Compulsory Traffic Insurance, which is *lex specialis* in relation to the Pension and Disability Insurance Laws.[35]

From the presented analysis of conflict-of-law rules for subrogation claims, as well as numerous examples from recent case law of domestic courts and the Court of Justice of the European Union (CJEU), we highlight that international social security agreements, as well as Regulation 883/2004, allow for the transfer of rights from the direct injured party to the social security institution and obligate member states to mutually recognize subrogation claims. However, these acts do not contain provisions regarding the content of the liability of the tortfeasor or their liability insurer, who is usually the party responsible for paying such claims. The determination of the existence and amount of the insurer's liability based on the concluded insurance contract for damages arising from the use of a motor vehicle is done in accordance with the relevant Law on Compulsory Traffic Insurance.[36]

The EU Court is also consistent in interpreting that member states are free to regulate rules and criteria for compensation for damage resulting from the use of motor vehicles differently from those applied to other non-contractual damage

[34] Regulation 883/2004, Article 85, Paragraph 1.

[35] Judgment of the Higher Court in Ljubljana, No. VSL I Cpg 533/2017, of 22.11.2018.

[36] See: Loris Belanić, „Redefiniranje obveze osiguratelja od automobilske odgovornosti s obzirom na upotrebu vozila u kontekstu prakse Suda EU", *Croatian Academy of legal sciences yearbook*., Vol. XII, 1/2021, p. 346; Jasmina Đokić, „Kriteriji za odmjeravanje naknade nematerijalne štete nastale upotrebom motornog vozila u praksi Suda EU i Ustavnog suda BiH", *Proceedings of the 34th Meeting of Insurers and Reinsurers*, Sarajevo, 2023, p. 118.

claims.[37] Directives in the field of motor insurance mandate that civil liability for damage caused to third parties should be covered by compulsory insurance, but the extent of damage compensation is subject to national legislation. Therefore, member states are free to independently regulate their system of liability that applies to compensation for damage resulting from the use of motor vehicles.[38]

IV Determining the Scope of Compensation in Subrogation Claims of Foreign Social Security Institutions by Applying the Law of the Place of Accident

In subrogation claims by foreign pension and health insurance institutions against domestic motor liability insurers, where the legal relationship involves a foreign element and the conflict-of-law rule directs the application of the law of the place of the accident, the question arises as to which domestic regulation determines the obligation and the scope of rights for such institutions. An analysis of international social security agreements reveals that they allow foreign institutions to submit subrogation claims against domestic tortfeasors or their civil liability insurers. In the following, we will see that the scope of rights for foreign insurance institutions is an area that is not regulated by our legislation, indicating a legal gap. In legal theory, it is held that a legal gap is an area that the legislator has not regulated for certain reasons.[39] Several tools are used to fill legal gaps, with the primary method being interpretation by **analogy**. This means that a legal norm intended for another case, which is similar to the specific case, is applied exactly due to that similarity.[40] We will analyze how analogical interpretation can assist in resolving subrogation claims of foreign health and social insurance institutions.

1. Subrogation Claims of Health Insurance Institutions

As previously mentioned, the scope of insurance coverage under the compulsory motor vehicle liability insurance contract is regulated by the provisions of the Law on Compulsory Traffic Insurance. In the Federation of Bosnia and Herzegovina, insurers are obligated to compensate the actual damages to the competent Health

[37] Judgment in Case C-577/21, LM and NO v HUK-COBURG-Allgemeine Versicherung AG, ECLI:EU:C:2022:992.
[38] Judgment in Case C-371/12, *Petillo v. Unipol SAI*, ECLI:EU:C:2014:26
[39] Prof. Visković cites two main causes of legal gaps: first, when the lawmakers of a new legal order, following a revolution or similar event, do not immediately create legal norms to replace those that were abolished, leaving certain relationships unregulated; second, the emergence of socially significant conflicting relationships that the legislator has not recognized or regulated in time. (Nikola Visković, *Država i pravo*, Zagreb, 1997., pp. 218-220.)
[40] Hrvoje Kačer, Blanka Ivančić Kačer, „O rješavanju antinomija i pravnih praznina ..." *Collection of Papers of the Faculty of Law in Split*, vol. 54, 2/2017, p. 410.

Insurance Fund.[41] In the Republic of Srpska, this right belongs to the Health Insurance Fund of RS.[42] We notice that both entity laws use the incorrect term "recourse claim" when it actually pertains to a subrogation claim. The difference is not merely terminological but also substantive. While in insurance terminology a recourse claim is often equated with a subrogation claim, legal theory generally holds that recourse in insurance represents an original right of the insurer to pursue its own insured whose civil liability the insurer covers. This applies when the insured was driving under some circumstances (e.g. under the influence of alcohol above the legal limit) that give the insurer the right to seek partial or full reimbursement of the amount paid for damage compensation.[43]

In both entities, the insurance company compensates the actual damage within the limits of its insurer's liability and the obligations assumed under the insurance contract.[44] Actual damage is considered to be the costs of medical treatment and other necessary expenses of the injured party, in accordance with the health insurance regulations.[45] A reciprocal provision is also contained in the Health Insurance Act of FBiH, which stipulates that cantonal Health Insurance Funds have the right to a direct claim for compensation against the motor liability insurer of the tortfeasor if the damage was caused by the use of a motor vehicle.[46]

The entity-level Laws on Compulsory Traffic Insurance do not regulate the rights of foreign health and pension insurance institutions, but instead grant such rights exclusively to domestic institutions that are explicitly designated to administer compulsory health insurance at the entity level.

The active standing of foreign health insurance institutions is most often based on an international agreement, specifically the Social Security Agreement. Since the rights of such insurers are not regulated by our legislation, by analogously applying the provisions of the Law on Compulsory Traffic Insurance and the Health Insurance Law, we can conclude that they are entitled to actual damages, which include medical expenses and other necessary costs recognized by domestic health insurance regulations. The term "other necessary costs" can be interpreted as other forms of actual damages resulting from bodily injury or death, which may include,

[41] In FBiH, health insurance and healthcare are administered at the level of ten cantons. The framework law is the Health Insurance Act of FBiH, *Official Gazette of FBiH*, Nos. 30/1997, 7/2002, 70/2008, 48/2011, 100/2014 - Constitutional Court decision, 36/2018, and 61/2022, which mandates the establishment of Health Insurance Funds in each canton to ensure the realization of rights and the provision of funds from compulsory health insurance.

[42] The Law on Compulsory Traffic Insurance of the Republic of Srpska, *Official Gazette of RS*, Nos. 82/15, 78/20, 1/24, Article 31.

[43] More on this: B. Matijević, 387.; Slobodan Stanišić, „Regres i zakonska subrogacija u osiguranju od autoodgovornosti", *Yearbook of the Faculty of Law Sciences, Apeiron*, Banja Luka, 5/2015, p. 85.

[44] LCTI of FBiH, Article 28, Paragraph 1.

[45] LCTI of FBiH, Article 28, Paragraph 2.

[46] Health Insurance Act of FBiH, Article 70.

inter alia, transportation costs, repatriation expenses, and similar items. However, lump-sum payments in the form of daily allowances for treatment costs, which do not constitute actual damages and are recognized as health insurance rights by the legislation of certain European countries, would not fall under this category.

2. Subrogation Claims of Pension and Disability Insurance Institutions

In the Law on Pension and Disability Insurance of FBiH, the right to recourse for pension and disability insurance institutions is conditioned on the damage being caused intentionally or through gross negligence. Similar to health insurance, these insurers have the right to make a direct claim against the motor liability insurer if the damage resulted from the use of a motor vehicle.[47]

In the Republic of Srpska, there is only a general provision stating that the Pension Insurance Fund is obligated to seek compensation from the tortfeasor, i.e. from the person who caused the disability or death of the insured.[48]

Although targeted interpretation might conclude that passive standing exists on the part of the tortfeasor's insurer, the law in RS does not provide the possibility of submitting a direct claim against the liability insurer.

As we have already noted, the Law on Compulsory Traffic Insurance (LCTI) in both the Federation of Bosnia and Herzegovina (FBiH) and the Republic o Srpska (RS) has allowed only domestic health insurance institutions to submit subrogation claims directly to the motor liability insurer, and not to pension and disability insurance institutions. We see that the entity laws on pension and disability insurance (PDI) and LCTI regulate the same issues, i.e. subrogation claims of pension and disability insurance institutions, in different ways, with neither of these laws mentioning foreign insurers. Considering the timeframe for the enactment of these two laws, i.e. that the PDI Law was adopted in 2018 and LCTI in 2020, it leads to an interpretation based on the principle of *lex posterior derogat legi priori*. This would ultimately mean the exclusive application of LCTI, which would entirely dispute the rights of those insurers because LCTI does not regulate subrogation claims of pension and disability insurance institutions but grants this right only to the explicitly designated cantonal health insurance institutes.

Equally to health insurance claims, the active standing for subrogation claims by foreign pension insurance institutions is grounded in international social security agreements, and the content of these rights can be determined through the analogical application of the Pension and Disability Insurance Law (PDI). According to the relevant provision of the PDI Law in FBiH, such a claim is valid only if the bodily

[47] Law on Pension and Disability Insurance FBiH, *Official Gazette FBiH*, Nos. 13/18, 93/19, Articles 132 and 135.
[48] Law on Pension and Disability Insurance of the Republic of Srpska, *Official Gazette RS*, No. 134/2011 with amendments up to 43/2023, Article 164.

injury, disability, or death of the insured person was caused intentionally or through gross negligence. The amount of damage is calculated based on the amount of the recognized pension or monetary compensation for bodily injury, as well as the expected average duration of that right.[49] Thus, the obligation of the domestic motor liability insurer to a foreign pension insurance institution exists if the damage was caused intentionally or through gross negligence, and the extent of this obligation is determined in a lump sum, depending on the amount of the recognized pension or disability compensation and the average duration of that right.

To avoid uncertainties and analogical application, it would be advisable to regulate subrogation claims by pension and disability insurance providers in the entity legislation in Bosnia and Herzegovina concerning compulsory traffic insurance. In this regard, the current Laws on Compulsory Traffic Insurance of the Republic of Croatia and the Republic of Serbia could serve as models. These laws detail the rights of such providers and the method for calculating the amounts as actual damage resulting from the payment of pensions or disability compensation due to the use of motor vehicles, and which do not limit these rights solely to domestic insurance institutions.

In a recent judgment by the Supreme Court of the Republic of Croatia in a dispute between an Austrian pension insurance provider and a Croatian motor liability insurer concerning a subrogation claim for payment for disability pensions, it was determined that the substantive law governing the specific insurance contract, namely the provisions of the Law on Compulsory Traffic Insurance (LCTI), applies to the relationship between the claimant and the defendant regarding the determination of the amount and scope of the defendant's liability as an insurer. An interesting point was made in the reasoning of the cited judgment that the claimant's demand cannot exceed the limits prescribed by the LCTI. Otherwise, the claimant, as a foreign pension fund, would be placed in a more favorable legal position under Croatian law compared to the position of the defendant relative to a domestic (Croatian) pension fund. This would be contrary to public order and the Social Security Agreement between Croatia and Austria.[50]

V Conclusion

Resolving subrogation claims by foreign health and pension insurance institutions is a challenge not only for domestic insurers under compulsory motor liability insurance, who are often the parties required to make payments, but also for courts, which, often due to neglecting the foreign element and conflict-of-law regulations, interpret the scope of the rights of these institutions differently. From

[49] Pension and Disability Insurance Law FBiH, Article 133.

[50] Judgment of the Supreme Court of the Republic of Croatia, case no. Rev 1005/2020-2 of 27.2.2024.

the analysis of regulations and case law, we can conclude that Social Security Agreements, as bilateral international treaties, are designed to facilitate the realization of social rights, as well as Regulation 883/2004, which allows for the transfer of rights (subrogation) from the insured to the insurance provider. However, the determination of the obligation of motor liability insurers and the extent of that obligation is governed by the state's national law, which states that the insured event occurred due to the use of a motor vehicle. This involves the application of the Law on Compulsory Traffic Insurance, which establishes the limits of insurer liability concerning subrogation claims by foreign social security institutions. Entity-level compulsory traffic insurance laws in FBiH and RS prescribe subrogation solely for domestic health insurance institutions, but through analogy, the same provisions can be applied to foreign health insurance institutions. In the absence of provisions regarding subrogation for foreign pension insurance institutions, the extent of the liability of motor liability insurers for claims from foreign pension insurance institutions should be determined by applying relevant domestic pension insurance regulations. Nevertheless, in any case, the insurance contract for motor liability establishes the limits of the insurer's obligations for the submitted claim.

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ZASTARELOST POTRAŽIVANJA NAKNADE ŠTETE TREĆEG OŠTEĆENOG LICA PREMA OSIGURAVAČU KOD OSIGURANJA OD UGOVORNE ODGOVORNOSTI

ORIGINALNI NAUČNI RAD

Apstrakt

„Reč odgovornost je uteha svima koji smatraju da im je učinjena neka nepravda, a strašilo za one koju su nepravdu počinili", reči su profesora Jakova Radišića. Nastavimo li njegovu misao, reč osiguranje je uteha i onome koji je nepravdu učinio, ali pre svega dodatna uteha onome kome je nepravda učinjena. Međutim, šta ako onaj kome je nepravda učinjena nepravdu trpi i pogrešnom primenom zakonskih odredaba? Uzimajući u obzir rastući značaj osiguranja od ugovorne odgovornosti, autorka analizira direktan zahtev trećeg oštećenog lica prema osiguravaču i njegov odnos s pravilima o građanskoj odgovornosti. Sistemskim tumačenjem odredaba Zakona o obligacionim odnosima kojima se reguliše zastarelost prava na naknadu štete, autorka zaključuje da se u praksi odomaćila nepravilna primena ovih odredaba. Analizirajući uzroke te prakse, autorka konstatuje da primena načela zakonitosti treba da prevlada moguće posledice njegove primene.

Ključne reči: *osiguranje od odgovornosti, ugovorna odgovornost, zastarelost, direktan zahtev trećeg oštećenog lica prema osiguravaču.*

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I Osiguranje od odgovornosti

1. O osiguranju od odgovornosti uopšte

Prema klasičnoj podeli vrsta osiguranja, osiguranje od odgovornosti[2] spada među osiguranja imovine, zbog čega se zakonske odredbe koje se odnose na osiguranja imovine primenjuju i na osiguranje od odgovornosti.[3] Međutim, predmet osiguranja od odgovornosti je građanska odgovornost,[4] koja zahteva učešće dva lica – lica koje je štetu prouzrokovalo i za nju je odgovorno (štetnik) i lice kojem je šteta pričinjena (oštećenik). Kada se u taj odnos uključi i osiguravač, dolazimo do glavne specifičnosti osiguranja od odgovornosti – ono „po svojoj prirodi zahteva postojanje tri strane"[5] – osiguravača, osiguranika i treće oštećeno lice.[6]

Čini se da kontinuirani tehnološki razvoj koji je počeo krajem XIX veka[7] dobija na ubrzanju do današnjeg dana. Čovečanstvo se neprestano suočava sa štetama koje su prouzrokovane ostvarenjem novih i povećanjem postojećih rizika koji se javljaju u svakodnevnom životu i poslovanju.[8] Za te štete neko (građanskopravno) odgovara, a neko mora i da ih nadoknadi. A ko je spremniji da te štete nadoknadi nego osiguravač, koji će pružiti finansijsku sigurnost trećim oštećenim licima?[9]

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[2] Osiguranje od odgovornosti je sredstvo u službi oslobođenja čoveka od prinude nad njegovom imovinom. Videti: Nikola Nikolić, „Odgovornost i osiguranje", GRAĐANSKA ODGOVORNOST, Referati i diskusija sa Simpozijuma održanog 11. i 12. februara 1966. godine u Beogradu, Beograd, 1966, str. 125.

[3] Zakon o obligacionim odnosima – ZOO, *Sl. list SFRJ*, br. 29/78, 39/85, 45/89 – odluka USJ i 57/89, *Sl. list SRJ*, br. 31/93, *Sl. list SCG*, br. 1/2003 – Ustavna povelja i *Sl. glasnik RS*, br. 18/2020, Deo drugi, Glava XXVII, Odeljak 2.

[4] O drugim vrstama pravne odgovornosti kao predmetima osiguranja od odgovornosti videti: Yvonne Lambert- Faivre, Laurent Laveneur, *Droit des assurances*, Paris, 2018, str. 496.

[5] Videti: Jérôme Bonnard, *Droit des assurances*, Paris, 2012, str. 10.

[6] Iako se u teoriji građanskog prava za lice kome je šteta pričinjena koristi izraz oštećenik, iz ugla prava osiguranja to lice je treće lice, jer nije ugovorna strana u ugovoru o osiguranju od odgovornosti. Zbog toga se u pravu osiguranja to lice naziva trećim oštećenim licem. U ovom radu ćemo koristiti taj izraz.

[7] O tome: Nataša Petrović Tomić, *Pravo osiguranja – Sistem, knjiga I*, Beograd, 2019, str. 490.

[8] Pravo osiguranja osim prilagođavanja negativnim aspektima tehnološkog razvoja (kroz osiguranje novih rizika) odlikuje se i praćenjem pozitivnih aspekata tehnološkog razvoja. U XXI veku je to pre svega mogućnost zaključenja ugovora o osiguranju na daljinu, kao posledica opšte dostupnosti interneta koja omogućava obavljanje različitih transakcija na daljinu. O pravnim dilemama prilikom zaključivanja ugovora o osiguranju na daljinu videti: Nenad Grujić, „Pravne dileme u vezi s načinima zaključenja ugovora o osiguranju na daljinu – putem mobilne aplikacije i internet prezentacije", *Tokovi osiguranja*, br. 1/2024, str. 105-118.

[9] O tome: Nataša Petrović Tomić, „Liability insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory", *Annals FLB – Belgrade Law Review*, No 4, Year LXVIII, 2020, str. 88.

2. Osiguranje od ugovorne odgovornosti

Shodno tome da se u skladu s pravilima građanskog prava za štetu može odgovarati zbog povrede opšteg načela zabrane prouzrokovanja štete drugome[10] i zbog povrede ugovorne obaveze,[11] razvile su se i dve vrste osiguranja od odgovornosti – osiguranje od vanugovorne odgovornosti i osiguranje od ugovorne odgovornosti, i to ovim redom. Naime, dugo je postojao otpor tome da se osigura ugovorna odgovornost za štetu. Tome je pre svega doprineo argument da osiguranju od ugovorne odgovornosti nedostaje aleatornost[12] koja je bitan element svakog ugovora o osiguranju.

S druge strane, pravilo da je samo onaj ko štetu prouzrokuje i odgovoran je za nju dužan da je naknadi, isticano je kao argument i protiv osiguranja od ugovorne odgovornosti.[13] Pravni poredak je još jednom odbijao da prihvati to da „odgovornost podrazumeva nadoknadu štete, ali svaka nadoknada nije odgovornost".[14]

Međutim, zahvaljujući razvoju standarda profesionalne pažnje i profesionalne odgovornosti, u XX veku počelo je da se razvija i osiguranje ugovorne odgovornosti.[15] Nepostupanje lica u skladu sa zakonskim standardima profesionalne pažnje, nužno je dovodilo do prouzrokovanja štete kako licima s kojima su profesionalci bili u ugovornom odnosu, tako i trećim oštećenim licima.[16] Kao i u slučaju osiguranja

[10] Videti: ZOO, čl. 16.

[11] Iako ugovorna odgovornost ne podrazumeva samo odgovornost za štetu koja je prouzrokovana zbog neispunjenja, neurednog ili neblagovremenog ispunjenja ugovorne obaveze, već zbog neispunjenja, neurednog ili neblagovremenog ispunjenja bilo koje obaveze iz postojećeg obligacionog odnosa, za potrebe ovog rada ugovornu odgovornost izjednačavaćemo sa neispunjenjem ugovorne obaveze, te sa neurednim ili neblagovremenim ispunjenjem ugovorne obaveze.

[12] Više o tome: Marijan Ćurković, *Osiguranje od izvanugovorne i ugovorne (profesionalne) odgovornosti*, Zagreb, 2015, str. 41 i dalje.

[13] Razvoju osiguranja od vanugovorne odgovornosti presudno je pomogla objektivna odgovornost za štetu. Od štetnika koji objektivno odgovara za štete koje nastanu od mašina kao opasnih stvari i opasnih delatnosti koje su se razvijale pod uticajem tehnološkog razvoja, nije se moglo očekivati da snosi sve štetne posledice koje ta stvar može da prouzrokuje. Tada je interes pravičnosti da imalac opasne stvari odnosno lice koje obavlja opasnu deltanost ne nadoknađuje svaku štetu koja je prozrokovana opasnom stvari ili opasnom delatnosti koja služi društvu u celini, prevagnuo nad opštim pravilom građanskog prava da je onaj koji prouzrokuje štetu dužan i da je nadoknadi. Slično ovome: Marija Karanikić Mirić, *Objektivna odgovornost za štetu*, Beograd, 2019, str. 7.

[14] Jakov Radišić, *Obligaciono pravo – opšti deo*, IX izdanje, Niš, 2014, str. 200.

[15] N. Petrović Tomić (2020) str. 85.

[16] Iako se u teoriji i praksi u vezi s profesionalnom odgovornosti pretežno govori samo kao o ugovornoj odgovornosti, naglašavamo da profesionalac osim što može da odgovara za prouzrokovanje štete drugoj strani iz postojećeg obligacionog odnosa, može da odgovara i trećem licu za štetu koju mu pričinjava obavljanjem svoje delatnosti prema pravilima vanugovorne odgovornosti. Primera radi, greške u projektu za koje odgovara projektant mogu dovesti do prouzrokovanja štete kako naručiocu radova sa kojim je projektant u ugovornom odnosu, tako i trećim licima. Više o vanugovornoj profesionalnoj odgovornosti: Predrag Šulejić, „Osiguranje od odgovornosti davalaca usluga", *Anali Pravnog fakulteta u Beogradu*, 6/1982,

vanugovorne odgovornosti za štetu, još jednom je prevladao jak društveni interes da se odgovornost socijalizuje,[17] a osiguranje je prihvaćeno kao način socijalizacije odgovornosti.[18]

2.1. Profesionalna odgovornost kao dominantna vrsta ugovorne odgovornosti

Razvoj osiguranja od ugovorne odgovornosti pod uticajem dominantnog praktičnog značaja profesionalne odgovornosti[19] u odnosu na druge vrste ugovorne odgovornosti doveo je do dominantnog shvatanja profesionalne odgovornosti kao posebne vrste odgovornosti,[20] ali čini se i do nepotpunog razumevanja pravne prirode osiguranja od profesionalne odgovornosti.

Pre svega, skrećemo pažnju da osiguranje od ugovorne odgovornosti ne treba izjednačavati sa osiguranjem od profesionalne odgovornosti. Predmet osiguranja od ugovorne odgovornosti može biti i ugovorna odgovornost koja se ne

str. 1012 i dalje. Loris Belanić, „Obvezna osiguranja od odgovornosti izvan djealtnosti prometa i prijevoza u hrvatskom i poredbenom pravu, s osvrtom na određivanje obveznika sklapalja osiguranja i kruga trećih osoba", *Zbornik Pravnog fakulteta Sveučilišta u Rijeci*, 1/2009, str. 551-555.

[17] O socijalizaciji odgovornosti u jugloslovenskom pravu videti: Mihailo Konstantinović, „Osiguranje i odgovornost u jugoslovenskom pravu", *Anali Pravnog fakulteta u Beogradu*, 7-9/58, str. 266.

[18] Nataša Petrović Tomić, „Liability insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory", *Annals FLB – Belgrade Law Review*, No 4, Year LXVIII, 2020, str. 85.

[19] Profesionalna odgovornost je pojam koji je razvijen u pravnoj praksi, međutim, zakonodavac ne definiše ovaj pojam. U pravnoj teroriji je prihvaćen stav da je profesionalna odgovornost vezana za profesije koje karakteriše postojanje strukovnih udruženja, kodeksa ponašanja, visok stepen autonomije i slično. O tome: Predrag Šulejić, „Osiguranje od odgovornosti davalaca usluga", *Anali Pravnog fakulteta u Beogradu*, 6/1982, str. 1014 i dalje. M. Ćurković, str. 42. Silvija Petrić, „O nekim problemima profesionalne odgovornosti za štetu" *Osiguranje naknada štete i novi Zakon o parničnom postupku* (urednici Zdravko Petrović i Nataša Mrvić Petrović), Zlatibor, 2012, str. 223 i dalje. ZOO je među opšta načela obligacionog prava uvrstio i načelo koje se odnosi na ponašanje u izvršavanju obaveza i ostvarivanju prava. Na osnovu tog načela, strana u obligacionom odnosu dužna je da u izvršavanju obaveze iz svoje profesionalne delatnosti postupa s povećanom pažnjom, prema pravilima struke i običajima (pažnja dobrog stručnjaka). Tumačenjem tog načela, mogli bismo da dođemo do zaključka da profesionalno odgovara onaj ko je dužan da u izvršavanju svojih obaveza postupa s pažnjom dobrog stručnjaka. Primera radi, u skladu sa odredbama ZOO, za štetu koju prevozilac prozrokuje putniku zakašnjenjem u prevozu, prevozilac odgovara putniku, osim ako je zakašnjenje izazvano uzrokom koji prevozilac nije mogao otkloniti ni pažnjom stručnjaka. Međutim prevozilac koji obavlja prevoz putnika, ne može se smatrati profesionalcem u skladu sa prethodno iznetim stavom, budući da prevozioci (u Republici Srbiji) nemaju strukovna udruženja, njihova delatnost nije regulisana kodeksom ponašanja, niti autonomno obavljaju delatnost u smislu opšteprihvaćenog pojma profesionalne odgovornosti. Videti: čl. 18. st. 2. i čl. 683. st. 2. ZOO.

[20] I među našim piscima se prepoznaje značaj i posvećuje pažnja različitim vrstama osiguranja od profesionalne odgovornosti koje poslednjih godina uvodi domaći zakonodavac. Primera radi videti: Slobodan Ilijić, „Dva aktuelna oblika obaveznog osiguranja od profesionalne odgovornosti u Republici Srbiji", Tokovi osiguranja, br. 1/2020, str. 25-35.

može smatrati profesionalnom,[21] kao što postoje i profesionalci koji prvenstveno odgovaraju vanugovorno.[22] [23]

Dalje, u praksi se profesionalna odgovornost smatra ugovornom odgovornošću u meri koja odgovara zakonskoj odgovornosti profesionalca za pričinjenu štetu, isključujući ugovorna proširenja odgovornosti.[24] Retki su opšti uslovi osiguranja koji ne poznaju takvo isključenje obaveze osiguravača.[25] Takvo postupanje osiguravača u skladu je s teoretski prihvaćenim ograničenjima obaveze osiguravača,[26] mada su ovakva ograničenja teško objašnjiva iz aspekta ugovorne odgovornosti, koja po svojoj prirodi često prevazilazi zakonske okvire.

Ostavljajući na ovom mestu sve izazove na koje u praksi nailazi ugovorna odgovornost, zaključujemo da je osiguranje od ugovorne odgovornosti vrsta osiguranja koja će, bez sumnje, u budućnosti sticati sve veći praktični značaj. Osiguranje od odgovornosti je postalo osnovni tip osiguranja[27] i preuzelo je zadatak zaštite

[21] Primera radi, izvođači radova (građevinski radnici, stolari, moleri, stakloresci i slično), osim što za kvalitet izvedenih radova mogu da odgovaraju izvođaču radova, mogu da odgovaraju i trećim licima koja pretrpe štetu usled nekvalitetno izvedenih radova. Međutim, izvođači radova se ne mogu smatrati profesionalcima.

[22] Odličan primer su javni beležnici koji bez dileme profesionalno odgovaraju. Kako su obavezni da postupaju u skladu s javnim ovlašćenjem, nepristrasno, oni licima kojima prouzrokuju štetu nepostupanjem u skladu sa standardom profesionalne pažnje odgovaraju prema pravilima vanugovorne odgovornosti. O prirodi odgovornosti javnih beležnika videti: Marija Karanikić Mirić, „Odgovornost javnih beležnika u srpskom građanskom pravu", *Pravni život*, 10/2014, str. 569 i dalje. O specifičnosti osiguranja od odgovornosti javnih beležnika videti: Slobodan Jovanović, „Pravni položaj javnog beležnika i specifičnosti osiguranja od njegove profesionalne odgovornosti", *Tokovi osiguranja*, br. 3/2020, str. 7-18.

[23] Izjednačavanje profesionalne odgovornosti i ugovorne odgovornosti u ugovornom pravu osiguranja dovodi do nedoumica o vrstama odgovornosti pojedinih profesionalaca. Dobar primer su posrednici u osiguranju i pitanje da li oni osiugravaču odgovaraju prema pravilima ugovorne ili vanugovorne odgovornosti. O prirodi odgovornosti posrednika u osiguranju videti: Jasna Pak, „Obaveze, odgovornost i osiguranje od odgovornosti posrednika u osiguranju", *Tokovi osiguranja*, 1/2018, str. 48.

[24] Primera radi: WIENER STADTISCHE OSIGURANJE ADO BEOGRAD, *Opšti uslovi za osiguranje od profesionalne odgovornosti*, WS.C06.1.C.11.1399_7 od 16. 2. 2011, str. 1. SAVA NEŽIVOTNO OSIGURANJE A.D.O. BEOGRAD, *Opšti uslovi za osiguranje od profesionalne odgovornosti*, 10/2021 od 12. 2. 2010, str. 1. GLOBOS OSIGURANJE ADO BEOGRAD, PREDUGOVORNE INFORMACIJE ZA UGOVARAČA OSIGURANJA – OSIGURANJE PROFESIONALNE ODGOVORNOSTI ADVOKATA, https://globos.rs/storage/files/Predugovorna_informacija_-_profesionalna_odgovornost_advokata_03-18-2022_14:24:38.pdf, pristupljeno: 11. 5. 2024, str. 1. GLOBOS OSIGURANJE ADO BEOGRAD, PREDUGOVORNE INFORMACIJE ZA UGOVARAČA OSIGURANJA - OSIGURANJE PROFESIONALNE ODGOVORNOSTI POSREDNIKA U OSIGURANJU, https://globos.rs/storage/files/Predugovorna_informacija_osiguranje_profesionalne_odgovornosti_posrednika_u_osiguranju_03-18-2022_14:14:42.pdf, pristupljeno: 11. 5. 2024, str. 1.

[25] Primera radi: DDOR NOVI SAD, ADO NOVI SAD, *Uslovi za osiguranje profesionalne odgovornosti advokata*, DDOR-RS-OA-37-0315 od 12. 3. 2015, str. 3.

[26] Predrag Šulejić, „Osiguranje od odgovornosti davalaca usluga", *Anali Pravnog fakulteta u Beogradu*, 6/1982, str. 1026. Nataša Petrović Tomić, „Osiguranje od profesionalne odgovornosti advokata", *Pravni život*, 10/2011, str. 860.

[27] André Tunc, „Građanskopravna odgovornost i osiguranje", *Pravni život*, 2/1982, str. 228.

oštećenog lica jer mu olakšava i ubrzava naknadu pretrpljene štete.[28] Međutim, kako treće oštećeno lice od osiguravača potražuje naknadu štete za koju je ugovorno odgovoran osiguranik?

II Direktan zahtev trećeg oštećenog lica prema osiguravaču

Vratimo se glavnoj specifičnosti osiguranja od odgovornosti, a to je dvostruka zaštita[29] koju osiguravač pruža licima koja su učestvovala u štetnom događaju za koji se građanski odgovara i zbog kog postoji obaveza naknade štete. Ukratko, osiguravač štiti osiguranika preuzimanjem njegove obaveze naknade štete trećem oštećenom licu, a štiti treće oštećeno lice garantujući mu naknadu prouzrokovane štete.[30] Posmatrajući osiguranje od odgovornosti iz ugla štetnika i oštećenog, ugovarač osiguranja ugovara osiguranje od odgovornosti kako bi obezbedio da oštećeni pored (a u praksi umesto njega) štetnika (osiguranika) bude dužnik obaveze naknade štete oštećenom, a oštećeni osiguranjem od odgovornosti dobija pored štetnika još jednog, i to solventnog dužnika.[31,32]

Međutim, kako treće lice nije u obligacionom odnosu sa osiguravačem, niti je korisnik osiguranja[33] u skladu s pravilima ugovornog prava osiguranja,[34,35] a smatra se centralnim licem osiguranja od odgovornosti,[36] postavlja se pitanje po kom osnovu treće oštećeno lice ima pravo da potražuje naknadu štete od osiguravača.

[28] Loris Belanić, str. 553.

[29] Osim što pruža zaštitu širem krugu lica od ugovarača osiguranja i osiguranika, osiguranje usmerava obavezu naknade štete ka solventnom dužniku, osiguravaču, čime na posredan način omogućava nesmetan ekonomski rast svojim osiguranicima. O tome: Nataša Petrović Tomić, „Liability insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory", *Annals FLB – Belgrade Law Review*, No 4, Year LXVIII, 2020, str. 81-83.

[30] Nataša Petrović Tomić, „Liability insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory", *Annals FLB – Belgrade Law Review*, No 4, Year LXVIII, 2020, str. 81.

[31] N. Petrović Tomić (2019), str. 493. Zvonimir Matić, „Pravni i društveno-ekonomski aspekti osiguranja od odgovornosti", *Zbornik Pravnog fakulteta Sveučilišta u Zagrebu*, broj 47, str. 1029.

[32] S obzirom na to da su u praksi usluge osiguranja od odgovornosti pretežno potrošačka osiguranja, veliki uticaj na podizanje nivoa zaštite trećih oštećenih lica u evropskom kontinentalnom pravu izvršilo je i pravo Evropske unije. Potrošačka prava su decenijama jedna od glavnih tema u pravu Evropske unije. O tome: Emilia Mišćenić, „The constant change of EU consumer law: the real deal or just an illusion?", *Annals FLB – Belgrade Law Review*, 3/2022, str. 699-730.

[33] Iako ZOO i pravna praksa treće oštećeno lice ne smatraju korisnikom osiguranja, budući da se izraz korisnik osiguranja pretežno vezuje za osiguranje života, čini se da nije pogrešno reći da treće lice jeste korisnik osiguranja, jer se ugovor o osiguranju od odgovornosti u smislu odredaba ZOO može smatrati ugovorom u korist trećeg lica. Videti: Čl. 149. st. 1. ZOO.

[34] Zakon o osiguranju – ZO, *Sl. glasnik RS*, br. 139/2014 i 44/2021, kao statusni zakon u oblasti prava osiguranja, prepoznaje treće oštećeno lice kao korisnika osiguravajuće usluge, poštujući opšti stav u ugovornom pravu osiguranja da treće oštećeno lice nije korisnik osiguranja. Videti: čl. 15. st. 1. ZO.

[35] O potrebi da se ugovorno pravo osiguranja u Republici Srbiji reguliše posebnim zakonom videti: Nataša Petrović Tomić, „O potrebi unapređenja srpskog regulatornog okvira osiguranja usvajanjem zakona o ugovoru o osiguranju", Tokovi osiguranja, br. 2/2018, str. 7-18.

[36] Videti: M. Ćurković, str. 249.

Jedini način da se treće oštećeno lice i osiguravač uvedu u obligacioni odnos bilo je utvrđivanje zakonskog osnova[37] da ono ističe osiguravaču direktan zahtev[38] za naknadu štete.[39,40]

Na ovom mestu treba istaći da je obim prava trećeg oštećenog lica prema osiguravaču uži[41] od obima prava trećeg oštećenog lica prema štetniku (osiguraniku)

[37] U pravnoj teoriji postoje dileme o osnovu prava trećeg oštećenog lica prema osiguravaču – da li je osnov prava trećeg oštećenog lica prema osiguravaču zakon, ugovor ili pretrpljena šteta. O tome: Predrag Šulejić, *Osiguranje od građanske odgovornosti*, Beograd, 1967, str. 124–127. Vladimir Marjanski, „Pravna priroda ugovora o osiguranju od odgovornosti", *Pravni život*, 10/2005, str. 1135 i dalje.

[38] U ovom radu koristićemo izraz direktan zahtev trećeg oštećenog lica prema osiguravaču, iako ZOO na mestu na kome utvrđuje ovo pravo koristi izraz direktna tužba. Prvo, taj izraz implicitno (pogrešno) ukazuje na to da treće oštećeno lice svoje pravo može ostvarivati samo u sudskom postupku. Drugo, izraz direktan zahtev trećeg oštećenog lica prema osiguravaču više odgovara savremenim tendencijama vansudskog rešavanja sporova iz osiguranja, koje su naročito značajne za osiguranje od odgovornosti koje ima veliki parnični potencijal. Slično o ovome: Nataša Petrović Tomić (2019), str. 525. S druge strane, odredba kojom ZOO reguliše dužinu roka zastarelosti direktnog zahteva oštećenog lica, koristi izraz *neposredan zahtev* trećeg oštećenog lica, koji je daleko više u skladu s pomenutim tendencijama.

[39] U našem pravnom sistemu, to pravo je ustanovljeno odredbom čl. 941. st. 1. ZOO pre svega pod uticajem sudske prakse koja je kod osiguranja od odgovornosti vlasnika motornih vozila počela da ustanovljava ovo pravo trećim oštećenim licima i pre stupanja na snagu ZOO. O tome: Predrag Šulejić, *Pravo osiguranja*, peto izdanje, Beograd, 2005, str. 417. U čl. 918. st. 1. Skice za Zakonik o obligacijama i ugovorima profesora Mihaila Konstantinovića, postojala je ista odredba, ali je direktan zahtev trećeg oštećenog lica prema osiguravaču bio uslovljen time da treće oštećeno lice nije dobilo naknadu od štetnika. Videti: Mihailo Konstantinović, *Obligacije i ugovori – Skica za Zakonik o obligacijama i ugovorima*, Beograd, 1996, str. 308.

[40] Na ovom mestu ističemo da je do ovako ranog razvoja prava trećeg oštećenog lica prema osiguravaču došlo pod uticajem francuskog prava, koje poznaje pravo na direktan zahtev trećeg oštećenog lica prema osiguravaču od donošenja zakona od 13. jula 1930. godine, koji je donet pod uticajem sudske prakse. Videti: Bonnard, str. 257 i dalje; Lambert- Faivre, Laveneur, str. 15; Jean Bigot, Jérôme Kullmann, Luc Mayaux, *Traité de Droit des Assurances, Les Assurances de Dommages, Tome 5*, Paris, 2017, 707. Međutim, pravni sistemi koji, poput srpskog i francuskog, regulišu zahtev trećeg oštećenog lica prema osiguravaču pre su izuzeci nego pravilo. Veliki broj evropskih pravnih sistema ovo pravo priznaje mnogo kasnije, i to prvenstveno pod uticajem direktiva Evropske unije koje regulišu ostvarivanje prava u oblasti obaveznog osiguranja u saobraćaju. U tu grupu spadaju i veliki evropski pravni sistemi poput nemačkog, austrijskog i italijanskog. O tome: Nataša Petrović Tomić (2019), str. 527–528. Loris Belanić, str. 579–586. U Velikoj Britaniji, pravo trećeg oštećenog lica je, iz ugla našeg i francuskog prava, izuzetno ograničeno. U skladu s britanskim Third Parties (Rights against Insurers) Act 2010, treće oštećeno lice ima pravo na direktan zahtev ka osiguravaču u slučaju kada je „osiguranik insolventan ili u nekim drugim slučajevima". Time je pravo Velike Britanije napravilo pomak u odnosu na prethodni zakon u ovoj oblasti. Za razliku od prethodno važećeg zakona (Third Parties (Rights against Insurers) Act 1930), sada osiguranik može podneti zahtev osiguravaču a da pritom nije utvrđena odgovornost osiguranika. Ipak, prava ne može da ostvari bez utvrđivanja odgovornosti koja se u skladu s tim zakonom može utvrditi na osnovu presude ili naredbe, odlukom u arbitražnom postupku ili izvršnim sporazumom. Prema: Thomas Rhidian, „Third Party Direct Rights of Action against Insurers under UK Law and International Maritime Liability Conventions", *Regulation of Risk – Transport, Trade and Environment in Perspective*, (Editors: Abhinayan Basu Bal, Trisha Rajput, Gabriela Argüello, and David Langlet, Brill Nijhoff), 2023, str. 685. Britanski Zakon o trećim licima (prava prema osiguravačima) iz 2010. godine (Third Parties (Rights against Insurers) Act 2010), par. 4.

[41] Postoje kako zakonska tako i ugovorna ograničenja obima obaveze naknade štete osiguravača prema trećem oštećenom licu.

shodno pravilima građanske odgovornosti, što je posledica mogućnosti i interesa osiguravača da osigura građansku odgovornost osiguranika u punom obimu.[42] Međutim, postavlja se pitanje da li je postojanje samog prava na isticanje direktnog zahteva trećeg oštećenog lica prema osiguravaču izjednačeno s postojanjem njegovog prava prema štetniku u skladu s pravilima građanske odgovornosti. Kako je postojanje svakog prava pre svega uslovljeno mogućnošću da se to pravo ostvaruje, analiziraćemo u kom roku treće oštećeno lice ima pravo da potražuje naknadu štete od štetnika, a u kom roku od osiguravača, odnosno kada njegovo pravo prema dužnicima naknade štete zastareva.

III Zastarelost prava na naknadu štete

1. O zastarelosti uopšte

Zastarelost se može definisati kao vremensko ograničenje prava poverioca da sudskim putem zahteva od dužnika ispunjenje obaveze.[43] Institutom zastarelosti prvenstveno se rasterećuje pravosudni sistem i sankcioniše poverilac koji u određenom periodu ne preduzima radnje u cilju namirenja svog potraživanja, jer postoji opravdana pretpostavka da nije ni zainteresovan za njegovo namirenje.[44]

S obzirom na to da se zastarelošću vremenski ograničava pravo poverioca da zahteva ispunjenje obaveze, jasno je da je ključno pitanje to posle kog vremena se smatra da poveriocu treba oduzeti pravo da zahteva namirenje svog potraživanja. Čini se da se rokovi zastarelosti određuju pre svega shodno prirodi potraživanja i svojstvima poverioca i dužnika. Može se reći je to bila i zakonodavna logika prilikom utvrđivanja roka zastarelosti potraživanja trećeg oštećenog lica prema štetniku odnosno osiguravaču.

2. Dužina rokova zastarelosti potraživanja trećeg oštećenog lica

U duhu izjednačavanja prava trećeg oštećenog lica prema štetniku i prema osiguravaču, srpski zakonodavac je izbegao da se na zastarelost potraživanja trećeg oštećenog lica prema osiguravaču primene opšta pravila o zastarelosti potraživanja iz ugovora o osiguranju,[45] te je predvideo da neposredan zahtev trećeg oštećenog

[42] Predrag Šulejić, „Odnos osiguranja i građanskopravne odgovornsoti", *Pravni* život, 9-10/1992, 2253-2267. Marija Karanikić Mirić, „Odgovornost vlasnika motornog vozila kao preduslov obaveze osiguravača", *Pravni život,* 10/2011, str. 687 i dalje.

[43] Slično: Nebojša Jovanović, *Ključne razlike engleskog i srpskog ugovornog prava*, II izdanje, Beograd, 2018, str. 136.

[44] Slično: Jakov Radišić, str. 421. Marija Karanikić Mirić, „Ograničenja odgovornosti za štetu u srpskom pravu", *Anali Pravnog fakulteta u Beogradu*, 1/2012, str. 246.

[45] Videti: Čl. 380. st. 1. i 2. ZOO.

lica prema osiguravaču zastareva za isto vreme za koje zastareva njegov zahtev prema osiguraniku odgovornom za štetu.[46] Pored toga, zabranio je produžavanje i skraćivanje rokova zastarelosti pravnim poslom.[47]

Uzimajući u obzir da postoje pravni sistemi kod kojih potraživanje trećeg oštećenog lica prema osiguravaču ne zastareva u istom roku kada i njegovo potraživanje prema štetniku,[48] kao i da imperativnost dužine rokova zastarelosti nije sveprisutna u uporednom pravu,[49] možemo reći da su rokovi zastarelosti u srpskom pravu, u domenu direktnog prava trećeg oštećenog lica prema osiguravaču, u dobroj meri okrenuti ka zaštiti trećeg oštećenog lica, jer održavaju izvesnost u pravnom prometu.

Međutim, kada se podsetimo da građanska odgovornost nije jedinstvena, odnosno da razlikuje ugovornu i vanugovornu odgovornost koje su međusobno drugačije u nizu aspekata,[50] postavlja se pitanje da li među njima postoji razlika u zastarelosti prava na naknadu štete koja bi se dalje odrazila na zastarelosti prava trećeg oštećenog lica prema osiguravaču.

3. Zastarelost prava na naknadu štete na osnovu ugovorne i vanugovorne odgovornosti

Ako analiziramo zastarelost prava uopšte, ključno je odgovoriti na dva pitanja. Prvo, kada počinje da teče rok zastarelosti potraživanja naknade štete, a drugo, koje vreme je potrebno za nastupanje zastarelosti. Kod zastarelosti prava na naknadu štete na osnovu ugovorne i vanugovorne odgovornosti, na prvi pogled, odgovor na oba pitanja će nam dati odredbe člana 376 ZOO, koji nosi naziv *Potraživanje naknade štete*.

[46] Videti: Čl. 380. st. 5. ZOO.

[47] Videti: Čl. 364. st. 1. ZOO.

[48] Francusko pravo je iz ugla trećeg oštećenog lica pozitivan izuzetak u ovom smislu. Iako je Francuski kasacioni sud još presudom iz 1939. izjednačio rokove zastarelosti potraživanja trećeg oštećenog lica prema štetniku i osiguravaču, u francuskom pravu se primenjuje dvogodišnji rok zastarelosti potraživanja iz ugovora o osiguranju utvrđen članom 114 st. 1 francuskog Zakonika o osiguranju u slučaju kada potraživanje trećeg oštećenog lica u skladu sa odredbama građanskog prava zastareva u roku kraćem od dve godine. Na primer, u skladu s francuskim Trgovačkim zakonikom, potraživanje naknade štete oštećenika prema prevozicu zastareva za godinu dana. Međutim, pravo trećeg oštećenog lica prema osiguravaču kod osiguranja ugovorne odgovornosti prevozioca zastareva u roku od dve godine, primenom dvogodišnjeg roka iz Zakonika o osiguranju. Videti: J. Bonnard, str. 271. Francuski Zakonik o osiguranju iz 1989. godine (Code des assurance), par. L144-1. Francuski Trgovinski zakonik iz 1807. godine (Code de commerce), par. 133–6.

[49] Primer su nemačko i austrijsko pravo, koja dozvoljavaju skraćenje roka zastarelosti. Prema: Marija Karanikić Mirić, „Zastarelost potraživanja naknade štete prouzrokovane krivičnim delom", *Anali Pravnog fakulteta u Beogradu*, 1/2011, str. 181. U engleskom pravu, ugovorne strane mogu ugovorom da skrate rok zastarelosti, a i da ga produže, nakon što je počeo da teče. Prema: N. Jovanović, str. 136.

[50] O tome: Nenad Grujić, „Odnos ugovorne i vanugovorne odgovornosti za štetu", *Zbornik radova Pravnog fakulteta u Nišu*, br. 52, str. 211–234.

3.1. Početak toka rokova zastarelosti potraživanja naknade štete

Zastarelost potraživanja naknade štete za koju se odgovara po pravilima vanugovorne odgovornosti počinje teći kad je oštećenik doznao za štetu i za lice koje je štetu pričinilo, što je eksplicitno propisano odredbom čl. 376. st. 1. ZOO, koja reguliše zastarelost naknade štete za koju se odgovara po pravilima vanugovorne odgovornosti. S druge strane, odgovor na pitanje kada počinje teći zastarelost potraživanja naknade štete za koju se odgovara po pravilima ugovorne odgovornosti, nećemo ovako direktno naći u odredbi čl. 376. st. 3. ZOO koja reguliše zastarelost naknade štete za koju se odgovara po pravilima ugovorne odgovornosti. Tumačenjem odredaba ZOO dolazimo do zaključka da su pravila o vanugovornoj odgovornost za štetu opšta, a pravila o ugovornoj odgovornosti posebna,[51] kao i da odredba čl. 376. st. 1. ZOO utvrđuje početak i trajanje roka zastarelosti, dok čl. 376. st. 3. ZOO isključivo utvrđuje trajanje roka zastarelosti. Zbog toga dolazimo do zaključka da zastarelost naknade štete po osnovu ugovorne odgovornosti počinje teći prema pravilu koje je ustanovljeno čl. 376. st. 1. ZOO, odnosno u istom trenutku kada počinje teći zastarelost potraživanja naknade štete za koju se odgovara po pravilima vanugovorne odgovornosti.[52]

Na ovom mestu zaključujemo da su do ove tačke pravila o zastarelosti potraživanja naknade štete za koju se odgovara po pravilima vanugovorne i ugovorne odgovornosti u potpunosti izjednačena – zastarelost potraživanja naknade štete u oba slučaja počinje teći kad je oštećenik doznao za štetu i za lice koje je štetu pričinilo. Posledično, bez obzira na to da li je predmet osiguranja od odgovornosti ugovorna ili vanugovorna odgovornost za štetu, zastarelost prava trećeg oštećenog lica prema osiguravaču takođe počinje teći kad je oštećenik doznao za štetu i za lice koje je štetu pričinilo. Međutim, još uvek nismo odgovorili na pitanje koje vreme je potrebno za nastupanje zastarelosti potraživanja naknade štete kod vanugovorne, a koje kod ugovorne odgovornosti.

3.2. Dužina rokova zastarelosti potraživanja naknade štete

Zastarelost potraživanja naknade štete za koju se odgovara po pravilima vanugovorne odgovornosti traje tri godine od kad je oštećenik doznao za štetu i za lice koje je štetu učinilo, a u svakom slučaju u roku od pet godina od kad je šteta nastala,[53] što je eksplicitno propisano odredbama čl. 376. st. 1. i st. 2. ZOO, koje

[51] Tako i: Marija Karanikić Mirić, *Objektivna odgovornost za štetu*, Drugo izdanje, Beograd, 2019, str. 50.

[52] Tako i: Nenad Grujić, *Raskid ugovora zbog neispunjenja i pravna dejstva raskida*, Prvo izdanje, Beograd, 2016, str. 500.

[53] Komisija za izradu Građanskog zakonika razmatra produženje objektivnog roka zastarelosti potraživanja naknade štete na deset godina. Videti: Komisija za izradu Građanskog zakonika, Prednacrt. Građanski

regulišu zastarelost naknade štete za koju se odgovara po pravilima vanugovorne odgovornosti.

Međutim, opšta odredba iz čl. 376. st. 3. ZOO o potraživanju naknade štete za koju se odgovara po pravilima ugovorne odgovornosti eksplicitno reguliše drugačiju dužinu roka zastarelosti. Ona kaže da potraživanje naknade štete nastale povredom ugovorne obaveze zastareva za vreme određeno za zastarelost te obaveze. Ta upućujuća odredba ZOO nalaže dva koraka pre odgovora na pitanje. Prvo, potrebno je utvrditi povredom koje obaveze je prouzrokovana šteta oštećenom, jer je zakonodavac rok zastarelosti potraživanja naknade štete za koju se odgovara po pravilima ugovorne odgovornosti vezao za rok zastarelosti ugovorne obaveze koja je povređena.[54] Drugo, potrebno je utvrditi i dužinu roka zastarelosti potraživanja naknade štete za koju se odgovara po pravilima ugovorne odgovornosti. Kako ZOO nije propisao opšti rok zastarelosti ugovorne obaveze koja je povređena, dilemu moramo razrešiti sistemskim tumačenjem odredaba o vremenu potrebnom za nastupanje zastarelosti potraživanja uopšte. Ostavljajući po strani posebne rokove koje ZOO propisuje za pojedina potraživanja,[55] dolazimo do zaključka da potraživanje naknade štete na osnovu ugovorne odgovornosti zastareva u opštem roku zastarelosti odnosno protekom deset godina[56] od kada je zastarelost počela teći, osim ako je do prouzrokovanja štete došlo povredom ugovorne obaveze na osnovu ugovora o prometu robe i usluga koji su zaključila pravna lica kada potraživanje naknade štete na osnovu ugovorne odgovornosti zastareva protekom roka od tri godine od kada je zastarelost počela teći.[57]

Na osnovu ove analize dolazimo do zaključaka da potraživanje oštećenika za štetu za koju štetnik odgovara po pravilima ugovorne odgovornosti ne zastareva za isto vreme kada i potraživanje oštećenika za štetu za koju štetnik odgovara po pravilima vanugovorne odgovornosti. Kada se podsetimo da neposredan zahtev

zakonik Republike Srbije. Druga knjiga. Obligacioni odnosi, Vlada Republike Srbije, Beograd, 2009, *https://akv.org.rs/wp-content/uploads/2016/03/knjiga-2.pdf*, pristupljeno: 6. 5. 2024, str. 125. Isti rok zastarelosti je bio propisan i Zakonom o zastarelosti potraživanja (*Službeni list FNRJ*, br. 40/53 i 57/54), koji se primenjivao do stupanja na snagu ZOO. Prema: Marija Karanikić Mirić, „Ograničenja odgovornosti za štetu u srpskom pravu", *Anali Pravnog fakulteta u Beogradu*, 1/2012, str. 256.

[54] Tako i: N. Grujić, str. 497 i dalje.

[55] Primera radi, potraživanja povremenih davanja koja dospevaju godišnje ili u kraćim određenim razmacima vremena zastarevaju za tri godine od dospelosti svakog pojedinog davanja. Potraživanje zakupnine zastareva za tri godine. Za jednu godinu zastarevaju potraživanja naknade za isporučenu električnu i toplotnu energiju, plin, vodu, za dimničarske usluge i za održavanje čistoće, kad je isporuka odnosno usluga izvršena za potrebe domaćinstva, potraživanja radio-stanice i radio-televizijske stanice za upotrebu radio-prijemnika i televizijskog prijemnika, potraživanja pošte, telegrafa i telefona za upotrebu telefona i poštanskih pregradaka, kao i druga njihova potraživanja koja se naplaćuju u tromesečnim ili kraćim rokovim, potraživanja pretplate na povremene publikacije, računajući od isteka vremena za koje je publikacija naručena. Videti: čl. 372, čl. 375. i čl. 378. ZOO.

[56] Videti: Čl. 371. ZOO.

[57] Videti: Čl. 374. st. 1. ZOO.

trećeg oštećenog lica prema osiguravaču zastareva za isto vreme za koje zastareva njegov zahtev prema osiguraniku odgovornom za štetu, dolazimo do zaključka da neposredan zahtev trećeg oštećenog lica prema osiguravaču vanugovorne odgovornosti zastareva u roku od tri godine od kad je doznao za štetu i za lice koje je štetu učinilo, a u svakom slučaju u roku od pet godina od kad je šteta nastala. Neposredan zahtev trećeg oštećenog lica prema osiguravaču ugovorne odgovornosti zastareva u roku od tri odnosno deset godina od kada je doznao za štetu i za lice koje je štetu pričinilo. S obzirom na veliku razliku u dužini mogućih rokova zastarelosti potraživanja trećeg oštećenog lica prema osiguravaču ugovorne odgovornosti, postavlja se pitanje kada će se primeniti koji od ova dva roka zastarelosti.

3.3. Kada će direktan zahtev trećeg oštećenog lica prema osiguravaču zastarevati za tri, a kada za deset godina?

Dilemu da li je vreme potrebno za nastupanje zastarelosti potraživanja trećeg oštećenog lica prema osiguravaču tri ili deset godina od trenutka kad je oštećenik doznao za štetu i za lice koje je štetu pričinilo, analiziraćemo iz perspektive ugovorne odgovornosti osiguranika za štetu koju je prouzrokovao oštećenom licu zbog neispunjenja, odnosno neurednog ili neblagovremenog ispunjenja ugovorne obaveze. Potraživanje naknade štete prema pravilima ugovorne odgovornosti po opštem pravilu zastareva za deset godina, a izuzetno za tri godine ako je do prouzrokovanja štete došlo povredom ugovorne obaveze na osnovu ugovora o prometu robe i usluga koji su zaključila pravna lica. Prema tome, treba da odgovorimo na pitanje kada će potraživanje oštećenog lica prema osiguraniku odgovornom za štetu zastareti za tri godine, jer će u suprotnom zastareti za deset. Tumačenjem odredbe čl. 374. st. 1. ZOO, dolazimo do zaključka da se rok zastarelosti od tri godine primenjuje ako su ispunjena dva kumulativna uslova: (i) da su poverilac i dužnik pravna lica, (ii) da je osnov potraživanja ugovor o prometu robe i usluga.

Vraćajući se u okvire osiguranja od ugovorne odgovornosti, potraživanje trećeg oštećenog lica prema osiguravaču će zastareti za deset godina, osim (i) ako su treće oštećeno lice i osiguranik odgovoran za štetu pravna lica i (ii) ako je osiguranik štetu prouzrokovao oštećenom licu povredom obaveze iz ugovora o prometu robe i usluga, kada će zastareti za tri godine. Analiziraćemo oba uslova, i to tako što ćemo krenuti od drugog. Čini se da je uslov da je šteta prouzrokovana oštećenom licu povredom obaveze iz ugovora o prometu robe i usluga najmanje sporan, jer je predmet osiguranja od odgovornosti mahom ugovorna odgovornost zbog propusta u pružanju usluga.[58] Polazeći od toga da je kod osiguranja od ugovorne odgovornosti

[58] Ovo je naročito tačno ako ovo pitanje posmatramo iz ugla prakse osiguranja. Podsećamo da je do izjednačavanja osiguranja od profesionalne odgovornosti i osiguranja od ugovorne odgovornosti došlo pre svega jer profesionalna odgovornost u praksi dominira kao predmet osiguranja od ugovorne odgovornosti, a profesionalna odgovornost najčešće podrazumeva profesionalnu odgovornost za pruženu uslugu.

ispunjen drugi uslov, analizirajući prvi uslov, za primenu roka zastarelosti od tri godine, vidimo da je potrebno da oštećeno lice i osiguranik budu pravna lica. Kako oštećeno lice mogu biti različiti pravni subjekti, te da takva analiza prevazilazi okvire ovog rada, dalju analizu usmerićemo ka pitanju pravnog subjektiviteta osiguranika, i to na primeru osiguranja od advokatske odgovornosti. [59]

Advokat se može baviti advokaturom samostalno, u zajedničkoj advokatskoj kancelariji ili kao član advokatskog ortačkog društva.[60] Advokat koji delatnost obavlja samostalno, tu delatnost obavlja kao preduzetnik, dok zajednička advokatska kancelarija nema svojstvo pravnog lica.[61] To znači da ako je štetnik samostalan advokat ili zajednička advokatska kancelarija, obaveza štetnika, pa i osiguravača da oštećenom licu naknade štetu zastareva za deset godina od trenutka kad je oštećenik doznao za štetu i za lice koje je štetu pričinilo. S druge strane, ako je štetnik advokatsko ortačko društvo[62] koje je pravno lice,[63] obaveza štetnika, pa i osiguravača da oštećenom pravnom licu, naknade štetu zastareva za tri godine od trenutka kad je oštećenik doznao za štetu i za lice koje je štetu pričinilo.

Međutim, izneto tumačenje dužine rokova zastarelosti neposrednog zahteva trećeg oštećenog lica prema osiguravaču ugovorne odgovornosti nije u potpunosti u skladu s tumačenjima tih rokova zastarelosti u teoriji i praksi.[64]

IV Razlozi neprimenjivanja zakonskog roka zastarelosti obaveze osiguravača kod osiguranja ugovorne odgovornosti

Što se tiče teoretskih razmatranja kod nas, prema autorki dostupnim izvorima do sada nije posebno analizirana dužina rokova zastarelosti neposrednog zahteva trećeg oštećenog lica kod osiguranja od ugovorne odgovornosti.[65] S druge strane,

[59] Više o osiguranju od advokatske odgovornosti: Nataša Petrović Tomić, „Osiguranje od profesionalne odgovornosti advokata - srpska verzija novog oblika obaveznog osiguranja", Tokovi osiguranja, br. 3/2012, str. 17-40.

[60] Videti: Zakon o advokaturi – ZA, *Sl. glasnik RS*, br. 31/2011 i 24/2012 – odluka US, čl. 44.

[61] Videti: čl. 45. st. 5. ZA.

[62] O uređivanju slobodnih profesija, među koje spada i advokatura, videti: Mirko Vasiljević, *Kompanijsko pravo*, deveto izdanje, Beograd, 2015, str. 449 i dalje.

[63] Na rad i poslovanje advokatskih ortačkih društava primenjuju se odredbe zakona kojim je uređeno poslovanje ortačkih društava. Videti: čl. 52. st. 1. ZA. Ortačka društva su privredna društva, a privredna društva su pravna lica koja obavljaju delatnost u cilju sticanja dobiti. Videti: Zakon o privrednim društvima, *Sl. glasnik RS*, br. 36/2011, 99/2011, 83/2014 – dr. zakon, 5/2015, 44/2018, 95/2018, 91/2019 i 109/2021, čl. 2. i čl. 93. st. 1.

[64] Što se tiče rokova zastarelosti neposrednog zahteva trećeg oštećenog lica prema osiguravaču vanugovorne odgovornosti, izneto tumačenje u potpunosti je u skladu s tumačenjima ovih rokova zastarelosti u sudskoj praksi. Videti: Presuda Vrhovnog kasacionog suda Rev 1672/2016 od 15. 12. 2016. Presuda Vrhovnog kasacionog suda Rev 4490/2018 od 2. 7. 2020.

[65] Prema podacima koji su nam bili dostupni u toku pisanja ovog rada, došli smo do zaključka da se prilikom analize zastarelosti uopšte teorija zadržava na odredbi čl. 390. st. 5. ZOO, a da se naučni radovi

naša sudska praksa zauzima stav da potraživanje trećeg oštećenog lica prema osiguravaču kod osiguranja od ugovorne odgovornosti takođe zastareva u roku od tri godine od kad je oštećenik doznao za štetu i za lice koje je štetu učinilo, a u svakom slučaju u roku od pet godina od kad je šteta nastala,[66] kao i u slučaju osiguranja od vanugovorne odgovornosti. To pravilo nije bez izuzetka, te se nailazi i na sudsku praksu koja prepoznaje razliku između obaveze osiguravača prema trećem oštećenom licu na osnovu ugovorne i vanugovorne odgovornosti.[67] Smatramo da je stav sudske prakse da su rokovi zastarelosti neposrednog zahteva trećeg oštećenog lica prema osiguravaču ugovorne i vanugovorne odgovornosti isti, posledica tri okolnosti.

Prvo, kako smo i pokazali u ovom radu, ZOO je daleko jasnije definisao rokove zastarelosti potraživanja naknade štete prema pravilima vanugovorne nego ugovorne odgovornosti.[68] Nijedan aspekt zastarelosti kod ugovorne odgovornosti (početak roka i trajanje roka) nije zakonski izričito regulisan, već proizlazi iz pravila tumačenja, tako da se nije moglo očekivati da će njegova primena biti nesporna u praksi.[69] Naspram toga, rokovi zastarelosti naknade štete prema pravilima vanugovorne odgovornosti definisani su kroz dva stava jednog člana i to na način da zakonodavac nije ostavio nikakav prostor za različita tumačenja u praksi.

Drugo, mora se imati na umu da na tržištu osiguranja u Republici Srbiji i sudskoj praksi još uvek apsolutno dominiraju neposredni zahtevi trećih oštećenih lica prema osiguravaču kod vanugovorne odgovornosti u odnosu na ugovornu odgovornost, kako u postupcima na osnovu zahteva za naknadu štete, tako i u sudskim postupcima. To je pre svega posledica apsolutne dominacije obaveznog osiguranja od odgovornosti vlasnika motornih vozila za štete pričinjene trećim licima na tržištu osiguranja Republike Srbije.[70] Dodatno, obavezno osiguranje od odgovornosti

koji su posvećeni osiguranju od ugovorne odgovornosti ne koncentrišu na rokove zastarelosti, što je i razumljivo s obzirom na niz drugih specifičnosti osiguranja ugovorne (naročito profesionalne) odgovornosti. U jednom radu smo naišli na tumačenje rokova zastarelosti neposrednog zahteva trećeg oštećenog lica prema osiguravaču, koje je isključivo bilo usmereno na pitanje osiguranja ugovorne odgovornosti. Videti: Dionis Jurić, Loris Belanić, „Odgovornost za štetu zakonskog revizora i obveza osiguranja od odgovornosti za štetu", *Zbornik pravnog fakulteta Sveučilišta u Rijeci*, vol. 39. br. 4 2018 (Posebni broj), str. 1836.

[66] Videti: Presuda Osnovnog suda u Paraćinu, sudska jedinica u Ćupriji P 629/22 od 21. 2. 2023. Presuda Višeg suda u Nišu Gž 3547/21 od 8. 2. 2022. Presuda Trećeg osnovnog suda u Beogradu P 7770/17 od 14. 6. 2019.

[67] Videti: Presuda Osnovnog suda u Nišu P 6513/2019 od 26. 3. 2021.

[68] Pravila o zastarelosti potraživanja naknade na osnovu ugovorne odgovornosti su samoodrediva. Prema: N. Grujić, 497.

[69] Čini se da je u materiji koja je od izuzetno velikog praktičnog značaja, kao što su pravila o građanskoj odgovornosti, zakonodavac morao posegnuti za zakonodavnom tehnikom koja bi ova pravila učinila vidljivijim prosečnom pravnom praktičaru.

[70] Prema podacima koje društva za osiguranje u Republici Srbiji periodično dostavljaju Narodnoj banci Srbije, u 2022. zaključene su 2.810.204 polise obaveznog osiguranja od odgovornosti vlasnika motornih vozila za štete pričinjene trećim licima, dok su društva za osiguranje u 2022. ukupno zaključila 7.915.497 polisa osiguranja. To znači da od ukupnog broja zaključenih polisa osiguranja, 35,50% čine polise

vlasnika motornih vozila za štete pričinjene trećim licima je i obavezno osiguranje[71] i osiguranje od odgovornosti, zbog čega ima izuzetno veliki parnični potencijal.[72]

Treće, posmatrajući rokove zastarelosti potraživanja naknade štete prema pravilima vanugovorne i ugovorne odgovornosti, primećujemo izvesne nelogičnosti u zakonodavnoj tehnici ZOO. Za potrebe ove analize, uzećemo u obzir primenu opšteg roka zastarelosti od deset godina kod ugovorne odgovornosti.[73] Podsećamo, rokovi zastarelosti potraživanja naknade štete bez obzira na vrstu odgovornosti počinju teći od trenutka kad je oštećenik doznao za štetu i za lice koje je štetu pričinilo. Međutim, nesporno je da je oštećeno lice kome je šteta prouzrokovana povredom ugovorne obaveze u prednosti u odnosu na oštećeno lice kome je šteta prouzrokovana povredom opšteg pravila o zabrani prouzrokovanja štete drugome. Štetu povredom ugovorne obaveze može prouzrokovati samo jedna strana u obligacionom odnosu drugoj strani, odnosno kod ugovorne odgovornosti oštećenik će uvek znati koje lice mu je štetu pričinilo.[74] Ta komparativna prednost oštećenog lica kome je šteta prouzrokovana povredom ugovorne obaveze trebalo bi iz perspektive zakonodavca da se odrazi na pojačanu zaštitu oštećenog lica kome je šteta prouzrokovana povredom opšteg pravila o zabrani prouzrokovanja štete drugome, između ostalog i propisivanjem dužeg roka zastarelosti potraživanja naknade štete. Međutim, u našem pravu je došlo do apsurdne situacije da bi u najvećem broju slučajeva oštećeno lice kome se duguje naknada štete zbog povrede ugovorne obaveze imalo pravo

obaveznog osiguranja od odgovornosti vlasnika motornih vozila za štete pričinjene trećim licima. Što se tiče premije osiguranja, u 2022. neto premija obaveznog osiguranja od odgovornosti vlasnika motornih vozila za štete pričinjene trećim licima iznosila je 38.378.207.000 RSD, a ukupna neto premija osiguranja 133.925.041.000 RSD, što znači da je udeo neto premije obaveznog osiguranja od odgovornosti vlasnika motornih vozila za štete pričinjene trećim licima u ukupnoj neto premiji osiguranja u 2022. iznosio 28,65%. Videti: Narodna banka Srbije, Pregled broja osiguranja, broja osiguranika i premije po vrstama i tarifama osiguranja za Srbiju u 2022. godini. *https://www.nbs.rs/export/sites/NBS_site/documents/osiguranje/godisnji/god_T1_2022.pdf*, pristupljeno 6. 5. 2024.

[71] Budući da se obaveznim osiguranjim teži da se osigura cela zajednica rizika, očekivano je da kod obaveznih osiguranja postoji relativno veći broj (direktnih) zahteva za naknadu štete nego kod zajednica rizika koje su slične veličine, ali kojima nije nametnuta obaveza osiguranja. U Republici Srbiji u 54 zakonska i podzakonska akta (potencijalno i više) propisana je obaveza osiguranja, i to mahom osiguranja od odgovornosti. Videti: Narodna banka Srbije, Obavezna osiguranja u Republici Srbiji, https://www.nbs.rs/export/sites/NBS_site/documents/osiguranje/obavezna_osiguranja.pdf, pristupljeno: 6. 5. 2024.

[72] Najveći broj sporova iz osiguranja odnosi se na osiguranja od odgovornosti. Parnični potencijal osiguranja od odgovornosti je posledica i učestvovanja tri strane u ovom odnosu. O tome: Nataša Petrović Tomić, *Arbitraža i alternativno rešavanje sporova iz osiguranja i reosiguranja*, Beograd, 2024, str. 26.

[73] Rok od tri godine od kada je zastarelost počela teći u slučaju kada je do prouzrokovanja štete došlo povredom ugovorne obaveze na osnovu ugovora o prometu robe i usluga koji su zaključila pravna lica, ostavićemo po strani kao izuzetak.

[74] Slično ovome: Nina Zupan, „Konstantinovićeva koncepcija uređenja zastarelosti: da li su ideje o uticaju vremena u pravu izdržale uticaj vremena na pravo?", *Anali Pravnog fakulteta u Beogradu*, Poseban broj u čast profesora Mihaila Konstantinovića, str. 369.

da potražuje naknadu štete u dva puta dužem roku[75] nego oštećeno lice kome se duguje naknada štete zbog povrede vanugovorne obaveze.

Naše pravo poslednjih trideset godina na ovaj način reguliše dužinu rokova zastarelosti potraživanja naknade štete. Ranije, ti rokovi zastarelosti su četrdeset godina u kontinuitetu bili uvek izjednačeni, iako se njihova dužina menjala.[76] Na zastarelost potraživanja naknade štete zbog povrede ugovorne obaveze primenjuje se opšti rok zastarelosti i ne može se očekivati da će se dužina ovog roka određivati prema odnosu dužine rokova zastarelosti naknade štete.

V Zaključak

Zaključujemo da potraživanje trećeg oštećenog lica prema osiguravaču kod osiguranja od ugovorne odgovornosti za štetu zastareva po pravilu u roku od deset godina od kada je treće oštećeno lice saznalo za štetu i za lice koje je štetu pričinilo. Izuzetno, to potraživanje zastareva u roku od tri godine od kada je treće oštećeno lice saznalo za štetu i za lice koje je štetu pričinilo, pod uslovom da su štetnik i oštećeno lice pravna lica. Kao što smo pokazali u ovom radu, primenjivanje tog roka zastarelosti zavisi od pravnog subjektiviteta trećeg oštećenog lica i štetnika i može se razlikovati čak i u okviru jedne vrste ugovorne odgovornosti. To je posledica opravdanog interesa zakonodavca da skraćuje rok zastarelosti potraživanja između pravnih lica, te dužinu roka zastarelosti treba utvrđivati u svakom pojedinačnom slučaju.

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[75] Čak i u višestruko dužem roku ako u slučaju vanugovorne odgovornosti subjektivni rok od tri godine protekne pre objektivnog roka od pet godina.

[76] Osvrtom na odredbe našeg prava koje su se primenjivale posle Drugog svetskog rata, dolazimo do zaključka da je potraživanje naknade štete za koju štetnik odgovara po pravilima ugovorne odgovornosti u slučajevima kada se primenjivao opšti rok zastarelosti, dugo (od 1953. do 1993.) zastarevalo za isto vreme kada i potraživanje naknade štete za koju štetnik odgovara po pravilima vanugovorne odgovornosti. Prema odredbama Zakona o zastarelosti potraživanja (*Službeni list FNRJ*, br. 40/53 i 57/54), koji je uređivao materiju zastarelosti potraživanja pre ZOO, rok zastarelosti potraživanja naknade štete trajao je koliko i opšti rok zastarelosti – deset godina. Donošenjem ZOO prestao je da važi Zakon o zastarelosti potraživanja. Ipak i ZOO je u svojoj prvoj verziji zadržao izjednačeno trajanje tih rokova, osim što su ovi rokovi trajali pet godina. Tek je izmenama i dopunama ZOO iz 1993. izmenjen čl. 371. ZOO i opšti rok zastarelosti je sa pet produžen na deset godina, kada se i javila ova neujednačenost u dužini rokova zastarelosti. Videti: Marija Karanikić Mirić, „Ograničenja odgovornosti za štetu u srpskom pravu", *Anali Pravnog fakulteta u Beogradu*, 1/2012, str. 256. Nina Zupan, str. 353.

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Jovana V. Brajić[1]

THE STATUTE OF LIMITATIONS FOR THIRD-PARTY CLAIMS FOR DAMAGES AGAINST THE INSURER IN CONTRACTUAL LIABILITY INSURANCE

SCIENTIFIC PAPER

Abstract

Professor Jakov Radišić stated: "The word 'responsibility' serves as a comfort to those who feel that an injustice has been done to them, and a scarecrow to those who have committed the injustice." Following his line of thought, the term 'insurance' provides comfort to those who have committed an injustice and, above all, to those who have suffered from it. However, what if the wronged party suffers further due to the incorrect application of legal provisions? Given the increasing importance of liability insurance, the author analyzes the direct claim of the third party against the insurer and its relationship with the rules of civil liability. Through a systematic interpretation of the provisions of the Law of Contract and Torts that regulate the statute of limitations for claims for damages, the author concludes that the incorrect application of these provisions has become customary in practice. By analyzing the causes of this practice, the author asserts that adherence to the principle of legality should prevail over the potential consequences of its application.

Keywords: *liability insurance, contractual liability, statute of limitations, direct claim of third party against the insurer.*

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I Liability Insurance

1. General Overview of Liability Insurance

According to the general classification of types of insurance, liability insurance[2] is categorized under property insurance. As a result, the legal provisions related to property insurance are also applicable to liability insurance.[3] However, the subject of liability insurance is civil liability[4], which involves two primary parties – the party that caused the damage and is liable for it (tortfeasor) and the party who suffered the damage (the injured party). When the insurer is added to this relationship, we encounter the core specificity of liability insurance – it "involves three parties by its nature"[5] – the insurer, the insured, and the third-party injured party.[6] It appears that the continuous technological development, which began in the late 19th century,[7] has accelerated to the present day. Humanity is constantly faced with damages caused by new risks and increasing of existing risks that arise in everyday life and business.[8] For these damages, someone (under civil law) is held liable, and someone must provide compensation for damages. And who is better equipped to offer such compensation than the insurer, who provides financial security to third-party injured parties?[9]

[2] Liability insurance is a tool for freeing individuals from the compulsion over their property. See Nikola Nikolić, "Odgovornost i osiguranje", GRAĐANSKA ODGOVORNOST, Papers and Discussions from the Symposium held on February 11-12, 1966 in Belgrade, Belgrade, 1966, p. 125.

[3] Law of Contract and Torts – LCT, *Official Gazette of the SFRY*, No. 29/78, 39/85, 45/89 - decision of the CCY and 57/89, *Official Gazette of the FRY* /Federal Republic of Yugoslavia/, No. 31/93, *Official Gazette of SCG* /Serbia and Montenegro/, No. 1/2003. and *Official Gazette of the RS*, No. 18/2020, Part two, Chapter XXVII, Section 2.

[4] For other types of legal liability as subjects of liability insurance, See Yvonne Lambert-Faivre, Laurent Laveneur, *Droit des assurances*, Paris, 2018, p. 496.

[5] See Jérôme Bonnard, *Droit des assurances*, Paris, 2012, p.10.

[6] Although in civil law theory the term 'injured party' is used for the person who has suffered damage, from the perspective of IL, that person is considered a third party, as they are not a contractual party in the liability insurance agreement. Therefore, in IL, this person is referred to as a third-party injured party. This term will be used in this paper.

[7] See Nataša Petrović Tomić, *Pravo osiguranja – Sistem, knjiga I*, Belgrade, 2019, p.490.

[8] In addition to adapting to the negative aspects of technological development (through insurance of new risks), the IL is characterized by monitoring the positive aspects of technological development. In XXI cenury, it is primarily the possibility of concluding an insurance contract at a distance, as a consequence of the general availability of the Internet, which enables the performance of various transactions at a distance. On legal dilemmas when concluding distance insurance contracts, see: Nenad Grujić, " Pravne dileme u vezi s načinima zaključenja ugovora o osiguranju na daljinu – putem mobilne aplikacije i internet prezentacije", *Insurance Trends*, no. 1/2024, p. 105-118.

[9] See Nataša Petrović Tomić, „Liability insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory", *Annals FLB – Belgrade Law Review*, No.4, Year LXVIII, 2020, p. 88.

2. Contractual Liability Insurance

In accordance with the principles of civil law, liability for damages can arise from both a violation of the general principle prohibiting harm to others[10] and a breach of contractual obligations.[11] As a result, two types of liability insurance have developed: insurance for non-contractual (or tort) liability and insurance for contractual liability, in that order. For a long time, there was resistance to insuring contractual liability for damages. This resistance was primarily based on the argument that contractual liability insurance lacks the element of aleatory risk[12] which is a key component of any insurance contract.

On the other hand, the principle that only those who cause damage and are responsible for it are obligated to compensate for it was also highlighted as an argument against contractual liability insurance.[13] The legal system has repeatedly rejected the notion that "liability entails compensation for damages, but not every form of compensation constitutes liability."[14]

However, due to the development of standards for professional care and professional liability, the contractual liability insurance began to develop in the 20th century.[15] Failure to act in accordance with statutory standards of professional care inevitably led to damages not only to the parties with whom professionals had contractual relationships but also to third parties.[16] As with non-contractual

[10] See LCT, art. 16.

[11] Although contractual liability does not only encompass responsibility for damage caused by the non-performance, improper performance, or untimely performance of a contractual obligation, but also for the non-performance, improper performance, or untimely performance of any obligation arising from an existing contractual relationship, for the purposes of this paper, we will equate contractual liability with the non-performance, improper performance, or untimely performance of a contractual obligation.

[12] For more on this topic: Marijan Ćurković, *Osiguranje od izvanugovorne i ugovorne (profesionalne) odgovornosti*, Zagreb, 2015, p. 41 et seq.

[13] The development of liability insurance for non-contractual (or tort) liability was significantly influenced by the concept of objective liability for damages. It was deemed unreasonable to expect individuals who are objectively liable for damages caused by hazardous objects, such as machinery, or dangerous activities—both of which have evolved due to technological advancements—to bear all the harmful consequences. At that time, the principle of fairness, which holds that the owner of a hazardous object or the person engaged in a dangerous activity should not be required to cover every damage caused by such objects or activities that serve societal interests, outweighed the general civil law principle that the person causing the damage must also compensate for it. For more on this topic, see Marija Karanikić Mirić, *Objektivna odgovornost za štetu*, Belgrade, 2019, p. 7.

[14] Jakov Radišić, *Obligaciono pravo – opšti deo*, IX edition, Niš, 2014, p. 200.

[15] For more on this topic: Nataša Petrović Tomić, *Liability insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory*, *Annals FLB – Belgrade Law Review*, No. 4, Year LXVIII, 2020, p. 85.

[16] Although the theory and practice predominantly discuss professional liability as contractual liability, it is important to emphasize that a professional can be held liable not only for damages caused to another party within the existing contractual relationship but also to a third party for damages arising from

(tort) liability insurance, a strong societal interest in socializing liability prevailed once again,[17] and insurance was accepted as a means of socializing responsibility.[18]

2.1. Professional Liability as the Dominant Form of Contractual Liability

The development of contractual liability insurance, influenced by the predominant practical significance of professional liability[19] compared to other types of contractual liability, has led to the dominant perception of professional liability as a distinct type of liability.[20] However, this has also resulted in an incomplete understanding legal nature of contractual liability insurance.

their professional activities under the principles of non-contractual (tort) liability. For instance, errors in a project for which the designer is responsible can result in damages both to the client with whom the designer has a contractual relationship and to third parties. For more on non-contractual professional liability, see Predrag Šulejić, *Osiguranje od odgovornosti davalaca usluga, Annals FLB – Belgrade Law Review*, 6/1982, pp. 1012 and following. Loris Belanić, *Mandatory Liability Insurance Outside the Scope of Traffic and Transportation Activities in Croatian and Comparative Law, with Reference to Determining Obligations for Insurance and the Scope of Third Parties, Faculty of Law*, *University of Rijeka Poreč, Croatia,* 1/2009, pp. 551-555.

[17] On the socialization of liability in Yugoslav law, see Mihailo Konstantinović, *Osiguranje i odgovornost u jugoslovenskom pravu*, *Anali Pravnog fakulteta u Beogradu*, 7-9/58, p. 266.

[18] For more on this issue: Nataša Petrović Tomić, *Liability insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory*, *Annals FLB – Belgrade Law Review*, No. 4, Year LXVIII, 2020, p. 85.

[19] Professional responsibility is a concept developed in legal practice; however, the legislator does not define this term. In legal theory, it is accepted that professional responsibility is associated with professions characterized by the existence of professional associations, codes of conduct, a high degree of autonomy, and the like. For more on this: Predrag Šulejić, *Osiguranje od odgovornosti davalaca usluga, Anali Pravnog fakulteta u Beogradu*, 6/1982, p. 1014 *et seq.;* M. Ćurković, p. 42; Silvija Petrić, "O nekim problemima profesionalne odgovornosti za štetu" *Osiguranje naknada* štete i novi Zakon o parničnom postupku (editors Zdravko Petrović and Nataša Mrvić Petrović), Zlatibor, 2012, p. 223 *et seq.* Law of Contract and Torts includes among the general principles of obligation law the principle relating to conduct in the performance of obligations and the exercise of rights. Based on this principle, a party to an obligation is required to perform their professional duties with increased care, according to professional rules and customs (the care of a good expert). Interpreting this principle, we might conclude that a professional is someone who is obliged to perform their duties with the care of a good expert. For example, according to the provisions of the Law of Contract and Torts, a carrier is liable to the passenger for any damage caused by a delay in transportation unless the delay was caused by a reason that the carrier could not prevent even with the care of an expert. However, a carrier transporting passengers cannot be considered a professional according to the aforementioned standpoint, since carriers (in the Republic of Serbia) do not have professional associations, their activity is not regulated by a code of conduct, nor do they autonomously conduct their activities in the sense of the generally accepted concept of professional responsibility. See Article 18, paragraph 2 and Article 683, paragraph 2 of the Law of Contract and Torts.

[20] Our writers recognized the importance and paid attention to different types of professional liability insurance introduced by the domestic legislator in recent years. For example, see: Slobodan Ilijić, " Pravni položaj javnog beležnika i specifičnosti osiguranja od njegove profesionalne odgovornosti", *Insurance Trands*, no. 1/2020, p. 25-35.

First and foremost, it is important to note that contractual liability insurance should not be equated with professional liability insurance. The subject of contractual liability insurance can encompass contractual liability that is not necessarily considered professional liability,[21] just as there are professionals who primarily bear non-contractual liability.[22,23]

In practice, professional liability is often regarded as a contractual liability to the extent that corresponds to the legal liability of a professional for damage caused, excluding any contractual extensions of liability.[24] General insurance conditions rarely do not recognize such exclusions of the insurer's obligation.[25] This approach by insurers aligns with the theoretically accepted limitations on the insurer's obligations,[26] although such limitations are difficult to justify from the perspective of contractual liability, which often extends beyond legal boundaries by its very nature.

Setting aside the challenges that contractual liability faces in practice, we conclude that contractual liability insurance is a type of insurance that will undoubtedly gain increasing importance in the future. Liability insurance has become

[21] For example, contractors (such as construction workers, carpenters, painters, glaziers, and similar tradespeople) can be held liable not only to the main contractor for the quality of their work but also to third parties who suffer damage due to poorly executed work. However, contractors cannot be considered professionals in this context.

[22] A great example is notaries, who unquestionably bear professional liability. Since they are required to act in accordance with their public authority and impartially, they are liable to parties for damages resulting from failure to adhere to professional standards of care under the rules of non-contractual liability. For more on the nature of notaries' liability, see: Marija Karanikić Mirić, "Odgovornost javnih beležnika u srpskom građanskom pravu", *Pravni život*, No. 10/2014, pp. 569 et seq. On peculiarity of notaries' liability insurance, see: Slobodan Jovanović, „Pravni položaj javnog beležnika i specifičnosti osiguranja od njegove profesionalne odgovornosti", *Insurance Trands*, no. 3/2020, pp. 7-18.

[23] Equating professional liability with contractual liability in insurance contract law leads to uncertainties regarding the types of liability of certain professionals. A good example is insurance brokers and the question of whether they are liable to insurers under the rules of contractual or non-contractual liability. For more on the nature of insurance brokers' liability, see Jasna Pak, Obligations, Responsibilities and Professional Liability of Insurance Intermediaries, *Insurance Trends*, No. 1/2018, p. 48.

[24] For example: WIENER STADTISCHE OSIGURANJE ADO BEOGRAD, General Terms for Professional Liability Insurance, WS.C06.1.C.11.1399_7 from 16.2.2011, p. 1. SAVA NEŽIVOTNO OSIGURANJE A.D.O. BEOGRAD, General Terms for Professional Liability Insurance, 10/2021 from 12.2.2010, p. 1. GLOBOS OSIGURANJE A.D.O. BEOGRAD, Pre-Contractual Information for the Policyholder – Professional Liability Insurance for Lawyers, *https://globos.rs/storage/files/Predugovorna_informacija_-_profesionalna_odgovornost_advokata_03-18-2022_14:24:38.pdf*, accessed on: 11.5.2024, p. 1. GLOBOS OSIGURANJE A.D.O. BEOGRAD, Pre-Contractual Information for the Policyholder – Professional Liability Insurance for Insurance Brokers, *https://globos.rs/storage/files/Predugovorna_informacija_osiguranje_profesionalne_odgovornosti_posrednika_u_osiguranju_03-18-2022_14:14:42.pdf*, accessed on: 11.5.2024, p. 1.

[25] For example: DDOR NOVI SAD, A.D.O. NOVI SAD, *Terms for Professional Liability Insurance for Lawyers*, DDOR-RS-OA-37-0315 from 12.3.2015, p. 3.

[26] Predrag Šulejić, *Osiguranje od odgovornosti davalaca usluga*, *Anali Pravnog fakulteta u Beogradu*, No. 6/1982, p. 1026. Nataša Petrović Tomić, *Osiguranje od profesionalne odgovornosti advokata*, *Pravni život*, No. 10/2011, p. 860.

a fundamental type of insurance,[27] designed to protect the injured party by facilitating and expediting compensation for the suffered damage.[28] However, how does a third party seek to claim compensation from the insurer for which the policyholder is contractually liable?

II Direct Compensation Claim by a Third-Party Injured Party Against the Insurer

Let us return to the main specificity of liability insurance: the dual function[29] provided by the insurer to parties involved in a harmful event for which civil liability exists and for which there is an obligation to compensate damages.[30] In other words, the insurer protects the insured by assuming their obligation to compensate the third party and protects the third-party injured party by guaranteeing compensation for the damage caused. Viewed from the perspective of the tortfeasor and the injured party, the insurance contract is arranged to ensure that, in addition to (or in practice, instead of) the tortfeasor (insured), the injured party has a debtor to compensate for damages. The injured party benefits from having not just the tortfeasor but also another, solvent debtor through liability insurance.[31, 32]

However, since the third party is not in a contractual relationship with the insurer, nor is it a beneficiary of the insurance[33] according to the principles of

[27] André Tunc, "Građanskopravna odgovornost i osiguranje", *Pravni život*, No. 2/1982, p. 228.

[28] Loris Belanić, p. 553.

[29] In addition to providing protection to a broader range of parties beyond the policyholder and the insured, insurance directs the obligation to compensate damages towards a solvent debtor, the insurer, thereby indirectly facilitating uninterrupted economic growth for its insureds. For more on this: **Nataša Petrović Tomić**, "Liability Insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory," *Annals FLB – Belgrade Law Review*, No. 4, Year LXVIII, 2020, pp. 81-83.

[30] For more on this, see **Nataša Petrović Tomić**, "Liability Insurance as a (social) response to the changing regulatory framework: from prohibited to compulsory", *Annals FLB – Belgrade Law Review*, No. 4, Year LXVIII, 2020, p. 81.

[31] N. Petrović Tomić (2019), p. 493. Zvonimir Matić, „Pravni i društveno-ekonomski aspekti osiguranja od odgovornosti", *Zbornik Pravnog fakulteta Sveučilišta u Zagrebu*, No. 47, p. 1029.

[32] Considering that liability insurance services in practice are predominantly consumer insurances, European Union law has had a significant impact on enhancing the protection of third-party injured parties in European continental law. Consumer rights have been one of the main topics in European Union law for decades. *For more on this, see* Emilia Mišćenić, "The constant change of EU consumer law: the real deal or just an illusion?", *Annals FLB – Belgrade Law Review*, 3/2022, pp. 699-730.

[33] Although the Law on Obligations (LCT) and legal practice do not consider the third party to be the insurance beneficiary, as this term is predominantly associated with life insurance, it does not seem incorrect to say that a third party is indeed an insurance beneficiary. This is because a liability insurance contract, according to the provisions of The LCT can be considered a contract for the benefit of a third party. See Article 149, paragraph 1. LCT.

contractual insurance law,[34,35] and yet is considered the central figure in liability insurance,[36] the question arises on what grounds a third-party injured party has the right to claim compensation from the insurer. The only way to establish a contractual relationship between the third-party injured party and the insurer was to determine a legal basis[37] that allows the third-party injured party to make a direct claim[38] for compensation from the insurer.[39 40]

[34] Insurance Law – IL, *Official Gazette of RS*, No. 139/2014 and 44/2021, which, as the status law in the field of insurance law, recognizes the third-party injured party as a beneficiary of insurance services, while respecting the general stance in contractual insurance law that a third-party injured party is not considered an insurance beneficiary. See Article 15, paragraph 1 of the IL.

[35] On the need for insurance contract law in the Republic of Serbia to be regulated by a special law, see: Nataša Petrović Tomić, " O potrebi unapređenja srpskog regulatornog okvira osiguranja usvajanjem zakona o ugovoru o osiguranju", *Insurance Trands*, no. 2/2018, pp. 7-18

[36] See M. Ćurković, p. 249.

[37] In legal theory, there are dilemmas about the basis of the third-party injured party's rights against the insurer - whether the basis for the third-party injured party's rights against the insurer is the law, the contract, or the suffered damage. See Predrag Šulejić, *Osiguranje od građanske odgovornosti*, Beograd, 1967, pp. 124–127. Vladimir Marjanski, "Pravna priroda ugovora o osiguranju od odgovornosti", *Pravni život*, 10/2005, pp. 1135 et seq.

[38] In this paper, we will use the term "direct claim of the third-party injured party against the insurer," although the Law on Contracts and Torts (LCT) uses the term "direct lawsuit" where it establishes this right. First, the term "direct lawsuit" implicitly (and incorrectly) suggests that the third-party injured party can exercise their right only through court proceedings. Second, the term "direct claim of the third-party injured party against the insurer" aligns more closely with contemporary trends in out-of-court settlement of insurance disputes, which are particularly significant for liability insurance due to its high litigation potential. For similar views, see Nataša Petrović Tomić (2019), p. 525. On the other hand, the provision of the LCT that regulates the limitation period for the direct claim of the injured party uses the term "*immediate claim* of the third-party injured party," which is much more in line with the aforementioned trends.

[39] In our legal system, this right is established by the provision of Article 941, Paragraph 1 of the Law on Contracts and Torts (LCT), primarily influenced by court practice which began to establish this right for third-party injured parties in motor vehicle liability insurance even before the LCT came into force. For more on this, see Predrag Šulejić, *Pravo osiguranja*, fifth edition, Belgrade, 2005, p. 417. Article 918, Paragraph 1 of the *Draft Law on Contracts and Torts* by Professor Mihailo Konstantinović contained the same provision, but the direct claim of the third-party injured party against the insurer was conditioned on the third-party injured party not receiving compensation from the tortfeasor. See Mihailo Konstantinović, *Obligacije i ugovori – Skica za Zakonik o obligacijama i ugovorima*, Belgrade, 1996, p. 308.

[40] We highlight here that the early development of the right of the third-party injured party against the insurer occurred under the influence of French law, which has recognized the right to a direct claim of the third-party injured party against the insurer since the enactment of the law on July 13, 1930, which was adopted under the influence of court practice. See Bonnard, p. 257 *et seq*.; Lambert-Faivre, Laveneur, p. 15; Jean Bigot, Jérôme Kullmann, Luc Mayaux, *Traité de Droit des Assurances, Les Assurances de Dommages*, *Tome 5*, Paris, 2017, p. 707. However, legal systems that regulate the third-party injured party's claim against the insurer, like the Serbian and French systems, are more the exception than the rule. A large number of European legal systems recognized this right much later, primarily under the influence of European Union directives regulating the exercise of rights in the field of compulsory traffic insurance. This group includes major European legal systems such as the German, Austrian, and Italian systems. *For more on this, see* Nataša Petrović Tomić (2019), pp. 527–528; Loris Belanić, pp. 579–586. In the United

At this point, it should be noted that the scope of the rights of a third-party injured party against the insurer is narrower[41] than the scope of the third-party injured party's rights against the tortfeasor (insured) according to civil liability rules. This is due to the insurer's possibility and interest to cover the civil liability of the insured to its full extent.[42] However, the question arises as to whether the very existence of the right for the third-party injured party to make a direct claim against the insurer is equivalent to the existence of their right against the tortfeasor in accordance with the rules of civil liability. Since the existence of any right is primarily conditioned by the possibility of its enforcement, we will analyze the time frame in which the insured has the right to claim compensation for damages from the tortfeasor and the time frame in which the third-party injured party has the right to claim compensation from the insurer, i.e. when the statute of limitations on the right to compensation becomes time-barred.

III Statute of Limitations for Claiming Damages

1. General Overview of Statute of Limitations

The statute of limitations can be defined as the time limit within which a creditor can legally demand the fulfillment of an obligation from a debtor.[43] The institution of the statute of limitations primarily serves to alleviate the judiciary system and penalizes a creditor who fails to take action to recover their claims, based on the justified presumption that they are not interested in its settlement.[44]

Kingdom, the right of the third-party injured party is extremely limited from the perspective of our and French law. In accordance with the British Third Parties (Rights against Insurers) Act 2010, the third-party injured party has the right to a direct claim against the insurer when the "insured is insolvent or in some other cases." This represents an improvement in British law compared to the previous law in this area. Unlike the previously applicable law (Third Parties (Rights against Insurers) Act 1930), the insured can now submit a claim to the insurer without the insured's liability being established. However, the right cannot be exercised without establishing liability, which can be determined based on a judgment or order, a decision in arbitration proceedings, or an enforceable agreement. According to: Thomas Rhidian, "Third Party Direct Rights of Action against Insurers under UK Law and International Maritime Liability Conventions", *Regulation of Risk – Transport, Trade and Environment in Perspective* (Editors: Abhinayan Basu Bal, Trisha Rajput, Gabriela Argüello, and David Langlet, Brill Nijhoff), 2023, p. 685. The British Third Parties (Rights against Insurers) Act 2010, para. 4.

[41] There are both legal and contractual limitations on the scope of the insurer's obligation to compensate damages to the third injured party.

[42] On this topic: Predrag Šulejić, "Odnos osiguranja i građanskopravne odgovornosti", *Pravni život*, 9-10/1992, pp. 2253-2267. Marija Karanikić Mirić, "Odgovornost vlasnika motornog vozila kao preduslov obaveze osiguravača", *Pravni život*, 10/2011, pp. 687 et seq.

[43] Similarly: Nebojša Jovanović, *Ključne razlike engleskog i srpskog ugovornog prava*, 2nd edition, Belgrade, 2018, p. 136.

[44] Similarly: Jakov Radišić, p. 421. Marija Karanikić Mirić, *"Ograničenja odgovornosti za štetu u srpskom pravu"*, *Annals of the Faculty of Law in Belgrade*, 1/2012, p. 246.

Since the statute of limitations imposes a time limit on the creditor's right to demand fulfillment of the obligation, it is crucial to determine the period after which the creditor's right to seek recovery of their claim is considered forfeited. It appears that limitation periods are primarily determined based on the nature of the claim and the characteristics of both the creditor and the debtor. It can be said that this was also the legislative logic behind establishing the limitation period for claims by third-party injured parties against the tortfeasor or the insurer.

2. Duration of Limitation Periods for Claims by Third-Party Injured Parties

In order to equate the rights of a third-party injured party against both the tortfeasor and the insurer, Serbian legislator has avoided applying the general rules on the statute of limitations for insurance claims to third-party injured party's claim against insurers.[45] Instead, he has stipulated that the direct claim of a third-party injured party against the insurer is subject to the same limitation period as the claim against the tortfeasor liable for the damage.[46] Furthermore, he has prohibited the extension or shortening of limitation periods through legal transactions.[47]

Considering that there are legal systems where the statute of limitations for a third-party injured party's claim against the insurer differs from that against the tortfeasor,[48] and that the imperative nature of limitation periods is not universal in comparative law,[49] we can say that the limitation periods in Serbian law, with regard to the direct claim of a third-party injured party against the insurer, are largely oriented towards protecting the third-party injured party by maintaining certainty in legal transactions.

However, when we recall that civil liability is not monolithic, i.e. it distinguishes between contractual and non-contractual liability, which differ in several

[45] See Art. 380, para. 1 and 2 of the Law on Contracts and Torts (LCT).

[46] See Art. 380, para. 5 (LCT).

[47] See Art. 364, para. 1 (LCT).

[48] French law is a positive exception in this sense from the perspective of the third-party injured party. Although the French Court of Cassation equalized the statute of limitations for third-party claims against both the tortfeasor and the insurer in 1939, French law applies a two-year limitation period for insurance claims as established by Article 114, para. 1 of the French Insurance Code in cases where the third-party claim, according to civil law provisions, would otherwise be subject to a shorter limitation period. For example, in accordance with the French Commercial Code, a claim for damages by a third-party injured party against a carrier is subject to a one-year limitation period. However, the third-party injured party's claim against the insurer for carrier's liability insurance is subject to a two-year limitation period, applying the two-year period from the Insurance Code. See J. Bonnard, p. 271. French Insurance Code of 1989 (Code des assurances), para. L144-1. French Commercial Code of 1807 (Code de commerce), paras. 133-6.

[49] An example is German and Austrian law, which allows shortening of the limitation period. See Marija Karanikić Mirić, 'Zastarelost potraživanja naknade štete prouzrokovane krivičnim delom,' *Annals of the Faculty of Law in Belgrade*, 1/2011, p. 181. In English law, contracting parties can shorten or extend the limitation period once it has commenced. See N. Jovanović, p. 136.

aspects,[50] the question arises whether there is a difference in the limitation period for compensation between these types of liability and how this might affect the limitation period for a third-party injured party's claim against the insurer.

3. Limitation of the Right to Compensate Based on Contractual and Non-Contractual Liability

When analyzing the statute of limitations in general, it is crucial to address two key questions. First, when does the statute of limitations period for making claim compensation commence, and second, how long is needed for the statute of limitations to apply? In the case of the limitation period for claims based on contractual and non-contractual liability, the provisions of Article 376 of the Law of Contract and Torts, titled *Claim for damages*, will provide answers to both questions at first glance.

3.1. Commencement of Limitation Periods for Claims for Damages

The limitation period for claims for damages based on non-contractual liability begins to run from the moment the injured party becomes aware of the damage and the person who caused it. This is explicitly stipulated by Article 376, Paragraph 1 of the Law of Contract and Torts (LCT), which regulates the limitation period for claims arising from non-contractual liability.

On the other hand, the exact starting point for the limitation period for claims based on contractual liability we cannot directly find in Article 376, Paragraph 3 of the Law of Contract and Torts (LCT) which regulates the limitation period for claims based on contractual liability. Interpretation of the provisions of the LCT we conclude that the rules for non-contractual liability are general, whereas the rules for contractual liability are specific.[51] Article 376, Paragraph 1 establishes both the commencement and duration of the limitation period, whereas Article 376, Paragraph 3 exclusively determines the duration of the limitation period. Therefore, we can conclude that the limitation period for claims for damages based on contractual liability begins in the same manner as that for non-contractual liability, according to the rule established by Article 376, Paragraph 1 of the Law of Contract and Torts (LCT). This means that the limitation period for contractual claims starts at the same time as the statute of limitations for claims for damages under non-contractual liability.[52]

[50] For this, see Nenad Grujić, "Odnos ugovorne i vanugovorne odgovornosti za štetu", *Zbornik radova Pravnog fakulteta u Nišu*, No. 52, pp. 211–234.

[51] See also Marija Karanikić Mirić, *Objektivna odgovornost za štetu*, Second Edition, Belgrade, 2019, p. 50.

[52] See also Nenad Grujić, *Raskid ugovora zbog neispunjenja i pravna dejstva raskida*, First Edition, Belgrade, 2016, p. 500.

At this point, we conclude that the rules regarding the statute of limitations for claims for damages arising from both non-contractual and contractual liability are fully aligned—the limitation period for claims in both cases begins when the injured party becomes aware of the damage and the person responsible for it. Consequently, regardless of whether the insurance covers contractual or non-contractual liability for damages, the statute of limitations for the third-party claim against the insurer also starts when the injured party learns of the damage and the responsible party. However, we have not yet addressed the question of the duration required for the limitation period to apply to claims for damages under non-contractual versus contractual liability.

3.2. Duration of the Statute of Limitations for Claims for Damages

The statute of limitations for a claim for damages based on non-contractual liability lasts three years from the date the injured party became aware of the damage and the party responsible for it, and in any case, within five years from the date the damage occurred.[53] This is explicitly stipulated in Articles 376, paragraphs 1 and 2 of the Law of Contract and Torts (LCT), which regulate the statute of limitations for claims for damages based on non-contractual liability.

However, the general provision in Article 376, paragraph 3 of the Law of Contract and Torts (LCT) regarding claims for damages based on contractual liability explicitly regulates a different duration for the statute of limitations. It states that a claim for damages arising from a breach of a contractual obligation is subject to the limitation period applicable to the breach of that obligation. This referencing provision of LCT requires two steps before answering the question. First, it is necessary to determine which obligation was breached that caused the damage to the injured party, as the legislator has linked the statute of limitations for a claim for damages based on contractual liability to the limitation period of the breached contractual obligation.[54]

Second, it is essential to determine the duration of the statute of limitations for claims for damages based on contractual liability. Since the Law of Contract and Torts (LCT) does not specify a general limitation period for the breached contractual

[53] The Commission for Drafting the Civil Code is considering extending the objective limitation period for damage claims to ten years. See Commission for Drafting the Civil Code, Preliminary Draft. Civil Code of the Republic of Serbia. Volume Two. Obligatory Relations, Government of the Republic of Serbia, Belgrade, 2009, https://akv.org.rs/wp-content/uploads/2016/03/knjiga-2.pdf, accessed on: 6.5.2024, p. 125. The same limitation period was also prescribed by the Law on Limitation of Claims (*Official Gazette of the FNRJ*, No. 40/53 and 57/54), which was in effect until the adoption of the LCT. *According to* Marija Karanikić Mirić, "Ograničenja odgovornosti za štetu u srpskom pravu", *Annals of the Faculty of Law in Belgrade*, 1/2012, p. 256.

[54] See also N. Grujić, p. 497 *et seq.*

obligation, this issue must be resolved through a systematic interpretation of the provisions regarding the time required for the onset of limitation periods in general. Setting aside the specific periods prescribed by the Law of Contract and Torts (LCT) for individual claims,[55] we conclude that a claim for damages based on contractual liability is subject to the general limitation period, which is ten years[56] from when the limitation period begins. However, if the damage arises from a breach of a contractual obligation under a contract for the sale of goods or services concluded by legal entities, the claim for damages based on contractual liability is limited by a three-year period from when the limitation period begins.[57]

Based on this analysis, we conclude that a claim for damages by the injured party against a liable party under contractual liability does not have the same limitation period as a claim against a liable party under non-contractual liability. Considering that a third party's direct claim against the insurer is subject to the same limitation period as their claim against the insured liable party, we conclude that a third party's direct claim against the insurer for non-contractual liability is limited to three years from the time the injured party became aware of the damage and the liable party, and in any case, within five years from when the damage occurred. Conversely, a third party's direct claim against the insurer for contractual liability is limited to either three or ten years from the time the injured party became aware of the damage and the liable party. Given the significant difference in the potential limitation periods for a third party's claim against an insurer under contractual liability, the question arises as to when each of these two limitation periods will apply.

3.3. When Will the Direct Claim of a Third Party Against the Insurer Be Subject to a Three-Year or a Ten-Year Limitation Period?

We will analyze the dilemma of whether the limitation period for a third party's direct claim against the insurer is three or ten years from the moment the injured party became aware of the damage and the responsible party, from the perspective of the insured's contractual liability for the damage caused to the injured party due

[55] For example, claims for periodic payments that are due annually or at shorter specified intervals become time-barred after three years from the due date of each payment. Claims for rent are time-barred after three years. Claims for compensation for supplied electricity, heating, gas, water, chimney services, and cleanliness maintenance, when provided for household purposes, become time-barred after one year. Claims by radio and television stations for the use of radio and television receivers, claims by postal, telegraph, and telephone services for the use of telephones and postal boxes, as well as other claims collected quarterly or at shorter intervals, and subscription claims for periodic publications, are time-barred after one year from the end of the period for which the publication was ordered. See Articles 372, 375, and 378 of the Law of Contract and Torts (LCT).

[56] See Article 371 of the Law of Contract and Torts (LCT).

[57] See Article 374 of the Law of Contract and Torts (LCT).

to non-fulfillment, or improper or untimely fulfillment of contractual obligations. By general rule, a claim for damages becomes time-barred after ten years.

However, if the damage arises from a breach of contractual obligations under a contract for the sale of goods and services concluded between legal entities, the limitation period is three years. Therefore, we must answer when the third-party injured party's claim against the insured party liable for the damage will be subject to a three-year limitation period, as otherwise, it will be time-barred after ten years. By interpreting Article 374, Paragraph 1 of the Law of Contract and Torts (LCT), we conclude that the three-year limitation period applies if two cumulative conditions are met: (i) both the creditor and debtor are legal entities, and (ii) the claim is based on a contract for the sale of goods or services.

Returning to the framework of liability insurance, a third-party injured party's claim against the insurer will be time-barred after ten years, except in the following cases: (i) if both the injured party and the insured liable for the damage are legal entities, and (ii) if the insured caused the damage to the third-party injured by breaching a contract for the sale of goods and services, in which case the claim will be time-barred after three years. We will analyze both conditions, starting with the second. It seems that the condition of the damage being caused to the injured party through a breach of obligations under a contract for the sale of goods and services is the least disputed, as liability insurance primarily covers contractual liability arising from failures in providing services.[58] Assuming the second condition is met in cases of insurance for contractual liability, we will then analyze the first condition: for the three-year limitation period to apply, both the injured party and the insured must be legal entities. Given that the injured party could be various legal entities and that such an analysis exceeds the scope of this paper, we will focus further on the issue of the legal status of the insured, using the example of legal malpractice insurance.[59]

An attorney may practice law independently, within a shared law office, or as a member of a law partnership.[60] An attorney who independently operates as a sole proprietor, while a shared law office does not have the status of a legal entity.[61] This implies that if the tortfeasor is a sole practitioner or a shared law office, the obligation of the tortfeasor, as well as that of the insurer, to compensate the injured party is subject to a limitation period of ten years from the moment the injured

[58] This is especially true if we observe it from the perspective of insurance practice. It is important to remember that the alignment of professional liability insurance with contractual liability insurance occurred primarily because professional liability dominates as a subject of contractual liability insurance in practice, and professional liability most often involves responsibility for the services provided.

[59] More on legal malpractice insurance: Nataša Petrović Tomić, „Osiguranje od profesionalne odgovornosti advokata - srpska verzija novog oblika obaveznog osiguranja", *Insurance Trands*, no. 3/2012, pp. 17-40.

[60] See Zakon o advokaturi – ZA, *Official Gazette of the Republic of Serbia*, No. 31/2011 and 24/2012 – Constitutional Court Decision, Article 44.

[61] See Article 45. para 5. ZA.

party became aware of the damage and the liable party. On the other hand, if the tortfeasor is a law partnership[62] that is a legal entity,[63] the obligation of the tortfeasor, as well as that of the insurer, to compensate the injured party that is a legal entity is subject to a limitation period of three years from the moment the injured party became aware of the damage and the liable party.

However, the interpretation of the limitation periods for a direct claim by a third-party injured party against the liability insurer is not entirely consistent with the interpretations of these limitation periods in theory and practice.[64]

IV Reasons for the Non-Application of the Statutory Limitation Period for the Insurer's Liability in Contractual Liability Insurance

Regarding theoretical considerations within our jurisdiction, existing sources have not extensively analyzed the duration of limitation periods for direct claims by third-party injured parties in the context of contractual liability insurance.[65] On the other hand, our judicial practice indicates that claims by the third-party injured party against the insurer in contractual liability insurance also fall under a three-year limitation period from the time the claimant became aware of the damage and the person who caused it, and in any case, within five years from the occurrence of the damage,[66] similar to the situation in non-contractual liability insurance. However,

[62] On the regulation of free professions, including the legal profession, see Mirko Vasiljević, *Kompanijsko pravo*, ninth edition, Belgrade, 2015, p. 449 et seq.

[63] The operations and business activities of law partnerships are governed by the provisions of the law regulating the operations of partnerships. See Article 52, Paragraph 1 of the ZA. Partnership companies are commercial companies, and commercial companies are legal entities that conduct activities with the aim of making a profit. See Company Law, *Official Gazette of the Republic of Serbia*, No. 36/2011, 99/2011, 83/2014 – other law, 5/2015, 44/2018, 95/2018, 91/2019, and 109/2021, Articles 2 and 93, Paragraph 1.

[64] As for the limitation periods for direct claims by a third-party injured party against the insurer for non-contractual liability, the presented interpretation is fully consistent with the interpretations of these limitation periods in judicial practice. See Judgment of the Supreme Court of Cassation Rev 1672/2016 from 15.12.2016. Judgment of the Supreme Court of Cassation Rev 4490/2018 from 2.7.2020.

[65] Based on the data available during the writing of this paper, we concluded that, in analyzing the statute of limitations in general, the theory primarily focuses on Article 390, Paragraph 5 LCT, in addition, academic works dedicated to contractual liability insurance do not concentrate on limitation periods, which is understandable given the numerous other specificities of contractual (particularly professional) liability insurance. We encountered one study that specifically addressed the limitation periods for direct claims by third-party injured parties against insurers, with a focus particularly on contractual liability insurance. See Dionis Jurić, Loris Belanić, " Odgovornost za štetu zakonskog revizora i obveza osiguranja od odgovornosti za štetu," *Zbornik pravnog fakulteta Sveučilišta u Rijeci*, vol. 39, No. 4 2018 (Special Issue), p. 1836.

[66] See Judgment of the Basic Court in Paraćin, Court Unit in Ćuprija, P 629/22 from 21.2.2023. Judgment of the Higher Court in Niš, Gž 3547/21 from 8.2.2022. Judgment of the Third Basic Court in Belgrade, P 7770/17 from 14.6.2019.

this rule is not without exceptions, and the judicial practice does recognize a distinction between the insurer's obligations to the third-party injured party based on contractual versus non-contractual liability.[67] We believe that the judicial stance, which treats the limitation periods for direct claims by the third-party injured party against the insurer in both contractual and non-contractual liability insurance as identical, is the result of three factors.

First, as demonstrated in this paper, the Law of Contract and Torts (LCT) has more clearly defined the limitation periods for damage claims under non-contractual liability than for contractual liability.[68] No aspect of limitation periods for contractual liability (including the commencement and duration of the limitation period) is explicitly regulated by law; rather, it is derived from interpretative rules, making its application less straightforward in practice.[69] In contrast, the limitation periods for damage claims under non-contractual liability are defined through two paragraphs of a single article, leaving no room for varying interpretations in practice.

Second, it must be noted that in the insurance market of the Republic of Serbia and in judicial practice, direct claims by third parties against insurers in non-contractual liability cases overwhelmingly predominate compared to contractual liability, both in claims procedures and in court proceedings. This is primarily due to the absolute predominance of mandatory motor vehicle liability insurance for damages caused to third parties in the insurance market of the Republic of Serbia.[70] Additionally, compulsory motor vehicle liability insurance for damages caused to third parties is both compulsory and liability insurance, which gives it an exceptionally high litigious potential.[71]

[67] See Judgment of the Basic Court in Niš, P 6513/2019 from 26.3.2021.

[68] Rules on the limitation periods of claims for damages based on contractual liability are self-determined. According to: N. Grujić, p. 497.

[69] It seems that in a matter of exceptionally great practical importance, such as rules on civil liability, the legislator should have resorted to legislative technique that would make these rules more accessible to the average legal practitioner.

[70] According to data periodically submitted to the National Bank of Serbia by insurance companies, in 2022, a total of 2.810.204 policies for compulsory motor vehicle liability insurance for damages caused to third parties were issued, while insurance companies issued a total of 7.915.497 insurance policies throughout the year. This means that 35.50% of all insurance policies issued were for compulsory motor vehicle liability insurance for damages caused to third parties. Regarding insurance premiums, in 2022, the net premium for mandatory motor vehicle liability insurance amounted to 38.378.207.000 RSD, and the total net premium for all insurance was 133.925.041.000 RSD. This indicates that the share of the net premium for compuldory motor vehicle liability insurance in the total net insurance premium in 2022 was 28.65%. See National Bank of Serbia, Overview of the Number of Insurances, Number of Insured, and Premiums by Types and Tariffs of Insurance for Serbia in 2022. *https://www.nbs.rs/export/sites/NBS_site/documents/osiguranje/godisnji/god_T1_2022.pdf,* accessed on: 6.5.2024.

[71] Since compulsory insurance aims to cover the entire risk community, it is expected that there will be a relatively higher number of (direct) claims for damages in mandatory insurance compared to similar-sized risk communities where insurance is not mandated. In the Republic of Serbia, the obligation to obtain

Third, when examining the limitation periods for claims for damages based on non-contractual and contractual liability rules, we notice certain inconsistencies in the legislative technique of the Serbian Law of Contract and Torts (LCT). For the purposes of this analysis, we will consider the application of the general ten-year limitation period for contractual liability. It is important to recall that limitation periods for claims for damages, regardless of the type of liability, begin to run from the moment the injured party becomes aware of the damage and the party liable for it. However, it is undisputed that a person who has suffered damage due to a breach of a contractual obligation is at an advantage compared to a person who has suffered damage due to a violation of the general rule against causing harm to others. Damage caused by a breach of a contractual obligation can only be caused by one party in an obligatory relationship with the other party, meaning that in cases of contractual liability, the injured party will always know who caused the damage. This comparative advantage for the injured party in cases of a contractual obligation should, from a legislative perspective, be reflected in increased protection for the injured party who has suffered harm due to a breach of the general rule against causing harm to others, among other things, by stipulating a longer limitation period for claims for damages. However, in our legal system, an absurd situation has arisen where, in most cases, an injured party seeking damages for a breach of a contractual obligation has the right to claim damages for twice as long as an injured party seeking damages for a breach of non-contractual obligations.

For the past thirty years, our legal system has regulated the length of limitation periods for claims for damages in this manner. Previously, these limitation periods were consistently equal for a period of forty years, although their length varied. The general limitation period applies to claims for damages resulting from a breach of a contractual obligation, and it cannot be expected that the length of this period will be determined based on the relationship between the limitation periods for different types of damages.

V Conclusion

We conclude that a claim by a third-party injured party against the insurer in contractual liability insurance generally becomes time-barred after ten years from the date when the third-party injured party became aware of the damage and the entity liable for the damage. Exceptionally, this claim may be time-barred after three years from the date when the third-party injured party became aware of the damage and the entity liable, provided that both the tortfeasor and the injured party are legal entities.

insurance is stipulated in 54 legal and subordinate acts (potentially even more), primarily for liability insurance. See National Bank of Serbia, Mandatory Insurance in the Republic of Serbia, https://www.nbs.rs/export/sites/NBS_site/documents/osiguranje/obavezna_osiguranja.pdf, accessed on: 6.5.2024.

As demonstrated in this paper, the application of this limitation period depends on the legal status of the third-party injured party and the tortfeasor and may vary even within the same type of contractual liability. This is due to the legislator's justified interest in shortening the limitation period for claims between legal entities, thus the duration of the limitation period should be determined on a case-by-case basis.

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DOBROVOLJNO ZDRAVSTVENO OSIGURANJE U SRBIJI

STRUČNI RAD

Apstrakt

U radu je prikazan razvoj zdravstvenog osiguranja od njegovih začetaka u 19. veku, do savremenog doba. Ukazano je na razlike između obaveznog i dobrovoljnog zdravstvenog osiguranja, kao i na nedostatke i jednog i drugog modela, na principe solidarnosti i uzajamnosti kod obaveznog zdravstvenog osiguranja, ali i na prednosti dobrovoljnog zdravstvenog osiguranja koje ne nudi solidarnost i uzajamnost, ali iziskuje manje troškove. Prikazan je rast učešća dobrovoljnog zdravstvenog osiguranja u Srbiji, koje se kod nas pojavilo 2005. godine, a 2022. je dostiglo značajno učešće u odnosu na sektor neživotnih osiguranja. Ukazano je na zavisnost dobrovoljnog zdravstvenog osiguranja od prihoda stanovništva i generalno BDP-a, kao i na povezanost sektora neživotnog osiguranja i sektora životnog osiguranja. Analizirano je učešće pojedinih elemenata dobrovoljnog zdravstvenog osiguranja u ukupnim premijama, kao i broj ugovora i broj osiguranika.

Ključne reči: dobrovoljno, zdravstveno, osiguranje, paralelno, dodatno, privatno.

I Uvod

Začetke zdravstvenog osiguranja nalazimo pred kraj 19. veka kada je u Nemačkoj donet Zakon o zdravstvenoj zaštiti s ciljem da se određenim slojevima stanovništva pruži socijalna odnosno zdravstvena sigurnost po principu „bolničke kase".[2]

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Rad je prihvaćen: 20. 5. 2024.
[2] D. I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji –faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, Beograd, br. 2/2018, str.374–393.

Socijalna zaštita a samim tim i zdravstvena zaštita se tokom vremena proširila na sve delove Evrope i sveta, poprimajući određene regionalne specifičnosti, ali sa osnovnim principom univerzalnosti za sve građane. Trenutna pokrivenost zdravstvenim osiguranjem u zemljama Evrope je gotovo potpuna, pa tako preko 98% ukupne populacije ima neki vid zdravstvenog osiguranja. Dominantni izvori finansiranja zdravstvene zaštite na teritoriji Evrope su: doprinosi za zdravstveno osiguranje zaposlenih, privatna (dobrovoljna) zdravstvena osiguranja i direktno plaćanje za zdravstvene usluge. Zdravstveni sistem se i dalje u najvećoj meri finansira od centralizovanog javnog sistema finansiranja, pa se spram takvog načina finansiranja moraju tražiti i odgovarajući modeli zdravstvenog osiguranja, koje svakom pojedincu može da obezbedi univerzalnu zdravstvenu zaštitu. S razvojem društva, kao i s razvojem nauke pa samim tim i zdravstvene zaštite, došlo se u situaciju da se životni vek produžio, što predstavlja „teret" za zdravstveni sistem, jer starijoj populaciji je više potrebna zdravstvena zaštita nego mlađoj, a zdravstvene procedure su sve komplikovanije i skuplje. Kroz istoriju zdravstvenog osiguranja razvilo se nekoliko modela, od kojih treba izdvojiti:

- Bizmarkov, koji se zasniva na doprinosima zaposlenih kao osiguranika, pri čemu je doprinos proporcionalan zaradi, i zasniva se na principima neprofitabilnosti i solidarnosti fondova odnosno „bolničkih kasa";
- Beveridžov, koji se zasniva na finansiranju zdravstvene zaštite iz budžeta države i bazira se na solidarnosti i univerzalnosti za sve građane i za sve vidove zdravstvene zaštite kako državnih tako i privatnih zdravstvenih ustanova;
- Semaškov model, koji se zasniva na tome da je država odgovorna za organizovanje i finansiranje zdravstvene zaštite za sve stanovnike, pri čemu je isključena mogućnost privatnih zdravstvenih ustanova;
- tržišni model, koji se zasniva na tome da zdravstveno osiguranje organizuju i sprovode organizacije na profitnoj osnovi, pri čemu se ne bazira na solidarnosti i univerzalnosti.[3]

II Obavezno zdravstveno osiguranje i dobrovoljno zdravstveno osiguranje u Republici Srbiji

Na teritoriji Republike Srbije (dalje: RS) do 2005. godine funkcionisao je samo sistem obaveznog zdravstvenog osiguranja (dalje: OZO), kao i u svim bivšim socijalističkim državama. OZO se zasnivao na:

- načelu obaveznosti da se izdvaja određeni procenat zarade za OZO;
- načelu solidarnosti i uzajamnosti;

[3] D. Janković, „Zdravstveno osiguranje kao faktor troškova zdravstvene zaštite", Škola *biznisa,* Novi Sad, br. 4/2011, str. 69–82.

- načelu javnosti i zaštite prava osiguranih lica;
- načelu stalnog unapređivanja kvaliteta OZO, ali i ekonomičnosti i efikasnosti.

Prva dva načela bila su ispunjena u potpunosti, ali druga dva načela su dovedena u pitanje jer su osigurana lica često bila prinuđena da čekaju na određene zdravstvene usluge, a samim tim je dovedeno u pitanje i načelo efikasnosti.[4]

Godine 2005. donet je novi Zakon o zdravstvenom osiguranju[5] (dalje: ZZO), koji je omogućio dva sistema zdravstvenog osiguranja, a to su obavezno zdravstveno osiguranje (OZO) i dobrovoljno zdravstveno osiguranje (dalje: DZO). Zajednički cilj ta dva sistema je da pojedincu obezbede potpunu zdravstvenu zaštitu, odnosno u najvećoj meri zdravstvenu zaštitu koja je moguća. DZO je detaljno regulisano Uredbom o dobrovoljnom zdravstvenom osiguranju,[6] koja je prestala da važi izmenama i dopunama ZZO[7] iz 2019. koji je regulisao DZO. Tim aktima su postavljeni temelji DZO u Srbiji, odnosno DZO kao dopunski oblik obaveznom socijalnom zdravstvenom osiguranju. DZO je na početku razvoja u RS i susreće se s mnogim problemima koji nisu rešeni, ili nisu definisani, kao što su: regulisanje rada lekara i medicinskog osoblja, regulisanje pitanja privatnih zdravstvenih ustanova, regulisanje statusa državnih bolnica van redovnog radnog vremena, pitanje poreskog tretmana premija DZO, navika stanovništva, ekonomskih mogućnosti stanovništva i sl. Svakako da DZO delimično rešava probleme s kojima se susreće OZO, a to je pre svega moralni „hazard" kada pojedinac u slučaju kada nema nikakve troškove zloupotrebljava zdravstveni sistem tražeći i ono što mu nije neophodno.[8] Najveći deo prihoda OZO potiče od doprinosa osiguranika (otprilike 2/3 ukupnih prihoda OZO fondova), dok ostatak potiče iz transfera penzijsko-invalidskih fondova i transfera iz budžeta.[9] Troškovi zdravstvene zaštite su visoki, a iznos sredstava kojim se u ovom sistemu raspolaže je manji. Međutim, izražen je bio problem evazije plaćanja doprinosa za obavezno zdravstveno osiguranje. Prema izveštaju Poreske uprave za 2012. godinu, dug po osnovu doprinosa za zdravstveno osiguranje iznosio je preko 148 milijardi dinara, od čega je bilo nenaplativo preko 78 milijardi dinara, odnosno više od 50%.[10] Tu činjenicu treba sagledati u kontekstu da je veliki deo tog duga nastao u periodu do 2000. godine, odnosno u periodu sankcija i poremećenih tržišnih uslova, a deo

[4] D. I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji – faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, br. 2/2018, str.374–393.

[5] Zakon o zdravstvenom osiguranju – ZZO, *Službeni glasnik RS,* br. 107/05, 109/05.

[6] Uredba o dobrovoljnom zdravstvenom osiguranju, *Službeni glasnik RS*, br. 108/08, 49/09.

[7] Zakon o zdravstvenom osiguranju – ZZO, *Službeni glasnik RS*, br. 25/19, 92/23.

[8] D. Janković, „Zdravstveno osiguranje kao faktor troškova zdravstvene zaštite", Škola *biznisa,* Novi Sad, br. 4, 2011, str. 69–82.

[9] Republički fond za zdravstveno osiguranje – RFZO, Izveštaj o finansijskom poslovanju Republičkog fonda za zdravstveno osiguranje za 2016, Beograd, 2017.

[10] J. Kočović, T. Rakonjac Antić, V. Rajić, „Dobrovoljno zdravstveno osiguranje kao dopuna obaveznom zdravstvenom osiguranju u Srbiji", *Ekonomske teme*, br. 3/2013, str. 541–560.

nakon 2000. godine u periodu tranzicije. Izmenama Zakona o poreskom postupku i poreskoj administraciji (dalje u tekstu ZPPPA) iz 2012. godine, značajno je povećana naplata poreza i doprinosa na zarade, jer je onemogućena isplata zarada ukoliko nisu plaćeni porezi i doprinosi.[11]

Problem manjka sredstava u budžetu OZO uzrokovan je mnogim faktorima, ali jedan od faktora koji predstavlja ozbiljno ugrožavanje budžeta OZO je tzv. starenje stanovništva, što je tendencija u celoj Evropi, izuzev pojedinih regiona. Starenje stanovništva je kompleksan sociološki problem, ali kao posledica starenja stanovništva imamo povećanje učešća stanovništva starijeg od 65 godina u odnosu na ukupnu populaciju. S jedne strane, stanovništvo starije od 65 godina pripada kategoriji penzionera, za koje se ne plaćaju realni doprinosi, odnosno doprinosi koji nastaju iz privredne aktivnosti, a s druge strane, stanovništvo starije od 65 godina je stanovništvo koje više koristi usluge zdravstva u odnosu na mlađe stanovništvo. Pored starenja stanovništva javlja se još jedna tendencija, a to je da se u svetu sve manje mladih obrazuje na način na koji su se obrazovali njihovi roditelji, i ponašaju se ravnodušno i neambiciozno. Sasvim je moguće da se slično desi i u Srbiji i da se poveća broj moćnih i bogatih ljudi koji će biti stariji od 55 godina i koji će biti lideri u biznisu, imati dobre zarade, ali biti skloniji bolestima. Karakteristika Evrope danas jeste to da stariji izdržavaju mlade, kojima u celoj Evropi preti nezaposlenost.[12]

Troškovi zdravstvene zaštite stanovništva neprekidno rastu, pa se tako u zemljama EU taj trošak *per capita* kreće i do 4.000 evra u Nemačkoj, dok je u većini evropskih država u rasponu 2.000–3.000 evra, za Srbiju trošak je 1.049 €.[13] Prihodi OZO u Srbiji *per capita* su na nivou od 250 evra godišnje, i teško je obezbediti funkcionisanje zdravstvenog sistema, koji troši gotovo 800 evra više nego što OZO može da pokrije iz svojih prihoda.

Sve države teže da obezbede maksimalnu pokrivenost stanovništva zdravstvenom zaštitom, jer se teži da se postigne socijalno odgovorno društvo, pa i sama Svetska zdravstvena organizacija donela je dokument „Zdravlje za sve u 21. veku", koji obavezuje sve članice da obezbede solidarnost i univerzalnu dostupnost ZO, uz istovremeno savlađivanje troškova.[14]

U razvijenim državama postoji tzv. pozitivna konkurencija između OZO i DZO, u smislu da se osiguravajući sistemi takmiče i za broj osiguranika, ali i za

[11] Zakon o poreskom postupku i poreskoj administraciji, *Službeni glasnik RS 80/2002, 84/2002, ispr. 23/2003, ispr. 70/2003, 55/2004, 61/2005, 85/2005, 53/2010, 101/2011, 2/2012, ispr. 93/2012, 47/2013, 108/2013, 68/2014, 105/2014, 91/2015- autentično tumačenje, 112/2015,15/2016, 108/2016, 30/2018, 95/2018.*

[12] M. Zekić, S. Šegrt, „Uticaj privatnog zdravstvenog osiguranja na makroekonomski ambijent Republike Srbije, Oditor", Centar za ekonomska i finansijska istraživanja, Beograd, 2015, str.4–9.

[13] D. I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji – faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, Beograd, 2018, str.374–393.

[14] D. Čepić, V. Avdalović, „Zdravstveno osiguranje", *Zbornik radova fakulteta tehničkih nauka Novi Sad,* Novi Sad, 2011, str. 2136–2144.

kvalitativnu strukturu osiguranika, jer im je u interesu da privuku najbogatije osiguranike, koji mogu da plate veće premije, pa se oba sistema osiguranja nadmeću u pogledu ponuđenih usluga, kao i kvaliteta tih usluga, što posledično dovodi do unapređenja usluga koje se pružaju svim osiguranicima, jer jednom unapređene usluge postaju dostupne svima.

Jedna od prednosti DZO je i sama forma zaključenja ugovora, jer se tom prilikom procenjuje rizičnost samog osiguranika – rizičniji plaćaju veće premije, ali upravo ta procena rizika, a rizik može biti procenjen samo na osnovu pregleda kao i preventivnih pregleda, može značajno sama po sebi da unapredi zdravstvenu zaštitu stanovništva, jer prilikom preventivnih pregleda moguće je dijagnostikovati rizik od bolesti ili bolest u ranoj fazi, kada je izlečenje izvesnije, ali ne samo što je izvesnije već je i jeftinije. Takvim pristupom „bolje sprečiti nego lečiti" znatno se rasterećuje zdravstveni sistem generalno, ali i sistem OZO i posledično i sistem DZO.[15]

Dobrovoljno zdravstveno osiguranje predstavlja udruživanje osiguranika u zajednice rizika u okviru kojih se, na bazi uplaćenih sredstava premija, obezbeđuje zaštita u slučaju ostvarenja određenog broja zdravstvenih rizika, i to na dobrovoljnoj osnovi. Sa većom zajednicom rizika i premije za osiguranike su niže, tj. predstavljaju manje opterećenje u odnosu na to da se zdravstvene usluge plaćaju direktno.[16]

III Dobrovoljno zdravstveno osiguranje kao vid osiguranja

Dobrovoljno zdravstveno osiguranje spada u kategoriju neživotnih osiguranja,[17] pri čemu se pored Zakona o osiguranju primenjuju i odredbe Zakona o zdravstvenom osiguranju, a do donošenja novog zakona o zdravstvenom osiguranju primenjivala se Uredba o dobrovoljnom zdravstvenom osiguranju. DZO mogu sprovoditi Republički zavod za zdravstveno osiguranje i pravna lica koja obavljaju delatnost osiguranja u skladu sa Zakonom o osiguranju. Pored te opšte formulacije ko može da obavlja delatnost DZO, Zakonom je regulisano da Narodna banka Srbije (NBS) izdaje posebnu dozvolu pravnom licu koje obavlja delatnost osiguranja za poslove DZO kome je Ministarstvo dalo pozitivno mišljenje o ispunjenosti uslova za organizovanje i sprovođenje DZO. Davalac osiguranja vodi sredstva DZO po vrstama osiguranja koje sprovodi odvojeno na posebnim računima, odnosno odvojeno od sredstava i računa obaveznog zdravstvenog osiguranja, odnosno drugih sredstava osiguravajućeg društva, u skladu sa Zakonom.[18] [19]

[15] A. Gavrilović, D. Ugrinov, I. Radošević, M. Nikolić "Modern management in the function of increasing of health service quality in primary health care", *Serbian Journal of engineering management,* Belgrade, 5(1), 2020, str. 14-28.

[16] T. Rakonjac Antić, M. Koprivica, "Specifičnost privatnih izvora finansiranja zdravstvene zaštite" *Revija kopaoničke* škole *biznisa prirodnog prava,* Beograd, 2020, str. 83-97.

[17] Zakon o osiguranju, *Službeni Glasnik RS* 139/2014, 44/2021 (dalje: ZO), čl. 9.

[18] Uredba o dobrovoljnom zdravstvenom osiguranju, *Službeni Glasnik RS*, br. 108/08,49/09.

[19] Zakon o zdravstvenom osiguranju - ZZO, *Službeni Glasnik RS*, 25/19, 92/23.

Zakon o zdravstvenom osiguranju je trenutno jedini zakon kojim je regulisano DZO, i kao takav definiše minimalni period trajanja osiguranja, pri čemu je zakonodavac članom 170 predvideo da je to rok od 12 meseci, uz izuzetke da osiguranje može da traje i kraće za slučajeve privremenog boravka osiguranika u inostranstvu, ukoliko svojstvo osiguranika u sistemu OZO traje kraće od navedenih 12 meseci, te ako osiguranik u toku ugovorenog perioda stekne osnov za osiguranje kod kolektivnih ugovora, kao i za lica sa stranim državljanstvom tokom njihovog privremenog boravka u Republici Srbiji.

Članom 171 ZZO[20] regulisano je da DZO ne može da se organizuje i sprovodi za prava koja su već obuhvaćena sistemom OZO, kao i za preventivne programe imunizacije i hemioprofilakse. Takvim dosta krutim stavom Zakona isključuje se mogućnost izbora osiguranicima koji imaju zaključene ugovore o DZO, jer za ostvarivanje pojedinih prava definisanih sistemom OZO osiguranici su prinuđeni da budu na tzv. „listama čekanja", a postoji mogućnost da se ostvarivanje tih prava reguliše putem DZO i samim tim da osiguranici koji plaćaju premiju koja obuhvata i ostvarivanje takvih prava njih ostvare u privatnim zdravstvenim ustanovama, ili čak i državnim, ali bez čekanja. S jedne strane, time se osiguranici DZO stavljaju u povoljniji položaj u odnosu na osiguranike OZO, što svakako nije dobro, jer predstavlja vid diskriminacije. Ali pored samog problema diskriminacije postoji i problem i pitanje lica koja nisu u sistemu OZO. Pitanje je šta s licima koja nisu obuhvaćena sistemom OZO po bilo kom osnovu a državljani su RS. Ovde se kao ilustrativan primer može navesti problem poljoprivrednika koji su zaključili ugovore sa PIO fondom i RZZO, ali usled izmenjenih finansijskih okolnosti nisu bili u mogućnosti da dalje uplaćuju doprinose, pa se nalaze u situaciji da su dugovi za neplaćene doprinose izuzetno visoki, a istovremeno takva lica ne mogu da ostvaruju prava predviđena sistemom OZO. U takvim situacijama bi DZO kroz program privatnog zdravstvenog osiguranja moglo biti privremeno rešenje dok se ne regulišu obaveze ili ne pronađe drugo rešenje za nagomilane dugove.

Vrste DZO na osnovu ZZO[21] prema članu 174 su:

- paralelno zdravstveno osiguranje;
- dodatno zdravstveno osiguranje;
- privatno zdravstveno osiguranje.

Članom 175 ZZO[22] regulisano je da svojstvo osiguranika DZO prestaje istovremeno kada osiguraniku to svojstvo prestane i u sistemu OZO.

Članovima 177–193 ZZO[23] definisano je organizovanje i sprovođenje DZO u pogledu uslova za organizovanje i sprovođenje DZO, što je bliže regulisano

[20] ZZO, čl. 171.
[21] ZZO, čl. 174.
[22] ZZO, čl. 175.
[23] ZZO, čl. 177–193.

podzakonskim aktima pre svega NBS. Regulisani su i elementi koje mora da sadrži sam ugovor, kao i ko može da zaključi ugovor, te to da je pored ugovarača neophodna pismena saglasnost samog osiguranika ukoliko teret plaćanja premije u potpunosti ili delimično pada na osiguranika. Pored samog ugovora, regulisani su i elementi polise i liste pokrića, kao i obaveze osiguravača u vezi s pravima koje osiguranik ostvaruje u skladu sa ugovorom odnosno polisom.

Problemi koji se javljaju kod DZO tiču se pre svega svesti građana da je potrebno da dodatno plaćaju za zdravstveno osiguranje, jer su decenijama bili naviknuti da je zdravstvo nešto besplatno i svima dostupno, pa sada kada su ekonomske prilike teže nego pre nekoliko decenija, treba da izdvajaju dodatni novac za zdravstvo.

Dobrovoljnim zdravstvenim osiguranjem stanovništvu bi trebalo da se pruža mogućnost izbora i ovaj sistem bi trebalo da omogući bržu, kvalitetniju i dostupniju zdravstvenu uslugu koja bi morala da utiče na bolji kvalitet i produženje trajanja života, smanjenje zloupotreba (smanjenje prekomernog korišćenja zdravstvenih usluga), povećanje investicija u zdravstvo, smanjenje korupcije, osiguranje od finansijskih rizika, raznolikost i elastičnost sistema zdravstvenog osiguranja.[24]

Postoji interesovanje poslodavaca da svojim zaposlenim ponude DZO kao vid stimulacije i vid vezivanja za poslodavca, jer zaključeno DZO važi za zaposlenog sve dok je kod jednog određenog poslodavca, a ukoliko napusti poslodavca, napušta i DZO koje mu je poslodavac obezbedio. Iako postoji verovatnoća da će kod narednog poslodavca ponovo dobiti DZO, pitanje je da li će dobiti DZO kod iste osiguravajuće kuće, pa je tako DZO instrument koji obezbeđuje lojalnost zaposlenog poslodavcu.

Pored DZO koje dobijaju preko poslodavca, sve veći broj građana je svestan potrebe i neophodnosti zaključenja DZO, pa je broj individualnih ugovora građana sa osiguravajućim kućama u konstantnom porastu. DZO građanima nudi mogućnost da paket osiguranja prilagode sebi i svojim potrebama.

DZO nije bilo regulisano u zakonodavstvima zemalja bivše SFRJ odmah nakon njihovog osamostaljenja, jer je na snazi bio stari sistem OZO. Tek nakon završetka sukoba na prostorima bivše SFRJ i usklađivanja zakonodavstava novoformiranih država po principima slobodne tržišne ekonomije, donose se i regulative koje se odnose pre svega na zdravstveno osiguranje, a protokom vremena i s približavanjem novoformiranih država Evropskoj uniji, kao i s pristupanjem samoj EU, donose se propisi koji se odnose na zdravstveno osiguranja u skladu sa zakonodavstvom EU. Samo obavezno zdravstveno osiguranje ne predstavlja privrednu aktivnost, ali DZO već predstavlja privrednu aktivnost, jer postoji tržišna konkurencija među osiguravajućim kućama koje pružaju usluge DZO, pa saglasno takvoj situaciji treba doneti i odgovarajuću pravnu regulativu koja se odnosi na DZO.[25] Pri tome se mora uzeti

[24] Detaljno: T. Rakonjac Antić, *Penzijsko i zdravstveno osiguranje*, Centar za izdavačku delatnost, Ekonomski fakultet, Beograd, 2012.

[25] T. Sokol, F. Stančić, „Pravila Europske unije o tržišnom natjecanju i državnim potporama i dopunsko zdravstveno osiguranje u Republici Hrvatskoj, krivo srastanje", *Pravni vjesnik*, Zagreb, 2021, str. 37.

u obzir da je EU donela niz mera radi deregulacije tržišta DZO, što je regulatornim telima država oduzelo pravo da zaštite potrošače u pojedinim slučajevima.[26]

IV Struktura DZO u Republici Srbiji

DZO u Republici Srbiji je uhvatilo korena 2005. godine, kada je prvi put regulisano ZZO,[27] koje je kasnije i detaljnije regulisano.[28] Od trenutka kada je DZO uvedeno u sistem osiguranja u RS, bilo je potrebno mnogo vremena i truda da se stanovništvo, ali i poslodavci edukuju o prednostima DZO, te da prestanu da osiguranje tretiraju kao trošak već da ga posmatraju kao investiciju. Direktno plaćanje zdravstvenih troškova može ljude da uvede u siromaštvo.[29] Zdravstveno osiguranje je dugi niz godina posmatrano kao nešto što je „dužnost države" i društva, i što su država i društvo dužni da obezbede i sprovode. Takav stav je neispravan, jer doprinose za zdravstveno osiguranje i u periodu socijalizma je plaćao poslodavac, a na osnovu zarade zaposlenog. Država je bila dužna da organizuje sistem zdravstvene zaštite, da ga finansira iz doprinosa OZO, i delom iz budžeta. Počeci DZO u Srbiji, kao i u zemljama u okruženju, bili su teški, i DZO je stidljivo ulazilo u sistem osiguranja. Edukacijom stanovništva, ali i stanjem u zdravstvenom sistemu DZO je napredovalo, jer su ljudi počeli da shvataju njegov značaj i prednosti. Da bismo došli do željenog učešća dobrovoljnog, a naročito dopunskog zdravstvenog osiguranja u portfelju domaćeg tržišta osiguranja, ključno je da se sprovede akcija u cilju povećanja zdravstvene pismenosti stanovništva. Zdravstvena pismenost stanovništva je od krucijalnog značaja za održivost zdravstvenog osiguranja. Svetska zdravstvena organizacija definiše zdravstvenu pismenost kao znanje pojedinca i sposobnost da razume i primeni informacije o zdravlju kako bi mogao da donosi odluke vezane za zdravlje i time utiče na održavanje i/ili poboljšanje zdravlja tokom života. Veća je verovatnoća da će lica koja su zdravstveno opismenjena uvideti prednosti dobrovoljnog zdravstvenog osiguranja.[30] DZO ima funkciju da korisnicima omogući viši nivo zdravstvenih usluga u odnosu na sistem obaveznog ZO. Obavezno ZO neke od usluga nema uopšte u ponudi, ili ih nudi korisnicima, ali tako da participiraju u ceni tih usluga. Samo participiranje može biti veoma visoko za pojedine usluge, a to je upravo prednost DZO, gde korisnik kroz plaćenu premiju sprečava mogući trošak

[26] E. Mossialos, S. Thomson, „Voluntary health insurance in the Europian Union: a critical assessment", *International Journal of Health Service*, London, 2002.

[27] Zakon o zdravstvenom osiguranju – ZZO, *Službeni glasnik RS*, br. 107/05, 109/05.

[28] Uredba o dobrovoljnom zdravstvenom osiguranju, *Službeni glasnik RS*, br. 108/08,49/09.

[29] M. Tabaković, J. Todorović, U. Babić, Z. Terzić, M. Santrić Milićević, „Development of voluntary health insurance in Serbia: the insurance companies viewpoins", *Europian Journal of public health*, Utrecht, Netherlands, 2018, str. 445.

[30] N. Petrović Tomić, „Dopunsko zdravstveno osiguranje u funkciji doprinosa razvoju održivog sistema zdravstvene zaštite u Republici Srbiji", *Tokovi osiguranja*, br. 1/2024, str. 7-39.

u pogledu zdravstvenih usluga.[31] Glavna prednost DZO sistema je smanjenje visine troškova iz džepa građana u pogledu zdravstvenih usluga, no ne samo direktno od pojedinaca koji moraju te usluge da plate, već generalno smanjenje opterećenja budžetskog sistema Republike Srbije.

Tabela, br. 1: Struktura DZO, broj osiguranika i premija po osiguraniku u periodu 2017–2022. godine.

	2017							2020					
	broj ugovora	broj osiguranika	osiguranika po ugovoru	ukupna premija (000) din	premija po osiguraniku (din)	% u odnosu na uk. prem.		broj ugovora	broj osiguranika	osiguranika po ugovoru	ukupna premija (000) din	premija po osiguraniku (din)	% u odnosu na uk. prem.
paralelno ZO	3827	3839	1,0	26607	6931	0,92	paralelno ZO	428	429	1,0	14138	32956	0,26
dodatno ZO	6583	1220215	185,4	729036	597	25,29	dodatno ZO	9233	2064640	223,6	1063985	515	19,64
privatno ZO	2236	9189	4,1	232871	25342	8,08	privatno ZO	8279	8861	1,1	228127	25745	4,21
kombinacija vrsta DZO	2570	45285	17,6	1265065	27936	43,88	kombinacija vrsta DZO	17059	130657	7,7	3276509	25077	60,49
putno ZO	29195	47539	1,6	42959	904	1,49	putno ZO	4699	6518	1,4	6895	1058	0,13
sva druga DZO	4658	147586	31,7	563016	3815	19,53	sva druga DZO	4549	166970	36,7	826531	4950	15,26
	49069	1473653	30,0	2859554	1940			44247	2378075	53,7	5416185	2278	
	2018							2021					
	broj ugovora	broj osiguranika	osiguranika po ugovoru	ukupna premija (000) din	premija po osiguraniku (din)	% u odnosu na uk. prem.		broj ugovora	broj osiguranika	osiguranika po ugovoru	ukupna premija (000) din	premija po osiguraniku (din)	% u odnosu na uk. prem.
paralelno ZO	5116	5116	1,0	35258	6892	1,02	paralelno ZO	471	488	1,0	16108	33008	0,23
dodatno ZO	8132	2232026	274,5	788056	353	22,74	dodatno ZO	9183	4462741	486,0	1303241	292	18,87
privatno ZO	2512	5863	2,3	232171	39599	6,70	privatno ZO	2627	7471	2,8	263208	35231	3,81
kombinacija vrsta DZO	9707	70696	7,3	1747507	24719	50,43	kombinacija vrsta DZO	27174	193334	7,1	4405768	22788	63,81
putno ZO	28202	45474	1,6	41813	919	1,21	putno ZO	12433	20011	1,6	22967	1148	0,33
sva druga DZO	5107	151902	29,7	620546	4085	17,91	sva druga DZO	5322	179108	33,7	893666	4990	12,94
	58776	2511077	42,7	3465351	1380			57210	4863153	85,0	6904958	1420	
	2019							2022					
	broj ugovora	broj osiguranika	osiguranika po ugovoru	ukupna premija (000) din	premija po osiguraniku (din)	% u odnosu na uk. prem.		broj ugovora	broj osiguranika	osiguranika po ugovoru	ukupna premija (000) din	premija po osiguraniku (din)	% u odnosu na uk. prem.
paralelno ZO	8278	8298	1,0	65597	7905	1,43	paralelno ZO	468	474	1,0	7142	15068	0,25
dodatno ZO	8971	2450347	273,1	944846	386	20,62	dodatno ZO	9483	2960150	312,2	516984	175	17,93
privatno ZO	2388	2793	1,2	157921	56542	3,45	privatno ZO	4061	18606	4,6	108685	5841	3,77
kombinacija vrsta DZO	14371	103277	7,2	2665474	25809	58,18	kombinacija vrsta DZO	41094	229816	5,6	1823143	7933	63,24
putno ZO	27035	43157	1,6	39031	904	0,85	putno ZO	16492	26539	1,6	443	17	0,02
sva druga DZO	5225	160371	30,7	708600	4419	15,47	sva druga DZO	6744	101473	15,0	426379	4202	14,79
	66268	2768243	41,8	4581469	1655			78342	3337058	42,6	2882776	864	

(Narodna Banka Srbije, 2017,2018,2019,2020,2021,2022)[32]

Tabela, br. 1: Struktura DZO, broj osiguranika i premija po osiguraniku u periodu 2017–2022. godine. Može da se uoči tendencija kretanja DZO u Republici Srbiji u periodu 2017–2022. godine. Broj ugovora u tom periodu je sa početnih 49 hiljada premašio 78 hiljada, a broj osiguranika je sa početnih 1,47 miliona dostigao

[31] Marija B. Kovačević, „Faktori koji utiču na razvoj dobrovoljnog zdravstvenog osiguranja u Republici Srbiji", *Tokovi osiguranja*, br. 1/2023, str. 75-102.

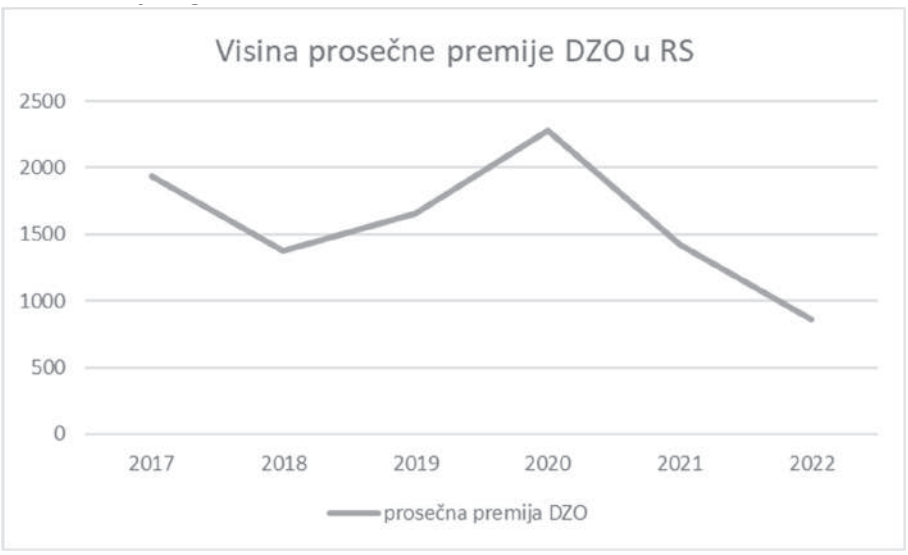
[32] Narodna banka Srbije, *Sektor osiguranja u Republici Srbiji, izveštaji za tromesečje*, Beograd 2017, 2018, 2019, 2020, 2021, 2022.

gotovo 3,0 miliona. Primetno je da sve više poslodavaca zaključuje ugovore o DZO, i uključuje svoje zaposlene u sistem DZO, što se uočava po ugovorima koji uključuju veliki broj osiguranika, pa se tako ugovori koji predviđaju dodatno ZO odnose od 185 pa do maksimalnih 483 osiguranika prosečno po ugovoru. Dominantna vrsta DZO je dodatno ZO ili kombinacija dodatnog ZO sa nekim drugim oblikom ZO, i ova vrsta DZO čini preko 70% uplaćenih premija u navedenom periodu.

Period kovida 19 se karakteriše time da je došlo do značajnog pada zaključenih ugovora o putnom ZO, što je i logično s obzirom na potpuno zatvaranje, tzv. *lock-down*, a s druge strane 2021. godine došlo je do značajnog povećanja i ugovora i samih osiguranika koji koriste usluge DZO jer su ljudi postali svesni značaja zdravstvenih usluga koje moraju biti dostupne brzo, ali i u širem obimu nego što nudi sistem OZO.

Iz napred navedenog jasno je da je DZO uhvatilo korena u Republici Srbiji, pogotovo nakon pandemije kovida 19, jer se jasno uočava povećanje i broja osiguranika i uplaćenih premija. Razvoj DZO ima dalju perspektivu u Republici Srbiji.

Kretanje prosečno uplaćene premije po osnovu DZO u periodu 2017–2022. godine je fluktuiralo, što se može i videti prema Grafikonu br. 1: Kretanje prosečne premije DZO u RS u periodu 2017–2022. godine (Grafikon br. 1), gde se uočava pad prosečne premije 2018. godine u odnosu na 2017, što se objašnjava činjenicom da je skoro udvostručen broj osiguranika po osnovu dodatnog ZO, a broj ugovora je porastao za 23,5%, pri čemu je došlo do smanjenja premije po osiguraniku, odnosno osiguravajuće kuće su ponudile dodatno ZO po povoljnijim uslovima, sa manjim stepenom pokrića, ali tako da bude široko prihvaćeno. Stoga je premija sa 537 RSD pala na 353 RSD po osiguraniku, odnosno za 45,4%. Kako je dodatno ZO najmasovniji oblik DZO, to je logično dovelo do pada prosečne premije. Godine 2019. došlo je do blagog rasta prosečne premije, dok se u 2020. beleži maksimum koji se može objasniti činjenicama da je usled pandemije došlo do straha za zdravlje kod stanovništva, što je uslovilo zaključivanje polisa koje se odnose na privatno ZO koje sa sobom nose i relativno visoke premije, pa usled toga dolazi do povećanja prosečne premije po osiguraniku. U periodu 2021. i 2022. godine dodatno ZO je dostiglo gotovo tri miliona korisnika, postalo je široko dostupno, ali sa niskim premijama, koje su pale na simboličnih 175 dinara po osiguraniku, što je rezultiralo niskom prosečnom premijom. Činjenica da gotovo tri miliona ljudi ima zaključen neki vid dodatnog osiguranja je ohrabrujuća sa stanovišta promocije DZO, jer i sa tako simboličnim premijama ipak imaju neki vid dodatnog ZO, pa se zaključuje da je stanovništvo svesno važnosti DZO i da ga prihvata kao nužnu investiciju u svoju sigurnost, ali i investiciju koja predstavlja vid zaštite životnog standarda usled nekih nepredvidljivih zdravstvenih problema koji se mogu javiti u budućnosti. Ta činjenica ohrabruje u odnosu na stanje kakvo je bilo u bliskoj prošlosti, kada se zdravstvena zaštita posmatrala kao obaveza države prema svojim građanima.



Grafikon, br. 1: Kretanje prosečne premije DZO u RS u periodu 2017–2022. godine

V Učešće dobrovoljnog zdravstvenog osiguranja u Republici Srbiji u ukupnom osiguranju i faktori koji ukazuju na tendencije

Broj ugovora koji se odnose na DZO kao vid neživotnog osiguranja je u porastu, no učešće ugovora o DZO i premija koje su uplaćene po osnovu DZO i dalje je relativno mali. U Tabeli br. 1 se vidi učešće uplaćene premije DZO u odnosu na ukupne premije osiguranja, kao i u odnosu na ukupne premije neživotnih osiguranja. Uočava se da je porast uplaćenih premija DZO od početnih 7,87 miliona dinara u 2017. godini dostigao 24,49 miliona dinara u 2022. godini, što predstavlja rast uplaćenih premija od 16,62 miliona dinara za period od šest godina, ili rast od 311%, odnosno rast od približno 50% godišnje. Takvi podaci ukazuju na to da tržište DZO ima perspektivu, i da treba raditi na razvijanju ovog segmenta tržišta osiguranja.

Tabela 2: Učešće premija DZO u odnosu na ukupne premije i premije NŽO

	iznos ukupnih premija	premija neživotnih osiguranja	premija DZO	premija DZO u odnosu na ukupne premije	premija DZO u odnosu na ukupne premije neživotnih osiguranja
	mln.	mln.	mln.	%	
2017.	236946	186284	7878	3,32	4,23
2018.	247948	193565	9603	3,87	4,96
2019.	264736	205673	12701	4,80	6,18
2020.	273171	200167	15181	5,56	7,58
2021.	295620	230230	18348	6,21	7,97
2022.	317465	263117	24493	7,72	9,31
	272648	213173	14701	5,39	6,90

(Narodna Banka Srbije, 2017,2018,2019,2020,2021,2022)[33]

Tabela 2 korelacija iznosa UP, PNŽO i premija DZO

Correlations

		ukupne_UP	premije_NŽO	premije_DZO
ukupne_UP	Pearson Correlation	1	,960**	,995**
	Sig. (1-tailed)		,001	,000
	N	6	6	6
premije_NŽO	Pearson Correlation	,960**	1	,964**
	Sig. (1-tailed)	,001		,001
	N	6	6	6
premije_DZO	Pearson Correlation	,995**	,964**	1
	Sig. (1-tailed)	,000	,001	
	N	6	6	6

**. Correlation is significant at the 0.01 level (1-tailed).

[33] Narodna banka Srbije, *Sektor osiguranja u Republici Srbiji, izveštaji za tromesečje*, Beograd 2017, 2018, 2019, 2020, 2021, 2022.

Tabela 3 Korelacija uplaćenih premija DZO i BDP

Correlations

		VAR00009	VAR00010
VAR00009	Pearson Correlation	1	,986**
	Sig. (1-tailed)		,000
	Sum of Squares and Cross-products	185957205,3	26205173,00
	Covariance	37191441,07	5241034,600
	N	6	6
VAR00010	Pearson Correlation	,986**	1
	Sig. (1-tailed)	,000	
	Sum of Squares and Cross-products	26205173,00	3796388,000
	Covariance	5241034,600	759277,600
	N	6	6

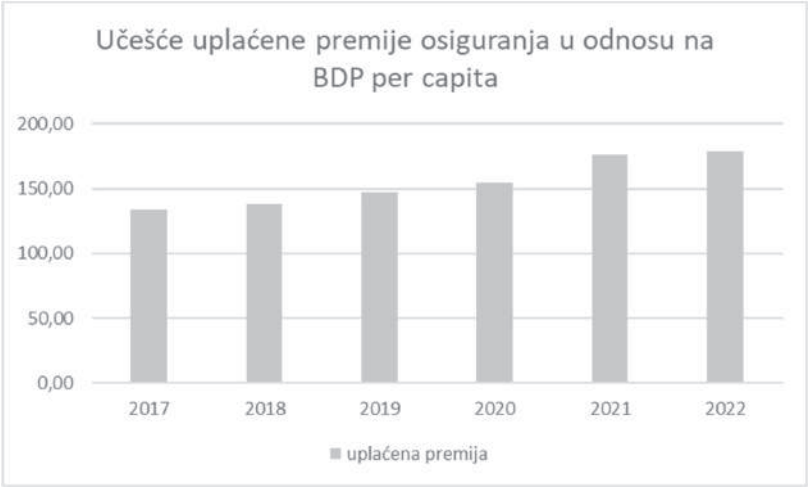
**. Correlation is significant at the 0.01 level (1-tailed).

Iz Tabele 2 se uočava da postoji visoka korelacija između iznosa uplaćenih ukupnih premija, uplaćenih premija neživotnih osiguranja i premija dobrovoljnih zdravstvenih osiguranja.

Iz Tabele 3 se uočava da postoji visoka korelacija između iznosa uplaćenih premija dobrovoljnih zdravstvenih osiguranja i BDP-a.

Iz napred navedenog nameće se zaključak da pored toga što stanovništvo postaje svesno potrebe posedovanja polise DZO, na odluku da zaključe DZO značajno utiče i rast BDP-a, odnosno BDP-a *per capita,* jer se s rastom prihoda stanovništva otvaraju mogućnosti da se zadovolje i neke neegzistencijalne potrebe, i da se ulaže u budućnost (ulaganje u DZO tokom aktivnog mlađeg perioda je ulaganje u budućnost, tj. za period kada će biti potrebne zdravstvene usluge, a to je period poznije životne dobi).

Iako je u periodu 2017–2022. iznos uplaćene premije *per capita* varirao, što se vidi na Grafikonu 1, i kretao se od minimalnih 134 evra *per capita* do maksimalnih 179 evra, jasno je da sa porastom uplaćene premije došlo i do porasta uplate premija DZO.



Grafikon 2 uplaćena premija per capita

VI Zaključak

Tržište DZO je perspektivno tržište koje treba razvijati, jer povećanjem broja ugovora, kao i povećanjem iznosa uplaćenih premija DZO, unapredиće se zdravstvena zaštita stanovništva, a samim tim doći će do povećanja kvaliteta života i produžetka životnog veka. Problem sa kojim se susreće sektor neživotnih osiguranja, podsektor DZO, jeste nedovoljna informisanost stanovništva, pa treba pristupiti pre svega informisanju stanovništva o postojanju ove usluge u portfelju osiguranja. „Povećanje ukupnih prihoda pojedinaca i porodica predstavljaće jednu od pretpostavki za dalji rast tržišta DZO, što će doprineti tome da stanovništvo bude zdravije zbog veće pristupačnosti zdravstvene zaštite, radni vek duži i život kvalitetniji."[34] „Produžetak životnog veka ima veliki značaj za sektor životnih osiguranja, jer u Srbiji više od 50% smrtnih slučajeva nastupi usled oboljenja kardiovaskularnih organa." Kada se unapredi zdravstvena zaštita stanovništva, posledično tome verovatno će se produžiti životni vek, i iz aspekta osiguravajućih kuća doći će do smanjenja isplate osiguranih slučajeva u sektor životnih osiguranja (nastupanja smrti ili teške bolesti). Sistemi obaveznog i dobrovoljnog osiguranja preko kojih se finansira zdravstvena zaštita u Srbiji moraju da imaju proaktivniji pristup tržištu zdravstvenih usluga, ali i da grade međusobno održiv odnos koji će biti osnova za održivost celokupnog zdravstvenog sistema.[35]

[34] OECD, „Health in glance-Europe 2012", *OECD publishing*, Brussel, Belgium, 2012.

[35] Damir I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji –faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, Beograd , 2018, str. 374–393.

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Srđan B. Segić[1]

VOLUNTARY HEALTH INSURANCE IN SERBIA

PROFESSIONAL PAPER

Abstract

The paper presents the evolution of health insurance from its origins in the 19th century to the present day. It highlights the differences between compulsory and voluntary health insurance, as well as the limitations of each model, the principles of solidarity and mutuality in compulsory health insurance, and the advantages of voluntary health insurance, which does not offer solidarity and mutuality but incurs lower costs. The paper also details the growth of voluntary health insurance in Serbia, which first appeared in 2005 and reached significant participation compared to the non-life insurance sector by 2022. The dependency of voluntary health insurance on the population's income and overall GDP is noted, as well as the connection between the non-life insurance sector and the life insurance sector. Additionally, the paper analyzes the participation of individual elements of voluntary health insurance in total premiums, as well as the number of contracts and insured persons.

***Keywords**: voluntary, health, insurance, complementary, supplementary, private.*

I. Introduction

The origins of health insurance can be traced back to the late 19th century when Germany enacted the Health Insurance Act to provide social and health security to certain segments of the population through the "sickness fund" principle.[2]

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[2] D.I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji – faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, Beograd, No. 2/2018, pp. 374–393.

Over time, social protection, and consequently health protection, expanded across Europe and the world, adopting regional specificities while maintaining the fundamental principle of universality for all citizens. Today, health insurance coverage in European countries is nearly complete, with over 98% of the total population having some form of health insurance. The dominant sources of health care financing in Europe include employee health insurance contributions, private (voluntary) health insurance, and direct payment for health services. The health system is still largely funded by a centralized public financing system, which necessitates the development of suitable health insurance models that can provide universal health care to every individual. With the development of society, science, and health care, life expectancy has increased, posing a "burden" for the health system, as the older population requires more health care than the younger population, and medical procedures are becoming more complex and expensive. Throughout the history of health insurance, several models have developed, including the following:

- Bismarck model: based on employee contributions as insured persons, with contributions proportional to earnings, and founded on the principles of non-profitability and solidarity of funds, often referred to as "sickness funds";
- Beveridge model: based on funding health care from the state budget and rooted in solidarity and universality for all citizens, covering all types of health care in both public and private health institutions;
- Semashko model: the state is responsible for organizing and financing health care for all residents, excluding the possibility of private health institutions;
- Market model: health insurance is organized and implemented by profit-based organizations, without relying on solidarity and universality.[3]

II Compulsory Health Insurance and Voluntary Health Insurance in the Republic of Serbia

In the territory of the Republic of Serbia (hereafter: RS), until 2005, only the compulsory health insurance system (hereafter: CHI) functioned, as was the case in all former socialist states. CHI was based on:

- the principle of being compulsory, requiring a certain percentage of earnings to be allocated to CHI;
- the principles of solidarity and reciprocity;
- the principle of transparency and protection of the insured persons' rights;
- the principle of continuous quality improvement, along with cost-effectiveness and efficiency.

[3] D. Janković, „Zdravstveno osiguranje kao faktor troškova zdravstvene zaštite", Škola *biznisa,* Novi Sad, No. 4/2011, pp. 69–82.

The first two principles were completely fulfilled, but the other two principles were brought into question because the insured individuals often faced delays in receiving certain health services, thus challenging the principle of efficiency.[4]

In 2005, a new Health Insurance Act[5] (hereinafter: HIA) was enacted, which enabled two health insurance systems: compulsory health insurance (CHI) and voluntary health insurance (hereinafter: VHI). The common goal of these two systems is to provide individuals with comprehensive health protection, i.e. the best possible health care. VHI is thoroughly regulated by the Decree on Voluntary Health Insurance[6], which ceased to be valid with the amendments and supplements to the HIA[7] in 2019, which regulated VHI. These acts laid the foundations for VHI in Serbia, making it a supplementary form of compulsory social health insurance. VHI is in its early stages of development in Serbia and faces many unresolved or undefined issues, such as the regulation of the work of doctors and medical staff, the regulation of private health institutions, the status of state hospitals outside regular working hours, the tax treatment of VHI premiums, the habits of the population, economic capabilities of the population, etc.

VHI partially addresses issues faced by CHI, primarily the moral "hazard" where individuals abuse the health system by seeking unnecessary services when they have no costs.[8] The majority of CHI revenue comes from insured individuals' contributions (approximately two-thirds of total CHI fund revenue), with the remainder coming from pension and disability fund transfers and budget transfers.[9] Health care costs are high, and the available funds in this system are insufficient. However, there was a significant problem with evasion of CHI contribution payments. According to the Tax Administration's report for 2012, the debt for health insurance contributions exceeded 148 billion dinars, of which over 78 billion dinars, or more than 50%, was uncollectible.[10] This fact should be viewed in the context that a large portion of this debt accumulated until 2000, during the period of sanctions and disrupted market conditions, and another part after 2000 during the transition period. Amendments to the Law on Tax Procedure and Tax Administration (hereinafter: LTPA) in 2012 significantly improved the collection of taxes and contributions on wages, as it became impossible to pay wages without paying taxes and contributions.[11]

[4] D. I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji – faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, No. 2/2018, pp. 374–393.

[5] Health Insurance Act – HIA, *Official Gazette of the RS,* No. 107/05, 109/05.

[6] Decree on Voluntary Health Insurance, *Official Gazette of the RS*, No. 108/08, 49/09.

[7] Health Insurance Act – HIA, *Official Gazette of the RS*, No. 25/19, 92/23.

[8] D. Janković, „Zdravstveno osiguranje kao faktor troškova zdravstvene zaštite", Škola biznisa, Novi Sad, No. 4, 2011, pp. 69–82.

[9] Republic Health Insurance Fund – RHIF, Financial Report of the Republic Health Insurance Fund for 2016, Belgrade, 2017.

[10] J. Kočović, T. Rakonjac Antić, V. Rajić, „Dobrovoljno zdravstveno osiguranje kao dopuna obaveznom zdravstvenom osiguranju u Srbiji", *Ekonomske teme*, No. 3/2013, pp. 541–560.

[11] Law on Tax Procedure and Tax Administration, *Official Gazette of the Republic of Serbia*, Nos. *80/2002, 84/2002, corr. 23/2003, corr. 70/2003, 55/2004, 61/2005, 85/2005, 53/2010, 101/2011, 2/2012, corr. 93/2012,*

The problem of insufficient funds in the CHI budget is caused by many factors, but one of the critical threats to the CHI budget is the so-called aging population, which is a trend throughout Europe, except in certain regions. The aging population is a complex sociological issue, resulting in an increase in the proportion of people over the age of 65 relative to the total population. On one hand, the population over 65 years old belongs to the category of retirees, for whom real contributions, i.e. contributions arising from economic activity, are not paid. On the other hand, the population over 65 uses healthcare services more than the younger population. In addition to the aging population, another trend is emerging, which is that fewer young people worldwide are being educated in the same manner as their parents were, and they behave indifferently and unambitiously. It is quite possible that a similar trend may occur in Serbia, with an increase in the number of powerful and wealthy individuals over the age of 55 who will be business leaders, have good earnings, but be more prone to illnesses. A characteristic of Europe today is that the elderly support the young, who face unemployment across the continent.[12]

Healthcare costs for the population are continuously rising. In EU countries, these costs can reach up to €4,000 *per capita* in Germany, while in most European countries, the costs range from €2,000 to €3,000. In Serbia, the cost is €1,049 per capita.[13] The revenues of the Compulsory Health Insurance (CHI) in Serbia are about €250 *per capita* annually, making it challenging to ensure the functioning of the healthcare system, which spends nearly €800 more than the CHI can cover from its revenues.

All countries strive to ensure maximum coverage of the population with healthcare protection, aiming to achieve a socially responsible society. The World Health Organization itself has issued the document "Health for All in the 21st Century," which obligates all member states to ensure solidarity and universal accessibility of healthcare while simultaneously managing costs.[14]

In developed countries, there exists a so-called positive competition between compulsory health insurance (CHI) and voluntary health insurance (VHI). This means that insurance systems compete not only for the number of insured individuals but also for the qualitative structure of the insured population. It is in their interest to attract the wealthiest insured individuals who can afford higher premiums. Consequently, both insurance systems compete in terms of the services offered and the quality of

47/2013, 108/2013, 68/2014, 105/2014, 91/2015 - authentic interpretation, 112/2015, 15/2016, 108/2016, 30/2018, 95/2018.

[12] M. Zekić, S. Šegrt, *Uticaj privatnog zdravstvenog osiguranja na makroekonomski ambijent Republike Srbije*, *Oditor*, Centar za ekonomska i finansijska istraživanja, Beograd, 2015, pp. 4–9.

[13] D. I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji – faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, Beograd, 2018, pp. 374–393.

[14] D. Čepić, V. Avdalović, „Zdravstveno osiguranje", *Zbornik radova fakulteta tehničkih nauka Novi Sad,* Novi Sad, 2011, pp. 2136–2144.

those services, which ultimately leads to the improvement of services provided to all insured individuals. Once improved, these services become available to everyone.

One of the advantages of VHI is the very form of contract conclusion. During this process, the riskiness of the insured individual is assessed — those at higher risk pay higher premiums. This risk assessment, which can only be conducted through examinations and preventive check-ups, can significantly improve the healthcare protection of the population. Preventive check-ups can diagnose the risk of illness or early-stage disease when treatment is more certain and less costly. This approach, "prevention is better than cure", significantly eases the burden on the healthcare system overall, including both the CHI and VHI systems.[15]

Voluntary health insurance represents the pooling of insured individuals into risk communities. Within these communities, protection is provided against certain health risks based on the premiums paid, and this is done on a voluntary basis. With a larger risk community, the premiums for the insured are lower, meaning they represent a smaller burden compared to paying for healthcare services directly.[16]

III Voluntary Health Insurance as a Form of Insurance

Voluntary health insurance falls under the category of non-life insurance.[17] Alongside the Insurance Law, the provisions of the Health Insurance Law also apply, and until the enactment of the new Health Insurance Law, the Regulation on Voluntary Health Insurance was in effect. Voluntary health insurance (VHI) can be carried out by the Republic Institute for Health Insurance and legal entities engaged in insurance activities in accordance with the Insurance Law. In addition to this general formulation regarding who can conduct VHI, the law stipulates that the National Bank of Serbia (NBS) issues a special license to a legal entity engaged in insurance activities for VHI provided the Ministry has given a positive opinion on the fulfillment of the conditions for organizing and implementing VHI. The insurer manages VHI funds by type of insurance separately in special accounts, distinct from the funds and accounts of compulsory health insurance and other resources of the insurance company, in accordance with the law.[18] [19]

The Health Insurance Law is currently the only law regulating Voluntary Health Insurance (VHI), and as such, it defines the minimum period of insurance

[15] A. Gavrilović, D. Ugrinov, I. Radošević, M. Nikolić "Modern management in the function of increasing of health service quality in primary health care", *Serbian Journal of engineering management,* Belgrade, 5(1), 2020, pp. 14-28.

[16] T. Rakonjac Antić, M. Koprivica, "Specifičnost privatnih izvora finansiranja zdravstvene zaštite" *Revija kopaoničke* škole *biznisa prirodnog prava,* Beograd, 2020, pp. 83-97.

[17] Insurance Law, *Official Gazette of RS* 139/2014, 44/2021 (hereinafter: IL), Article 9.

[18] Regulation on Voluntary Health Insurance, *Official Gazette of the RS*, Nos. 108/08, 49/09.

[19] Health Insurance Law - HIL, *Official Gazette of the RS*, Nos. 25/19, 92/23.

coverage. The legislator, in Article 170, has specified that this period is 12 months, with exceptions allowing for shorter coverage in cases of temporary residence of the insured abroad, if the insured's status in the compulsory health insurance system lasts less than the specified 12 months, if the insured acquires the basis for insurance under collective agreements during the agreed period, and for foreign nationals during their temporary stay in the Republic of Serbia.

Article 171 of the Health Insurance Law[20] stipulates that VHI cannot be organized and implemented for rights already covered by the compulsory health insurance system (CHI), as well as for preventive immunization and chemoprophylaxis programs. Such a rigid stance of the Law excludes the possibility of choice for insured individuals who have contracts for VHI. For certain rights defined by the CHI system, insured individuals are forced to be on so-called "waiting lists", and there is a possibility that these rights could be addressed through VHI, allowing insured individuals who pay a premium covering such rights to access them in private healthcare facilities, or even in public ones, without waiting. On one hand, this places VHI insured individuals in a more favorable position compared to those covered by CHI, which is certainly undesirable as it constitutes a form of discrimination. However, besides the issue of discrimination, there is also the problem concerning individuals who are not part of the CHI system. The question arises regarding what happens to those who are not covered by the CHI system for any reason but are citizens of the Republic of Serbia. An illustrative example is the issue faced by farmers who have contracts with the Pension and Disability Insurance Fund (PDI) and the Republic Health Insurance Fund (RHIF), but due to changed financial circumstances, they were unable to continue paying contributions. Consequently, they find themselves with exceptionally high debts for unpaid contributions, such individuals cannot exercise the rights provided by the CHI system. In such situations, VHI through private health insurance programs could serve as a temporary solution until obligations are settled or another solution is found for the accumulated debts.

Types of Voluntary Health Insurance (VHI) according to the Health Insurance Law (HIL)[21], as per Article 174, are:

– **complementary health insurance**;
– **supplementary health insurance**;
– **private health insurance**.

Article 175 of the HIL[22] stipulates that the status of a VHI insured individual ceases simultaneously when their status also ends in the compulsory health insurance system (CHI).

[20] HIL, art. 171.
[21] HIL, art. 174.
[22] HIL, art. 175.

Articles 177–193 of the Health Insurance Law (HIL)[23] define the organization and implementation of Voluntary Health Insurance (VHI) detailing the conditions for its organization and execution, which are further regulated by bylaws, primarily by the National Bank of Serbia (NBS). The articles also specify the elements that must be included in the contract, as well as who can enter into the contract, and the requirement for written consent from the insured individual if the obligation to pay the premium fully or partially falls on them. In addition to the contract, the elements of the policy and coverage list are regulated, as well as the obligations of the insurer concerning the rights that the insured individual acquires under the contract or policy.

Problems arising with Voluntary Health Insurance (VHI) primarily concern citizens' awareness of the need to pay additionally for health insurance. For decades, people have been accustomed to health care being free and universally accessible. Now, as economic conditions are more challenging than a few decades ago, they are required to allocate additional funds for health care.

Voluntary health insurance should offer citizens the opportunity to choose, providing a system that ensures faster, higher-quality, and more accessible health services. This, in turn, should lead to better quality and longevity of life, reduced abuse (less overuse of health services), increased investment in health care, decreased corruption, financial risk coverage, and greater diversity and flexibility within the health insurance system.[24]

There is an interest among employers to offer Voluntary Health Insurance (VHI) to their employees as a form of incentive and employee retention. This is because VHI provided by an employer remains valid for the employee as long as they are with that particular employer. If the employee leaves the employer, they also lose the VHI provided by the employer. Although there is a possibility of receiving VHI with a new employer, it is uncertain whether the employee will get VHI from the same insurance company, making VHI a tool that ensures employee loyalty to the employer.

In addition to VHI provided through employment, an increasing number of citizens are becoming aware of the need and necessity of obtaining VHI individually. As a result, the number of individual insurance contracts with insurance companies is constantly rising. VHI offers citizens the opportunity to customize their insurance packages to suit their personal needs.

VHI was not regulated in the legal systems of the countries of the Socialist Federal Republic of Yugoslavia (SFRY) immediately after their independence, as the

[23] HIL, arts. 177–193.

[24] Detailed: T. Rakonjac Antić, *Penzijsko i zdravstveno osiguranje*, Centar za izdavačku delatnost, Ekonomski fakultet, Beograd, 2012.

old system of compulsory health insurance (CHI) was still in place. Only after the conflicts in the former SFRY and the alignment of the legal systems of the newly formed states with the principles of a free market economy were regulations concerning health insurance introduced. As time progressed and the newly formed states moved closer to the European Union (EU) and eventually joined the EU, regulations concerning health insurance in accordance with EU legislation were introduced. While compulsory health insurance does not represent a commercial activity, VHI does, as there is market competition among insurance companies providing VHI services. Accordingly, appropriate legal regulations concerning VHI must be enacted.[25] It must be taken into account that the EU has implemented a series of measures to deregulate the VHI market, which has removed the regulatory bodies' right to protect consumers in certain cases.[26]

IV Structure of Voluntary Health Insurance (VHI) in the Republic of Serbia

Voluntary health insurance (VHI) in the Republic of Serbia was established in 2005 with the initial regulation under the Health Insurance Law (HIL),[27] which was later detailed further.[28] Since the introduction of VHI into the insurance system in Serbia, it has taken considerable time and effort to educate both the population and employers about the benefits of VHI, and to shift the perception of insurance from a cost to an investment. Direct payment of healthcare expenses can lead individuals into poverty.[29] For many years, health insurance was viewed as a "duty of the state" and society, something that the state and society were obligated to provide and implement. This perspective is incorrect, as health insurance contributions during the socialist period were paid by employers based on employees' earnings. The state was responsible for organizing the healthcare system, financing it from compulsory health insurance contributions, and partially from the budget. The beginnings of VHI in Serbia, as in neighboring countries, were challenging, and VHI initially entered the insurance system timidly. Through educating the population and improving the healthcare system, VHI advanced as people began to understand its importance and

[25] T. Sokol, F. Stančić, „Pravila Europske unije o tržišnom natjecanju i državnim potporama i dopunsko zdravstveno osiguranje u Republici Hrvatskoj, krivo srastanje", *Pravni vjesnik*, Zagreb, 2021, p. 37.

[26] E. Mossialos, S. Thomson, „Voluntary health insurance in the Europian Union: a critical assessment", *International Journal of Health Service*, London, 2002.

[27] Health Insurance Law - HIL, *Official Gazette of the RS*, Nos.107/05, 109/05.

[28] Regulation on Voluntary Health Insurance, *Official Gazette of the RS*, Nos.108/08, 49/09.

[29] M. Tabaković, J. Todorović, U. Babić, Z. Terzić, M. Santrić Milićević, „Development of voluntary health insurance in Serbia: the insurance companies viewpoins", *Europian Journal of public health*, Utrecht, Netherlands, 2018, p. 445.

benefits. To achieve the desired participation of voluntary, particularly supplementary health insurance in the domestic insurance market portfolio, it is crucial to undertake initiatives aimed at increasing the population's health literacy. Health literacy is essential for the sustainability of health insurance. The World Health Organization defines health literacy as an individual's knowledge and ability to understand and apply health information to make informed health decisions, thereby impacting the maintenance and/or improvement of health throughout life. Individuals with higher health literacy are more likely to recognize the benefits of voluntary health insurance. Individuals with higher health literacy are more likely to recognize the benefits of voluntary health insurance.[30] VHI aims to provide users with a higher level of healthcare services compared to the compulsory health insurance system. Compulsory health insurance may lack certain services entirely or offer them to users with the requirement to share the costs of these services. The cost-sharing can be very high for certain services, which is precisely the advantage of VHI, where the user, through the paid premium, prevents potential expenses for health services.[31] The main advantage of the VHI system is the reduction of out-of-pocket expenses for health services, not only directly from individuals who have to pay for these services but also the general reduction of the burden on the budget system of the Republic of Serbia.

[30] N. Petrović Tomić, "Supplementary Health Insurance as a Contribution to Development of a Sustainable Healthcare System in the Republic of Serbia", *Insurance Trends*, No. 1/2024, pp. 7-39.

[31] Marija B. Kovačević, "Factors Affecting Development of Voluntary Health Insurance in the Republic of Serbia", *Insurance Trends*, No. 1/2023, pp. 75-102.

Table 1 Structure of Voluntary Health Insurance (VHI), Number of Insured Persons, and Premium per Insured Person for the Period 2017–2022

	2017						2020					
	number of contracts	number of insured	insured per contract	total premium (000) RSD	premium per insured (RSD)	% compared to total premium	number of contracts	number of insured	insured per contract	total premium (000) RSD	premium per insured (RSD)	% compared to total premium
complementary HI	3827	3839	1,0	26607	6931	0,92	428	429	1,0	14138	32956	0,26
supplementary HI	6583	1220215	185,4	729036	597	25,29	9233	2064640	223,6	1063985	515	19,64
private HI	2236	9189	4,1	232871	25342	8,08	8279	88481	1,1	228127	25745	4,21
combinetio n of types of VHI	2570	45285	17,6	1265065	27936	43,88	17059	130657	7,7	3276509	25077	60,49
travel HI	29195	47539	1,6	42959	904	1,49	travel HI	4699	6518	1,4	6895	1058	0,13
all other types of VHI	4658	147586	31,7	563016	3815	19,53	all other types of VHI	4549	166970	36,7	826531	4950	15,26
	49069	1473653	30,0	2859554	1904			44247	2378075	53,7	5416185	2278	
	2018						2021					
	number of contracts	number of insured	insured per contract	total premium (000) RSD	premium per insured (RSD)	% compared to total premium	number of contracts	number of insured	insured per contract	total premium (000) RSD	premium per insured (RSD)	% compared to total premium
complementary HI	5116	5116	1,0	35258	6892	1,02	complementary HI	471	488	1,0	16108	33008	0,23
supplementary HI	8132	2232026	274,5	788056	353	22,74	supplementary HI	9183	4462741	486,0	1303341	292	18,87
private HI	2512	5863	2,3	232171	39599	6,7	private HI	2627	7471	2,8	263208	35231	3,81
combinetio n of types of VHI	9707	70696	7,3	1747507	24719	50,43	combinetio n of types o	27174	193334	7,1	4405768	22788	63,81
travel HI	28202	45474	1,6	41813	919	1,21	travel HI	13433	20011	1,6	22967	1148	0,33
all other types of VHI	5107	151902	29,7	620546	4085	17,91	all other types of VHI	5322	179108	33,7	893666	4990	12,94
	58776	2511077	42,7	3465351	1380			57210	4863153	85,0	6904958	1420	
	2019						2022					
	number of contracts	number of insured	insured per contract	total premium (000) RSD	premium per insured (RSD)	% compared to total premium	number of contracts	number of insured	insured per contract	total premium (000) RSD	premium per insured (RSD)	% compared to total premium
complementary HI	8278	8298	1,0	65597	7905	1,43	complementary HI	468	474	1,0	7142	15068	0,25
supplementary HI	8971	2450347	273,1	944846	386	20,62	supplementary HI	9483	2960150	312,2	519684	175	17,93
private HI	2388	2793	1,2	157921	56542	3,45	private HI	4081	18606	4,6	108685	5841	3,77
combinetio n of types of VHI	14371	103277	7,2	2665474	25809	58,18	combinetio n of types o	41094	229816	5,6	1823143	7933	63,24
travel HI	27035	43157	1,6	39031	904	0,85	travel HI	16492	26539	1,6	443	17	0,02
all other types of VHI	5225	160371	30,7	708600	4419	15,47	all other types of VHI	6744	101473	15,0	426379	4202	14,79
	66268	2768243	41,8	4581469	1655			78342	3337058	42,6	2882776	864	

(National Bank of Serbia, 2017,2018,2019,2020,2021,2022)[32]

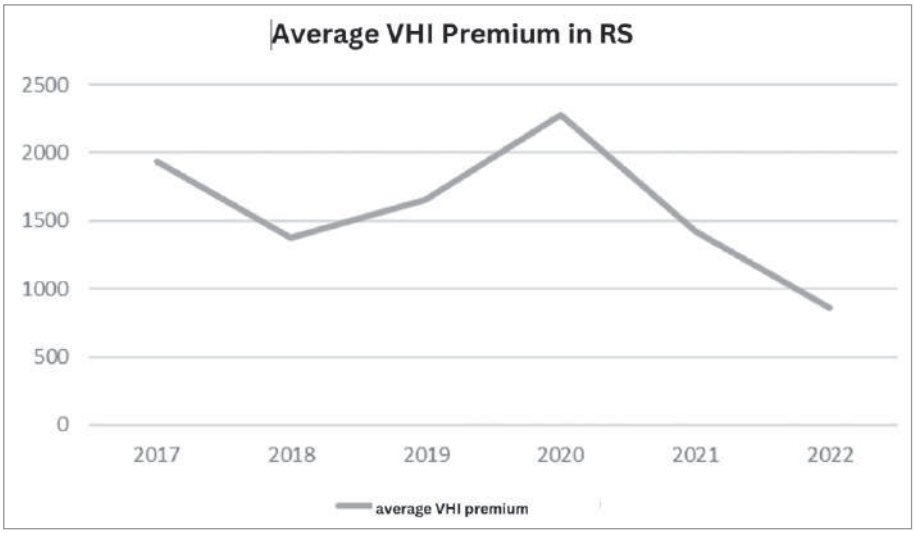
Table 1: Structure of Voluntary Health Insurance (VHI), number of insured persons, and premium per insured for the period 2017–2022. This table illustrates the trend of voluntary health insurance (VHI) in the Republic of Serbia from 2017 to 2022. The number of contracts increased from an initial 49,000 to over 78,000, while the number of insured persons grew from 1.47 million to nearly 3 million. It is noticeable that an increasing number of employers are entering into VHI agreements and including their employees in the VHI system, as evidenced by contracts involving a large number of insured persons, with the average number of insured per contract ranging from 185 to a maximum of 483. The dominant type of VHI is additional health insurance or a combination of additional health insurance with other forms of insurance, which constitutes over 70% of premiums paid during the period.

[32] National Bank of Serbia, Insurance Sector in the Republic of Serbia, Quarterly Reports, Belgrade 2017, 2018, 2019, 2020, 2021, 2022.

The COVID-19 period is characterized by a significant decline in travel insurance contracts, which is logical given the complete lockdown. On the other hand, in 2021, there was a significant increase in both the number of contracts and the number of insured persons utilizing VHI services, as people became more aware of the importance of health services that need to be available quickly and in a broader scope than what the compulsory health insurance system offers.

From the above, it is clear that VHI has established a foothold in the Republic of Serbia, especially after the COVID-19 pandemic, as evidenced by the increase in both the number of insured persons and premiums paid. The development of VHI has a promising future in the Republic of Serbia.

The trend of the average premium paid for VHI from 2017 to 2022 has fluctuated, as shown in Graph 1: Movement of Average VHI Premiums in RS from 2017 to 2022. A drop in the average premium in 2018 compared to 2017 can be explained by the nearly doubled number of insured persons under additional health insurance and a 23.5% increase in contracts, resulting in a decrease in the premium per insured person. Insurers offered additional health insurance under more favorable conditions, with lower coverage but wide acceptance. Consequently, the premium fell from 537 RSD to 353 RSD per insured person, a decrease of 45.4%. Given that additional health insurance is the most widespread form of VHI, this logically led to a decrease in the average premium. In 2019, there was a slight increase in the average premium, while 2020 recorded a peak, which can be explained by the population's health concerns during the pandemic, leading to the purchase of private health insurance policies with relatively high premiums, resulting in an increase in the average premium per insured person. In 2021 and 2022, additional health insurance reached nearly three million users, became widely available, but with low premiums, falling to a symbolic 175 RSD per insured person, leading to a low average premium. The fact that nearly three million people have some form of additional insurance is encouraging from the perspective of promoting VHI, as even with such symbolic premiums, people have some form of additional health insurance. This indicates that the population is aware of the importance of VHI and accepts it as a necessary investment in their security and as a safeguard for their standard of living against unforeseen health issues that may arise in the future. This fact is encouraging compared to the recent past, when health care was seen as a government obligation to its citizens.



Graph 1 Movement of the average VHI premium in RS for the period 2017–2022

V Participation of Voluntary Health Insurance in the Total Insurance Market in the Republic of Serbia and Factors Indicating Trends

The number of contracts related to voluntary health insurance (VHI) as a form of non-life insurance is increasing, but the share of VHI contracts and premiums paid remains relatively small. Table 1 illustrates the share of VHI paid premiums in relation to total insurance premiums and total non-life insurance premiums. It can be observed that the increase in VHI premiums, from an initial 7.87 million RSD in 2017 to 24.49 million RSD in 2022, represents a growth of 16.62 million RSD over a six-year period, or an increase of 311%, which translates to approximately 50% annual growth. Such data indicate that the VHI market has potential and highlights the need to focus on developing this segment of the insurance market.

Table 1 Overview of voluntary health insurance premiums in relation to total insurance premiums and non-life insurance premiums

	Total Premi-ums	Non-Life Insurance Premiums	VHI Premiums	VHI Premiums as % of Total Premiums	VHI Premiums as % of Non-Life Insurance Premiums
	mln.	mln.	mln.	%	
2017.	236946	186284	7878	3,32	4,23
2018.	247948	193565	9603	3,87	4,96
2019.	264736	205673	12701	4,80	6,18
2020.	273171	200167	15181	5,56	7,58
2021.	295620	230230	18348	6,21	7,97
2022.	317465	263117	24493	7,72	9,31
	272648	213173	14701	5,39	6,90

(National Bank of Serbia, 2017,2018,2019,2020,2021,2022)[33]

Table 2 Correlation of the amounts of TP, NLI premiums, and VHI Premiums

Correlations

		TP	NLI_premiums	VHI_premiums
TP	Pearson Correlation	1	,960**	,995**
	Sig. (1-tailed)		,001	,000
	N	6	6	6
NLI_premiums	Pearson Correlation	,960**	1	,964**
	Sig. (1-tailed)	,001		,001
	N	6	6	6
VHI_premiums	Pearson Correlation	,995**	,964**	1
	Sig. (1-tailed)	,000	,001	
	N	6	6	6

**. Correlation is significant at the 0.01 level (1-tailed).

[33] National Bank of Serbia, Insurance Sector in the Republic of Serbia, Quarterly Reports, Belgrade 2017, 2018, 2019, 2020, 2021, 2022.

Table 3 Correlation of paid VHI premiums and GDP

Correlations

		VAR00009	VAR00010
VAR00009	Pearson Correlation	1	,986**
	Sig. (1-tailed)		,000
	Sum of Squares and Cross-products	185957205,3	26205173,00
	Covariance	37191441,07	5241034,600
	N	6	6
VAR00010	Pearson Correlation	,986**	1
	Sig. (1-tailed)	,000	
	Sum of Squares and Cross-products	26205173,00	3796388,000
	Covariance	5241034,600	759277,600
	N	6	6

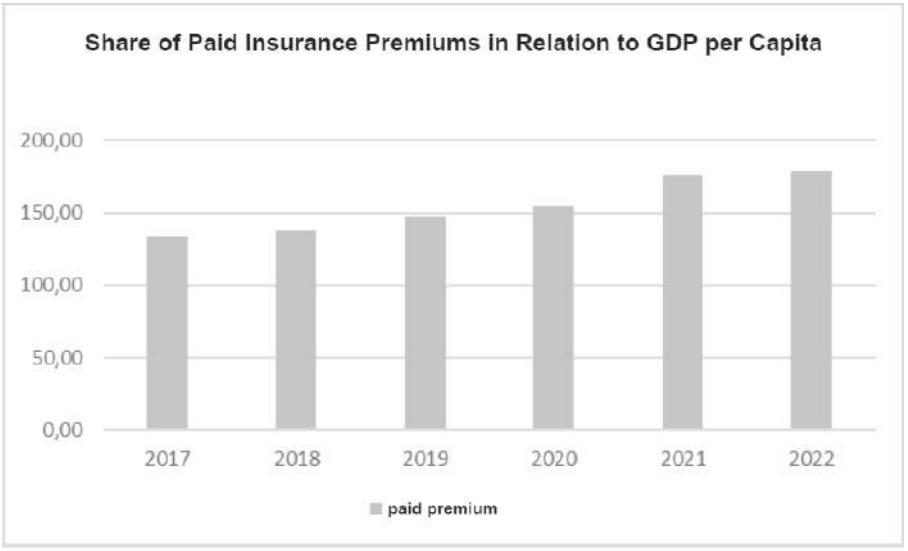
**. Correlation is significant at the 0.01 level (1-tailed).

Table 2 shows that there is a high correlation between the amounts of paid total premiums, non-life insurance premiums, and voluntary health insurance premiums.

Table 3 demonstrates a high correlation between the amounts of paid voluntary health insurance premiums and GDP.

From the above, it can be concluded that, in addition to the population becoming aware of the necessity for VHI coverage, the decision to purchase VHI is significantly influenced by GDP growth, i.e. GDP *per capita*. As income increases, opportunities arise to satisfy non-essential needs and invest in the future (investing in VHI during younger, active years represents a future-oriented investment, which will be beneficial when they need healthcare services later in life).

Although the amount of paid premiums *per capita* varied between 2017 and 2022, as illustrated in Graph 2, which ranged from a minimum of 134 euros *per capita* to a maximum of 179 euros, it is clear that as the paid premium amount increased, so did the payment of VHI premiums.



Graph 2 Paid premium per capita

VI Conclusion

The market for voluntary health insurance (VHI) in Serbia is promising and warrants further development. Increasing the number of contracts and the amount of VHI premiums will enhance the healthcare system, thereby improving the quality of life and extending life expectancy. A significant challenge facing the non-life insurance sector, particularly the VHI subsector, is the lack of awareness among the population. Therefore, efforts should be focused on informing the public about the existence and benefits of this service within insurance portfolios.

"An increase in the total income of individuals and families is expected to be a significant factor for the continued growth of the VHI market. This growth will contribute to improved population health due to better accessibility to healthcare, longer working lives, and improved quality of life."[34] "The extension of life expectancy is of considerable importance for the life insurance sector, given that over 50% of deaths in Serbia are due to cardiovascular diseases. By improving the healthcare system, it is likely that life expectancy will increase. From the perspective of insurance companies, this could result in a reduction in payouts for life insurance claims (e.g. death or severe illness)." Both compulsory and voluntary insurance systems that finance healthcare in Serbia need to adopt a more proactive approach to the healthcare

[34] OECD, „Health in glance-Europe 2012", *OECD publishing*, Brussels, Belgium, 2012.

market and build a mutually sustainable relationship. This will be fundamental for the overall sustainability of the healthcare system.[35]

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[35] Damir I. Mirković, „Proaktivan odnos obaveznog i dobrovoljnog zdravstvenog osiguranja u Republici Srbiji –faktor veće efikasnosti celokupnog zdravstvenog sistema osiguranja", *Vojno delo*, Beograd , 2018, pp.374–393.

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Primer:

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1.1. Razlike između osiguranja imovine i osiguranja lica
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Primer:

Nebojša Žarković, *Pojmovnik osiguranja*, Novi Sad, 2013, str. 100.

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Marjan Ćurković, Vladimir Miletić, *Pravo osiguranja Europske ekonomske zajednice*, Croatia osiguranje d. d., Zagreb, 1993.

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Mirko Vasiljević (urednik), *Akcionarska društva, berze i akcije*, Beograd, 2006, 30.

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Primer:

N. Žarković, str. 125.

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Primer:

N. Žarković (2013), str. 25.

2. Članci

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Primer:

Jasna Pak, „Pravna zaštita korisnika usluga osiguranja“, *Privreda i pravo u tranziciji*, Palić, 2004, str. 35.

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Primer:

Jelena Kočović, Marija Jovović, „Uticaj liberalizacije i privatizacije na razvoj tržišta osiguranja u Srbiji", *Tokovi osiguranja*, br. 1/2016, str. 5.

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Primer:

Vladimir Kovčić, „Stečaj akcionarskog društva za osiguranje", *Pravo osiguranja u tranziciji* (urednici Predrag Šulejić i Jovan Slavnić), Palić, 2003, str. 56.

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Primer:

Jasna Pak, str. 57.

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Primer:

Zakon o obaveznom osiguranju u saobraćaju, *Službeni glasnik RS*, br. 51/09, čl. 15.

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Primer:

Zakon o osiguranju – ZO, *Službeni glasnik RS*, br. 55/04, čl. 38, st. 2.

c) Član, stav i tačka propisa označavaju se skraćenicama čl., st., tač., a paragraf skraćenicom par.

Primer:

čl. 35 st. 5 tač. 8 ili par. 8.

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Primeri:

Zakon o osiguranju, čl. 15.

ZO, čl. 15.

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Primeri:

nemački Trgovački zakonik iz 1897. godine (*Handelsgesetzbuch*), par. 29.

britanski Kompanijski zakon iz 2006. godine (*Companies Act*; dalje u fusnotama: CA), čl. 53.

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Primer:

Christos Gortsos, The Supervision of Financial Conglomerates under European Financial Law (Directive 2002/87/EC), 2010,

http://fic.wharton.upenn.edu/fic/papers/09/0936.pdf, pristupljeno: 16. 7. 2016, str. 2

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Primer:

C. Gortsos, The Supervision of Financial Conglomerates under European Financial Law (Directive 2002/87/EC), str. 12.

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Primer:

Žarković, N., *Pojmovnik osiguranja*, Novi Sad, 2013, str. 100.

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I Insurance classification
1. Insurance of property and persons
1.1. Differences between insurance of property and insurance of persons
1.1.1. Indemnity principle

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Nebojša Žarković, *Glossary of Insurance Terms,* Novi Sad, 2013, pp. 100

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Example:

Marjan Ćurković, Vladimir Miletić, *Pravo osiguranja Europske ekonomske zajednice,* Croatia osiguranje d. d., Zagreb, 1993.

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Example:

Mirko Vasiljević (urednik), *Akcionarska društva, berze i akcije*, Beograd, 2006, 30.

d) Repeated citations from the same author should include only the first initial and a full stop before the last name of the author and the number of the page.

Example:

N. Žarković, pp. 125

e) If two or more references to the same author are cited, the first initial and a full stop should be included before the last name of the author, and then the year of publication in brackets and the page number.

Example:

N. Žarković (2013), pp. 25

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Jasna Pak, „Pravna zaštita korisnika usluga osiguranja", *Privreda i pravo u tranziciji*, Palić, 2004, str. 35.

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Jelena Kočović, Marija Jovović, „Uticaj liberalizacije i privatizacije na razvoj tržišta osiguranja u Srbiji", *Tokovi osiguranja*, br. 1/2016, str. 5

c) The article published in edited conference proceedings or a book is cited as follows: first and last name of author, title of article enclosed in quotation marks, title of book or proceedings written in italics, word *editor* or *sub-editor,* fist and last name of editor typed in parenthesis, edition number in ordinal form, place and year of publication, page number.

Example:

Vladimir Kovčić, „Stečaj akcionarskog društva za osiguranje", *Pravo osiguranja u tranziciji* (urednici Predrag Šulejić i Jovan Slavnić), Palić, 2003, str. 56.

d) Repeated citations from the same author should include only the first initial followed by a full stop before the last name of the author and the number of the page.

Example:

Jasna Pak, pp. 57

3. Regulations

a) The regulations are cited as follows: full title of regulation, gazette in which the regulation was published typed in italics, gazette number and year of publishing, abbreviations art., par., item and/or par. and regulation number.

Example:

Law on Compulsory Traffic Insurance, *Official Gazette of the Republic of Serbia,* no.51/09, art.15

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Example:

Insurance Law – IL, *Official Gazette of the Republic of Serbia*, no.55/04, art.38, par.2

c) Article, paragraph and item of a regulation are referred to as abbreviations art., par., item

Example:

art.35, par.5 item 8 or par.8

d) when repeating the reference to a specific regulation, please specify its full title or abbreviation introduced during the first citing, abbreviation art., item or par. and number of regulation.

Examples:
Insurance Law, art.15
IL, art.15

e) The regulations written in a language other than Serbian should be cited as follows: full title of regulation translated into the Serbian language, year of publishing and/or adoption, full title of regulation in original language, typed in italics, enclosed in brackets, optionally, the abbreviation under which the regulation will be referred to further in the text, abbreviation art., par., item or par.

Examples:
German Commercial Code 1897 (*Handelsgesetzbuch*), par. 29.
British Companies Act 2006 (*Companies Act*; referred in footnotes as: CA), art.53

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Example:
Christos Gortsos, The Supervision of Financial Conglomerates under European Financial Law (Directive 2002/87/EC), 2010, *http://fic.wharton.upenn.edu/fic/papers/09/0936.pdf,* accessed on: 16/7/2016, pp. 2

b) For repeated citations from the Web source, the first initial followed by a full stop before the last name of the author should be included, that is, the name of organization from which the paper originates, the paper title and page number.

Example:
C. Gortsos, The Supervision of Financial Conglomerates under European Financial Law (Directive 2002/87/EC), pp. 12.

Footnotes should be placed at the bottom of each page, and the list of used references should appear at the end of the article.

The rules for citing bibliography at the end of the article are slightly different in terms of placing the last name of the author first, followed by a comma, and then the first initial of the name followed by a full stop.

Example:
Žarković, N., *Glossary of Insurance Terms,* Novi Sad, 2013, pp. 100

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Editorial Board of the Journal *Tokovi osiguranja*

ISPRAVKA

ISPRAVKA: „OCENA STEPENA MONOPOLISANOSTI SEKTORA OSIGURANJA U SRBIJI U PERIODU 2011-2022“ (2024, Broj 2, str. 296-313, DOI: 10.5937/TokOsig2402296B)

Dr Rajko M. Bukvić

U radu autora dr Rajka M. Bukvića, pod naslovom „Ocena stepena monopolisanosti sektora osiguranja u Srbiji u periodu 2011-2022“, objavljen u broju 2/2024 na str. 325, 326, 327 i 329 napravljena je greška u prevodu na engleski jezik, te se ovom prilikom izvinjavamo autoru i čitaocima. Uz saglasnost autora, u ovom broju objavljujemo ispravak:

Greška o kojoj je reč načinjena je u napomenama ispod tabele 1 (str. 325), slike 1 (str. 326), tabele 2 (str. 327) i slike 2 (str. 329). U sva četiri slučaja umesto * Central Serbia only, odnosno * Central Serbia, potrebno je napisati * Without Kosovo and Metohia.

ERRATUM

CORRECTION: "ASSESSMENT OF DEGREE OF MONOPOLIZATION IN INSURANCE SECTOR IN SERBIA IN THE PERIOD 2011-2022" (2024, Issue 2, p. 296/313, DOI: 10.5937/TokOsig2402296B)

Rajko M. Bukvić, PhD

In the article "Assessment of Degree of Monopolization in Insurance Sector in Serbia in the Period 2011-2022," authored by Rajko M. Bukvić, published in the journal "Tokovi osiguranja" (2024, issue number 2, pp. 325, 326, 327, 329), an error in the English translation of the text was made. The Editorial board apologizes to the author and our readers. With the consent of the author, we publish the correct translation in this issue.

The error being referred to is made in the notes below Table 1 (p. 325), Figure 1 (p. 326), Table 2 (p. 327), and Figure 2 (p. 329). In all four cases, instead of * Central Serbia only or * Central Serbia, it should be written * Without Kosovo and Metohia.

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