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Association of Serbian Insurers

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SADRŽAJ/CONTENTS

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Prof. dr Nataša Petrović-Tomić[1]
Prof. dr Ivana Bodrožić[2]

NAČELNA PITANJA REVERZIBILNOG ODNOSA KRIVIČNOG PRAVA I PRAVA OSIGURANJA

ORIGINALNI NAUČNI RAD

Apstrakt

U radu se *a priori* polazi od pretpostavke da se, u kontekstu kompleksnosti pravnog sistema kao takvog i željenog stepena njegove koherentnosti, između krivičnog prava, kao javnog prava, i prava osiguranja, kao privatnog prava, pojavljuje odnos povezanosti, koji je obeležen reverzibilnošću.

Iako u osnovi potpuno različite pravne discipline, u savremeno doba, a prema svojoj osnovnoj funkciji i usmerenosti, one imaju niz dodirnih tačaka i odnos koji se zasniva na međusobnom uticaju. O karakteru odnosa te dve grane prava, u kontekstu održivosti željenog stepena funkcionisanja celokupnog tržišta osiguranja, kao značajnog segmenta modernog i efikasnog finansijskog sektora, u radu se vodi polemika, uz osnovnu istraživačku ideju da se krivično pravo posmatra kao *ultima ratio societatis* u zaštiti prava i interesa osiguranika, osiguravača i reosiguravača, odnosno u najširem smislu celokupne delatnosti osiguranja.

Dominantno teorijska rasprava, zasnovana najvećma na pravno-dogmatskom metodu, pionirska je ove vrste u domaćoj pravnoj teoriji. Zasnovana je na ideji o potrebi povezivanja različitih pravnih aspekata osiguranja, u cilju obezbeđivanja projektovanog stepena sigurnosti, to jest zaštite tržišta osiguranja. Autorke ukazuju na međusobnu uslovljenost oblikovanja krivičnopravnih normi uslovima savremenog ekonomskog

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Ovaj koautorski prilog pripremila sam oslanjajući se u velikoj meri na svoje istraživanje za knjigu: Nataša Petrović Tomić, *Pravo osiguranja*, *Sistem, Knjiga prva*, Službeni glasnik, Beograd, 2019 (nap. aut).
[2] Vanredna profesorka, Kriminalističko-policijski univerzitet u Beogradu. e-mail: ivana.bodrozic@kpu.edu.rs. ORCID https://orcid.org/0000-0001-5010-7832.
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kriminaliteta, te pitanjima kako kriminalitet *vice versa* oblikuje usluge osiguranja. U zaključku autorke ukazuju na značaj daljeg, kontinuiranog istraživanja u ovoj oblasti radi adekvatnog razvoja *de lege ferenda* rešenja u nacionalnom, krivičnom zakonodavstvu.

Ključne reči: krivično pravo, pravo osiguranja, reverzibilnost, kriminalitet i osiguranje.

I Uvodna razmatranja

Krivično pravo savremene demokratske države zasnovano je na utilitarističkom principu, koji podrazumeva da ono kao racionalan sistem pravnih propisa ima prioritetno zaštitnu funkciju. Osnovni cilj i svrha postojanja krivičnog prava jeste zaštita društva od kriminaliteta, odnosno društveno opasnih obrazaca ponašanja kojima se ugrožavaju ili povređuju najvažnija dobra čoveka i društva.

Pravo osiguranja, s druge strane, predstavlja skup pravnih propisa kojima se reguliše celokupno tržište osiguranja, kao značajan segment modernog i efikasnog finansijskog sektora, uključujući ugovore, poslove osiguranja, kao i postupanje sa odštetnim zahtevima. I pravo osiguranja prevashodno jeste zasnovano na ideji o zaštiti interesa osiguranika od potencijalnih osiguranih slučajeva, tačnije nastupanje štete prouzrokovane osiguranim slučajem, ali u krajnjoj liniji i na ideji o zaštiti osiguravača i reosiguravača, a u savremenom kontekstu i lica izvan ugovornog odnosa osiguranja.[3] Njegova zaštitna funkcija se prirodno nadovezuje na etimološko značenje. U svim jezicima termin osiguranje (engl.: *insurance*; franc.: *assurance*; nem.: *Versicherung*; špan.: *seguro*) ukazuje na sigurnost, bezbednost, pružanje zaštite, itd.[4] Preuzimanjem posledica određenog događaja (osiguranog rizika čijim ostvarenjem nastaje osigurani slučaj) osiguravač pruža zaštitu pojedincu čineći neometanim njegov dalji život.[5] Zaštitna funkcija osiguranja utoliko pre dolazi do izražaja kada je reč o pravnim licima i uopšte privrednim subjektima, kojima nepredviđeni događaji mogu naneti ogromne štete. Osiguranje omogućava da do zastoja u njihovom poslovanju ne dođe.

U toj zaštitnoj funkciji oličena je bazična povezanost ove dve naizgled potpuno različite pravne discipline. Polazeći od kompleksnosti pravnog sistema i projek-

[3] Nataša Petrović Tomić, *Pravo osiguranja, Sistem, Knjiga I*, Službeni glasnik, Beograd, 2019, 41–43.

[4] Helmut Heiss, „Insurance contracts", *Encyclopedia of Private International Law* (eds. Jürgen Basedow *et al.*), Vol. 2, Entries I-Z, Edward Edgar Publishing, Northampton, 2017, 954–955.

[5] Da stvari budu jasnije, zaštitna funkcija osiguranja nastupa *post festum*. Osiguravač nema čarobni štapić kojim bi mogao sprečiti da osiguranik doživi prirodne nepogode, povredu usled nesrećnog slučaja, invaliditet ili odgovornost usled preduzimanja neke radnje. Osiguranje stupa na scenu upravo kada se ostvari događaj od koga se osiguranik osigurao (osigurani slučaj). Umesto da se sam bori s posledicama nemilog događaja, osiguranik ili korisnik prava iz osiguranja ostvaruje naknadu ili osiguranu sumu, koja mu omogućava da lakše sanira posledice neizvesnih događaja.

tovanog stepena njegove koherentnosti, autorke u radu analiziraju upravo karakter i vrstu odnosa između krivičnog prava, kao dela javnog prava, i prava osiguranja, kao privatnog prava. Zaštitna funkcija i usmerenost ka maksimalnom izbegavanju štetne posledice predstavljaju osnov njihovog odnosa, o čijoj se reverzibilnosti odnosno uslovljenosti i vodi osnovna polemika u radu.

S krajnjim ciljem utvrđivanja prerogativa njihove međusobne uslovljenosti i usklađenosti, posmatrano najpre iz perspektive njih kao delova pravnog sistema, autorke postavljaju sledeće grupe pitanja i nude odgovore na nekoliko složenih pravnih tema: Kakav je odnos osnovnih načela krivičnog prava i prava osiguranja, sledstveno tome da li su i u kojoj meri krivičnopravne norme uslovljene razvojem savremenih oblika ekonomskog kriminaliteta u čijim okvirima se nalaze i inkriminacije koje za neposredni objekat zaštite imaju osiguranje kao delatnost *per se*? Na kraju, postavlja se pitanje kako kriminalitet oblikuje usluge osiguranja.

II O odnosu načela krivičnog prava i prava osiguranja

Osiguranje kao institut ima prioritetno ciljnu funkciju. Ona se ogleda u pružanju zaštite.[6] **Zaštitna funkcija osiguranja, u savremenom kontekstu posmatrano, odnosi se ne samo na osiguranika odnosno korisnika, već i na lica izvan ugovornog odnosa osiguranja**.[7] Osnovna funkcija krivičnog prava takođe je zaštitna. **Krivično pravo pretenduje da propisivanjem nedozvoljenih obrazaca ponašanja i njima pripadajućih krivičnih sankcija bude najsnažniji instrument državne reakcije na društveno štetno ponašanje kojim se povređuju ili ugrožavaju najvrednija dobra i vrednosti. Ono je duboko zasnovano na ideji o izuzetnosti, odnosno o *ultima ratio societatis* karakteru**.[8]

Posmatrano kroz prizmu osnovnih funkcija obe pravne grane, autorke polaze od unekoliko modifikovane latinske sentencije, vezane za utvrđivanje stepena demokratičnosti društva, *Quis custodiet ipsos custodes?* – koja postavlja pitanje: **ko će nas čuvati od čuvara?** Iz nje modifikovano i derivirano istraživačko pitanje jeste pitanje ko će i (kako) čuvati čuvare, to jest koji su načini i modaliteti koji krivičnom pravu, kao pravu sa zaštitnom funkcijom, stoje na raspolaganju, u zaštiti onih koji obezbeđuju zaštitu. Reč je o dvostrukom hipotetičkom kauzalitetu koji treba da pruži odgovor na pitanje kakvo je mesto i uloga krivičnog prava u zaštiti prava osiguranja, tačnije celokupnog tržišta osiguranja.

[6] Marija Karanikić Mirić, „Forma ugovora o osiguranju", *Tokovi osiguranja*, br. 1/2025, 22–23; N. Petrović Tomić (2019a), 41.

[7] Reč je o širenju zaštitne funkcije osiguranja, koja nastaje kao proporcionalna posledica kontinuiranog razvoja prava osiguranja. Nataša Petrović Tomić, *Osnovi prava osiguranja,* Pravni fakultet Univerziteta u Beogradu, Beograd, 2023, 21–26.

[8] Zoran Stojanović, *Krivično pravo – Opšti deo,* Pravna knjiga, Beograd, 2019, 3.

Kako se pitanje sistematike jedne grane prava najpre odnosi na pitanje njenog odnosa s drugim granama prava, a sve u kontekstu očekivane koherentnosti pravnog sistema, u radu će se dve pravne grane, obe zasnovane na ideji ostvarivanja zaštitne funkcije, posmatrati u kontekstu njihovog međusobnog odnosa. Pravo osiguranja, koje pripada porodici građanskog, tačnije poslovnog prava, kao svoj predmet prepoznaje različite vrste odnosa: imovinskopravne, statusnopravne i upravnopravne, u vezi s kojima istovremeno koristi i građanskopravni i javnopravni metod.[9] Krivično pravo, nasuprot tome, predstavlja čistu granu javnog prava.

Obe pravne grane poznaju određene svojstvene im principe odnosno načela, koja predstavljaju osnov i graničnik njihovog bitisanja kao pozitivnopravnih disciplina.

Iako naizgled pitanja načela jesu pitanja naglašeno dogmatskopravne prirode, ona *a contrario* imaju naglašen praktični značaj, jer od njihove određenosti i pravca kojim usmeravaju celokupnu pravnu disciplinu zavisi tumačenje i primena normi, koja u krajnjoj liniji i jeste najvažniji segment jedne pravne discipline.

Odnos krivičnog prava i prava osiguranja može se posmatrati kroz analizu odnosa njihovih osnovnih načela. Ta načela imaju različite ciljeve, ali se međusobno prepliću, najpre u onim odnosima u kojima obrasci ponašanja subjekata tržišta osiguranja imaju obeležja krivičnog dela. Osnovna načela krivičnog prava su načelo zakonitosti, načelo legitimnosti, načelo krivice, načelo humanosti i načelo srazmernosti i pravednosti. Osnovna načela prava osiguranja su: načelo savesnosti i poštenja, načelo obeštećenja, načelo ograničene i usmerene slobode ugovaranja i načelo pojačane zaštite slabije strane.

1. Ukratko o načelima krivičnog prava

Pođe li se od sadržine načela zakonitosti, koje se izražava latinskom formulacijom *nullum crimen nulla poena sine lege,* koja podrazumeva da nema krivičnog dela niti kazne bez zakona,[10] nije dozvoljeno da se bilo koje ponašanje učesnika tržišta osiguranja smatra krivičnim delom dok ono ne bude *explicitum* predviđeno Krivičnim zakonikom (KZ).[11] Kako se u KZ Republike Srbije pojavljuje samo jedno krivično delo

[9] Nataša Petrović Tomić, „O ograničenoj i usmerenoj slobodi ugovaranja u ugovornom pravu osiguranja: Fenomen 'pokoravanja' ugovora o osiguranju", *Anali Pravnog fakulteta u Beogradu*, br. 1/2020, 100–125.

[10] Formulacija tog načela vezuje se za nemačkog teoretičara Anselma Fojerbaha (*Anselm Feuerbach*) i u najširem smislu podrazumeva „da niko ne može biti kažnjen za neko ponašanje, odnosno da prema njemu ne može biti primenjena krivična sankcija ako pre nego što ga je preduzeo ono nije bilo zakonom predviđeno kao krivično delo i ako za njega nije bila zakonom predviđena kazna". Z. Stojanović, 20.

[11] Republika Srbija dobila je 2006. godine nov Krivični zakonik (*Službeni glasnik,* br. 85/2005, 88/2005 – ispr. 107/2005, ispr. 72/2009, 111/2009, 121/2012, 104/2013, 108/2014, 94/2016, 35/2019 i 94/2024) koji je rezultanta dugogodišnjih nastojanja da se u oblasti materijalnog krivičnog prava izvrši kodifikacija, kao pravni mehanizam koji olakšava primenu prava, budući da najveći broj relevantnih odredaba iz kodifikovane oblasti sistematizuje u okviru jednog pravnog akta. Taj zakonski propis, od najvećeg dela naučne i stručne javnosti označen je kao savremeni, liberalno orijentisani zakonik, koji je čvrsto utemeljen na

koje kao svoj neposredni objekat zaštite prepoznaje zakonito obavljanje delatnosti osiguranja, krivično delo prevara u osiguranju, čl. 223a KZ, načelo zakonitosti podrazumeva da ono (kao uostalom i sva ostala krivična dela u Posebnom delu krivičnog zakonodavstva) mora biti precizno definisano.[12]

Načelo legitimnosti u krivičnom pravu podrazumeva da se legitimnim može smatrati samo ono krivično pravo čiji su osnov i granice postavljeni tako da se imaju smatrati opravdanim i nužnim u društvu. Kako je osiguranje rastuća delatnost i važan deo održivog razvoja društva kao celine,[13] što se može uvideti na osnovu podataka Narodne banke Srbije (NBS), to se njena razvojnost[14] pojavljuje kao društvena vrednost koja zaslužuje krivičnopravnu zaštitu. U pogledu potrebe izdvajanja krivičnog dela prevara u osiguranju, kao *lex specialis* norme u odnosu na krivično delo prevare iz čl. 208 KZ, legitimitet inkriminacije opravdan je stepenom značaja koji tržište osiguranja ima u odnosu na značaj u celokupnoj privrednoj delatnosti Republike Srbije. Kako se tržište osiguranja pojavljuje kao jedno od najbrže rastućih, a budući da njegov značaj u posttehnološkom društvu počinje da bude relevantan ne samo u kontekstu njegove osnovne zaštitne funkcije nego i funkcije koje ima u tzv. društvu rizika, postojanje krivičnopravne norme koja doprinosi osnaženju kapitala poverenja ima svoj jasan i nesporan društveni značaj.

U kontekstu načela krivice, koje u krivičnom pravu podrazumeva individualnu i subjektivnu odgovornost, odnosno pravilo da svako odgovara samo za svoje postupke, na osnovu kojih država, kao nosilac prava na kažnjavanje *(ius puniendi)* može da mu izrekne odgovarajući društveno-etički prekor u formi kazne, sankcionisanje učinilaca krivičnih dela prevara u osiguranju, kao i svih ostalih inkriminatornih izraza koji se u širem smislu mogu konsekventno primeniti na oblast osiguranja kao privrednu delatnost *per se,*[15] moraju biti zasnovana na krivici – i to njenom

utilitarističkom principu i kojim je uspostavljena optimalna ravnoteža između osnovnih sloboda i prava čoveka i građanina, s jedne strane, i nužne represije, s druge. Ivana P. Bodrožić, „Kontinuirani krivičnopravni ekspanzionizam – na raskršću politike i prava", *Srpska politička misao*, br. 2/2020, 384.

[12] Načelo zakonitosti ima četiri segmenta: *lex scripta, lex praevia, lex stricta i lex certa*, a domet načela zakonitosti se u pomenutom kontekstu odnosi na potrebu da norma kojom se inkriminiše prevarno ponašanje u osiguranju mora biti u što je većoj meri određena i precizna.

[13] Ivana Soković, „Značaj osiguranja i perspektive razvoja u Srbiji", *Tokovi osiguranja,* br. 2/2024, 265.

[14] Koja se i dalje nalazi ispod proseka zemalja članica EU, kako prema učešću premije u bruto domaćem proizvodu tako i prema visini premije po stanovniku. *Ibid.,* 274.

[15] Osiguranje spada u red privrednih delatnosti koje karakteriše naglašena razvojnost. Ono može biti shvaćeno i kao svojevrstan civilizaciji fenomen, jer se njegovo uobličavanje pojavljivalo kao direktno proporcionalno razvoju potrebe čoveka za zaštitom i sigurnošću. Taj fenomen nije zaobišao ni krivično pravo. Opseg obrazaca ljudskog ponašanja koji se imaju smatrati krivičnim delima i koji su kao takvi predviđeni u Posebnom delu krivičnog prava određene države, poznat je pod terminom dinamika inkriminacija. Iako mu je kao osnovna naglašena i izdvojena zaštitna funkcija, u savremeno doba razvoj i dinamika kriminaliteta praćeni su strahom, odnosno paranojom sigurnosti, te se i krivičnom pravu pripisuje bezbednosna funkcija, koja mu nije svojstvena, i koja ga vodi ka totalnoj krizi legitimnosti.
Izmenjeni uslovi života i paralelno uslovi kriminaliteta, doveli su do pojačane potrebe za osiguranjem, ali i za sve oštrijom i širom krivičnopravnom zaštitom.

pretpostavljenom obliku – umišljaju, a samo izuzetno nehatu, onda kada zakon *explicitus* predviđa kažnjavanje i za ovaj blaži stepen krivice.

Načelo humanosti i srazmernosti pravednosti, kao i u svim ostalim slučajevima krivičnopravne zaštite, načelno posmatrano, i u slučajevima konkretizovanog neprava u oblasti tržišta osiguranja, podrazumeva human odnos prema učiniocu krivičnog dela i izricanje kazne, koja je po vrsti i meri odgovarajuća, tačnije srazmerna i pravedna učinjenom obliku konkretizovanog neprava.

2. O načelima prava osiguranja

Kada su načela prava osiguranja posredi, na prvom mestu je načelo savesnosti. Prema ZOO, učesnici obligacionih odnosa dužni su da se u zasnivanju i izvršavanju obaveza iz obligacionih odnosa ponašaju u skladu s načelom savesnosti i poštenja, tj. da ugovore izvršavaju *secundum bonam fidem et consuetudinem mercatorum*.[16] Iako bi se pomenuto načelo moglo shodno primenjivati i u osiguranju, teoretičari prava osiguranja poklanjaju veliku pažnju ovom načelu uzdižući ga na rang vrhovnog načela prava osiguranja.[17] Suština tog načela bi se ukratko mogla izraziti na sledeći način: ugovarač osiguranja i osiguravač dužni su da se u kontaktu s drugom ugovornom stranom ponašaju naročito savesno, tj. da otkriju drugoj strani svaku okolnost (činjenicu) koja utiče na rizik i visinu premije pre zaključenja ugovora.[18] Istorijski posmatrano, načelo savesnosti nastalo je u cilju prevazilaženja informacione asimetrije, koja je uticala na poslovne rezultate osiguravača.[19] Kako je kandidat za osiguranika bio u posedu svih relevantnih informacija o riziku, pozivom na ovo načelo nastala je obaveza prijavljivanja okolnosti od značaja za ocenu rizika. Interesantno je da je u vreme inauguracije tog principa akcenat bio na obavezama

U pogledu prava osiguranja i tržišta osiguranja, reč je o pozitivnoj tendenciji razvoja jedne privredne delatnosti, koja se uklapa u tradicionalne faze klasičnih privrednih ciklusa, ali u oblasti krivičnog prava ove težnje ka preventivno orijentisanim inkriminacijama i krivičnom pravu, koje bi trebalo da se koristi i u najranijim fazama kriminalne progresije, moraju biti ocenjene kao negativne kriminalno-političke težnje, koje krivično pravo vode u krizu legitimiteta i željenog stepena aplikabilnosti. I. Soković, 278; Đorđe Ignjatović, *Kriminologija,* Pravni fakultet Univerziteta u Beogradu, Beograd, 2021, 155; Jelena Radović Stojanović, *Osnovi ekonomije*, Kriminalističko-policijski univerzitet, Beograd, 2024, 180–181 i Ivana P. Bodrožić, *Terorizam kao kategorija nacionalnog i međunarodnog krivičnog prava,* Kriminalističko-policijski univerzitet, Beograd, 2022.

[16] ZOO, čl. 12. Detaljnije o načelu savesnosti i poštenja Slobodan Perović, *Obligaciono pravo, Knjiga prva,* Sedmo izdanje, Novinsko-izdavačka ustanova „Službeni glasnik SFRJ", Beograd, 1990, 56–61.

[17] Rebekah Dixon, *A Leap of Good Faith: A Possible Response to Unfair Claims-Handling Practices in Insurance,* Otago, 2012, 3–8.

[18] John Lowry, Philip Rawlings, *Insurance Law, Doctrines and Principles,* Second Edition, Hart Publishing, Oregon, 2005, 77–78.

[19] Nataša Petrović Tomić, Mirjana Glintić, „The Hybridization of the Regulatory Framework of Insurance Contract Law: Elements of a New Setting", *Annals of the Faculty of Law*, No. 2/2024, 223–250.

osiguranika da osiguravaču otkrije sve što zna o riziku, dok o analognoj obavezi osiguravača nije bilo govora.[20] Tek pod uticajem konzumerizma, pozivom na načelo savesnosti i poštenja uvodi se predugovorna obaveza osiguravača da pruži određene informacije ugovaraču osiguranja.

Načelo savesnosti i poštenja „služi za moralizaciju prava, za jačanje njegove etičnosti, i to tako što ograničava slobodu ugovaranja i **postavlja standard ophođenja prema drugoj strani koji svako mora da poštuje u pregovaranju, ugovaranju, ostvarivanju svojih prava i ispunjavanju svojih obaveza**".[21] Naglašavamo da se načelo savesnosti i poštenja tiče međusobnog tretmana učesnika u obligacionom odnosu, kako u njegovom zasnivanju, tako i u ostvarivanju prava i izvršavanju obaveza iz tog odnosa. **Iz tog načela proizlazi obaveza da učesnik u obligacionom odnosu uzme u obzir i interese druge strane, a pre svega njenu opravdanu veru odnosno poverenje da će se on ponašati na lojalan, pouzdan, neprotivrečan i obziran način.**

Načelo savesnosti i poštenja oslanja se na pojam uzročnosti između povezanosti štete i osiguranog rizika, na isti način kao što između radnje i nastale posledice krivičnog dela mora postojati utvrđena uzročnost u odnosu na koju se i utvrđuje stepen krivice. Ovde u jednom širem smislu u koliziji mogu biti načelo pretpostavke nevinosti, *in dubio pro reo* – u sumnji u korist optuženog, koje predstavlja načelo krivičnoprocesnog prava, i načelo savesnosti i poštenja. Primer može biti slučaj u kojem osiguravač odbije da isplati osiguranu sumu zbog sumnje na prevaru u osiguranju, dok krivični sud još nije utvrdio krivicu učinioca u zakonito sprovedenom krivičnom postupku.

Ukratko, princip obeštećenja znači da osiguranje može pokriti celokupnu štetu i ništa više od pretrpljene štete.[22] Naknada iz osiguranja ne može da bude veća od štete koju je pretrpeo osiguranik nastankom osiguranog slučaja.[23] Svrha osiguranja nije poboljšanje finansijske situacije osiguranika nakon obeštećenja, već omogućavanje da povrati prethodnu imovinsku situaciju.[24] Primena načela obeštećenja iziskuje da se u svakom konkretnom slučaju, najpre, pristupi utvrđivanju nastale štete. Pored tačnog odmeravanja pretrpljene štete, bitno je uzeti u obzir i sumu

[20] Herman Cousy, „Changing Insurance Contract Law: An Age-Old, Slow and Unfinished Story", *Insurance Regulation in the European Union: Solvency II and Beyond* (eds. Pierpaolo Marano, Michele Siri), Springer International Publishing, 2017, 35.

[21] Marija Karanikić Mirić, *Obligaciono pravo*, Službeni glasnik, Beograd, 2024, 78.

[22] Jasna Pak, *Pravo osiguranja*, Univerzitet Singidunum, Beograd, 2011, 229.

[23] „U poslovnom odnosu po osnovu osiguranja imovine, bez obzira na visinu osigurane sume, iznos na koji osiguranik ima pravo ne može biti veći od obima štete koju je pretrpeo." (Presuda Privrednog apelacionog suda, Pž 7279/2014(1) od 24. 11. 2014. godine – Sudska praksa privrednih sudova – Bilten br. 1/2015).

[24] Rafael Illeskas Ortiz, „Principios Fundamenstales del Contrato de Seguro", *Derecho de Seguros y Reaseguros*, Liber Amicorum en homenaje al profesor Arturo Díaz Bravo (ed. Carlos Ignacio Jaramillo), Ibañez, Bogotá, 2015, 17–18.

osiguranja budući da ona predstavlja gornju granicu obaveze osiguravača. Pored toga, bitna je i zbog uticaja na visinu premije osiguranja. Vrednost stvari u trenutku nastanka štete takođe je relevantna. Osiguravači ne mogu obračunati naknadu iz osiguranja uvažavanjem načela obeštećenja ako se ne bi vodilo računa o vrednosti koju je stvar imala u trenutku realizacije osiguranog slučaja. Na osiguraniku je teret dokazivanja vrednosti stvari.

Načelo obeštećenja, odnosno načelo indemniteta, podrazumeva da se u ostvarivanju prava iz osiguranja osiguranik može pozivati samo na naknadu stvarne štete, a nikako na sticanje neopravdane koristi. To se, sledstveno pravilima krivičnog prava, može povezati sa stavom da niko ne može zadržati imovinu koja proističe iz krivičnog dela.

Sloboda ugovaranja je u ugovornom pravu osiguranja ograničena u većoj meri nego kod ostalih ugovora. Zbog prirode tog kompleksnog ugovora (kojim se pribavlja složena i neopipljiva finansijska usluga) i tipične potrošačke pozicije strane koja pribavlja uslugu osiguranja zakonodavac natprosečno interveniše u ugovorni odnos osiguranja. Otuda smo skloni da za izvore ugovornog prava osiguranja tradicionalno vežemo obeležje detaljizma.[25] Iz ugla osiguravača i osiguranika, sloboda ugovaranja se svodi na slobodu izbora vrste ugovora o osiguranju koji se želi zaključiti. I to samo u domenu dobrovoljnih osiguranja. Ako je reč o nekom od rizika sa izraženom socijalnom konotacijom, ni sloboda izbora pokrića ne postoji, već se ugovor zaključuje radi ispunjenja zakonske obaveze. To je u skladu sa opštim odredbama ZOO, koji već na početku odeljka posvećenog zaključenju ugovora sadrži član naslovljen obavezno zaključenje i obavezna sadržina ugovora (čl. 27).

U grani prava koja uređuje odnose između strana nejednake upućenosti u predmet transakcije i/ili nejednake ekonomske snage, sloboda ugovaranja u izvornom obliku ne može opstati. U kojoj će meri biti ograničena sloboda ugovaranja, zavisiće najviše od značaja predmetnog pitanja za poziciju slabije strane. Ako je reč o pitanju čijom se regulativom direktno tangiraju interesi slabije strane, zakonodavac će pribeći ograničenju slobode ugovaranja kogentnim normama. Ako je pak u pogledu nekog pitanja dovoljno osiguravaču pružiti smernice u kom pravcu treba da se kreće, zakonodavac se može zadovoljiti i usmerenom slobodom ugovaranja, koja se postiže polukogentnim metodom.

Prilikom uređenja ugovora o osiguranju zakonodavac je iskoristio opštu normu koja pruža odstupnicu za ograničavanje slobode ugovaranja na dva načina: prvi je uvođenje obaveze da se zaključi neki ugovor, a drugi je određivanje sadržine ugovora, delimično ili u celini. U brojnim posebnim propisima uvedena je obaveza zaključenja ugovora za osiguranika, a njoj je korelativna obaveza osiguravača koji

[25] Nataša Petrović Tomić, „Razvoj ugovora o osiguranju u jugoslovenskom i srpskom pravu", *Razvojne tendence v obligacijskem pravu, Ob 40-letnici Zakona o obligacijskih razmerjih* (ur. Damjan Možina), Inštitut za primerjalno pravo, Pravna fakulteta, Ljubljana, 2019, 389–412.

se bavi obaveznim vrstama osiguranja da prihvati ponude koje ne odstupaju od uslova pod kojima on inače pruža ta osiguranja. Štaviše, ima primera da je uvedena obaveza osiguravača da prihvati ponudu za zaključenje ugovora i kod dobrovoljnih osiguranja. Najbolji primer je dobrovoljno zdravstveno osiguranje, koje je tek nedavno dobilo zakonsku legitimaciju.[26] Što se tiče obavezne sadržine ugovora o osiguranju, ona je u bitnim crtama propisana ZOO. Ako se zna da u oblasti osiguranja dominira zakonsko uređenje obavezne sadržine ugovora, kao i da postoje još dva ograničenja slobode ugovaranja, lako je zaključiti u kom je stepenu derogirana sloboda ugovaranja. Nije stvar samo u tome da je ugovornim stranama nametnuta obaveza da pribave neki oblik osiguravajućeg pokrića. Njihovu slobodu ugovaranja više tangira zakonsko propagiranje obaveznog sadržaja tog ugovora, uz istovremenu prateću aparaturu sankcionisanja svake odredbe koja je u suprotnosti sa obaveznim zakonskim sadržajem ugovora, a koja je produkt dogovora strana.

Načelo pojačane zaštite slabije strane prva je asocijacija za moderno ugovorno pravo osiguranja. Međutim, ono je bilo poznato i pravnim sistemima koji su početkom dvadesetog veka kodifikovali materiju osiguranja. Naime, u prvoklasnim pravnim sistemima (poput nemačkog i francuskog) mnogo pre razvoja ugovornog potrošačkog prava postojao je veliki broj zakonskih odredbi posvećenih upravo zaštiti slabije strane ugovora o osiguranju.[27] U tom smislu tvrdimo da je *ugovorno pravo osiguranja preteča zaštite potrošača*.[28] Razlika je samo terminološka: dok se danas izričito govori o zaštiti potrošača usluga osiguranja, početkom dvadesetog veka provejavala je ideja zaštite osiguranika, korisnika prava i uopšte lica koje je u slabijoj poziciji.

Zakonsko regulisanje ugovora o osiguranju imperativnim normama instrument je zaštite osiguranika u odnosu na osiguravača mnogo stariji od potrošačkog zakonodavstva. Pre nego što se ta grana prava razvila, zakonodavci evropskih zemalja nastojali su da spreče korišćenje klauzula nepovoljnih po osiguranika upravo putem imperativnih normi. Najštetnije po interes osiguranika bile su jednostrano redigovane klauzule o ništavosti, isključenim štetama i gubitku prava iz osiguranja.[29] Osim

[26] Dobrovoljno zdravstveno osiguranje nije u pravom smislu reči dobrovoljno. ZZO je, naime, uvedena obaveza za osiguravače koji se bave tim osiguranjem da zaključe ugovor o dobrovoljnom zdravstvenom osiguranju sa ugovaračem osiguranja pod uslovima propisanim zakonom i podzakonskim aktima za sprovođenje ovog zakona, bez obzira na rizik kojem je osiguranik ovog osiguranja izložen, odnosno bez obzira na godine života, pol i zdravstveno stanje osiguranika. Vid. N. Petrović Tomić (2019a), 503–505.

[27] Zaštita slabije strane je „ideja vodilja istorije osiguranja". Vid. Yvonne Lambert-Faivre, Laurent Leveneur, *Droit des assurances*, Dalloz, Paris, 2011, 1; Mandep Lakhan, Helmut Heiss, „Towards a European Insurance Contract Law: Restatemant – Common Frame of Reference – Optional Instrument?", *Utrecht Journal of International and European Law*, Vol. 26, No. 71/2010, 1–11.

[28] Nataša Petrović Tomić, *Zaštita potrošača usluga osiguranja*, *Analiza i predlog unapređenja regulatornog okvira,* Pravni fakultet Univerziteta u Beogradu, Beograd, 2015, 54–55.

[29] Tako je francuski zakonik o ugovoru o osiguranju sadržao 83 norme posvećene ovom ugovoru, od kojih je čak 61 bila imperativna, dok su preostale (njih 21) bile poluimperativne. Y. Lambert-Faivre, L. Laveneur, 160.

toga, „originalnost" prava osiguranja su i tzv. *poluprinudne ili jednostrano prinudne norme*, koje su se zadržale do danas. Upravo su one u davna vremena predstavljale kamen temeljac zaštite ugovarača osiguranja. Na današnjem stupnju razvoja prava osiguranja može se govoriti o razvoju *potrošačkog ugovornog prava osiguranja* kao podgrane (ugovornog) prava osiguranja.

Načelo pojačane zaštite slabije strane i detaljnost regulative ugovora o osiguranju doveli su do postepenog povlačenja načela slobode ugovaranja u ovom delu ugovornog prava. Naime, danas se može govoriti o načelu ograničene i usmerene slobode ugovaranja, koje nastaje kao odgovor na brojne zakonodavne intervencije u ugovor o osiguranju.[30]

Kombinacijom osnovnih krivičnopravnih načela i načela prava osiguranja spajaju se dva potpuno različita pravna režima. Jedan javnopravne prirode, fokusiran na sankcionisanje društveno štetnog ponašanja, i jedan pretežno privatnopravne prirode, koji reguliše ugovorne odnose između osiguravača i osiguranika. Ta interakcija načela ukazuje na to da se **krivično pravo, kao i u odnosu s drugim pravnim granama, pojavljuje kao *last resort* sredstvo društvene reakcije na nezakonito poslovanje u osiguranju, koji je duboko supsidijaran, izrazito fragmentaran i akcesoran načelima i pravnim propisima prava osiguranja.**

Supsidijarnost je oličena u tome što se tek onda kada se redovni mehanizmi zaštite poslovanja u osiguranju pokažu kao neefikasni, pojavljuje krivičnopravna reakcija. Fragmentarnost se iskazuje postojanjem samo jednog inkriminatornog izraza prevara u osiguranju, u okviru *XXII Glave krivičnih dela protiv privrede,* a akcesornost usled zavisnosti krivičnog prava u odnosu na prvi instrumentarijum i izvore prava osiguranja, kojima se definišu najvažniji pojmovi kojima se krivičnim pravom pruža pojačana zaštita.

III Krivični zakonik i inkriminisanje društveno štetnih obrazaca ponašanja na tržištu osiguranja, kao vida savremenog ekonomskog kriminaliteta

U savremenom društvu, razvoj privrede jedne zemlje i obavljanje privrednih aktivnosti dobijaju takav značaj da država u sve većoj meri interveniše u privredi, kako bi se uspostavili i održavali normalni odnosi subjekata privrednog poslovanja na način koji odgovara privrednim interesima zemlje i potrebama građana. U takvim uslovima pojavljuju se različiti novi oblici kriminaliteta koji se, kao društvena pojava, po načinu vršenja uvek brzo prilagođavaju uslovima u društvu.

Kako je privredni život uvek dinamičan i podložan promenama, i privredni odnosno ekonomski kriminalitet po oblicima i strukturi brzo se menja. Zbog toga se

[30] Nataša Petrović Tomić, „O ograničenoj i usmerenoj slobodi ugovaranja u ugovornom pravu osiguranja: Fenomen 'pokoravanja' ugovora o osiguranju", *Anali Pravnog fakulteta u Beogradu*, br. 1/2020, 100–125.

i krivičnopravnom aspektu suzbijanja tog tipa kriminaliteta pridaje sve veći značaj, što vodi postojanju sve većeg broja pravnih, pa i krivičnopravnih propisa u ovoj oblasti.[31]

Postoje ozbiljne poteškoće u definisanju pojma privrednog krivičnog dela. U pravom smislu te reči, reč je o društveno štetnim obrascima ponašanjima čije sankcionisanje, u prvom redu, ima za cilj zaštitu privrednog sistema i njegovog funkcionisanja. Osnovna svrha inkriminisanja te kategorije delikata je sprečavanje smanjivanja poverenja u privredni sistem. Između ostalog, u pogledu modela privrede koji je poželjno štititi normama krivičnog prava, dominantno je prihvaćen stav da je u pitanju model tržišne privrede.[32]

Kako je udeo ekonomski motivisanog kriminaliteta u Republici Srbiji relativno visok, sabiranjem krivičnih dela protiv imovine i protiv privrede, u strukturi ukupnog kriminaliteta, dolazi se do broja od 48,6% krivičnih dela koja su ekonomski motivisana. Ona po svojoj pravnoj prirodi jesu šarolika, ali u svojoj osnovi sadrže ekonomske motive, te se kao takva registruju u okviru redovnih godišnjih statistika Republičkog zavoda za statistiku.[33] Navedeni podatak predstavlja materijalnu legitimaciju krivičnih dela protiv privrede, odnosno jedan od zakonodavnih motiva inkriminisanja. Kako se pravo osiguranja pojavljuje kao jedna od najbrže rastućih privrednih grana, naporedo s njenim razvojem, pojavljuje se i značajna oblast u okviru koje se javljaju novi pojavni oblici kriminalnog ponašanja, koji imaju potencijal da se predvide kao krivična dela.

U pozitivnom krivičnom zakonodavstvu Republike Srbije, KZ se smatra osnovnim pravnim aktom, u kojem se predviđa najveći deo ponašanja koja se imaju smatrati krivičnim delima. Kako bilo, kodifikacijom krivičnog zakonodavstva iz 2006. godine ipak je ostao određeni deo posebnih propisa, tzv. sporedno krivično zakonodavstvo, u okvirima kojih su se iz određenih legislativno-tehničkih razloga zadržale određene krivičnopravne odredbe, odnosno zasebna krivična dela.

Kada je oblast osiguranja u pitanju, jedino krivično delo kojim se neposredno štiti delatnost osiguranja jeste krivično delo prevare u osiguranju iz člana 223a, koje je sistematizovano u okvirima krivičnih dela koja kao svoj grupni zaštitni objekta imaju privredu.[34] I to je opravdano. Pored tog krivičnog dela, i brojne druge inkriminacije

[31] Đorđe Đorđević, Ivana Bodrožić, *Krivično pravo – Posebni deo*, Kriminalističko-policijski univerzitet, Beograd, 2024, 177.

[32] Zoran Stojanović, *Krivično pravo – Posebni deo,* Pravni fakultet Univerziteta u Novom Sadu, Novi Sad, 2022, 176–177.

[33] Visoko učešće ekonomski motivisanog kriminala u ukupnom kriminalu znači da ekonomski faktori u velikoj meri utiču na kriminal i da su jedan od važnijih uzroka kriminala u Republici Srbiji. Jelena Radović Stojanović, *Kriminal i ekonomija Srbije,* Kriminalističko-policijski univerzitet, Beograd, 2021, 55–57.

[34] Kako srpski krivičnopravni ambijent karakteriše dinamična faza zakonodavnog intervencionizma, ova glava krivičnih dela bila je jedna od onih koje su u okvirima čak osam izmena i dopuna KZ vršenih od 2006. do trenutka u realnom vremenu, značajno i temeljito menjana 2016. godine. Tada su krivična dela iz ove glave strukturalno i sadržinski značajno unapređena, sistematizovana su po srodnosti, propisano

mogu biti korišćene u zaštiti prava i interesa subjekata tržišta osiguranja,[35] ali se samo prevara u osiguranju smatra klasičnom l*ex specialis* normom u ovoj oblasti.

U Zakonu o osiguranju (ZO),[36] u okviru *Glave XV* pod nazivom Kaznene odredbe, Odeljak 1. Krivična dela predviđena su tri posebna krivična dela iz oblasti osiguranja: neovlašćeno obavljanje delatnosti osiguranja, čl. 256 ZO,[37] davanje lažnih mišljenja i izveštaja, čl. 257 ZO[38] i davanje lažne procene, čl. 258 ZO.[39]

Krivično delo prevara u osiguranju uvedeno je u KZ 2009. godine. U svojoj prvoj redakciji u KZ-u bilo je sistematizovano u okviru *Glave XXI Krivičnih dela protiv imovine*, u članu 208a i predstavljalo je poseban oblik krivičnog dela prevare. Prevara u osiguranju, dakle, predstavljala je normu koja se u odnosu na krivično delo prevare iz čl. 208 nalazi u odnosu *lex specialis derogat lege generali.* Radnja te prve verzije prevare u osiguranju iz 2009. godine podrazumevala je navođenje drugog lica da u vezi sa osiguranjem učini nešto na štetu svoje ili tuđe imovine, činjenjem ili propuštanjem. Zakon je u toj verziji krivičnog dela izdvajao tipične radnje izvršenja, kao lažno prikazivanje činjenica, prikrivanje činjenica, podnošenje neistinite dokumentacije ili neki drugi način dovođenja ili održavanja u zabludi. Biće krivičnog dela je kao subjektivno obeležje podrazumevalo nameru da se sebi ili drugom pribavi protivpravna imovinska korist. Pomenute delatnosti morale su biti preduzete u odnosu na osiguranje, bez preciziranja o kojoj se vrsti osiguranja radilo. Delo je imalo dva teža oblika koja su podrazumevala nastupanje teže posledice, kao i lakši oblik.[40]

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je čak sedam novih inkriminacija, što je očiti primer krivičnopravnog ekspanzionizma, koji se kao krimi-nalno-politički trend mora označiti kao negativan, a izvršene su i terminološke korekcije i normativna preoblikovanja, ali i dekriminalizovana tri krivična dela. Nataša Delić, *Krivično pravo – Posebni deo,* Pravni fakultet Univerziteta u Beogradu, Beograd, 2023, 242–243; I. Bodrožić (2020).

[35] Prevara u obavljanju privredne delatnosti, čl. 223 KZ; pronevera u obavljanju privredne delatnosti, čl. 224 KZ; zloupotreba poverenja u obavljanju privredne delatnosti, čl. 224a KZ; oštećenje poverilaca, čl. 233 KZ i brojna druga.

[36] *Službeni glasnik RS,* br. 139/2014 i 44/2021.

[37] **Neovlašćeno obavljanje delatnosti osiguranja:** Odgovorno lice u društvu za osiguranje, društvu za reosiguranje, društvu za posredovanje u osiguranju i društvu za zastupanje u osiguranju, kao i kod zastupnika u osiguranju, koje obavlja delatnost osiguranja za koju nije dobijena dozvola Narodne banke Srbije, kazniće se za krivično delo kaznom zatvora od tri do šest godina.
Odgovorno lice pravnog subjekta koje, u svojstvu pružaoca usluga, s drugim licima zaključuje ugovore o osiguranju ili ugovore koji su po svojoj pravnoj prirodi ugovori o osiguranju, kazniće se za krivično delo kaznom zatvora od tri do šest godina.

[38] **Davanje lažnih mišljenja i izveštaja:** ovlašćeni aktuar ili revizor koji protivno odredbama ovog zakona sačini lažno mišljenje, odnosno izveštaj, kazniće se za krivično delo kaznom zatvora od jedne do tri godine.

[39] **Davanje lažne procene:** odgovorno lice u društvu za osiguranje, društvu za reosiguranje, društvu za posredovanje u osiguranju i društvu za zastupanje u osiguranju, kao i kod zastupnika u osiguranju, koje pri utvrđivanju i proceni rizika i šteta sačini lažne procene i izjave, kazniće se za krivično delo novčanom kaznom ili kaznom zatvora do tri godine.

[40] Ljubiša Lazarević, *Komentar Krivičnog zakonika,* Drugo izmenjeno i dopunjeno izdanje, Pravni fakultet Univerziteta Union, Beograd, 2011, 704.

Kako je reč bila o specijalnom obliku prevare koja je bila vezana za delatnost osiguranja, biće krivičnog dela prevare u osiguranju oslanjalo se, odnosno poklapalo, s bićem krivičnog dela prevare, kao klasičnog krivičnog dela imovinskog kriminaliteta.[41]

Pomenute izmene KZ iz 2016. godine kojima je zakonodavac intenzivno intervenisao u okviru krivičnih dela protiv privrede izuzetno su se odrazile na inkriminisanje krivičnog dela prevara u osiguranju. Ono je najpre presistematizovano, dakle prebačeno iz Glave krivičnih dela protiv imovine u Glavu krivičnih dela protiv privrede, što ocenjujemo kao poželjno, jer se kao zaštitni objekat novog krivičnog dela sa istim nazivom ali promenjenim obeležjima bića najpre pojavljuje osiguranje kao privredna delatnost.

Razlozi zbog kojih je opravdana bila tako ozbiljna intervencija odnose se najpre na dominantni objekat zaštite, dakle na ono čemu se zaštita analiziranim krivičnim delom u prvom planu nastoji obezbediti, a drugo na potrebu da se suštinski obezbedi zaštita od tzv. osiguraničke prevare,[42] na način kako to radi najveći broj uporednih krivičnopravnih zakonodavstava.

Republika Srbija se, kao kandidat za članstvo u Evropskoj uniji (EU) nalazi na putu kompletne zakonodavne reforme, pa se ti oblici harmonizacije konsekventno odnose i na propise u oblasti krivičnog zakonodavstva. Krivično delo **prevara u osiguranju** predviđeno od 2016, a zatečeno sa stanjem Krivičnog zakonika iz 2024. godine u **čl. 223a**:

(1) Ko u nameri da od društva za osiguranje naplati ugovorenu sumu, uništi, ošteti ili sakrije osiguranu stvar, pa zatim prijavi štetu, kazniće se zatvorom od tri meseca do tri godine.

(2) Kaznom iz stava 1 ovog člana kazniće se i ko u nameri da od društva za osiguranje naplati ugovorenu sumu za slučaj telesnog oštećenja, telesne

[41] **Prevara u osiguranju,** u prvobitnoj verziji KZ iz 2009 iz **čl. 208a** glasilo je: (1) Ko u nameri da sebi ili drugom pribavi protivpravnu imovinsku korist dovede koga lažnim prikazivanjem ili prikrivanjem činjenica, davanjem lažnih mišljenja i izveštaja, davanjem lažne procene, podnošenjem neistinite dokumentacije ili ga na drugi način dovede u zabludu ili ga održava u zabludi, a u vezi sa osiguranjem i time ga navede da ovaj na štetu svoje ili tuđe imovine nešto učini ili ne učini, kazniće se zatvorom od šest meseci do pet godina i novčanom kaznom. (2) Ko delo iz stava 1 ovog člana učini samo u nameri da drugog ošteti, kazniće se zatvorom do šest meseci i novčanom kaznom. (3) Ako je delom iz st. 1 i 2 ovog člana pribavljena imovinska korist ili je naneta šteta u iznosu koji prelazi četristo pedeset hiljada dinara, učinilac će se kazniti zatvorom od jedne do osam godina i novčanom kaznom. (4) Ako je delom iz st. 1 i 2 ovog člana pribavljena imovinska korist ili je naneta šteta u iznosu koji prelazi milion i petsto hiljada dinara, učinilac će se kazniti zatvorom od dve do deset godina i novčanom kaznom. Dragoljub Simonović, *Krivična dela u srpskoj legislativi,* Službeni glasnik, Beograd, 2010, 414.

[42] Izmenama i dopunama, krivično delo prevara u osiguranju je preciznije određeno, jer je krivično delo prevara u osiguranju (član 208a KZ-a) u potpunosti praktično bilo obuhvaćeno postojećim krivičnim delom prevare. Krivično delo prevara u osiguranju je delo tzv. osiguraničke prevare, a koje delo se znatno razlikuje od krivičnog dela prevare, pa se zato i uvodi u mnoga krivična zakonodavstva, onako kako je to uobičajeno i u uporednom zakonodavstvu, što opravdava uvođenje ovog krivičnog dela kao posebnog dela, jer za razliku od krivičnog dela prevare, ovde je kriminalna zona znatno šire postavljena i nije potrebno dovođenje ili održavanje u zabludi pasivnog subjekta.

povrede ili narušenja zdravlja, prouzrokuje sebi takvo oštećenje, povredu ili narušenje zdravlja, pa zatim podnese zahtev osiguravajućem društvu.

(3) Ako je delom iz st. 1 i 2 ovog člana pribavljena imovinska korist ili je naneta šteta koja prelazi iznos od četristo pedeset hiljada dinara, učinilac će se kazniti zatvorom od jedne do osam godina.

(4) Ako je delom iz st. 1 i 2 ovog člana pribavljena imovinska korist ili je naneta šteta koja prelazi iznos od milion i petsto hiljada dinara, učinilac će se kazniti zatvorom od dve do deset godina.

Krivično delo ima osnovni i dva teža oblika. Radnja izvršenja osnovnog oblika je određena alternativno i može se sastojati ili iz uništenja, oštećenja ili sakrivanja osigurane stvari ili u prijavljivanju šteta, koje takođe ima dva akta – prouzrokovanje sebi oštećenja, povrede ili narušenja zdravlja i podnošenja zahteva osiguravajućem društvu.

Objekat radnje može biti osigurana stvar ili sam izvršilac.

Delo se vrši sa umišljajem, a izvršilac može biti svako lice.

Teži i najteži oblik vezuju se za pribavljanje imovinske koristi ili nastupanje štete u određenom iznosu.

Tako postavljeno krivično delo prevare u osiguranju u odnosu na krivična dela iz čl. 257 i 258 ZO potencijalno je moglo biti problematično u razgraničenju.

Međutim, zakonski opisi tih krivičnih dela dovoljno se razlikuju u odnosu na definisanje radnje izvršenja krivičnog dela prevara u osiguranju, te oni jedni sa drugima nisu u koliziji i postoji opravdanje za njihovo paralelno egzistiranje u ova dva propisa.[43]

IV Značaj krivičnog prava u oblikovanju usluga osiguranja

Krivično pravo tradicionalno je zasnovano na ideji o sopstvenoj razvojnosti ili(ti) *Ius criminale semper reformandum est* – krivično pravo je u stalnom razvoju. Ono prati razvitak novih oblika kriminalnog ponašanja i oblikuje norme kojima se nastoje sprečiti i suzbiti i novi pojavni oblici kriminaliteta. U tom razvoju ono je zasnovano na sopstvenim načelima (ali i ograničeno njima), kao i na karakteru koji mora biti karakter izuzetnosti. Savremeni evropski krivičnopravni sistemi karakterišu se, osim razvojnošću, i negativnim kriminalno-političkim tendencijama, na koje nije ostao imun ni zakonodavac u Republici Srbiji.[44] lako je o intervencionizmu, povećavanju broja inkriminacija

[43] Zoran Stojanović, *Komentar Krivičnog zakonika,* Deseto dopunjeno izdanje, Službeni glasnik, Beograd, 2020, 748–749.

[44] Kako je krivično pravo postalo jedna od komponenti ciljeva Unije, EU je dobila eksplicitne nadležnosti u oblasti materijalnog krivičnog prava. Minimalna pravila o materijalnom krivičnom pravu olakšavaju princip uzajamnog priznavanja, omogućavaju približavanje kaznene politike država članica i kandidata za punopravno članstvo i postavljaju osnove za zajedničke opise bića krivičnih dela, omogućavajući na

i ograničenosti tako hipertrofiranog krivičnog prava reči bilo u delu rada kojim se ukazuje i na ograničenja ovakvih težnji, to nikako, s druge strane, ne bi trebalo razumeti kao težnju da se ostane isključivo na formi i strukturi postojećih inkriminacija.[45]

Razvoj tržišta osiguranja,[46] uticaj novih poslovnih rešenja i usluga, ali i potreba očuvanja održivog razvoja ovog tržišta,[47] vodi neminovno i prilagođavanju krivičnopravnih normi. Taj proces je dvosmeran i može se, iz ugla potencijalnih rešenja, sagledati kroz nekoliko slučajeva.

Krivično pravo značajno utiče na oblikovanje usluga osiguranja jer postavlja pravni okvir koji osiguravajuće kompanije moraju poštovati prilikom uobličenja polisa, procene rizika i obrade potraživanja.[48] Evo ključnih načina na koje krivično pravo oblikuje usluge osiguranja:

taj način reagovanje na globalne kriminalne tokove. Zakonodavac EU bi stoga trebalo da bude oprezan kada vrši uticaj na oblikovanje krivičnopravnih odgovora u procesima približavanja materijalnog krivičnog prava svojih država članica. Principi kriminalizacije nude zakonodavcu argumentativni okvir, koji se može koristiti za utvrđivanje da li je kriminalizacija legitimna i opravdana, a uvek se mora voditi računa i o osobenostima pravnog nasleđa i pravne tradicije. Opširnije o principima kriminalizacije, negativnim tendencijama i budućnosti materijalnog krivičnog prava EU, kao orijentira harmonizacije nacionalnih krivičnih zakonodavstava, videti više: Sanne Buisman„The Future of EU Substantive Criminal Law", *European Journal of Crime, Criminal Law and Criminal Justice,* Vol. 30, No. 2/2022, 161–162.

[45] Vid. fn. 15.

[46] Na obeležavanju jubileja časopisa *Tokovi osiguranja*, viceguverner NBS, Željko Jović, izneo je sledeće podatke koji govore u prilog razvoju tržišta osiguranja i njegovog mesta u celokupnom finansijskom tržištu: „U finansijskom sektoru, koji je pod nadzorom NBS, drugo mesto po bilansnoj aktivi, po kapitalu i broju zaposlenih zauzima osiguranje. Premija osiguranja po stanovniku iznosi 216 dolara a njeno učešće u bruto domaćem proizvodu je 1,9 procenata. Poređenja radi, premija po stanovniku u zemljama u razvoju Evrope i centralne Azije je 207 dolara a učešće u BDP-u 2,3 odsto. Podaci za prvo polugodište ove godine ukazuju na rast svih parametara u delatnosti osiguranja, te je ukupna premija u odnosu na isti period prethodne godine veća za 13,2 odsto, tehničke rezerve su povećane za 12,3 posto, adekvatnost kapitala iznosi 212,9 procenata i on je viši od zakonom propisane obaveze, što uz pokazatelj profitabilnosti od 92,2 odsto i pozitivan privremeni rezultat u iznosu od 6,5 mlrd dinara govori u prilog stabilnosti sektora osiguranja." „Četrdeseti rođendan časopisa *Tokovi osiguranja*", *http:// https://www.dunav.com/cetrdeseti-rodjendan-casopisa-tokovi-osiguranja/,* pristupljeno: 1. 6. 2025.

[47] O održivosti razvoja kao *conditio sine qua non* kompletnog tržišta osiguranja, kao i regulatornog okvira koji ga prati, na primeru prvobitne podnormiranosti zakonodavnog okvira, pa sledstveno tome željenom regulatornom napretku, u oblasti dopunskog zdravstvenog osiguranja u Republici Srbiji, opširnije u: Nataša Petrović Tomić, „Dopunsko zdravstveno osiguranje u funkciji doprinosa razvoju održivog sistema zdravstvene zaštite u Republici Srbiji", *Tokovi osiguranja,* br. 1/2024, 7–70.

[48] O pitanjima na koji način kriminalitet utiče na potražnju za osiguranjem, ali i o pitanju uticaja ponuđenih usluga osiguranja na stvaranje novih pojavnih oblika kriminaliteta u oblasti osiguranja, Tom Bejker (*Tom Baker)* i Anja Šortland (*Anja Shortland)* razmatraju pet studija slučaja (krađa automobila, krađa umetničkih dela, otmica i otmica radi otkupa i prevara s platnim karticama) i ukazuju na koevolucioni proces kroz koji osiguravači sarađuju sa osiguranicima, vladama i pravnim i vanpravnim trećim licima kako bi ublažili gubitke, pogotovo kada kriminalne inovacije destabilizuju tržište osiguranja. *Insurance as crime governance* – „Osiguranje kao upravljanje kriminalom" sintagma je u vezi sa kojom se i autorke ovog rada nastoje izraziti u jednom širem potencijalno *de lege ferenda* odnosu. Tom Baker, Anja Shortland, „How Crime Shapes Insurance and Insurance Shapes Crime", *Journal of Legal Analysis,* Vol. 15, No. 1/2023, 185–196.

1. **Definisanje krivičnih dela i osiguravajućih pokrića:** krivično pravo određuje šta se smatra nezakonitim ponašanjem (npr. krađa, pronevera, prevara, uništenje imovine). Osiguravajuće kuće koriste ove definicije da oblikuju polise, na primer osiguranje od krađe ili uništenje ili oštećenje tuđe stvari. Međutim, polise po pravilu isključuju pokriće za štete nastale usled umišljajnih krivičnih dela počinjenih od strane osiguranika, jer krivično pravo zabranjuje profitiranje od zločina.[49]
2. **Uticaj na procenu rizika:** krivično pravo utiče na aktuarske modele kojima osiguravači procenjuju rizike. Na primer, na područjima s visokom stopom kriminala (npr. krađa automobila), premije osiguranja su veće, jer krivično pravo indirektno signalizira veću verovatnoću štetnih događaja.
3. **Zaštita od prevara u osiguranju:** krivično pravo, pogotovo odredbe o prevarama, oblikuje mehanizme za sprečavanje lažnih potraživanja. Osiguravači razvijaju usluge sa strogim uslovima i procedurama provere kako bi se zaštitili od krivičnih dela poput lažnog prijavljivanja šteta. Na primer, u slučaju osiguranja imovine, polise mogu zahtevati dokaze o vlasništvu ili policijski izveštaj.
4. **Osiguranje od odgovornosti:** krivično pravo utiče na usluge osiguranja od građanske i profesionalne odgovornosti. Na primer, u slučajevima gde krivično delo (kod umišljajno izvršenih krivičnih dela protiv bezbednosti javnog saobraćaja) izazove štetu, polise odgovornosti ograničavaju pokriće ako je osiguranik počinio krivično delo sa umišljajem.[50]
5. **Obavezna osiguranja:** krivično pravo može zahtevati određene vrste osiguranja. Na primer, u Srbiji, Zakon o obaveznom osiguranju u saobraćaju (koji ima elemente krivičnog prava u slučaju nepoštovanja) obavezuje vlasnike vozila na osiguranje od auto-odgovornosti, što direktno oblikuje ovaj segment tržišta osiguranja.[51]

[49] U krivičnom pravu takođe eksplicitno je određeno u čl. 91 KZ da:
„ (1) Niko ne može zadržati imovinsku korist pribavljenu krivičnim delom.
(2) Korist iz stava 1. ovog člana oduzeće se, pod uslovima predviđenim ovim zakonikom i sudskom odlukom kojom je utvrđeno izvršenje krivičnog dela." KZ, čl. 91.

[50] Opširnije o postupcima po regresnoj tužbi osiguravača protiv osiguranika, kao i o pitanjima utvrđivanja odgovornosti za prouzrokovanje udesa videti: Milica Goravica, „Utvrđivanje odgovornosti za prouzrokovanje udesa u postupcima po regresnoj tužbi osiguravača protiv osiguranika", *Tokovi osiguranja,* br. 1/2025, 201–206.

[51] O distinkciji između tzv. moralnog hazarda i krivičnopravnog hazarda, dakle situacija kada određeno lice ima viši nivo tolerancije da poveća svoju izloženost potencijalnom riziku, usled svesti o ograničenim troškovima takvog postupanja, usled postojanja polise osiguranja, kao i o potrebi ispunjenosti najmanje dva uslova da bi moralni hazard prerastao u krivičnopravni hazard i implicirao kažnjavanje, videti opširnije u: Per-Johan Horgby, Annette Wittkau- Horgby, „Beyond Moral Hazyard-Some Thoughts on Criminal Hazard and Insurance", *Nordic Insurance Quarterly (NFT),* No. 2/2008, 147–153.

6. **Usklađenost sa zakonima o sprečavanju pranja novca i finansiranja terorizma:**[52] krivično pravo, pogotovo u oblasti privrednih krivičnih dela, nameće obaveze osiguravačima da proveravaju klijente i izvore sredstava. To utiče na oblik usluge, jer osiguravači moraju uključiti procedure za proveru identiteta i usklađenost sa zakonima, što može povećati troškove i usložiti procese.
7. **Isključenja u polisama:** krivična dela često dovode do isključenja iz pokrića. Na primer, ako je šteta nastala usled terorističkog akta (krivično delo po KZ), standardne polise imovinskog osiguranja ne pokrivaju takve događaje, što podstiče razvoj specijalizovanih usluga za pokriće rizika od terorizma.

Zaključno, krivično pravo oblikuje usluge osiguranja kroz regulaciju rizika, definisanje uslova pokrića, sprečavanje zloupotreba i usklađivanje sa zakonskim obavezama. Osiguravači moraju pažljivo balansirati između zaštite klijenata i poštovanja krivičnopravnih normi kako bi ponudili održive i sa zakonom usklađene usluge.

V Zaključna razmatranja

Osobenosti pravnog sistema kao skupa normi kojima se regulišu javnopravni i privatnopravni odnosi, određuju međusobne odnose pojedinih pravnih grana. Krivično pravo i pravo osiguranja, u njegovim okvirima, imaju specifičan, kako je u radu potvrđeno, reverzibilan odnos.

Najpre je reč o pravnim granama koje kao osnovnu funkciju imaju zaštitnu funkciju, pa se između njih uspostavlja odnos povezanosti osnovnom usmerenošću, to jest ciljna povezanost. Krivično pravo se u ovom odnosu pojavljuje kao snažniji i ekskluzivniji instrument zaštite onih odnosa koji prethodno, primarno nisu uspeli da budu obezbeđeni normama prava osiguranja.

Krivično pravo pruža zaštitu zakonitom funkcionisanju osiguranja kao delatnosti u okvirima finansijskog sektora i kao takvo direktno štiti i privrednu aktivnost, pogotovo u odnosu na grupni zaštitni objekat koji krivično delo prevara u osiguranju ima u okvirima Posebnog dela KZ-a.

Krivičnopravne norme sadržane su i u okvirima ZO, što pokazuje da se ovaj propis u oblasti krivičnopravne zaštite nalazi u okvirima sporednog zakonodavstva, ali kako je u radu potvrđeno, legitimno i bez nepotrebnih preklapanja inkriminacija.

Poštujući svoj *ultima ratio* karakter i supsidijarnost s drugim granama prava, kojima pruža krivičnopravnu zaštitu, krivično pravo racionalno sadrži samo jedno

[52] Osobenosti novog pristupa definisanju krivičnih dela terorizma, nomotehničke korekcije, usklađivanje sa evropskim krivičnopravnim standardima doveli su ne samo do promena u okvirima materijalnog krivičnog zakonodavstva Republike Srbije, nego i do pratećih, sa njima povezanih propisa, poput Zakona o sprečavanju pranja novca i finansiranja terorizma, *Službeni glasnik RS*, br. 113/2017, 91/2019, 153/2020, 92/2023, 94/2024 i 19/ 2025, vid. I. Bodrožić (2022).

krivično delo, pri čemu se neposredno pruža zaštita od osiguraničke prevare, i ono je u okvirima pozitivnopravnih propisa imalo interesantnu dinamiku. Nije samo preoblikovano, nego i presistematizovano, na način da to odgovara i evropskim standardima, ali i standardima nacionalnog krivičnog zakonodavstva. Kako to Elena Makulan *(Elena Maculan)* i Alicija Gil Gil (*Alicia Gil Gil)* smatraju, važno je održavanje statusa krivičnog prava kao *ius puniendi* i kao oruđa države, ali ne kao jedinog raspoloživog oruđa, niti apsolutne obaveze – za postizanje krajnjeg cilja zaštite pravnih interesa i time obezbeđivanja mirnog suživota među pojedincima koji čine zajednicu, već i kao dopunskog i supsidijarnog.[53]

Odnos krivičnog prava i prava osiguranja, upravo posmatran kroz navedenu prizmu, prikazan je kroz sedam ključnih načina kojima krivično pravo može uticati na oblikovanje usluga osiguranja, u nastojanjima da celokupnom tržištu osiguranja obezbedi održivost i željeni stepen zaštite.

Kako je reč o pionirskom radu u oblasti teorijske analize odnosa krivičnog prava i prava osiguranja, autorke se nadaju da će ponuđeni načini i opcije međusobnog, povratnog, to jest reverzibilnog uticaja, biti osnov i *Teezer* za neka dalja istraživanja u ovoj oblasti, koja bi, svako zasebno, mogla biti specijalna tema nekog naučnog članka, poslenika materijalnog krivičnog prava ili prava osiguranja, a u najdirektnijoj vezi s praktičnim aspektima njihove primene.

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[53] Ovo omogućava upotrebu krivičnog prava samo ukoliko je korisno i neophodno. Kada postoje drugi mehanizmi koji pružaju tu zaštitu na zadovoljavajući način, ili kada krivično pravo rizikuje da, ako se primeni, postane opasnost za ove pravne interese, ukoliko na kraju destabilizuje pravni sistem kome je poverena ova zaštita, onda krivično gonjenje i kažnjavanje moraju da naprave korak unazad i da budu prilagođeni i ograničeni prema specifičnim okolnostima svakog slučaja. Elena Maculan, Alicia Gil Gil, „The Rationale and Purposes of Criminal Law and Punishment in Transitional Contexts", *Oxford Journal of Legal Studies,* Vol. 40, No. 1/2020, 157.

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GENERAL ISSUES OF THE REVERSIBLE RELATIONSHIP BETWEEN CRIMINAL AND INSURANCE LAW

ORIGINAL SCIENTIFIC PAPER

Summary

This paper is based *a priori* on the assumption that, within the complexity of the legal system as such and the desired level of its coherence, there exists a relationship of interconnection between criminal law, as public law, and insurance law, as private law, which is characterized by reversibility.

Although fundamentally distinct legal disciplines, in the contemporary era, and in accordance with their primary functions and orientations, criminal law and insurance law share a number of points of intersection and a relationship based on mutual influence. The paper discusses the nature of this relationship in the context of maintaining a functional and sustainable insurance market, which is a significant component of a modern and efficient financial sector. The central research premise is that criminal law should be viewed as the *ultima ratio societatis* in protecting the rights and interests of policyholders, insurers, and reinsurers, i.e. in the broadest sense, the entire insurance industry.

This predominantly theoretical discussion, grounded mainly in the legal-dogmatic method, represents a pioneering contribution of its kind within the domestic legal theory. It is based on the idea that different legal aspects of insurance must be interconnected in order to to ensure the projected level of security, that is, protection

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of the insurance market. The authors emphasize the interdependence between the formation of criminal law norms and the conditions of contemporary economic crime, as well as how crime, *vice versa*, shapes insurance services. In conclusion, the authors highlight the importance of further and continuous research in this area, in order to develop adequate *de lege ferenda* solutions within the national criminal legislation.

Keywords: criminal law, insurance law, reversibility, crime and insurance

I Introductory considerations

The criminal law of a modern democratic state is based on a utilitarian principle, which implies that it functions as a rational system of legal norms whose primary role is protective. The fundamental goal and purpose of criminal law is to protect society from criminal behavior, that is, from socially dangerous patterns of conduct that threaten or violate the most important values of individuals and society as a whole.

Insurance law, on the other hand, encompasses a body of legal rules regulating the entire insurance market, which constitutes a significant segment of the modern and efficient financial sector, including insurance contracts, insurance activities, and claims handling. Insurance law is primarily based on the idea of protecting the interests of the insured against potential insured events, more precisely, the occurrence of damage caused by a covered risk. Ultimately, it also incorporates the protection of insurers, reinsurers, and, in the modern context, even third parties outside the contractual relationship.[3] Its protective function is naturally aligned with its etymological meaning. In all languages, the term *insurance* (English: *insurance*, French: *assurance*, German: *Versicherung*, Spanish: *seguro*) signifies safety, security, the provision of protection, etc.[4] By assuming the consequences of a particular event (the insured risk, whose realization constitutes an insured event), the insurer provides protection to the individual, thereby enabling the uninterrupted continuation of their life.[5] This protective function becomes even more prominent in the case of legal entities and business enterprises, for whom unexpected events can cause significant financial losses. Insurance ensures that such events do not disrupt their operations.

[3] Nataša Petrović Tomić, *Pravo osiguranja, Sistem, Knjiga I*, Službeni glasnik, Belgrade, 2019, 41–43.

[4] Helmut Heiss, "Insurance contracts", *Encyclopedia of Private International Law* (eds. Jürgen Basedow et al.), Vol. 2, Entries I-Z, Edward Edgar Publishing, Northampton, 2017, 954–955

[5] To clarify, the protective function of insurance is triggered *post festum*. The insurer does not possess a magic wand to prevent the insured from experiencing natural disasters, accidental injuries, disability, or liability arising from certain actions. Insurance becomes relevant precisely at the moment the insured event occurs. Instead of facing the consequences of an adverse event alone, the insured, or the beneficiary of the insurance, receives compensation or a sum insured, which facilitates the mitigation of the impact of uncertain events.

Within this protective role lies the fundamental connection between these two seemingly unrelated branches of law. Taking into account the complexity of the legal system and the intended degree of its coherence, the authors of this paper analyze the nature and type of relationship between criminal law, as a branch of public law, and insurance law, as a branch of private law. Their mutual focus toward preventing or minimizing harmful consequences forms the basis of their relationship - a relationship whose reversibility and conditionality are the subject of the central discussion in this paper.

With the ultimate aim of determining the prerogatives of their mutual dependence and harmonization, particularly from the perspective of these branches as integral parts of the legal system, the authors raise several groups of questions and offer answers to complex legal issues: What is the relationship between the fundamental principles of criminal law and insurance law? To what extent are criminal law norms shaped by the development of modern forms of economic crime, within which certain criminal offenses may directly target insurance as an economic activity *per se*? Finally, how does crime shape insurance services?

II On the relationship between the principles of criminal law and insurance law

Insurance, as as a legal institution, has a primarily purpose-driven function, which is reflected in the provision of protection.[6] **The protective function of insurance, especially in the modern context, pertains not only to the insured or beneficiary but also extends to persons outside the insurance contractual relationship.**[7] Similarly, the core function of criminal law is protective. **Criminal law aims to be the strongest instrument of state response to socially harmful behavior by prescribing prohibited forms of conduct and corresponding criminal sanctions for violations that harm or endanger the most fundamental values and goods. It is deeply grounded in the idea of exceptionality, embodying the concept of *ultima ratio societatis*.**[8]

Viewed through the prism of the fundamental functions of these two branches of law, the authors begin with a modified version of a Latin maxim used to assess the level of democracy in a society: *Quis custodiet ipsos custodes?* - which poses the question: **Who will guard the guards themselves?** From this, a modified

[6] Marija Karanikić Mirić, „Forma ugovora o osiguranju", *Tokovi osiguranja*, No. 1/2025, 22–23; N. Petrović (2019a), 41.

[7] This refers to the expansion of the protective function of insurance, which arises as a proportional consequence of the continuous development of insurance law. Nataša Petrović Tomić, *Osnovi prava osiguranja,* Faculty of Law, University of Belgrade, Belgrade, 2023, 21–26.

[8] Zoran Stojanović, *Krivično pravo – Opšti deo,* Pravna knjiga, Belgrade, 2019, 3.

and derived research question emerges: who and (how) will guard the guards, i.e. what means and modalities does criminal law, as a branch of law with a protective function, have at its disposal to protect those who provide protection? This involves a dual hypothetical causality intended to answer the question of the place and role of criminal law in the protection of insurance law, or more precisely, the entire insurance market.

Since the systematic study of any branch of law primarily concerns its relationship with other branches within the context of the expected coherence of the legal system, this paper examines these two legal branches, both founded on the idea of fulfilling a protective function, in the context of their mutual relationship. Insurance law, which belongs to the family of civil law, more precisely business law, governs various types of legal relations: property-law relations, status-law relations, and administrative-law relations. In addressing these, it simultaneously applies both private law and public law methods.[9] Criminal law, in contrast, represents a distinct branch of public law.

Both legal branches have their inherent principles that form the foundation and boundaries of their existence as positive legal disciplines. Although, at first glance, questions of principles appear to be predominantly dogmatic-legal, they, *a contrario*, carry significant practical importance. This is because the clarity and direction these principles provide guide the interpretation and application of legal norms, which ultimately represents the most crucial segment of any legal discipline.

The relationship between criminal law and insurance law can be analyzed through the relationship between their fundamental principles. These principles have different objectives but intersect primarily in situations where the behavior of insurance market participants exhibits characteristics of a criminal offense. The fundamental principles of criminal law are: the principle of legality, the principle of legitimacy, the principle of culpability, the principle of humanity, and the principle of proportionality and fairness. The fundamental principles of insurance law are: the principle of good faith and fair dealing, the principle of indemnity, the principle of limited and directed freedom of contract, and the principle of enhanced protection of the weaker party.

1. Brief overview of the principles of criminal law

Starting with the content of the principle of legality, expressed in the Latin maxim *nullum crimen, nulla poena sine lege,* which means that there is no crime and no punishment without a law,[10] it follows that no behavior by participants in

[9] Nataša Petrović Tomić, „O ograničenoj i usmerenoj slobodi ugovaranja u ugovornom pravu osiguranja: Fenomen 'pokoravanja' ugovora o osiguranju", *Anali Pravnog fakulteta u Beogradu*, No. 1/2020, 100–125.
[10] The formulation of this principle is attributed to the German theorist Anselm Feuerbach and, in the broadest sense, means that "no one can be punished for a certain behavior, nor can a criminal sanction be

the insurance market may be considered a criminal offense unless it is *explicitum* provided for in the Criminal Code (CC).[11] Since the Criminal Code of the Republic of Serbia contains only one criminal offense that explicitly identifies the lawful conduct of insurance activities as its direct object of protection, insurance fraud, Article 223a CC, the principle of legality requires that this offense (like all other offenses in the Special Part of criminal legislation) must be precisely defined.[12]

The principle of legitimacy in criminal law entails that only such criminal law can be considered legitimate whose foundations and limits are deemed socially justified and necessary. Given that insurance is a growing industry and an essential component of the sustainable development of society as a whole,[13] as demonstrated by data from the National Bank of Serbia (NBS), its development[14] emerges as a social value worthy of criminal law protection. With regard to the need to distinguish the criminal offense of insurance fraud as a *lex specialis* provision in relation to the general offense of fraud under Article 208 of the CC, the legitimacy of the incrimination is justified by the significant role the insurance market plays within the broader economic activity of the Republic of Serbia. Since the insurance market is among the fastest growing, and considering that its importance in post-technological society is becoming relevant not only in the context of its primary protective function, but also in its role within the so-called risk society, the existence of a criminal law norm that contributes to strengthening the capital of trust has clear and undeniable social significance.

In the context of the principle of culpability, which in criminal law implies individual and subjective responsibility, meaning that each person is liable solely for their own actions, based on which the state, as the bearer of the *ius puniendi* (right to punish), may impose a socially and ethically appropriate punishment, the sanctioning of perpetrators of insurance fraud, as well as of all other criminalized behaviors that may more broadly apply to the field of insurance as an economic activity *per*

imposed, if at the time the behavior occurred, it was not already prescribed by law as a criminal offense, and if no penalty was prescribed for it." – Z. Stojanović, 20.

[11] The Republic of Serbia adopted a new CC in 2006 (*Official Gazette of the Republic of Serbia*, Nos. 85/2005, 88/2005 – correction, 107/2005 – correction, 72/2009, 111/2009, 121/2012, 104/2013, 108/2014, 94/2016, 35/2019, and 94/2024), which was the result of years of efforts to codify substantive criminal law. Codification serves as a legal mechanism that facilitates legal application by systematizing most relevant provisions within a single legal act. This law has been widely regarded by both scholars and practitioners as a modern, liberally oriented code, firmly grounded in utilitarian principles, and one that establishes an optimal balance between fundamental human and civil rights on the one hand, and necessary state repression on the other. Ivana P. Bodrožić, "Kontinuirani krivičnopravni ekspanzionizam – na raskršću politike i prava", *Srpska politička misao*, No. 2/2020, 384.

[12] The principle of legality consists of four elements: *lex scripta, lex praevia, lex stricta*, and *lex certa*. In this context, the reach of the principle of legality refers to the need for the provision incriminating insurance fraud to be as specific and precise as possible.

[13] Ivana Soković, "Značaj osiguranja i perspektive razvoja u Srbiji", *Tokovi osiguranja,* No. 2/2024, 265.

[14] Which still lags behind the EU average in terms of insurance premium share of GDP and premium per capita. *Ibid*., 274.

se,[15] must be grounded in culpability. More precisely, on its presumed form - intent, and only exceptionally on negligence, in cases where the law *explicitum* prescribes punishment for this milder degree of fault.

The principle of humanity and the principle of proportionality and fairness, as in all other instances of criminal law protection, also apply in cases concretized wrongdoing related to the insurance market. These principles require a humane approach toward the offender and the imposition of a punishment that is appropriate in both type and degree, i.e. proportionate and fair in relation to the specific form of wrongdoing committed.

2. On the principles of insurance law

When it comes to the principles of insurance law, the principle of good faith holds primary importance. According to the Law of Contract and Torts (ZOO), parties to contractual obligations are required to act in accordance with the principle of good faith and fair dealing when establishing and performing obligations arising from such relationships, i.e. to execute contracts *secundum bonam fidem et consuetudinem mercatorum*.[16] Although this principle may be accordingly applied to insurance law, insurance law theorists pay special attention to it, elevating it to the status of the supreme principle of insurance law.[17] The essence of this principle can be briefly expressed as follows: both the policyholder and the insurer are required

[15] Insurance is among the economic activities marked by strong development potential. It may also be viewed as a kind of civilizational phenomenon, having evolved in direct proportion to humanity's growing need for protection and security. This phenomenon has not escaped criminal law. The range of human behaviors deemed criminal and codified in the Special Part of a country's criminal law is known as the dynamics of incrimination. Though criminal law's primary function is protective, the evolution of crime and associated fear, especially the security paranoia of modern times, has led to the assignment of a security function to criminal law. This is a function alien to its original purpose and drives criminal law into a full-blown crisis of legitimacy.
Changes in life conditions and parallel developments in crime have led to increased demand for both insurance and more extensive criminal law protection.
In the context of insurance law and the insurance market, this reflects a positive development trend of a business activity aligned with the traditional stages of economic cycles. However, in criminal law, the tendency toward preventively oriented criminalization and the use of criminal law in the early phases of criminal progression must be viewed as negative criminal policy tendencies, ones that lead criminal law into a crisis of legitimacy and reduced applicability. I. Soković, 278; Đorđe Ignjatović, *Kriminologija*, Faculty of Law, University of Belgrade, 2021, 155; Jelena Radović Stojanović, *Osnovi ekonomije,* University of Criminal Investigation and Police Studies, Belgrade, 2024, 180–181; and Ivana P. Bodrožić, *Terorizam kao kategorija nacionalnog i međunarodnog krivičnog prava,* University of Criminal Investigation and Police Studies, Belgrade, 2022.

[16] ZOO, art.12. For more on the principle of good faith and fair dealing, see: Slobodan Perović, *Obligaciono pravo, Knjiga prva,* 7th Edition, Službeni glasnik SFRJ, Belgrade, 1990, 56–61.

[17] Rebekah Dixon, *A Leap of Good Faith: A Possible Response to Unfair Claims-Handling Practices in Insurance,* Otago, 2012, 3–8.

to act with particular good faith in their dealings with the other contracting party. Specifically, they must disclose to the other party any circumstance (fact) that affects the risk and the amount of the premium prior to the conclusion of the contract.[18] Historically, the principle of good faith emerged as a mechanism to overcome informational asymmetry, which impacted the business performance of insurers.[19] Since the applicant for insurance possessed all relevant information about the risk, the duty to disclose all circumstances relevant for risk assessment was introduced based on this principle. Interestingly, at the time this principle was introduced, the emphasis was placed solely on the insured's duty to disclose all risk-related information to the insurer, while no such corresponding obligation for the insurer was recognized.[20] It was only under the influence of consumerism, grounded in the principle of good faith and fair dealing, that a pre-contractual duty of disclosure by the insurer to the policyholder was introduced.

The principle of good faith and fair dealing "serves to moralize the law, to reinforce its ethical dimension, by limiting freedom of contract and **establishing a standard of conduct toward the other party that must be respected during negotiations, contracting, the exercise of rights, and the fulfillment of obligations**".[21] It is important to emphasize that this principle governs the reciprocal treatment of parties to the obligational relationship, both in its formation and in the execution of rights and obligations. **From this principle arises the duty on each party to consider the interests of the other party, and above all, their legitimate expectation or trust that the other will behave in a loyal, reliable, consistent, and considerate manner**.

The principle of good faith and fair dealing rests upon the concept of causality, specifically, the causal link between damage and the insured risk, in the same way that criminal law requires the establishment of causality between the act and the consequence of the criminal offense in order to assess the degree of culpability. In this broader sense, a potential conflict may arise between the presumption of innocence, *in dubio pro reo - when in doubt, in favor of the accused,* which is a fundamental principle of criminal procedure law, and the principle of good faith and fair dealing. An example would be a case where an insurer refuses to pay out the insured sum due to suspicion of insurance fraud, while the criminal court has not yet determined the perpetrator's guilt in a lawfully conducted criminal proceeding.

[18] John Lowry, Philip Rawlings, *Insurance Law, Doctrines and Principles,* Second Edition, Hart Publishing, Oregon, 2005, 77–78.

[19] Nataša Petrović Tomić, Mirjana Glintić, "The Hybridization of the Regulatory Framework of Insurance Contract Law: Elements of a New Setting", *Annals of the Faculty of Law*, No. 2/2024, 223–250.

[20] Herman Cousy, "Changing Insurance Contract Law: An Age-Old, Slow and Unfinished Story", *Insurance Regulation in the European Union: Solvency II and Beyond* (eds. Pierpaolo Marano, Michele Siri), Springer International Publishing, 2017, 35.

[21] Marija Karanikić Mirić, *Obligaciono pravo*, Službeni glasnik, Belgrade, 2024, 78.

In brief, the principle of indemnity means that insurance may cover the entire damage but no more than the actual damage suffered.[22] The indemnification from insurance cannot exceed the amount of damage the insured suffered due to the insured event.[23] The purpose of insurance is not to improve the insured's financial situation after indemnification, but to restore their previous financial position.[24] The application of the indemnity principle requires that in each specific case, the damage suffered must first be determined. In addition to accurately assessing the damage incurred, it is essential to consider the insured sum, as it represents the upper limit of the insurer's obligation. Furthermore, it significantly influences the amount of the insurance premium. The value of the insured item at the time the damage occurred is also relevant. Insurers cannot calculate compensation in accordance with the principle of indemnity without considering the value of the item at the time the insured event occurred. The burden of proving the value of the item lies with the insured.

The principle of indemnity prescribes that in exercising insurance rights, the insured may claim only actual damages and not pursue any unjust enrichment. This is, following criminal law rules, aligned with the notion that no one may retain property derived from a criminal offense.

Freedom of contract, in insurance contract law, is more limited than in other types of contracts. Due to the nature of this complex contract (which procures a complex and intangible financial service) and the typical consumer position of the party acquiring the insurance service, the legislator intervenes more extensively in the insurance contractual relationship. For this reason, we are inclined to associate the sources of insurance contract law traditionally with the feature of detailed regulation.[25] From the perspective of both the insurer and the insured, freedom of contract is essentially reduced to the freedom to choose the type of insurance contract they wish to conclude. And that only within the domain of voluntary insurance. When dealing with risks that have a pronounced social connotation, even freedom of coverage choice does not exist; instead, the contract is concluded to fulfill a legal obligation. This aligns with the general provisions of the ZOO, which, at the beginning of the

[22] Jasna Pak, *Pravo osiguranja*, Singidunum University, Belgrade 2011, 229.

[23] "In a business relationship based on property insurance, regardless of the insured amount, the amount the insured is entitled to cannot exceed the extent of the damage suffered." (Judgment of the Commercial Appellate Court, Pž 7279/2014(1) of November 24, 2014 – Judicial Practice of Commercial Courts – Bulletin No. 1/2015)

[24] Rafael Illeskas Ortiz, "Principios Fundamenstales del Contrato de Seguro", *Derecho de Seguros y Reaseguros*, Liber Amicorum en homenaje al profesor Arturo Díaz Bravo (ed. Carlos Ignacio Jaramillo), Ibañez, Bogotá, 2015, 17–18.

[25] Nataša Petrović Tomić, „Razvoj ugovora o osiguranju u jugoslovenskom i srpskom pravu", *Razvojne tendence v obligacijskem pravu, Ob 40-letnici Zakona o obligacijskih razmerjih* (ed. Damjan Možina), Inštitut za primerjalno pravo, Pravna fakulteta, Ljubljana, 2019, 389–412.

section on contract conclusion, contains an article titled "Mandatory conclusion and mandatory content of the contract" (Art. 27).

In a branch of law that regulates relationships between parties with unequal familiarity with the subject of the transaction and/or unequal economic power, freedom of contract in its original form cannot be sustained. The extent to which freedom of contract is limited depends primarily on the importance of the issue for the position of the weaker party. If a regulation directly concerns the interests of the weaker party, the legislator will resort to limiting freedom of contract through mandatory norms. If, however, it is sufficient to provide the insurer with guidelines on how to proceed regarding a particular matter, the legislator may opt for directed freedom of contract, achieved by a semi-mandatory method.

In regulating insurance contracts, the legislator has used a general provision to impose limitations on freedom of contract in two primary ways: first, by introducing the obligation to conclude a contract, and second, by partially or fully prescribing its content. Numerous special regulations impose on the insured the obligation to conclude an insurance contract. Correspondingly, insurers engaged in compulsory types of insurance are required to accept offers that do not deviate from the terms under which they typically provide such insurance. Moreover, there are instances where insurers are required to accept an offer for voluntary insurance contracts as well. The best example is voluntary health insurance, which only recently received statutory legitimization.[26] As for the mandatory content of insurance contracts, it is essentially prescribed by the Law of Contract and Torts (ZOO). Given that in the field of insurance, mandatory content dominates, along with the existence of the two aforementioned limitations on freedom of contract, it is evident to what extent freedom of contract has been derogated. It is not merely about the parties being obliged to obtain some form of insurance coverage. Their freedom of contract is even more affected by the legislative imposition of mandatory contract content, coupled with sanctioning mechanisms for any contractual provision contrary to the mandatory legal content, even if such provision was mutually agreed upon by the parties.

The principle of enhanced protection of the weaker party is the first association with modern insurance contract law. However, this principle was already familiar to legal systems that codified insurance law in the early 20th century. In first-rate legal systems (such as German and French law), long before the development of consumer contract law, there existed a multitude of statutory provisions aimed specifically at protecting the weaker party in insurance contracts.[27] In that sense, *insurance*

[26] Voluntary health insurance is not truly voluntary. The Health Insurance Act (ZZO) introduced an obligation for insurers offering this type of insurance to conclude a contract under the terms prescribed by law and secondary legislation, regardless of the risk to which the insured is exposed, including age, gender, and health status. See: N. Petrović Tomić (2019a), 503–505.

[27] Protection of the weaker party is "the guiding idea in the history of insurance". See: Yvonne Lambert-Faivre, Laurent Leveneur, *Droit des assurances*, Dalloz, Paris, 2011, 1; Mandep Lakhan, Helmut Heiss, "Towards

contract law may be seen as a precursor to consumer protection law.[28] The difference lies only in terminology: whereas we explicitly speak of consumer protection in the context of insurance services today, in the early 20th century, the prevailing notion was the protection of the insured, the beneficiary, and, more generally, the party in a weaker position.

The legislative regulation of insurance contracts through mandatory norms has long served as an instrument of protection for the insured against the insurer, predating consumer legislation. Before that legal branch developed, European legislators sought to prevent the use of clauses unfavorable to the insured through the implementation of mandatory rules. The most harmful to the insured were unilaterally drafted clauses on nullity, excluded damages, and loss of insurance rights.[29] Additionally, the "originality" of insurance law lies in the use of so-called *semi-mandatory* or *unilaterally mandatory provisions*, which remain in force today. These norms were the foundation of insurance contract protection mechanisms in earlier times. At the current stage of development, one may speak of the emergence of *consumer insurance contract law* as a sub-branch of (contractual) insurance law.

The principle of enhanced protection of the weaker party and the detailed regulation of insurance contracts have gradually led to the retreat of the principle of contractual freedom in this area of contract law. Namely, today we can speak of a principle of limited and directed contractual freedom, which has emerged in response to numerous legislative interventions in insurance contracts.[30]

By combining the fundamental principles of criminal law and the principles of insurance law, two entirely different legal regimes converge. One is public law nature, focused on sanctioning socially harmful behavior, and the other is predominantly private law, regulating contractual relations between insurer and insured. This interaction of principles indicates that **criminal law, consistent with its role in relation to other legal branches, serves as a means of *last resort* in responding to unlawful conduct within the insurance sector**. **It remains profoundly subsidiary, highly fragmented, and accessory to the principles and legal norms of insurance law.**

Subsidiarity is reflected in the fact that **c**riminal law only intervenes when regular mechanisms for regulating the insurance activities prove ineffective. Fragmentation is reflected in the existence of only a single incriminating provision - insurance

a European Insurance Contract Law: Restatement – Common Frame of Reference – Optional Instrument?", *Utrecht Journal of International and European Law*, Vol. 26, No. 71/2010, 1–11.

[28] Nataša Petrović Tomić, *Zaštita potrošača usluga osiguranja*, *Analiza i predlog unapređenja regulatornog okvira,* University of Belgrade Faculty of Law, Belgrade, 2015, 54–55.

[29] The French Insurance Code contained 83 provisions on insurance contracts, 61 of which were mandatory, and the remaining 21 semi-mandatory. Y. Lambert-Faivre, L. Leveneur, 160.

[30] N. Petrović Tomić (2020), 100–125.

fraud, found in *Chapter XXII of the Criminal Code on economic offence.* Accessory character stems from the dependence of criminal law on the primary instruments and sources of insurance law, which define the key concepts that criminal law aims to protect in a reinforced manner.

III The criminal code and the incrimination of socially harmful conduct patterns in the insurance market as a form of modern contemporary crime

In contemporary society, the economic development of a country and the conduct of economic activities have acquired such significance that the state increasingly intervenes in economy to establish and maintain normal relations among economic entities in a manner aligned with national economic interests and the needs of its citizens. Under such circumstances, various new forms of criminal behavior emerge, which, as a social phenomenon, always adapt rapidly to the prevailing societal conditions.

As economic life is always dynamic and subject to change, economic crime likewise evolves quickly in terms of its forms and structure. Accordingly, the criminal law response to this type of crime is gaining increasing importance, resulting in a growing number of legal, and specifically criminal, regulations in this area.[31]

There are significant difficulties in defining the concept of an economic criminal offense. In the proper sense, it refers to socially harmful behavioral patterns whose punishment primarily serves to protect the economic system and its functioning. The primary purpose of criminalizing this category of offenses is to prevent the erosion of trust in the economic system. Among other things, regarding the economic model deemed desirable for protection under criminal law, the dominant view is that it is the market economy model.[32]

Given that the share of economically motivated crime in the Republic of Serbia is relatively high, by aggregating crimes against property and against the economy accounts for 48.6% of all criminal offenses that are economically motivated. Although varied in their legal nature, these offenses share a underlying economic motives and are, thus, registered as such in the annual reports of the Statistical Office of the Republic of Serbia.[33] This data serves as material legitimacy for the existence

[31] Đorđe Đorđević, Ivana Bodrožić, *Krivično pravo – Posebni deo*, University of Criminal Investigation and Police Studies, Belgrade, 2024, 177.

[32] Zoran Stojanović, *Krivično pravo – Posebni deo,* The University of Novi Sad Faculty of Law, Novi Sad, 2022, 176–177.

[33] The high share of economically motivated crime in overall crime means that economic factors have a significant influence on criminal activity and represent one of the more important causes of crime

of offenses against the economy and is one of the legislative motives behind their incrimination. As insurance law has emerged as one of the fastest-growing branches of the economy, its development is paralleled by the emergence of a significant area in which new forms of criminal behavior arise, which have the potential to be addressed as criminal offenses.

In the positive criminal legislation of the Republic of Serbia, the Criminal Code (CC) is considered the principal legal act that defines the vast majority of behaviors deemed criminal offenses. Nevertheless, following the codification of criminal legislation in 2006, certain special provisions, commonly referred to as subsidiary criminal legislation, have remained in force due to specific legislative and technical reasons. These contain individual criminal provisions and distinct criminal offenses.

In the field of insurance, the only criminal offense that directly protects insurance activities is the offense of insurance fraud, as prescribed in Article 223a of the CC. This offense is classified among crimes that collectively aim to protect the economy.[34] This is justified.

In addition to this criminal offense, numerous other incriminations may be used to protect the rights and interests of participants in the insurance market,[35] yet insurance fraud is regarded as the *classical lex specialis* provision in this area.

Alongside this offense, the Insurance Law (ZO),[36] under *Chapter XV* (Penal Provisions), Section 1 (Criminal Offenses**)**, sets forth three specific criminal offenses related to insurance: unauthorized performance of insurance activities (Art. 256 ZO),[37]

in the Republic of Serbia. Jelena Radović Stojanović, *Kriminal i ekonomija Srbije,* University of Criminal Investigation and Police Studies, Belgrade, 2021, 55–57.

[34] As the Serbian criminal law environment is characterized by a dynamic phase of legislative interventionism, this chapter on criminal offenses was among those that underwent significant and thorough changes in 2016, within the framework of no fewer than eight amendments to the CC enacted since 2006 up to the present. At that time, the offenses in this chapter were substantially improved both structurally and substantively; they were systematized by similarity, and as many as seven new incriminations were introduced, an evident example of criminal law expansionism, which, as a criminal-political trend, must be labeled as negative. Additionally, terminological corrections and normative reconfigurations were made, and three offenses were decriminalized. Nataša Delić, *Krivično pravo – Posebni deo*, Faculty of Law, University of Belgrade, Belgrade, 2023, 242–243; I. Bodrožić (2020).

[35] Fraud in the conduct of business activity (Article 223 of the CC); embezzlement in the conduct of business activity (Article 224 of the CC); abuse of trust in the conduct of business activity (Article 224a of the CC); damage to creditors (Article 233 of the CC), among many others.

[36] *Official Gazette of the Republic of Serbia*, Nos. 139/2014 and 44/2021.

[37] **Unauthorized conduct of insurance activities:** A responsible person within an insurance company, reinsurance company, insurance brokerage company, insurance agency, or among insurance agents, who engages in insurance activities without obtaining authorization from the National Bank of Serbia, shall be punished for a criminal offense with a prison sentence ranging from three to six years. A responsible person of a legal entity who, in the capacity of a service provider, enters into insurance contracts, or contracts that, by their legal nature, constitute insurance contracts, with other persons, shall be punished for a criminal offense with a prison sentence ranging from three to six years.

issuing false opinions and reports (Art. 257 ZO),[38] and issuing false assessments (Art. 258 ZO).[39]

The criminal offense of insurance fraud was introduced into the CC in 2009. In its original version, it was classified under *Chapter XXI Criminal Offenses Against Property*, as Article 208a, and represented a specific form of the general offense of fraud. Thus, insurance fraud represented a specific legal norm, standing in a *lex specialis derogat legi generali* relationship to the general offense of fraud under Article 208. The act of insurance fraud in this original 2009 version involved inducing another person, in connection with insurance, to act to the detriment of their own or another's property, either by commission or omission. The law, in that version of the offense, specified typical forms of conduct such as falsely presenting facts, concealing facts, submitting false documentation, or otherwise misleading or maintaining a state of deception. The elements of crime, as a subjective characteristic, included the intent to unlawfully obtain material gain for oneself or another. The aforementioned activities had to be undertaken in relation to insurance, without specifying the type of insurance involved. The offense included two aggravated forms, involving more severe consequences, and one basic form.[40]

As a special type of fraud related to the insurance industry, the elements of crime of insurance fraud corresponded to, or overlapped with, those of the general offense of fraud, as a classic property crime.[41]

[38] **Providing false opinions and reports:** An authorized actuary or auditor who, contrary to the provisions of this law, prepares a false opinion or report shall be punished for a criminal offense with a prison sentence of one to three years.

[39] **Providing a false assessment:** A responsible person within an insurance company, reinsurance company, insurance brokerage company, insurance agency, or among insurance agents, who prepares false assessments or statements when determining and evaluating risks and damages, shall be punished for a criminal offense with a fine or a prison sentence of up to three years.

[40] Ljubiša Lazarević, *Komentar Krivičnog zakonika*, Second Revised and Expanded Edition, Faculty of Law, Union University, Belgrade, 2011, 704.

[41] **Insurance fraud**, in its original version from **Article 208a** of the 2009 CC, read as follows:
(1) Whoever, with the intent to obtain unlawful material gain for themselves or another, misleads someone, by misrepresenting or concealing facts, providing false opinions or reports, submitting false assessments, presenting false documentation, or by otherwise deceiving or maintaining a state of deception, in connection with insurance, and thereby induces that person to act or refrain from acting to the detriment of their own or another's property, shall be punished with a prison sentence of six months to five years and a fine. (2) Whoever commits the act referred to in paragraph 1 of this Article solely with the intent to cause harm to another, shall be punished with a prison sentence of up to six months and a fine. (3) If the offense referred to in paragraphs 1 and 2 of this Article results in material gain or damage exceeding 450,000 dinars, the offender shall be punished with a prison sentence of one to eight years and a fine. (4) If the offense referred to in paragraphs 1 and 2 of this Article results in material gain or damage exceeding 1,500,000 dinars, the offender shall be punished with a prison sentence of two to ten years and a fine. Dragoljub Simonović, *Krivična dela u srpskoj legislativi,* Službeni glasnik, Belgrade, 2010, 414.

However, the 2016 amendments to the CC, through which the legislator significantly intervened in the area of criminal offenses against the economy, had a notable impact on the incrimination of insurance fraud. The offense was reclassified**,** moving from the chapter on criminal offenses against property to the chapter on criminal offenses against the economy. This is considered desirable, as the protected legal interest under the new criminal offense, though it retained the same name but modified legal elements, is now insurance as an economic activity.

The reasons justifying this major legislative intervention include, first, the primary protected object**,** namely, what the analyzed criminal offense seeks to protect in the first place. Secondly, they relate to the necessity of effectively safeguarding against so-called insurance fraud[42] in a manner consistent with the approaches adopted by most comparative criminal law systems.

As the Republic of Serbia is a candidate for European Union (EU) membership, it is undergoing comprehensive legal reforms**,** including efforts to harmonize criminal law provisions as well. The criminal offense of **insurance fraud,** as regulated since 2016, remains in effect under the 2024 version of the CC**,** in **Article 223a**:

(1) Whoever, with the intent to collect the agreed sum from an insurance company, destroys, damages, or conceals the insured item and then reports the loss, shall be punished by imprisonment from three months to three years.

(2) The same punishment as in paragraph 1 shall apply to anyone who, with the intent to collect the agreed sum from an insurance company for bodily harm, injury, or health impairment, causes such harm, injury, or impairment to themselves and then submits a claim to the insurance company.

(3) If the acts referred to in paragraphs 1 and 2 result in financial gain or cause damage exceeding four hundred and fifty thousand dinars, the perpetrator shall be punished by imprisonment from one to eight years.

(4) If the acts referred to in paragraphs 1 and 2 result in financial gain or cause damage exceeding one million five hundred thousand dinars, the perpetrator shall be punished by imprisonment from two to ten years.

[42] Through the amendments and supplements, the criminal offense of insurance fraud was more precisely defined, as the offense of insurance fraud (Article 208a of the CC) had previously been practically encompassed entirely by the existing offense of fraud. Insurance fraud constitutes a form of so-called policyholder fraud, which significantly differs from the general offense of fraud. For this reason, it is introduced as a separate criminal offense in many criminal law systems, in line with comparative legal practice. This justifies its introduction as a distinct offense, since, unlike the general offense of fraud, the criminal domain in insurance fraud is defined more broadly, and there is no requirement for inducing or maintaining a misconception on the part of the passive subject.

The criminal offense has a basic form and two aggravated forms. The conduct constituting the basic form is defined alternatively and may consist either of the destruction, damage, or concealment of the insured item or of the reporting of a loss, which itself comprises two acts – causing harm, injury, or health impairment to oneself and submitting a claim to the insurance company.

The object of the act may be either the insured item or the perpetrator.

The offense is committed with intent, and the perpetrator may be any person.

The aggravated and the most severe forms are linked to obtaining financial gain or causing damage exceeding certain monetary thresholds.

This structuring of the criminal offense of insurance fraud, in relation to the offenses specified in Articles 257 and 258 of the Insurance Law, could potentially pose challenges in delineation.

However, the statutory descriptions of these offenses differ sufficiently regarding the definition of the act of the crime of insurance fraud, so that they do not conflict with each other, and there is justification for their parallel existence in these two legal provisions.[43]

IV The role of criminal law in shaping insurance services

Criminal law has traditionally been founded on the principle of its evolutionary nature, encapsulated in the maxim *Ius criminale semper reformandum est* - criminal law is in a state of continual development. It evolves in response to the emergence of new forms of criminal behavior and develops norms aimed at preventing and suppressing new manifestations of criminality. In this process, criminal law remains rooted in its own principles (while also being constrained by them), and it must retain its character of exceptional application. Contemporary European criminal law systems are characterized not only by this evolutionary capacity but also by certain negative criminal policy tendencies, to which the legislator in the Republic of Serbia has not remained immune.[44] Although issues such as legal interventionism, the expansion

[43] Zoran Stojanović, *Komentar Krivičnog zakonika, Tenth revised edition,* Official Gazette, Belgrade, 2020, 748–749.

[44] As criminal law became one of the components of the Union's objectives, the EU acquired explicit competence in the field of substantive criminal law. Minimum rules on substantive criminal law facilitate the principle of mutual recognition, enable the approximation of criminal policies of member states and candidate countries for full membership, and lay the foundation for common definitions of criminal offenses. This, in turn, allows for an effective response to global criminal flows. Therefore, the EU legislator should exercise caution when influencing the shaping of criminal law responses in the process of approximating the substantive criminal law of its member states.
The principles of criminalization provide the legislator with an argumentative framework that can be used to determine whether criminalization is legitimate and justified. At the same time, attention must

of incriminations, and the limitations of such hypertrophied criminal law have been addressed in earlier parts of this paper, particularly where the drawbacks of these tendencies are highlighted, this should not be interpreted as an argument in favor of preserving only the existing form and structure of incriminations.[45]

The development of the insurance market,[46] the influence of new business models and services, and the imperative of ensuring the sustainable development of this sector[47] necessarily lead to the adjustment of criminal law norms. This is a bidirectional process and, from the standpoint of potential legal solutions, it can be examined through several examples.

Criminal law significantly influences the structuring of insurance services by establishing a legal framework that insurance companies must adhere to when designing policies, assessing risks, and processing claims.[48] The key ways in which criminal law shapes insurance services include:

always be paid to the particularities of legal heritage and legal tradition. For a more detailed discussion of the principles of criminalization, negative tendencies, and the future of EU substantive criminal law as a guiding framework for the harmonization of national criminal laws, see: Sanne Buisman, "The Future of EU Substantive Criminal Law", *European Journal of Crime, Criminal Law and Criminal Justice*, Vol. 30, No. 2/2022, 161–162.

[45] See fn. 15.

[46] At the celebration of the anniversary of the journal *Tokovi osiguranja*, Deputy Governor of the National Bank of Serbia, Željko Jović, presented the following data, which support the development of the insurance market and its role within the overall financial sector: "In the financial sector supervised by the National Bank of Serbia, insurance ranks second in terms of total assets, capital, and number of employees. Insurance premiums per capita amount to 216 US dollars, representing 1.9 percent of the gross domestic product (GDP). For comparison, the premium per capita in developing countries of Europe and Central Asia is 207 US dollars, with a GDP share of 2.3 percent. Data for the first half of this year indicate growth in all parameters within the insurance industry, with total premiums increasing by 13.2 percent compared to the same period last year, technical reserves rising by 12.3 percent, and capital adequacy reaching 212.9 percent, exceeding the statutory requirement. Alongside a profitability ratio of 92.2 percent and a positive interim result of 6.5 billion dinars, these indicators testify to the stability of the insurance sector". "*Četrdeseti rođendan časopisa Tokovi osiguranja*", https://www.dunav.com/cetrdeseti-rodjendan-casopisa-tokovi-osiguranja/, accessed on June 1, 2025.

[47] On the sustainability of development as a *conditio sine qua non* for the entire insurance market, as well as the regulatory framework that accompanies it, illustrated by the example of the initial underregulation of the legislative framework and, consequently, the desired regulatory progress in the field of supplementary health insurance in the Republic of Serbia, see in detail: Nataša Petrović Tomić, "Dopunsko zdravstveno osiguranje u funkciji doprinosa razvoju održivog sistema zdravstvene zaštite u Republici Srbiji", *Tokovi osiguranja*, No. 1/2024, 7–70.

[48] Regarding the ways in which crime influences the demand for insurance, as well as the impact of offered insurance services on the emergence of new forms of criminality within the insurance sector, Tom Baker and Anja Shortland examine five case studies (car theft, art theft, kidnapping and ransom, and credit card fraud). They highlight a co-evolutionary process through which insurers collaborate with policyholders, governments, and both formal and informal third parties to mitigate losses, particularly when criminal innovations destabilize the insurance market.

1. **Definition of criminal offenses and insurance coverage**: criminal law defines what constitutes unlawful conduct (e.g. theft, embezzlement, fraud, destruction of property). Insurers rely on these definitions when drafting policies, such as those covering theft or damage to third-party property. However, insurance policies typically exclude coverage for damages resulting from intentional criminal acts committed by the insured, as criminal law prohibits profiting from criminal conduct.[49]
2. **Impact on risk assessment**: criminal law influences actuarial models used by insurers to evaluate risk. For instance, in areas with high crime rates (e.g. frequent car theft), insurance premiums are typically higher because criminal law indirectly signals an increased likelihood of insured events.
3. **Protection against insurance fraud**: criminal law, particularly provisions addressing fraud, helps shape mechanisms for preventing false claims. Insurers develop services with strict conditions and verification procedures to protect against criminal acts such as fraudulent claims. For example, property insurance policies may require proof of ownership or a police report as part of the claim process.
4. **Liability insurance**: criminal law affects services related to civil and professional liability insurance. For instance, in cases where a criminal offense (such as an intentional traffic safety violation) causes damage, liability coverage may be limited if the insured committed the offense with intent.[50]
5. **Mandatory insurance**: criminal law can require specific types of insurance. In Serbia, for example, the Law on Compulsory Traffic Insurance (which includes criminal law elements in the event of non-compliance) mandates that vehicle owners carry third-party liability insurance, directly shaping this segment of the insurance market.[51]

The phrase *Insurance as crime governance* reflects a concept that the authors of this paper also seek to express in a broader, potentially *de lege ferenda* context. For further reading, see: Tom Baker, Anja Shortland, "How Crime Shapes Insurance and Insurance Shapes Crime," *Journal of Legal Analysis*, Vol. 15, No. 1/2023, 185–196.

[49] Criminal law explicitly stipulates in Article 91 of the CC that: "(1) No one may retain property benefits obtained through the commission of a criminal offense. (2) The benefit referred to in paragraph 1 of this article shall be confiscated under the conditions prescribed by this Code and by a court decision establishing the commission of the criminal offense." Criminal Code, Article 91.

[50] For a detailed discussion on proceedings involving insurers' recourse claims against the insured, as well as issues concerning the determination of liability for causing accidents, see: Milica Goravica, "Utvrđivanje odgovornosti za prouzrokovanje udesa u postupcima po regresnoj tužbi osiguravača protiv osiguranika", *Tokovi osiguranja*, No. 1/2025, 201–206.

[51] For a detailed discussion on the distinction between so-called moral hazard and criminal hazard, i.e. situations in which an individual exhibits a higher tolerance for increasing their exposure to potential risk due to the awareness of limited costs associated with such behavior as a result of having insurance

6. **Compliance with anti-money laundering and counter-terrorism financing laws**:[52] criminal law, particularly in the area of economic crime, imposes obligations on insurers to verify client identities and the sources of their funds. This affects the structure of services, as insurers must implement procedures for identity checks and legal compliance, which may increase operational costs and complicate business processes.
7. **Policy exclusions**: criminal offenses often result in exclusions from coverage. For example, if damage is caused by a terrorist act (a criminal offense under the Criminal Code), standard property insurance policies typically do not cover such events. This has led to the development of specialized products for terrorism risk coverage.

In conclusion, criminal law shapes insurance services by regulating risk, defining coverage conditions, preventing abuse, and ensuring compliance with legal obligations. Insurers must strike a careful balance between client protection and adherence to criminal law standards in order to provide sustainable and legally compliant services.

V Concluding considerations

The characteristics of the legal system, as a set of norms regulating public and private legal relations, determine the mutual relationship between different branches of law. Criminal law and insurance law, within this framework, have a specific-reversible, as confirmed in this paper-relationship.

Primarily, these are branches of law whose fundamental function is protective in nature. Therefore, a connection is established between them based on a shared orientation, i.e. a goal-oriented linkage. In this relationship, criminal law acts as a more forceful and exclusive instrument for protecting legal relations that have not been successfully safeguarded by insurance law norms.

Criminal law protects to the lawful operation of insurance as an activity within the financial sector and, in doing so, directly protects economic activity, es-

coverage, as well as on the requirement that at least two conditions be met for moral hazard to escalate into criminal hazard and imply criminal liability, see: Per-Johan Horgby, Annette Wittkau-Horgby, "Beyond Moral Hazard - Some Thoughts on Criminal Hazard and Insurance," *Nordic Insurance Quarterly (NFT)*, No. 2/2008, 147–153.

[52] The specific features of the new approach to defining terrorist offenses, nomotechnical revisions, and the harmonization with European criminal law standards have led not only to changes within the substantive criminal legislation of the Republic of Serbia but also to amendments in related regulations, such as the Law on the Prevention of Money Laundering and the Financing of Terrorism (*Official Gazette of the Republic of Serbia*, Nos. 113/2017, 91/2019, 153/2020, 92/2023, 94/2024, and 19/2025). For further details, see: I. Bodrožić (2022).

pecially in relation to the collective legal interest protected by the criminal offense of insurance fraud, as regulated in the Special Part of the CC.

Criminal law norms are also contained within the Insurance Law (ZO), demonstrating that this regulation, within the domain of criminal protection falls under the category of subsidiary legislation. However, as confirmed in this paper, such criminal provisions are legitimate and do not create unnecessary overlaps in incriminations.

Respecting its nature as *ultima ratio* and its subsidiarity in relation to other branches of law, criminal law rationally encompasses only one criminal offense, through which direct protection is provided against insurance fraud. Within the framework of positive law, this offense has undergone a notable evolution: not has it only been reshaped but also resystematized in a manner aligned with both European and national criminal law standards. As Elena Maculan and Alicia Gil Gil argue, it is important to maintain the status of criminal law as *ius puniendi* and as an instrument of the state, but not as the only available instrument or an absolute obligation. Rather, it should function as a complementary and subsidiary tool.[53]

The relationship between criminal law and insurance law, observed through this prism, has been illustrated through seven key ways in which criminal law can influence the shaping of insurance services, to ensure sustainability and the desired level of protection across the insurance market.

As a pioneering work in the theoretical analysis of the relationship between criminal law and insurance law, the authors hope that the proposed methods and options for mutual, reciprocal, or reversible, influence will serve as a foundation and *teaser* for further research in this field. Each of these aspects could, on its own, become the subject of a dedicated scholarly article by a specialist in substantive criminal law or insurance law, particularly in direct connection with the practical aspects of their application.

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[53] This allows for the use of criminal law only when it is both useful and necessary. When other mechanisms exist that can provide such protection in a satisfactory manner, or when criminal law, if applied, risks becoming a threat to the very legal interests it is intended to protect, particularly if it ultimately destabilizes the legal system entrusted with that protection, then prosecution and punishment must take a step back and be adapted and limited according to the specific circumstances of each case. Elena Maculan, Alicia Gil Gil, "The Rationale and Purposes of Criminal Law and Punishment in Transitional Contexts," *Oxford Journal of Legal Studies*, Vol. 40, No. 1/2020, 157.

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IMPLEMENTACIJA SISTEMA KALKULACIJE REZERVI I PLAĆANJA U UPRAVLJANJU ODŠTETAMA U SAP ERP SISTEMU

ORIGINALNI NAUČNI RAD

Apstrakt

U ovom radu biće predstavljena implementacija SAP rešenja u oblasti osiguranja. Na početku -je dat osvrt na ERP sisteme i SAP, a fokus ovog rada je modul za upravljanje odštetama FS-CM *Claims Management*. Cilj rada je da predstavi informacioni sistem za složen proces isplate naknada, koji je jedan od ključnih procesa u radu osiguravajuće kuće. U implementaciji se nailazi na brojne izazove: na koji način automatizovati celokupan proces i kako integrisati sve sisteme koji su uključeni. Potrebno je ispratiti proces od kreiranja zahteva za odštetu, preko kalkulacije isplate i obrade zahteva, sve do krajnje isplate osiguraniku. Prikazano rešenje je integracija više modula i sistema unutar SAP-a kako bi proces mogao da se izvrši, kao i upotreba nekih SAP modula na drugačiji način od njihove standardne upotrebe. SAP kao ERP sistem je u mogućnosti da pruži ovakvu integraciju celokupnog procesa od početka do kraja.

Ključne reči: *SAP, ERP sistemi, FS-CM Claims Management, upravljanje odštetama*

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I Uvod

Svaki poslovni sistem se može opisati preko određene strukture i skupa poslovnih procesa koji se izvršavaju u okviru te strukture. Ukoliko se ovi procesi žele automatizovati potrebno je da se naprave odgovarajući informacioni sistemi koji će obezbediti da svaki poslovni proces, odnosno njegova aktivnost, bude što je moguće više automatizovana[4]. Iako informacioni sistemi stvaraju mnoge uzbudljive mogućnosti za preduzeća, oni su takođe izvor novih problema, pitanja i izazova za menadžere. Veliki softverski i hardverski sistemi i dalje ne uspevaju uprkos brzim naprecima u informacionoj tehnologiji.[5]

Povećanje efikasnosti, optimizacija troškova i resursa predstavljaju glavni zadatak menadžmenta. Samo oni poslovni sistemi koji su obezbedili smislen tok informacija i dobara u lancu snabdevanja, izvrsno upravljanje odnosima sa klijentima i koji su primenili e-poslovanje, mogu ostvariti strategijsku prednost.[6] Integrisana softverska rešenja, među kojima se ističu ERP sistemi, pomažu da se industrijska slika promeni.[7] ERP sistem obuhvata module za sve ključne oblasti poslovanja, kao što su nabavka, proizvodnja, upravljanje materijalima, prodaja, marketing, finansije i ljudski resursi.

SAP je bio jedna od prvih kompanija koja je razvila standardni softver za poslovna rešenja i nastavlja da nudi vodeća ERP rešenja u industriji.[8] Među brojnim kompanijama koje su implementirale SAP softversko rešenje, nalazi se i dosta osiguravajućih kuća. U osiguranju je potrebno upravljati složenim i raznolikim procesima koji uključuju upravljanje polisama, obračun premija, obradu šteta, aktuarstvo, kao i upravljanje rizicima. Potrebno je pratiti ogromnu količinu podataka o klijentima, ugovorima i regulatornim izveštajima. Često je neophodna integracija sa eksternim sistemima i bazama podataka. Ovo je razlog zašto ne postoji jedno gotovo poslovno rešenje koje može pokriti sve zahteve osiguravajućih kompanija. Umesto toga, neophodna je integracija više SAP modula i rešenja, i prilagođavanje specifičnim potrebama svakog klijenta. To ujedno predstavlja i najveći izazov implementacije SAP rešenja u oblasti osiguranja.

Ovaj rad bavi se jednim od vrlo bitnih procesa u upravljanju odštetama - sistemom kalkulacije rezervi i plaćanja. Cilj je podržati proces u celini, sa visokim

[4] Bojan Jovičić, Siniša Vlajić, „Evolucija ERP sistema", *ИНФО М* , 22/2007, 18-22.

[5] Chetan S. Sankar, Karl-Heinz Rau, *Implementation Strategies for SAP R/3 in a Multinational Organization: Lessons from a Real-World Case Study*, IGI Global, 2006, 2.

[6] Dragana Rejman Petrović, „ERP sistemi u funkciji unapređenja kvaliteta poslovanja", *Nacionalna konferencija o kvalitetu, Mašinski fakultet Univerziteta u Kragujevcu, Kragujevac,* 2009, A15-A22.

[7] Thomas F. Wallace, Michael H. Krezmar, *ERP: making it happen: the implementers' guide to success with enterprise resource planning,* Hoboken, NJ, USA 2001, 4.

[8] *https://www.sap.com/westbalkans/about/what-is-sap.html,* pristupljeno: 21. 8.2024.

stepenom automatizacije, kako bi se osiguralo što jednostavnije korišćenje rešenja od strane zaposlenih, olakšavajući im svakodnevne operacije i povećavajući ukupnu efikasnost poslovanja. U ovom radu je detaljno prikazano rešenje koje je implementirano na projektu. Svi prikazi iz sistema su originalne slike sa projekta, pa su zbog toga na holandskom ili engleskom jeziku.

II ERP sistemi

Sistemi za planiranje resursa preduzeća (ERP) imali su ogroman uticaj na preduzeća i organizacije širom sveta[9]. ERP sistemi se u većini slučajeva implementiraju s ciljem da poboljšaju neki aspekt organizacije, npr. strateški, organizacioni, poslovni, menadžerski, operativni ili IT-infrastrukturu.[10] ERP sistem (eng. *Enterprise Resource Planning*) predstavlja softversko rešenje namenjeno upravljanju svim poslovnim funkcijama preduzeća. To je integrisani sistem koji povezuje sve delove organizacije, omogućava njihovu međusobnu koordinaciju i protok informacija između njih. Korišćenjem ERP sistema organizacija celokupno poslovanje vodi upotrebom jednog softvera i sve važne informacije čuva na jednom mestu.[11]

Pored vodećih vlasničkih ERP sistema poput SAP-a i *Microsoft Dynamic*-a, na tržištu se primećuje prisustvo velikog broja ERP sistema otvorenog koda. Mala i srednja preduzeća često se opredeljuju za korišćenje ERP sistema otvorenog koda, a razlog za to su prvenstveno niski troškovi implementacije i održavanja.[12]

Strukturu ERP sistema najčešće čine kolekcije aplikacija. One su organizovane u funkcionalne oblasti, koje se nazivaju moduli. Naravno, postoje razlike između pojedinih ERP sistema po pitanju modula, što znači da svi ERP sistemi nemaju sva funkcionalna područja, niti uključuju uvek iste module,[13]

1. Prednosti ERP sistema

Bredford se u svojoj knjizi o modernim ERP sistemima osvrnula na prednosti i mane implementacije ERP sistema u preduzeću. Među glavnim prednostima je integracija podataka. U ERP sistemima, podaci se jednom prikupljaju i dele širom

[9] Debra Howcroft, Duane Truex, „A critical analysis of ERP systems: the macro-level", *The Database for Advances in Information Systems,* 4/2001, 13-18.

[10] Jonas Hedman, Andreas Borell, The Impact of Enterpise Resource Planning Systems on Organizational Effectiveness: An Artifact Evaluation. In *Enterprise Resource Planning: Global Opportunities*, Hershey, PA: Idea Group Publishing, 2002, 78-96.

[11] Milena Ristić, „Šta je ERP – Značaj ERP rešenja u poslovanju preduzeća", 2017, *https://beleske.com/sta-je-erp-znacaj-erp-resenja-u-poslovanju-preduzeca/,* pristupljeno: 10.8.2024.

[12] Dragana Maljković, Ognjen Pantelić, „Komparativna analiza ERP sistema otvorenog tipa", *STED Journal,* 5/2019, 9-18.

[13] D. Rejman Petrović, A16-A17.

preduzeća, smanjujući rizik od netačnosti i redundanse u podacima i eliminišući vreme izgubljeno na proveravanje, ponovnu proveru i usaglašavanje podataka.[14] Jedna od posledica uvođenja ERP-a u kontekstu integracije je centralizacija. Preduzeće uvođenjem ovog sistema može da zameni dve ili više nezavisnih aplikacija i da eliminiše potrebu za spoljnim interfejsima, koji su ranije bili potrebni za spajanje ovih sistema.[15] Za organizacije koje obrađuju velike količine podataka, njihov kvalitet je osnova uspeha organizacije.[16] [17] Loš kvalitet podataka kompaniju može koštati i do 10% ili 20% ukupnih prihoda.[18] Još jedna prednost ERP sistema je pristup informacijama u realnom vremenu, što poboljšava saradnju i komunikaciju širom preduzeća.

ERP sistem takođe zahteva da kompanija deli zajednički proces i model podataka koji pokriva složene operativne procese od početka do kraja, kao što su oni koji se nalaze u proizvodnji i lancu snabdevanja. Ova standardizacija poboljšava koordinaciju unutar organizacije i širom organizacije, čineći lakšim interakciju sa unutrašnjim i eksternim zainteresovanim stranama. ERP dobavljači dizajniraju svoja rešenja oko procesa zasnovanih na industrijskim najboljim praksama.

Na kraju, ERP sistemi mogu smanjiti operativne troškove i povećati prihode. Kompanije koje implementiraju ERP to rade kako bi postigle efikasnosti kao što su niži troškovi zaliha, proizvodni troškovi ili troškovi nabavke.

2. Nedostaci ERP sistema

Implementacija ERP sistema uključuje mnogo više od jednostavne instalacije gotovog softvera. To je složen, vremenski zahtevan poduhvat, koji može uključivati mnoštvo problema. Mnogi od problema na koje se nailazi tokom implementacije odnose se na takozvani *soft stuff* (ljudski faktor) za razliku od *technical stuff* (softver/hardver problemi). Nedostatak učešća zaposlenih može biti problem ako zaposleni nisu edukovani o motivaciji organizacije za ulaganje u ERP sistem ili ako njihova mišljenja i povratne informacije nisu uzeti u obzir tokom procesa implementacije. Ponekad se ERP sistemi susreću sa otporom jer zaposleni mogu biti prilično zadovoljni starim sistemima koje su koristili decenijama.

Još jedan nedostatak ERP sistema je njihova visoka cena, posebno za softver od poznatih, većih ERP dobavljača, kao što su SAP i Oracle. ERP sistem i njegov proces implementacije mogu biti najskuplja investicija koju kompanija može napraviti. Manje

[14] Marianne Bradford, *Modern ERP: Select, implement and use today's advanced business systems,* third edition, Morrisville, NC, USA 2015, 6-9.

[15] B. Jovičić, S. Vlajić, 18-20.

[16] Stuart Madnik *et al.* ,„Overview and Framework for Data and Information Quality Research", *Journal of Data and Information Quality,* 1/2009, 1-22.

[17] Heinrich Bernd, Marcus Kaiser, Klier Mathias, "Does the EU insurance mediation directive help to improve data quality? A metric-based analysis", *ESCIS Proceedings,* 195/2008, 1871-1882 .

[18] Thomas Redman, „Data: An unfolding quality disaster", *Dm Review*, 14/2004, 21-23.

kompanije generalno imaju niže troškove implementacije, ali mogu iskusiti iste vrste implementacionih problema. ERP sistem zahteva stalno održavanje kako bi zadržao svoju stabilnost i kompatibilnost sa širokim spektrom stalno promenljivih softverskih aplikacija. Standardizacija poslovnih procesa koja se razmatra kao prednost takođe može biti i nedostatak ako ova struktura odstupa ili je u suprotnosti sa kulturom ili očekivanjima firme.

Iz ovih razloga, i mnogih drugih, kompanije ne bi trebalo da donose odluku o implementaciji ERP sistema olako. Uspešna implementacija zahteva da svi zaposleni — od funkcionalnih korisnika i IT osoblja, do najvišeg rukovodstva — budu motivisani da blisko sarađuju u cilju unapređenja misije organizacije.[19]

3. Budućnost ERP sistema

Budućnost ERP sistema je u donošenju efikasnosti, skalabilnosti i brzine u poslovanje. Klasični ERP sistemi moraju evoluirati, integrišući tehnologije poput senzora i veštačke inteligencije (AI). Budući ERP sistemi moraju biti prilagodljivi i skalabilni, uz primenu analitike i mašinskog učenja. Takođe, tradicionalni ERP sistemi su dizajnirani kao lokalna (*on-premise*) rešenja, tako da moraju izvršiti tranziciju na *cloud* sisteme. *Cloud* tehnologija omogućava korisnicima pristup ovim resursima putem interneta, što donosi brojne prednosti, uključujući skalabilnost, pristupačnost, uštedu troškova, lako održavanje i ažuriranje, te poboljšanu bezbednost. Tranzicija na *cloud* omogućava ERP sistemima da budu agilniji, efikasniji i spremni za buduće izazove.[20] Jedna od glavnih prednosti ERP sistema zasnovanih na *cloudu* jeste mogućnost da obezbede pristup podacima i analitiku u realnom vremenu. U jednoj studiji slučaja o upravljanju rizicima u lancu snabdevanja, otkriveno je da praćenje u realnom vremenu ERP sistemima zasnovanim na *cloudu* poboljšava sposobnost proaktivnog upravljanja rizicima.[21]

Otpornost snabdevanja postala je veoma važna za proizvođače. Naglašava se sposobnost lanca snabdevanja ne samo da izdrži, već i da se prilagodi i oporavi od nepovoljnih događaja, čime se osigurava kontinuirani učinak i konkurentska prednost.[22] U godini kada je izbio COVID-19, proizvođači su bili suočeni s velikim prekidama u snabdevanju i bili prinuđeni da razviju brze proizvodne odgovore. Ova kriza je otkrila potrebu za povećanjem otpornosti snabdevanja kako bi industrijske organizacije mogle efikasno da se prilagode prekidima koji mogu nastati, ublažavajući rizike povezane s neuspesima u snabdevanju. To uključuje, na primer, prikupljanje i analizu podataka

[19] M. Bradford, 6-9.

[20] Zahoor Syed *et al.* (2024) "Enhancing supply chain resilience with cloud-based ERP systems", *IRE Journals*, 8(2), 106-128

[21] Wennan Zhang *et al.*,"Digital-Twin Enabled Construction System For Supply Chain Risk Management.", 2023 IEEE 19th International Conference on Automation Science and Engineering (CASE), Auckland, New Zealand, 2023, 1-6.

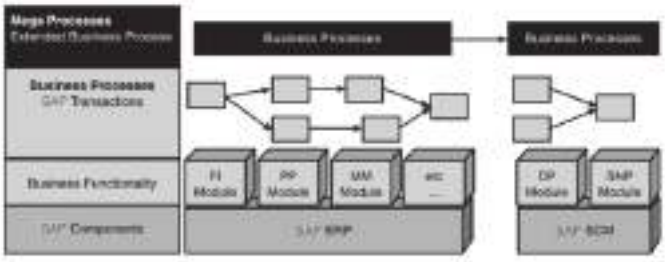
[22] Timothy J. Pettit, Keely L. Croxton, Joseph Fiksel, "The Evolution of Resilience in Supply Chain Management: A Retrospective on Ensuring Supply Chain Resilience," *Journal of Business Logistics,* br.40/2019, 56-65.

o različitim faktorima koji mogu uticati na snabdevanje, kao što su prirodne katastrofe, geopolitički događaji, kašnjenja u prevozu i rizici od dobavljača. U tu svrhu, ERP sistemi mogu prikupljati podatke u realnom vremenu iz više izvora, uključujući senzore, IoT (*Internet of Things*) uređaje i spoljne izvore podataka. Analiza ovih podataka može pružiti rane signale upozorenja i omogućiti proaktivno donošenje odluka.[23]

III SAP ERP sistem

SAP je osnovan pre skoro 40 godina u Manhajmu (Nemačka), od strane grupe bivših inženjera IBM-a. Ideja je bila da se kompanijama pomogne da zamene 10 ili 15 različitih poslovnih aplikacija - kao što su finansijski sistemi (vođenje računa o plaćanjima i potraživanjima), aplikacije za skladištenje, rešenja za planiranje proizvodnje, sistemi za održavanje postrojenja i tako dalje - sa jedinstvenim integrisanim sistemom. Ova vizija je postala stvarnost kada su *Systems, Applications and Products in Data Processing* (SAP) otvorili svoja vrata 1972. godine. Danas, SAP koristi više od milion poslovnih korisnika koji rade za više od 100.000 klijenata u preko 120 zemalja.

Važno je razumeti razlike između SAP komponenti, modula i transakcija. SAP koristi termin komponente naizmenično sa terminom poslovna aplikacija, a većinu vremena se ovaj poslednji termin skraćuje na aplikacija. S druge strane, SAP moduli pružaju specifičnu funkcionalnost unutar komponente. Finansijski modul, modul za planiranje proizvodnje i modul za upravljanje materijalima su dobri primeri koji se lako mogu objasniti. Ovi pojedinačni SAP moduli se kombinuju da bi formirali SAP ERP komponentu. Unutar određenog modula se konfigurišu i sklapaju poslovni procesi kompanije. Poslovni procesi se takođe nazivaju poslovni scenariji. Poslovni proces može zahtevati da se transakcije izvršavaju u nekoliko različitih modula, možda čak i iz nekoliko različitih komponenti[24], što je prikazano na Slici 1.



Slika 1. SAP komponente, moduli i transakcije[25]

[23] *https://www.itexchangeweb.com/blog/the-future-of-erp-systems/*, pristupljeno: 13.8.2024.
[24] George Anderson, *Sams teach yourself SAP in 24 hours,* fourth edition, Carmel, IN, USA 2011, 8-10.
[25] G. Anderson, 8-10.

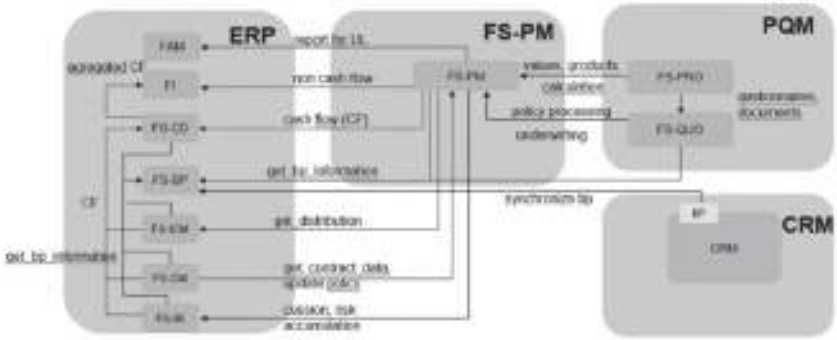
IV SAP za osiguranje

SAP za osiguranje je sveobuhvatan paket koji pokriva funkcionalnosti potrebne za podršku procesima specifičnim za osiguranje. Ovaj paket se može integrisati sa SAP i ne-SAP *front* i *back office* rešenjima, a sastoji se od različitih modula:

- FS-PRO *Product Lifecycle Management for Insurance* modul je odgovoran za modelovanje struktura proizvoda i održavanje svih aktuarskih proračuna, pravila tarifiranja i formula koje treba koristiti.
- FS-QUO - SAP *Quotation and Underwriting for Insurance* koristi se za pravljenje osiguravajućih ponuda. FS-PQM je naziv za kombinaciju FS-PRO i FS-QUO.
- FS-PM *Policy Management* komponenta se koristi za administraciju osiguravajućih polisa, od njenog početka i tokom celog životnog ciklusa polise. To je centralna komponenta SAP-a za osiguranje.
- FS-CM *Claims Management* je odgovoran za upravljanje potraživanjima od njihovog registrovanja do rešenja. Direktno je integrisan sa sistemima za plaćanje kako bi obrada potraživanja mogla biti obavljena sve do isplate klijentu.
- FS-CD *Collections & Disbursements* modul se koristi za rukovanje svim dolaznim i odlaznim uplatama osiguravajuće kompanije. Premije ili isplate odšteta se automatski prate i sve je integrisano sa bankarskim interfejsom za usklađivanje uplata.
- FS-ICM *Incentive and Comission Management* koristi se za rukovanje svim podacima o posrednicima i agentima i izračunava odgovarajuće provizije koje posrednici zarađuju.
- FS-RI *Reinsurance Management* upravlja svim procesima reosiguranja i potpuno je integrisan sa gore objašnjenim modulima osiguranja.

Svaki od modula može se kupiti i koristiti pojedinačno, iako je najbolja praksa koristiti ih zajedno kao potpuno integrisano SAP rešenje za osiguranje,[26] kao na Slici 2.

[26] *https://s4ic.com/sap-for-insurance/*, pristupljeno: 25. 8. 2024.



Slika 2. Integracija modula[27]

V Modul za upravljanje odštetama

FS-CM *Claims Management* se koristi za upravljanje odštetama, odnosno potraživanjima, od trenutka obaveštenja do ispunjenja zahteva. Glavni procesi u okviru upravljanja odštetama su:

- Obaveštenje o potraživanju – *Claim Notification*
- Obrada odštete - *Claim Handling*
- Ispunjenje odštete – *Claim Fulfillment*
- Povraćaj potraživanja – *Claim Recovery*

Modul za upravljanje polisama (FS-PM) agregira podatke relevantne za proviziju i šalje ih modulu za obračun provizija (FS-ICM). FS-ICM će pokrenuti modul za upravljanje isplatama (FS-CD) da kreira uplatu za proviziju. Isti princip važi za interfejs između FS-PM i FS-CD, gde FS-PM kreira sve novčane tokove i šalje ih u FS-CD. U slučaju da dođe do potraživanja, modul za upravljanje odštetama (FS-CM) će pozvati FS-PM da zatraži podatke o polisi, takozvani *snapshot* polise. U tom slučaju, FS-CM će pozvati ugrađenu funkcionalnost u FS-PM da prikupi relevantne podatke o osiguravajućoj polisi koji su dalje potrebni za kreiranje i obradu potraživanja. Kada se potraživanje obradi, FS-CM će pozvati FS-CD da kreira odlaznu uplatu kako bi se korisniku nadoknadila šteta koja je nastala.[28]

[27] S4IC, SAP for Insurance: how do the modules work together?, 2022, *https://www.linkedin.com/pulse/sap-insurance-how-do-modules-work-together-s4ic/*, pristupljeno: 25. 8. 2024.
[28] S4IC, SAP for Insurance: how do the modules work together?, 2022.

VI Proces kalkulacije rezervi i izvršenje plaćanja

Proces plaćanja implementiran u SAP-u za osiguravajuću kuću uključuje sledeće module:

- FS-CM *Claims Management* – sistem za upravljanje odštetama
- HCM *Human Capital Management* – sistem za upravljanje ljudskim kapitalom
- CD *Collections & Disbursements* – upravljanje naplatom i isplatama finansijskih usluga
- FICO *Financial Accounting and Controlling* – sistem za upravljanje finansijskim podacima, generisanje i analizu finansijskih izveštaja
- IA *Insurance Analyzer* – sistem za upravljanje finansijskim rizikom.

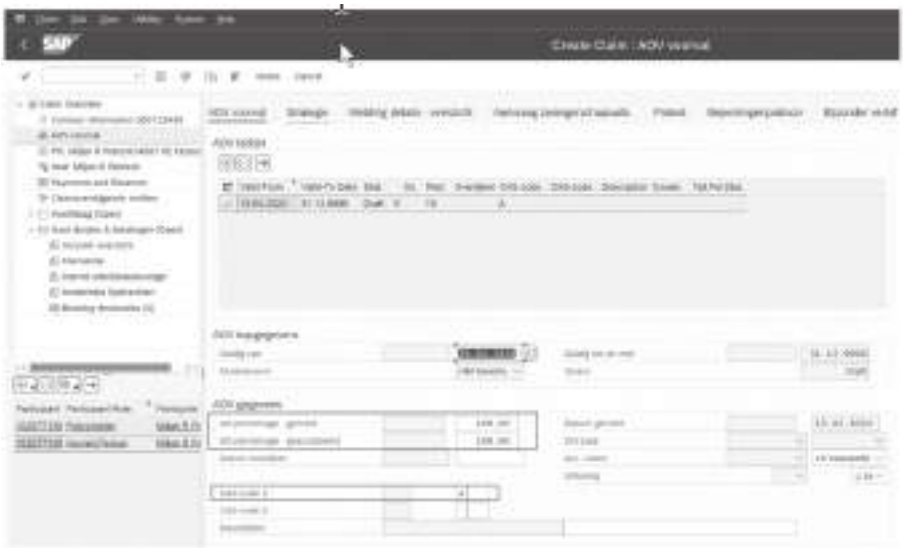
1. Kreiranje zahteva za odštetu u SAP sistemu

Proces počinje kreiranjem zahteva za odštetu (eng. *Claim*) u SAP sistemu. Transakcija ICLCDC01 je standardna transakcija u SAP-u za kreiranje odštete za osiguranje. Pored te standardne transakcije, moguće je napraviti i proizvoljne transakcije. ZICL_SZ_CDC01 je transakcija koja se koristi za kreiranje odštete na posmatranom projektu, kada je u pitanju potraživanje zbog nemogućnosti obavljanja posla. Na Slici 3 vidimo ekran za kreiranje odštete. Potrebno je da korisnik unese sistem za polise, kao i broj polise osiguranja. Obavezna polja su još i datum kada se podnosi zahtev za odštetu i datum od kog kreće potraživanje.

Za svaku odštetu se čuva vremenska linija, tj. hronološki se beleži kada je osiguranik (SAP *business partner*) po istom osnovu tražio odštetu. Potrebno je uneti procentualnu vrednost koja predstavlja stepen u kom osiguranik nije u mogućnosti da obavlja posao, kao i kod koji označava medicinski razlog za to. Na osnovu tog procenta vrši se obračun naknade. Na Slici 4 se nalazi prikaz ekrana sa vremenskom linijom i neophodnim poljima za kreiranje odštete.

Nakon što je odšteta sačuvana, ta vremenska linija mora biti odobrena od strane rukovodioca odštetnog zahteva.

Slika 3. Kreiranje zahteva za odštetu.



Slika 4. Kreiranje vremenske linije.

2. Kalkulacija rezervi za odštetu

Kreiranje rezervi u osiguravajućoj kompaniji je jedan od načina upravljanja rizikom, jer obezbeđuje da kompanija ima dovoljno sredstava za isplatu budućih obaveza prema osiguranicima. Potrebno je izvršiti obračun rezervi za neplaćene štete, kao i za buduće štete. Za ovo se koriste kompleksni matematički i statistički modeli.

Aktuarska rezerva se sastoji od sledećih rezervi:

- Rezerva za obaveze po osnovu potraživanja, koja se takođe naziva i rezerva za štete ili rezerva za neplaćene štete;
- Rezerva za premijske obaveze;
- i rezerva za druge obaveze[29]

Na našem primeru, za obračun rezervi koristi se program implementiran za potrebe konkretnog projekta, odnosno ne koristi se unapred predefinisan program SAP paketa. Programima se u SAP-u pristupa preko transakcije SE38. Za željeni program potrebno je uneti odgovarajuće parametre, npr. broj zahteva za potraživanje, a potom se program izvršava.

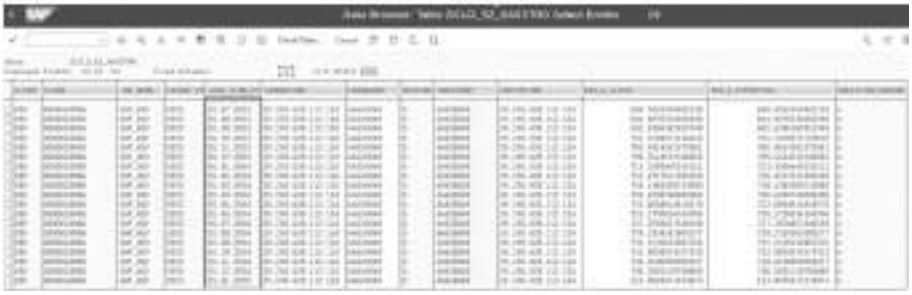
Rezultat izvršenja programa za obračun rezervi su rezerve sačuvane u korisničkoj tabeli ZICLD_SZ_KASSTRO, i na Slici 5 možemo videti strukturu tabele. Beleže se sve potrebne informacije: broj odštete, *timestamp* obračuna, polja RES_G_CLAIM i RES_G_EXPERTISE predstavljaju iznose.

Za odštetu sa brojem QS00624006 u tabeli na Slici 6 vidimo pregled novčanih rezervi po mesecima, za sve godine kada osiguranik ima pokriće.

U primeru koji ćemo dalje posmatrati nije izvršena kalkulacija rezervi, tako da će proces krenuti sa iznosom rezervi 0 EUR.

[29] *https://www.axxima.ca/blog/actuaries-and-annual-reserving-work-what-you-need-to-know/*, pristupljeno: 30. 8. 2024.

Slika 5. Struktura tabele za rezerve.



Slika 6. Primer rezervi

3. Kreiranje plaćanja u SAP sistemu

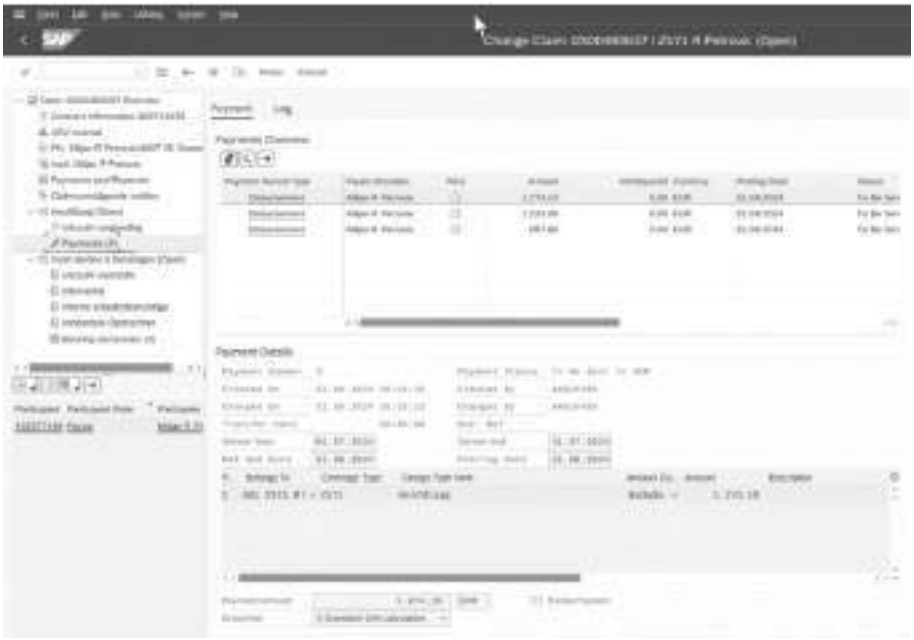
Na zahtevu za odštetu koji ima odobrenu vremensku liniju, moguće je izvršiti obračun naknade po zahtevu, i potom izvršiti plaćanje. Kada je vremenska linija odobrena, na zahtevu se prvo pojavljuje dugme za obračun naknade, a nakon što je naknada obračunata, umesto njega dugme za obavljanje plaćanja. U pozadini se pozivaju kompleksni funkcionalni moduli za finansijske obračune. Kao rezultat, imamo izmene na vremenskoj liniji i novi čvor za plaćanja, u stablu za navigaciju, prikazane na Slici 7.

Slika 7. Obračun naknade i kreiranje plaćanja.

Na ekranu za plaćanja vodi se evidencija o svim plaćanjima na odšteti: koji je tip plaćanja (isplata ili refundacija), koji je iznos, u kojoj valuti se vrši isplata ili refundacija, kao i njen trenutni status. Na osnovu statusa refundacije prati se da li je još uvek u sistemu za odštete, kada je poslata u sistem za obračune, kada je poslata u sistem za plaćanja. Još jedan bitan podatak koji se ovde beleži je i broj dokumenta. Taj dokument sadrži listing plaćanja po bankovnim računima, na strani sistema za finansije i kontrolu (FICO). Na zahtevu za odštetu prikazanom na Slici 8 postoje plaćanja za tri meseca.

U SAP sistemu kreirana je korisnička tabela ZCM_RESERVE u kojoj se mogu pratiti sve promene u plaćanjima i rezervama na nekom zahtevu za odštetu (Slika 9). Ova tabela nije standardna tabela u SAP sistemu, već je napravljena za potrebe osiguravajuće kuće, kako bi se pratili svi relevantni podaci prilikom plaćanja, a koji nisu dostupni u standardnoj SAP tabeli. U toj tabeli su detaljnije prikazane sume i kretanje toka novca. Neki od bitnih podataka koji se beleže u ovoj tabeli su:

1. *Reserve type* – različiti tipovi rezervi se šalju u različite sisteme za obradu
2. *Reserve lot* – broj serije za obradu
3. *Document ref* - broj dokumenta u sistemu za plaćanja
4. *Change Reason* - postoje različiti razlozi izmene sume: plaćanje, usklađivanje iznosa, različite vrste izmena u zavisnosti od tipa refundacije i drugi.
5. Poslednje tri kolone odnose se na konkretne iznose: prva kolona predstavlja izmenu u plaćanju, druga kolona predstavlja izmenu u nivou rezervi, i poslednja kolona predstavlja bilans rezervi.



Slika 8. Ekran za plaćanja.

Slika 9. Tabela ZCM_RESERVE.

Za tri plaćanja koja su izvršena ukupna suma je 3.164,70 EUR. Na primeru ove odštete nije izvršen obračun rezervi, pa je stanje rezervi jednako nuli. S obzirom na to da je prvobitno stanje rezervi 0 EUR, potrebno je povećati rezerve kako bi bilo moguće izvršiti plaćanje. Prvi red u tabeli, sa razlogom za izmenu '00' predstavlja usklađivanje rezervi, na iznos koji je potreban za isplatu. Drugi red u tabeli je isplata te sume, i smanjenje rezervi na nulu.

4. Okidači u SAP-u

Transakcija IMP_MANAGER pokreće program za upravljanje okidačima. Koristi se za manipulaciju transportnim objektima, gde se objekti kreiraju i na njima vrše

izmene u jednom okruženju (npr. na sistemu za testiranje odšteta) i zatim prenose u drugo okruženje (npr. u sistem za upravljanje finansijama). Okidači predstavljaju neke automatske akcije prilikom transporta ovih objekata iz jednog okruženja u drugo. Grupisani su u aplikacione klase, prema funkcionalostima. Nakon što su okidači kreirani, potrebno je odrediti objekte, na primer biznis partner ili odšteta na koju se odnose, a potom se okidači i izvrše.

Prilikom kreiranja zahteva za odštetu i plaćanja, kreira se i nekoliko okidača:

- 0HIRE okidač - vezan je za osiguranika, i prilikom obrade u sistemu za plaćanja osiguranik dobija jedistven broj na osnovu ovog okidača
- ZRECI - okidač za oporavak osiguranog lica
- ZREILL - okidač za zdravstveni problem osiguranog lica
- 10015 - po jedan okidač se kreira za svaki mesec plaćanja, u ovom slučaju to su tri okidača

Ova tri okidača za plaćanja će nastati tek nakon što se plaćanja iz sistema za odštete pošalju u sistem za plaćanja, korišćenjem posebnog programa. U SAP sistemu pristup programima se vrši preko transakcije SE38. Pomenuti okidači ne prave nikakve promene u sistemu za odštete, ali su neophodni za obradu odštete u sistemu za plaćanja. Na Slici 10 prikazani su okidači za odštetu koja se obrađuje u ovom primeru.

Slika 10. Okidači za odštetu QS480637.

5. Obračun neto isplate

HCM (*Human Capital Management*) - upravljanje ljudskim kapitalom, odnosi se na skup aplikacija koje se koriste za regrutovanje, upravljanje i razvoj radne snage jedne organizacije. Ovaj softver se odnosi na sisteme koji doprinose optimizaciji procesa, i često se i naziva sistemom za upravljanje ljudskim resursima (HRMS - *Human Resource Management System*).

Neke od funkcionalnosti su:

- upravljanje iskustvom zaposlenih
- obračun plata

• analiza ljudskih resursa i planiranje radne snage.[30]

Iz ove navedene definicije, kao i funkcionalnosti, može se videti da HCM nije deo standardnog SAP paketa za osiguranje. Nije čest slučaj da je HCM modul implementiran u osiguravajućoj kući. Međutim, za potrebe osiguranja i konkretnog projekta, ovaj sistem je implementiran tako da se ne bavi samo upravljanjem ljudskim resursima. U procesu plaćanja, HCM se koristi za obračun neto iznosa za isplatu.

Okidače koji su kreirani u prethodnom koraku procesa HCM izvršava, pri čemu se za svakog osiguranika (SAP *business partner*) kreira ID (indentifikacioni broj) u tom sistemu. Rezultat programa izvršenih u ovom sistemu je neto specifikacija plaćanja, koja se šalje sistemu za upravljanje odštetama. Za svaki mesec se isplate obrađuju pojedinačno. Na slici 11 nalazi se neto obračun za mesec jun. Slično izgledaju i obračuni za maj i jul.

Iz HCM sistema se ovaj obračun dalje šalje u CD sistem koji je zadužen za obavljanje isplata.

Slika 11. Neto obračun za mesec jun.

VII Kreiranje refundacije u SAP-u

U sistemu za upravljanje odštetama refundacija nastaje kada dođe do promene procenta koji označava u kojoj meri osoba nije u mogućnosti da obavlja svoj posao. Na primeru koji posmatramo, krenuli smo sa 100%. Ukoliko taj proce-

[30] *https://www.sap.com/westbalkans/about/what-is-sap.html,* pristupljeno: 30. 8. 2024.

nat smanjimo na, na primer 0%, odnosno osiguranik je opet sposoban da obavlja svoj posao, potrebno je izvršiti refundaciju za period za koji je procenat izmenjen. U prikazanom primeru, procenat je promenjen na nulu od 15.06.2024., tako da se kreiraju refundacije za dva meseca: jun i jul. Plaćanja nisu postojala u avgustu, tako da za taj mesec nema ni refundacije. Nova vremenska linija prikazana je na Slici 12.

Slika 12. Vremenska linija nakon izmene.

Ekran za plaćanja na Slici 13 sada prikazuje dva nova reda za refundacije sa statusom Parkirano (*Parked*).

Slika 13. Refundacije na ekranu za plaćanja.

1. Procesiranje refundacije

Kreiranjem refundacije pojavljuje se zadatak koji treba da obavi rukovodilac za obradu štete, koji se može videti na Slici 14.

Slika 14. Zadaci u SAP-u.

Koncept zadataka (*tasks*) u SAP-u je vrlo jednostavan i predstavlja isto što i u svakodnevnom životu: zahtev da osoba izvrši neku akciju. Mogu biti automatski kreirani, kao zadatak u ovom primeru, ali i manuelno. Zadatak ZSV180 treba da ispuni rukovodilac odštete. Kada klikne na *process step* biće preusmeren na ekran za refundacije, na kom treba da nastavi proces refundacije. U zavisnosti od izbora tipa refundacije, menjaju se i polja na ekranu, s obzirom na to da su za različite tipove refundacije potrebni različiti podaci. Dalji proces obrade teče isto.

Tipovi refundacije su:

1. Maksimalni obračun – vrši se refundacija celokupnog iznosa
2. Obračun sa iznosom otplate – obračun refundacije na rate
3. Direktna refundacija – refundacija celokupnog neto iznosa
4. Oslobađanje od plaćanja – osiguranik može biti oslobođen vraćanja dela iznosa ili celokupnog iznosa.

Na ovom primeru refundacija će biti procesirana kao direktna refundacija. Odabirom opcije 3 za direktnu refundaciju, ekran izgleda kao na Slici 15.

Slika 15. Direktna refundacija

Klikom na dugme *Berreken Netto bedrag (*izračunaj neto iznos) popunjava se polje *Netto vordering naar CD* (neto potraživanje prema CD-u). Čuvanjem promena i odobrenjem ovog iznosa od strane rukovodioca odštetnog zahteva kreira se nova refundacija na ekranu za plaćanja, sa statusom *Requested* (Zahtevano) – Slika 16.

Tabela ZCM_RESERVE se ažurira novim redovima za svaku od ovih izmena. Prilikom promene procenta, došlo je do kreiranja dve refundacije na ekranu za plaćanja sa statusom *Parked* (parkirano). One su u tabeli ZCM_RESERVE objedinjene u jedan red sa razlogom za promenu ZT. Procesiranjem refundacije kreira se novi red sa razlogom za izmenu ZX. Ažurirana tabela se nalazi za Slici 17.

Kao što je pomenuto u poglavlju 5.3 Kreiranje plaćanja u SAP sistemu, postoje različiti tipovi rezervi. U ovoj tabeli vidimo tipove S6 i SA. Tip rezervi S6 šalje se u sistem FICO – *Financial Accounting and Controlling*, dok se tip rezervi SA šalje u sistem IA – *Insurance Analyzer*.

Slika 16. Direktna refundacija na ekranu za plaćanja

Slika 17. ZCM_RESERVE tabela nakon refundacije

Redovi u tabeli sa razlogom za promenu 00 i 03 su obrađeni od strane sistema za upravljanje ljudskim kapitalom (HCM) i poslati u sistem za isplate (CD), kao i u sistem za finansijsko računovodstvo i kontrolu (FICO). Za ta dva reda se mogu i videti vrednosti polja *RESERVELOT* i *DOCUMENTREF*. Za nove redove koji su kreirani u procesu refundacije, slanje se obavlja manuelno.

2. Slanje refundacije u FICO

SAP FICO (Finansijsko računovodstvo i kontrola) je integralni modul unutar SAP ERP paketa koji omogućava organizacijama da efikasno upravljaju svojim finansijama i donose informisane odluke. SAP FICO igra ključnu ulogu u pomaganju preduzećima da racionalizuju svoje finansijske procese, steknu uvide i osiguraju usklađenost. Sastoji od dva osnovna modula – Finansijsko računovodstvo (FI) i Kontrola (CO). SAP FI se fokusira na računovodstvo i finansijsko izveštavanje, dok se SAP CO modul fokusira na praćenje troškova.

a) Finansijsko računovodstvo (SAP FI)

SAP finansijski modul je posvećen generisanju i upravljanju finansijskim izveštajima i izveštajima. SAP FI modul ima nekoliko pod-modula:

- *General Ledger* - Glavna knjiga: Modul glavne knjige deluje kao centralna komponenta za finansijsko izveštavanje. Integriše različite računovodstvene transakcije koje se evidentiraju u pod-modulima i pruža sveobuhvatan pregled finansijskog stanja organizacije u okviru kontnog plana[31].

Transformacija glavne knjige u velikim kompanijama fokusira se na standardizaciju upotrebe kodnih blokova u ERP FI – GL modulu koji koriste. Ova transformacija omogućava korišćenje većine dostupnih kodnih blokova u ERP modulu, što rezultira proizvodnjom finansijskih izveštaja prema različitim kriterijumima, kao što su profitni centri, proizvodi ili računi[32].

- *Accounts Payable* - Obaveze prema dobavljačima: Modul obaveza prema dobavljačima se bavi upravljanjem fakturama, plaćanjima, automatskim programom plaćanja, izveštajima i drugim transakcijama sa dobavljačima.
- *Accounts Receivable* - Potraživanja: SAP FICO upravlja celokupnim procesom potraživanja, od kreiranja faktura do prijema plaćanja. Modul potraživanja upravlja računima i transakcijama sa kupcima, uključujući fakture, kreditne memorandume, izveštaje o kupcima i slično.
- *Asset Accounting* - Računovodstvo imovine: SAP modul za računovodstvo imovine omogućava organizacijama da upravljaju svojim osnovnim sredstvima, uključujući zemljište, opremu i nekretnine. Ovaj modul sadrži transakcije vezane za penzionisanje, amortizaciju, revalorizaciju i slično.
- *Bank Ledger* - Bankovna knjiga: Modul bankovne knjige obuhvata transakcije povezane sa podacima o bankovnim računima kompanije. Ovaj

[31] *https://webtel.in/Blog/SAP-FICO-Module-and-Sub-Modules/1343*, pristupljeno: 3. 9. 2024.
[32] Bhuvnesh Kumar, "Impact and Need for Financial Transformation in the Insurance Industry Using ERP", *Journal of Enterprise Resource Planning Studies*, 2018/2018, 2.

modul usklađuje transakcije iz bankovnih izveštaja sa transakcijama u pod-modulima SAP-a.

b) Finansijska kontrola (SAP CO)

SAP modul za kontrolu fokusira se na praćenje i izveštavanje o troškovima poslovnih operacija. SAP-CO modul ima nekoliko pod-modula koji su opisani u nastavku:

- Računovodstvo elemenata troškova: prati troškove i prihode povezane sa različitim poslovnim aktivnostima, pružajući detaljan uvid u strukture troškova i omogućavajući kontrolu troškova.
- Računovodstvo centara troškova omogućava organizacijama da alociraju troškove na specifične centre troškova, pomažući u praćenju i optimizaciji troškova odeljenja.
- Računovodstvo profitnih centara: omogućava preduzećima da analiziraju profite i gubitke na nivou pojedinačnih poslovnih jedinica ili profitnih centara, pružajući granularni pregled finansijskog učinka.
- Interni nalozi: olakšava praćenje i upravljanje internim projektima, osiguravajući da su troškovi pod kontrolom i da se resursi efikasno koriste[33].

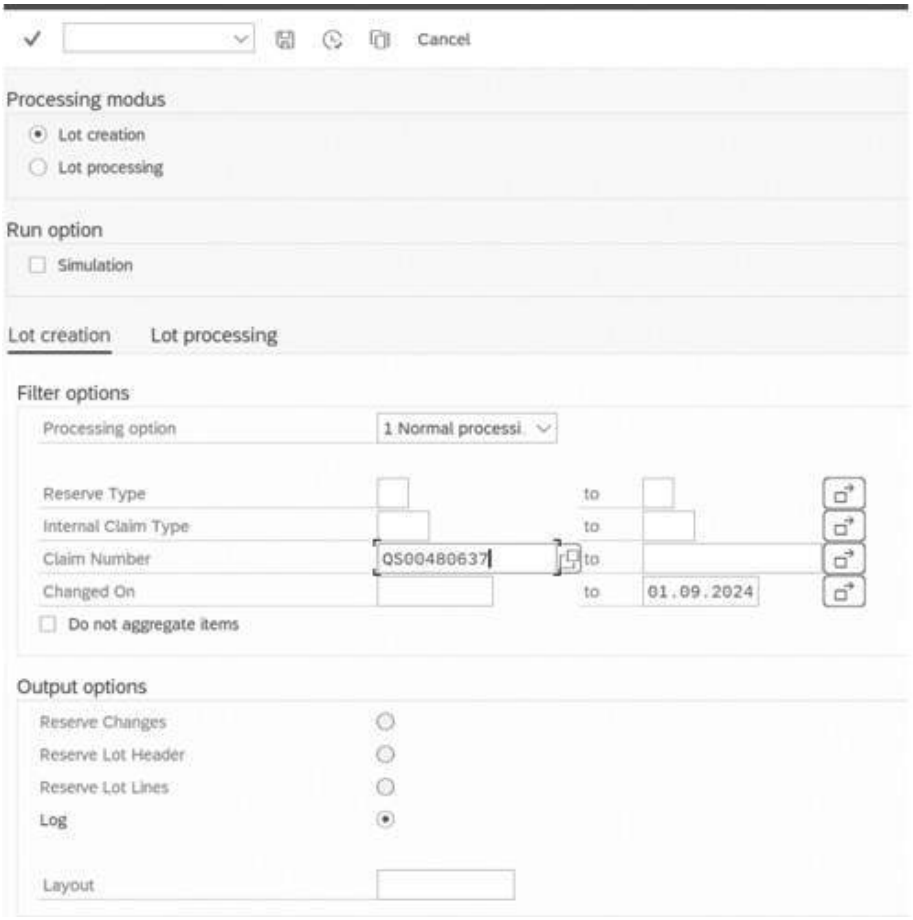
Plaćanja se iz sistema za upravljanje odštetama šalju u FICO u dva koraka:

1. Kreiranje serije – *lot creation*
2. Slanje serije u FICO – *lot processing*

c) Kreiranje serije

Kreiranje serije za plaćanje (*payment lot*) obavlja se preko transakcije ZFCD_CM_RESERVE. U okviru iste transakcije se nalazi i program za slanje serije u FICO. Na prvom ekranu je kreiranje serije, i sve što je potrebno uneti je broj odštete i izvršiti – Slika 18.

[33] *https://webtel.in/Blog/SAP-FICO-Module-and-Sub-Modules/1343*, pristupljeno: 3. 9. 2024.

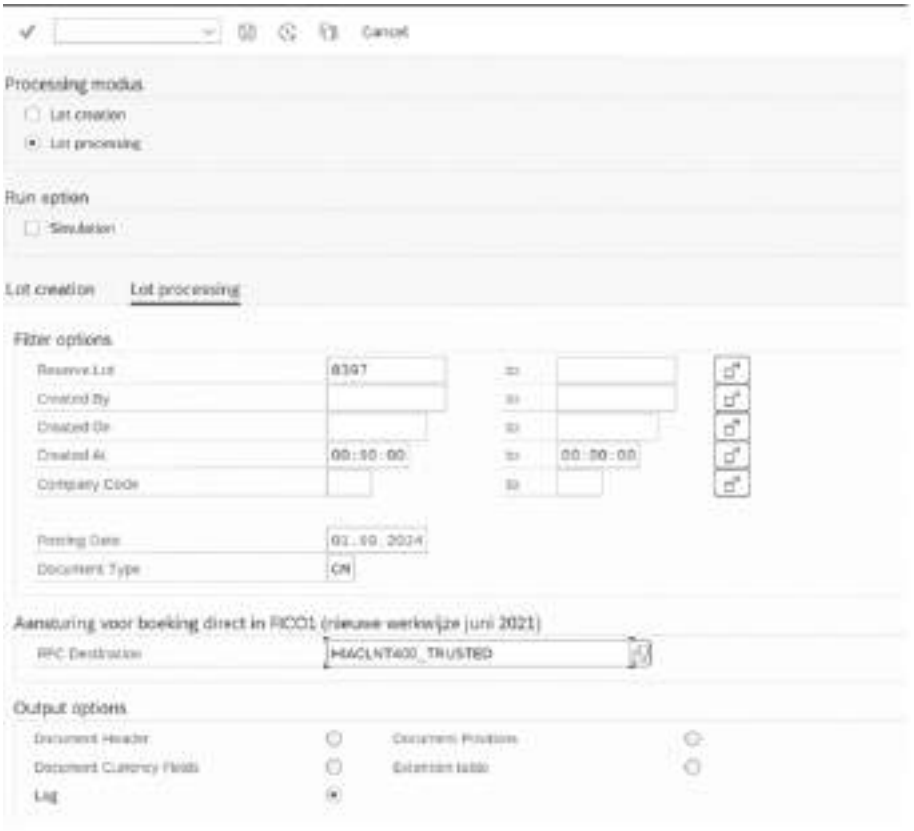


Slika 18. Kreiranje serije.

d) Slanje serije u FICO

Slanje serije u FICO se obavlja istom transakcijom kojom se serija i kreira. *Lot processing* ekran se nalazi odmah pored ekrana za kreiranje serije. Podaci koje je potrebno uneti su broj serije i FICO pod-sistem u koji se šalje serija. Na Slici 19 uneseni su broj serije koja je kreirana u prethodnom koraku, i sistem koji je krajnja destinacija: HIACLNT400_TRUSTED.

Kao rezultat ovog procesa dobija se novi dokument i njegov broj u FICO sistemu – Slika 20.



Slika 19. Slanje serije u FICO

Slika 20. Kreiranje FICO dokumenta

e) Rezultat transporta u FICO

Tabela ZCM_RESERVE se automatski ažurira ovim procesom: za unose koji se odnose na refundaciju sada postoje vrednosti za RESERVELOT i DOCUMENTREF polja, što je prikazano za Slici 21. Kao što je već rečeno, samo redovi sa tipom rezervi S6 se šalju u FICO.

Slika 21. Ažurirana ZCM_RESERVE tabela nakon slanja u FICO.

Kao krajnja destinacija (*RFC destination*) za ovu seriju naveden je sistem: HIACLNT400_TRUSTED. Kada se korisnik uloguje na HIA sistem sa klijentom 400, može pristupiti ovom dokumentu. Dokumentima se pristupa putem transakcije FB03, gde je potrebno uneti broj dokumenta, u ovom slučaju: 2600000904. Na Slici 22 nalazi se dokument koji pruža detaljan prikaz o iznosu novčanih sredstava i računima na koje su oni uplaćeni.

Slika 22. FICO dokument 1.

3. Slanje refundacije u IA

SAP *Insurance Analyzer* i dodatne komponente SAP FRDP (*Financial Risk and Data Platform*) predstavljaju najnaprednije aplikacije za finansijsko i upravljanje rizicima osiguravajućih kompanija kako bi implementirali relevantne IFRS4/9/17 i Solvency propise. SAP *Insurance Analyzer* se sastoji od komponenti *Accounting for Insurance Contracts* (Računovodstvo za osiguravajuće ugovore) i SAP *Solvency Management for Insurance* (Upravljanje solventnošću za osiguranje)[34].

Transport u IA nije manuelni proces, već se obavlja preko zakazanog *Job*-a u SAP-u. *Job* predstavlja posao koji se u SAP-u obavlja pozadinski, u neko zakazano vreme. Poslovi i koraci posla omogućavaju da se složeni zadaci tretiraju kao jedinice.

[34] *http://www.gwantec.de/en/services-sap-en/sap-insurance-analyzer,* pristupljeno: 30. 9. 2024.

Može se zakazati nekoliko programa potrebnih za završetak određenog zadatka, kao korake u okviru jednog posla, sa prednošću da posao bude jedan logički kontejner za sve korake potrebne za završetak zadatka.

Koraci posla rade delimično nezavisno od statusa jedan drugog. To jest, nenormalni prekid jednog koraka posla ne vraća rad prethodno završenog koraka posla unazad ako je taj prethodni korak izvršio *commit*. Ako bilo koji korak posla ne uspe, međutim, onda ceo posao ne uspeva. Nikakvi dalji koraci posla se ne izvršavaju i status posla se menja u *canceled* [35].

Na primeru koji posmatramo, *Job* je zakazan da se izvršava svakodnevno u 18 časova. Po završetku, podaci su dostupni u IA za dalju obradu, a u sistemu za upravljanje odštetama može se videti PUBSUB_ID vrednost u ZCM_RESERVE tabeli. Kao što je već navedeno, ako je *reserve type* S6, podaci se šalju u FICO. Tip SA se šalje u *Insurance Analyzer*, i zato na slici 23 PUBSUB_ID ima vrednost 0 za *reserve type* S6, a vrednost 202408311005141 za tip SA.

Slika 23. Ažurirana tabela ZCM_RESERVE nakon transporta u IA.

4. Slanje refundacije u CD

Još jedan sistem koji je deo ovog složenog procesa je CD *Collections and Disbursements*. Nakon što je isplata kreirana na strani sistema za odštetu, dalji obračun neto isplate se odvija u HCM sistemu, koji direktno komunicira sa CD sistemom i šalje mu isplatu na dalju obradu i izvršenje. Kada je u pitanju refundacija, ona se direktno šalje iz sistema za upravljanje odštetama u sistem za isplate (CD).

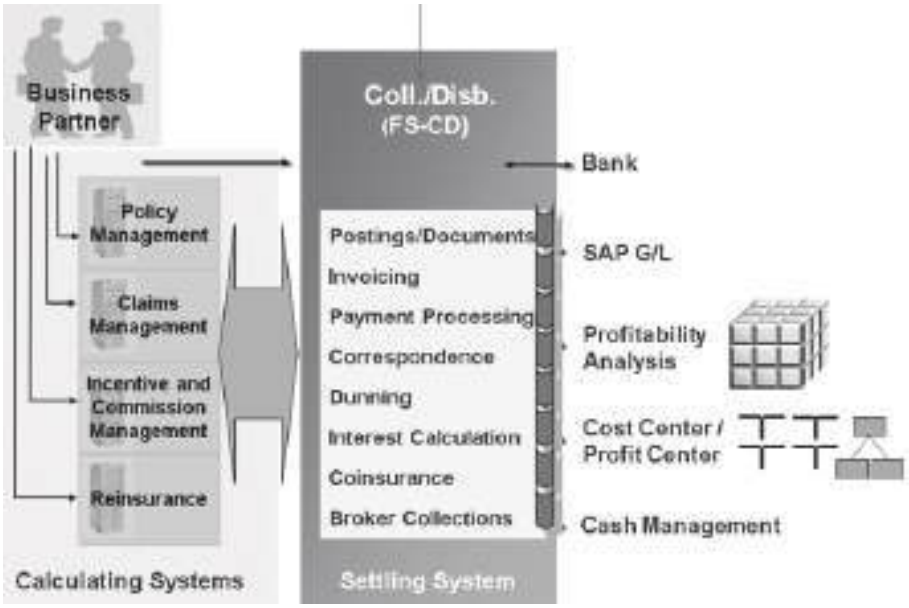
Kolekcije i isplate su u centru operacija, a većina nasleđenih sistema (*Legacy systems*) jednostavno nema funkcionalnost za stvaranje besprekornih interakcija koje današnji kupci zahtevaju. SAP *Collections and Disbursements* (FS-CD) je osnovni operativni deo koji pruža robusnu funkcionalnost za upravljanje naplatom, kolekcijama, upravljanjem plaćanjem i komisijama agenata/brokera[36].

Kao sistem za obračunavanje, CD mora biti opremljen neophodnim podacima o obračunu od administrativnih sistema kao što su Upravljanje podsticajima i komisijama (FS-ICM), Upravljanje odštetama (FS-CM), Upravljanje reosiguranjem

[35] *https://help.sap.com/doc/saphelp_nw73ehp1/7.31.19/en-US/4b/2bc12b4c594ba2e10000000a42189c/content.htm?no_cache=true,* pristupljeno: 30. 9. 2024.

[36] *https://www.msg-global.com/solutions/sap-fscd-collections-and-disbursements,* pristupljeno: 2. 9. 2024.

(FS-RI) i Upravljanje polisama (FS-PM). Za tu svrhu je dostupan otvoreni interfejs[37]. Slika 24 pokazuje poziciju CD kao sistema za obračunavanje u mogućem sistemskom okruženju.



Slika 24. Integracija CD-a sa ostalim sistemima[38].

Komunikacija između sistema za upravljanje odštetama i CD-a odvija se u dva koraka:

1. Kreiranje plaćanja i slanje u CD – *payment lot*
2. Slanje *info container*-a od CD-a do CM-a.

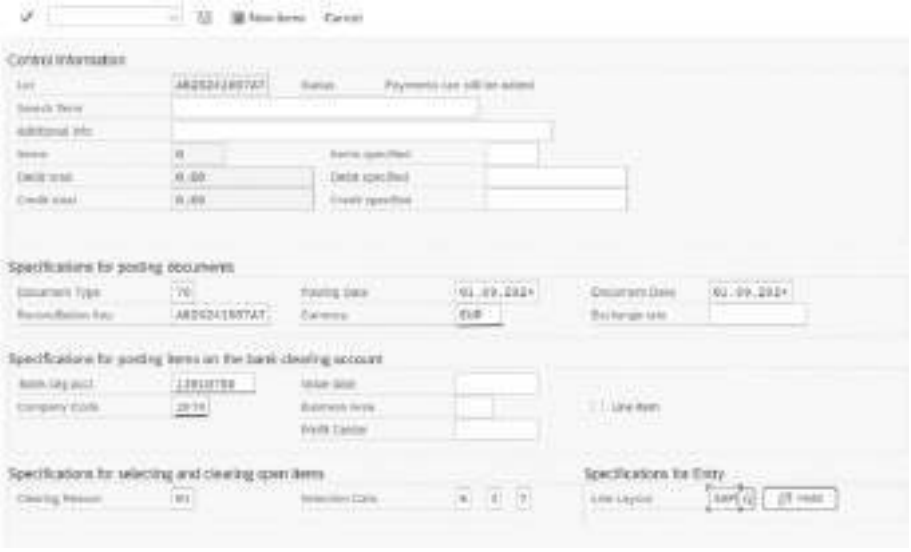
a) Kreiranje plaćanja i slanje u CD

U sistemu za upravljanje odštetama tranksakcija FP05 se koristi za kreiranje serije za plaćanje i slanje te serije u sistem za isplate (FS-CD). Ekran za kreiranje nove serije za isplatu je veoma jednostavan, potrebno je samo uneti neki jedinstven ID broj i kliknuti na dugme za kreiranje. Dva važna dugmića su *close* i *post*. U seriji se

[37] *https://help.sap.com/docs/SAP_ERP/531a600f03624826bdcd98f6f723ef1b/c174cb53f0f67314e-10000000a174cb4.html,* pristupljeno: 2. 9. 2024.
[38] *https://help.sap.com/docs/SAP_ERP/531a600f03624826bdcd98f6f723ef1b/c174cb53f0f67314e-10000000a174cb4.html,* pristupljeno: 2. 9. 2024.

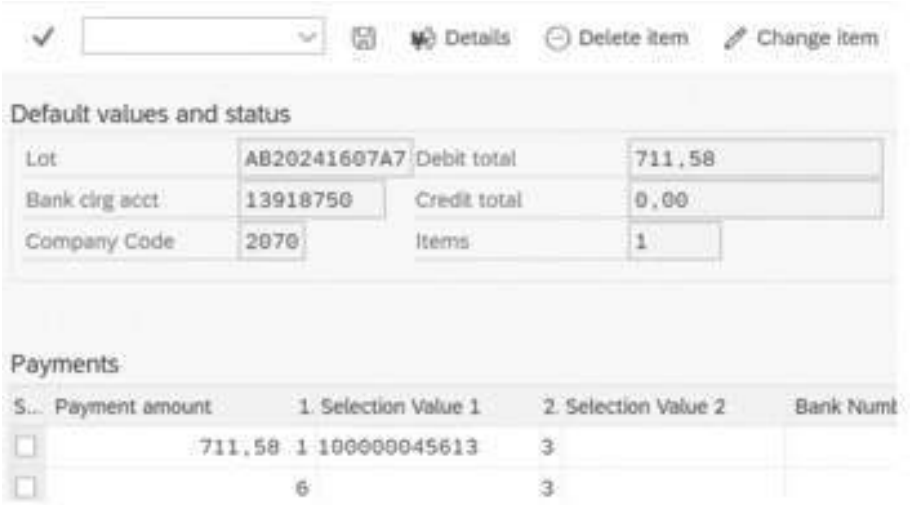
može naći više isplata i sve dok je korisnik ne zatvori, moguće je dodati nove. Klikom na dugme *close* serija je zatvorena za nove isplate, a klikom na dugme *post* je poslata u CD.

Pre nego što se zatvori i pošalje, u seriju treba dodati plaćanja. Na Slici 25 nalazi se nova serija za isplate. Neka polja su automatski popunjena na osnovu konfiguracije sistema, a neka mora popuniti korisnik. *Currency, Bank clearing account* i *Company code* su polja koja unosi korisnik, a klikom na dutme *New items* prelazi se na ekran za dodavanje isplata.



Slika 25. Kreiranje nove serije za isplate za CD.

Za dodavanje isplate potrebno je uneti iznos i broj dokumenta koji je vezan za tu isplatu na ekranu za plaćanja u FS-CM sistemu (Slika 26). Moguće je izvršiti celu isplatu odjednom, a moguće je i podeliti sumu na više delova u okviru jedne serije, ili čak poslati u različitim serijama za isplatu. Nakon zatvaranja serije dugmetom *close*, serija može biti poslata u FS-CD dugmetom *post*.



Slika 26. Dodavanje plaćanja u seriju.

b) Slanje info container-a od CD-a do CM-a

Sa strane sistema za upravljanje odštetama šalje se zahtev FS-CD sistemu da pošalje takozvani *info container*. Funkcionalnost kontejnera informacija u CD svetu je ključan poslovni proces u SAP osiguranju gde kontejneri informacija čuvaju podatke koje možete poslati spoljnim sistemima u kasnijem trenutku. Ovo je veoma dobra funkcionalnost koju pruža SAP za interakciju sa spoljnim sistemima bez potrebe za puno kodiranja. Aktivnosti koje su deo ovog procesa su:

- Tip informacije (Kategorija)
- Potvrda
- Čuvanje potvrde u kontejner informacija
- Prosleđivanje i čitanje potvrda
- Prikaz kontejnera informacija[39]

Transakcija za kreiranje kontejnera informacija je FPINFCO1. Potrebno je uneti ID koji čine datum i neki identifikacioni broj od 6 karaktera, kao i *Contract* – broj odštete. Postoje i dodatna tehnička podešavanja na drugom ekranu, kao i ekran za pregled izvršenih programa – *Logs*. Nakon što su uneseni parametri sačuvani, može se kliknuti na dugme *Schedule Program Run* i program se može izvršiti ili odmah, ili zakazati za neko buduće vreme.

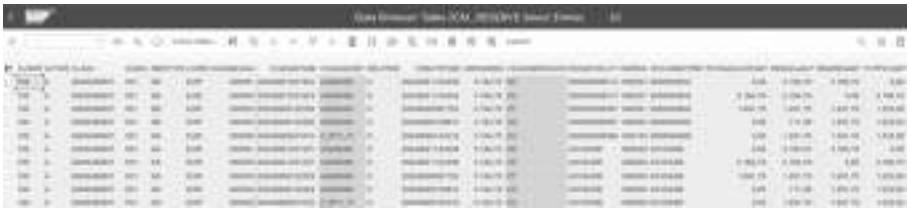
[39] *https://community.sap.com/t5/sap-for-insurance-blogs/sap-fscd-information-container-functionality/ba-p/13146814,* pristupljeno: 2. 9. 2024.

Nekoliko stvari se dešava kao rezultat ovog procesa:

1. Refundacija na ekranu za plaćanja menja status iz Zahtevano (*Requested*) u Primljeno (*Received*) (Slika 27),

Slika 27. Promena statusa refundacije u Primljeno.

2. Tabela ZCM_RESERVE je ažurirana i dodat je novi red sa razlogom za izmenu ZU (Slika 28),



Slika 28. Ažuriranje tabele ZCM_RESERVE nakon primljene refundacije.

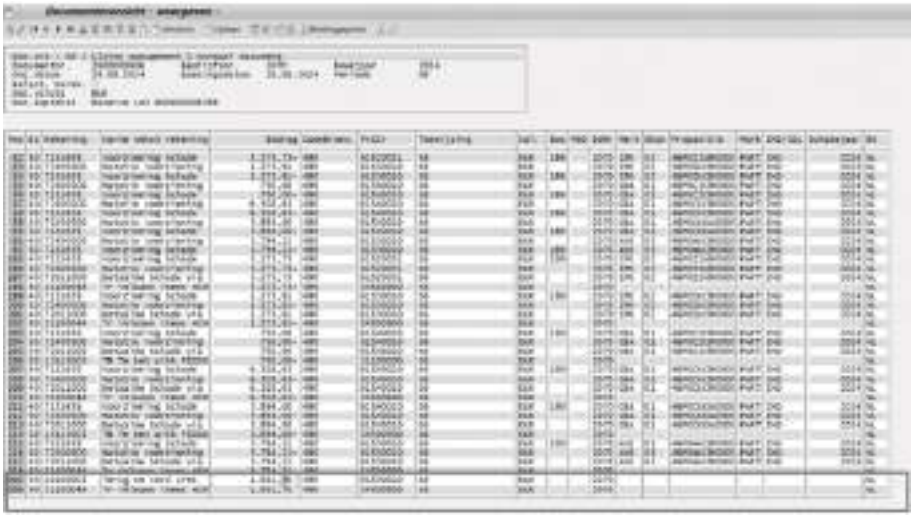
3. Od FS-CD sistema FS-CM sistemu je poslat XML fajl (Slika 29).

Slika 29. XML fajl.

5. Nova obrada refundacije u FICO, IA i HCM

Kako bi se proces priveo kraju, potrebno je poslati i poslednju izmenu u tabeli ZCM_RESERVE u FICO i IA, odnosno poslati red u tabeli sa razlogom za izmenu ZU. Ponovljen je proces kreiranja serije i transport serije u FICO. *Job* koji se automatski završava je obavio transport u IA. Na FICO strani kreiran je novi dokument, prikazan na Slici 30. Poslednja dva reda dokumenta odnose se na refundaciju obrađenu u ovom primeru.

HCM sistem ponovo pokreće okidače za *business partnera*, i ponovo se obračunava neto iznos isplate za tri meseca u kojima postoje plaćanja. Na kraju procesa, HCM šalje pismo sa neto specifikacijom osiguranom licu (Slika 31).



Slika 30. FICO document 2.

Slika 31. Pismo neto specifikacije za osiguranika.

Na sistemu za odštetu takođe se vidi da je proces u potpunosti završen (Slika 32). Refundacija na ekranu za plaćanja menja status u Izvršeno (*Completed*).

Slika 32. Promena statusa refundacije u Izvršeno.

VIII Zaključak

Analiza procesa isplata u SAP ERP sistemu jasno pokazuje značaj ERP sistema u modernim poslovnim okruženjima. SAP ERP sistem je u mogućnosti da pruži organizacijama potpunu integraciju svih sistema neophodnih da se izvrše kompleksni procesi. U ovom radu je prikazan samo jedan primer takvog procesa, u koji je uključeno pet sistema. Proces je podržan u celini sa visokim stepenom automatizacije i prikazano rešenje olakšava zaposlenima izvršavanje svakodnevnih operacija.

Na ovom primeru prikazana je efikasnost SAP-a kao ERP sistema i kao rešenja za kompanije koje traže način da poboljšaju svoju poziciju na tržištu. Za kompanije je vrlo značajno da proces isplata bude centralizovan proces, kako bi se obezbedila bolja kontrola i praćenje troškova.

U budućnosti, dalji razvoj SAP sistema prati napredne tehnologije kao što su veštačka inteligencija i mašinsko učenje, što može unaprediti brojne procese, i daje prostor SAP-u da kontinuirano pruža organizacijama kvalitetno rešenje za upravljanje organizacijom.

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IMPLEMENTATION OF RESERVE AND PAYMENT CALCULATION SYSTEM IN CLAIMS MANAGEMENT WITHIN THE SAP ERP SYSTEM

ORIGINAL SCIENTIFIC PAPER

Summary

This paper presents the implementation of an SAP solution in the insurance sector. It begins with an overview of ERP systems and SAP, with a focus on the FS-CM Claims Management module. The aim of the paper is to introduce an information system for the complex process of claims payments, which is one of the key processes in an insurance company. The implementation encounters numerous challenges: how to automate the entire process and how to integrate all the systems involved. It is necessary to follow the process from the creation of a claim request, through payment calculation and claim processing, to the final payment to the policyholder. The presented solution involves the integration of multiple SAP modules and systems to enable the process, as well as the use of some SAP modules in a different way than their standard application. As an ERP system, SAP has the capability to provide such integration of the entire process from start to finish.

Keywords: *SAP, ERP systems, FS-CM Claims Management, claims management*

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I. Introduction

Every business system can be described through a specific structure and a set of business processes executed within that structure. If these processes are to be automated, it is necessary to develop appropriate information systems that ensure each business process, or its individual activities, is automated to the greatest possible extent.[4] Although information systems create many exciting opportunities for enterprises, they also represent a source of new problems, questions, and challenges for managers. Large software and hardware systems still fail despite rapid advances in information technology.[5]

Increasing efficiency, optimizing costs, and managing resources represent the primary tasks of management. Only those business systems that have ensured a meaningful flow of information and goods within the supply chain, achieved excellent customer relationship management, and implemented e-business can gain a strategic advantage.[6] Integrated software solutions, among which ERP systems stand out, contribute to transforming the industrial landscape.[7] An ERP system encompasses modules for all key areas of business, such as procurement, production, materials management, sales, marketing, finance, and human resources.

SAP was one of the first companies to develop standard software for business solutions and continues to offer leading ERP solutions in the industry.[8] Among the numerous companies that have implemented SAP software solutions, many are insurance companies. The insurance sector requires the management of complex and diverse processes, including policy administration, premium calculation, claims processing, actuarial activities, and risk management. It is necessary to track and record vast amounts of data on clients, contracts, and regulatory reports. Integration with external systems and databases is often required. This is why there is no single ready-made business solution that can meet all the requirements of insurance companies. Instead, it is necessary to integrate multiple SAP modules and solutions and tailor them to the specific needs of each client. This, in turn, represents the greatest challenge in implementing SAP solutions in the insurance sector.

This paper addresses one of the most important processes in claims management – the reserve and payment calculation system. The goal is to support the process entirely, with a high level of automation, to ensure that employees can use

[4] Bojan Jovičić, Siniša Vlajić, „Evolucija ERP sistema", *ИНФО М* , 22/2007, 18–22.

[5] Chetan S. Sankar, Karl-Heinz Rau, *Implementation Strategies for SAP R/3 in a Multinational Organization: Lessons from a Real-World Case Study*, IGI Global, 2006, 2.

[6] Dragana Rejman Petrović, „ERP sistemi u funkciji unapređenja kvaliteta poslovanja", *Nacionalna konferencija o kvalitetu,* Faculty of Mechanical Engineering, University of Kragujevac, Kragujevac, 2009, A15–A22.

[7] Thomas F. Wallace, Michael H. Krezmar, *ERP: making it happen: the implementers' guide to success with enterprise resource planning,* Hoboken, NJ, USA 2001, 4.

[8] *https://www.sap.com/westbalkans/about/what-is-sap.html***,** accessed on August 21, 2024.

the solutions as easily as possible, thereby simplifying their daily operations and increasing overall business efficiency. This paper provides a detailed presentation of the solution implemented in the project. All system screenshots are original from the project and are therefore shown in Dutch or English.

II. ERP Systems

Enterprise resource planning (ERP) systems have had a profound impact on enterprises and organizations worldwide.[9] In most cases, ERP systems are implemented with the objective of improving a particular aspect of an organization, such as strategic, organizational, operational, managerial, or IT infrastructure capabilities.[10] An ERP system (*Enterprise Resource Planning*) represents a software solution designed to manage all of an enterprise's business functions. It is an integrated system that connects all parts of the organization, enabling their mutual coordination and the flow of information between them. By using an ERP system, an organization manages its entire business through a single software platform and stores all critical information in one centralized location.[11]

In addition to leading proprietary ERP systems such as SAP and *Microsoft Dynamics*, the market has also seen a significant presence of open-source ERP systems. Small and medium-sized enterprises often opt for open-source ERP solutions, primarily due to their lower implementation and maintenance costs.[12]

The structure of an ERP system typically consists of a collection of applications. These are organized into functional areas referred to as modules. Naturally, there are differences among individual ERP systems in terms of module composition, which means that not all ERP systems encompass the same functional areas, nor do they always include identical modules.[13]

1. Advantages of ERP Systems

In her book on modern ERP systems, Bradford discussed the advantages and disadvantages of ERP implementation within an enterprise. Among the primary

[9] Debra Howcroft, Duane Truex, „A critical analysis of ERP systems: the macro-level", *The Database for Advances in Information Systems,* 4/2001, 13–18.

[10] Jonas Hedman, Andreas Borell, The Impact of Enterpise Resource Planning Systems on Organizational Effectiveness: An Artifact Evaluation. In *Enterprise Resource Planning: Global Opportunities*, Hershey, PA: Idea Group Publishing, 2002, 78–96.

[11] Milena Ristić, „Šta je ERP – Značaj ERP rešenja u poslovanju preduzeća", 2017, *https://beleske.com/sta-je-erp-znacaj-erp-resenja-u-poslovanju-preduzeca/,* accessed on August 10, 2024.

[12] Dragana Maljković, Ognjen Pantelić, „Komparativna analiza ERP sistema otvorenog tipa", *STED Journal,* 5/2019, 9–18.

[13] D. Rejman Petrović, A16-A17.

advantages is data integration. In ERP systems, data is collected once and shared throughout the enterprise, thereby reducing the risk of inaccuracies and redundancies in the data and eliminating time lost on verification, re-verification, and data reconciliation.[14] One of the outcomes of ERP introduction in the context of integration is centralization. By implementing such a system, an enterprise can replace two or more independent applications and eliminate the need for external interfaces that were previously required to link these systems.[15] For organizations that process large volumes of data, data quality is the foundation of organizational success.[16] [17] Poor data quality can cost a company as much as 10% to 20% of its total revenue.[18] Another advantage of ERP systems is real-time access to information, which improves collaboration and communication across the enterprise.

An ERP system also requires the company to share a common process and data model that encompasses complex operational processes from start to finish, such as those found in manufacturing and supply chain management. This standardization improves coordination within the organization and across the organizational network, facilitating interaction with both internal and external stakeholders. ERP vendors design their solutions around processes based on industry best practices.

Finally, ERP systems can reduce operational costs and increase revenue. Companies that implement ERP do so in order to achieve efficiencies such as lower inventory costs, reduced manufacturing expenses, or decreased procurement costs.

2. Disadvantages of ERP Systems

Implementing an ERP system involves far more than simply installing off-the-shelf software. It is a complex, time-consuming undertaking that can involve numerous issues. Many of the issues encountered during implementation relate to the so-called *soft stuff* (human factors) as opposed to *technical stuff* (software/hardware issues). A lack of employee involvement can present a significant obstacle if staff members are not informed about the organization's motivation for investing in an ERP system, or if their opinions and feedback are not taken into account during the implementation process. In some cases, ERP systems face resistance because employees may be quite content with legacy systems they have used for decades.

[14] Marianne Bradford, *Modern ERP: Select, implement and use today's advanced business systems,* third edition, Morrisville, NC, USA 2015, 6-9.

[15] B. Jovičić, S. Vlajić, 18–20.

[16] Stuart Madnik *et al.*, „Overview and Framework for Data and Information Quality Research", *Journal of Data and Information Quality,* 1/2009, 1–22.

[17] Heinrich Bernd, Marcus Kaiser, Klier Mathias, „Does the EU insurance mediation directive help to improve data quality? A metric-based analysis", *ESCIS Proceedings,* 195/2008, 1871–1882 .

[18] Thomas Redman, „Data: An unfolding quality disaster", *Dm Review*, 14/2004, 21–23.

Another disadvantage of ERP systems is their high cost, particularly for software from well-known, larger ERP vendors such as SAP and Oracle. An ERP system and its implementation process can be the most expensive investment a company will make. Smaller companies generally incur lower implementation costs, but they can experience the same types of implementation issues. An ERP system also requires ongoing maintenance to preserve its stability and compatibility with a broad range of constantly evolving software applications. Furthermore, the standardization of business processes, considered an advantage, can also be a disadvantage if this structure deviates from, or conflicts with, the company's culture or expectations.

For these and many other reasons, companies should not make the decision to implement an ERP system lightly. Successful implementation requires that all employees - from functional users and IT staff to top management - be motivated to work closely together to advance the organization's mission.[19]

3. The Future of ERP Systems

The future of ERP systems lies in delivering efficiency, scalability, and speed to business operations. Conventional ERP systems must evolve by integrating technologies such as sensors and artificial intelligence (AI). Next-generation ERP systems will need to be both adaptable and scalable, leveraging analytics and machine learning. Furthermore, conventional ERP systems were originally designed as *on-premise* solutions, and therefore must transition to *cloud*-based systems. *Cloud* technology enables users to access these resources via the internet, offering numerous advantages, including scalability, accessibility, cost savings, ease of maintenance and updates, and enhanced security. Transition to the *cloud* allows ERP systems to become more agile, more efficient, and better prepared for future challenges.[20] One of the main advantages of *cloud*-based ERP systems is their ability to provide real-time data access and analytics. In a supply chain risk management case study, it was found that real-time monitoring using *cloud*-based ERP systems significantly improves the ability to proactively manage risks.[21]

Supply chain resilience has become increasingly important for manufacturers. The emphasis is on the ability of the supply chain not only to withstand adverse events, but also to adapt to and recover from them, ensuring sustained performance and competitive advantage.[22] In the year when COVID-19 emerged, manufacturers

[19] M. Bradford, 6–9.

[20] Zahoor Syed *et al.,* (2024) „Enhancing supply chain resilience with cloud-based ERP systems", IRE Journals, 8(2), 106–128.

[21] Wennan Zhang *et al.*, „Digital-Twin Enabled Construction System For Supply Chain Risk Management", 2023 IEEE 19th International Conference on Automation Science and Engineering (CASE), Auckland, New Zealand, 2023, 1–6.

[22] Timothy J. Pettit, Keely L. Croxton, Joseph Fiksel, „The Evolution of Resilience in Supply Chain Management: A Retrospective on Ensuring Supply Chain Resilience", *Journal of Business Logistics,* br.40/2019, 56–65.

faced significant disruptions in supply chains and were compelled to develop rapid production responses. This crisis highlighted the need to enhance supply chain resilience so that industrial organizations can effectively adapt to potential disruptions, mitigating risks associated with supply chain failures. This includes, for example, collecting and analyzing data on various factors that can affect supply, such as natural disasters, geopolitical events, transport delays, and supplier risks. For this purpose, ERP systems can collect real-time data from multiple sources, including sensors, IoT (*Internet of Things*) devices, and external data providers. Analysis of such data can provide early warning signals and enable proactive decision-making.[23]

III. SAP ERP SYSTEM

SAP was founded nearly 40 years ago in Mannheim, Germany, by a group of former IBM engineers. The idea was to assist companies in replacing 10 to 15 different business applications, such as financial systems (managing accounts payable and accounts receivable), warehouse applications, production planning solutions, plant maintenance systems, and others, with a single integrated system. This vision became a reality when *Systems, Applications, and Products in Data Processing* (SAP) opened its doors in 1972. Today, SAP is utilized by more than one million business users working for over 100,000 clients across more than 120 countries.

It is important to understand the distinctions between SAP components, modules, and transactions. SAP uses the term *component* interchangeably with *business application*, the latter often abbreviated simply as *application*. In contrast, SAP modules provide specific functionality within a component. Examples such as the Financial module, Production Planning module, and Materials Management module are easily explained. These individual SAP modules combine to form an SAP ERP component. Within a given module, the company's business processes are configured and assembled. Business processes are also referred to as business scenarios. A business process may require transactions to be executed across several different modules, possibly even from multiple components,[24] as illustrated in Figure 1.

[23] *https://www.itexchangeweb.com/blog/the-future-of-erp-systems/*, accessed on August 13, 2024.
[24] George Anderson, *Sams teach yourself SAP in 24 hours,* fourth edition, Carmel, IN, USA 2011, 8–10.

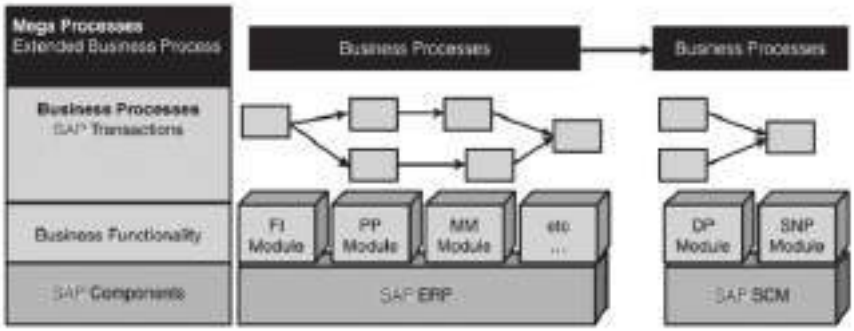

Figure 1. SAP Components, Modules, and Transactions.[25]

IV. SAP For Insurance

SAP for Insurance is a comprehensive package covering the functionalities required to support insurance-specific processes. This package can be integrated with both SAP and non-SAP *front-office* and *back-office* solutions and consists of various modules:

- FS-PRO *Product Lifecycle Management for Insurance* module is responsible for modeling product structures and maintaining all actuarial calculations, rating rules, and formulas to be applied.
- FS-QUO SAP *Quotation and Underwriting for Insurance* is used for creating insurance quotations. FS-PQM refers to the combination of FS-PRO and FS-QUO.
- FS-PM *Policy Management* component is used for the administration of insurance policies from inception throughout the entire policy lifecycle. It is the central SAP component for insurance.
- FS-CM *Claims Management* is responsible for managing claims from registration to settlement. It is directly integrated with payment systems to enable claims processing through to client disbursement.
- FS-CD *Collections & Disbursements* module handles all incoming and outgoing payments of the insurance company. Premiums or claim payments are automatically tracked, and the module is fully integrated with banking interfaces for payment reconciliation.
- FS-ICM *Incentive and Commission Management* manages all data related to intermediaries and agents and calculates the corresponding commissions earned by intermediaries.

[25] G. Anderson, 8–10.

• FS-RI *Reinsurance Management* manages all reinsurance processes and is fully integrated with the aforementioned insurance modules.

Each module can be purchased and used individually, although best practice is to use them together as a fully integrated SAP insurance solution,[26] as illustrated in Figure 2.

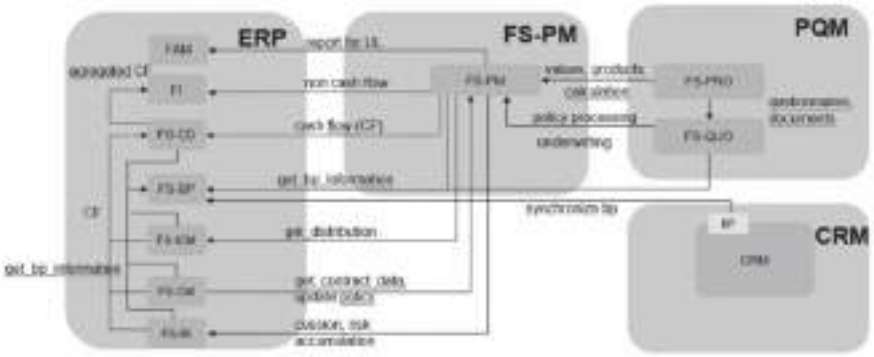

Figure 2. Integration of modules.[27]

V. Claims Management Module

FS-CM *Claims Management* is used for managing claims from the moment of notification through to claim settlement. The primary processes within claims management are:

• *Claim Notification*
• *Claim Handling*
• *Claim Fulfillment*
• *Claim Recovery.*

The Policy Management module (FS-PM) aggregates data relevant for commissions and sends it to the Incentive and Commission Management module (FS-ICM). FS-ICM then triggers the Collections & Disbursements module (FS-CD) to generate a commission payment. The same principle applies to the interface between FS-PM and FS-CD, where FS-PM creates all cash flows and transmits them to FS-CD. In the event of a claim, the Claims Management module (FS-CM) will call FS-PM to request policy data, known as the policy *snapshot*. In this case, FS-CM invokes the built-in

[26] *https://s4ic.com/sap-for-insurance/*, accessed on August 25, 2024.
[27] S4IC, SAP for Insurance: how do the modules work together?, 2022, *https://www.linkedin.com/pulse/sap-insurance-how-do-modules-work-together-s4ic/*, accessed on August 25, 2024.

functionality within FS-PM to collect the relevant insurance policy data necessary for claim creation and processing. Upon claim settlement, FS-CM will call FS-CD to generate an outgoing payment to reimburse the insured party for the incurred loss.[28]

VI. Reserve Calculation Process and Payment Execution

The payment process implemented in SAP for an insurance company involves the following modules:

- FS-CM *Claims Management* – claims management system
- HCM *Human Capital Management* – human capital management system
- CD *Collections & Disbursements* – financial services collections and disbursements management
- FICO *Financial Accounting and Controlling* – financial data management system for generating and analyzing financial reports
- IA *Insurance Analyzer* – financial risk management system

1. Creation of a Claim in the SAP System

The process begins with the creation of a *claim* in the SAP system. The transaction ICLCDC01 is the standard SAP transaction used for creating insurance claims. In addition to this standard transaction, custom transactions can also be created. The transaction ZICL_SZ_CDC01 is used for claim creation in the project under consideration, specifically for claims related to the inability to perform work. Figure 3 shows the claim creation screen. The user is required to enter the policy system as well as the insurance policy number. Mandatory fields also include the date the claim request is submitted and the date from which the claim period begins.

For each claim a timeline is maintained, i.e. chronologically recording when the insured party (SAP *business partner*) submitted previous claims for the same cause. It is necessary to enter a percentage value representing the degree to which the insured party is unable to perform work, along with a code indicating the medical reason for this inability. Compensation is calculated based on this percentage. Figure 4 displays the screen showing the timeline and the required fields for claim creation.

Once the claim is saved, the timeline must be approved by the claims request supervisor.

[28] S4IC, SAP for Insurance: how do the modules work together?, 2022.

Figure 3. Claim Request Creation.

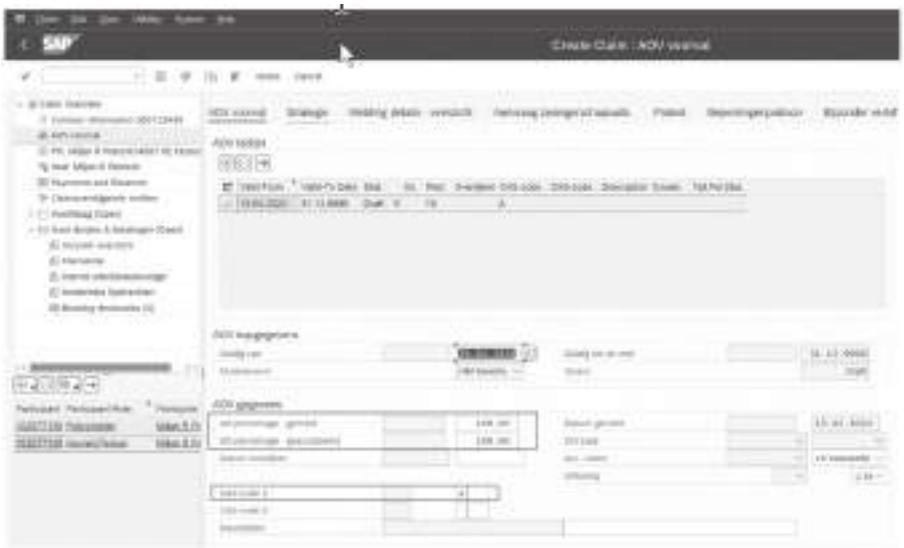

Figure 4. Timeline Creation.

2. Reserve Calculation for Claims

The creation of reserves within an insurance company is a key risk management practice, ensuring that the company holds sufficient funds to meet future obligations to policyholders. It is necessary to calculate reserves for incurred but not yet paid claims, as well as for future claims. This process relies on complex mathematical and statistical models.

The actuarial reserve consists of the following components:

- reserve for claim liabilities, also known as the reserve for losses or incurred but not reported (IBNR) reserve
- reserve for premium liabilities
- reserve for other liabilities.[29]

In our example, reserve calculation is carried out using a program implemented specifically for the specific project requirements, rather than a predefined SAP package program. SAP programs are accessed via transaction SE38. The desired program is executed after entering the relevant parameters, such as the claim number.

The output of the reserve calculation program is the reserves saved in the user table ZICLD_SZ_KASSTRO, the structure of which is shown in Figure 5. All necessary information is recorded: claim number, calculation *timestamp*, with the fields RES_G_CLAIM and RES_G_EXPERTISE representing the reserve amounts.

For the claim numbered QS00624006, Figure 6 displays a monthly breakdown of monetary reserves for all years during which the insured had coverage.

In the example under consideration, reserve calculation has not yet been performed, so the process will start with a reserve amount of 0 EUR.

[29] *https://www.axxima.ca/blog/actuaries-and-annual-reserving-work-what-you-need-to-know/*, accessed on August 30, 2024.

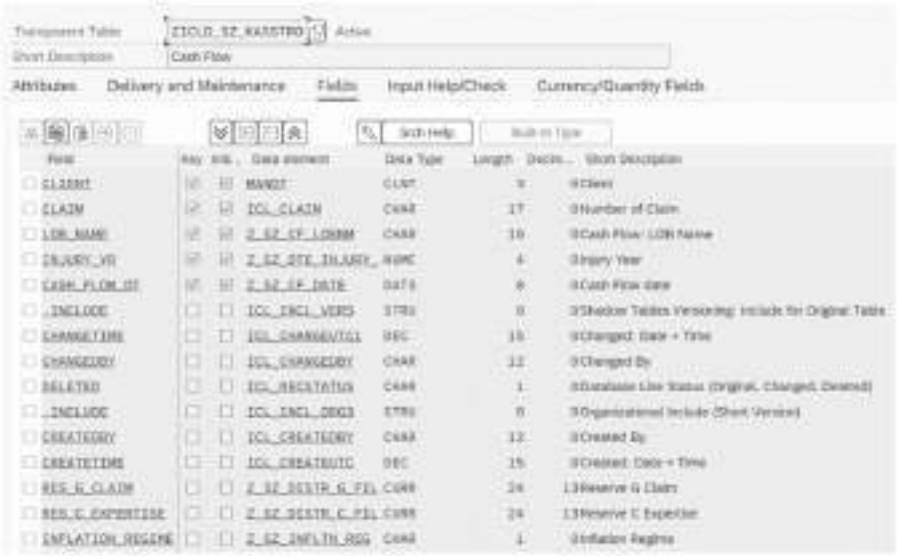

Figure 5. Reserve Table Structure.

Figure 6. Reserve Example.

3. Payment creation in the SAP system

For a claim with an approved timeline, it is possible to perform the compensation calculation and subsequently execute the payment. Once the timeline is approved, a button for compensation calculation appears on the claim. After the compensation has been calculated, this button is replaced by a payment execution button. In the background, complex functional modules for financial calculations are triggered. As a result, updates occur on the timeline, and a new payment node appears in the navigation tree, as shown in Figure 7.

Figure 7. Compensation Calculation and Payment Creation.

The payment screen records all payments related to the claim, including the payment type (disbursement or refund), the amount, the currency of the payment or refund, and its current status. Based on the refund status, the system tracks whether the payment is still in the claims system, when it was sent to the accounting system, and when it was sent to the payment system. Another important data point recorded here is the document number. This document contains a payment listing by bank accounts on the Finance and Controlling (FICO) system side. The claim shown in Figure 8 has payments for three months.

A custom table, ZCM_RESERVE, has been created in the SAP system to track all changes in payments and reserves related to a specific claim (Figure 9). This table is not a standard SAP table but was developed specifically for the insurance company to monitor all relevant payment data not available in standard SAP tables. This table provides a more detailed view of amounts and cash flow movements. Some key data recorded in this table include:

1. *Reserve type* – different types of reserves are sent to different processing systems
2. *Reserve lot* – batch number for processing
3. *Document ref* – document number in the payment system
4. *Change Reason* – various reasons for amount changes such as payment, amount adjustment, different types of changes depending on refund type, and others.
5. The last three columns relate to specific amounts: the first column represents changes in payments, the second column represents changes in reserve levels, and the last column represents the reserve balance.

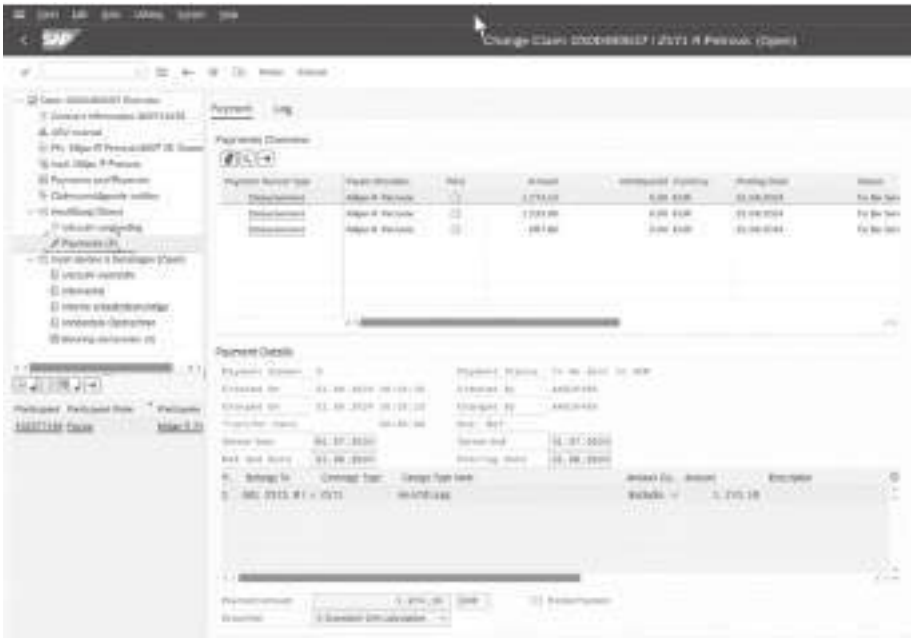

Figure 8. Payment Screen.

Figure 9. ZCM_RESERVE Table.

For the three payments made, the total amount is EUR 3.164,70. In the case of this claim, reserve calculation has not been performed, so the reserve balance is zero. Since the initial reserve balance is EUR 0, reserves must be increased to enable payment execution. The first row in the table, with change reason '00', represents the reserve adjustment for the amount required for payment. The second row represents the disbursement of that amount and the reduction of reserves back to zero.

3. Triggers in SAP

Transaction IMP_MANAGER initiates the trigger management program. It is used for manipulating transport objects, where objects are created and modified within one environment (e.g. the claims testing system) and then transported to

another environment (e.g. the financial management system). Triggers represent automated actions that occur during the transport of these objects from one environment to another. They are grouped into application classes according to their functionalities. After the triggers are created, it is necessary to assign the relevant objects, such as a business partner or claim to which they pertain, and subsequently the triggers are executed.

During the creation of claim requests and payments, several triggers are generated:

- 0HIRE trigger – associated with the insured party and during processing in the payment system the insured receives a unique number based on this trigger
- ZRECI – trigger for recovery of the insured party
- ZREILL – trigger for the insured party's medical issue
- 10015 – a separate trigger is created for each payment month; in this case, there are three triggers.

These three payment triggers are generated only after the payments from the claims system are sent to the payment system using a dedicated program. Access to programs in the SAP system is performed via transaction SE38. These triggers do not produce any changes in the claims system but are essential for processing claims in the payment system. Figure 10 shows the triggers related to the claim being processed in this example.

Figure 10. Triggers for Claim QS480637.

4. Net Payment Calculation

HCM (*Human Capital Management*) refers to a set of applications used for recruiting, managing, and developing an organization's workforce. This software pertains to systems that contribute to process optimization and is often referred to as a H*uman Resource Management System* (HRMS).

Some of the key functionalities include:
- employee experience management
- payroll calculation
- human resources analytics and workforce planning.[30]

From the above definition and functionalities, it is evident that HCM is not part of the standard SAP insurance package. The implementation of the HCM module in insurance companies is uncommon. However, for the purposes of insurance and the specific project at hand, this system has been implemented to extend beyond traditional human resource management. Namely, within the payment process, HCM is utilized to calculate the net payment amount.

Triggers created in the previous step of the process are executed by HCM, whereby an ID (*identification number*) is generated for each insured party (SAP *business partner*) within this system. The output of the programs executed in HCM is a net payment specification, which is forwarded to the Claims Management system. Payments for each month are processed individually. Figure 11 shows the net calculation for the month of June. Similar calculations exist for May and July.

The net calculation from the HCM system is then transmitted to the CD (Collections & Disbursements) system, which is responsible for executing the payments.


Uitteringsspecificatie Juni 2024 1

******* DIT IS EEN VOORBEELD UIT UITBETALINGSSYSTEEM, NIET VOOR KLANTEN! *******

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PIG-nummer 40033002
Geb.datum 12.12.1986

	Tabelloon	Bijz. bel.	Uitbetaling
AOV Uitkering	1.233,00		1.233,00
Basis LH	1.233,00		
Loonheffing	455,83-		455,83-
WW-premie ZVW totaal			65,55-
Nettoloon		→	711,58
Te betalen bedrag			711,58

Figure 11. Net Calculation for the Month of June.

[30] *https://www.sap.com/westbalkans/about/what-is-sap.html*, accessed on 30 August 2024.

VII. Creation of Refunds in SAP

In the Claims Management system, a refund is generated when there is a change in the percentage indicating the extent to which a person is unable to perform their work. In the example considered, the initial percentage was 100%. If this percentage is reduced to, for instance, 0%, meaning the insured is again capable of performing their work, a refund must be processed for the period during which the percentage was modified. In the illustrated example, the percentage was changed to zero as of June 15, 2024, resulting in refunds being created for two months: June and July. No payments existed for August, so no refund applies for that month. The updated timeline is shown in Figure 12.

Figure 12. Timeline after modification.

The Payments screen in Figure 13 now displays two new refund entries with the status *Parked*.

Figure 13. Refunds on the Payments screen.

1. Refund Processing

Upon creating a refund, a task is generated which must be completed by the Claims Manager, as shown in Figure 14.

Figure 14. Tasks in SAP.

The concept of *tasks* in SAP is quite simple and corresponds to everyday use: a request for a person to perform an action. Tasks can be created automatically, as in this example, or manually. Task ZSV180 must be completed by the claims manager. By clicking on the *process step*, the user is redirected to the refund screen where the refund process continues. Depending on the refund type selected, the screen fields change accordingly, since different refund types require different data. The subsequent processing follows the same workflow.

The refund types are:

1. maximum calculation – refund of the entire amount
2. instalment calculation – refund in installments
3. direct refund – refund of the entire net amount
4. payment waiver – the insured may be exempted from repaying part or all of the amount.

In this example, the refund will be processed as a direct refund. Selecting option 3 for direct refund results in the screen shown in Figure 15.

Figure 15. Direct refund.

Clicking the button *Berreken Netto bedrag* (calculate net amount) populates the field *Netto vordering naar CD* (net claim to CD). Saving the changes and approving the amount by the claims manager creates a new refund entry on the payments screen with status *Requested*, as shown in Figure 16.

The ZCM_RESERVE table is updated with new rows for each change. When the percentage changed, two refund entries with status *Parked* were created on the payments screen. These are consolidated into a single row with change reason ZT in the ZCM_RESERVE table. Processing the refund creates a new row with change reason ZX. The updated table is shown in Figure 17.

As mentioned in section 5.3 Creation of Payments in SAP System, there are different reserve types. In this table, reserve types S6 and SA are visible. Reserve type S6 is sent to the FICO (*Financial Accounting and Controlling*) system, while reserve type SA is sent to the IA (*Insurance Analyzer*) system.

Figure 16. Direct refund on the Payments screen.

Figure 17. ZCM_RESERVE table after refund.

Rows in the table with change reasons 00 and 03 are processed by the Human Capital Management (HCM) system and sent to the Collections & Disbursements (CD) system, as well as to the Financial Accounting and Controlling (FICO) system. The fields *RESERVELOT* and *DOCUMENTREF* can also be seen for these two rows. For the new rows created during the refund process, transmission is performed manually.

2. Refund Transmission to FICO

SAP FICO (Financial Accounting and Controlling) is an integral module within the SAP ERP set that enables organizations to efficiently manage their financial processes and make informed decisions. SAP FICO plays a key role in helping enterprises streamline financial operations, gain insights, and ensure compliance. It consists of two primary modules – Financial Accounting (FI) and Controlling (CO). SAP FI focuses on accounting and financial reporting, while SAP CO concentrates on cost tracking.

a) Financial Accounting (SAP FI)

The SAP Financial module is dedicated to generating and managing financial statements and reports. The SAP FI module comprises several submodules:

- *General Ledger* - this module serves as the central component for financial reporting. It integrates various accounting transactions recorded in submodules and provides a comprehensive overview of the organization's financial position according to the chart of accounts.[31] In large enterprises, General Ledger transformation focuses on standardizing the use of coding blocks within the ERP FI-GL module employed. This transformation enables the utilization of most available coding blocks in the ERP module, resulting in financial statements produced according to different criteria such as profit centers, products, or accounts.[32]
- *Accounts Payable* - this module handles vendor invoice management, payments, automatic payment programs, reporting, and other supplier-related transactions.
- *Accounts Receivable* - SAP FICO manages the entire receivables process, from invoice creation to payment receipt. This submodule oversees customer accounts and transactions including invoices, credit memos, customer reports, and related functions.
- *Asset Accounting* - this SAP asset accounting module enables organizations to manage fixed assets such as land, equipment, and real estate. It covers transactions related to retirement, depreciation, revaluation, and similar processes.
- *Bank Ledger* - this module manages transactions associated with the company's bank account information, reconciling bank statement transactions with those recorded in SAP submodules.

[31] *https://webtel.in/Blog/SAP-FICO-Module-and-Sub-Modules/1343*, accessed on 3 September, 2024.
[32] Bhuvnesh Kumar, „Impact and Need for Financial Transformation in the Insurance Industry Using ERP", *Journal of Enterprise Resource Planning Studies,* 2018/2018, 2.

b) Financial Controlling (SAP CO)

The SAP Controlling module focuses on monitoring and reporting business operation costs. The SAP CO module includes several submodules, described below:

- Cost Element Accounting: tracks costs and revenues associated with various business activities, providing detailed insight into cost structures and enabling cost control.
- Cost Center Accounting: allows organizations to allocate costs to specific cost centers, aiding in departmental cost tracking and optimization.
- Profit Center Accounting: enables businesses to analyze profit and loss at the level of individual business units or profit centers, providing granular financial performance views.
- Internal Orders: facilitate tracking and management of internal projects, ensuring costs remain controlled and resources are used efficiently.[33]

Payments from the claims management system are transmitted to FICO in two steps:

1. *Lot creation*
2. *Lot processing* (transmission of the lot to FICO).

c) Lot Creation

The creation of a *payment lot* is performed via transaction ZFCD_CM_RESERVE. Within the same transaction, the program for transmitting the lot to FICO is also located. The first screen is used for lot creation, where only the claim number needs to be entered and executed – see Figure 18.

[33] *https://webtel.in/Blog/SAP-FICO-Module-and-Sub-Modules/134,* accessed on 3 September, 2024.

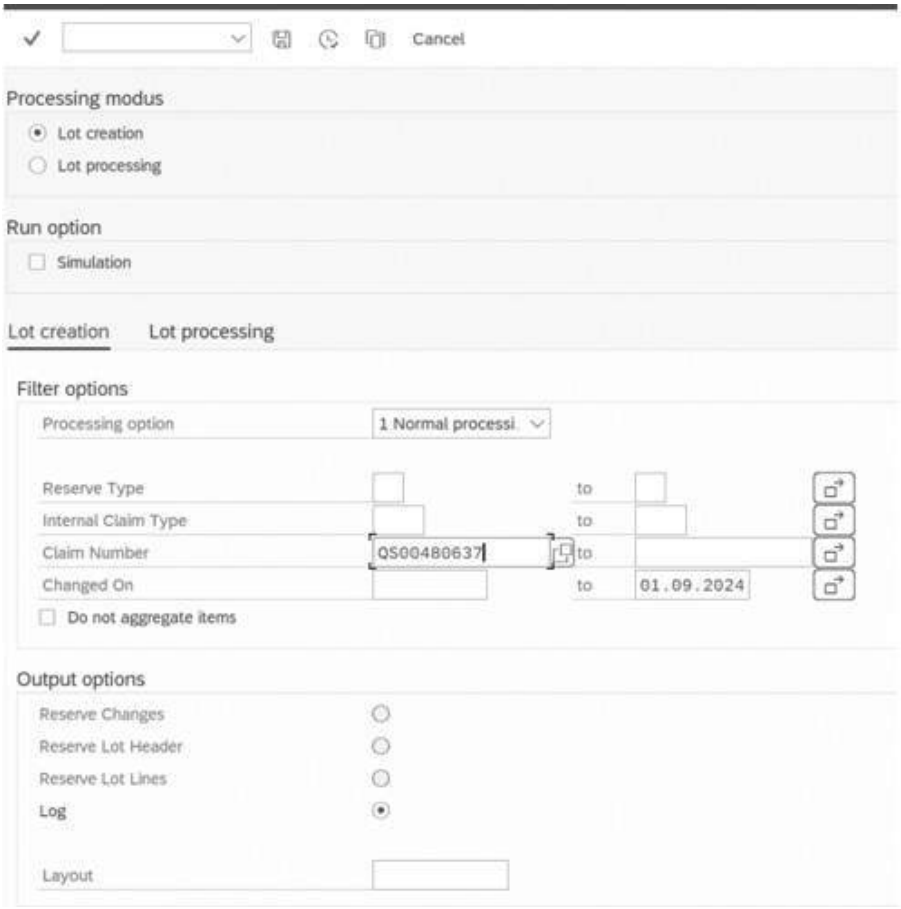

Figure 18. Lot Creation.

d) Lot Transmission to FICO

The transmission of the lot to FICO is performed using the same transaction as the lot creation. The *lot processing* screen is located adjacent to the lot creation screen. The required data to be entered include the lot number and the FICO subsystem to which the lot is being sent. Figure 19 shows the lot number created in the previous step and the target system: HIACLNT400_TRUSTED.

As a result of this process, a new document and its number are generated in the FICO system – see Figure 20.

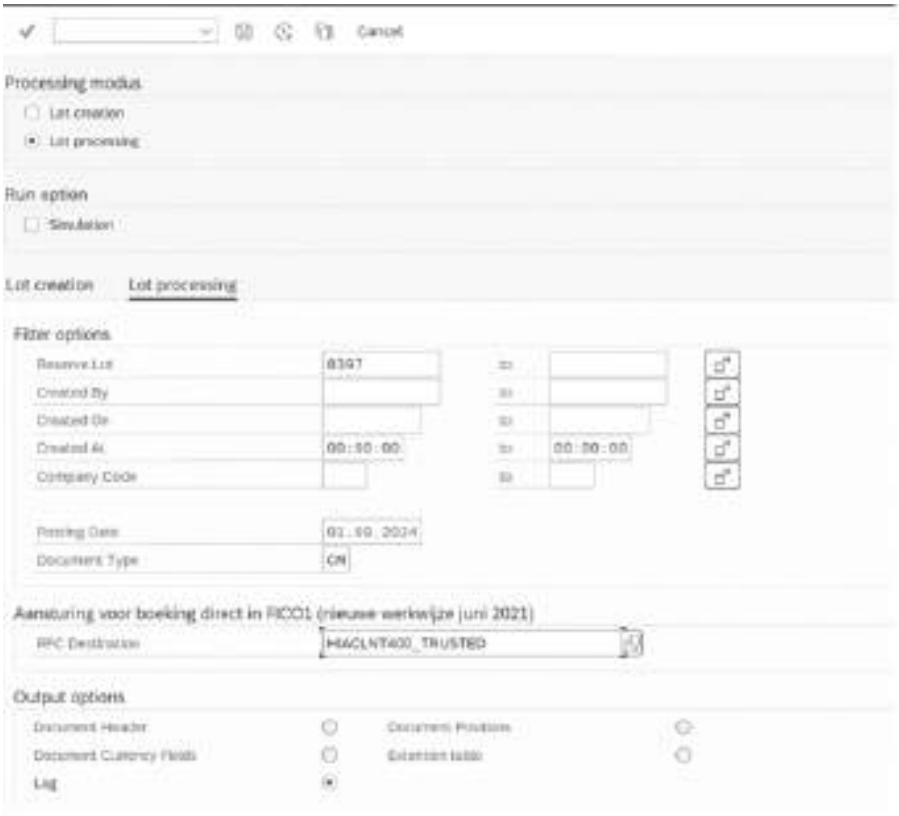

Figure 19. Lot Transmission to FICO.

Figure 20. FICO Document Creation.

e) Result of Transmission to FICO

The ZCM_RESERVE table is automatically updated by this process: for the entries related to the refund, values for the RESERVELOT and DOCUMENTREF fields now exist, as shown in Figure 21. As stated earlier, only entries with reserve type S6 are transmitted to FICO.

Figure 21. Updated ZCM_RESERVE Table after Transmission to FICO.

The *RFC destination* for this lot is the system HIACLNT400_TRUSTED. When a user logs into the HIA system with client 400, they can access the document. Documents are accessed via transaction FB03, where the document number must be entered, in this case: 2600000904. Figure 22 shows the document providing a detailed overview of cash amounts and the accounts to which they were posted.

Figure 22. FICO Document 1.

3. Refund Transmission to IA

SAP *Insurance Analyzer* and the additional SAP FRDP (*Financial Risk and Data Platform*) components represent the most advanced applications for financial management and risk management in insurance companies, facilitating the implementation of relevant IFRS 4/9/17 and Solvency regulations. SAP *Insurance Analyzer* consists of the components *Accounting for Insurance Contracts* and SAP *Solvency Management for Insurance*.[34]

The transport to IA is not a manual process, it is performed via a scheduled *Job* in SAP. A *Job* is a background task executed in SAP at a scheduled time. Jobs and job steps allow complex tasks to be treated as units. Several programs necessary to complete a task can be scheduled as steps within one job, providing the advantage of having a single logical container for all steps required to complete the task.

Job steps operate partially independently from one another. That is, an abnormal termination of one job step does not roll back the work of the previously completed job step if that previous step has performed a *commit*. However, if any

[34] *http://www.gwantec.de/en/services-sap-en/sap-insurance-analyzer*,accessed on 30 September, 2024.

job step fails, the entire job fails. No further job steps are executed, and the job status changes to *canceled*.[35]

In the observed example, the *Job* is scheduled to run daily at 18:00. Upon completion, the data becomes available in IA for further processing, and the PUBSUB_ID value can be seen in the ZCM_RESERVE table within the claims management system. As previously mentioned, if the *reserve type* is S6, data is sent to FICO. The type SA is sent to *Insurance Analyzer*, which is why in Figure 23, PUBSUB_ID has a value of 0 for *reserve type* S6 and a value of 202408311005141 for type SA.

Figure 23. Updated ZCM_RESERVE Table after Transmission to IA.

4. Refund Transmission to CD

Another system involved in this complex process is CD *Collections and Disbursements*. After a payment is created in the claims management system, the further calculation of the net payment is performed in the HCM system, which communicates directly with the CD system and sends the payment for further processing and execution. In the case of a refund, it is transmitted directly from the claims management system to the payment system (CD).

Collections and disbursements are at the core of operations, and most *Legacy systems* simply lack the functionality to create seamless interactions demanded by today's customers. SAP *Collections and Disbursements* (FS-CD) is the primary operational module providing robust functionality for managing receivables, collections, payment processing, and agent/broker commission management.[36]

As a settlement system, CD must be equipped with the necessary settlement data from administrative systems such as Incentive and Commission Management (FS-ICM), Claims Management (FS-CM), Reinsurance Management (FS-RI), and Policy Management (FS-PM). An open interface is available for this purpose.[37] Figure 24 shows the position of CD as a settlement system within a possible system landscape.

[35] *https://help.sap.com/doc/saphelp_nw73ehp1/7.31.19/en-US/4b/2bc12b4c594ba2e10000000a42189c/content.htm?no_cache=true* , accessed on 30 September, 2024.

[36] *https://www.msg-global.com/solutions/sap-fscd-collections-and-disbursements,* accessed on 2 September, 2024.

[37] *https://help.sap.com/docs/SAP_ERP/531a600f03624826bdcd98f6f723ef1b/c174cb53f0f67314e-10000000a174cb4.html,* accessed on 2 September, 2024.

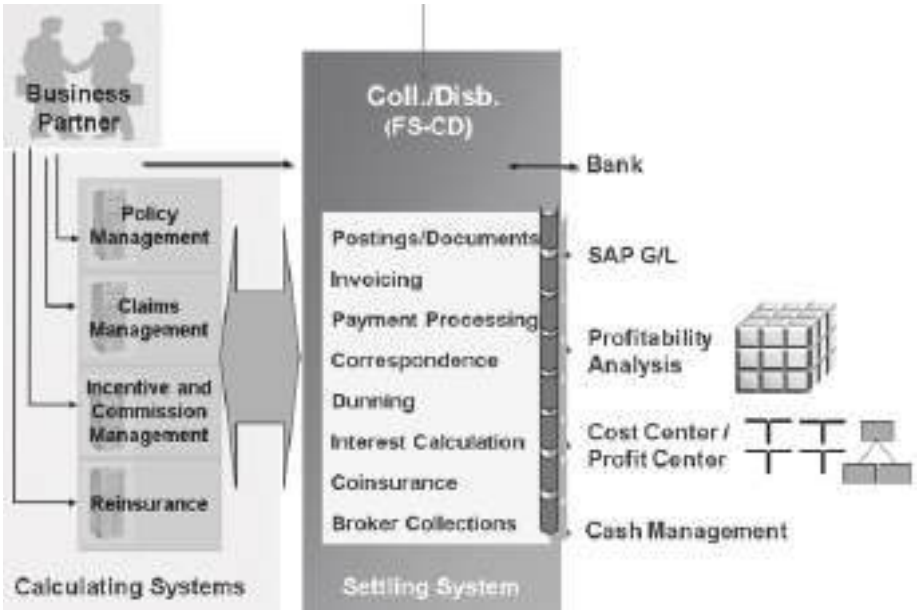

Figure 24. Integration of CD with other systems.[38]

Communication between the claims management system and CD occurs in two steps:

1. Creation of payment and transmission to CD – *payment lot*
2. Transmission of the *info container* from CD to CM.

a) Payment Creation and Transmission to CD

In the claims management system, transaction FP05 is used to create a payment lot and send that lot to the payment system (FS-CD). The screen for creating a new payment lot is very simple: only a unique ID number must be entered and the create button clicked. Two important buttons are *close* and *post*. A lot can contain multiple payments, and as long as the user does not close it, new payments can be added. Clicking *close* locks the lot for new payments, and clicking *post* sends the lot to CD.

Before closing and sending, payments must be added to the lot. Figure 25 shows a new payment lot. Some fields are automatically filled based on system

[38] *https://help.sap.com/docs/SAP_ERP/531a600f03624826bdcd98f6f723ef1b/c174cb53f0f67314e10000000a174cb4.html,* accessed on 2 September, 2024.

configuration, while others must be entered by the user. *Currency*, *Bank clearing account*, and *Company code* are user inputs. Clicking the *New items* button opens the screen for adding payments.

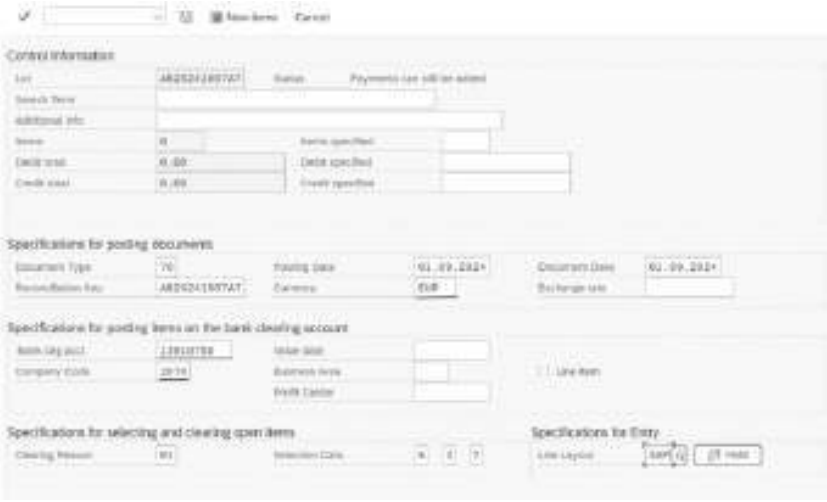

Figure 25. Creating a New Payment Lot for CD.

To add a payment, the amount and document number linked to that payment must be entered on the FS-CM payments screen (Figure 26). Full payments can be processed at once, or the amount can be split into multiple parts within one lot, or even sent in different payment lots. After closing the lot with the *close* button, it can be sent to FS-CD by clicking the *post* button.

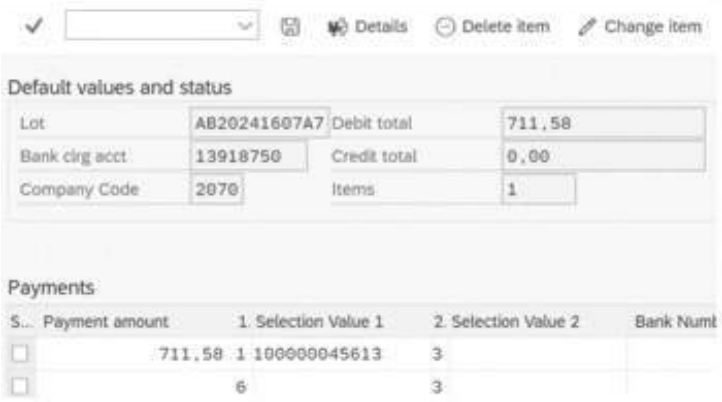

Figure 26. Adding Payments to the Lot.

b) Transmission of Info Container from CD to CM

From the claims management system side, a request is sent to the FS-CD system to transmit the so-called *info container*. The information container functionality in the CD domain is a key business process in SAP Insurance, where info containers store data that can be sent to external systems at a later time. This is a very useful SAP feature enabling interaction with external systems without extensive coding. Activities involved in this process include:

- information type (category)
- confirmation
- storing confirmation in the info container
- forwarding and reading confirmations
- display of info containers.[39]

The transaction for creating info containers is FPINFCO1. It requires entering an ID composed of a date and a six-character identification number, as well as the *Contract* – the claim number. Additional technical settings are available on a secondary screen, along with a screen for reviewing executed programs – *Logs*. Once the parameters are saved, the *Schedule Program Run* button can be clicked to execute the program immediately or schedule it for a future time.

Several outcomes result from this process:

1. The refund status on the payments screen changes from *Requested* to *Received* (Figure 27),

Figure 27. Refund Status Changed to Received.

[39] *https://community.sap.com/t5/sap-for-insurance-blogs/sap-fscd-information-container-functionality/ba-p/13146814,* accessed on 2 September, 2024.

2. The ZCM_RESERVE table is updated with a new entry for reason code ZU (Figure 28),

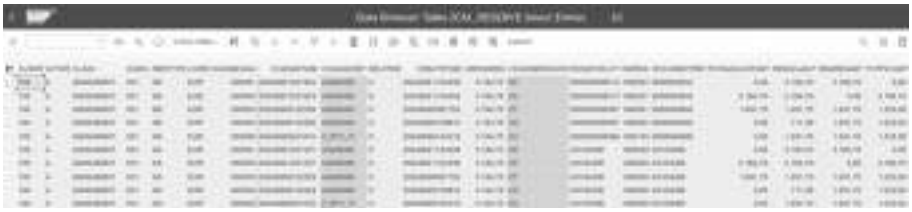

Figure 28. ZCM_RESERVE Table Update after Received Refund.

3. An XML file is sent from the FS-CD system to the FS-CM system (Figure 29).

Figure 29. XML File.

5. Final Refund Processing in FICO, IA, and HCM

To finalize the process, the last modification in the ZCM_RESERVE table must be transmitted to both FICO and IA, specifically by sending the row with the change reason code ZU. The series creation and series transport to FICO process is repeated. The *job* responsible for transport to IA completes automatically. On the FICO side, a new document is generated, shown in Figure 30. The last two lines of the document pertain to the refund processed in this example.

The HCM system re-triggers the *business partne*r-related processes and re-calculates the net payment amount for the three months in which payments exist. At

the end of the process, HCM sends a letter containing the net payment specification to the insured party (Figure 31).

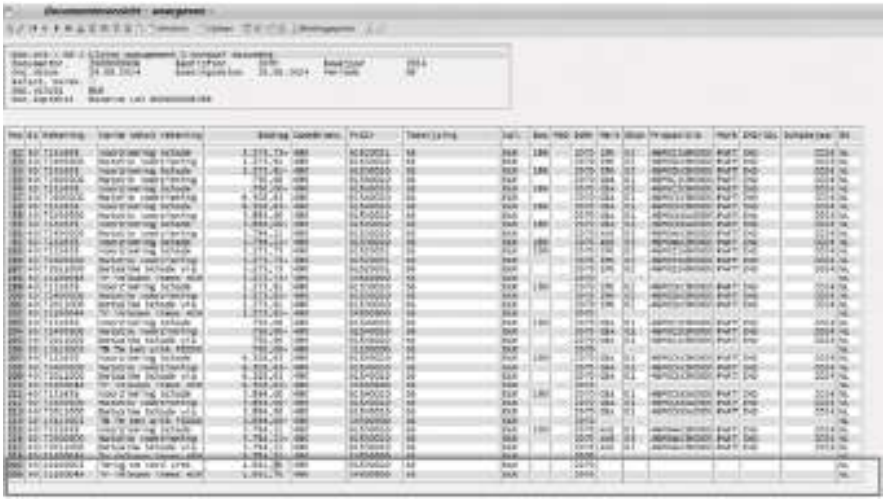

Figure 30. FICO Document 2.

Figure 31. Net Specification Letter to the Insured.

The claims management system also reflects that the process has been fully completed (Figure 32). The refund status on the payments screen changes to *Completed*.

Figure 32. Refund Status Changed to Completed.

VIII. Conclusion

The analysis of the payment process within the SAP ERP system clearly demonstrates the significance of ERP systems in modern business environments. The SAP ERP system is capable of providing organizations with full integration of all necessary systems required to execute complex processes. This paper presented a single example of such a process involving five integrated systems. The process is fully supported with a high degree of automation, and the demonstrated solution facilitates employees in performing daily operations. This example highlights the efficiency of SAP both as an ERP system and as a solution for companies seeking ways to improve their market position. For companies, centralizing the payment process is crucial to ensure better control and monitoring of costs.

In the future, further development of SAP systems follows advanced technologies such as AI and machine learning, which have the potential to enhance numerous processes and enable SAP to continuously provide organizations with high-quality management solutions.

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NOVI RAČUNOVODSTVENI PRISTUP ZA UGOVORE O OSIGURANJU PREMA IZMENJENOJ PROFESIONALNOJ REGULATIVI

STRUČNI RAD

Apstrakt

Uvođenjem novog regulatornog standarda *MSFI 17 – Ugovori o osiguranju*, delatnost osiguranja je pre dve godine pretrpela značajne promene na polju finansijskog izveštavanja. Cilj rada jeste upoznavanje s novim pristupom u računovodstvenoj praksi ugovora o osiguranju. U radu je objašnjena priroda promena koje su uvedene novom regulativom, uticaj promena na iskazivanje pojedinih bilansnih pozicija u finansijskim izveštajima, kao i efekti promena na transparentnost, uporedivost i korisnost finansijskih informacija koje služe zainteresovanim stranama za procenu poslovanja i rizika kojima su osiguravajuće kuće izložene u obavljanju svoje delatnosti. Najznačajnije promene desile su se u oblasti grupisanja ugovora o osiguranju i primenljivosti zahteva standarda na grupe ugovora, priznavanja prihoda, vrednovanja obaveza iz ugovora o osiguranju, prezentacije sadašnje i buduće dobiti, kao i iskazivanja i obelodanjivanja pojedinih pozicija u finansijskim izveštajima. Rad je prvenstveno namenjen teoretičarima i praktičarima u oblasti osiguranja, finansija

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i računovodstva, kao i svim zainteresovanim stranama koje koriste informacije iz finansijskih izveštaja osiguravajućih kompanija.

Ključne reči: *regulativa, osiguravajuća kuća, finansijski rizik, finansijski izveštaji, obaveze, ugovorna marža usluge.*

I Uvod

Intenzivan proces ukrupnjavanja kapitala, konsolidacije u osiguranju, digitalizacije i automatizacije poslovnih procesa neke su od promena u poslovanju osiguravajućih kuća koje su nastupile pod uticajem usporavanja rasta globalne ekonomije, inflatornih pritisaka, geopolitičkih događaja, prirodnih katastrofa, pandemije kovida 19 i pooštravanja regulative.[3] Budući da regulatorni okvir u velikoj meri utiče na razvoja tržišta osiguranja, tokom poslednje decenije sprovedeno je nekoliko važnih promena u regulativi koje se odnosi na poslovanje društava za osiguranje[4]. Jedna od njih jeste donošenje *MSFI 17 – Ugovori o osiguranju*, novog međunarodnog standarda koji uspostavlja principe za priznavanje, odmeravanje, prezentaciju i obelodanjivanje ugovora o osiguranju.

Set Međunarodnih standarda finansijskog izveštavanja (skraćeno MSFI), koje donosi Odbor za međunarodne računovodstvene standarde (skraćeno IASB), primenjuje se u Republici Srbiji od 1. januara 2004. godine. MSFI su sastavni deo međunarodne računovodstvene regulative koja je po Zakonu o računovodstvu[5] obavezna za primenu kod velikih pravnih lica, pravnih lica koja imaju obavezu sastavljanja konsolidovanih finansijskih izveštaja, javnih društava i društava koja se pripremaju da postanu javna, a u skladu sa zakonom kojim se uređuje tržište kapitala, nezavisno od veličine.

Poslednji donet i aktivno u primeni od 1. januara 2023. godine jeste ranije pomenut standard *MSFI 17 – Ugovori o osiguranju*. MSFI 17 je zamišljen od strane IASB kao jedan računovodstveni model za sve ugovore o osiguranju u svih 168 MSFI jurisdikcijama širom sveta koje primenjuju set MSFI. Primena MSFI 17 bi trebalo da obezbedi više korisnih i transparentnijih informacija, kao i bolju informisanost o profitabilnosti osiguravajućih kuća. MSFI 17 pruža dosledne principe za sve aspekte računovodstvene prakse ugovora o osiguranju. On uklanja nedoslednosti koje su postojale ranije i omogućuje investitorima, analitičarima i drugim eksternim korisnicima finansijskih izveštaja da smisleno uporede kompanije, ugovore i delatnosti.

MSFI 17 je najavljen kao prvi istinski Međunarodni standard finansijskog izveštavanja za ugovore o osiguranju. On je zamenio *MSFI 4 – Ugovori o osiguranju*,

[3] Jelena Kočović et al., „Pravci razvoja tržišta osiguranja", *Tokovi osiguranja*, br. 3/2024, 546.
[4] *Ibidem*, 545.
[5] Zakon o računovodstvu, *Službeni glasnik RS*, br. 73/2019 i 44/2021 – dr. zakon, čl. 24.

koji je, kada je objavljen pre 17 godina, najavljen kao privremeni standard koji bi u nekom skorijem vremenu bio zamenjen standardom MSFI 4 Faza II, kasnije preimenovanim u MSFI 17. Prvobitno, datum stupanja na snagu dugonajavljivanog MSFI 17 bio je određen za 1. januar 2021. godine. Međutim, u junu 2020. godine IASB je odlučio da odloži datum stupanja na snagu MSFI 17 za 1. januar 2023. godine.

Osnovi cilj donošenja MSFI 17 bio je povećana transparentnost u finansijskom izveštavanju osiguravajućih kuća i pružanje relevantnih informacija koje verno predstavljaju ugovore o osiguranju. Do rasta transparentnosti dolazi kada osiguravajuće kuće, primenjujući odredbe MSFI 17, vrednuju ugovore o osiguranju koristeći ažurirane procene i pretpostavke koje odražavaju vremenske tokove gotovine i svaku neizvesnost u vezi sa ugovorima o osiguranju. Na osnovu informacija iz izveštaja, korisnici finansijskih izveštaja osiguravajućih društava procenjuju efekat koji ugovori o osiguranju imaju na finansijski položaj, finansijske performanse i tokove gotovine ovih društava. Pružajući jasniju sliku obaveza i profila rizika kojima su izložene osiguravajuće kuće, primenom MSFI 17 može se poboljšati poverenje tržišta, što potencijalno dovodi do nižih troškova kapitala. MSFI 17 je doneo veću preciznost i usklađenost u načinu vrednovanja ugovora o osiguranju i načinu prezentacije rezultata, što omogućuje vertikalnu uporedivost i harmonizaciju u finansijskom izveštavanju osiguravajućih kuća u svim MSFI jurisdikcijama.

U delokrugu MSFI 17 definisano je da se standard primenjuje na ugovore o osiguranju i ugovore o reosiguranju koje entitet emituje, ugovore o reosiguranju koje entitet drži, kao i na investicione ugovore sa obeležjima diskrecionog učešća koje entitet emituje, pod uslovom da on takođe emituje i ugovore o osiguranju.[6] Dakle, MSFI 17 se odnosi isključivo na računovodstvenu praksu ugovora o osiguranju, dok je računovodstvo osiguravajućih kompanija uređeno drugim propisima iz oblasti međunarodne i zakonske regulative. IASB je bio stava da je optimalno rešenje da se standard dodeli samo delatnosti osiguranja, a ne entitetu (osiguravajućoj kući) kao celini. Stoga se MSFI 17 primenjuje na sve ugovore o osiguranju koji su uključeni u njegov delokrug tokom ugovora, bez obzira na prirodu tih ugovora.[7] Zbog toga se u MSFI 17 koristi termin „računovodstvena praksa ugovora o osiguranju", a ne termin „računovodstvo osiguravajućih kuća".

Uvođenje MSFI 17, kao i kod bilo kog drugog novog MSFI, podrazumeva značajne izazove i dovodi do povećanja troškova osiguravajućih društava u pogledu prilagođavanja softvera i IT sektora, razvoja novih vrsta alata, promena u ključnim indikatorima performansi, ažuriranja internih procedura, izdataka za obuku i edukaciju

[6] Rada Stojanović *et al.*, *Primena Međunarodnih standarda finansijskog izveštavanja*, Računovodstvo d.o.o., Beograd, 2019, 514.

[7] Omar Alhawtmeh, „The Impact of IFRS 17 on the Development of Accounting Measurement and Disclosure, in Addition to Improving the Quality of Financial Reports, Considering Compliance with the Requirements of IFRS 4 – Jordanian Insurance Companies-Field Study", *Sustainability*, Vol. 2023, No. 15, 8612, 7.

zaposlenih. S druge strane, dolazi do povećanja kvaliteta finansijskih izveštaja. Dahiyata i Owaisa[8] u svom istraživanju dokazuju da je očekivani uticaj primene MSFI 17 na kvalitet finansijskih izveštaja značajan i pozitivan, pogotovo u delu uporedivosti finansijskih izveštaja, vernog predstavljanja i relevantnosti. Navedenim istraživanjem je takođe utvrđeno da se primenom MSFI 17 objedinjuje procena nezarađene dobiti na početku ugovora o osiguranju, što omogućuje poređenje različitih osiguravajućih društava, a priznavanje prihoda i rashoda osiguravajućih društava pruža mogućnost poređenja i sa ostalim delatnostima.

Stoga se može zaključiti da poboljšanje kvaliteta finansijskog izveštavanja, bolje upravljanja rizikom i ostale dugoročne koristi od primene MSFI 17, u sinergiji svog dugoročnog delovanja treba da nadmaše početne troškove primene, shodno troškovnom ograničenju[9] za korisno finansijsko izveštavanje.

II Novine u MSFI 17 u odnosu na prethodnu regulativu

Uvođenje MSFI 17, kako je gore navedeno, donelo je niz prednosti i poboljšanja. Kako bi se iste lakše razumele i bolje identifikovale, neophodno je izvršiti konkretno poređenje novina sadržanih u MSFI 17 sa prethodnim *MSFI 4 – Ugovori o osiguranju*. Značajne novine čine unapređenja na polju uporedivosti, transparentnosti i korisnosti informacija, zatim uvođenje grupisanja ugovora o osiguranju, kao i tri modela vrednovanja obaveza iz ugovora o osiguranju.

1. Razlike između MSFI 4 i MSFI 17

Ključne izmene u MSFI 17 u odnosu na MSFI 4 su:[10]

- Prihodi od osiguranja više ne uključuju depozite, nego samo usluge.
- Prihodi se priznaju kada su zarađeni (tržišno verfikovani), a rashodi kada nastanu. Na taj način priznavanje prihoda bolje je usklađeno s drugim MSFI i drugim delatnostima.
- Prezentacija rashoda od finansiranja osiguranja sa odgovarajućim prihodima.
- Omogućeno je pojednostavljeno merenje nekih kratkoročnih ugovora o osiguranju.

[8] Ahmad Dahiyata, Walid Owaisa, „The expected impact of applying IFRS (17) insurance contracts on the quality of financial reports", *Accounting*, Vol. 2021, No. 7, 581–590.

[9] IASB, Conceptual Framework for Financial Reporting, 2018, 2.39-2.43, dostupno na adresi: *https://www.ifrs.org/content/dam/ifrs/publications/pdf-standards/english/2021/issued/part-a/conceptual-framework-for-financial-reporting.pdf* pristupljeno 05. 01. 2025.

[10] Darrel Scott, Najnovije informacije o IFRS-ima za regulatore: IFRS 17 – Ugovori o osiguranju, 13-14. 12. 2021, dostupno na adresi: *https://cfrr.worldbank.org/sites/default/files/2021-12/4.%20%20IFRS%2017%20Regulation-new%20BCS.pdf* pristupljeno 2. 1. 2025.

- Primenljivost zahteva standarda na grupu ugovora, a ne samo na pojedinačne ugovore.
- Posebna prezentacija dva izvora za ostvarenje dobiti, odnosno posebno prezentacija i priznavanje dobiti po osnovu pružanja usluga iz ugovora o osiguranju.

Detaljniji prikaz razlika u pogledu uporedivosti, transparentnosti i korisnosti informacija između starog i novog standarda sledi u uporednim tabelama 1 i 2 u nastavku teksta.

Tabela 1. Razlike između MSFI 4 i MSFI 17 u pogledu uporedivosti[11]

MSFI 4 – nedostatak uporedivosti	MSFI 17 – dosledan okvir
Uporedivost između kompanija u različitim zemljama	
Računovodstvena praksa ugovora o osiguranju značajno je varirala između kompanija koje posluju u različitim zemljama.	Kompanije dosledno primenjuju računovodstvenu praksu na sve ugovore o osiguranju.
Uporedivost između ugovora o osiguranju	
Neke multinacionalne kompanije su konsolidovale svoje filijale koristeći različite računovodstvene politike za istu vrstu ugovora o osiguranju zaključenih u različitim zemljama.	Multinacionalna kompanija dosledno meri ugovore o osiguranju unutar grupe, što olakšava poređenje rezultata po proizvodu i po geografskom području.
Uporedivost između delatnosti	
Neke kompanije su priznavale gotovinu ili primljene depozite kao prihod. Ovo se razlikovalo od računovodstvene prakse u drugim delatnostima, pogotovo u bankarstvu i upravljanju investicijama.	Prihod odražava samo obezbeđeno osiguranje i isključuje komponente depozita, kao u bilo kojoj drugoj delatnosti.

Tabela 2. Razlike između MSFI 4 i MSFI 17 u pogledu transparentnosti i korisnosti informacija[12]

MSFI 4 – malo transparentnih ili korisnih informacija	MSFI 17 – transparentnije i korisnije informacije
Podaci o vrednostima obaveza osiguranja	
Neke kompanije su vrednovale ugovore o osiguranju koristeći zastarele informacije.	Kompanije vrednuju ugovore o osiguranju po tekućoj (sadašnjoj) vrednosti.
Neke kompanije nisu uzimale u obzir vremensku vrednost novca prilikom merenja obaveza i potraživanja.	Kompanije prikazuju vremensku vrednost novca u procenjenim isplatama za izmirenje nastalih potraživanja.

[11] Prilagođeno prema: IFRS Foundation, IFRS Standards Fact Sheet, 2017, dostupno na adresi: *https://www.ifrs.org/content/dam/ifrs/project/insurance-contracts/ifrs-standard/ifrs-17-factsheet.pdf* pristupljeno 11. 2. 2025.

[12] *Ibidem*.

Neke kompanije su vrednovale ugovore o osiguranju na osnovu vrednosti svog investicionog portfelja.	Kompanije vrednuju svoje ugovore o osiguranju samo na osnovu obaveza koje su nastale ovim ugovorima.
Informacije o profitabilnosti	
Neke kompanije nisu davale dosledne informacije o izvorima dobiti od ugovora o osiguranju.	Kompanije pružaju dosledne informacije o komponentama sadašnje i buduće dobiti od ugovora o osiguranju.
Mnoge kompanije su obezbeđivale alternativne mere učinka (koje ne spadaju u profesionalnu regulativu) da bi dopunile informacije dobijene primenom MSFI 4, kao što su informacije o ugrađenoj vrednosti (EV).	Kompanije i korisnici finansijskih izveštaja koriste manje mera koje nisu u domenu profesionalne regulative tako da dopunske informacije omogućuju značajnija poređenja.

Naročito se naglašavaju informacije o budućoj dobiti koju MSFI 17 uvodi u obliku ugovorne marže usluge. Prema MSFI 17, dobit se ne priznaje pri početnom priznavanju ugovora. Umesto toga, svaki višak tokova gotovine za ispunjenje obuhvaćen je stavkom u bilansu stanja pod nazivom ugovorna marža usluge.[13] U II poglavlju u tački *2. Ostali modeli vrednovanja obaveza* biće više reči o ugovornoj marži usluge.

2. Uvođenje grupisanja ugovora o osiguranju

Ugovori o osiguranju daleko su neizvesniji od drugih ugovora iz kojih proističu usluge. Rizici osiguranja predstavljaju suštinu ugovora o osiguranju. Ako se ugovorom na društvo za osiguranje prenose samo finansijski rizici bez rizika osiguranja, onda se ne radi o ugovoru o osiguranju, s obzirom na to da neki ugovori o osiguranju na početku ne prenose rizike osiguranja na osiguravajuće društvo, već ih prenose kasnije, na osnovu sadašnje vrednosti koristeći diskontne stope.[14] U zavisnosti od toga da li je šteta isplaćena, bilo koji pojedinačni ugovor o osiguranju mogao bi rezultirati dobitkom ili gubitkom, ali ishod toga nije poznat u trenutku emitovanja ugovora. U cilju prevazilaženja te neizvesnosti, MSFI 17 zahteva grupisanje, odnosno agregaciju ugovora o osiguranju. To grupisanje ugovora se radi samo u računovodstvene svrhe, te neće imati uticaja na ukupan rezultat ugovora na kraju perioda, nego samo na nastanak rezultata tokom vremena.

Grupisanje ugovora o osiguranju podrazumeva svrstavanje emitovanih ugovora u više portfelja. Svaki portfelj treba da sadrži ugovore koji podležu sličnim

[13] Björn Widing, Jimmy Jansson, „Valuation Practices of IFRS 17", Royal Institute of Technology, School of Engineering Sciences, Stockholm, Sweden, 2018, 2.

[14] Omar Alhawtmeh, „The Impact of IFRS 17 on the Development of Accounting Measurement and Disclosure, in Addition to Improving the Quality of Financial Reports, Considering Compliance with the Requirements of IFRS 4—Jordanian Insurance Companies-Field Study", *Sustainability*, Vol. 2023, No. 15, 8612, 23.

rizicima, a kojima se zajedno upravlja (tzv. linije proizvoda). MSFI 17 preporučuje da se svaki portfelj dalje grupiše prema vremenskom aspektu, odnosno po godinama kada su ugovori emitovani. Dalje raščlanjavanje podrazumeva da se svaki skup ugovora o osiguranju deli na najmanje tri podgrupe prema riziku: štetni (neprofitabilni) ugovori prilikom početnog priznavanja,[15] očekivano profitabilni ugovori, ugovori za koje postoji značajna mogućnost da naknadno postanu štetni, preostali ugovori. Navedena agregacija je neophodna zbog određivanja ukupnog procenjenog gubitka štetnih ugovora koji treba da bude priznat u bilansu uspeha na teret rezultata kako bi se gubitak u tekućem periodu umanjio ili izbegao.[16]

3. Novine u prezentaciji finansijskih izveštaja

Prezentacija bilansa uspeha predstavlja potpunu novinu u odnosu na tradicionalni način prezentovanja rezultata osiguravajuće kuće. Novina je u tome da polisirane premije, koje su najčešće predstavljale prvu liniju bilansa uspeha, tj. prihoda od osiguranja, više nisu na taj način prezentovane, niti uopšte vidljive u bilansu uspeha. Polisirane premije i očekivane štete i troškovi obračunati su u okviru vrednovanja samog ugovora, tako da razlika između tih prihoda i rashoda jeste u stvari projekcija budućeg profita, tj. ugovorna marža usluge koja je merodavno priznata kroz rezultat tokom ugovora[17].

U bilansu uspeha je zahtevano posebno iskazivanje **rezultata usluga osiguranja**. Stoga osiguravajuća kompanija iskazuje u bilansu uspeha prihode i troškove usluga osiguranja koji proizlaze iz grupa emitovanih ugovora o osiguranju, gde troškovi obuhvataju nastale štete i druge nastale troškove usluga osiguranja. Prihodi od ugovora o osiguranju priznaju se na osnovu pružanja usluga osiguranja, a ne na osnovu prijema premija. Taj pristup usklađuje priznavanje prihoda s realizacijom obaveza osiguravajuće kuće, kao što je to slučaj i u ostalim delatnostima[18]. Prihodi i troškovi usluga osiguranja isključuju sve komponente ulaganja. Kompanija neće prikazati premije u bilansu uspeha ako te informacije nisu u skladu s prikazanim prihodima.[19]

[15] MSFI 17 (par. 47) definiše da je ugovor o osiguranju štetan kada svi gotovinski tokovi na dan početnog priznavanja čine neto odliv. Taj gubitak se odmah priznaje u bilansu uspeha.

[16] Rastko Filipović, Šta nam donosi standard MSFI 17? 15. 6. 2022, dostupno na adresi: *https://bonitet.com/sta-nam-donosi-standard-msfi-17/* pristupljeno dana 24. 1. 2025.

[17] *Ibidem*.

[18] Harry Nikolaou, An Introduction to IFRS 17, 15. 7. 2024, dostupno na adresi: *https://www.addactis.com/blog/ifrs17-definitions*, pristupljeno dana 17. 1. 2025.

[19] IFRS Foundation, IFRS 17 Insurance Contracts, par. 83–85, dostupno na adresi: *https://www.ifrs.org/content/dam/ifrs/publications/pdf-standards/english/2022/issued/part-a/ifrs-17-insurance-contracts.pdf?bypass=on*, pristupljeno dana 21. 1. 2025.

Prihodi ili rashodi od finansiranja osiguranja obuhvataju promenu knjigovodstvene vrednosti grupe ugovora o osiguranju koja proizilazi iz:[20]

- efekta vremenske vrednosti novca i promene vremenske vrednosti novca; i
- efekta promena u pretpostavkama koje se odnose na finansijski rizik; ali
- uz isključivanje svih takvih promena za grupe ugovora o osiguranju s direktnim učešćem koje bi korigovale ugovornu maržu usluge (jer su ove promene već sastavni deo troškova usluga osiguranja).

Osiguravajuća kuća, kreirajući računovodstvene politike, odlučuje između uključivanja u bilans uspeha svih prihoda ili rashoda od finansiranja osiguranja za izveštajni period ili raščlanjivanja između iznosa prikazanog u bilansu uspeha i iznosa prikazanog u ostalom sveobuhvatnom rezultatu (engl. *Other Comprehensive Income – OCI*).[21]

Bilans stanja se nije suštinski promenio u svojoj strukturi. U aktivi i dalje najznačajniju poziciju čine ulaganja, koja se sada vrednuju primenom odredaba *MSFI 9 – Finansijski instrumenti* (koji za osiguravajuće kuće stupa na snagu istovremeno kada i MSFI 17 i odnosi se na priznavanje i merenje finansijske imovine). U aktivi više nema nedospelih potraživanja za premiju (kada su u pitanju neživotna osiguranja) i razgraničenih troškova nabavke. Naime, deo troškova nabavke koji se odnose na buduće obračunske periode razgraničava se kroz poziciju razgraničeni troškovi nabavke u aktivi. U pasivi su i dalje najzastupljenije obaveze iz ugovora o osiguranju.[22] Te obaveze se mere na osnovu trenutnih procena budućih novčanih tokova, diskontovanih na sadašnju vrednost i prilagođenih riziku. To omogućava precizniji prikaz finansijske pozicije osiguravajućeg društva.[23]

Zahtevi za prezentacijom prema MSFI 17 u dva osnovna finansijska izveštaja prikazani su u okviru Tabele 3, koja sledi u nastavku.

Tabela 3. Zahtevi za prezentacijom u finansijskim izveštajima prema MSFI 17

Bilans uspeha prema MSFI 17	Bilans stanja prema MSFI 17
Odvojeno prikazivanje rezultata:	Odvojeno prikazivanje u aktivi:
- Rezultat usluga osiguranja (razlika između poslovnih prihoda od osiguranja i rashoda od usluga osiguranja)	- Ugovori o osiguranju koji su emitovani kao imovina
- Prihodi ili rashodi od finansiranja osiguranja	- Ugovori o reosiguranju koji su imovina
Odvojeno prikazivanje prihoda ili rashoda:	Odvojeno prikazivanje u pasivi:

[20] *Ibid*., par. 87.
[21] *Ibid*., par. 88–90.
[22] Andreja Radić Blažin, „Nova era računovodstva u osiguranju: Međunarodni računovodstveni standard financijskog izvještavanja 17", *Hrvatski časopis za osiguranje*, br. 6/2022, 49.
[23] Harry Nikolaou, An Introduction to IFRS 17, 15. 7. 2024, dostupno na adresi: *https://www.addactis.com/blog/ifrs17-definitions* pristupljeno dana 17. 1. 2025.

Bilans uspeha prema MSFI 17	Bilans stanja prema MSFI 17
- Prihodi ili rashodi iz ugovora o reosiguranju	- Ugovori o osiguranju koji su emitovani kao obaveze
- Prihodi ili rashodi od emitovanih ugovora o osiguranju	- Ugovori o reosiguranju koji su obaveze

Poboljšani zahtevi za obelodanjivanje, koji prate MSFI 17, obezbeđuju da osiguravajuće kuće daju detaljne i korisne informacije o iznosima priznatim u finansijskim izveštajima. Poboljšana obelodanjivanja će dovesti do veće transparentnosti u finansijskim izveštajima, pomažući zainteresovanim stranama da razumeju finansijski učinak osiguravača i njegovu izloženost riziku, kao i da procene uticaj koji ugovori o osiguranju imaju na finansijsku poziciju, performanse i tokove gotovine osiguravajuće kuće. Poboljšana obelodanjivanja podrazumevaju da napomene uz finansijske izveštaje sadrže kvalitativne i kvantitativne informacije o:[24]

- iznosima priznatim u finansijskim izveštajima koji proizlaze iz ugovora o osiguranju;
- značajnim procenama i promenama u tim procenama koje su posledica primene MSFI 17; i
- prirodi i obimu rizika koji proizlaze iz ugovora o osiguranju.

III Modeli vrednovanja obaveza iz ugovora o osiguranju

Prema MSFI 17, inicijalno priznavanje ugovora o osiguranju nastaje najranije od početka perioda pokrića ili na datum dospeća prve uplate, odnosno od datuma kada činjenice/okolnosti ukazuju da je ugovor štetan. Prestanak priznavanja ugovora o osiguranju nastupa kada je obaveza izvršena, otkazana ili istekla, odnosno kada su ispunjene određene modifikacije uslova iz ugovora.[25]

U pogledu vrednovanja obaveza, MSFI 17 pravi razliku između obaveza koje proističu iz događaja pokrivenih zarađenom premijom (obaveze za nastala potraživanja, engl. *Liability for Incurred Claims – LIC*) i događaja za koje se očekuje da će nastati između datuma bilansa stanja i kraja ugovora (obaveze za preostala pokrića, engl. *Liability for Remaining Coverage – LFRC*). Koji god model vrednovanja da se primeni, obaveze za nastala potraživanja će biti iste, dok će izbor modela uticati samo na proračun obaveza za preostala pokrića.[26]

[24] IFRS Foundation, IFRS 17 Insurance Contracts, par. 93, dostupno na adresi: *https://www.ifrs.org/content/dam/ifrs/publications/pdf-standards/english/2022/issued/part-a/ifrs-17-insurance-contracts.pdf?bypass=on*, 21. 1. 2025.

[25] Mogomotsi Phage, Introduction to IFRS 17, 17. 5. 2021, dostupno na adresi: *https://www.munichre.com/content/dam/munichre/contentlounge/website-pieces/documents/Introduction-to-IFRS-17-May2021-LIMA-MoG.pdf/_jcr_content/renditions/original./Introduction-to-IFRS-17-May2021-LIMA-MoG.pdf* 29. 1. 2025.

[26] Detaljnije videti u: Vienna Insurance Group and KPMG, 10 Questions regarding IFRS 17, dostupno na adresi: *https://group.vig/media/i2ljz52m/10-questions-regarding-ifrs-17-kpmg-and-vig.pdf* pristupljeno

Tri modela vrednovanja obaveza iz ugovora o osiguranju koje MSFI 17 propisuje su:

a) Opšti model vrednovanja obaveza (engl. *General Measurement Model – GMM*), koji se zove još i pristup temeljen na „gradivnim blokovima" (engl. *Building Blocks Approach – BBA*);

b) Model varijabilne naknade (engl. *Variable Fee Approach – VFA*);

c) Model alociranih premija (engl. *Premium Allocation Approach – PAA*).

Opšti model je podrazumevani model za vrednovanje obaveza iz ugovora o osiguranju. Za ugovore sa periodom pokrića kraćim od jedne godine, postoji mogućnost izbora modela alociranih premija, kao pojednostavljenog modela merenja. Za ugovore s karakteristikama direktnog učešća obavezna je primena modela varijabilne naknade.

1. Opšti model vrednovanja obaveza

Kada je posredi stvarna vrednost ugovora o osiguranju pod delokrugom MSFI 17, osiguravajuća kuća bi trebalo da utvrdi koji modeli su, od tri postojeća, primenljivi. Podrazumevana je primena **opšteg modela vrednovanja obaveza**, koji pretpostavlja da će se obaveze iz osiguranja meriti u visini očekivanih budućih novčanih tokova, svedenih na sadašnju vrednost primenom relevantnih tržišnih stopa, uvećanih za korekciju za nefinansijski rizik i ugovornu maržu usluge.[27] Pristup „gradivnih blokova", što predstavlja drugi naziv tog modela, zahteva od kompanija da odvojeno mere komponente ugovora o osiguranju, kao što su verovatnoća šteta, vremenska vrednost novca i prilagođavanje rizika. Taj pristup ima za cilj da pruži precizniji odraz vrednosti ugovora o osiguranju i rizika povezanih s njima.[28] Opšti model vrednovanja obaveza sastoji se od sledećih „gradivnih blokova":

- Novčani tokovi po ispunjenju ugovorne obaveze, koji se sastoje od:
  - sadašnje vrednosti verovatno ponderisane procene budućih novčanih tokova, odnosno budućih priliva i odliva gotovine koji se direktno tiču ispunjenja portfelja ugovora (premije, štete i druge pogodnosti za korisnike ugovora);
  - korekcije koja odražava vremensku vrednost novca i finansijske rizike koji se odnose na buduće tokove gotovine, u meri u kojoj finansijski rizici nisu uključeni u procene budućih novčanih tokova;

07.04. 2025. i Jonathan Kemp, Clair Le Poidevin, IFRS 17 Insurance contracts measurement and applicability, 2021, dostupno na adresi: *https://www.bwcigroup.com/Factsheets/Insurance/IFRS17%20Measurement%20and%20Applicability.pdf* pristupljeno 31. 1. 2025.

[27] Katarina Mikić, *Vrednovanje obveza iz Ugovora o osiguranju prema MSFI 17*, Sveučilište u Zagrebu, Prirodoslovno-matematički fakultet, 2021, 14.

[28] Omar Alhawtmeh, „The Impact of IFRS 17 on the Development of Accounting Measurement and Disclosure, in Addition to Improving the Quality of Financial Reports, Considering Compliance with the Requirements of IFRS 4—Jordanian Insurance Companies-Field Study", *Sustainability*, Vol. 2023, No. 15, 8612, 3.

– korekcije rizika za nefinansijski rizik.
– ugovorne marže usluge (engl. *Contractual Service Margin – CSM*) koja je komponenta imovine ili obaveza iz ugovora o osiguranju i predstavlja procenjenu nezarađenu dobit koju će osiguravajuća kuća priznati ako i kada bude pružila usluge ugovora o osiguranju imaocu polise u budućem periodu.[29] Ugovorna marža usluge se priznaje u bilansu uspeha (ako se očekuje da će biti gubitak) ili u bilansu stanja kao obaveza (ako se očekuje da će biti dobit) i predstavlja procenu buduće profitabilnosti kompanije. Promene u marži pružaju informacije o profitabilnosti novih poslova i promenama u profitabilnosti postojećih ugovora.[30]

Zbir navedenih „gradivnih blokova" formira ukupne obaveze iz osiguranja. Vrednovanje obaveza iz ugovora o osiguranju obavlja se pri početnom priznavanju ugovora, ali i za svaki naredni izveštajni period. U svrhu objašnjenja opšteg modela vrednovanja obaveza, u nastavku će biti prikazan primer kako „gradivni blokovi" međusobno deluju u merenju portfelja ugovora o osiguranju.

Primer za opšti model vrednovanja obaveza[31]

„Planet osiguranje" d.o.o. sklopilo je 100 trogodišnjih polisa osiguranja koje počinju 1. januara 2022. godine. Te polise osiguravaju vlasnike kućnih ljubimaca do 50% svih veterinarskih računa koje imaju u vezi sa svojim ljubimcima tokom perioda pokrića polise.

Svaki nosilac polise dužan je da plati godišnju premiju od 90 novčanih jedinica (n. j.), koja se plaća prvog dana svake kalendarske godine tokom perioda pokrića. Za potrebe merenja ugovora o osiguranju prema MSFI 17, a na osnovu prethodnog iskustva sa sličnim vrstama polisa osiguranja, „Planet osiguranje" d.o.o. usvaja sledeće pretpostavke:

- očekivani godišnji odlivi gotovine su 7.000 novčanih jedinica godišnje (uključujući potraživanja i administrativne troškove);
- sva potraživanja iz osiguranja koja nastanu u toku godine biće isplaćena na kraju te godine;

[29] BDO Australia, Applying the General Measurement Model in IFRS 17 Insurance Contracts to a portfolio of insurance contracts, 2021, dostupno na adresi: *https://www.bdo.com.au/en-au/content/accounting-news/accounting-news-october-2021/general-measurement-model* pristupljeno 14. 2. 2025.

[30] Darrel Scott, Najnovije informacije o IFRS-ima za regulatore: IFRS 17 – Ugovori o osiguranju, 13–14. 12. 2021, dostupno na adresi: *https://cfrr.worldbank.org/sites/default/files/2021-12/4.%20%20IFRS%2017%20Regulation-new%20BCS.pdf* pristupljeno 2. 1. 2025.

[31] Prilagođeno prema: BDO Australia, Applying the General Measurement Model in IFRS 17 Insurance Contracts to a portfolio of insurance contracts, 2021, dostupno na adresi: *https://www.bdo.com.au/en-au/content/accounting-news/accounting-news-october-2021/general-measurement-model* pristupljeno14. 2. 2025.

- nijedna polisa neće isteći tokom perioda pokrića i nikakvi periodi produženja se ne nude u okviru polise;
- diskontna stopa iznosi 5% godišnje;
- „Planet osiguranje" d.o.o. nije izloženo bilo kakvom materijalnom finansijskom riziku u pogledu polisa osiguranja;
- korekcija rizika za nefinansijski rizik iznosi 5% sadašnje vrednosti očekivanih odliva gotovine;
- „Planet osiguranje" d.o.o. ne snosi početne troškove nabavke u vezi s polisama osiguranja.

Na osnovu gore navedenog, „Planet osiguranje" d.o.o. meri portfelj polisa osiguranja kućnih ljubimaca prilikom početnog priznavanja na sledeći način:[32]

Tabela 4. Početno vrednovanje portfelja polisa osiguranja

Procena sadašnje vrednosti budućih priliva gotovine	(25.735)
Procena sadašnje vrednosti budućih odliva gotovine	19.063
Procena sadašnje vrednosti budućih (neto) novčanih tokova	(6.672)
Korekcija rizika za nefinansijski rizik	953
Ispunjenje novčanih tokova – videti pod: a) ispod	(5719)
Ugovorna marža usluge – videti pod: b) ispod	5719
Ugovor o osiguranju (aktiva)/obaveze pri početnom priznavanju	0

Napomene uz Tabelu 4:

a) Nefinansijski rizici uključuju rizike razvoja potraživanja (isključujući rizike povezane s direktnim indeksom inflacije) i rizike od troškova (rizik neočekivanih promena u troškovima u vezi sa sprovođenjem ugovora) koji su povezani sa ugovorima o osiguranju, ali nisu finansijske prirode. Nefinansijski rizik takođe može uključivati rizike od prestanka i postojanosti, a to su rizici da će nosilac polise iskoristiti bilo kakvo obnavljanje, predaju, konverziju ili drugu opciju koja mu je dostupna u okviru polise a koja menja iznos, dospeće, prirodu ili neizvesnost iznosa koje će dobiti po polisi. Međutim, u tom primeru se pretpostavlja da nijedna polisa neće prestati tokom perioda pokrića i da se u okviru polise ne nude periodi produženja.

b) MSFI 17 (paragraf 38) zahteva od osiguravajućih kuća da mere ugovornu maržu usluge pri početnom priznavanju portfelja ugovora o osiguranju u iznosu koji ne dovodi do prihoda ili rashoda što proističu iz početnog priznavanja novčanih tokova ispunjenja ugovorne obaveze.

[32] MSFI 17 (par. 32) zahteva da novčani tokovi ispunjenja ugovorne obaveze obuhvataju procene budućih tokova gotovine (prilivi i odlivi), prilagođene da odražavaju vremensku vrednost novca i sve finansijske rizike u vezi s tim budućim tokovima gotovine i korekcije rizika za nefinansijski rizik.

Tabela 5. Prva godina od sklapanja trogodišnjih polisa osiguranja

Na dan 31. 12. 2022. godine	Procena sadašnje vrednosti budućih novčanih tokova	Korekcija rizika za nefinansijski rizik	Ugovorna marža usluge	Ugovor o osiguranju (aktiva)/ obaveze
Početno stanje – (aktiva)/ obaveze	0	0	0	0
Promene vezane za buduće usluge: novi ugovori o osiguranju	(6672)	953	5.719	0
Prilivi gotovine	9000	0	0	9000
Troškovi finansiranja osiguranja	953	48	286	1287
Prihodi od finansiranja osiguranja – videti pod: a) ispod	(837)	0	0	(837)
Promene koje se odnose na tekuće usluge – videti pod: b) ispod	0	(398)	(2,001)	(2399)
Odlivi gotovine	(7000)	0	0	(7000)
Zaključno stanje – (aktiva)/ obaveze	(4556)	603	4004	51

Tabela 6. Druga godina od sklapanja trogodišnjih polisa osiguranja

Na dan 31. 12. 2023. godine	Procena sadašnje vrednosti budućih novčanih tokova	Korekcija rizika za nefinansijski rizik	Ugovorna marža usluge	Ugovor o osiguranju (aktiva)/ obaveze
Početno stanje – (aktiva)/ obaveze	(4556)	603	4004	51
Promene vezane za buduće usluge: novi ugovori o osiguranju	0	0	0	0
Prilivi gotovine	9000	0	0	9000
Troškovi finansiranja osiguranja	651	30	200	881
Prihodi od finansiranja osiguranja – videti pod: a) ispod	(429)	0	0	(429)
Promene koje se odnose na tekuće usluge – videti pod: b) ispod	0	(380)	(2,102)	(2482)

Odlivi gotovine	(7000)	0	0	(7.000)
Zaključno stanje – (aktiva)/ obaveze	(2334)	253	2102	21

Tabela 7. Treća godina od sklapanja trogodišnjih polisa osiguranja

Na dan 31. 12. 2024. godine	Procena sadašnje vrednosti budućih novčanih tokova	Korekcija rizika za nefinansijski rizik	Ugovorna marža usluge	Ugovor o osiguranju (aktiva)/ obaveze
Početno stanje – (aktiva)/ obaveze	(2334)	253	2.102	21
Promene vezane za buduće usluge: novi ugovori o osiguranju	0	0	0	0
Prilivi gotovine	9000	0	0	9000
Troškovi finansiranja osiguranja	334	13	105	452
Prihodi od finansiranja osiguranja – videti pod: a) ispod	0	0	0	0
Promene koje se odnose na tekuće usluge – videti pod: b) ispod	0	(266)	(2207)	(2473)
Odlivi gotovine	(7000)	0	0	(7000)
Zaključno stanje – (aktiva)/ obaveze	0	0	0	0

Napomene uz Tabele 5, 6 i 7:

a) Kada ugovor o osiguranju dovede do budućih priliva gotovine u obliku godišnjih premija, kompanija koja emituje ugovore o osiguranju priznaće prihode od kamata kako se potraživanja za premiju budu gasila.

b) Kada se stvarno stanje poklapa s pretpostavkama kompanije u vezi sa ugovorima o osiguranju koje emituje, tada nema promena u vezi s tekućim uslugama koje utiču na procene sadašnje vrednosti budućih tokova gotovine. Međutim, korekcija rizika za nefinansijski rizik i ugovorna marža usluge će se gasiti tokom perioda pokrića, u skladu sa idejom da se „Planet osiguranje" d.o.o. oslobađa rizika osiguranja dok pruža usluge osiguranja.

2. Ostali modeli vrednovanja obaveza

U slučaju da u ugovoru o osiguranju postoje karakteristike direktnog učešća, kompanija treba da razmotri primenu **modela varijabilne naknade**, koji predstavlja

varijaciju opšteg modela i primenljiv je na ugovore u kojima su osiguranici većinski nosioci investicionog rizika. Takvi ugovori o osiguranju su u suštini ugovori o uslugama i oni se odnose na ulaganja prema kojima osiguravajuća kuća obećava povraćaj ulaganja na osnovu „osnovnih stavki". Primer takvih ugovora su ugovori o životnom osiguranju sa učešćem u dobiti od kamata koje su rezultat ulaganja štedne (investicione) premije u investicione fondove.

Prilikom početnog priznavanja obaveza, ne postoji razlika u merenju između ugovora sa karakteristika direktnog učešća ili bez njih: sve vrste ugovora se mere na isti način (osim modela alociranih premija, o čemu će biti reči u nastavku). To znači da se ugovorna marža usluge pri početnom priznavanju meri na isti način. Ključna razlika između opšteg modela i modela varijabilne naknade evidentna je tek pri naknadnom vrednovanju obaveza. Navedena razlika proizlazi iz shvatanja da ugovori s karakteristikama direktnog učešća generalno imaju profitabilnost koja u velikoj meri zavisi od kretanja na tržištu. Stoga su, samo za te ugovore, ekonomska kretanja u vrednosti udela osiguravajuće kuće u „osnovnim stavkama" ugrađena u ugovornu maržu usluge. Model varijable naknade prilagođava ugovornu maržu usluge na osnovu promena u udelu entiteta u fer vrednosti „osnovnih stavki", obezbeđujući da merenje obaveza iz ugovora o osiguranju odražava promenljivu prirodu ovih ugovora.

Model varijabilne naknade, kao što to stoji u samom nazivu, uvodi koncept *varijabilne naknade* koja je definisana kao udeo kompanije u „osnovnim stavkama" kao naknada za usluge koje pruža.[33] Naime, osiguravajuća kuća se obavezuje da će uložiti novac osiguranika u imovinu za koju se očekuje porast vrednosti. Osiguravajuća kuća naplaćuje naknadu za upravljanje tom imovinom, koja se naziva „varijabilna naknada". Vrednost te naknade se menja u zavisnosti od vrednosti imovine. Model varijabilne naknade, dakle, pruža mogućnost da se unošenjem ekonomskih kretanja u ugovornu maržu usluge ona redovno ažurira, što odražava činjenicu da je buduća profitabilnost kompanije značajno pod uticajem kretanja na tržištu. Bez tog ugrađenog mehanizma, rezultat usluga osiguranja za te proizvode ne bi odražavao stvarnost, a neto rezultat ulaganja bio bi više podložan promenama (izraženija volatilnost). Zbog toga se kaže da je glavna prednost primene modela varijabilne naknade bolje upravljanje volatilnošću bilansa stanja osiguravajuće kuće.[34]

Model alociranih premija je uprošćen, dakle najjednostavniji od tri modela. Primenljiv je na ugovore koji traju do godinu dana i može se dokazati da njegova primena neće dovesti do materijalno drugačijih rezultata nego pri primeni opšteg

[33] Wijdan Yousuf (Chair) *et al.*, IFRS 17: How to choose the measurement model. Institute and Faculty of Actuaries (IFoA), London, UK, 17.7.2019, dostupno na adresi: *https://www.actuaries.org.uk/system/files/field/document/IFRS%2017_How%20to%20choose%20the%20measurement%20model_20190717.pdf* pristupljeno 2. 2. 2025.

[34] *Ibidem*.

modela.[35] Taj model se primenjuje na ugovore o osiguranju u vezi s nesrećnim slučajem i imovinom.[36] To su ugovori o neživotnom osiguranju koji se obično povezuju s nesrećnim slučajem kao što su medicinski troškovi ili štete nastale na imovini.[37] Koristeći model alociranih premija, obaveze za preostala pokrića inicijalno će se priznati kao premije primljene pri početnom priznavanju, umanjene za sve tokove gotovine od sticanja osiguranja na taj datum. Naknadno, knjigovodstvena vrednost obaveze je knjigovodstvena vrednost na početku izveštajnog perioda uvećana za premije primljene u periodu, minus tokovi gotovine od sticanja osiguranja, plus amortizacija tokova gotovine od sticanja, umanjena za iznos priznat kao prihod od osiguranja za pokriće obezbeđeno u tom periodu, i umanjena za bilo koju komponentu investicionog potraživanja koja je plaćena ili preneta na nastalu obavezu (odštetni zahtevi).[38]

Razlike između opšteg modela i modela alociranih premija su:[39]

- pojednostavljeno merenje obaveza za preostalo pokriće za grupe ugovora o osiguranju koje nisu štetne;
- mogućnost neprilagođavanja budućih novčanih tokova na nastale štete za vremensku vrednost novca i finansijski rizik, ukoliko se očekuje da će ti novčani tokovi biti isplaćeni ili primljeni unutar jedne godine ili manje od datuma nastanka;
- mogućnost priznavanja troškova nabavke u vezi s polisama osiguranja kao rashoda kada nastanu;
- mogućnost procene štetnosti grupe ugovora samo ako činjenice i okolnosti ukazuju na to (dok opšti model zahteva procenu na svaki datum izveštavanja).

Uporedni prikaz opšteg modela i modela alociranih premija nalazi se u nastavku (videti Tabelu 8).

[35] Jonathan Kemp, Clair Le Poidevin, IFRS 17 Insurance contracts measurement and applicability, 2021, dostupno na adresi: *https://www.bwcigroup.com/Factsheets/Insurance/IFRS17%20Measurement%20and%20Applicability.pdf* pristupljeno 31. 1. 2025.

[36] Björn Widing, Jimmy Jansson, "Valuation Practices of IFRS 17", Royal Institute of Technology, School of Engineering Sciences, Stockholm, Sweden, 2018, 7.

[37] *Ibidem*, 5.

[38] Rada Stojanović *et al.*, *Primena Međunarodnih standarda finansijskog izveštavanja*, Računovodstvo d.o.o., Beograd, 2019, 534.

[39] Katarina Mikić, *Vrednovanje obveza iz Ugovora o osiguranju prema MSFI 17*, Sveučilište u Zagrebu, Prirodoslovno-matematički fakultet, 2021, 33.

Tabela 8. Uporedni prikaz opšteg modela i modela alociranih premija[40]

Opšti model vrednovanja obaveza	*Model alociranih premija*
Ugovorna marža usluge	Komponenta slična nezarađenoj premiji (umanjena za direktne troškove nabavke)
Korekcija rizika	
Diskontovanje	
Najbolja procena ispunjenja novčanih tokova	
Korekcija rizika	Korekcija rizika
Diskontovanje	Diskontovanje
Najbolja procena ispunjenja novčanih tokova	Najbolja procena ispunjenja novčanih tokova

U svrhu objašnjenja modela alociranih premija za vrednovanje obaveza, u nastavku će biti prikazan primer.

Primer za model alociranih premija

Osnove pretpostavke primera date su u Tabeli 9.

Tabela 9. Osnovne pretpostavke primera

Osiguranje od auto-odgovornosti	
Broj polisa:	1
Početak osiguranja:	1. 7. 2023.
Trajanje osiguranja u godinama:	1
Premija osiguranja:	100 novčanih jedinica (n. j.)
Dinamika plaćanja premije:	godišnje

Pretpostavke od značaja za vrednovanje obaveza:
- Premija je u potpunosti primljena pri sklapanju ugovora o osiguranju.
- Osiguravajuća kuća se odlučuje na odlaganje direktnih troškova nabavke.
- Pretpostavka je da ugovor nije štetan, te da nema diskontovanja zbog njegovog kratkog trajanja.
- Na datum bilansa 31. 12. 2023. godine postoje isplaćene štete od 10 n. j., te štete koje su nastale u periodu ali još nisu isplaćene čine rezervu u iznosu od 18 n. j. Korekcija za nefinansijski rizik za nastale štete iznosi 3 n. j.

[40] Korigovano prema: Wijdan Yousuf (Chair) *et al.*, IFRS 17: How to choose the measurement model. Institute and Faculty of Actuaries (IFoA), London, UK, 17.7.2019, dostupno na adresi: *https://www.actuaries.org.uk/system/files/field/document/IFRS%2017_How%20to%20choose%20the%20measurement%20model_20190717.pdf* pristupljeno 2. 2. 2025.

- Na datum bilansa 31. 12. 2024. godine postoje isplaćene štete od 30 n. j., te štete koje su nastale u periodu ali nisu isplaćene čine rezervu od 27 n. j. Korekcija za nefinansijski rizik za nastale štete iznosi 6 n. j.

Budući da je trajanje ugovora jedna godina, moguće je automatski primeniti model alociranih premija. U nastavku (videti Tabelu 10) biće prikazane obaveze za preostalo pokriće i obaveze za nastale štete na kraju svakog izveštajnog perioda.

Tabela 10. Vrednovanje obaveza prema modelu alociranih premija[41]

Obaveze	Početno vrednovanje	Datum bilansa stanja	
	1. 7. 2023.	31. 12. 2023.	31. 12. 2024.
Obaveze za preostalo pokriće:	**90**	**45**	**0**
Premija	100	50	0
Direktni troškovi nabavke	(10)	(5)	0
Obaveze za nastale štete:	**0**	**21**	**33**
Sadašnja vrednost nastalih šteta	0	18	27
Korekcija za nefinansijski rizik	0	3	6

Obaveze za preostalo pokriće pri početnom vrednovanju iznose 90 n. j. Ovaj iznos je rezultat razlike između iznosa primljene premije (100 n. j.) i iznosa isplate povezane s novčanim tokovima nabavke (10 n. j.). Na datum bilansa 31. 12. 2023. godine obaveze za preostalo pokriće iznose 45 n. j. Taj iznos predstavlja zbir prethodne knjigovodstvene vrednosti obaveza za preostalo pokriće (90 n. j.) i iznosa amortizacije novčanih tokova nabavke za taj period (5 n. j.) koji se zatim umanjuje za iznos priznat kao prihod od premije tokom perioda (50 n. j.). Na isti datum bilansa, obaveze za nastale štete iznose 21 n. j. Do navedenog iznosa se dolazi tako što se štete nastale u periodu u iznosu od 18 n. j. (ali koje još nisu plaćene, pa se nalaze u rezervi šteta) saberu s korekcijom za nefinansijski rizik u iznosu od 3 n. j. U narednom izveštajnom periodu, na datum bilansa 31. 12. 2024. godine, obaveza za preostalo pokriće je istekla, odnosno iznosi 0 n. j., dok obaveze za nastale štete iznose 33 n. j. Navedeni iznos je dobijen sabiranjem rezervi šteta od 27 n. j. sa korekcijom za nefinansijski rizik od 6 n. j.[42]

IV Zaključak

Svaki novodoneti MSFI imao je za cilj slične reforme u oblasti finansijskog izveštavanja, koje su pak za posledicu imale nastavak harmonizacije, bolju transparentnost i veći kvalitet informacija sadržanih u finansijskim izveštajima. Koristi od

[41] Korigovano prema: Katarina Mikić, *Vrednovanje obveza iz Ugovora o osiguranju prema MSFI 17*, Sveučilište u Zagrebu, Prirodoslovno-matematički fakultet, 2021, 36.

[42] Korigovano prema: *Ibidem*, str. 36–37.

takvih reformi bile su uvek dvostrane: kompanije bi dobile uporedivije finansijske izveštaje, a zainteresovane strane bolju informacionu osnovu za bolju procenu uspeha, performansi i rizika kompanija. Donošenje standarda *MSFI 17 – Ugovori o osiguranju* najavljeno je kao nesumnjivo najznačajnija promena u zahtevima osiguranja u poslednjih 20 godina.

Usklađivanje vrednovanja i prezentacije pozicija u finansijskim izveštajima u svim MSFI jurisdikcijama, usklađivanje s drugim delatnostima u oblasti finansijskog izveštavanja, te unapređenje kvalitativnih karakteristika finansijskih izveštaja (uporedivost, transparentnost, korisnost) jesu najistaknutije prednosti MSFI 17, ali ujedno i nedostaci zamenjenog MSFI 4. Procena buduće profitabilnosti kompanije, utvrđivanje nezarađene dobiti, procene koje se ažuriraju u svakom izveštajnom periodu i diskontna stopa zasnovana na novčanim tokovima iz ugovora samo su neke od konkretnih novina koje su uvedene primenom MSFI 17. Značajne promene nakon uvođenja MSFI 17 pretrpeo je bilans uspeha, dok se bilans stanja nije značajno menjao. U bilans uspeha uvedeno je odvojeno prikazivanje rezultata, to jest zasebno prikazivanje rezultata od usluga osiguranja i rezultata od finansiranja osiguranja. Unapređenja su uvedena i u delu obelodanjivanja, tako da je sada održiva jedna računovodstvena politika za sve ugovore o osiguranju na nivou cele delatnosti.

Odlike novog pristupa računovodstvene prakse ugovora o osiguranja pomoći će zainteresovanim stranama da bolje razumeju finansijski učinak osiguravača i izloženost riziku, kao i da uspešnije procene uticaj koji ugovori o osiguranju imaju na finansijsku poziciju, performanse i tokove gotovine osiguravača u odnosu na druge osiguravajuće kuće, u odnosu na druge delatnosti i tokom vremena.

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NEW ACCOUNTING APPROACH TO INSURANCE CONTRACTS UNDER THE REVISED PROFESSIONAL REGULATION

PROFESSIONAL PAPER

Summary

With the introduction of the new standard *IFRS 17 – Insurance Contracts*, the insurance industry has undergone significant changes in the field of financial reporting over the past two years. This paper aims to present the new accounting approach related to insurance contracts, explaining the nature of the changes introduced by the new regulation, their impact on the presentation of certain items in the financial statements, as well as their effects on the transparency, comparability and usefulness of financial information that help stakeholders assess the business and risks that insurance companies are exposed to in the course of their activities. The most substantial changes occurred in the area of grouping of insurance contracts and the applicability of standard requirements to groups of contracts, recognition of income, valuation of insurance contract liabilities, presentation of current and future profit, as well as presentation and disclosure of certain items in financial statements.

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This paper is primarily intended for theorists and practitioners in the fields of insurance, finance, and accounting, as well as for all stakeholders who rely on financial statements of insurance companies.

Keywords: *regulation, insurance company, financial risk, financial statements, liabilities, contractual service margin.*

I Introduction

The insurance industry has undergone substantial transformation due to an intensive process of capital consolidation, mergers, digitalization, and the automation of business operations. These changes have been driven by the global economic slowdown, inflationary pressures, geopolitical events, natural disasters, the COVID-19 pandemic, and tightening regulatory frameworks.[3] Given that the regulatory framework significantly influences the development of the insurance market, several important regulatory reforms affecting insurance company operations have been introduced over the past decade.[4] One such reform is the adoption of *IFRS 17 – Insurance Contracts*, a new international standard that establishes principles for the recognition, measurement, presentation, and disclosure of insurance contracts.

The set of International Financial Reporting Standards (IFRS), issued by the International Accounting Standards Board (IASB), has been applied in the Republic of Serbia since January 1, 2004. IFRS are an integral part of the international accounting framework and, under the Law on Accounting,[5] are mandatory for large legal entities, entities required to prepare consolidated financial statements, public companies, and those preparing to go public in accordance with capital market regulations, regardless of their size.

The most recently issued standard, *IFRS 17 – Insurance Contracts*, came into force on January 1, 2023. It was conceived by the IASB as a single accounting model for all insurance contracts across the 168 IFRS jurisdictions worldwide. The implementation of IFRS 17 is expected to provide more useful and transparent information, as well as improved insights into the profitability of insurance companies. IFRS 17 provides consistent principles across all aspects of accounting for insurance contracts, eliminating previous inconsistencies and enabling investors, analysts, and other external users of financial statements to meaningfully compare companies, contracts, and business activities.

[3] Jelena Kočović et al., „Trends In Insurance Market Development", *Tokovi osiguranja*, No. 3/2024, 546.
[4] *Ibidem*, 545.
[5] Law on Accounting, *Official Gazette of the Republic of Serbia*, Nos. 73/2019 and 44/2021 – other law, art. 24.

IFRS 17 has been announced as the first truly international financial reporting standard for insurance contracts. It replaces *IFRS 4 – Insurance Contracts*, which was introduced 17 years ago as an interim standard and was originally intended to be replaced by a subsequent IFRS 4 Phase II, later renamed IFRS 17. The initial effective date for the long-awaited IFRS 17 was set for January 1, 2021, but in June 2020, the IASB decided to postpone the implementation to January 1, 2023.

The primary objective of adopting IFRS 17 was to enhance transparency in the financial reporting of insurance companies and to provide relevant information that faithfully represents insurance contracts. Increased transparency is achieved when insurers, in applying IFRS 17, measure insurance contracts using updated estimates and assumptions that reflect the timing of cash flows and any uncertainties related to those contracts. Financial statement users rely on this information to assess the impact of insurance contracts on an insurer's financial position, performance, and cash flows. By providing a clearer picture of liabilities and risk profiles to which insurers are exposed, the application of IFRS 17 may also help strengthen market confidence, potentially resulting in reduced capital costs. The standard has introduced greater precision and alignment in how insurance contracts are measured and how results are presented, thereby allowing for vertical comparability and harmonization of financial reporting across all IFRS jurisdictions.

According to its scope, IFRS 17 applies to insurance and reinsurance contracts issued by an entity, reinsurance contracts held by an entity, and investment contracts with discretionary participation features issued by entities that also issue insurance contracts.[6] Therefore, IFRS 17 pertains strictly to accounting for insurance contracts, while the overall accounting practices of insurance companies are governed by other legal and international regulations. The IASB considered it optimal to apply the standard to the insurance activity itself rather than to the entity (insurance company) as a whole. Accordingly, IFRS 17 applies to all insurance contracts within its defined scope throughout the contract's duration, regardless of the nature of those contracts.[7] This is why the term "accounting for insurance contracts" is used in IFRS 17, rather than "accounting of insurance companies".

The introduction of IFRS 17, as with any other new IFRS, presents substantial challenges and leads to increased costs for insurance companies related to software and IT system adjustments, the development of new tools, changes in key performance indicators, updates to internal procedures, and expenditures for employee training and education. On the other hand, the quality of financial statements is

[6] Rada Stojanović *et al.*, *Primena Međunarodnih standarda finansijskog izveštavanja*, Računovodstvo d.o.o., Belgrade, 2019, 514.

[7] Omar Alhawtmeh, „The Impact of IFRS 17 on the Development of Accounting Measurement and Disclosure, in Addition to Improving the Quality of Financial Reports, Considering Compliance with the Requirements of IFRS 4 – Jordanian Insurance Companies-Field Study", *Sustainability*, Vol. 2023, No. 15, 8612, 7.

expected to improve. In their research, Dahiyata and Owais[8] demonstrate that the expected impact of IFRS 17 on financial statements quality is both significant and positive, particularly in the areas of comparability of financial statements, faithful representation, and relevance. Their study also found that IFRS 17 enables the unified assessment of unearned profit at the inception of insurance contracts, thereby facilitating comparisons among different insurance companies. Moreover, the recognition of revenues and expenses by insurance companies allows for comparisons with other industries.

Therefore, it can be concluded that improvements in financial statements quality, enhanced risk management, and other long-term benefits resulting from IFRS 17 are expected to outweigh the initial implementation costs. This aligns with the cost-benefit constraint principle[9] on useful financial reporting.

II Innovations in IFRS 17 Compared to the Previous Regulation

As previously noted, the introduction of IFRS 17 has brought a range of advantages and improvements. To better understand and identify them, it is essential to make a direct comparison between the innovations introduced by IFRS 17 and the former standard, *IFRS 4 – Insurance Contracts*. The most significant innovations include advancements in comparability, transparency, and usefulness of information, the introduction of insurance contract grouping, and the establishment of three distinct measurement models for insurance contract liabilities.

1. Differences Between IFRS 4 and IFRS 17

The key changes introduced in IFRS 17 in comparison to IFRS 4 are as follows:[10]

- Insurance revenues no longer include deposit components**,** but only services provided.
- Revenue is recognized when it is earned (i.e. when it is market-verified), and expenses are recognized when incurred. This approach aligns revenue recognition more closely with other IFRS standards and practices in other industries.

[8] Ahmad Dahiyata, Walid Owaisa, „The expected impact of applying IFRS (17) insurance contracts on the quality of financial reports", *Accounting,* Vol. 2021, No. 7, 581–590.

[9] IASB, Conceptual Framework for Financial Reporting, 2018, 2.39-2.43, available at: *https://www.ifrs.org/content/dam/ifrs/publications/pdf-standards/english/2021/issued/part-a/conceptual-framework-for-financial-reporting.pdf*, accessed January 5, 2025.

[10] Darrel Scott, *Najnovije informacije o IFRS-ima za regulatore: IFRS 17 – Ugovori o osiguranju*, December 13–14, 2021, available at: https://cfrr.worldbank.org/sites/default/files/2021-12/4.%20%20IFRS%2017%20Regulation-new%20BCS.pdf accessed January 2, 2025.

- Presentation of insurance finance expenses is aligned with the corresponding revenue.
- Simplified measurement is allowed for certain short-term insurance contracts.
- Application of the standard's requirements to groups of insurance contracts, rather than to individual contracts only.
- Separate presentation of the two sources of profit, i.e. separate presentation and recognition of profit arising from the provision of insurance contract services.

A more detailed comparison of the differences in terms of comparability, transparency, and usefulness of financial information between the former and new standards is provided in comparative Tables 1 and 2 below.

Table 1. Differences Between IFRS 4 and IFRS 17 in Terms of Comparability[11]

IFRS 4 – lack of comparability	IFRS 17 – consistent framework
Comparability across companies in different countries	
Accounting practices for insurance contracts varied significantly among companies operating in different countries.	Companies consistently apply accounting practices to all insurance contracts.
Comparability across insurance contracts	
Some multinational companies consolidated their subsidiaries using different accounting policies for the same type of insurance contracts entered into in different countries.	A multinational company consistently measures insurance contracts within the group, facilitating the comparison of results by product line and geographic region.
Comparability across industries	
Some companies recognized cash flows or received deposits as revenue. This differed from accounting practices in other industries, particularly banking and investment management.	Revenue reflects only the insurance services provided and excludes deposit components, in line with practices in other industries.

[11] IFRS Foundation, *IFRS Standards Fact Sheet*, 2017, available at: *https://www.ifrs.org/content/dam/ifrs/project/insurance-contracts/ifrs-standard/ifrs-17-factsheet.pdf*, accessed on February 11, 2025.

Table 2. Differences Between IFRS 4 and IFRS 17 in Terms of Transparency and Usefulness of Information[12]

IFRS 4 – limited transparency and usefulness of information	IFRS 17 – more transparent and useful information
Data on the values of insurance liabilities	
Some companies measured insurance contracts using outdated information.	Companies measure insurance contracts at current (present) value.
Some companies did not consider the time value of money when measuring liabilities and receivables.	Companies reflect the time value of money in estimated settlement of incurred claims..
Some companies measured insurance contracts based on the value of their investment portfolios.	Companies measure their insurance contracts solely based on the liabilities arising from those contracts.
Information on profitability	
Some companies did not provide consistent information about the sources of profit from insurance contracts.	Companies provide consistent information on the components of current and future profit from insurance contracts.
Many companies relied on alternative performance measures (outside the scope of professional standards), such as embedded value (EV), to supplement the information provided under IFRS 4.	Companies and users of financial statements rely less on measures outside the scope of professional regulation, so additional information enables more meaningful comparisons.

Particular emphasis is placed on information about future profit, which IFRS 17 introduces in the form of the Contractual Service Margin (CSM)**.** According to IFRS 17, profit is not recognized at the initial recognition of the contract. Instead, any excess of cash flows to fulfill the contract is included as a line item in the statement of financial position, referred to as the contractual service margin.[13] Further details on the CSM will be discussed in Chapter II, section *2. Other Models for Measuring Liabilities***.**

2. Introduction of Grouping of Insurance Contracts

Insurance contracts are significantly more uncertain than other service-based contracts. Insurance risks constitute the core of an insurance contract. If a contract transfers only financial risks to the insurance company without transferring insurance risk, it is not considered an insurance contract. This is particularly relevant because some insurance contracts do not transfer insurance risks to the insurer at inception

[12] *Ibidem*.

[13] Björn Widing, Jimmy Jansson, „Valuation Practices of IFRS 17", Royal Institute of Technology, School of Engineering Sciences, Stockholm, Sweden, 2018, 2.

but transfer it later, based on the present value using discount rates.[14] Depending on whether a claim is paid, any individual insurance contract could result in a profit or a loss; however, the outcome is unknown at the contract's inception. To address this uncertainty, IFRS 17 requires the grouping, or aggregation, of insurance contracts. This grouping is done solely for accounting purposes and does not affect the overall result of the contracts at the end of the reporting period, but it does influence how that result is recognized over time.

Grouping insurance contracts involves classifying issued contracts into multiple portfolios. Each portfolio should contain contracts subject to similar risks and managed together (often referred to as product lines). IFRS 17 recommends further grouping of each portfolio based on the timing aspect, specifically, by the year in which the contracts were issued. Further breakdown implies that each portfolio of insurance contracts is divided into at least three subgroups according to risk: onerous (unprofitable) contracts at initial recognition,[15] expected profitable contracts, contracts for which there is a significant possibility of becoming onerous, and remaining contracts. This aggregation is necessary to determine the total estimated loss from onerous contracts, which must be recognized in the profit and loss statement, in order to reduce or avoid losses in the current period.[16]

3. Innovations in the Presentation of Financial Statements

The presentation of the income statement represents a complete innovation compared to the traditional way of presenting the results of an insurance company. The novelty lies in the fact that written premiums, which most often represented the first line of the income statement, i.e. insurance revenues, are no longer presented in that way, nor are they visible at all in the income statement. Written premiums, expected claims, and expenses are accounted for within the valuation of the contract itself, so the difference between these revenues and expenses is actually a projection of future profit, i.e. the contractual service margin, which is recognized through the result over the duration of the contract.[17]

The income statement requires a separate presentation of **insurance service results**. Therefore, the insurance company reports in the income statement

[14] Omar Alhawtmeh, „The Impact of IFRS 17 on the Development of Accounting Measurement and Disclosure, in Addition to Improving the Quality of Financial Reports, Considering Compliance with the Requirements of IFRS 4 - Jordanian Insurance Companies-Field Study", *Sustainability*, Vol. 2023, No. 15, 8612, 23.

[15] IFRS 17 (para. 47) defines an insurance contract as onerous when all expected cash flows at the date of initial recognition result in a net outflow. Such losses must be immediately recognized in the income statement.

[16] Rastko Filipović, "Šta nam donosi standard MSFI 17?", June 15, 2022, available at: *https://bonitet.com/sta-nam-donosi-standard-msfi-17/*, accessed on January 24, 2025.

[17] *Ibidem.*

the revenues and expenses of insurance services arising from groups of issued insurance contracts, where expenses include incurred claims and other incurred insurance service costs. Revenues from insurance contracts are recognized based on the provision of insurance services, not on the receipt of premiums. This approach aligns revenue recognition with the fulfillment of the insurance company's liabilities, as is the case in other industries.[18] Revenues and expenses from insurance services exclude all investment components. The company will not present premiums in the income statement if this information is not consistent with the reported revenues.[19]

Revenues or expenses from insurance finance include changes in the carrying amount of a group of insurance contracts resulting from:[20]

- the effect of the time value of money and changes in the time value of money; and
- the effect of changes in assumptions relating to financial risk; but
- excluding all such changes for groups of insurance contracts with direct participation that would adjust the contractual service margin (because these changes are already part of the insurance service expenses).

When establishing accounting policies, an insurance company decides whether to include all revenues or expenses from insurance finance in the income statement for the reporting period or to split the amounts between the income statement and *Other Comprehensive Income (OCI)*.[21]

The statement of financial position has not fundamentally changed in its structure. Investments still hold the most significant position on the asset side and are now measured according to *IFRS 9 – Financial Instruments* (which for insurance companies becomes effective simultaneously with IFRS 17 and relates to recognition and measurement of financial assets). On the asset side, there are no longer unearned premium receivables (in the case of non-life insurance) and deferred acquisition costs. Specifically, the portion of acquisition costs related to future accounting periods is deferred under deferred acquisition costs on the asset side. On the liabilities side, insurance contract liabilities remain predominant.[22] These liabilities are measured based on current estimates of future cash flows, discounted to present value and adjusted for risk. This enables a more accurate presentation of the insurance company's financial position.[23]

[18] Harry Nikolaou, An Introduction to IFRS 17, July 15, 2024, available at: *https://www.addactis.com/blog/ifrs17-definitions*, accessed on January17, 2025.

[19] IFRS Foundation, *IFRS 17 Insurance Contracts*, paras. 83–85, available at: *https://www.ifrs.org/content/dam/ifrs/publications/pdf-standards/english/2022/issued/part-a/ifrs-17-insurance-contracts.pdf?bypass=on* accessed on January 21, 2025.

[20] *Ibid*., para. 87.

[21] *Ibid*., paras. 88–90.

[22] Andreja Radić Blažin, "Nova era računovodstva u osiguranju: Međunarodni računovodstveni standard finansijskog izvještavanja 17", *Hrvatski časopis za osiguranje,* No. 6/2022, 49.

[23] Harry Nikolaou, "An Introduction to IFRS 17", July 15, 2024, available at: *https://www.addactis.com/blog/ifrs17-definitions*, accessed on January 17, 2025.

The presentation requirements under IFRS 17 in the two main financial statements are shown in Table 3 below.

Table 3. Presentation Requirements in Financial Statements According to IFRS 17

Income Statement According to IFRS 17	Statement of Financial Position According to IFRS 17
Separate presentation of results:	Separate presentation on the asset side:
- Insurance service result (the difference between insurance service revenues and expenses)	- Insurance contracts issued classified as assets
- Insurance finance income or expenses	- Reinsurance contracts held classified as assets
Separate presentation of income or expenses:	Separate presentation on the liabilities side:
- Income or expenses from reinsurance contracts	- Insurance contracts issued classified as liabilities
- Income or expenses from issued insurance contracts	- Reinsurance contracts classified as liabilities

Enhanced disclosure requirements accompanying IFRS 17 ensure that insurance companies provide detailed and useful information about the amounts recognized in the financial statements. Improved disclosures will lead to greater transparency in financial reporting, helping stakeholders understand the insurer's financial performance and risk exposure, as well as assess the impact insurance contracts have on the insurer's financial position, performance, and cash flows. Enhanced disclosures imply that the notes to the financial statements include both qualitative and quantitative information about:[24]

- amounts recognized in the financial statements arising from insurance contracts;
- significant estimates and changes in those estimates resulting from the application of IFRS 17; and
- the nature and extent of risks arising from insurance contracts.

III Models for Measuring Insurance Contract Liabilities

According to IFRS 17, the initial recognition of an insurance contract occurs no earlier than the beginning of the coverage period or the date of the first payment, or from the date when facts/circumstances indicate that the contract is onerous. Derecognition of an insurance contract occurs when the obligation is

[24] IFRS Foundation, IFRS 17 Insurance Contracts, para. 93, available at: *https://www.ifrs.org/content/dam/ifrs/publications/pdf-standards/english/2022/issued/part-a/ifrs-17-insurance-contracts.pdf?bypass=on*, accessed on 21 January, 2025.

fulfilled, canceled, expired, or when certain modifications to the contract terms have been met.[25]

Regarding the measurement of liabilities, IFRS 17 distinguishes between liabilities arising from events covered by earned premiums (*Liability for Incurred Claims – LIC*) and events expected to occur between the balance sheet date and the end of the contract (*Liability for Remaining Coverage – LFRC*). Regardless of the measurement model applied, the liabilities for incurred claims will remain the same, while the choice of model will only affect the calculation of liabilities for remaining coverage.[26]

The three measurement models for insurance contract liabilities prescribed by IFRS 17 are:

a) *General Measurement Model (GMM),* also known as the *Building Blocks Approach (BBA)*;

b) *Variable Fee Approach (VFA);*

c) *Premium Allocation Approach (PAA)*.

The General Measurement Model is the default model for measuring insurance contract liabilities. For contracts with a coverage period shorter than one year, there is an option to choose the Premium Allocation Approach as a simplified measurement model. For contracts with direct participation features, the Variable Fee Approach is mandatory.

1. General Measurement Model of Liabilities

When dealing with the fair value of an insurance contract under the scope of IFRS 17, the insurance company should determine which of the three existing models are applicable. The default application is the **general measurement model (GMM)**, which assumes that insurance liabilities are measured at the present value of expected future cash flows, discounted to present value using relevant market rates, adjusted for non-financial risk, and including the contractual service margin (CSM).[27] The "building blocks" approach, another name for this model, requires companies to measure separately the components of the insurance contract, such as the

[25] Mogomotsi Phage, *Introduction to IFRS 17*, May 17, 2021, available at: *https://www.munichre.com/content/dam/munichre/contentlounge/website-pieces/documents/Introduction-to-IFRS-17-May2021-LIMA-MoG.pdf/_jcr_content/renditions/original./Introduction-to-IFRS-17-May2021-LIMA-MoG.pdf* accessed on January 29, 2025.

[26] For more details, see: Vienna Insurance Group and KPMG, 10 Questions regarding IFRS 17, available at: *https://group.vig/media/i2ljz52m/10-questions-regarding-ifrs-17-kpmg-and-vig.pdf*, accessed April 7, 2025; and Jonathan Kemp, Clair Le Poidevin, IFRS 17 Insurance contracts measurement and applicability, 2021, available at: *https://www.bwcigroup.com/Factsheets/Insurance/IFRS17%20Measurement%20and%20Applicability.pdf* accessed on January 31, 2025.

[27] Katarina Mikić, *Vrednovanje obveza iz Ugovora o osiguranju prema MSFI 17*, University of Zagreb, Faculty of Science, 2021, 14.

probability of claims, the time value of money, and risk adjustments. This approach aims to provide a more accurate reflection of the value of insurance contracts and the risks associated with them.[28] The General Measurement Model consists of the following "building blocks":

- Cash flows related to fulfilling the contractual obligation, which include:
  - the present value of the probability-weighted estimates of future cash flows, i.e. future inflows and outflows directly related to fulfilling the portfolio of contracts (premiums, claims, and other benefits to policyholders);
  - an adjustment reflecting the time value of money and financial risks related to future cash flows, to the extent that financial risks are not included in the estimates of future cash flows;
  - a risk adjustment for non-financial risk;
  - *Contractual Service Margin (CSM),* which is a component of the insurance contract assets or liabilities and represents the estimated unearned profit that the insurer will recognize if and when it provides insurance contract services to the policyholder in the future period.[29] The CSM is recognized in the income statement (if a loss is expected) or as a liability on the statement of financial position (if a profit is expected) and represents an estimate of the company's future profitability. Changes in the margin provide information on the profitability of new business and changes in the profitability of existing contracts.[30]

The sum of these "building blocks" forms the total insurance contract liabilities. The measurement of insurance contract liabilities is performed at initial recognition and for each subsequent reporting period. To illustrate the General Measurement Model, an example will be presented showing how the "building blocks" interact in measuring a portfolio of insurance contracts.

[28] Omar Alhawtmeh, „The Impact of IFRS 17 on the Development of Accounting Measurement and Disclosure, in Addition to Improving the Quality of Financial Reports, Considering Compliance with the Requirements of IFRS 4—Jordanian Insurance Companies-Field Study", *Sustainability*, Vol. 2023, No. 15, 8612, 3.

[29] BDO Australia, *Applying the General Measurement Model in IFRS 17 Insurance Contracts to a portfolio of insurance contracts*, 2021, available at: *https://www.bdo.com.au/en-au/content/accounting-news/accounting-news-october-2021/general-measurement-model*, accessed on February 14, 2025.

[30] Darrel Scott, *Najnovije informacije o IFRS-ima za regulatore: IFRS 17 – Ugovori o osiguranju*, December 13–14, 2021, available at: *https://cfrr.worldbank.org/sites/default/files/2021-12/4.%20%20IFRS%2017%20Regulation-new%20BCS.pdf,* accessed on January 2, 2025.

Example of the General Measurement Model of Liabilities[31]

"Planet Insurance" d.o.o. has issued 100 three-year insurance policies starting on January 1, 2022. These policies insure pet owners for up to 50% of all veterinary bills related to their pets during the coverage period of the policy. Each policyholder is required to pay an annual premium of 90 monetary units (m.u.), payable on the first day of each calendar year during the coverage period. For the purpose of measuring the insurance contract under IFRS 17, and based on previous experience with similar types of insurance policies, "Planet Insurance" d.o.o. adopts the following assumptions:

- expected annual cash outflows amount to 7,000 monetary units per year (including claims and administrative costs);
- all claims arising during the year will be paid at the end of that same year;
- no policy will expire during the coverage period and no extension periods are offered under the policy;
- the discount rate is 5% per annum;
- "Planet Insurance" d.o.o. is not exposed to any material financial risk regarding these insurance policies;
- the risk adjustment for non-financial risk is 5% of the present value of expected cash outflows;
- "Planet Insurance" d.o.o. does not incur any acquisition costs related to the insurance policies.

Based on the above, "Planet Insurance" d.o.o. measures the portfolio of pet insurance policies at initial recognition as follows:[32]

Table 4. Initial Measurement of the Insurance Policy Portfolio

Present value estimate of future cash inflows	(25.735)
Present value estimate of future cash outflows	19.063
Present value estimate of future (net) cash flows	(6.672)
Risk adjustment for non-financial risk	953
Fulfillment cash flows – see (a) below	(5719)

[31] Adapted from BDO Australia, Applying the General Measurement Model in IFRS 17 Insurance Contracts to a portfolio of insurance contracts, 2021, available at: *https://www.bdo.com.au/en-au/content/accounting-news/accounting-news-october-2021/general-measurement-model* accessed on February 14, 2025.

[32] IFRS 17 (para. 32) requires that the fulfilment cash flows of the insurance contract obligation include estimates of future cash flows (inflows and outflows), adjusted to reflect the time value of money and any financial risks related to those future cash flows, as well as a risk adjustment for non-financial risk.

Contractual Service Margin – see (b) below	5719
Insurance contract (asset)/liability at initial recognition	0

Notes to Table 4:

a) Non-financial risks include claims development risks (excluding risks related to a direct inflation index) and expense risks (the risk of unexpected changes in costs related to contract fulfillment) that are associated with insurance contracts but are not financial in nature. Non-financial risk may also include lapse and persistency risks, which are the risks that the policyholder will exercise any renewal, surrender, conversion, or other option available under the policy that alters the amount, timing, nature, or uncertainty of the amount payable under the policy. However, in this case, it is assumed that no policy will lapse during the coverage period and no extension periods are offered under the policy.

b) IFRS 17 (para. 38) requires insurance companies to measure the Contractual Service Margin at initial recognition of the portfolio of insurance contracts at an amount that does not result in any income or expense arising from the initial recognition of the fulfillment cash flows.

Table 5. First Year of the Three-Year Insurance Policies

As of 31 December 2022	Estimated Present Value of Future Cash Flows	Adjustment for Non-Financial Risk	Contractual Service Margin	Insurance Contract (Asset)/ Liability
Opening balance – (asset)/ liability	0	0	0	0
Changes related to future services: new insurance contracts	(6672)	953	5.719	0
Cash inflows	9000	0	0	9000
Insurance finance costs	953	48	286	1287
Insurance finance incomes – see a) below	(837)	0	0	(837)
Changes related to current services – see b) below	0	(398)	(2,001)	(2399)
Cash outflows	(7000)	0	0	(7000)
Closing balance – (asset)/liability	(4556)	603	4004	51

Table 6. Second Year Since Issuance of Three-Year Insurance Policies

As of December 31, 2023	Present Value of Future Cash Flows	Risk Adjustment for Non-Financial Risk	Contractual Service Margin	Insurance Contract (Asset)/ Liability
Opening balance – (asset)/ liability	(4556)	603	4004	51
Changes related to future services: new insurance contracts	0	0	0	0
Cash inflows	9000	0	0	9000
Insurance financing costs	651	30	200	881
Insurance financing incomes – see a) below	(429)	0	0	(429)
Changes relating to current services – see b) below	0	(380)	(2,102)	(2482)
Cash outflows	(7000)	0	0	(7.000)
Closing balance – (asset)/liability	(2334)	253	2102	21

Table 7. Third year since entering into three-year insurance policies

As of December 31, 2024	Present Value of Future Cash Flows	Risk Adjustment for Non-Financial Risk	Contractual Service Margin	Insurance Contract (Asset)/ Liability
Opening balance – (asset)/ liability	(2334)	253	2.102	21
Changes related to future services: new insurance contracts	0	0	0	0
Cash inflows	9000	0	0	9000
Insurance financing costs	334	13	105	452
Insurance financing incomes – see a) below	0	0	0	0
Changes relating to current services – see b) below	0	(266)	(2207)	(2473)
Cash outflows	(7000)	0	0	(7000)
Closing balance – (asset)/liability	0	0	0	0

Notes to Tables 5, 6, and 7:

a) When an insurance contract leads to future cash inflows in the form of annual premiums, the company issuing the insurance contracts will recognize interest income as the premium receivables are settled.
b) When actual experience aligns with the company's assumptions regarding the insurance contracts it issues, there are no changes in the current service estimates that affect the present value of future cash flows. However, the risk adjustment for non-financial risk and the contractual service margin will be released over the coverage period, in line with the notion that "Planet Insurance" d.o.o. is being released from insurance risk as it provides insurance services.

2. Other Models for Measuring Liabilities

In cases where an insurance contract includes direct participation features, the company should consider applying the **variable fee approach (VFA)**, which is a variation of the general model and is applicable to contracts where policyholders bear most of the investment risk. These insurance contracts are essentially service contracts and relate to investments for which the insurance company promises a return based on "underlying items". An example of such contracts would be life insurance policies with profit participation**,** where the returns stem from investment of the savings (investment) premium into investment funds.

At the point of initial recognition of liabilities**,** there is no difference in measurement between contracts with or without direct participation features: all types of contracts are measured in the same way (except for the premium allocation approach**,** which will be discussed later). This means that the contractual service margin at initial recognition is measured consistently. The key difference between the general model and the variable fee approach becomes apparent only during subsequent measurement of liabilities. This difference arises from the understanding that contracts with direct participation features generally have profitability that heavily depends on market movements. Therefore, for such contracts only, economic changes in the value of the insurer's share in the "underlying items" are embedded in the contractual service margin**.** The variable fee approach adjusts the contractual service margin based on changes in the entity's share of the fair value of the "underlying items", ensuring that the measurement of insurance contract liabilities reflects the variable nature of these contracts.

As the name suggests, the variable fee approach introduces the concept of a *variable fee,* which is defined as the company's share in the "underlying items" as compensation for the services it provides.[33] Namely, the insurer commits to investing

[33] Wijdan Yousuf (Chair) *et al*., IFRS 17: How to choose the measurement model, Institute and Faculty of Actuaries (IFoA), London, UK, July 17, 2019, available at: *https://www.actuaries.org.uk/system/files/field/*

the policyholder's funds into assets expected to increase in value. The insurer charges a fee for managing these assets**,** known as the "variable fee". The value of this fee fluctuates based on the value of the assets. Therefore, the variable fee model allows the contractual service margin to be regularly updated to reflect economic changes, acknowledging that the company's future profitability is significantly influenced by market movements. Without this built-in mechanism, the performance result of insurance services for such products would not accurately reflect reality, and the net investment result would be more susceptible to fluctuations (higher volatility). That's why the main advantage of applying the variable fee approach is said to be better management of statement of financial position volatility for the insurance company.[34]

The **premium allocation approach (PAA)** is simplified and therefore the most straightforward of the three models. It is applicable to contracts with a coverage period of one year or less, and its application can be shown not to result in materially different outcomes compared to the general model.[35] This model is used for accident and property insurance contracts.[36] These are non-life insurance agreements typically associated with accidents such as medical expenses or property damage.[37] Using the premium allocation approach, the liability for remaining coverage is initially recognized as the premiums received at the time of initial recognition, reduced by any acquisition cash flows incurred on that date. Subsequently, the carrying amount of the liability is the opening balance at the start of the reporting period, increased by premiums received during the period**,** minus insurance acquisition cash flows**,** plus amortization of acquisition cash flows**,** minus the amount recognized as insurance revenue for coverage provided during the period, and minus any investment component that was paid or transferred to a liability incurred (e.g. claims).[38]

The differences between the general model and the premium allocation approach are as follows:[39]

- simplified measurement of the liability for remaining coverage for groups of insurance contracts that are not onerous;

document/IFRS%2017_How%20to%20choose%20the%20measurement%20model_20190717.pdf, accessed on February 2, 2025.

[34] *Ibidem*.

[35] Jonathan Kemp, Clair Le Poidevin, IFRS 17 Insurance Contracts: Measurement and Applicability, 2021, available at *https://www.bwcigroup.com/Factsheets/Insurance/IFRS17%20Measurement%20and%20Applicability.pdf,* accessed on January 31, 2025.

[36] Björn Widing, Jimmy Jansson, "Valuation Practices of IFRS 17", Royal Institute of Technology, School of Engineering Sciences, Stockholm, Sweden, 2018, 7.

[37] *Ibidem*, 5.

[38] Rada Stojanović *et al.*, *Primena Međunarodnih standarda finansijskog izveštavanja*, Računovodstvo d.o.o., Belgrade, 2019, 534.

[39] Katarina Mikić, *Vrednovanje obveza iz Ugovora o osiguranju prema MSFI 17*, University of Zagreb, Faculty of Science, 2021, 33.

- possibility of not adjusting future cash flows related to incurred claims for the time value of money and financial risk, if those cash flows are expected to be paid or received within one year or less from the date they arise;
- the option to recognize acquisition costs related to insurance policies as expenses when incurred;
- possibility to assess the onerousness of a group of contracts only when facts and circumstances indicate it (whereas the general model requires an assessment at each reporting date).

A comparative overview of the general model and the premium allocation approach is presented below (see Table 8).

Table 8. Comparative Overview of the General Model and the Premium Allocation Approach[40]

General Measurement Model for Liability Valuation	*Premium Allocation Approach*
Contractual Service Margin	Component similar to unearned premium (reduced by direct acquisition costs)
Risk Adjustment	
Discounting	
Best Estimate of Fulfillment Cash Flows	
Risk Adjustment	Risk Adjustment
Discounting	Discounting
Best Estimate of Fulfillment Cash Flows	Best Estimate of Fulfillment Cash Flows

To illustrate the premium allocation approach for liability valuation, an example will be presented below.

[40] Adapted from Wijdan Yousuf (Chair) *et al.*, IFRS 17: How to choose the measurement model. Institute and Faculty of Actuaries (IFoA), London, UK, 17.7.2019, availabe at: *https://www.actuaries.org.uk/system/files/field/document/IFRS%2017_How%20to%20choose%20the%20measurement%20model_20190717.pdf,* accessed on February 2, 2025.

Example of the Premium Allocation Approach

The basic assumptions of the example are provided in Table 9**.**

Table 9. Basic Assumptions of the Example

Motor Third-Party Liability Insurance	
Number of policies:	1
Insurance start date:	1. 7. 2023.
Insurance duration (years):	1
Insurance premium:	100 monetary units (m.u.)
Premium payment frequency:	annually

Assumptions relevant for liability valuation:

- The premium is fully received at the inception of the insurance contract.
- The insurance company opts to defer direct acquisition costs.
- The contract is assumed not to be onerous, and no discounting is applied due to its short duration.
- As of the balance sheet date, December 31, 2023, there are paid claims of 10 monetary units (m.u.), and claims incurred but not paid form a reserve of 18 m.u. The risk adjustment for non-financial risk on incurred claims amounts to 3 m.u.
- As of the balance sheet date, December 31, 2024, there are paid claims of 30 m.u., and claims incurred but not paid form a reserve of 27 m.u. The risk adjustment for non-financial risk on incurred claims amounts to 6 m.u.

Since the contract duration is one year, the premium allocation approach can be applied automatically. Below (see Table 10), liabilities for remaining coverage and liabilities for incurred claims at the end of each reporting period will be presented.

Table 10. Liability Valuation According to the Premium Allocation Approach[41]

Liabilities	Initial Valuation	Balance Sheet Date	
	1. 7. 2023.	31. 12. 2023.	31. 12. 2024.
Liabilities for Remaining Coverage:	**90**	**45**	**0**
Premium	100	50	0
Direct Acquisition Costs	(10)	(5)	0
Liabilities for Incurred Claims:	**0**	**21**	**33**
Present Value of Incurred Claims	0	18	27
Risk Adjustment for Non-Financial Risk	0	3	6

[41] Corrected according to: Katarina Mikić, *Vrednovanje obveza iz Ugovora o osiguranju prema MSFI 17*, University of Zagreb, Faculty of Science, 2021, 36.

The liabilities for remaining coverage at initial recognition amount to 90 monetary units (m.u.). This amount results from the difference between the premium received (100 m.u.) and the payment related to acquisition cash flows (10 m.u.). As of the balance sheet date, December 31, 2023, the liabilities for remaining coverage amount to 45 m.u. This amount represents the sum of the previous carrying amount of the liabilities for remaining coverage (90 m.u.) and the amortization of acquisition cash flows for the period (5 m.u.), which is then reduced by the amount recognized as premium revenue during the period (50 m.u.). On the same balance sheet date, the liabilities for incurred claims amount to 21 m.u. This amount is obtained by adding the claims incurred during the period of 18 m.u. (which have not yet been paid and are therefore included in the claims reserve) to the risk adjustment for non-financial risk of 3 m.u. In the following reporting period, as of the balance sheet date December 31, 2024, the liability for remaining coverage has expired and amounts to 0 m.u., while the liabilities for incurred claims amount to 33 m.u. This amount is the sum of the claims reserve of 27 m.u. and the risk adjustment for non-financial risk of 6 m.u.[42]

IV Conclusion

Each newly adopted IFRS aimed at similar reforms in financial reporting, which in turn resulted in continued harmonization, better transparency, and higher quality of information contained in financial statements. The benefits of such reforms were always twofold: companies would receive more comparable financial statements, and stakeholders would gain a better informational basis for improved assessment of companies' success, performance, and risks. The introduction of *IFRS 17 – Insurance Contracts* was announced as undoubtedly the most significant change in insurance reporting requirements in the last 20 years.

Harmonizing the valuation and presentation of positions in financial statements across all IFRS jurisdictions, aligning with other industries in financial reporting, and improving the qualitative characteristics of financial reports (comparability, transparency, usefulness) are the most prominent advantages of IFRS 17, but at the same time, they highlight the shortcomings of the replaced IFRS 4. Assessing future profitability of the company, determining unearned profit, estimates that are updated every reporting period, and a discount rate based on cash flows from the contracts are just some of the concrete novelties introduced by applying IFRS 17. The income statement underwent significant changes after IFRS 17 was introduced, while the statement of financial position did not change substantially. The income statement now includes separate presentation of results, i.e. separate display of results from insurance services and results from insurance financing. Improvements

[42] Corrected according to: *Ibid.,* 36–37.

were also introduced in the disclosures section, so now one accounting policy can be maintained for all insurance contracts at the industry level.

The features of the new accounting approach for insurance contracts will help stakeholders better understand the insurer's financial performance and risk exposure, as well as more successfully assess the impact insurance contracts have on the insurer's financial position, performance, and cash flows compared to other insurance companies, other industries, and over time.

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OSIGURANJE IMOVINE U FUNKCIJI INSTRUMENTA ZAŠTITE IMOVINSKIH DOBARA

PREGLEDNI NAUČNI RAD

Apstrakt

Autor analizira osiguranje imovine nastojeći da istakne odštetnu funkciju koja predstavlja sastavni deo zakonske regulative osiguranja. Osiguranje imovine, po autorovom mišljenju, stvara *win win* situaciju za lica koja se opredele za ovaj vid zaštite svojih imovinskih interesa. Uz to, na osnovu praktičnog iskustva, može se tvrditi da osiguranje kao delatnost poseduje prirodni monopol, budući da ne postoji instrument koji pruža imovinsku zaštitu na tako kompletan način i po cenovno uporedivim uslovima. Posebna pažnja je posvećena odnosu osiguranja stvari i principa naknade štete. Da bi se na najoptimalniji način iskoristile pogodnosti osiguravajuće zaštite, neophodno je da se usvoji strategija promocije osiguranja imovine i opismenjavanja građana u svojstvu korisnika usluga osiguranja. Građanin koji je investirao u osiguranje u povoljnijoj je situaciji nego onaj koji je to propustio da učini.

Ključne reči: stvari, imovina, osiguranje, zaštita, princip obeštećenja, opismenjavanje.

I Uopšteno o osiguranju imovine

Kada se kaže osiguranje, obično se pomisli na *osiguranja koja se zaključuju s ciljem zaštite imovine od brojnih rizika koji mogu dovesti do gubitka ili oštećenja*

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imovinskih vrednosti koja pripadaju fizičkim ili pravnim licima.[2] Pravno posmatrano, osiguranje imovine obuhvata brojne ugovore o osiguranju koji se zaključuju s ciljem naknade štete pretrpljene usled gubitka ili oštećenja imovinskih vrednosti ugovarača osiguranja ili osiguranika.[3] Najznačajnija podela imovinskih osiguranja je na dve velike i prilično različite oblasti: *osiguranje stvari i osiguranje od odgovornosti*. To je uobičajena kategorizacija ne samo za teoretičare prava osiguranja već i za praktičare, koja uporište nalazi u svim pravnim sistemima. Zašto je bitno već na početku pomenuti razliku između osiguranja stvari i osiguranja imovine? Iz više razloga, od kojih na ovom mestu izdvajamo to da se šteta ispoljava na različit način, a postoji i niz drugih razlika između pomenutih podvrsta imovinskih osiguranja.

Osiguranje stvari je podvrsta osiguranja imovine kojim se obezbeđuje naknada za slučaj gubitka, uništenja ili oštećenja stvari.[4] Predmet osiguranja je, dakle, *pojedinačni predmet* tj. deo aktive osiguranika izložen delovanju različitih rizika: nezavisno od toga da li je u pitanju pokretna ili nepokretna stvar, telesna ili bestelesna (potraživanje).[5] Što se tiče rizika koji se odnosi na osiguranu stvar, to može biti: požar, poplava, lom mašina, krađa itd.[6] Za potrebe delovanja osiguranja imovine, rizik ne mora nužno da dovede do materijalnog oštećenja; u slučaju krađe stvar ne mora biti oštećena… Ono što je krucijalno u osiguranju stvari, kako bi mogao da osigura bilo koji predmet, osiguranik mora imati interes osiguranja. Kada se pomene interes osiguranja, po prirodi stvari se najpre pomisli na vlasnika stvari, ali ovaj termin u modernom pravu osiguranja omogućava širokom krugu lica da zaključe neki oblik osiguranja stvari.[7] Jedini uslov je da su u pravno relevantnoj vezi s predmetom osiguranja, zbog čega mogu pretrpeti štetu usled njegovog gubitka ili oštećenja. Najjednostavnije rečeno, *osiguranje stvari omogućava obeštećenje licu koje je pretrpelo štetu na osiguranoj imovini*. U tom smislu se na osiguranje gleda kao na instrument koji doprinosi zaštitnoj funkciji kroz efikasnu naknadu štete na osiguranim

[2] Detaljnije o istoriji osiguranja: Ivana Soković, „Značaj osiguranja i perspektive razvoja u Srbiji", *Tokovi osiguranja*, br. 2/2024, 265–279.

[3] Detaljnije o ugovoru o osiguranju: Marija Karanikić Mirić, „Forma ugovora o osiguranju", *Tokovi osiguranja*, br. 1/2025, 22–25.
Osiguranje stanova, automobila, fabričkih postrojenja, osiguranje od odgovornosti za obavljanje profesije, osiguranje od kišnih dana na odmoru, osiguranje od prekida poslovanja itd. samo su neki pojavni oblici imovinskih osiguranja.

[4] O riziku osiguranja: Slobodan Ilijić, „O pravnim aspektima rizika i polise osiguranja u prednacrtu Građanskog zakonika Republike Srbije (2015)", *Tokovi osiguranja*, br. 2/2018, 31–41.

[5] Nataša Petrović Tomić, *Pravo osiguranja*, *Sistem, Knjiga prva*, Službeni glasnik, Beograd, 2019, 437.

[6] O tome kako se promena rizika odražava na obaveze osiguranika: Katarina Ivančević, „Pravne posledice promene rizika u toku trajanja ugovora o osiguranju imovine", *Evropska revija za pravo osiguranja*, br. 3/2021, 10–22.

[7] O razlici između tradicionalnog i modernog shvatanja interesa osiguranja, pogotovo kada se radi o interesu banaka da osiguranje ponude svojim klijentima kao deo benefit programa: Nataša Petrović Tomić, Nenad Grujić, „Kolektivno ugovaranje osiguranja od strane banaka – kanal distribucije i faktor financijskog opismenjavanja korisnika osiguranja", *Osiguranje, Hrvatski časopis za osiguranje*, br. 12/2025, 17–23.

dobrima. Umesto da prolazi kroz proces naknade štete koji podrazumeva pokretanje odgovarajućeg postupka protiv lica koju je za štetu odgovorno, nosilac interesa na predmetu osiguranja može da se obrati osiguravaču, koji je, po Zakonu o osiguranju[8] i Smernicama NBS,[9] dužan da na fer i korektan način likvidira odštetne zahteve.[10] Iako nisu obavezujuće, Smernice je usvojio nadzorni organ za tržište osiguranja u vidu preporuke, čime su postale deo *pravila struke osiguranja*, a na posredan način i deo pozitivnog prava imajući u vidu obavezu osiguravača da postupaju prema *pravilima struke osiguranja* u skladu sa odredbama ZO. Uostalom, nadzorni organ (NBS) uveliko kontroliše da li je ponašanje osiguravača prilikom ugovaranja, nakon ugovaranja i naročito prilikom postupanja sa odštetnim zahtevima u skladu s minimalnim standardima postavljenim Smernicama.[11] Od osiguravača se očekuje da zaštitu korisnika ostvare primenjujući i poštujući standarde koje propisuju Smernice.[12]

To znači da lice koje je investiralo u osiguranje uživa dvostruku pogodnost u odnosu na one koji svoju imovinu ostave neosiguranu: obeštećenje od strane solventnog saugovarača, čiju likvidnost i solventnost nadzire Narodna banka Srbije, i garantije fer i korektnog odnosa, što se nikako ne može očekivati u postupku koji bi se pokrenuo protiv odgovornog lica. **Osiguranje imovine, dakle, stvara *win win* situaciju za lica koja se opredele za ovaj vid zaštite svojih imovinskih interesa.[13] Uz to, na osnovu praktičnog iskustva, može se tvrditi da osiguranje kao delatnost**

[8] Zakon o osiguranju - ZO, *Službeni glasnik RS*, br. 139/2014 i 44/2021.

[9] Narodna banka Srbije, Smernice o minimalnim standardima ponašanja i dobroj praksi učesnika na tržištu osiguranja od 20. 4. 2018. (daljem u tekstu: *Smernice)*.

[10] Socijalni, privredni i širi društveni značaj koji ima delatnost osiguranja nalaže društvima za osiguranje da prilikom ispunjavanja prava i obaveza vode računa ne samo o sopstvenom interesu već i o interesu korisnika usluge osiguranja: „Društvo za osiguranje, društvo za posredovanje u osiguranju, društvo za zastupanje u osiguranju, zastupnik u osiguranju i pravna lica iz člana 98 stav 2 ovog zakona koja obavljaju poslove zastupanja u osiguranju na osnovu prethodne saglasnosti Narodne banke Srbije (dalje u tekstu: pravna lica iz člana 98 stav 2 ovog zakona) dužni su da obezbede zaštitu prava i interesa osiguranika, ugovarača osiguranja, korisnika osiguranja i trećih oštećenih lica (dalje u tekstu: korisnik usluge osiguranja), u skladu s propisima, pravilima struke i dobrim poslovnim običajima" (čl. 15 ZO). Podvlačim: društva za osiguranje dužna su da štite prava i interese korisnika usluga u skladu sa *propisima*, *pravilima struke osiguranja* i *dobrim poslovnim običajima*. Korisnici usluge osiguranja po pravilu nemaju dovoljna znanja o usluzi osiguranja koju pribavljaju, zbog čega osiguravači kao jača strana imaju niz obaveza pre zaključenja ugovora i nakon zaključenja sa ciljem zaštite poverenja korisnika usluge osiguranja. Bez zaštite poverenja, osiguranje koje ima važnu privrednu, društvenu i socijalnu funkciju ne može da ostvari svoju svrhu.

[11] Ivan D. Radojković, Aleksandar V. Kostić, Maja T. Aleksandrović Gajić, „Načela prihvata rizika i tehničke osnove osiguranja poljoprivrednih kultura", *Tokovi osiguranja,* br. 3/2021, 93.

[12] Herman Cousy, „Changing Insurance Contract Law: An Age-Old, Slow and Unfinished Story", *Insurance Regulation in the European Union: Solvency II and Beyond* (eds. P. Marano, M. Siri), Palgrave Macmillan, London, 2017, 32.

[13] Generalno govoreći, osiguranje je danas **visoko regulisana finansijska transakcija, koja je postala ne samo normalan nego i neophodan segment modernog društvenog i ekonomskog života.** Postoji intenzivna regulatorna aktivnost kako zakonodavca tako i tela nadzora, sve s namerom da se obezbedi adekvatna zaštita korisnika usluga. *Ibid.*, 35.

poseduje prirodni monopol, budući da ne postoji instrument koji pruža imovinsku zaštitu na tako kompletan način.

Osiguranje od odgovornosti je ugovor na osnovu koga osiguravač preuzima obavezu da umesto osiguranika pokrije imovinske posledice njegove odgovornosti. Kao što se iz definicija može primetiti, osnovna razlika u odnosu na osiguranje stvari – koja dovodi do različitog pravnog režima – jeste u predmetu osiguranja: dok je predmet osiguranja stvari *aktiva* osiguranika, predmet osiguranja od odgovornosti je njegova *pasiva*. Kod osiguranja stvari zaštitna funkcija usmerena je prema osiguraniku koji je štetu pretrpeo; u osiguranju od odgovornosti štiti se osiguranik koji je drugome izazvao štetu isplatom naknade umesto njega, što dovodi do pojave tzv. trećih oštećenih lica prema kojima se ispoljava zaštitna funkcija.

II Načelo obeštećenja kao vrhovni princip imovinskih osiguranja

Kada se kaže imovinska osiguranja, obično se pomisli na naknadu štete delovanjem osiguranja, to jest na isplatu odštete od strane osiguravača. Princip integralne naknade štete kao jedno od najznačajnijih načela obligacionog prava u oblasti osiguranja konkretizuje se u obliku načela obeštećenja. „Dosuđena naknada štete ne sme da služi ni kao kazna za štetnika odnosno za odgovorno lice, ni kao izvor bogaćenja za oštećenika."[14] Svrha načela obeštećenja u modernom pravu osiguranja više je nego jasna: ona, s jedne strane, moralizuje osiguranje imovine sprečavajući ga da izađe iz okvira odštetnog prava,[15] dok, s druge strane, omogućava jasno razgraničenje u odnosu na osiguranja lica.[16] Imovinska osiguranja zaključuju se s ciljem zaštite osiguranika ili trećeg oštećenog lica od štete, te je neophodno ograničiti obavezu osiguravača na iznos pretrpljene štete. Osiguranik ima pravo da mu se naknadi „šteta i ništa preko pretrpljene štete".[17] „Na ovaj način se zaštitna funkcija imovinskog osiguranja nadovezuje na naknadu štete, te se sprečava da postane

[14] Marija Karanikić Mirić, *Obligaciono pravo,* Službeni glasnik, Beograd, 2024, 94–96.

[15] Ako bi osiguranik na ime naknade iz osiguranja mogao da dobije više nego što je šteta koju je pretrpeo i dokazao, osiguranje bi postalo predmet interesovanja nesavesnih lica, koja bi nastojala da ga zloupotrebe. Pravni poredak to ne može prihvatiti, zbog čega se insistira na striktnoj primeni načela obeštećenja.

[16] Istorijski posmatrano, načelo obeštećenja odigralo je ključnu ulogu u razvoju posla osiguranja i njegovom prihvatanju od onih koji su od početka gajili sumnju u ovaj ugovor samo zbog njegovog aleatornog karaktera, koji su usled neznanja mešali sa igrama na sreću i uopšte sumnjivim transakcijama. Strah da osiguranje nije bitno drugačije od špekulativnih poslova, s jedne strane, i sumnja u osiguranika da će zloupotrebiti ugovor o osiguranju, s druge strane, uslovili su razvoj pravila i principa koji obeležavaju pravo osiguranja. Pod tim mislimo na koncept osiguranog interesa, načelo obeštećenja, načelo savesnosti i poštenja. Nataša Petrović Tomić, Mirjana Glintić, „The Hybridization of the Regulatory Framework of Insurance Contract Law: Elements of a New Setting", *Annals of the Faculty of Law*, No. 2/2024, 223–250.

[17] M. Karanikić Mirić (2024), 94.

izvor neosnovanog bogaćenja za nesavesne osiguranike.[18] Njima se, s jedne strane, onemogućava da na ime naknade iz osiguranja dobiju više nego što je šteta koju su pretrpeli, dok se s druge strane, kao isključena šteta navodi namerno izazivanje osiguranog slučaja. Sve to imperativnim normama. Dakle, osiguranik nije motivisan da namerno izaziva štetu na osiguranoj imovini, jer je u tom slučaju *ex lege* lišen pokrića. Jedino ako je šteta nastala nezavisno od njegove isključive volje, osiguranik ima pravo na naknadu, ali samo do visine pretrpljene štete i uz uvažavanje odnosa sume osiguranja i vrednosti osigurane stvari. To čini imovinsko osiguranje, najpre, ekonomski poželjnim, a zatim socijalno prihvatljivim institutom."[19]

Primena načela obeštećenja značajna je za praksu osiguranja jer utiče na postupak likvidacije odštetnog zahteva. Za razliku od osiguranja života, gde osiguravač na osnovu prijave osiguranog slučaja i relevantnih dokaza pristupa isplati unapred ugovorenog iznosa, u osiguranju imovine postoji *postupak odmeravanja naknade iz osiguranja*, koji prethodi samom činu obeštećenja. Po prirodi stvari, radnje vezane za odmeravanje naknade iz osiguranja mogu biti brojne i odrediti vremenski okvir isplate naknade iz osiguranja. Zato se kao jedna od razlika između osiguranja imovine i osiguranja lica ističe da je teret dokazivanja koji prati realizaciju prava iz imovinskih osiguranja neuporedivo teži nego kod osiguranja lica.

Šta se tačno podrazumeva pod sintagmom odmeravanje naknade iz osiguranja? Kada nastane gubitak u imovini osiguranika, prvi korak je *utvrđivanje nastale štete*. Osiguranik ili korisnik prava nosi teret dokazivanja štete, što u zavisnosti od okolnosti slučaja može biti i izuzetno zahtevno. U transportnom osiguranju, primera radi, uobičajeno je angažovanje specijalizovanih likvidatora šteta kako bi se postupak formalizovao i rezultirao sačinjavanjem odgovarajućeg zapisnika odnosno isprave koju priznaje osiguravač.[20] Polazeći od obligacionog prava, šteta u osiguranju stvari trebalo bi da obuhvata kako stvarnu štetu (*damnum emergens)* tako i izgubljenu dobit (*lucrum cessans*). Ali prema važećem pravu, obaveza osiguravača u osiguranju stvari ograničena je na naknadu stvarne štete, dok se izgubljena dobit pokriva samo po posebnom sporazumu. Iz toga proizlazi da u osiguranju imovine *ex lege* ne važi zakonsko načelo integralne naknade imovinske štete iz ZOO.[21] Šta to znači za osiguranike? To nije dobro rešenje, jer osiguranicima više odgovara da mogu računati na pokriće celokupne pretrpljene štete nego da posebno ugovaraju pokriće izgubljene

[18] Istorijski posmatrano, načelo obeštećenja je nastalo sa ciljem da se spreči namerno izazivanje osiguranih slučajeva. Ograničavanjem obaveze osiguravača na iznos pretrpljene štete osiguranicima je postalo neekonomično da namerno izazivaju osigurani slučaj.

[19] N. Petrović Tomić (2019), 438–439.

[20] Nataša Petrović Tomić, *Osiguranje robe u međunarodnom pomorskom prevozu*, Pravni fakultet u Beogradu, Beograd, 2009.

[21] Detaljnije: Marija Karanikić Mirić, *Krivica kao osnov deliktne odgovornosti u građanskom pravu,* Pravni fakultet Univerziteta u Beogradu, Beograd 2009, 177 i dalje.

dobiti.[22] U praksi, ako nije nešto drugo izričito ugovorio, osiguranik neće biti u istoj imovinskoj poziciji kao da se štetni događaj (osigurani slučaj) nije dogodio. On će dobiti samo naknadu stvarne štete, što znači da će biti delimično obeštećen. To dalje znači da osiguranik za deo štete koji odgovara izgubljenoj dobiti ostaje sam sebi osiguravač. Time se šalje loša poruka osiguranicima, jer oni ne mogu da dobiju naknadu štete u iznosu na koji su pretendovali. Izuzetak predstavlja osiguranje useva, gde se vrednost osiguranog predmeta utvrđuje na specifičan način. Naknada se ne utvrđuje prema vrednosti koju su usevi imali na dan štete, već na dan ubiranja (ako nešto drugo nije ugovoreno). Takvim pristupom se uvažava potreba za zaštitom u tom osobenom slučaju. Osiguranik ima interes da useve osigura na vrednost u trenutku ubiranja (koja obuhvata i izgubljenu dobit!), jer oni tada dostižu najvišu ekonomsku vrednost.

Postupak odmeravanja naknade iz osiguranja uključuje i uzimanje u obzir *sume osiguranja*, pošto ona predstavlja gornju granicu obaveze osiguravača. Suma osiguranja, pritom, nije ni dokaz ni pretpostavka vrednosti osigurane stvari u trenutku nastanka štete, osim ako je osiguranje zaključeno na ugovorenu vrednost. Vrednost stvari u času nastanka štete ne može se zanemariti. Osiguravači ne mogu obračunati naknadu iz osiguranja uvažavanjem načela obeštećenja ako se ne bi vodilo računa o vrednosti koju je stvar imala u trenutku realizacije osiguranog slučaja. Na osiguraniku je teret dokazivanja vrednosti stvari.[23] Načelo obeštećenja dovodi do primene dva pravila. Prema prvom, osiguranik na ime osiguranja ne može da naplati više od vrednosti stvari u času nastanka štete, čak i ako je zaključio više ugovora o osiguranju. Prema drugom, osiguranik ne može da dobije više od vrednosti stvari, bez obzira na sumu na koju je osiguranje zaključeno. Kao što se može primetiti, vrednost stvari je faktor ograničavajućeg karaktera u postupku odmeravanja naknade iz osiguranja.

ZOO precizira da prava iz osiguranja mogu imati samo lica koja su u času nastanka štete imala materijalni interes da se ne dogodi osigurani slučaj. Time se u imovinska osiguranja uvodi zahtev interesa, po čemu se ona razlikuju od osiguranja lica. Interes osiguranja je tesno povezan sa *svrhom osiguranja imovine: ono mora biti korisno onome ko ga zaključuje ili onome za čiji se račun zaključuje*.[24] Ako bi se dozvolilo zaključenje ugovora o osiguranju i vršenje prava iz osiguranja bez posedovanja interesa osiguranja, to bi otvorilo vrata paušalnim naknadama. Takođe, *interes određuje svojstvo osiguranika*. Interes osiguranja sastoji se u potrebi da se obezbedi ekonomska zaštita od određenih rizika isplatom naknade iz osiguranja.

[22] Nataša Petrović Tomić, *Posebna pravila koja se odnose na osiguranje imovine i osiguranje od odgovornosti, Priručnik za obuku za polaganje ispita i sticanje zvanja ovlašćenog posrednika i ovlašćenog zastupnika u osiguranju*, Privredna komora Srbije, Beograd, 2024, 89–90.

[23] U obzir dolaze različiti modaliteti određivanja vrednosti stvari: tržišna, upotrebna, ugovorena i nova vrednost. Detaljnije: *Ibid*., 90–92.

[24] N. Petrović Tomić (2019), 446.

Kada je reč o osiguranju stvari, sva lica koja mogu pretrpeti štetu usled propasti ili oštećenja stvari smatraju se licima koja imaju interes da zaključe osiguranje (vlasnik, suvlasnik, ostavoprimac, zakupac, založni poverilac). U osiguranju od odgovornosti interes ima svako lice koje je izloženo odgovornosti i koje želi da se zaštiti od štete koju može prouzrokovati drugima.

III Efikasnost obeštećenja – isplata naknade iz osiguranja

Kako se u teoriji naglašava*, faktori koji utiču na odmeravanje naknade iz osiguranja su:* 1) visina prouzrokovane štete; 2) visina sume osiguranja i 3) vrednost osigurane stvari.[25] Iz ugla prakse osiguranja, svaki od ta tri elementa može predstavljati limit tj. gornju granicu obaveze osiguravača.[26] Nijedan od njih nije bitniji od drugih generalno, ali to može postati u konkretnim okolnostima. Primera radi, ako se vrednost osigurane stvari i suma osiguranja poklapaju, osiguranik dobija naknadu u visini pretrpljene štete, pod uslovom da nije ugovorena franšiza. Ako je pak vrednost osigurane stvari veća od sume osiguranja, osiguranik će dobiti naknadu iz osiguranja koja ne pokriva celokupni iznos pretrpljene štete. S druge strane, ako je suma osiguranja veća od vrednosti osigurane stvari, prouzrokovana šteta predstavlja gornju granicu obaveze osiguravača.

Osigurana suma je od značaja za utvrđivanje naknade iz osiguranja jer je to iznos kojim je osiguranik pokrio osigurani rizik. Osigurana suma odgovara vrednosti osiguranog interesa na konkretnom predmetu, te stoga predstavlja gornju granicu obaveze osiguravača kada nastane totalna šteta. U najvećem broju slučajeva, *osigurana suma u osiguranju imovine ima čisto tehnički značaj.*[27] Ona, naime, nije ni dokaz ni pretpostavka vrednosti osigurane stvari u trenutku nastanka osiguranog slučaja, osim ako je osiguranje zaključeno na ugovorenu vrednost. Posebna pravila se primenjuju ako je suma veća od vrednosti stvari (nadosiguranje) ili manja (podosiguranje).

Kada govorimo o vrednosti stvari, odmah stičemo uvid u kompleksnost materije osiguranja imovine. U osiguravajućoj praksi pravi se razlika između vrednosti u trenutku zaključenja ugovora o osiguranju i vrednosti u času nastanka osiguranog slučaja.[28] Po logici stvari, vrednost koju stvar ima u trenutku zaključenja ugovora značajna je za određivanje visine premije osiguranja (*vrednost za osiguranje*). Što je stvar vrednija u smislu tržišne (upotrebne ili neke druge) vrednosti, to će i premija biti veća. Kako se može očekivati da stvar tokom redovne upotrebe ili samo protekom

[25] *Ibid*., 447.
[26] *Ibidem*.
[27] Za razliku od imovinskog osiguranja, u osiguranju lica osigurana suma je bitan element i kao takva ne može biti izostavljena. Ukoliko ugovarači ne unesu podatak o visini osigurane sume, ugovor ne proizvodi pravno dejstvo.
[28] N. Petrović Tomić (2019), 451.

vremena izgubi na vrednosti, ne uzima se u obzir ista vrednost prilikom obračuna naknade iz osiguranja. Dakle, vrednost stvari u momentu nastanka osiguranog slučaja predstavlja osnov za obračun naknade iz osiguranja (*vrednost za naknadu)*. Naknada koju osiguranik može dobiti od osiguravača zavisi od vrednosti uništene ili oštećene stvari u trenutku nastupanja osiguranog slučaja.

Uvođenjem dve vrste vrednosti stvari osiguravači su imali nameru da se osiguranjem pokriva samo *realna šteta* koju je osiguranik pretrpeo.[29] Prilikom isplate naknade iz osiguranja uzima se u obzir gubitak vrednosti stvari, koji je najčešće izazvan dotrajalošću usled redovne upotrebe, ali nije isključeno da se u obzir uzmu i drugi elementi koji dovode do smanjenja vrednosti osigurane stvari.

Na visinu naknade iz osiguranja utiče i to da li je ugovorena primena nekog oblika učešća osiguranika u šteti (franšize ili obaveznog učešća osiguranika u šteti tj. samopridržaja). Između ta dva modaliteta postoje značajne razlike. „Obavezno učešće u šteti kao što naziv sugeriše predstavlja onaj deo štete koji ostaje na teret osiguranika, bez obzira na uzrok štete i njenu visinu. Ugovaranje samopridržaja znači da se osiguraniku ne pruža potpuno pokriće. On je obavezan u tom smislu što ga osiguranik ne može osigurati ni kod drugog osiguravača. Obavezno učešće osiguranika u šteti (samopridržaj) je, stoga, *uslov pokrića*."[30] Franšize su uvedene u cilju smanjenja pritiska tzv. bagatelnih (manjih) šteta ili disciplinovanja osiguranika ostavljanjem na njegov teret određenog procenta štete u svakom slučaju. Osim toga, franšize imaju još dva značajna efekta: 1) smanjenje administrativnih troškova: one omogućavaju da se ne isplaćuju male štete, koje zbog učestalosti povećavaju troškove obrade odštetnih zahteva, kao i troškove osiguranika u vezi s prijavom i obradom šteta i 2) smanjenje premije osiguranja: pravilo je da što je veća franšiza, to je manja premija osiguranja.

Kod određivanja naknade iz osiguranja, osim vremena, veliki značaj se pridaje i mestu u kome se određuje vrednost osigurane stvari. Mesto procenjivanja štete se obično određuje uslovima osiguranja, i može biti: mesto gde se predmet osiguranja nalazi (obično za nekretnine), mesto polaska robe, mesto opredeljenja, mesto nastanka štete, mesto boravka osiguranika itd.

Naknada iz osiguranja ne obuhvata samo iznos štete već i troškove popravke, troškove spasavanja, a kod osiguranja od odgovornosti i troškove odbrane osiguranika od odštetnih zahteva, sudske troškove i sl. Koliki iznos naknade će biti isplaćen, kao i šta će se ubuduće dešavati sa ugovorom o osiguranju, zavisi od toga da li je nastupila totalna ili delimična šteta. Pojmom totalna šteta obuhvaćen je *potpuni nestanak osigurane stvari* usled nastupanja osiguranog slučaja (uništenje, nestanak osigurane stvari kao takve). U osiguranju stvari u slučaju totalne štete naknada iz

[29] Branko Jakaša, *Pravo osiguranja*, Informator, Zagreb, 1972, 178.
[30] N. Petrović Tomić (2019), 458.

osiguranja ne može preći vrednost koju je stvar imala u trenutku nastanka osiguranog slučaja.[31] Visina naknade iz osiguranja određuje se tako što se od vrednosti osigurane stvari određene ugovorom oduzima vrednost ostatka. Pošto je predmet osiguranja prestao da postoji, gase se i pravni odnosi nastali zaključenjem ugovora o osiguranju. Osiguravač ima pravo na premiju za tekuću godinu osiguranja.

Pojmom *delimična šteta* obuhvaćeni su svi slučajevi nastupanja oštećenja osigurane stvari. Modalitet procene štete i naknade koju duguje osiguravač zavisi od toga da li se oštećenje može popraviti. Ideja je da se isplati *naknada u visini troškova opravke*, kako bi se stvar dovela u prvobitno tj. ispravno stanje. Time se dolazi do pojma vrednosti za zamenu, koji predstavlja limit obaveze osiguravača u slučaju delimične štete. Dakle, razlikujemo osigurani slučaj koji je doveo do takvog oštećenja da se stvar može popraviti i osigurani slučaj koji je imao za posledicu oštećenje koje se ne može popraviti. U prvom slučaju na ime naknade se isplaćuju *troškovi popravke,* tj. izdaci potrebni da se stvar dovede u prvobitno stanje. Ako su troškovi popravke takvog obima da prelaze vrednost osigurane stvari na dan nastanka osiguranog slučaja, smatra se da je nastupila ekonomski totalna šteta. Načelo ekonomičnosti i zaštite interesa osiguranika nalaže primenu pravila koja važe za likvidaciju totalne štete, iako je formalnopravno nastalo samo oštećenje predmeta osiguranja. Kod osiguranja stvari, vrednost za zamenu je nabavna vrednost stvari umanjena za procenat amortizacije. U osiguranju od odgovornosti, vrednost za zamenu se određuje za svaku stvar *in concreto*, a najviše zavisi od stanja stvari i održavanja.

Kako do delimične štete može doći i više puta u toku osiguranja, postavlja se pitanje kako se to odražava na ugovor o osiguranju. Iz ugla osiguranika, najbitnije je dati odgovor na pitanje da li će osigurane stvari nakon nastanka delimične štete biti obuhvaćene osiguranjem srazmerno visini preostale vrednosti i da li će biti izmenjena osigurana suma. Rešenje koje poznaje ZOO predstavlja jedan od dva moguća pristupa problemu.[32] Prema našem pravu, ako se u toku istog perioda osiguranja dogodi više osiguranih slučajeva jedan za drugim, naknada iz osiguranja za svaki od njih određuje se i isplaćuje u potpunosti s obzirom na celu svotu osiguranja, bez njenog umanjenja za iznos ranije isplaćenih naknada u tom periodu.

IV Odnos imovinskih osiguranja i prava na naknadu štete

U praksi nije retkost da nastanak osiguranog slučaja ima za posledicu vanugovornu građansku odgovornost. U tom slučaju, osiguranik stiče prava po dva osnova. Prvo, u kapacitetu oštećenika može da se koristi institutom naknade štete

[31] Yvonne Lambert-Faivre, Laurent Leveneur, *Droit des assurances,* Dalloz, Paris, 2017, 420.

[32] Drugi – koji prihvata francusko pravo – jeste da se osigurana suma smanjuje nakon svake isplate u toku perioda osiguranja.

i da potražuje naknadu štete od štetnika. Drugo, u kapacitetu osiguranika može da zahteva naknadu iz osiguranja od osiguravača. Dakle, *postoji konkurencija dva osnova odgovornosti* i za pravni poredak je značajno da se uredi relacija ovih zahteva.

Pojmom zabrana kumuliranja prava označava se *zabrana istovremenog ostvarivanja prava po oba osnova u punom iznosu*: naknade štete po osnovu osiguranja i naknade po osnovu građanske odgovornosti lica koje je za štetu odgovorno.[33] To ne treba shvatiti kao zabranu osiguraniku da se za naknadu štete obrati i osiguravaču i štetniku, odnosno kao uslovljavanje i uvođenje redosleda namirenja. Zabrana kumuliranja prava odnosi se samo na *zabranu da se iz oba osnova dobije više nego što iznosi šteta koju je osiguranik pretrpeo*, jer bi to imalo višestruke negativne konsekvence. Za to postoji nekoliko razloga.

U uporednom pravu je doskora bilo najšire prihvaćeno shvatanje da u imovinskim osiguranjima kumuliranje prava nije dozvoljeno, dok je u osiguranju lica dozvoljeno.[34] Nema dileme da takvo razlikovanje polazi od principa obeštećenja kao suštinske razlike između ta dva tipa osiguranja. I u našem pravu je prihvaćeno to razlikovanje, uz izuzetak koji se odnosi na osiguranje od posledica nesrećnog slučaja. Sama zabrana kumuliranja može se sprovesti na dva načina: direktno (zabranom osiguraniku da po oba osnova primi više nego što je šteta koju je pretrpeo) i indirektno (priznanjem prava osiguravaču da se, nakon isplate naknade iz osiguranja, subrogira u prava osiguranika prema licu odgovornom za nastupanje osiguranog slučaja).[35] Naše pravo poznaje oba načina. Zabrana kumuliranja u imovinskim osiguranjima sprovedena je principom subrogacije osiguravača u prava osiguranika prema licu koje je za štetu odgovorno (ZOO, čl. 939). U osiguranju lica javljaju se obe tehnike: kumuliranje se dopušta uvođenjem zabrane osiguravaču da se subrogira u prava osiguranika na naknadu prema odgovornom licu (ZOO; čl. 948 st. 1), a takođe se osiguraniku priznaje pravo da se istovremeno naplati i od osiguravača i od štetnika (ZOO, čl. 948 st. 2). Ovde treba primetiti da zabrana subrogacije osiguravača prema

[33] Predrag Šulejić, *Pravo osiguranja*, Pravni fakultet u Beogradu, Beograd, 2005, 267–278.

[34] Posmatrano istorijski, na našim prostorima je u jednom periodu vladalo uverenje da kumulacija ne treba da bude dozvoljena ni u osiguranju života. Takvo rešenje je sadržao *hrvatsko-ugarski Trgovački zakonik*, kao i *srpski Zakon o obavezi na naknadu štete učinjene smrću ili telesnom povredom*. Poslednji je predviđao da je preduzimač železničkog saobraćaja obavezan da naknadi štetu ako lice pogine ili bude povređeno pri učestvovanju u železničkom saobraćaju, uz istovremeno isključenje mogućnosti kumuliranja naknade iz osiguranja sa naknadom koju može ostvariti od štetnika na osnovu pravila o odgovornosti. Vid. Zlatko Petrović, Vladimir Čolović, Duško Knežević, *Istorija osiguranja u Srbiji, Crnoj Gori i Jugoslaviji do 1941. godine*, Beograd, 2013, 73.
Ista tendencija se uočava i u domaćoj teoriji. Tako je prof. Jankovec bio mišljenja da je kumulacija prava iz osiguranja i prava na naknadu štete opravdana samo kada se radi o težim oblicima krivice štetnika. Ako je šteta izazvana namerno ili usled grube nepažnje, kumuliranje je dozvoljeno. Vid. Ivica Jankovec, „O kumuliranju naknade iz obaveznog osiguranja o odgovornosti sa naknadama, odnosno davanjima po drugim pravnim osnovama", *Zbornik Pravnog falkulteta u Novom Sadu*, 1974, 203–218.

[35] P. Šulejić, 267.

licu odgovornom za nastupanje osiguranog slučaja u osiguranju lica ne znači njegovu ekskulpaciju. Osiguranik ili korisnik prava je taj koji će podneti odštetni zahtev prema štetniku, i time sprečiti da osiguranje lica posluži kao faktičko osiguranje od odgovornosti štetnika. Ta pravila su imperativnog karaktera, od njih se ne može odstupati.

V Subrogacija – uloga osiguravača u sprečavanju da se osiguranje pretvori u svoju suprotnost

Jedno od pravila koje najviše intrigira pravnike u oblasti osiguranja jeste subrogacija.[36] Naime, ZOO izričito kaže da isplatom naknade iz osiguranja na osiguravača prelaze sva prava osiguranika prema trećem licu odgovornom za štetu po ma kom osnovu u visini isplaćene naknade štete. Do ovog prelaska prava dolazi na osnovu zakona isplatom naknade iz osiguranja osiguraniku, do visine isplaćene naknade. Pošto do subrogacije dolazi na osnovu zakona, osiguravač nije dužan da o tome obaveštava treće odgovorno lice. Iz ZOO takođe proizlazi da od trenutka isplate naknade iz osiguranja nastupaju dejstva subrogacije, a ne pre tog momenta! To, dalje, dovodi do sledećih pravnih posledica: od tada osiguranik gubi pravo da se obraća štetniku ili njegovom osiguravaču ako se obeštetio na osnovu naknade iz osiguranja, a to pravo prelazi na osiguravača.

Na osnovu tumačenja ZOO i poznavanja sudske prakse, naglašavamo da je za subrogaciju bitno kumulativno ispunjenje dva uslova. Prvi je da je *osiguravač isplatio naknadu iz osiguranja osiguraniku ili oštećenom licu*. U teoriji se s razlogom ističe da osiguravač ne može podneti tužbu protiv štetnika prema pravilima odštetnog prava, a pre isplate naknade iz osiguranja, iz najmanje dva razloga.[37] Prvo, on nije aktivno legitimisan za podnošenje tužbe za naknadu štete, jer nije oštećenik, te time ne ispunjava uslove koji se inače zahtevaju radi ostvarenja prava na naknadu štete (uzročna veza između štetne radnje i štetnih posledica). Drugo, možda i jasnije, osiguravač ne trpi štetu u pravom smislu te reči. Naknada koju isplaćuje osiguraniku za njega ne predstavlja gubitak, već deo njegovih proračuna u vezi s konkretnim ugovorom o osiguranju. Naknada koju duguje osiguraniku u slučaju nastanka osiguranog slučaja ima protivprestaciju u naplaćenim premijama. On, dakle, ispunjava ugovornu obavezu. Isplaćena naknada je limit subrogacionog zahteva. Suština je u tome da osiguravač na osnovu subrogacionog zahteva može samo da vrati onoliko koliko je isplatio svom osiguraniku. Moglo bi se reći da je to pravilo zaštitinički nastrojeno prema osiguraniku, kome zakon garantuje pravo starije od prava iz osiguranja.

[36] Detaljnije o trendovima u pogledu subrogacije: Wei Zou, Quiqwu Li, „Uporedni trendovi u regulisanju prava oštećenih lica, štetnika i Fonda za nadoknadu šteta prouzrokovanih neosiguranim motornim vozilima kroz pravo subrogacije", *Evropska revija za pravo osiguranja*, br. 2/2022, 18–28.

[37] Y. Lambert-Faivre, L. Laveneur, 449.

Tek kada mu osiguravač isplati naknadu i ispuni svoju ugovornu obavezu, može se govoriti o gubitku prava istovrsne ciljne funkcije. Drugi uslov subrogacije je da *postoji odštetni zahtev prema (trećem) odgovornom licu, po ma kom osnovu*. Naravno da taj uslov neće biti ispunjen u svakom slučaju. U tim situacijama, osiguravač će podneti teret obeštećenja, i to jeste u skladu sa ugovornim obećanjem. Ali ako su oba uslova za subrogaciju ispunjena, stvaraju se uslovi da zahvaljujući ulozi osiguravača dođe do ispunjenja pravila iz ZOO o obavezi naknade prouzrokovane štete. Na osnovu subrogacije, lice koje je štetu izazvalo treba da podnose teret naknade. Ali do primene subrogacije ne dolazi ako je štetu izazvalo lice u srodstvu u pravoj liniji sa osiguranikom, lice za čije postupke osiguranik odgovara, lice s kojim živi u istom domaćinstvu ili je radnik osiguranika, osim ako su ova lica štetu izazvala namerno.[38] Izuzetak postoji ako je neko od pomenutih lica osigurano od odgovornosti. Osiguravač se tada subrogira u prava osiguranika prema tim licima, ali ih ostvaruje protiv osiguravača od odgovornosti tih lica.

Poznavaoci osiguranja znaju da subrogacija stvara značajne pravne posledice. Najpre, subrogacija dovodi do prelaska prava prema odgovornom licu sa osiguranika na osiguravača. To stvara konkretne pravne posledice. Prvo, osiguravač je preuzeo prava svog osiguranika prema štetniku i u tom smislu je izložen svim prigovorima koji se mogu istaći i prema osiguraniku (poput prigovora kompenzacije). Ali samo do trenutka kada nastaje dejstvo subrogacije, a to je isplata naknade iz osiguranja. Prigovori koji eventualno kasnije nastanu ne mogu se isticati protiv osiguravača. Takođe, u trenutku kada je izvršena isplata naknade iz osiguranja osiguranik gubi pravo da podnosi odštetni zahtev prema štetniku.

Da bismo razumeli položaj osiguranika i štetnika u kontekstu subrogacije, bitno je naglasiti da osiguranik sam odlučuje da li će se za iznos štete koju je pretrpeo obratiti svom osiguravaču ili će je ostvariti od štetnika. Zaključenje ugovora o osiguranju ne dira u njegovo pravo izbora dužnika. Budući da se većina osiguranika rukovodi logikom da je osiguravač solventniji i da će naknadu brže ostvariti ako se njemu obrate, u praksi se često stiču uslovi za subrogaciju osiguravača u prava osiguranika prema štetniku.[39] Ako bi se desilo da zbog ograničenja u osiguravajućem pokriću osiguranik ne dobije potpuno obeštećenje od osiguravača, dolazi do izražaja pravilo da prelazak prava sa osiguranika na osiguravača *ne sme biti na štetu osiguranika*. Na osnovu tog pravila rešava se svaki potencijalni sukob interesa osiguravača i osiguranika.[40] Dakle, iako nesumnjivo koristi i osiguravačima, *institut subrogacije primarno je povezan s načelom obeštećenja i kao takav štiti javni poredak u osiguranju*.

[38] U pitanju su lica koja osiguranik, inače, ne bi tužio, bez obzira na to da li ima zaključeno osiguranje (srodnici), odnosno za koja po zakonu odgovara (radnici). Kako je rekao francuski autor, priznati pravo na subrogaciju značilo bi omogućiti osiguravaču da „ono što je jednom rukom dao osiguraniku, drugom oduzme".

[39] P. Šulejić, 377.

[40] Y. Lambert-Faivre, L. Leveneur, 463.

VI Zaključak

Osiguranje imovine predstavlja vrstu osiguranja koja je od neprocenjivog značaja za nesmetano odvijanje života u savremenom društvu. Naknadom uništenih ili oštećenih imovinskih vrednosti fizičkih i/ili pravnih lica, u postupku koji karakteriše efikasnost i uvažavanje interesa korisnika usluga, osiguravači vrše društveno korisnu funkciju. Delovanjem osiguranja gubitak ili oštećenje imovine brzo se nadoknađuju, a poslovne aktivnosti odvijaju bez zastoja.

Podvlačimo da **osiguranje kao delatnost ima prirodni monopol kada je reč o zaštiti imovine, budući da ne postoji konkurentska usluga sa istim obimom i kvalitetom zaštitne funkcije.** Da bi se na najoptimalniji način iskoristile pogodnosti osiguravajuće zaštite, neophodno je da se usvoji strategija promocije osiguranja imovine i opismenjavanja građana u svojstvu korisnika usluga osiguranja. Građanin koji je investirao u osiguranje u povoljnijoj je situaciji u odnosu na onoga koji je to propustio da učini. Naglašavamo da u mnogim slučajevima izdvajanja za osiguranje na ime premija ne predstavljaju udar na budžet klijenta. Najbolji primer je osiguranje stanova od osnovnih rizika, koje okvirno iznosi jedan evro po kvadratu.

Naš regulatorni okvir osiguranja imovine, iako etabliran ZOO koji je usvojen još 1978. godine, predstavlja solidnu osnovu za razvoj novih usluga. Ali ako se želi podstaći održivi rast osiguranja, treba očekivati da se u dogledno vreme pristupi izmenama regulatornog okvira osiguranja. Naglašavamo da je uloga osiguravača u stvaranju podsticajnog okruženja veoma izražena. Oni su, naime, značajno tome doprineli, budući da su uslovima osiguranja uspostavili sve pretpostavke za razvoj različitih oblika osiguranja imovine, koji odgovaraju potrebama za zaštitom različitih imovinskih vrednosti.

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PROPERTY INSURANCE AS AN INSTRUMENT FOR PROTECTING PROPERTY ASSETS

REVIEW SCIENTIFIC PAPER

Summary

The author examines property insurance with a particular focus on its indemnity nature, which is a fundamental component of insurance legislation. According to the author, property insurance creates a *win-win* situation for individuals who choose this form of protection for their material interests. Based on practical experience, it can also be argued that the insurance industry holds a natural monopoly, as there is no alternative instrument that offers such comprehensive protection under comparably favorable financial conditions. Special attention is given to the relationship between property insurance and the principle of indemnification. To fully leverage the benefits of insurance coverage, it is essential to adopt a strategy for promoting property insurance and enhancing public literacy in this area. Someone who invested in insurance is in a more advantageous position than one who has neglected to do so.

Keywords: assets, property, insurance, protection, indemnity principle, literacy

I General remarsk on property insurance

Term *insurance* is most commonly associated with *insurance contracts concluded for the purpose of protecting property from various risks that can lead to loss or damage of assets belonging to individuals or legal entities*.[2] Legally speaking, property

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[2] For more details on the history of insurance: Ivana Soković, „Značaj osiguranja i perspektive razvoja u Srbiji", *Tokovi osiguranja*, No. 2/2024, 265–279.

insurance encompasses various types of insurance contracts aimed at compensating damage incurred due to loss or damage of the policyholder's or insured's assets.[3] The most significant classification within property insurance divides it into two major and quite different areas: *insurance of things* and *liability insurance*. This is a common classification not only among insurance law theorists but also among practitioners, and it is supported across many legal systems. Why is it important to mention the difference between insurance of property and liability insurance right from the start? For several reasons, main among them is the fact that damage manifests differently in these subtypes of property insurance. Additionally, there are numerous other distinctions between these types of property insurance.

Insurance of property refers to a subcategory of property insurance that provides compensation in the event of loss, destruction, or damage to insured properties.[4] The insured subject matter is a specific object or part of the insured's assets, exposed to various risks: regardless of whether the property is movable or immovable, corporeal or incorporeal (such as receivables).[5] As for risks related to the insured property, they may involve fire, flood, machinery breakdown, theft, and others.[6] Notably, for property insurance purposes, a risk does not necessarily have to cause physical damage, as in the case of theft, where a property may be lost without being physically damaged… What is crucial in insurance of property is that, in order to insure any subject matter, the insured must have an insurable material interest. When the term insurable material interest is mentioned, one naturally first thinks of the owner of the property, but this term in modern insurance law allows a wide range of persons to conclude some form of insurance of property.[7] The only condition is that they have a legally recognized material interest to the insured property, so they can suffer damage due to its loss or damage. Simply put, *insurance of property enables compensation to the person who has suffered damage to the insured property*. In this sense, insurance is seen as an instrument that contributes to the protective function through efficient compensation for damage to insured property. Instead

[3] More on the insurance contract: Marija Karanikić Mirić, „Forma ugovora o osiguranju", *Tokovi osiguranja*, No. 1/2025, 22–25. Insurance of apartments, cars, industrial facilities, professional liability insurance, vacation rain insurance, business interruption insurance, etc., are just some of the various forms of property insurance.

[4] On the risk in insurance: Slobodan Ilijić, „O pravnim aspektima rizika i polise osiguranja u prednacrtu Građanskog zakonika Republike Srbije (2015)", *Tokovi osiguranja*, No. 2/2018, 31–41.

[5] Nataša Petrović Tomić, *Pravo osiguranja*, *Sistem, Knjiga prva*, Službeni glasnik, Belgrade, 2019, 437.

[6] On how changes in risk affect the liabilities of the insured: Katarina Ivančević, „Pravne posledice promene rizika u toku trajanja ugovora o osiguranju imovine", *Evropska revija za pravo osiguranja*, No. 3/2021, 10–22.

[7] On the difference between the traditional and modern understanding of insurable interest, especially regarding banks' interest in offering insurance to their clients as part of benefit programs: Nataša Petrović Tomić, Nenad Grujić, "Kolektivno ugovaranje osiguranja od strane banaka – kanal distribucije i faktor finansijskog opismenjavanja korisnika osiguranja", *Osiguranje, Hrvatski časopis za osiguranje*, No. 12/2025, 17–23.

of going through the damage compensation process, which involves initiating appropriate proceedings against the person responsible for the damage, the holder of material interest in the insured property can directly address the insurer, who, in accordance with the Insurance Law[8] and the Guidelines of the National Bank of the Republic of Serbia,[9] is obliged to settle claims fairly and properly.[10] Although not legally binding, the Guidelines were adopted by the insurance market supervisory authority as recommendations, thus becoming part of *the insurance professional standards*, and indirectly part of positive law, considering the insurer's obligation to act according to *insurance professional standards* pursuant to the provisions of the Insurance Law. Moreover, the supervisory authority (National Bank of the Republic of Serbia) closely monitors whether insurers' conduct during contracting, after contracting, and especially when handling claims complies with the minimum standards set by the Guidelines.[11] Insurers are expected to ensure the protection of consumers by applying and complying the standards prescribed by the Guidelines.[12]

This means that a person who invests in insurance enjoys a dual benefit compared to those who leave their property uninsured: compensation from a solvent co-insurer whose liquidity and solvency is supervised by the National Bank of Serbia, and guarantees of fair and proper treatment, which cannot be expected in proceedings initiated against the liable party. **Property insurance, therefore, creates a win-win situation for those who opt for this type of protection of their material**

[8] Insurance Law, *Official Gazette of the Republic of Serbia*, Nos. 139/2014 and 44/2021 (hereinafter referred to as ZO).

[9] National Bank of Serbia, Guidelines on Minimum Standards of Conduct and Good Practices for Participants in the Insurance Market dated April 20, 2018 (hereinafter referred to as: *Guidelines*).

[10] The social, economic, and broader societal significance of the insurance activity requires insurance companies, when fulfilling rights and obligations, to consider not only their own interest but also the interest of insurance service users: "An insurance company, insurance brokerage company, insurance agency company, insurance agent, and legal entities from Article 98, paragraph 2 of this law, which perform insurance agency activities based on prior consent from the National Bank of Serbia (hereinafter: legal entities from Article 98, paragraph 2 of this law), are obliged to ensure the protection of the rights and interests of the insured, the policyholders, the users of insurance, and third-party injured persons (hereinafter: users of insurance services), in accordance with regulations, professional standards, and good business practices" (Article 15 of the Insurance Law).
To emphasize: insurance companies are required to protect the rights and interests of service users in accordance with *regulations, insurance professional standards, and good business practices*. Users of insurance services generally do not have sufficient knowledge about the insurance service they acquire, which is why insurers, as the stronger party, have numerous obligations before and after contract conclusion aimed at protecting the trust of the users of insurance services. Without protecting this trust, insurance, which has an important economic, social, and societal function, cannot fulfill its purpose.

[11] Ivan D. Radojković, Aleksandar V. Kostić, Maja T. Aleksandrović Gajić, „Načela prihvata rizika i tehničke osnove osiguranja poljoprivrednih kultura", *Tokovi osiguranja,* No. 3/2021, 93.

[12] Herman Cousy, „Changing Insurance Contract Law: An Age-Old, Slow and Unfinished Story", *Insurance Regulation in the European Union: Solvency II and Beyond* (eds. P. Marano, M. Siri), Palgrave Macmillan, London, 2017, 32.

interests.[13] Furthermore, based on practical experience, it can be argued that insurance as an activity holds a natural monopoly, since there is no instrument that provides property protection in such a comprehensive way.

Liability insurance is a contract under which the insurer covers the financial consequences of the insured's liability instead of the insured. As can be seen from the definitions, the fundamental difference compared to insurance of property, which leads to a different legal regime, is the insured subject matter: while the insured subject matter of insurance of property is the insured's *property*, the insured subject matter of liability insurance is the insured's *liability*. The protective function of insurance of property is directed towards the insured who suffered the damage; in liability insurance, the insured who caused damage to another is protected by paying compensation on their behalf, which leads to the emergence of so-called third-party injured persons towards who benefit from the protective function of insurance liability.

II Indemnity principle as the supreme principle of property insurance

When we talk about property insurance, it is typically understood as compensation for damage through insurance, that is, indemnification by the insurer. The principle of full damage compensation**,** one of the most important principles of the law of obligations in the insurance domain, is manifested specifically through the indemnity principle**.** "The awarded compensation must neither serve as punishment for the tortfeasor, nor as a source of enrichment for the injured party."[14] The purpose of indemnity principle in modern insurance law is more than clear: on the one hand, it ensures a moral framework for property insurance by preventing it from going beyond the limits of compensation law.[15] On the other hand, it clearly distinguishes property insurance from insurance of persons.[16] Property insurance contract is

[13] Generally speaking, insurance today is a **highly regulated financial transaction, which has become not only a normal but also a necessary segment of modern social and economic life.** There is intense regulatory activity both by the legislature and supervisory bodies, all aimed at ensuring adequate protection for users of insurance services. *Ibid*., 35.

[14] Marija Karanikić Mirić, *Obligaciono pravo*, Službeni glasnik, Belgrade, 2024, 94–96.

[15] If the insured could receive insurance compensation exceeding the damage they have suffered and proven, insurance would become an object of interest for unscrupulous individuals seeking to exploit it. The legal system cannot accept this, which is why strict application of the principle of indemnity is insisted upon.

[16] Historically, the principle of indemnity played a key role in the development of the insurance business and its acceptance by those who were initially sceptical about this contract due to its aleatory nature, which, out of ignorance, they confused with gambling and generally suspicious transactions. The fear that insurance was not significantly different from speculative activities, on one hand, and suspicion that

concluded with the aim of protecting the insured party, or in some cases, a third injured party against damage. Accordingly, the insurer's liability must be limited to the actual amount of the damage suffered**.** The insured is entitled to be compensated for "the damage, and nothing beyond the actual damage suffered".[17] "In this way, the protective function of property insurance is directly tied to damage indemnification, while also preventing unjust enrichment of dishonest insured parties.[18] On one hand, the insured individuals cannot receive more from the insurer than the value of the damage actually suffered. On the other hand, claims arising from intentionally caused insurance cases are explicitly excluded. All of this is regulated by mandatory norms. Therefore, an insured party is not motivated to intentionally cause damage to the insured property, as in such cases they are *ex lege* deprived of coverage. Only in cases where the damage occurs independently of the insured's exclusive intent, the insured has the right to damage compensation, and even then, only up to the actual amount of the damage**,** taking into account the relation between the sum insured and the actual value of the insured property. This makes property insurance, first and foremost, an economically desirable and then socially acceptable institution."[19]

The application of indemnity principle is particularly important in insurance practice, as it directly affects the claims settlement process**.** Unlike in life insurance, where the insurer, upon receiving notice of the insurance case and relevant documentation, pays out a pre-agreed amount, in property insurance there is *a process for assessing the insurance compensation* that precedes the actual act of indemnification. By its nature, this valuation involves multiple procedural steps and can significantly extend the timeframe of compensation**.** For this reason, one of the main distinctions between property and insurance of persons lies in the burden of proof, accompanying the realization of rights under property insurance is incomparably heavier than in insurance of persons.

What does the term valuation of indemnity exactly mean? When a loss to the insured's property occurs, the first step is to *determine the damage caused*. The burden of proof lies with the insured or the beneficiary, and depending on the case, this can be quite demanding. In transport insurance**,** for example, it is common to engage specialized loss adjusters**,** whose task is to formalize the process and draft

the insured might abuse the insurance contract, on the other, led to the development of the rules and principles characterizing insurance law. This refers to the concepts of insurable interest, the principle of indemnity, and the principles of good faith and fairness. Nataša Petrović Tomić, Mirjana Glintić, "The Hybridization of the Regulatory Framework of Insurance Contract Law: Elements of a New Setting", *Annals of the Faculty of Law*, No. 2/2024, 223–250.

[17] M. Karanikić Mirić (2024), 94.

[18] Historically, the principle of indemnity was established with the aim of preventing the intentional causing of insurance cases. By limiting the insurer's liability to the amount of the actual damage suffered, it became economically unfeasible for the insured to deliberately cause an insurance case.

[19] N. Petrović Tomić (2019), 438–439.

an appropriate report or document accepted by the insurer.[20] According to the main principle of tort and contract law, damages in property insurance should include both the actual damage (*damnum emergens*) and the profit lost (*lucrum cessans*). However, under positive law, the insurer's liability in property insurance is limited to compensation for actual damage**,** while lost profits are only covered by special agreement. This effectively means that, in property insurance, the statutory principle of full compensation for financial loss from the Law on Contract and Torts (ZOO) does not apply *ex lege*.[21] What does this mean for the insured? This is not a favorable solution, because the insured parties would benefit more if they could rely on coverage for the entire loss suffered, rather than having to separately negotiate coverage for the profit lost.[22] In practice, unless otherwise explicitly agreed, the insured will not be in the same financial position as if an insurance case had not occurred. They will receive compensation only for actual damage, which implies partial indemnification. As a result, for the portion of the loss that corresponds to the profit lost, the insured effectively becomes their own insurer. This sends a discouraging message to insured parties, as they are unable to recover the full compensation they expected. An exception exists in crop insurance, where the value of the insured property is determined in a specific manner. In such cases, compensation is not based on the value of crops at the time of damage, but rather at the time of harvest (unless otherwise provided by contract). This approach acknowledges the need for tailored protection in this unique case. The insured has an interest in insuring crops at their harvest value (which includes the profit lost!), as that is when they reach their highest economic value.

The assessment of insurance compensation also involves taking into account the *sum insured*, as it represents the upper limit of the insurer's liability. However, the sum insured does not constitute proof or presumption of the value of the insured subject matter at the time of the insurance case, unless the insurance is concluded on an agreed value basis. The actual value of the insured object at the time of the damage cannot be disregarded. Insurers cannot calculate compensation in accordance with the principle of indemnity without considering the value the insured object held at the moment of the insurance case . The burden of proving the value rests with the insured.[23] The principle of indemnity leads to the application of two

[20] Nataša Petrović Tomić, *Osiguranje robe u međunarodnom pomorskom prevozu*, University of Belgrade Faculty of Law, Belgrade, 2009.

[21] For more detail: Marija Karanikić Mirić, *Krivica kao osnov deliktne odgovornosti u građanskom pravu*, Faculty of Law, University of Belgrade, Belgrade, 2009, 177 and following.

[22] Nataša Petrović Tomić, *Posebna pravila koja se odnose na osiguranje imovine i osiguranje od odgovornosti, Priručnik za obuku za polaganje ispita i sticanje zvanja ovlašćenog posrednika i ovlašćenog zastupnika u osiguranju*, Privredna komora Srbije, Belgrade, 2024, 89–90.

[23] Various methods of determining the value of an property may be taken into account: market value, use value, agreed value, and new value. *Ibid*., 90–92.

rules. First, the insured cannot collect more than the value of the insured object at the time of the damage occurrence, even if multiple insurance contracts have been concluded for the same object. Second, the insured cannot receive more than the actual value of the property, regardless of the sum insured under the policy. As these rules make clear, the value of the insured object acts as a limiting factor in the process of assessing compensation.

The Law of Contract and Torts (ZOO) specifies that rights from an insurance contract belong only to those who, at the time of the damage occurrence, held a material interest in the insurance case not occurring. This introduces the requirement of insurable interest into property insurance, distinguishing it from insurance of persons.

The concept of insurable interest is closely linked to *the purpose of property insurance: it must benefit the party taking out the insurance or the person on whose behalf it is taken*.[24] If insurance contracts and the exercise of insurance rights were allowed without the existence of an insurable interest, it would pave the way for lump-sum (or arbitrary) payouts. Moreover, *the existence of insurable interest determines who qualifies as the insured*. It consists of the need to secure economic protection against specific risks through the payment of insurance compensation. In the context of insurance of property, anyone who stands to suffer damage due to the destruction or deterioration of the insured property is considered to have a valid insurable interest in concluding an insurance contract (such as the owner, co-owner, depositary, lessee, or pledgee). In liability insurance, any person exposed to legal liability and seeking protection against potential damages caused to others is considered to have an insurable interest.

III Efficacy of indemnification – payment of insurance compensation

As highlighted in theory, the factors influencing the assessment of insurance compensation are: 1) the amount of the damage caused; 2) the sum insured; and 3) the value of the insured subject matter.[25] From the perspective of the practice, each of these three elements may represent a limit, i.e. the upper boundary of the insurer's liability.[26] None of them is generally more important than the others, but specific circumstances may make one particularly relevant. For instance, if the value of the insured subject matter and the sum insured match, the insured will receive compensation equal to the amount of damage sustained, provided no deductible (franchise) has been agreed upon. If the value of the insured subject matter exceeds

[24] N. Petrović Tomić (2019), 446.
[25] *Ibid*., 447.
[26] *Ibidem*.

the sum insured, the insurance compensation will not cover the full extent of the damage. On the other hand, if the sum insured is greater, the damage itself becomes the upper limit of the insurer's liability.

The sum insured is significant in determining insurance compensation, as it represents the amount by which the insured has covered the insured risk. The sum insured corresponds to the value of the insurable interest in the specific property, and therefore serves as the upper limit of the insurer's liability in the event of total loss. In most cases, *the sum insured in property insurance has a purely technical function*.[27] It is neither proof nor a presumption of the value of the insured subject matter at the time of the insurance case, unless the insurance contract was concluded on an agreed value basis. Special rules apply if the sum insured is greater than the property's value (overinsurance) or lower (underinsurance).

When discussing the value of the property, the complexity of property insurance becomes immediately evident. In insurance practice, a distinction is made between the value at the time the insurance contract is concluded and the value at the time the insurance case occurs.[28] Logically, the property's value at the time of contracting is relevant for calculating the insurance premium (*value for insurance*). The higher the market (or use, or other) value of the property, the higher the premium. Since it is expected that the property will lose value through regular use or simply over time, the same value is not used when calculating compensation. Thus, the property's value at the time of the insurance case serves as the basis for calculating insurance compensation (*value for compensation*). The compensation that the insured may receive depends on the value of the damaged or destroyed property at the time of the insurance case.

By introducing two types of property value, insurers intended for insurance to cover only the *actual damage* sustained by the insured.[29] When paying out indemnity, depreciation is considered, most often due to wear and tear from regular use, but other elements that contribute to the depreciation of the insured property may also be considered.

The amount of compensation also depends on whether some form of the insured's participation in the loss has been agreed upon (a deductible or mandatory participation, i.e. insured's retention). There are significant differences between these two modalities. "Mandatory participation in the damage, as the term implies, refers to the portion of the damage that remains at the policyholder's expense, regardless of the cause or the amount of the damage. The arrangement of self-retention means

[27] Unlike in property insurance, in insurance of persons the sum insured is an important element and, as such, cannot be omitted. If the contracting parties fail to specify the amount of the insured sum, the contract does not produce legal effect.

[28] N. Petrović Tomić (2019), 451.

[29] Branko Jakaša, *Pravo osiguranja*, Informator, Zagreb, 1972, 178.

the insured is not provided with full coverage. It is mandatory in the sense that the insured may not insure it with another insurer. Thus, mandatory participation (insured's retention) is a *condition of coverage*."[30] Deductibles were introduced to reduce the frequency of so-called minor (trivial) claims or discipline insureds by making them bear a certain percentage of the loss in every case. In addition, deductibles have two other significant effects: 1) reduction of administrative costs: they make it possible not to pay out minor claims, which, due to their frequency, increase the cost of processing claims as well as the insured's costs related to reporting and managing the claims process; and 2) reduction of the insurance premium: as a general rule, the higher the deductible, the lower the insurance premium.

When determining the amount of insurance compensation, in addition to the time of the insurance case, significant importance is also given to the location at which the value of the insured property is assessed. The place of damage assessment is usually stipulated in the insurance terms and conditions, and may be: the location of the insured property (commonly for real estate), the place of dispatch of goods, the destination point, the place where the damage occurred, the residence of the insured, etc.

Indemnity does not only include the amount of the damage itself, but also repair costs, salvage expenses, and in liability insurance - legal defense costs, court expenses, and similar. The amount of compensation to be paid, as well as the future status of the insurance contract, depends on whether the damage is classified as total or partial.

The term total loss refers to the *complete disappearance of the insured property* due to the occurrence of an insurance case (destruction or disappearance of the property as such). In property insurance, in the event of a total loss, the compensation cannot exceed the property's value at the time of the insurance case.[31] The compensation amount is calculated by deducting the residual value from the value of the insured property as determined in the contract. Since the subject matter of insurance no longer exists, the legal relationship established by the insurance contract ceases to exist as well. The insurer retains the right to the premium for the current insurance year.

The term *partial loss* encompasses all cases of damage to the insured property. The assessment method and the indemnity owed by the insurer depend on whether the damage can be repaired. The idea is to pay an *indemnity equal to the cost of repairs*, in order to restore the property to its original, i.e. functional condition. This introduces the concept of replacement value, which represents the limit of the insurer's liability in the case of partial loss. Thus, a distinction is made between an insurance case resulting in damage that can be repaired and one causing irreparable

[30] Nataša Petrović Tomić (2019), 458.

[31] Yvonne Lambert-Faivre, Laurent Leveneur, *Droit des assurances,* Dalloz, Paris, 2017, 420.

damage. In the first case, the indemnity corresponds to the *costs of repair,* i.e. the expenses necessary to restore the property to its original state. If the repair costs exceed the value of the insured property at the time the insurance case occurred, the situation is treated as an economic total loss. The principle of cost-efficiency and the protection of the insured's interests require the application of rules governing total loss settlements, even if the damage is formally classified as partial. In property insurance, replacement value refers to the purchase value of the property reduced by the depreciation percentage. In liability insurance, the replacement value is determined for each property *in concreto*, and primarily depends on the property's condition and maintenance.

Since partial loss may occur multiple times during the insurance period, the question arises as to how this affects the insurance contract. From the insured's perspective, it is essential to determine whether the insured object remains covered after a partial loss, proportionate to their remaining value, and whether the sum insured will be modified.

The solution provided under the Law on Contract and Torts (ZOO) represents one of two possible approaches to the issue.[32] According to domestic law, if multiple insurance cases occur consecutively within the same insurance period, compensation for each event is determined and paid in full based on the total sum insured, without reduction for any amounts previously paid during that period.

IV Relationship between property insurance and the right to compensation for damage

In practice, it is not uncommon for the occurrence of an insurance case to give rise to extra-contractual civil liability. In such cases, the insured acquires rights on two separate legal grounds. First, in the capacity of an injured party (claimant), they may request compensation for damage from the tortfeasor. Second, in the capacity of the insured, they may claim compensation from the insurer under the insurance policy. Therefore, *there exists a concurrence of two legal grounds for compensation*, and it is important for the legal system to regulate the relationship between these claims.

The concept of the prohibition of cumulation of rights refers to *the prohibition of simultaneous realization of both rights in their full amount:* namely, compensation from the insurer under the insurance contract, and damages from the liable third party under civil liability.[33] This, however, should not be understood as a prohibition for the insured to pursue claims against both the insurer and the tortfeasor, nor should

[32] The other, as accepted in French law, provides that the sum insured is reduced after each indemnity payment during the insurance period.

[33] Predrag Šulejić, *Pravo osiguranja*, Faculty of Law University of Belgrade, Belgrade, 2005, 267–278.

it be interpreted as imposing a sequence of enforcement or recovery. Rather, the prohibition applies only to *receiving more than the actual damage sustained*, as such overcompensation would have several negative consequences. There are several reasons for this restriction.

In comparative law, it was until recently widely accepted that cumulation of rights is not allowed in property insurance, whereas it is permitted in insurance of persons.[34] This distinction undeniably arises from the principle of indemnity, which fundamentally differentiates these two types of insurance. This distinction is also recognized in our domestic legal system, with an exception pertaining to accident insurance.

The prohibition of cumulation may be implemented in two ways: directly (by prohibiting the insured from receiving more than the amount of the actual loss on both grounds) and indirectly (by granting the insurer the right of subrogation after paying compensation under the policy, whereby the insurer steps into the shoes of the insured with respect to their claim against the liable party responsible for the insurance case).[35] Both ways are recognized in our domestic law. The prohibition of cumulation in property insurance is enforced through the principle of subrogation, whereby the insurer acquires the insured's rights against the party responsible for the damage (ZOO, art. 939). In insurance of persons, both approaches are applied: cumulation is permitted by prohibiting the insurer from exercising subrogation against the liable party (ZOO, art. 948, para. 1), and the insured is entitled to receive payment from both the insurer and the tortfeasor (ZOO, art. 948, para. 2). It should be noted, however, that the prohibition of subrogation by the insurer in insurance of persons does not absolve the responsible party from liability. It is the insured or the beneficiary who retains the right to file a claim for damages against the tortfeasor, thereby preventing insurance of persons from effectively becoming liability insurance for the wrongdoer. These rules are mandatory in nature, and deviations from them are not permitted.

[34] Historically, in the former Yugoslav region, there was a time when even life insurance did not allow double recovery. This was the case under the *Austro-Hungarian Commercial Code* and t*he Serbian law on compensation for death or bodily injury*. The latter stipulated that a railway operator was liable for injuries or death in railway accidents, while explicitly excluding the possibility of combining compensation from insurance with damages from the responsible party. See: Zlatko Petrović, Vladimir Čolović, Duško Knežević, *Istorija osiguranja u Srbiji, Crnoj Gori i Jugoslaviji do 1941. godine*, Belgrade, 2013, 73.
The same tendency appears in domestic legal theory. For example, Professor Jankovec believed that combining insurance and tort-based compensation was justified only in cases of serious fault by the tortfeasor. If the damage was caused intentionally or by gross negligence, double recovery was acceptable. See: Ivica Jankovec, „O kumuliranju naknade iz obaveznog osiguranja o odgovornosti sa naknadama, odnosno davanjima po drugim pravnim osnovama", *Zbornik Pravnog falkulteta u Novom Sadu,* 1974, 203–218.
[35] P. Šulejić, 267.

V Subrogation – the insurer's role in preventing insurance from becoming its own opposite

One of the most intriguing principles for legal professionals in the field of insurance is the concept of subrogation.[36] Namely, the Law on Contract and Torts (ZOO) explicitly states that, upon payment of compensation, all rights of the insured against any third party liable for the damage, on any legal basis, are transferred to the insurer, up to the amount of compensation paid. This transfer of rights occurs *ex lege* upon the payment of compensation by the insurer to the insured. Since subrogation arises from the law, the insurer is not obligated to notify the third party liable for the damage. The ZOO also makes it clear that the effects of subrogation commence only at the moment of compensation payment, and not before. This leads to the following legal consequences: from the time of compensation payment, the insured loses the right to pursue claims against the tortfeasor or their liability insurer, as that right is transferred to the insurer.

Based on the interpretation of the ZOO and judicial practice, it is important to emphasize that subrogation requires the cumulative fulfillment of two conditions. The first condition is that *the insurer must have paid compensation under the insurance contract to the insured or to the injured party*. Legal theory rightly points out that the insurer cannot file a claim for damage against the tortfeasor under tort law prior to paying the insurance compensation, for at least two reasons.[37] First, the insurer lacks active legal standing to file a claim for damages, as it is not itself the injured party and therefore does not meet the general requirements for asserting a right to compensation (namely, the causal link between the wrongful act and the resulting damage). Second, and perhaps more clearly, the insurer does not suffer damage in the proper legal sense of the word. The compensation paid to the insured does not constitute a loss for the insurer but is rather a contractual obligation, factored into the premium calculations under specific insurance contract. The compensation due to the insured upon the occurrence of an insurance case is offset by the premiums collected. The insurer is thus fulfilling his contractual obligation. The amount of compensation paid constitutes the upper limit of the subrogation claim. The essence of subrogation is that the insurer may recover from the tortfeasor only up to the amount it paid to the insured This rule serves a protective function in favor of the insured, whose right to compensation under general tort principles has legal priority over the insurer's subrogation right. Only once the insurer has paid compensation and fulfilled his contractual obligation can it be said that the insured has lost a right serving an equivalent compensatory function. The second condition for subrogation is that *there must be an*

[36] More on subrogation trends: Wei Zou, Quiqwu Li, "Wei Zou, Quiqwu Li, „Uporedni trendovi u regulisanju prava oštećenih lica, štetnika i Fonda za nadoknadu šteta prouzrokovanih neosiguranim motornim vozilima kroz pravo subrogacije", *Evropska revija za pravo osiguranja*, No. 2/2022, 18–28.

[37] Y. Lambert-Faivre, L. Laveneur, 449.

existing claim for damages against a third party, regardless of the legal basis. Naturally, this condition will not be met in all cases. In such cases, the insurer bears the burden of indemnification, which is consistent with the nature of his contractual promise. However, when both subrogation conditions are met, the insurer plays a key role in ensuring that the principle of compensation, stipulated in the ZOO, is fulfilled: namely, that the party who caused the damage ultimately bears the cost of compensation. However, transfer of rights of the insured to the insurer if the damage was caused by a person who is related to the insured in a direct line of kinship, a person for whose actions the insured is legally responsible, a person living in the same household as the insured, or an employee of the insured, except when such persons caused the damage intentionally.[38] An exception is also made if any of these persons is covered by liability insurance. In that case, the insurer is subrogated to the rights of the insured against such individuals, but enforcement occurs against the liability insurer of the person at fault.

Insurance professionals are well aware that subrogation carries significant legal consequences. Primarily, it results in the transfer of rights from the insured to the insurer against the liable party. This brings about concrete legal effects. Firstly, the insurer assumes the insured's rights against the tortfeasor and is, accordingly, subject to all defenses and objections (e.g. set-off) that the tortfeasor could raise against the insured, but only up until the moment subrogation takes effect, which is the moment of compensation payment. Any defenses arising after this point cannot be asserted against the insurer. Also, once compensation is paid, the insured loses the right to bring a claim for damages against the tortfeasor.

To fully understand the positions of the insured and the tortfeasor within the context of subrogation, it is important to emphasize that the insured retains the choice of whether to claim compensation from their insurer or directly from the tortfeasor. Entering into an insurance contract does not affect the insured's discretion to select the debtor. Since most insured persons perceive the insurer as more solvent and capable of providing faster compensation, they usually opt to claim from the insurer, enabling the insurer to exercise the insured's rights against the tortfeasor.[39] In cases where, due to limits in insurance coverage, the insured does not receive full compensation, the principle applies that the transfer of rights from the insured to the insurer *must not harm the insured*. This principle resolves any potential conflict of interest between the insurer and the insured.[40] Therefore, although subrogation undoubtedly serves the interests of insurers, *it is primarily tied to the principle of indemnity and, as such, serves to protect the public order in insurance law*.

[38] These are individuals whom the insured would not ordinarily sue, regardless of whether insurance coverage exists, such as close relatives, or those for whose actions the insured bears legal responsibility, such as employees. As one French author aptly put it, recognizing the insurer's right of subrogation in such cases would amount to allowing the insurer to "take back with one hand what it has given with the other".

[39] P. Šulejić, 377.

[40] Y. Lambert-Faivre, L. Leveneur, 463.

VI Conclusion

Property insurance represents a type of insurance that is of immeasurable importance for the uninterrupted functioning of life in modern society. By compensating for destroyed or damaged assets of individuals and/or legal entities, through a process characterized by efficiency and consideration of the interests of service users, insurers perform a socially beneficial function. The role of insurance ensures that losses or damages to property are swiftly compensated, allowing business operations to continue without interruption.

It must be emphasized **that insurance, as an industry, holds a natural monopoly when it comes to the protection of property, given that no competing service offers the same scope or quality of protective function.** To make optimal use of the benefits provided by insurance protection, it is essential to adopt a strategy for promoting property insurance and increasing insurance literacy among citizens as service users. A citizen who has invested in insurance is in a more favorable position than one who has not. It is important to highlight that in many cases, premium contributions do not place a significant financial burden on the client's budget. A prime example is home insurance against basic risks, which typically costs approximately one euro per square meter.

Our regulatory framework for property insurance, although established under the Law on Contract and Torts (ZOO) adopted in 1978, provides a solid foundation for the development of new insurance services. However, if sustainable growth in the insurance sector is to be encouraged, amendments to the regulatory framework should be expected in the foreseeable future. It should be emphasized that insurers play a key role in creating a stimulating environment for the development of property insurance. Indeed, they have significantly contributed to this by establishing, through insurance conditions, all the necessary prerequisites for the development of various forms of property insurance tailored to the needs of protecting different types of property assets.

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DUŽNOST OBAVEŠTAVANJA OSIGURAVAČA O PROMENI RIZIKA PO ZAKLJUČENJU UGOVORA O OSIGURANJU[2]

PREGLEDNI NAUČNI RAD

Apstrakt

Okolnosti koje su od značaja za ocenu rizika mogu se promeniti nakon zaključenja ugovora o osiguranju. Kako ugovarač osiguranja jedini ima potpuni uvid u sve okolnosti relevantne za procenu rizika, on je dužan da o takvim promenama obavesti osiguravača. U radu će se govoriti o prirodi dužnosti informisanja saugovornika kao konkretizaciji načela savesnosti i poštenja, bliže odrediti relevantan rizik čije smanjenje ili povećanje konstituiše dužnost obaveštavanja, analizirati prava osiguravača nakon što je obavešten o promeni okolnosti, kao i pravne posledice povrede ove dužnosti. Dužnost obaveštavanja osiguravača o povećanju ili smanjenju rizika uređena je u čl. 914–916 ZOO. Osim analize srpskog prava, autorka će analizirati relevantne odredbe francuskog i nemačkog prava, kao i Principe evropskog ugovornog prava osiguranja (PEICL).

Ključne reči: *ugovor o osiguranju, rizik, povećanje rizika, smanjenje rizika, dužnost obaveštavanja*

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I Uvod

Ugovor o osiguranju jeste sporazum kojim se ugovarač osiguranja obavezuje da plati određeni iznos osiguravaču, a osiguravač se obavezuje da osiguraniku ili nekom trećem licu, ako se desi događaj koji predstavlja osigurani slučaj, isplati naknadu ili učini nešto drugo. Novčani iznos koji ugovarač osiguranja plaća naziva se premija, a iznos koji po nastupanju osiguranog slučaja plaća osiguravač naziva se ugovorena svota ili osiguranina. Drugim rečima, osiguravač, u zamenu za premiju koju mu plaća ugovarač osiguranja, isplaćuje ugovorenu svotu ili pruža drugu vrstu naknade u slučaju nastupanja osiguranog slučaja.

Prilikom zaključenja ugovora, osiguravač procenjuje koliki je rizik da osigurani slučaj nastupi. Imajući u vidu sam rizik, tj. verovatnoću njegovog nastupanja, on utvrđuje visinu premije koju naplaćuje od ugovarača osiguranja. Kako bi pravilno odredio visinu premije, za osiguravača je važno da zna sve relevantne okolnosti, prvenstveno prilikom zaključenja ugovora, ali i tokom njegovog trajanja. Važno je naglasiti da se radi o ugovoru u kome, po prirodi stvari, postoji asimetrija informacija u pogledu relevantnih okolnosti koje se tiču imovine odnosno lica koje se osigurava. Osiguravač je ovde „informacijski slabija strana", budući da on takve informacije ne poseduje, već do njih može doći isključivo na osnovu izjave ugovarača osiguranja.[3] Ugovarač osiguranja je dužan da prijavi sve okolnosti koje su važne za ocenu rizika, a to čini najčešće popunjavajući formular, tj. odgovarajući na konkretna pitanja osiguravača.[4] Osiguravač računa na lojalnost svog saugovornika i oslanja se na njegove izjave, a pritom ne proverava njihovu potpunost i istinitost.[5]

Nakon što izda polisu, osiguravač se nada da neće doći do značajnog povećanja rizika.[6] Važno je, međutim, imati u vidu da je ugovor o osiguranju ugovor s trajnim izvršenjem, koji konstituiše obaveze čije se ispunjenje prostire u vremenu.[7] Kako je rizik promenljiva kategorija, a za ispunjenje obaveze osiguravača je po prirodi stvari potrebno da protekne određeno vreme, u periodu od izvršenja ugovora do nastupanja osiguranog slučaja može doći do oscilacije rizika. Sa stanovišta osiguranika, postoji

[3] Marijan Ćurković, „Obaveza ugovaratelja osiguranja, odnosno osiguranika, prijaviti osiguratelju okolnosti značajne za ocjenu rizika", *Zbornik radova Aktualnosti građanskog i trgovačkog zakonodavstva i pravne prakse* br. 15/2017, 103.

[4] Ranije je ugovarač osiguranja samostalno odlučivao koje okolnosti smatra važnim i koje će prijaviti osiguravaču i spontano mu je govorio o njima. Takav pristup se pokazao kao prevelik teret za ugovarača, te je postepeno zamenjen sistemom u kojem osiguravač postavlja konkretna pitanja u formi upitnika (vid. Herman Cousy, „The Principles of European Insurance Contract Law: the Duty of Disclosure and the Aggravation of Risk", *ERA Forum* no. 9/2008, 120).

[5] M. Ćurković (2017), 102.

[6] Project Group Restatement of European Insurance Contract Law, Fritz Reichert-Facilides, Jürgen Basedow, *Principles of European Insurance Contract Law: (PEICL)*, München, 2009, 181.

[7] Više o ugovorima sa trajnim izvršenjem vid. u Marija Karanikić Mirić, *Obligaciono pravo*, Beograd, 2024, 186–187.

razumljiva težnja da nastave sa uobičajenim aktivnostima koje su praktikovali pre zaključenja ugovora o osiguranju, da svoje postupanje ne ograničavaju radi održavanja osiguranog rizika. Takođe, društvo u celini ima legitiman interes da osiguravajući sektor funkcioniše efikasno i ostane finansijski stabilan, ali i da se ne sputavaju delatnosti koje donose ekonomski razvoj i inovacije.[8] Samim tim, razumljivo je što tokom perioda osiguranja može doći do značajne oscilacije rizika, bilo da se radi o njegovom povećanju ili smanjenju. Ipak, ukoliko dođe do značajnije promene rizika, ugovarač osiguranja je dužan da o tome obavesti osiguravača, kako bi ovaj mogao adekvatno da proceni novonastalu situaciju i, ako je to potrebno, prilagodi uslove ugovora tim prilikama.

Dužnost obaveštavanja propisana je s ciljem da smanji asimetriju u pogledu informisanosti ugovornih strana. Za osiguravača je važno da sazna svaku okolnost koja može dovesti do povećanja ili smanjenja rizika.[9] Iza te dužnosti stoje dva razloga. Prvo, sprečava se da osiguranik profitira od osiguranog slučaja.[10] Drugim rečima, radi se o primeni principa integralne naknade – oštećeni ima pravo da mu se nadoknadi celokupna šteta, ali ništa preko toga. Ukoliko ne prijavi naknadne promene rizika, ugovarač osiguranja plaća nižu premiju nego što bi trebalo, odnosno dobija veću naknadu štete nego što bi je dobio da su sve relevantne okolnosti bile prijavljene – osiguranje za njega postaje izvor sticanja dobiti umesto naknade štete. Drugo, takva dužnost doprinosi smanjenju moralnog hazarda.[11] Da ona nije propisana, osiguranik bi nakon zaključenja ugovora mogao uticati na promenu rizika po svom nahođenju, oslanjajući se na činjenicu da će mu, po nastupanju osiguranog slučaja, unapred ugovorena svota svakako pripasti.

Kako dužnost obaveštavanja ne postoji u svim pravnim sistemima, u radu će najpre biti izloženi pristupi u uporednom pravu u pogledu te obaveze, kao i teorijska objašnjenja kojim su takva rešenja potkrepljena. Centralni deo rada posvećen je analizi same dužnosti informisanja – koga ona obavezuje, u čemu se tačno sastoji i do kojih pravnih posledica dovodi promena rizika za vreme trajanja ugovora, bilo da se radi o njegovom uvećanju ili smanjenju, kada ugovarač osiguranja blagovremeno obavesti osiguravača o promeni ili mu takvu informaciju prećuti. Najzad, prikazano je rešenje koje Principi evropskog ugovornog prava osiguranja (PEICL) propisuju u pogledu promene rizika za vreme trajanja osiguranja.

II Dužnosti obaveštavanja tokom ugovora u uporednom pravu

Dok svi pravni sistemi predviđaju dužnost ugovarača osiguranja da prijavi sve relevantne okolnosti u vreme zaključenja ugovora, o dužnosti informisanja

[8] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181.
[9] Predrag Šulejić, *Pravo osiguranja*, Beograd, 2005, 233.
[10] Irma Nozadze, „Duty to inform as a Specifity of Demonstration of Good Faith Principle in Voluntary and Compulsory Insurance", *Journal of Law (TSU)* no. 1/2017, 137.
[11] *Ibidem*.

o oscilaciji rizika tokom ugovora nailazimo na različita rešenja u uporednom pravu.[12] Naime, u zemljama tzv. „pomorske tradicije osiguranja" ugovarač osiguranja načelno nema obavezu da po zaključenju ugovora prijavljuje okolnosti koje dovode do povećanja ili smanjenja rizika.[13] To je slučaj u Engleskoj i Holandiji. Dužnost obaveštavanja osiguravača može biti nametnuta osiguraniku jedino posebnom klauzulom. Međutim, engleski i holandski sudovi takve klauzule obično tumače restriktivno, u korist osiguranika, i retko ih prihvataju kao obavezujuće.[14] S druge strane, u državama tzv. „alpske tradicije osiguranja",[15] ugovarač osiguranja je dužan da informiše osiguravača o svim relevantnim okolnostima tokom ugovora o osiguranju. Takvu dužnost zakonodavci izričito propisuju. Francuski Zakonik o osiguranju (*Code des assurances*; dalje u tekstu: CA)[16] predviđa da je ugovarač osiguranja dužan da tokom ugovora prijavi nove okolnosti koje imaju za posledicu ili povećanje rizika, ili nastanak novih rizika, i koje time čine neistinitim ili zastarelim ranije date odgovore osiguravaču.[17] Nemački Zakon o ugovoru o osiguranju (*Gesetz über den Versicherungsvertrag* ili *Versicherungsvertragsgesetz*; dalje u tekstu: VVG)[18] obavezuje ugovarača koji je povećao rizik ili dozvolio njegovo povećanje bez pristanka osiguravača da bez odlaganja obavesti osiguravača o takvom povećanju, odnosno da o povećanju rizika koje je nastupilo nezavisno od njegove volje obavesti osiguravača čim je za povećanje rizika saznao.[19] Sličnu obavezu na strani ugovarača osiguranja predviđa i srpski Zakon o obligacionim odnosima (dalje u tekstu ZOO).[20] Zašto pravni sistemi tom pitanju pristupaju različito?

[12] Takođe, ugovarač osiguranja je dužan da prijavi sve relevantne okolnosti koje su se izmenile u periodu od slanja ponude osiguravaču za zaključenje ugovora o osiguranju do zaključenja ugovora (H. Cousy, 127). To je osobito važno kod auto-odgovornosti, budući da vozilo između prijave, kada je osiguranik dao izjavu o tome da je vozilo ispravno, i zaključenja ugovora, može preći u tehnički neispravno stanje (Dirk Looschelders *et al.*, *Versicherungsvertragsgesetz Mit Nebengesetzen Und Systematischen Erläuterungen. 4. Auflage*, Hürth, 2023, 510).

[13] H. Cousy, 131. To potvrđuju i presude kao što su *Pim v Reid* (1843) i *Kausar v Eagle Star Insurance Co Ltd.* (1997) (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181).

[14] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 183. Važno je naglasiti da ni u tim državama zakonodavac ne odobrava namerno ili krajnje nepažljivo ponašanje osiguranika kojim se izaziva nastupanje osiguranog slučaja (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181).

[15] H. Cousy, 131.

[16] Zakonik o osiguranju (CA), konsolidovana verzija od 3. maja 2025, dostupno na: https://www.legifrance.gouv.fr/codes/texte_lc/LEGITEXT000006073984/ (poslednji pristup 30. maj 2025. godine).

[17] CA, čl. L113-2 tačka 3.

[18] Zakon o ugovoru o osiguranju (VVG), verzija od 23. novembra 2007. godine (*Savezni službeni list I*, str. 2631), poslednji put izmenjen članom 15 Zakona od 20. decembra 2022. godine (*Savezni službeni list I*, str. 2793), dostupno na: *https://www.gesetze-im-internet.de/vvg_2008/* (poslednji pristup 30. maj 2025. godine).

[19] VVG, čl. 23 st. 2 i 3.

[20] Zakon o obligacionim odnosima, *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, dostupno na: *https://www.paragraf.rs/propisi/zakon_o_obligacionim_odnosima.html* (poslednji pristup 30. maj 2025). Vid. ZOO, čl. 914.

Najpre, radi se o pitanju koje „zadire u samu srž osiguranja".[21] S jedne strane, ugovor o osiguranju je aleatorni ugovor – njegovo pravno dejstvo u času zaključenja nije poznato, već zavisi od buduće neizvesne okolnosti, to jest okolnosti koja je ugovornim stranama nepoznata.[22] U vreme zaključenja ugovora ne zna se da li će nastupiti osigurani slučaj. Od osiguravača se može očekivati da, prilikom zaključenja ugovora, prihvati ne samo rizik koji postoji u tom trenutku već i njegove promene tokom ugovora.[23] Upravo je računanje na rizik svojstveno ugovoru o osiguranju kao aleatornom ugovoru, te se može braniti stanovište da pravo ne bi trebalo da štiti osiguravače od loše procene rizika.

Uticaj na stav zakonodavca o tom pitanju ima i period osiguranja. Što je takav period kraći, manje je opravdano zahtevati od ugovarača osiguranja da prijavljuje okolnosti koje doprinose povećanju odnosno smanjenju rizika. U zemljama gde osiguranje obično traje godinu dana ili kraće, zakon najčešće ide u korist osiguranika, te ne predviđa pravne mehanizme koji bi osiguravačima omogućili da izmene uslove polise u slučaju značajnog povećanja rizika.[24] U većini evropskih zemalja, međutim, osiguravajući periodi obično traju duže od jedne godine, pa zakon dopušta izmenu ugovora u slučaju značajnog povećanja rizika tokom tog perioda.[25]

Najzad, (ne)postojanje dužnosti obaveštavanja o promeni relevantnih okolnosti nakon zaključenja ugovora umnogome zavisi od načina na koji se shvata načelo savesnosti i poštenja u konkretnom pravnom sistemu. Ugovor o osiguranju temelji se na načelu krajnje savesnosti i poštenja (*principle of utmost good faith*), koji podrazumeva viši stepen poverenja među ugovornicima nego što se zahteva u drugim ugovorima.[26] Reč je o ugovoru *uberrimae fidei*.[27] Kontinentalni pravni sistemi, utemeljeni na tradiciji rimskog prava, propisuju to načelo i konkretizuju ga nizom posebnih pravila. Primenjuje se ne samo prilikom zaključenja ugovora već i prilikom izvršenja ugovornih obaveza.[28] Između ostalog, princip savesnosti i poštenja manifestuje se u obavezi ugovarača osiguranja da informiše osiguravača o relevantnim okolnostima koje se tiču osiguranog dobra tokom važenja ugovora.[29] Ekvivalent načelu savesnosti

[21] H. Cousy, 131.
[22] Vid. M. Karanikić Mirić, 188–189.
[23] H. Cousy, 131.
[24] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181.
[25] *Ibidem*.
[26] I. Nozdaze, 131. Načelo krajnje savesnosti i poštenja vodi poreklo iz pomorskog osiguranja. Kod ove vrste osiguranja osiguravač je morao imati poverenje u izjave ugovarača osiguranja o brodu i robi koja se prevozi, budući da se ugovor često zaključivao u mestu koje je veoma udaljeno od tereta i broda (I. Nozadze, 131).
[27] Hein Kötz, Gill Mertens, Tony Weir, *European Contract Law: Second edition*, Oxford, 2017, 181.
[28] Hugh Collins, „Implied Duty to Give Information during Performance of Contracts", *The Modern Law Review* Vol. 5, No 4/1992, 557.
[29] I. Nozdaze, 135. Primera radi, čl. 1104 *Code Civil* propisuje da se o ugovorima mora pregovarati i, da se moraju zaključivati i izvršavati u dobroj veri. BGB u čl. 241 st. 2 propisuje da obligacioni odnos može, prema

i poštenja u *common law* jeste princip dobre vere, postupanje u dobroj veri (*good faith principle*). Međutim, *good faith principle* nema opšti karakter kao što je to slučaj s načelom savesnosti i poštenja. Naprotiv, primenjuje se samo u malobrojnim situacijama kada je to izričito propisano, sveden na konkretne dužnosti.[30] Ugovor o osiguranju, kao *uberrimae fidei* ugovor, jeste upravo jedan od izuzetaka gde je princip našao svoju primenu, ali isključivo u fazi zaključenja ugovora.[31] Nakon što ugovor bude zaključen, obaveza postupanja u dobroj veri, preciznije obaveza ugovarača osiguranja da otkriva informacije prestaje.[32] Takva obaveza ne bi ni imala smisla, budući da od trenutka kada je vezan ugovorom, osiguravač više ne može menjati ugovorene uslove pokrića rizika iz straha da je zaključio nepovoljan ugovor.[33] Ukoliko se radi o značajnom povećanju rizika, takav rizik prestaje da bude pokriven polisom, a osiguranik je primoran da novi rizik osigura kod istog ili drugog osiguravača, gde će prilikom zaključenja ugovora imati obavezu da ga podrobno informiše.[34] Zbog toga je u engleskom pravu praksa da ugovori o osiguranju sadrže izričitu klauzulu o dužnosti ugovarača osiguranja da obavesti osiguravača o svakoj promeni okolnosti koje utiču na rizik.[35]

III O dužnosti obaveštavanja o promenama rizika tokom trajanja ugovora o osiguranju

U pravnim sistemima koji predviđaju dužnost obaveštavanja o promenama rizika tokom ugovora o osiguranju, postavlja se pitanje kome se takva dužnost nameće

svojoj sadržini, obavezivati svaku stranu da vodi računa o pravima, pravnim dobrima i interesima druge strane. Iz citiranih odredbi proizlazi dužnost ugovornika da obaveštava svog saugovornika o činjenicama koje su od uticaja na njihov međusobni odnos. U srpskom pravu takva dužnost izričito je propisana u čl. 268 ZOO, a kao sankcija za njeno nepoštovanje predviđena je naknada štete.

[30] Radi se o principu koji „odiše robustnim viktorijanskim individualizmom" da se svaki ugovornik sam mora informisati o činjenicama koje su mu relevantne za zaključenje ugovora i da se ne može uzdati u svog saugovornika da će mu servirati takve informacije (H. Kötz, G. Mertens, T. Weir, 180–181).

[31] H. Kötz, G. Mertens, T. Weir, 181.

[32] U slučaju *New Hampshire Insurance Company v MGN Ltd*, postavilo se pitanje u kom trenutku je postojala obaveza osiguranika da otkrije relevantne činjenice osiguravaču. Trgovački sud je smatrao nespornim da je osiguranik imao obavezu otkrivanja informacija u trenutku: (a) zaključenja osiguranja, (b) obnove osiguranja (što zapravo predstavlja sklapanje novog ugovora), i (c) davanja i prezentacije zahteva za naknadu štete, iako je ova poslednja tačka bila odbačena. Istaknuto je da „obaveza postupanja u dobroj veri... ne podrazumeva pozitivne obaveze otkrivanja činjenica koje utiču na rizik tokom pokrića, osim u vezi sa nekim događajem ili situacijom predviđenom polisom na koju se obaveza dobre vere odnosi" (vid. Peter Eggers MacDonald, Simon Picken, Patrick Foss, *Good Faith and Insurance Contracts. 3. ed.,* London, 2010, 56).

[33] P. Eggers MacDonald, S. Picken, P. Foss, 53.

[34] *Ibid*., 56–57. Najbliža doktrina koja se ovde može primeniti, a koju englesko pravo poznaje jeste neka vrsta estopela, poput estopela po osnovu konvencije ili promisornog estopela kao oblika izmene ugovora, ali bi i on mogao biti onemogućen zbog izostanka bilo kakve izričite izjave osiguravača (H. Collins, 557).

[35] H. Collins, 557.

i u čemu se ona tačno sastoji. Drugim rečima, ko, u kom roku, na koji način i u kakvim okolnostima ima obavezu da informiše osiguravača nakon što je ugovor zaključen?

Dužnost prijave relevantnih okolnosti za ocenu rizika po slovu srpskog i nemačkog zakona ima ugovarač osiguranja (*Versicherungsnehmer*).[36] Rešenje je logično, budući da je on strana u ugovoru, te ga ugovor može obavezati. Najčešće on zaključuje ugovor u svoje ime i za svoj račun, te je istovremeno i osiguranik. Međutim, ukoliko to nije slučaj, nema prepreke da osiguravača obaveste osiguranik (lice za čiji račun ugovarač osiguranja zaključuje ugovor sa osiguravačem), kao i korisnik osiguranja (lice u čiju korist je ugovoreno osiguranje). Ukoliko osiguranik ili korisnik osiguranja prijave osiguravaču da je došlo do promene relevantnih okolnosti, oni na taj način otklanjaju opasnost da osigurani slučaj nastupi „u međuvremenu", tj. nakon što su se okolnosti izmenile, a pre nego što osiguravač o tome bude obavešten.[37] Francuski zakonodavac, s druge strane, propisuje takvu dužnost za osiguranika (*l'assuré*).[38]

Kakve se okolnosti mogu smatrati relevantnim? Načelno posmatrano, radi se o svim onim okolnostima o kojima bi ugovarač osiguranja bio dužan da informiše osiguravača da su postojale u vreme zaključenja ugovora o osiguranju.[39] Ćurković ističe da je osiguravač jedini koji zna koje su mu okolnosti relevantne za ocenu rizika.[40] To su one okolnosti koje on percipira i kalkuliše u iznos premije, od kojih zavisi iznos premije.[41] Kako se takve okolnosti nakon zaključenja ugovora mogu izmeniti, informacije koje je ugovarač saopštio osiguravaču prilikom zaključenja ugovora mogu postati netačne i zastarele.[42] Ipak, dužnost informisanja postoji samo u odnosu na one okolnosti koje značajno menjaju percepciju o riziku. VVG izričito propisuje da se obaveza prijave ne odnosi na neznatno povećanje rizika.[43] Osim toga, potrebno je da promene budu trajnog karaktera, budući da se dužnost prijavljivanja ne odnosi na one okolnosti koje su samo kratkotrajno povećale ili umanjile rizik.[44] Radi se, prema tome, o okolnostima koje stvaraju stanje povećane ili umanjene opasnosti, te dugoročno povećavaju ili umanjuju verovatnoću nastanka osiguranog slučaja, dok

[36] ZOO, čl. 914 st. 1; VVG, čl. 23.

[37] Ivica Jankovec, „Čl. 901–923", *Komentar Zakona o obligacionim odnosima* (urednici Borislav T. Blagojević, Vrleta Krulj), Beograd, 1980, 475.

[38] CA, L113-2 tačka 3.

[39] I. Jankovec, 475.

[40] M. Ćurković (2019), 41.

[41] Nataša Petrović Tomić, *Osnovi prava osiguranja: treće izmenjeno i dopunjeno izdanje*, Beograd, 2024, 312.

[42] Claude J. Berr, Hubert Groutel, Code Des Assurances: 9. éd., Paris, 2003, 31.

[43] Nije relevantno ni ono uvećanje rizika za koje se može smatrati da je ugovoreno da se povećani rizik takođe pokriva (VVG, čl. 27).

[44] I. Jankovec, 475. Može se dogoditi da u isto vreme nastupe okolnosti koje povećavaju opasnost i one koje je smanjuju, kada je neophodno razmatranje celokupnog slučaja i ispitati da li su okolnosti koje povećavaju opasnost možda uravnotežene sa onima koje je smanjuju (tzv. kompenzacija opasnosti) – npr. iseljenje stanara iz zgrade u okviru osiguranja od požara umanjuje rizik usled nepažnje stanara, ali povećava rizik usled požara koji mogu izazvati beskućnici ukoliko se tu nastane (D. Looschelders *et. al*, 508).

se jednokratno rizično ponašanje ne uzima u obzir.[45] Takođe, ponašanje osiguranika ili neka druga okolnost koja je još uvek u ranoj fazi, ali potencijalno može dovesti do povećanja odnosno umanjenja rizika u budućnosti se ne uzima u obzir – relevantne su samo one okolnosti usled kojih je povećanje odnosno umanjenje rizika već nastupilo.[46] Razlikuju se u slučaju osiguranja imovine i osiguranja lica.

Kada je reč o osiguranju lica, jedina relevantna okolnost u srpskom pravu jeste promena zanimanja lica, u pravcu povećanja rizika. To ZOO izričito propisuje.[47] Ostale okolnosti, poput pogoršanja zdravstvenog stanja osiguranika, osiguravač svakako kalkuliše u iznos premije prilikom zaključenja ugovora, imajući u vidu prvenstveno njegove godine života i zdravstveno stanje.[48] Pod zanimanjem se podrazumeva redovno zaposlenje ili poziv, a ne privremena aktivnost koju osiguranik može obavljati, niti rekreacija.[49] Primera radi, činjenica da je osiguranik bio angažovan na lomljenju betona u već iskopanom tunelu ili na natkrivenom iskopu ne znači nužno da je njegovo zanimanje kopanje tunela.[50] Samim tim, osiguranik nije dužan da prijavi jednokratne ili kratkotrajne poslove koje obavlja tokom osiguranja.[51] Nemački zakonodavac takođe oprezno pristupa dužnosti informisanja kod osiguranja života, navodeći da se povećanjem rizika smatra se samo ona promena koja je izričitim pisanim sporazumom definisana kao povećanje rizika, a osiguravač se ne može pozvati na povećanje rizika nakon što je proteklo pet godina od tog povećanja.[52] Isto važi i za okolnosti koje dovode do smanjenja rizika.[53] Francuski CA propisuje da osiguranikova obaveza prijave novih okolnosti ne važi za ugovor o osiguranju života.[54]

Kada se radi o osiguranju imovine, relevantne okolnosti se tiču same imovine koja se osigurava. Primera radi, to su promena namene stvari, njeno premeštanje s mesta koje je označeno u ispravi osiguranja na neko drugo mesto,[55] izloženost

[45] D. Looschelders *et al*., 507.
[46] *Ibid*, 509.
[47] ZOO, čl. 914 st. 1.
[48] Vid. N. Petrović Tomić, 310–311, 312 fn. 651.
[49] George James Couch, Ronald Aberdeen Anderson, *Couch Cyclopedia of Insurance Law (2. ed.): sections 35:1 – 37:420*, New York, 1961, 685, 693.
[50] *Ibid*, 686.
[51] Takođe, promena samo naziva zanimanja, dok osiguranik nastavlja da radi iste poslove, ne predstavlja promenu zanimanja (G. Coach, R. Anderson, 691). Međutim, obavljanje sezonskog posla koji je drugačiji od stalnog zaposlenja može predstavljati relevantnu okolnost koju je ugovarač dužan da prijavi (npr. direktor škole koji je tokom letnjeg raspusta radio kao čuvar šuma), pogotovo ukoliko je takav posao opasniji, odnosno povezan s većim rizikom od nezgode (vid. G. Coach, R. Anderson, 693).
[52] Vid. čl. 158 VVG. Ako je ugovarač osiguranja namerno ili prevarom prekršio svoju obavezu, rok iznosi deset godina.
[53] VVG, čl. 158 st. 3.
[54] CA, čl. L113-2 st. 5.
[55] P. Šulejić, 234; I. Jankovec, 475.

opasnim materijama, značajno povećanje njene vrednosti i slično. S druge strane, davanje stvari u zakup može ali ne mora biti relevantna okolnost, u zavisnosti od toga da li zakup povećava opasnost koju osiguranje pokriva.[56] Kod osiguranja od odgovornosti za štetu uzrokovanom upotrebom motornog vozila (tzv. auto-osiguranje), relevantne okolnosti čiju promenu ugovarač mora prijaviti jesu, primera radi, promena namene vozila, kretanje po području na kome je rizik od nezgode povećan, promena vrste pogonskog goriva, značajno povećana pređena kilometraža.[57]

Zakonodavci predviđaju različite rokove u kojima je ugovarač osiguranja dužan obavestiti osiguravača o povećanju rizika. ZOO i VVG propisuju da je on dužan da to učini bez odlaganja ako se rizik povećao nekim njegovim postupkom, odnosno postupkom osiguranika koji je on dozvolio.[58] Primera radi, u podrum unese zapaljiv materijal,[59] pretvori kuću u radionicu, postavi solarne panele bez odgovarajućih odobrenja i slično. Suprotno, ako se povećanje rizika dogodilo bez njegovog učešća, on je dužan da ga, prema odredbama našeg prava, obavesti u roku od četrnaest dana od kad je za to saznao.[60] Na primer, može doći do povećanja vodostaja usled poplava i pojave podzemnih voda u podrumu, oštećenja na krovu usled zemljotresa, opterećenja električnih instalacija usled komšijinih radnji… Ako ugovarač nije saznao za takve okolnosti i sve dok ne sazna, nema ni dužnosti obaveštavanja.[61] Nemački zakonodavac ugovarača osiguranja i za slučaj povećanja rizika nezavisno od njegove volje obavezuje da odmah po saznanju obavesti osiguravača.[62] Francusko pravo propisuje rok od petnaest dana, koji se računa od saznanja, nezavisno od toga kako je do promene rizika došlo.[63]

Najzad, kada je reč o načinu na koji se osiguravač obaveštava, jedino francuski zakonodavac propisuje da se obaveštenje mora poslati preporučenim pismom ili preporučenom elektronskom poštom.[64] Sledi da u nemačkom i srpskom pravu važe opšta pravila o izjavi volje, što znači da takva obaveštenja mogu biti data usmeno, u prostorijama osiguravača. Svakako, ugovarač osiguranja će u slučaju eventualnog spora lakše dokazati da je obavestio osigurača ukoliko to učini pismom ili elektronskom poštom.

[56] P. Šulejić, 234. Vrhovni privredni sud istakao je da davanje osigurane stvari u zakup ne mora samo po sebi biti povećanje rizika o kojem je ugovarač osiguranja dužan da obavesti osiguravača (Sl. 732/68 od 8. avgusta 1988. godine) (navedeno prema Jankovec 1980, 475).

[57] M. Ćurković (2019), 42.

[58] ZOO, čl. 914 st. 2. U pojedinim pravnim sistemima, poput švajcarskog prava, pravne posledice koje nastupaju usled promene okolnosti koje su značajne za ocenu rizika zavise od toga da li je do promene došlo radnjom ugovarača osiguranja ili ne (vid. I. Jankovec, 475–476).

[59] P. Šulejić, 235.

[60] ZOO, čl. 914 st. 2; VVG čl. 23 st. 2.

[61] I. Jankovec, 476.

[62] VVG čl. 23 st. 3.

[63] CA, čl. L113-2 st. 2.

[64] CA, čl. L113-2 st. 2.

IV Pravne posledice obaveštavanja osiguravača o promeni rizika

1. Povećanje rizika

Nakon što je obavešten o povećanju rizika, osiguravač ima dve opcije – da raskine ugovor ili da ugovaraču osiguranja predloži novu (višu) stopu premije. Po svojoj prirodi, navedene opcije osiguravača predstavljaju pravne moći (preobražajna prava). ZOO ne ostavlja sasvim slobodan izbor osiguravaču između optiranja za jedno od preobražajnih prava, već njegova odluka mora biti srazmerna povećanom riziku – ako je rizik povećan tako da ugovor ne bi ni zaključio, može optirati za raskid; ako je rizik povećan da bi ugovor ipak zaključio ali pod drugačijim uslovima, može povećati premiju. Čini se da naš zakonodavac vodio načelom *favori contractus*, dopuštajući raskid samo kao krajnje sredstvo. Tako rezonuje i francuski zakonodavac.[65] Suprotno, VVG propisuje da osiguravač može raskinuti ugovor ili *umesto toga* (naglašava autorka) povećati premiju.[66] Sledi da je jednako povećanje rizika dovoljno za raskid i povećanje premije, što znači da je osiguravač potpuno slobodan da bira između alternativno postavljenih ovlašćenja.

Pritom, nakon što sazna za povećanje rizika, osiguravač ima rok od mesec dana da odluči o tome kako će postupiti. Takav rok predviđaju srpsko i nemačko pravo.[67] Ukoliko se ponaša pasivno, tj. ne ponudi ugovaraču osiguranja novu premiju niti mu saopšti da raskida ugovor, ugovor ostaje na snazi pod istim uslovima, a osiguravač se ne može naknadno koristiti svojim ovlašćenjima.[68] Isto važi i u slučajevima kada izričito ili konkludentno pokaže da prihvata produženje ugovora pod istim uslovima (primi premiju, isplati naknadu za osigurani slučaj koji se desio posle tog povećanja i sl.). [69] Nemački zakonodavac dodaje da osiguravačeva prava prestaju i ukoliko se okolnosti nanovo promene, tako da se uspostavi stanje koje je postojalo pre povećanja rizika.[70] Pritom, odredbu ne bi trebalo tumačiti restriktivno te zahtevati obnovu identičnog stanja koje je postojalo ranije, nego je dovoljno da se uspostavi odnos koji je pretpostavljen ugovorom u pogledu odnosa rizika i premije.[71]

Ako je povećanje toliko da on ne bi zaključio ugovor da je takvo stanje postojalo u trenutku njegovog zaključenja, može raskinuti ugovor. Dejstvo ugovora

[65] Vid. CA, čl. L113-4 st. 1.
[66] Vid. VVG, čl. 24 i 25.
[67] ZOO, čl. 914 st. 6; VVG čl. 24 st. 2.
[68] ZOO, čl. 914 st. 6.
[69] ZOO, čl. 914 st. 6. Slično je i u francuskom pravu, vid. čl. L113-4 st. 4 CA.
[70] VVG čl. 24 st. 3.
[71] D. Looschelders *et al*., 527. Ako, s druge strane, do obnove ranijeg stanja dođe tek nakon što je ugovor raskinut, takva izmena okolnosti nema pravnih dejstava, raskid ostaje na snazi (D. Looschelders *et al*. 2023, 527).

prestaje u trenutku kada osiguravač saopšti ugovaraču osiguranja svoju odluku o raskidu.[72] Izuzetno, u francuskom pravu, pravne posledice raskida se odlažu za deset dana od časa obaveštavanja ugovarača.[73] U tom roku ugovarač može da razmisli, informiše se i promeni osiguranje.[74] Pritom, raskid dejstvuje *ex nunc* – od tog trenutka osiguravajuće pokriće prestaje, a ugovarač ima pravo na povraćaj dela premije koji odgovara preostalom delu perioda osiguranja.[75] Prema tome, nastupanje osiguranog slučaja pre nego što je odluka o raskidu saopštena ugovaraču osiguranja rađa obavezu za osiguravača da isplati osiguranu svotu.

Ukoliko je povećanje rizika toliko da bi osiguravač zaključio ugovor samo uz veću premiju da je takvo stanje postojalo u času zaključenja ugovora, on ugovaraču osiguranja može predložiti novu stopu premije.[76] Povećanje premije, ako ugovarač osiguranja pristane, proizvodi pravno dejstvo od dana kada je on dao svoj pristanak.[77] Ako ugovarač osiguranja odbije osiguravačev predlog ili se o njemu ne izjasni u roku od četrnaest dana od prijema predloga, ugovor prestaje po samom zakonu u srpskom pravu.[78] Slično je i u francuskom pravu, s tim što je predviđen rok od trideset dana, a ugovor raskida osiguravač jednostranom izjavom volje.[79] Pritom, pravne posledice (o eventualnom raskidu u slučaju ćutanja) moraju biti naznačene u samom predlogu. Smatram da bi to rešenje bilo korisno uneti i u srpsko pravo *de lege ferenda*. Nemački zakonodavac ovlašćuje osiguravača da jednostrano poveća premiju i o tome samo obavesti ugovarača osiguranja, ali istovremeno daje pravo ugovaraču osiguranja da ugovor raskine u roku od mesec dana od prijema obaveštenja, pod uslovom da je premija povećana za više od deset procenata, odnosno ako je osiguravač isključio pokriće za povećani rizik.[80] Takvo jednostrano ovlašćenje osiguravača opravdava se institutom promenjenih okolnosti iz čl. 313 BGB (*Störung der Geschäftsgrundlage*).[81]

[72] I. Jankovec, 476.

[73] CA, čl. L113-4 st. 2.

[74] Slične odredbe mogu se naći u zakoni(ci)ma širom Evrope. Rok nakon kojeg raskid proizvodi pravno dejstvo iznosi 7 dana u Danskoj (čl. 47 danskog Zakona o osiguranju), 15 dana u Grčkoj (čl. 4 st. 2 i prva rečenica čl. 3 st. 7 grčkog Zakona o osiguranju), jedan mesec u Belgiji (čl. 26 st. 1(2) belgijskog Zakona o osiguranju) i Luksemburgu (čl. 34 st. 1(3) luksemburškog Zakona o osiguranju), dok u Italiji, raskid proizvodi dejstvo odmah ili nakon 15 dana, u zavisnosti od stepena povećanja rizika (čl. 1898 st. 3 italijanskog Građanskog zakonika) (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 187).

[75] I. Jankovec, 476; D. Looschelders *et al*., 523. Isto i u čl. L113-4 st. 2 CA.

[76] ZOO, čl. 914 st. 4.

[77] I. Jankovec, 476.

[78] ZOO, čl. 914 st. 5.

[79] CA, čl. L113-4 st. 3.

[80] VVG, čl. 25.

[81] D. Looschelders *et al*., 528. BGB, čl. 313 st. 1: Ako se okolnosti koje su postale osnova ugovora značajno promene nakon zaključenja ugovora, i ako bi strane, da su predvidele ovu promenu, zaključile ugovor sa drugačijim sadržajem ili ga uopšte ne bi zaključile, strana koja je pogođena promenom može zahtevati izmenu ugovora, ukoliko se, uzimajući u obzir sve okolnosti konkretnog slučaja, pogotovo raspodelu

2. Smanjenje rizika

Okolnosti se nakon zaključenja ugovora mogu i izmeniti u pravcu umanjenja rizika. Moguća je i situacija da okolnosti koje značajno uvećavaju rizik prestanu da postoje, npr. prostoru se promeni namena (umesto radionice za zavarivanje postane garaža), uklone se opasne materije koje su se do tada tu skladištile, primenjuje se protivpožarna zaštita ili zaštita od krađe. U tom slučaju ugovarač osiguranja ima pravo da zahteva srazmerno umanjenje premije. Takvo rešenje je predviđeno odredbama srpskog, nemačkog i francuskog prava.[82] Predlog ugovarača ne podleže bilo kakvoj formi, niti se ograničava rokovima. Naime, ovde je njemu u interesu da prijavi takve okolnosti, tako da će razuman ugovarač osiguranja svakako to učiniti odmah po saznanju. Pravo na odgovarajuće umanjenje premije ugovarač osiguranja ima od dana kada je obavestio osiguravača. VVG dodaje da iste pravne posledice nastupaju u slučaju da je povećana premija bila utvrđena na osnovu netačnih navoda ugovarača, nastalih usled zablude u vezi s tim okolnostima.[83]

Nakon što ugovarač osiguranja obavesti ugovarača o promeni okolnosti i zahteva adekvatno umanjenje premije, moguće su dve situacije. Osiguravač može pristati na umanjenje premije, koje će dejstvovati od dana kada je obavešten. Međutim, on može i odbiti da redukuje premiju koju plaća ugovarač.[84] Tada ZOO predviđa pravo ugovarača osiguranja da raskine ugovor.[85] Pritom, srpski zakonodavac ne propisuje otkazni rok.[86] Smatram da raskid i u ovom slučaju dejstvuje po saopštavanju osiguravaču, prema opštim pravilima. Drugačije je u francuskom pravu, gde raskid proizvodi dejstvo trideset dana nakon obaveštenja.[87] Takođe, po analogiji s pravilima gde je osiguravač taj koji raskida ugovor usled povećanja rizika, ugovaraču osiguranja sleduje pravo na povraćaj dela premije koji odgovara preostalom delu perioda osiguranja.

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rizika po ugovoru ili zakonu, ne može razumno očekivati da ostane vezana ugovorom u njegovom izvornom obliku.

[82] Vid. čl. 916 ZOO, čl. 41 VVG i čl. L113-4 st. 4.

[83] VVG, čl. 41.

[84] VVG ne reguliše pravne posledice odbijanja osiguravača da redukuje iznos premije. Tada ugovarač osiguranja ima pravo na prigovor *exceptio non adimpleti contractus* prema čl. 320 BGB, pravo na raskid ugovora po osnovu čl. 323 BGB i, ukoliko su ispunjeni uslovi, pravo na naknadu štete iz čl. 280 BGB (Looschelders et al. 2023, 693).

[85] ZOO, čl. 916 st. 2.

[86] Slobodan Jovanović, „Uticaj povećanja osiguranog rizika na prava i obaveze iz ugovora o osiguranju u nemačkom, francuskom, češkom i srpskom pravu", *Strani pravni život* Vol. 53 no. 3/2013, 215.

[87] Jovanović (*Ibidem*) govori o otkaznom roku.

V Propuštanje ugovarača osiguranja da obavesti osiguravača o promenama rizika

U praksi neretko dolazi do situacija u kojima se ugovarač osiguranja ogluši o svoju dužnost prijave relevantnih okolnosti za ocenu rizika, te ne prijavi uvećanje ili umanjenje rizika do koga je u međuvremenu došlo. Razlozi za takvo postupanje mogu biti različiti – nepažnja odnosno nemar ugovarača osiguranja, pogrešna ocena da se ne radi o relevantnoj izmeni koja bi trebalo da bude prijavljena ili namerno prećutkivanje kako bi izbegao raskid ugovora ili povećanje premije. Takođe, moguće je da ugovarač osiguranja nije znao niti je mogao saznati da je došlo do oscilacije. Osiguravač za promenu okolnosti tada saznaje *post festum*, nakon nastupanja osiguranog slučaja, a prilikom odmeravanja štete koja je nastupila. Koje pravne posledice nastupaju u tom slučaju? Najčešće se radi o slučajevima gde je rizik nakon zaključenja ugovora o osiguranju uvećan, budući da tada ugovarač osiguranja, svestan po njega nepovoljnih posledica, nije podstaknut da blagovremeno obavesti osiguravača o promeni.

Domaći zakonodavac govori o situaciji kada se osigurani slučaj dogodi „u međuvremenu", imajući u vidu period od pogoršanja rizika do preduzimanja pravnih posledica od strane osiguravača povodom tog pogoršanja.[88] Tada se naknada koju osiguravač isplaćuje smanjuje u srazmeri između plaćenih premija i premija koje bi trebalo platiti prema povećanom riziku.[89] Štaviše, ukoliko srazmeru nije moguće izračunati jer je promena okolnosti tolika da osiguravač ne bi ni zaključio ugovor da su takve okolnosti postojale u vreme njegovog zaključenja, odnosno raskinuo bi ga da je o njima blagovremeno obavešten, on ne duguje nikakvu naknadu ugovaraču – obaveza isplate ugovorene svote prestaje.[90] Odredba se primenjuje kako na onog ugovarača koji je namerno prećutao pogoršanje rizika, tako i na onog ugovarača koji za pogoršanje nije mogao da sazna. Odredba se primenjuje i na onog ugovarača koji je saznao za uvećanje rizika, ali je neposredno nakon tog saznanja nastupio osigurani slučaj, te nije stigao da izvrši svoju dužnost obaveštavanja. Srpski zakonodavac, dakle, ne propisuje strože posledice za ugovarača koji je namerno prećutao o pogoršanju rizika. Takođe, čini se da zakonodavac nije imao u vidu situacije kada je osigurani slučaj nastupio ne zbog povećanog rizika nego iz nekog drugog razloga. Domaća teorija smatra da se pravne posledice iz čl. 915 primenjuju i u tom slučaju.[91]

Nemačko pravo, s druge strane, uzima u obzir više faktora: stepen krivice ugovarača osiguranja, vreme nastupanja osiguranog slučaja i uzročnu vezu između

[88] ZOO ne pravi razliku između slučajeva kada on o pogoršanju nije obavešten ili jeste obavešten ali još uvek nije raskinuo ugovor, odnosno izmenio uslove ugovora u sporazumu sa ugovaračem osiguranja. Svakako, predmet analize jeste prva situacija.

[89] ZOO, čl. 915.

[90] I. Jankovec, 477.

[91] *Ibidem.*

povećanja rizika i nastanka štete. Osiguravač se može u potpunosti osloboditi obaveze plaćanja naknade pod tri uslova. VVG predviđa da osiguravač nije dužan izvršiti isplatu ako osigurani slučaj nastupi nakon jednog meseca od trenutka kada je osiguravač trebalo da bude obavešten, osim ako je u tom trenutku već znao za povećanje rizika.[92] Prvi uslov jeste da povećanje rizika nije na vreme prijavljeno. Zakonodavac vezuje otpočinjanje roka za trenutak kada je osiguravač o promeni rizika trebalo da bude obavešten (tzv. fiktivni prijem obaveštenja).[93] Od tog trenutka mora proći mesec dana. Rok od mesec dana propisan je zato što osiguravač, i kada dobije obaveštenje o promeni rizika, svakako ima mesec dana da odluči želi li da raskine ugovor (vid. gore). Fingiranje prijema obaveštenja ima za cilj da obezbedi to da osiguravač ne bude u lošijoj poziciji nego što bi bio da je uredno obavešten.[94] Drugi uslov jeste da osiguravač nije znao (npr. iz drugog izvora) za povećanje rizika u trenutku kada je trebalo da bude obavešten. Teret dokazivanja da je osiguravač ipak znao za povećan rizik snosi ugovarač osiguranja.[95] Treći uslov jeste da je ugovarač osiguranja postupao s namerom kao najtežim stepenom krivice. U pravnoj teoriji je sporno na kome je teret dokazivanja krivice.[96] Naime, iako se to ne kaže izričito, takav zaključak se nameće budući da zakonodavac u narednim stavovima propisuje druge pravne posledice za postupanje s grubom i običnom nepažnjom. U slučaju grube nepažnje ugovarača osiguranja, osiguravač ima pravo da umanji svoja ugovorna davanja u skladu s težinom krivice osiguranika, pri čemu teret dokazivanja da nije bilo grube nepažnje snosi ugovarač osiguranja.[97] Najzad, osiguravač ipak odgovara (plaća ugovorenu svotu) ako povreda obaveze obaveštavanja nije bila namerna.[98] Takođe, osiguravač ostaje dužan da izvrši isplatu ako: povećanje osiguranog rizika nije bilo uzrok nastanka osiguranog slučaja, niti je uticalo na obim odgovornosti osiguravača, ili je u trenutku nastanka osiguranog slučaja već istekao rok za raskid ugovora od strane osiguravača, a ugovor nije bio raskinut.[99] Radi se o situacijama gde nedostaje uzročna veza između povećanog rizika i nastupanja osiguranog slučaja.

Francuski zakonodavac propisuje različite pravne posledice u zavisnosti od krivice ugovarača osiguranja. Ukoliko je on prećutao (zatajio) ili namerno lažno predstavio činjenice koje utiču na rizik, bilo da se radi o izmeni predmeta rizika bilo o uopšteno osiguravačevoj oceni rizika, ugovor o osiguranju će biti ništav,

[92] VVG, čl. 26 st. 2 (prva rečenica).
[93] D. Looschelders, 533.
[94] *Ibidem*.
[95] *Ibidem*.
[96] Iz formulacije čl. 26 VVG sledi da ugovarač osiguranja snosi teret dokazivanja da nije postupao s namerom, što odstupa od opšteg pravila po kome teret dokazivanja za postojanje namere snosi osiguravač, a u literaturi se smatra da je u pitanju greška u formulaciji (D. Looschelders, 534).
[97] VVG, čl. 26 st. 2 (druga rečenica) u vezi sa čl. 26 st. 1.
[98] VVG, čl. 26 st. 2.
[99] VVG, čl. 26 st. 3.

čak i ako zatajeni ili iskrivljeni rizik nije imao uticaja na nastali osigurani slučaj.[100] Štaviše, uplaćene premije tada ostaju osiguravaču, koji ima pravo i na plaćanje svih dospelih premija, kao naknadu štete.[101] Suprotno, propust ili netačna izjava osiguranika, ako nije dokazana njegova loša vera, ne povlači ništavost ugovora o osiguranju.[102] Ako se takav propust ili netačnost utvrdi pre nastanka osiguranog slučaja, osiguravač ima pravo da optira između povećanja premije koje prihvata osiguranik i raskida ugovora deset dana nakon što osiguraniku uputi obaveštenje preporučenim pismom, uz povraćaj dela premije koji se odnosi na period u kojem osiguranje više ne važi.[103] Ukoliko se propust ili netačna izjava otkriju tek nakon nastanka osiguranog slučaja, naknada se umanjuje srazmerno odnosu između plaćenih premija i premija koje bi bile plaćene da su rizici bili u potpunosti i tačno prijavljeni.[104]

VI Promena rizika u principima Evropskog ugovornog prava osiguranja (PEICL)

Principi evropskog ugovornog prava osiguranja (dalje u tekstu: PEICL) predstavljaju alternativni, jedinstveni pravni okvir namenjen ugovorima o osiguranju unutar Evropske unije, koji strane mogu izabrati da primene na svoj ugovor umesto nacionalnog prava. Svrha PEICL jeste da omoguće osiguravačima ponudu istovetnih osiguravajućih usluga u različitim državama članicama, čime se smanjuju troškovi, prevazilaze pravne razlike i povećava pravna sigurnost u prekograničnoj trgovini.[105] Prema čl. 4:201 PEICL, ako ugovor o osiguranju sadrži odredbu koja se odnosi na povećanje osiguranog rizika, ta odredba nema dejstvo, osim ako je povećanje rizika suštinsko i vrsta tog povećanja je navedena u ugovoru o osiguranju.

PEICL se, dakle, ograničavaju na one slučajeve u kojima polise sadrže klauzule koje predviđaju dužnost ugovarača da informiše osiguravača o relevantnim okolnostima za vreme ugovora. Pravilo nastoji da pronađe kompromis između autonomije volje i zaštite osiguranika.[106] Radna grupa se odlučila za takvo rešenje jer je posredi pitanje koje je uporednopravno različito uređeno (vid. gore).[107] PEICL

[100] CA, čl. L113-8 st. 1.
[101] CA, čl. L113-8 st. 2.
[102] CA, čl. L113-9 st. 1.
[103] CA, čl. L113-9 st. 2.
[104] CA, čl. L113-9 st. 3.
[105] Christoph Brömmelmeyer, „Principles of European Insurance Contract Law", *European Review of Contract Law*, vol. 7 no. 3/2011, 446.
[106] H. Cousy, 130.
[107] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181–182. Pritom, odredbe PEICL se ne primenjuju na lično osiguranje, poput zdravstvenog osiguranja ili osiguranja života (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 182).

ostavljaju ugovornicima slobodu (pre svega osiguravaču, budući da se radi o ugovoru po pristupu) da u ugovor umetnu klauzulu o promeni rizika.[108] Međutim, ukoliko se osiguravač odluči za takvu klauzulu, on mora poštovati ograničenja koja mu čl. 4:201 nameće. Prvo, povećanje rizika mora biti suštinsko (*material*). Pridev „suštinsko" bi trebalo tumačiti u vezi sa članom 2:103(b) PEICL, što znači da se je relevantna samo ona okolnost koja utiče na ponašanje osiguravača, u smislu da bi osigurač, da je za nju znao, zaključio ugovor pod drugačijim uslovima ili ga ne bi zaključio uopšte.[109] Kouzi ističe da ono mora biti suštinsko po veličini i/ili po verovatnoći.[110] Povećanje koje je posledica amortizacije (u osiguranju imovine) ili starenja lica (u životnom osiguranju), ne smatra se suštinskim.[111] Drugo, vrsta takvog povećanja mora biti navedena u samom ugovoru. Propisivanjem tog ograničenja, radna grupa je nastojala obezbediti da osiguranik bude upoznat sa svojom obavezom tokom ugovora, polazeći od pretpostavke da razuman i pažljiv osiguranik čita svoju polisu.[112]

Ako klauzula zahteva da osiguravač bude obavešten o povećanju rizika, dužnost obaveštavanja je na ugovaraču osiguranja, osiguraniku ili korisniku osiguranja, u zavisnosti od slučaja, pod uslovom da je lice koje je dužno da obavesti znalo ili je moralo znati za postojanje osiguranja i za povećanje rizika.[113] Posebna pravila u pogledu načina obaveštavanja nisu propisana. Zatim, ukoliko klauzula zahteva da osiguravač bude obavešten u određenom roku, propisano je da taj rok mora biti razuman.[114] Radi se o faktičkom pitanju koje zavisi od okolnosti slučaja, pogotovo od toga da li je do promene rizika došlo radnjom dužnika ili ne. Obaveštenje proizvodi dejstvo u trenutku slanja.[115] Naime, radna grupa se za takvo rešenje odlučila budući da je slanje jednostavnije dokazati nego prijem.[116] Koje pravne posledice nastupaju ukoliko ugovarač osiguranja povredi svoju obavezu, odnosno ne obavesti osiguravača u razumnom roku? Propisano je da u tom slučaju osiguravač nema pravo da, samo zbog toga, odbije isplatu ugovorene svote, osim ako je šteta nastala upravo zbog tog povećanog rizika.[117]

[108] H. Cousy, 131.

[109] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 86, 182. Čl. 2:103 PEICL predviđaju izuzetke kada osiguravač nema pravo da sankcioniše osiguranika za netačne ili nepotpune informacije. Između ostalog, osiguravač nema pravo na pravni lek ukoliko te informacije nisu bile bitne za njegovu razumnu odluku da zaključi ugovor pod ugovorenim uslovima (čl. 2:103 (b)). Sledi da je ugovarač osiguranja dužan da otkrije samo one informacije koje su objektivno bitne za konkretan rizik (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 86).

[110] H. Cousy, 131.

[111] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 182.

[112] *Ibidem*.

[113] PEICL, čl. 4:402 st. 1.

[114] PEICL, čl. 4:402 st. 2.

[115] PEICL, čl. 4:402 st. 2.

[116] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 184.

[117] PEICL, čl. 4:402 st. 3.

Najzad, PEICL predviđaju i „sankcije", odnosno pravne posledice promene rizika. Ako je to ugovoreno, u slučaju povećanja osiguranog rizika osiguravač ima pravo da raskine ugovor. Razume se, raskid ugovora je moguć samo pod gorenavedenim uslovima u pogledu rizika iz čl. 4:201 PEICL. Takođe, predviđen je i uslov u pogledu načina obaveštavanja – osiguravač raskid mora učiniti pismenim obaveštenjem upućenim ugovaraču osiguranja u roku od jednog meseca od trenutka kada je saznao za povećanje rizika ili kada je postalo očigledno da je do povećanja došlo.[118] Ukoliko se osiguravač odluči na raskid, pokriće prestaje po proteku jednog meseca nakon od raskida. [119] Otkazni rok od mesec dana ostavljen je ugovaraču osiguranja kako bi imao vremena da pronađe novo pokriće.[120] Međutim, ako ugovarač osiguranja namerno nije obavestio osiguravača o povećanju rizika, tada nema otkaznog roka, već ugovor prestaje u času raskida.[121] Na taj način PEICL sankcionišu ugovarača osiguranja koji je o povećanju rizika prećutao kako bi izbegao uvećanje premije. U tom slučaju, ako je osigurani događaj prouzrokovan povećanim rizikom za koji je ugovarač osiguranja znao ili je morao znati, naknada se ne isplaćuje ako osiguravač ne bi inače uopšte prihvatio taj rizik. Međutim, ako bi osiguravač osigurao taj rizik pod višom premijom ili pod drugačijim uslovima, naknada se isplaćuje srazmerno ili u skladu sa tim uslovima.[122] Suprotno, ugovarač osiguranja koji ne zna niti je morao znati za povećanje rizika, ne snosi ni pravne posledice.[123]

Kada je reč o smanjenju rizika, u slučaju bitnog smanjenja osiguranik ima pravo da zatraži srazmerno smanjenje premije za preostali period ugovora.[124] Takvo rešenje nalažu razlozi pravičnosti. Budući da svaka pretplata premije za prethodni period predstavlja teret za osiguranika, na taj način mu se omogućava da zahteva izmenu uslova ugovora.[125] Ako se strane ne usaglase oko srazmernog smanjenja u roku od mesec dana od podnošenja zahteva, osiguranik ima pravo da raskine ugovor pismenim obaveštenjem u roku od dva meseca od dana podnošenja zahteva.[126]

VII Zaključak

Za razliku od dužnosti prijavljivanja relevantnih okolnosti koje određuju rizik prilikom zaključenja ugovora, koja kao takva postoji u svim pravnim sistemima, obaveza prijave takvih okolnosti tokom ugovora nije svuda prihvaćena. Glavni razlog

[118] PEICL, čl. 4:403 st. 1.
[119] PEICL, čl. 4:403 st. 2.
[120] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 186.
[121] PEICL, čl. 4:403 st. 2.
[122] PEICL, čl. 4:403 st. 3.
[123] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 186.
[124] PEICL, čl. 4:301 st. 1.
[125] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 189.
[126] PEICL, čl. 4:301 st. 2.

jeste što takva dužnost predstavlja konkretizaciju načela savesnosti i poštenja prilikom izvršenja ugovora, koju *common law* ne poznaje kao opšti princip koji prožima ugovor u svim njegovim fazama. Ipak, i tada se ona može izričito ugovoriti. Takvu mogućnost predviđa i PEICL, propisujući uslove pod kojima će klauzula o dužnosti ugovarača osiguranja da informiše osiguravača po zaključenju ugovora proizvoditi pravno dejstvo. U pravnim sistemima kontinentalnog prava, s druge strane, dužnost obaveštavanja je uobičajena i zakonodavci predviđaju pravne posledice promene rizika za vreme ugovora.

U svakom slučaju, bilo da je dužnost informisanja propisana ili ugovorena, ugovarač osiguranja dužan je da po zaključenju ugovora prijavi osiguravaču relevantne okolnosti koje vode oscilaciji rizika. Pitanje šta se u konkretnom slučaju smatra relevantnim okolnostima prepušteno je pravnoj teoriji i sudskoj praksi. Relevantnim se smatraju samo one okolnosti koje značajno i trajno menjaju rizik, na način da bi ugovarač osiguranja ugovor zaključio pod drugačijim uslovima da su takve okolnosti postojala u trenutku zaključenja ugovora, ili ga ne bi zaključio uopšte. Rokovi u kome obaveštenje mora biti učinjeno se u srpskom pravu razlikuju u zavisnosti od toga da li je sam ugovarač prouzrokovao umanjenje odnosno uvećanje rizika, ili je do njegove promene došlo na drugi način, nezavisno od njegove volje. S druge strane, nemački i francuski zakonodavac ne prave takvu razliku, propisujući dužnost obaveštavanja odmah po saznanju (nemačko pravo), odnosno petnaest dana od saznanja (francusko pravo). PEICL propisuje da ugovoreni rok za obaveštavanje mora biti razuman. Smatram da ne bi trebalo praviti razliku u pogledu rokova informisanja, kao što to čini naš zakonodavac, budući da je jedino važno da je ugovarač za izmenjene okolnosti saznao, nezavisno od toga kako je do tog saznanja došao. Francuski zakonodavac propisuje pisanu formu obaveštenja (preporučeno pismo ili imejl), što ne predstavlja dodatni teret za ugovarača osiguranja u današnjem tehnološkom okruženju, a doprinosi pravnoj sigurnosti.

Pravne posledice se razlikuju u zavisnosti od toga da li se rizik u međuvremenu povećao ili smanjio. U slučaju povećanja rizika, osiguravač može izmeniti uslove ugovora (povećati premiju) ili raskinuti ugovor. Srpsko i francusko pravo uslovljavaju raskid ugovora činjenicom da su se okolnosti toliko izmenile da on ugovor ne bi ni zaključio da su takve okolnosti postojale ranije. Takvo rešenje čini se opravdanim, budući da je raskid ugovora i u opštem ugovornom pravu predviđen kao krajnje sredstvo, kada interesi ugovornika ne mogu biti ostvareni na drugi način. Nemačko pravo, s druge strane, omogućuje osiguravaču da slobodno bira između raskida i povećanja premije. Dodatno, nemačko i francusko pravo predviđaju otkazni rok, koji omogućava ugovaraču osiguranja da se pripremi i pronađe drugo pokriće. To čine i PEICL. Mišljenja sam da bi otkazni rok trebalo predvideti i u srpskom pravu *de lege ferenda*. U svakom slučaju, premija se ne može povećati jednostrano, a pravni sistemi predviđaju različite mehanizme omogućavanja ugovaraču da se o izmenama ugovora

saglasi u određenom roku. Ako ugovarač ne pristane na izmene, alternativa je raskid ugovora. Nasuprot tome, u slučaju smanjenja rizika ugovarač osiguranja je ovlašćen zahtevati izmenu uslova ugovora (smanjenje premije), a ukoliko se osiguravač s tim ne saglasi, on može da raskine ugovor.

Kada je reč o pravnim posledicama propuštanja ugovarača osiguranja da obavesti osiguravača o izmenjenom riziku, čini se da srpsko pravo zaostaje u pogledu nijansiranja pravnih posledica u poređenju s nemačkim i francuskim pravom. Prvo, ZOO ne pravi razliku u zavisnosti od stepena krivice ugovarača osiguranja. Situacije u kojima je ugovarač namerno prećutao izmenu okolnosti osiguravaču kako bi zadržao povoljnije uslove ugovora, ili svoju dužnost nije izvršio iz puke nepažnje, po slovu zakona vode istim posledicama. To je razumljivo, budući da je nameru teško dokazati. Drugo, moguća je i situacija da se rizik poveća usled okolnosti koje su opštepoznate, te bi trebalo predvideti izuzetak od dužnosti obaveštavanja u tom slučaju. Najzad, naročito je problematično to što srpski zakonodavac ne razmatra uzročnu vezu između uvećanja rizika i nastupanja osiguranog slučaja. Kada povećanje osiguranog rizika nije bilo uzrok nastanka osiguranog slučaja, već je do osiguranog slučaja došlo iz potpuno drugog razloga, osiguravaču ne bi trebalo omogućiti da srazmerno umanji iznos naknade.

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***Ksenija Džipković, LL.M.*[1]**

THE DUTY TO NOTIFY THE INSURER OF CHANGE IN RISK AFTER THE CONCLUSION OF THE INSURANCE CONTRACT[2]

REVIEW SCIENTIFIC PAPER

Summary

Circumstances relevant to the assessment of risk may change after the conclusion of an insurance contract. Since the policyholder is the only party with full insight into all circumstances relevant to the risk assessment, he has a duty to notify the insurer of any such changes. This paper will examine the nature of the duty to notify the other contracting party as a manifestation of the principle of good faith. It will further define the relevant risk, the aggravation or reduction of which constitutes the duty to notify, analyze the insurer's rights upon being informed of a change in circumstances, and examine the legal consequences of breaching this duty by the policyholder. The duty to notify the insurer of an aggravation or reduction of risk is regulated by Articles 914–916 of the Serbian Law on Contracts and Torts. In addition to the analysis of Serbian law, the author will examine the relevant provisions of French and German law, as well as the Principles of European Insurance Contract Law (PEICL).

Keywords: *insurance contract, risk, aggravation of risk, reduction of risk, duty to notify*

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I Introduction

An insurance contract is an agreement by which the policyholder agrees to pay a certain amount to the insurer, and the insurer undertakes to pay compensation or perform another action for the insured or a third party if an event defined as the insured event occurs. The monetary amount paid by the policyholder is called the premium, while the amount paid by the insurer upon the occurrence of the insured event is referred to as the insured sum or insured amount. In other words, in exchange for the premium paid by the policyholder, the insurer pays the agreed amount or provides another form of compensation if the insured event takes place.

At the time the contract is concluded, the insurer assesses the probability of the insured event occurring. Based on this risk assessment, i.e. the probability of its occurrence, the insurer determines the amount of the premium to be charged to the policyholder. In order to accurately determine the premium, it is crucial for the insurer to be aware of all relevant circumstances, primarily at the time of contract conclusion, but also throughout its duration. It is important to emphasize that this is a contract in which, by its very nature, there is an asymmetry of information regarding the relevant circumstances pertaining to the insured property or person. In this respect, the insurer is the "information-disadvantaged party" as it does not possess such information and can obtain it only based on the statements of the policyholder.[3] The policyholder is obliged to disclose all circumstances relevant to risk assessment, which is most commonly done by filling out a form or answering specific questions posed by the insurer.[4] The insurer relies on the loyalty of its contracting party and depends on their statements, without verifying their completeness or accuracy.[5]

Once the policy is issued, the insurer hopes there will be no significant aggravation of risk.[6] However, it must be borne in mind that the insurance contract is a contract of continuous performance, creating obligations whose fulfillment extends over time.[7] Given that risk is a variable category, and that the performance of the insurer's obligation, by its very nature, requires a certain passage of time, the

[3] Marijan Ćurković, "Obveza ugovaratelja osiguranja, odnosno osiguranika, prijaviti osiguratelju okolnosti značajne za ocjenu rizika", *Zbornik radova Aktualnosti građanskog i trgovačkog zakonodavstva i pravne prakse* No. 15/2017, 103.

[4] In the past, the policyholder independently decided which circumstances were important and which to disclose to the insurer and voluntarily informed them. This approach proved too burdensome for the policyholder and was gradually replaced by a system in which the insurer asks specific questions in the form of a questionnaire (see Herman Cousy, "The Principles of European Insurance Contract Law: The Duty of Disclosure and the Aggravation of Risk", ERA Forum No. 9/2008, 120).

[5] M. Ćurković (2017), 102.

[6] Project Group Restatement of European Insurance Contract Law, Fritz Reichert-Facilides, Jürgen Basedow, *Principles of European Insurance Contract Law: (PEICL)*, München, 2009, 181.

[7] More on contracts with continuous performance, see Marija Karanikić Mirić, *Obligaciono pravo*, Belgrade, 2024, 186–187.

risk level may fluctuate between the conclusion of the contract and the occurrence of the insured event. From the insured's standpoint, there is an understandable tendency to continue their usual activities practiced prior to the conclusion of the insurance contract, without having to limit their conduct to maintain the insured risk. Additionally, there is a legitimate public interest to ensure that the insurance sector operates efficiently and remains financially stable, while not hindering activities that contribute to economic development and innovation.[8] Accordingly, it is understandable that during the insurance period, there may be significant fluctuations in risk, whether aggravations or reductions. Still, if a significant change in risk occurs, the policyholder is obligated to notify the insurer, so the latter can adequately assess the new situation and, if necessary, adjust the contract terms accordingly.

The duty to notify is prescribed with the aim of reducing the information asymmetry between the contracting parties. It is essential for the insurer to be aware of any circumstance that could lead to an aggravation or reduction of risk.[9] This duty is underpinned by two main reasons. First, it prevents the insured from profiting from the insured event.[10] In other words, it represents an application of the principle of full compensation – the injured party has the right to be compensated for the entire damage, but nothing beyond that. If the policyholder fails to report subsequent changes in risk, they may end up paying a lower premium than they should have or receiving greater compensation than they would have if all relevant circumstances had been disclosed – in effect, insurance becomes a source of profit rather than a means of compensation. Second, this duty contributes to reducing moral hazard.[11] Without such a duty, the insured could influence the risk after concluding the contract at their discretion, relying on the fact that the agreed sum would still be payable upon the occurrence of the insured event.

Since the duty to notify does not exist in all legal systems, this paper will first present comparative law approaches to this obligation, along with the theoretical rationales supporting those solutions. The central part of the paper is dedicated to the analysis of the duty to notify itself – who is bound by it, what exactly it entails, and what legal consequences result from a change in risk during the term of the contract, whether it be an aggravation or reduction of risk, depending on whether the policyholder informs the insurer in a timely manner or withholds such information. Finally, the paper presents the solution prescribed by the Principles of European Insurance Contract Law (PEICL) concerning changes in risk during the insurance period.

[8] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181.
[9] Predrag Šulejić, *Pravo osiguranja*, Beograd, 2005, 233.
[10] Irma Nozadze, "Duty to inform as a Specifity of Demonstration of Good Faith Principle in Voluntary and Compulsory Insurance", *Journal of Law (TSU)* No. 1/2017, 137.
[11] *Ibidem*.

II The duty to notify during the term of the contract in comparative law

While all legal systems recognize the policyholder's duty to disclose all relevant circumstances at the time the insurance contract is concluded, comparative law reveals differing approaches regarding the duty to notify about fluctuations in risk during the term of the contract.[12] Specifically, in countries with a so-called "maritime insurance tradition", the policyholder is generally not obligated to report circumstances that lead to an aggravation or reduction of risk after the contract has been concluded.[13] This is the case in England and the Netherlands. In these jurisdictions, the duty to notify the insurer may only be imposed on the insured through a specific contractual clause. However, English and Dutch courts typically interpret such clauses restrictively, in favour of the insured, and rarely treat them as binding obligations.[14] On the other hand, in the countries of the so-called "Alpine insurance tradition",[15] the policyholder is obliged to notify the insurer of all relevant circumstances throughout the duration of the insurance contract. This duty is expressly stipulated by law. The French Insurance Code (*Code des assurances*; hereinafter: CA)[16] stipulates that the policyholder must notify the insurer during the contract period of any new circumstances that result in either an increase in risk or the emergence of new risks, and that thereby render previously provided answers to the insurer untrue or outdated.[17] The German Insurance Contract Act (*Gesetz über den Versicherungsvertrag* or *Versicherungsvertragsgesetz*; hereinafter: VVG)[18] obliges the policyholder who has

[12] Also, the insurance contracting party is obliged to report all relevant circumstances that have changed in the period from sending the offer to the insurer to conclude the insurance contract until the conclusion of the contract (H. Cousy, 127). This is particularly important in motor liability insurance, since the vehicle between the declaration, when the insured stated that the vehicle was in proper condition, and the conclusion of the contract may become technically defective (Dirk Looschelders *et al*., *Versicherungsvertragsgesetz Mit Nebengesetzen Und Systematischen Erläuterungen. 4. Auflage*, Hürth, 2023, 510).

[13] H. Cousy, 131. This is confirmed by judgments such as *Pim v Reid* (1843) and *Kausar v Eagle Star Insurance Co Ltd.* (1997) (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181).

[14] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 183. It is important to emphasize that even in those countries the legislature does not allow deliberate or grossly negligent behavior by the insured that causes the occurrence of the insured event (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181).

[15] H. Cousy, 131.

[16] Insurance Code (CA), consolidated version of May 3, 2025, available at: *https://www.legifrance.gouv.fr/codes/texte_lc/LEGITEXT000006073984/* (last accessed May 30, 2025).

[17] CA, art. L113-2 point 3.

[18] Insurance Contract Act (VVG), version of November 23, 2007 (*Federal Law Gazette I,* 2631), last amended by Article 15 of the Act of December 20, 2022 (*Federal Law Gazette I*, 2793), available at: *https://www.gesetze-im-internet.de/vvg_2008/* (last accessed May 30, 2025).

increased the risk or allowed it to be increased without the insurer's consent to immediately inform the insurer of such an increase, or, in cases where the risk increase has occurred independently of the policyholder's will, to notify the insurer as soon as they become aware of the increased risk.[19]A similar obligation on the part of the policyholder is prescribed by the Serbian Law on Contracts and Torts (hereinafter: ZOO).[20] Why do legal systems approach this issue so differently?

First and foremost, this is a matter that "touches the very essence of insurance".[21] On one hand, an insurance contract is an aleatory contract, its legal effect at the time of conclusion is unknown and depends on an uncertain future event, that is, a circumstance unknown to the contracting parties.[22] At the time the contract is concluded, it is not known whether the insured event will occur. It may be expected of the insurer to accept, at the moment of contract conclusion, not only the existing risk but also any changes to that risk during the contract period.[23] Indeed, the very calculation of risk is inherent to the insurance contract as an aleatory agreement, and it can be argued that the law should not protect insurers from a poor risk assessment.

The legislator's stance on this issue is also influenced by the duration of the insurance period. The shorter the period, the less justified it is to require the policyholder to report circumstances that contribute to an increase or decrease in risk. In countries where insurance typically lasts one year or less, the law usually favours the insured and does not provide legal mechanisms for insurers to adjust policy terms in the event of a significant increase in risk.[24] In most European countries, however, insurance periods usually exceed one year, so the law permits the contract to be modified in case of a significant increase in risk during that time.[25]

Finally, the (non-)existence of the duty to inform about changes in relevant circumstances after the contract is concluded largely depends on how the principle of good faith and fair dealing is understood within a particular legal system. The insurance contract is based on the *principle of utmost good faith,* which entails a higher level of trust between the parties than is required in other contracts.[26]

[19] VVG, art. 23 para. 2 and 3.

[20] Law on Contracts and Torts, *Official Gazette of SFRY*, No. 29/78, 39/85, 45/89 – decision of the Constitutional Court of Yugoslavia and 57/89, *Official Gazette of SRJ*, No. 31/93, *Official Gazette of SCG*, No. 1/2003 – Constitutional Charter and *Official Gazette of RS*, No. 18/2020, available at: *https://www.paragraf.rs/propisi/zakon_o_obligacionim_odnosima.html* (last accessed May 30, 2025). See Law on Contracts and Torts, art. 914.

[21] H. Cousy, 131. H. Cousy, 131.

[22] See M. Karanikić Mirić, 188–189.

[23] H. Cousy, 131.

[24] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181.

[25] *Ibidem*.

[26] I. Nozadze, 131. The principle of utmost good faith originates from marine insurance. In this type of insurance, the insurer had to trust the statements of the contracting party about the ship and the cargo, since the contract was often concluded far from the cargo and the ship (I. Nozadze, 131).

It is a contract of *uberrimae fidei*.[27] Continental legal systems, rooted in Roman law tradition, prescribe this principle and give it concrete expression through several specific rules. It applies not only at the time of contract conclusion but also during the performance of contractual obligations.[28] Among other things, the principle of good faith and fair dealing is reflected in the policyholder's obligation to inform the insurer of relevant circumstances concerning the insured object throughout the term of the contract.[29] The equivalent of the principle of good faith and fair dealing in *common law* is the *good faith principle*. However, the *good faith principle* does not have the general character it holds in continental systems. On the contrary, it is applied only in a limited number of cases where it is explicitly stipulated and is reduced to specific duties.[30] The insurance contract, as a *uberrimae fidei* contract, is one of the few exceptions where the principle finds application, but only at the stage of contract formation.[31] Once the contract is concluded, the duty to act in good faith, more precisely, the policyholder's duty to disclose information, ceases to exist.[32] Such a duty would serve no purpose, as from the moment the contract is binding, the insurer can no longer change the agreed terms of risk coverage out of fear that an unfavourable contract has been concluded.[33] In the case of a significant increase in risk, such a risk is no longer covered by the policy, and the insured is required to insure the new risk with the same or a different insurer, where at the time of entering into the contract, they will once again have the obligation to fully inform the insurer.[34]

[27] Hein Kötz, Gill Mertens, Tony Weir, *European Contract Law: Second edition*, Oxford, 2017, 181.

[28] Hugh Collins, "Implied Duty to Give Information during Performance of Contracts", *The Modern Law Review* Vol. 5, No 4/1992, 557.

[29] I. Nozadze, 135. For example, art. 1104 *Code Civil* provides that contracts must be negotiated, concluded, and performed in good faith. BGB art. 241 para. 2 stipulates that an obligation relationship may, by its content, require each party to consider the rights, legal goods, and interests of the other party. From these provisions derives the obligation of contracting parties to inform their counterpart about facts affecting their mutual relationship. In Serbian law, such obligation is explicitly prescribed in art. 268 Law on Contracts and Torts, with damages provided as a sanction for its breach.

[30] This is a principle that "exudes robust Victorian individualism," that each contracting party must inform themselves about facts relevant for contract conclusion and cannot rely on the counterparty to provide such information (H. Kötz, G. Mertens, T. Weir, 180–181).

[31] H. Kötz, G. Mertens, T. Weir, 181.

[32] In *New Hampshire Insurance Company v MGN Ltd*, the issue was when the insured's obligation to disclose relevant facts to the insurer. The Commercial Court considered it indisputable that the insured had the duty to disclose information at (a) conclusion of insurance, (b) renewal of insurance (which actually constitutes concluding a new contract), and (c) submission and presentation of claims, although the last point was rejected. It was emphasized that "the duty to act in good faith... does not imply positive obligations to disclose facts affecting risk during coverage, except regarding some event or situation foreseen by the policy to which the duty of good faith relates" (see Peter Eggers MacDonald, Simon Picken, Patrick Foss, *Good Faith and Insurance Contracts. 3. ed.*, London, 2010, 56).

[33] P. Eggers MacDonald, S. Picken, P. Foss, 53.

[34] *Ibid*., 56–57. The closest doctrine applicable here under English law is some form of estoppel, such as estoppel by convention or promissory estoppel as a form of contract modification, but even that could be precluded by the absence of any express statement by the insurer (H. Collins, 557).

For this reason, in English law, it is common for insurance contracts to contain an explicit clause obliging the policyholder to inform the insurer of any change in circumstances that affect the risk.[35]

III On the duty to notify about changes in risk during the term of the insurance contract

In legal systems that provide for a duty to notify about changes in risk during the term of the insurance contract, the question arises as to whom this duty is imposed upon and what exactly it entails. In other words, who is obligated, within what period, in what manner, and under what circumstances, to inform the insurer after the contract has been concluded?

According to both Serbian and German law, the duty to notify relevant circumstances for risk assessment lies with the policyholder (*Versicherungsnehmer*).[36] This solution is logical, given that the policyholder is a contracting party and thus can be bound by the contract. Most often, the policyholder concludes the contract in their own name and for their own account and is also the insured person. However, if that is not the case, there is nothing preventing the insured (the person on whose behalf the policyholder concludes the contract with the insurer), as well as the beneficiary of the insurance (the person in whose favour the insurance has been agreed), from notifying the insurer. If the insured or the insurance beneficiary notifies the insurer that there has been a change in relevant circumstances, they thereby eliminate the risk of the insured event occurring "in the meantime", i.e. after the change in circumstances but before the insurer has been notified.[37] The French legislator, on the other hand, imposes this duty on the insured (*l'assuré*).[38]

What kinds of circumstances can be considered relevant? Generally speaking, these are all the circumstances that the policyholder would have been obliged to disclose to the insurer had they existed at the time of concluding the insurance contract.[39] Ćurković points out that the insurer alone determines which circumstances are relevant for assessing the risk.[40] These are the circumstances the insurer takes into account and uses to calculate the premium amount.[41] Since such circumstances may change after the contract is concluded, the information the policyholder

[35] H. Collins, 557.
[36] Law on Contracts and Torts, Art. 914 para. 1; VVG, Art. 23.
[37] Ivica Jankovec, "Articles 901–923", *Komentar Zakona o obligacionim odnosima* (eds. Borislav T. Blagojević, Vrleta Krulj), Belgrade, 1980, 475.
[38] CA, L113-2 point 3.
[39] I. Jankovec, 475.
[40] M. Ćurković (2019), 41.
[41] Nataša Petrović Tomić, *Osnovi prava osiguranja: treće izmenjeno i dopunjeno izdanje*, Belgrade, 2024, 312.

provided to the insurer at the time of contract formation may become inaccurate or outdated.[42] However, the duty to notify applies only to those circumstances that significantly alter the perception of risk. The **VVG** (German Insurance Contract Act) explicitly states that the duty to notify does not apply to a *minor* increase in risk.[43] Moreover, the changes must be of a *permanent* nature, since the duty to report does not extend to circumstances that temporarily increase or reduce the risk.[44] Therefore, it concerns circumstances that create a *state* of increased or reduced danger, those that, over the long term, raise or lower the probability of the insured event occurring, whereas isolated instances of risky behaviour are not taken into account.[45] Furthermore, conduct by the insured or other circumstances that are still in an early stage but may potentially lead to an increase or decrease in risk in the future are not considered relevant – the only relevant circumstances are those which have *already* resulted in a material increase or reduction of risk.[46] This distinction differs between property insurance and personal insurance.

In the case of **personal insurance**, the only relevant circumstance under Serbian law is a change in the insured person's occupation that results in an increased risk. This is explicitly stipulated by the Law on Contracts and Torts (ZOO).[47] Other circumstances, such as a deterioration in the insured's health, are typically already accounted for by the insurer when calculating the premium at the time the contract is concluded, particularly considering the insured's age and general health condition.[48] The term "occupation" refers to regular employment or a professional calling, not to temporary activities the insured might undertake, nor to recreational activities.[49] For example, the fact that the insured was temporarily engaged in breaking concrete in an already excavated tunnel or in a covered trench does not necessarily mean their occupation is tunnel excavation.[50] Accordingly, the insured is not obliged to report one-off or short-term jobs performed during the insurance period.[51] The **German**

[42] Claude J. Berr, Hubert Groutel, Code Des Assurances: 9. éd., Paris, 2003, 31.

[43] Not relevant is also the increase in risk that may be considered agreed to be covered (VVG, Art. 27).

[44] I. Jankovec, 475. It may happen that circumstances increasing and those reducing risk occur simultaneously, requiring examination of the entire case to see if circumstances increasing risk may be balanced by those reducing risk (so-called risk compensation) – e.g., eviction of tenants from a building under fire insurance reduces risk due to tenants' negligence but increases risk of fire caused by homeless persons occupying it (D. Looschelders *et al*., 508).

[45] D. Looschelders *et al*., 507.

[46] *Ibid*, 509.

[47] ZOO, Art. 914 para. 1.

[48] See N. Petrović Tomić, 310–311, 312 fn. 651.

[49] George James Couch, Ronald Aberdeen Anderson, *Couch Cyclopedia of Insurance Law (2. ed.): sections 35:1 – 37:420*, New York, 1961, 685, 693.

[50] *Ibid*, 686.

[51] Also, merely changing the job title, while the insured continues performing the same work, does not constitute a change of occupation (G. Couch, R. Anderson, 691). However, taking up seasonal work different

legislator also takes a cautious approach to the duty of disclosure in the context of life insurance, stating that an increase in risk is recognized only when such a change has been explicitly defined as a risk increase by written agreement, and the insurer cannot invoke an increase in risk after more than five years have passed since that increase occurred.[52] The same applies to circumstances that result in a **reduction** of risk.[53] The **French Insurance Code (CA)** provides that the insured's obligation to report new circumstances does *not* apply to life insurance contracts.[54]

When it comes to **property insurance**, the relevant circumstances concern the insured property itself. For example, these include a change in the intended use of the item, relocation of the item from the location specified in the insurance contract,[55] exposure to hazardous materials, a significant increase in its value, and similar changes. On the other hand, leasing the property may or may not be considered a relevant circumstance, depending on whether the lease increases the risk covered by the insurance.[56] In **motor vehicle liability insurance** (commonly referred to as auto insurance), relevant circumstances that the policyholder is required to report include, for instance, a change in the use of the vehicle, operating the vehicle in a higher-risk area of accidents, a change in the type of fuel used, or a significant increase in mileage.[57]

Legislators prescribe different timeframe within which the policyholder must notify the insurer of an increased risk. The **Serbian Law** on Contracts and Torts **(ZOO)** and the **German Insurance Contract Act (VVG)** stipulate that the policyholder is required to notify the insurer *without delay* if the increase in risk occurred as a result of their own action or of the insured's action that the policyholder permitted.[58] For example, if they bring flammable material into a basement,[59] convert a house into a workshop, install solar panels without appropriate permits, etc. Conversely, if the increase in risk occurred **without their involvement,** then according to Serbian

from the regular employment may be a relevant circumstance the contracting party must report (e.g. a school principal working as a forest ranger during summer vacation), especially if such work is more dangerous or linked to higher accident risk (see G. Couch, R. Anderson, 693).

[52] See Art. 158 VVG. If the contracting party intentionally or fraudulently breaches their obligation, the limitation period is ten years.

[53] VVG, Art. 158 para. 3**.**

[54] CA, Art. L113-2 para. 5.

[55] P. Šulejić, 234; I. Jankovec, 475.

[56] P. Šulejić, 234. *The Supreme Commercial Court emphasized that leasing the insured item does not in itself constitute an increase in risk which the policyholder is obliged to notify to the insurer (Official Gazette 732/68 of August 8, 1988)* (cited in **I. Jankovec,** 1980, 475).

[57] M. Ćurković (2019), 42.

[58] ZOO, art. 914 para. 2. In some legal systems, such as Swiss law, the legal consequences arising from a change in circumstances significant for risk assessment depend on whether the change was caused by the policyholder or not (see I. Jankovec, 475–476).

[59] P. Šulejić, 235.

law, they are obliged to notify the insurer **within fourteen days** from the moment they became aware of the change.[60] For instance, the water level may rise due to flooding or groundwater entering the basement, the roof may be damaged due to an earthquake, or electrical wiring may become overloaded as a result of a neighbour's actions… If the policyholder is unaware of such changes, there is no duty to notify the insurer.[61] Under German law, even in cases where the increase in risk occurred independently of the policyholder's will, they are still obliged to notify the insurer **immediately upon becoming aware** of it.[62] **French law** prescribes a period of **fifteen days**, counted from the moment of awareness, regardless of how the change in risk occurred.[63]

Finally, regarding the **method of notifying** the insurer, **only French law** requires that the notice be sent by **registered letter or registered electronic mail**.[64] Consequently, in both German and Serbian law, the general rules on declarations of intent apply, meaning such notifications may be made orally, at the insurer's premises. Nevertheless, in the event of a legal dispute, the policyholder will find it easier to prove that the insurer was notified if the notice was provided in writing or via electronic mail.

IV Legal consequences of notifying the insurer about a change in risk

1. Increase in Risk

Once the insurer has been notified of an increase in risk, they have two options: to terminate the contract or to propose a new (higher) premium rate to the policyholder. By their nature, these options constitute **the potestative rights (powers).** The **Law on** Contracts and Torts **(ZOO)** does not grant the insurer complete discretion to freely choose between these transformative rights, rather, their decision must be **proportional** to the increased risk. If the risk has increased to such an extent that the insurer would not have entered into the contract at all, they may choose to **terminate** it. If the risk has increased, but the insurer would still have agreed to the contract but under different terms, they may **adjust the premium** accordingly. It appears that the Serbian legislator followed the principle of ***favori contractus***, allowing termination only as a last resort. The **French legislator** reasons similarly.[65]

[60] **ZOO**, art. 914 para. 2; German Insurance Contract Act (VVG), art. 23 para. 2.
[61] I. Jankovec, 476.
[62] **VVG**, art. 23 para. 3.
[63] French Insurance Code (CA), art. L 113-2 para. 2.
[64] CA, art. L 113-2 para. 2
[65] *See* CA, art. L 113-4 para. 1;

In contrast, the **German Insurance Contract Act (VVG)** stipulates that the insurer may **terminate the contract or *instead*** (as the author emphasizes) increase the premium.[66] This means that the same increase in risk is sufficient for either termination or premium adjustment, giving the insurer full freedom to choose between these alternative rights.

After being informed of the increased risk, the insurer has **one month** to decide how to proceed. This deadline is stipulated under both **Serbian and German law**.[67] If the insurer remains passive i.e. does not offer the policyholder a new premium or declare the contract terminated, the contract remains in force **under the original terms**, and the insurer **cannot later exercise its rights**.[68] The same applies in cases where the insurer **explicitly or implicitly** demonstrates acceptance of the extension of the contract under the same terms (e.g. by accepting payment of the premium or paying compensation for an insured event that occurred after the risk increased, etc.).[69] The **German legislator** also adds that the insurer's rights cease if the circumstances change again, thereby reestablishing the prior risk aggravation.[70] This provision should not be interpreted restrictively to require the **exact** reinstatement of the former state, but rather it is sufficient that the **relationship between risk and premium** assumed under the contract is restored.[71]

If the increase in risk is such that the insurer would not have concluded the contract had that condition existed at the time of contracting, the insurer may terminate the contract. The effect of the contract ceases at the moment when the insurer notifies the policyholder of their decision to terminate.[72] Exceptionally, in **French law**, the legal consequences of termination are deferred for **ten days** from the time of notification to the policyholder.[73] During this period, the policyholder may reconsider, seek information, and change the insurance.[74] The termination operates ***ex nunc***, from that moment, the insurance coverage ceases, and the

[66] See VVG, arts. 24 and 25.

[67] ZOO, art. 914 para. 6; VVG, art. 24 para. 2.

[68] ZOO, art. 914 para. 6.

[69] ZOO, art. 914 para. 6. A similar provision exists in French law, see CA, art. L 113-4 para. 4.

[70] VVG, art. 24 para. 3.

[71] D. Looschelders *et al.,* 527. If, however, the restoration of the prior state occurs only after the contract has been terminated, such a change in circumstances has no legal effect and the termination remains valid (D. Looschelders *et al.* 2023, 527).

[72] I. Jankovec, 476.

[73] CA, art. L 113-4 para. 2.

[74] *Similar provisions can be found in laws across Europe. The effective notice period after which termination takes effect is 7 days in Denmark (art. 47 of the Danish Insurance Act), 15 days in Greece (art. 4 para. 2 and first sentence of art. 3 para. 7 of the Greek Insurance Act), one month in Belgium (art. 26 para. 1(2) of the Belgian Insurance Act) and Luxembourg (art. 34 para. 1(3) of the Luxembourg Insurance Act), while in Italy termination takes effect immediately or after 15 days depending on the degree of risk increase (art. 1898 para. 3 of the Italian Civil Code) (*Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 187*).*

policyholder is entitled to a refund of the portion of the premium corresponding to the remaining insurance period.[75] Therefore, if the insured event occurs before the termination notice is communicated to the policyholder, the insurer is obligated to pay the insured amount.

If the increase in risk is such that the insurer would have entered into the contract **only with a higher premium** had such a condition existed at the time of contracting, the insurer may propose a new premium rate to the policyholder.[76] If the policyholder agrees, the premium increase produces legal effect from the day they give their consent.[77] If the policyholder rejects the insurer's proposal or fails to respond within **fourteen days** of receiving the proposal, the contract terminates **by operation of law** under Serbian law.[78] The situation is similar under French law, except the deadline is **thirty days,** and termination occurs through a **unilateral declaration of will by the insurer**.[79] The legal consequences (especially the possibility of termination in case of silence) must be explicitly stated in the proposal. I believe that this solution would be useful to introduce into Serbian law ***de lege ferenda***. The German legislator authorizes the insurer to unilaterally increase the premium and merely notify the policyholder of this, but simultaneously grants the policyholder the right to terminate the contract within **one month** from receiving the notification, provided the premium increase exceeds **ten percent** or if the insurer excluded coverage for the increased risk.[80] This unilateral authority of the insurer is justified by the doctrine of **changed circumstances** under Article 313 of the German Civil Code (BGB) (*Störung der Geschäftsgrundlage*).[81]

2. Reduction of Risk

After the contract has been concluded, circumstances may also change in a way that reduces the risk. It is also possible that circumstances significantly increasing the risk cease to exist, e.g. the purpose of a premise changes (from a welding workshop becomes a garage), hazardous materials previously stored there are removed, fire protection or theft protection measures are implemented. In such cases, the policyholder has the right to request a proportional reduction of the premium.

[75] I. Jankovec, 476; D. Looschelders *et al*., 523. *Same also in CA, art. L 113-4 para. 2.*
[76] ZOO, art. 914 para. 4.
[77] I. Jankovec, 476.
[78] ZOO, art. 914 para. 5.
[79] CA, art. L 113-4 para. 3.
[80] VVG, art. 25.
[81] D. Looschelders *et al.,* 528. German Civil Code (BGB), art. 313 para. 1: If circumstances forming the basis of the contract significantly change after contract conclusion, and if the parties, had they foreseen this change, would have entered into a contract with different content or not at all, the affected party may request contract modification, provided that, considering all pertinent circumstances, especially distribution of risk under contract or law, it cannot reasonably be expected to remain bound by the original contract.

This solution is provided for by the provisions of Serbian, German, and French law.[82] The policyholder's request is not subject to any formal requirements or time limits. Indeed, it is in their interest to report such changes, so a reasonable policyholder will notify the insurer immediately upon becoming aware. The right to a corresponding premium reduction applies from the day the insurer is notified. The German Insurance Contract Act (VVG) adds that the same legal consequences apply if the increased premium was based on incorrect statements made by the policyholder, which arose from a mistake concerning those circumstances.[83]

After the policyholder notifies the insurer about the change in circumstances and requests an adequate premium reduction, two scenarios are possible. The insurer may agree to reduce the premium, which will take effect from the day of notification. However, the insurer may refuse to reduce the premium paid by the policyholder.[84] In that case, the **Serbian Law** on Contracts and Tort (ZOO) grants the policyholder the right to terminate the contract.[85] The Serbian legislator does not prescribe a notice period for termination.[86] I believe that termination in this case takes effect upon notification to the insurer, according to general rules. The situation is different under French law, where termination becomes effective thirty days after notification.[87] Also, by analogy with the rules where the insurer terminates the contract due to an increase in risk, the policyholder is entitled to a refund of the portion of the premium corresponding to the remaining insurance period.

V Failure of the policyholder to notify the insurer about changes in risk

In practice, situations often arise where the policyholder ignores their duty to notify relevant circumstances for risk assessment and thus fails to notify the insurer of an aggravation or reduction of risk that has occurred in the meantime. The reasons for such conduct may vary, carelessness or negligence of the policyholder, mistaken belief that the change is not relevant and therefore does not require notification, or intentional concealment to avoid contract termination or a premium increase. It is also possible that the policyholder did not know and could not have known that

[82] *See* ZOO, art. 916 para. 2; VVG, art. 41; CA, art. L 113-4 para. 4.

[83] VVG, art. 41.

[84] *The VVG does not regulate the legal consequences if the insurer refuses to reduce the premium. In that case the policyholder has the right to raise the defense of exceptio non adimpleti contractus under BGB art. 320, the right to terminate the contract under BGB art. 323, and, if conditions are met, the the right to comepnsation under BGB art. 280 (*Looschelders *et al.,* 2023, 693*).*

[85] ZOO, art. 916 para. 2.

[86] Slobodan Jovanović, "Uticaj povećanja osiguranog rizika na prava i obaveze iz ugovora o osiguranju u nemačkom, francuskom, češkom i srpskom pravu", *Strani pravni život,* Vol. 53 No. 3/2013, 215.

[87] Jovanović (*Ibidem*) discusses the termination period.

a change in risk had occurred. The insurer then learns of the changed circumstances *post festum*, after the insured event has occurred, during the damage assessment process. What legal consequences arise in such cases? Most often, these are cases where the risk increased after the insurance contract was concluded, since in such cases the policyholder, aware of the unfavourable consequences for themselves, is not motivated to timely notify the insurer about the change.

Domestic legislator refers to situations in which the insured event occurs "in the meantime", considering the period from the risk deterioration to the insurer taking legal action in response to that deterioration.[88] In such a cases, the compensation paid by the insurer is reduced proportionally between the premiums actually paid and the premiums that should have been paid according to the increased risk.[89] Moreover, if such proportionality cannot be calculated because the change in circumstances is so significant that the insurer would not have entered into the contract had such circumstances existed at the time of conclusion, or would have terminated the contract if timely informed, the insurer owes no compensation to the policyholder; the obligation to pay the agreed sum ceases.[90] This provision applies equally to a policyholder who intentionally concealed the increased risk and to one who could not have known about the deterioration. It also applies to a policyholder who became aware of the increased risk, but the insured event occurred immediately after that knowledge, so the policyholder did not have time to fulfil the duty of notification. The Serbian legislator, therefore, does not prescribe stricter consequences for a policyholder who deliberately failed to report the increase. Furthermore, it appears that the legislator did not consider situations where the insured event occurred not because of the increased risk but for some other reason. Serbian legal theory holds that the legal consequences under Article 915 apply even in such cases.[91]

German law, on the other hand, takes into account several factors: the policyholder's level of fault, the time of occurrence of the insured event, and the causal link between the increase in risk and the occurrence of damage. The insurer can be fully released from the obligation to pay compensation under three conditions. The VVG provides that the insurer is not obligated to pay if the insured event occurs after one month from the moment the insurer should have been informed, unless the insurer was already aware of the risk increase at that time.[92] The first condition is that the increase in risk was not reported on time. The legislator ties the start of the deadline to the moment the insurer should have been informed about the change

[88] Under ZOO there is no distinction between cases where the policyholder was not notified of deterioration and cases where they were notified but have not yet terminated or amended the contract in agreement with the insurer. The primary focus of analysis remains the former scenario.

[89] ZOO, art. 915.

[90] I. Jankovec, 477.

[91] *Ibidem.*

[92] VVG, art. 26 para. 2 (first sentence).

in risk (the so-called fictional receipt of notification).[93] One month must pass from that moment. The one-month period is prescribed because the insurer, even when it receives notification about the change in risk, has one month to decide whether to terminate the contract (see above). The purpose of fictional receipt is to ensure that the insurer is not in a worse position than if it had been properly notified.[94] The second condition is that the insurer did not know (e.g. from another source) about the increased risk at the time they should have been notified. The burden of proving that the insurer did know about the increased risk lies with the policyholder.[95] The third condition is that the policyholder acted intentionally, as the most serious degree of fault. Legal theory debates who bears the burden of proving intent.[96] Although not explicitly stated, such a conclusion is suggested since the legislator in subsequent paragraphs prescribes different legal consequences for conduct characterized by gross and ordinary negligence. In the case of gross negligence of the policyholder, the insurer has the right to reduce its contractual obligations in proportion to the severity of the insured's fault, and the burden of proving the absence of gross negligence lies with the policyholder.[97] Finally, the insurer is still liable (must pay the agreed sum) if the breach of the duty to notify was not intentional.[98] The insurer is also required to pay if the increased risk did not cause the insured event or affect the extent of the insurer's liability, or if the insurer's right to terminate had already expired when the insured event occurred and the contract had not been terminated.[99] These are cases where the causal link between the increased risk and the insured event's occurrence is missing.

The French legislator prescribes different legal consequences depending on the policyholder's fault. If the policyholder concealed (withheld) or intentionally misrepresented facts affecting the risk, whether regarding a change in the risk object or the insurer's general risk assessment, the insurance contract will be void, even if the concealed or distorted risk had no effect on the insured event that occurred.[100] Moreover, the premiums paid remain with the insurer, who is entitled to payment of all due premiums as compensation for damages.[101] Conversely, an omission or inaccurate statement by the insured, if bad faith is not proven, does not lead to the nullity of the insurance contract.[102] If such omission or inaccuracy is discovered before

[93] D. Looschelders, 533.
[94] *Ibidem*.
[95] *Ibidem*.
[96] From the wording of VVG art. 26 it follows that the policyholder bears the burden of proof that they did not act intentionally, which deviates from the general rule that the burden of proving intent lies with the insurer; literature suggests this is a drafting error. (D. Looschelders, 534).
[97] VVG, art. 26 para. 2 (second sentence) in conjunction with art. 26 para. 1.
[98] VVG, art. 26 para. 2.
[99] VVG, art. 26 para. 3.
[100] CA, art. L 113-8 para. 1.
[101] CA, art. L 113-8 para. 2.
[102] CA, art. L 113-9 para. 1.

the insured event occurs, the insurer has the right to choose between increasing the premium accepted by the insured or terminating the contract ten days after sending notification to the insured by registered mail, with a refund of the portion of the premium corresponding to the period during which the insurance no longer applies.[103] If the omission or inaccurate statement is discovered only after the insured event, the compensation is reduced proportionally between the premiums paid and the premiums that would have been paid if the risks had been fully and accurately declared.[104]

VI Change of risk in the principles of european insurance contract law (peicl)

The Principles of European Insurance Contract Law (hereinafter: PEICL) represent an alternative, unified legal framework intended for insurance contracts within the European Union, which parties may choose to apply to their contract instead of national law. The purpose of the PEICL is to enable insurers to offer identical insurance services in different member states, thereby reducing costs, overcoming legal differences, and increasing legal certainty in cross-border trade.[105] According to Article 4:201 of the PEICL, if an insurance contract contains a provision pertaining to an increase in the insured risk, that provision shall have no effect unless the increase in risk is substantial and the type of such increase is specified in the insurance contract.

The PEICL, therefore, limit themselves to cases where policies contain clauses that impose on the policyholder the duty to notify the insurer about relevant circumstances during the term of the contract. This rule aims to find a compromise between the autonomy of the will and the protection of the insured.[106] The working group opted for this solution because the issue is regulated differently across jurisdictions (see above).[107] The PEICL leave the contracting parties free (primarily the insurer, since this is an adhesion contract) to include a clause on change of risk in the contract.[108] However, if the insurer opts for such a clause, they must respect the limitations imposed by Article 4:201. First, the increase in risk must be substantial (*material*). The adjective "substantial" should be interpreted in connection with Article 2:103(b) PEICL, meaning that only circumstances that influence the insurer's behaviour

[103] CA, art. L 113-9 para. 2.
[104] CA, Art. L113-9, para. 3.
[105] Christoph Brömmelmeyer, "Principles of European Insurance Contract Law", *European Review of Contract Law*, Vol. 7 No. 3/2011, 446.
[106] H. Cousy, 130.
[107] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 181–182. The provisions of the PEICL do not apply to personal insurance, such as health insurance or life insurance (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 182).
[108] H. Cousy, 131.

are relevant, in the sense that the insurer would have concluded the contract under different terms, or would not have concluded it at all, had they known about it.[109] Cousy emphasizes that the increase must be substantial either in magnitude and/or in probability.[110] An increase resulting from depreciation (in property insurance) or aging of the person (in life insurance) is not considered substantial.[111] Second, the type of such increase must be specified in the contract itself. By prescribing this limitation, the working group aimed to ensure that the insured is aware of their obligation during the contract, based on the assumption that a reasonable and careful insured reads their policy.[112]

If the clause requires the insurer to be informed about an increase in risk, the duty to notify lies with the policyholder, the insured, or the beneficiary, depending on the case, provided that the person obliged to notify knew or ought to have known about the existence of the insurance and the increase in risk.[113] No special rules on the method of notification are prescribed. Furthermore, if the clause requires that the insurer be notified within a certain period, that period must be reasonable.[114] This is a question of fact depending on the circumstances of the case, especially whether the change in risk occurred due to the action of the obligated party or not. The notification takes effect upon dispatch.[115] The working group chose this solution because sending is easier to prove than receipt.[116] What legal consequences arise if the policyholder breaches their obligation and fails to notify the insurer within a reasonable time? It is prescribed that, in that case, the insurer does not have the right to refuse payment of the agreed sum solely on that ground, unless the damage occurred precisely because of that increased risk.[117]

Finally, the PEICL also provide for "sanctions", i.e. legal consequences of a change in risk. If agreed upon, in the event of an increase in the insured risk, the insurer has the right to terminate the contract. It is understood that contract termination is possible only under the conditions regarding risk set out in Article 4:201 PEICL.

[109] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 86, 182. Article 2:103 of the PEICL sets out exceptions under which the insurer has no right to sanction the policyholder for providing inaccurate or incomplete information. Among other things, the insurer is not entitled to any legal remedy if such information was not material to its reasonable decision to enter into the contract under the agreed terms (Art. 2:103(b)). It follows that the policyholder is only obliged to disclose information that is objectively material to the specific risk (Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 86).

[110] H. Cousy, 131.

[111] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 182.

[112] *Ibidem*.

[113] PEICL, art. 4:402(1).

[114] PEICL, art. 4:402(2).

[115] PEICL, art. 4:402(2).

[116] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 184.

[117] PEICL, art. 4:402(3).

Also, there is a requirement regarding the manner of notification - the insurer must terminate the contract by means of written notice sent to the policyholder within one month from the moment the insurer became aware of the increase in risk or when it became apparent that the increase occurred.[118] If the insurer decides to terminate, coverage ceases one month after the termination notice.[119] The one-month termination period is left to the policyholder to allow time to find new coverage.[120] However, if the policyholder intentionally failed to notify the insurer about the increase in risk, there is no termination period, and the contract ends immediately upon termination.[121] In this way, the PEICL sanction the policyholder who concealed the increase in risk to avoid a premium increase. In such a case, if the insured event was caused by the increased risk that the policyholder knew or ought to have known about, no compensation is paid if the insurer would not have accepted the risk at all otherwise. However, if the insurer would have accepted the risk under a higher premium or different terms, compensation is paid proportionally or in accordance with those terms.[122] Conversely, a policyholder who neither knew nor was required to know about the increase in risk does not bear legal consequences.[123]

Regarding a reduction in risk, in the case of a substantial decrease, the insured has the right to request a proportional reduction of the premium for the remaining term of the contract.[124] Such a solution is justified by reasons of fairness. Since each premium overpayment for the previous period is a burden for the insured, this allows them to request a change in the contract terms.[125] If the parties do not agree on the proportional reduction within one month from the submission of the request, the insured has the right to terminate the contract by written notice within two months from the date of the request.[126]

VII Conclusion

Unlike the duty to report relevant circumstances that determine risk at the time of contract conclusion which, as such, exists in all legal systems, the obligation to report such circumstances during the term of the contract is not universally accepted. The main reason is that this duty represents a concretization of the principle of good faith and fair dealing in contract performance, which *common law* does not

[118] PEICL, art. 4:403(1).
[119] PEICL, art. 4:403(2).
[120] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 186.
[121] PEICL, art. 4:403(2).
[122] PEICL, art. 4:403(3).
[123] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 186.
[124] PEICL, art. 4:301(1).
[125] Project Group Restatement of European Insurance Contract Law, F. Reichert-Facilides, J. Basedow, 189.
[126] PEICL, art. 4:301(2).

recognize as a general principle permeating the contract at all its stages. Still, even in common law systems, this duty can be explicitly agreed upon. This possibility is also provided by the PEICL, which prescribes the conditions under which a clause imposing on the policyholder a duty to inform the insurer after contract conclusion will produce legal effect. In contrast, in continental law systems, the duty of notification is common, and legislators provide legal consequences for changes in risk during the term of the contract.

In any case, whether the duty to inform is prescribed or agreed upon, the policyholder is obligated after contract conclusion to report to the insurer relevant circumstances that lead to risk fluctuation. The question of what is considered relevant in a specific case is left to legal theory and judicial practice. Only those circumstances that significantly and permanently change the risk are considered relevant, such that the policyholder would have concluded the contract under different terms had these circumstances existed at the time of contract conclusion or would not have concluded it at all. The deadlines for providing notification under Serbian law differ depending on whether the policyholder caused the increase or decrease in risk, or whether the change occurred in another way, independent of their will. On the other hand, German and French legislators do not make such distinctions, prescribing the duty to notify immediately upon knowledge (German law) or within fifteen days of becoming aware (French law). The PEICL prescribe that the agreed deadline for notification must be reasonable. I believe that no distinction should be made regarding notification deadlines, as the Serbian legislator does, since what matters is only that the policyholder became aware of the changed circumstances, regardless of how such awareness was obtained. The French legislator prescribes written form for the notification (registered letter or email), which does not constitute an additional burden for the policyholder in today's technological environment, and it contributes to legal certainty.

The legal consequences differ depending on whether the risk has increased or decreased in the meantime. In the case of an increase in risk, the insurer may amend the contract terms (increase the premium) or terminate the contract. Serbian and French law condition contract termination on the fact that the circumstances have changed so significantly that the contract would not have been concluded had those circumstances existed earlier. Such a solution appears justified, as contract termination is generally regarded in contract law as a last resort, when the interests of the contracting parties cannot be achieved in any other way. German law, on the other hand, allows the insurer free choice between termination and premium increase. Additionally, German and French law provide for a notice period, enabling the policyholder to prepare and find alternative coverage. PEICL also adopt this approach. I believe that a notice period should be introduced in Serbian law ***de lege ferenda*** (as a legislative proposal). In any case, the premium cannot be

unilaterally increased, and legal systems prescribe different mechanisms allowing the policyholder to consent to contract amendments within a specified deadline. If the policyholder does not agree to the changes, termination of the contract is the alternative. Conversely, in the case of a risk reduction, the policyholder is entitled to request a modification of the contract terms (premium reduction), and if the insurer does not agree, the policyholder may terminate the contract.

Regarding the legal consequences of the policyholder's failure to notify the insurer of the changed risk, Serbian law seems to lag behind in terms of nuanced legal consequences compared to German and French law. First, the **Serbian Law** on Contracts and Tort (ZOO) does not differentiate based on the degree of fault of the policyholder. Situations where the policyholder intentionally concealed the change in circumstances from the insurer to retain favourable contract terms, or where the duty was breached through mere negligence, lead to the same consequences under the law. This is understandable as the intent is difficult to prove. Second, there may be situations where the risk increases due to generally known circumstances, and in such cases, an exception to the duty to notify should be foreseen. Finally, it is especially problematic that the Serbian legislator does not consider the causal link between the increased risk and the occurrence of the insured event. When the increase in insured risk was not the cause of the insured event, but the insured event occurred for an entirely different reason, the insurer should not be allowed to proportionally reduce the compensation amount.

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DOPRINOS OŠTEĆENOG NASTANKU ILI UVEĆANJU ŠTETE NASTALE U SAOBRAĆAJNOM UDESU

Institut doprinosa oštećenog šteti predstavlja važan korektivni mehanizam u okviru sistema naknade štete. Njegova suština ogleda se u umanjenju ili potpunom isključenju obaveze naknade štete od strane odgovornog lica ukoliko je oštećeni svojim radnjama doprineo nastanku ili uvećanju štete koju je pretrpeo.

U pravu Republike Srbije taj institut regulisan je članom 192 Zakona o obligacionim odnosima koji propisuje: „Oštećenik koji je doprineo da šteta nastane ili da bude veća nego što bi inače bila, ima pravo samo na srazmerno smanjenu naknadu. Kad je nemoguće utvrditi koji deo štete potiče od oštećenikove radnje, sud će dosuditi naknadu vodeći računa o okolnostima slučaja.“ [2]

Princip podeljene odgovornosti može se primeniti kako prilikom odmeravanja naknade materijalne štete tako i prilikom odmeravanja naknade nematerijalne štete, imajući u vidu da je u članu 205 istog zakona predviđeno: „Odredbe o podeljenoj odgovornosti i sniženju naknade koje važe za materijalnu štetu shodno se primenjuju i na nematerijalnu štetu.“

Ta zakonska norma daje sudovima široku diskreciju u pogledu utvrđivanja doprinosa oštećenog, kako kroz kvantifikaciju procentualne odgovornosti tako i kroz celovitu ocenu okolnosti konkretnog slučaja.

Institut doprinosa oštećenog često je bio predmet razmatranja u praksi kod naknada šteta nastalih u saobraćajnim udesima, a najinteresantniji su predmeti po odštetnim zahtevima oštećenih lica koja su pristajala na vožnju sa vozačem koji je pod dejstvom alkohola ili vozačem koji ne poseduje vozačku dozvolu i oštećenih lica koja prilikom vožnje nisu vezala sigurnosni pojas.

Navedene situacije su značajne jer, s jedne strane, postoji protivpravno ponašanje vozača koje uzrokuje štetu, dok s druge strane ponašanje oštećenog može ukazivati na svesni i voljni pristanak na povećani rizik. Takvo ponašanje oštećenog, u nekim situacijama, može biti i većinski uzrok nastanka štete, a na oštećenom je,

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[2] 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.

ili pak na njegovom osiguravaču, da ovo ponašanje prepozna i istakne prigovor podeljene odgovornosti.

Osiguravač ne može prema oštećenom isticati prigovore iz odnosa sa osiguranikom (npr. da je osiguranik vozio bez dozvole ili pod dejstvom alkohola).[3] Međutim, prigovor doprinosa oštećenog ostaje dopušten, institut doprinosa zasniva se na ponašanju samog oštećenog, pa osiguravač može da traži sniženje naknade zbog doprinosa oštećenog.

Sudovi u Republici Srbiji procenjuju doprinos oštećenog uzimajući u obzir brojne faktore: stepen alkoholisanosti vozača, odnos između vozača i oštećenog, vreme i mesto vožnje, ponašanje oštećenog i njegov stepen svesti o opasnosti, tehničke okolnosti nezgode, kao i starost i zrelost oštećenog.

Kod saobraćajnih nezgoda, ocena doprinosa oštećenog neposredno se oslanja na standarde bezbednog ponašanja iz Zakona o bezbednosti saobraćaja na putevima,[4] jer povrede tih dužnosti signaliziraju nesavesnost oštećenog i uzročnu vezu s povećanjem štete.

Prikazom sledećih presuda ilustruju se različiti pristupi u oceni doprinosa oštećenog.

1. Viši sud u Užicu je u predmetu Gž 1398/21[5] ocenio da je tužilja kao putnik, propustom da veže sigurnosni pojas, doprinela nastanku svog povređivanja u visini od 50%, a time i visini nematerijalne štete.

2. U predmetu Rev 5302/19[6] činjenično stanje je bilo sledeće: maloletni E. E. i D. D., obojica bez položenog vozačkog ispita i neosposobljeni za bezbednu vožnju, vozili su odvojena putnička vozila. E. E. je vozio automobil svog oca, pri brzini od 74,9 km/h na oštećenom i krivudavom putu. U krivini je izgubio kontrolu nad vozilom, koje je izašlo sa kolovoza i prevrnulo se, a pošto E. E. nije bio vezan sigurnosnim pojasom, ispao je iz vozila na kolovoz i postao iznenadna prepreka za vozilo D. D., koje je išlo iza njega i pregazilo ga. Ni jedan ni drugi učesnik nije imao vozačku dozvolu. Veštačenje je utvrdilo da kontakta između vozila nije bilo pre prevrtanja, a da bi vezivanje sigurnosnog pojasa sprečilo izletanje E. E. iz automobila i posledično gaženje. Osiguravač je u vansudskom postupku porodici isplatio 50% od ukupno procenjene štete, smatrajući da je E. E. toliko doprineo nastanku posledica. Nižestepeni sudovi su potvrdili procenat doprinosa od 50%, navodeći da se radi o podjednakoj odgovornosti oba maloletnika – i vozača koji je pregazio E. E. i samog E. E., koji je svojom vožnjom bez dozvole, neprilagođenom brzinom

[3] Videti odredbu člana 28 Zakona o obaveznom osiguranju u saobraćaju, *Sl. glasnik RS,* br. 51/2009, 78/2011, 101/2011, 93/2012 i 7/2013 – odluka US.

[4] Videti odredbe članova 30. st. 1, 178 i 187 ZOBS, *Sl. glasnik RS,* br. 41/2009, 53/2010, 101/2011, 32/2013 - odluka US, 55/2014, 96/2015 – dr. zakon, 9/2016 – odluka US, 24/2018, 41/2018, 41/2018 – dr. zakon, 87/2018, 23/2019, 128/2020 - dr. zakon, 76/2023 i 19/2025.

[5] Dostupno na: http://www.propisionline.com/IndOk/Index.

[6] Dostupno na: https://www.vrh.sud.rs/sr.

i nevezivanjem pojasa stvorio rizik i omogućio nastanak fatalne posledice. Vrhovni kasacioni sud je odbio reviziju, potvrdivši da nevezivanje sigurnosnog pojasa ima neposrednu uzročnu vezu sa fatalnim ishodom, da vožnja bez dozvole i neosposobljenost uvećavaju doprinos oštećenog i da se procenat doprinosa (50%) zasniva na podjednakoj krivici oba učesnika.

3. Prilikom donošenja presude Gž 23/2023 od 29. 11. 2023. godine,[7] Apelacioni sud u Beogradu je našao da ne postoji doprinos tužioca nastaloj šteti u situaciji kada, vršeći svoju profesionalnu dužnost, u kolima hitne pomoći nije bio vezan sigurnosnim pojasom dok je pružao pomoć pacijentu. U tom predmetu je sud imao u vidu to da tužilac nije bio u mogućnosti da sedi na fiksiranoj stolici na kojoj bi mogao vezati pojas, jer je na toj stolici sedela supruga pacijenta, a tužilac je morao biti uz pacijenta, kako bi bio u mogućnosti da mu ukaže nužnu pomoć, te je našao da nema doprinosa.

4. Vrhovni kasacioni sud je u predmetu Rev 3096/20[8] našao da je oštećeni J. J., pristajanjem na vožnju sa licem bez vozačke dozvole i nevezivanjem pojasa, doprineo nastanku štete u visini od 30%. Okolnosti slučaja su bile takve da je mal. J. J. stradao kao saputnik u putničkom vozilu koje je prethodno protivpravno oduzeto vlasniku. Vozilom je u trenutku nezgode upravljao drugi maloletnik K. K., koji nije imao vozačku dozvolu niti je bio osposobljen za bezbedno upravljanje vozilom. J. J. je najpre i sam upravljao vozilom nakon što je pokrenuo motor, a zatim je došlo do zamene vozača. Do nezgode je došlo usled izletanja vozila sa puta i prevrtanja. Osiguravač je u vansudskom postupku porodici oštećenog isplatio deo naknade, umanjene za 50% zbog procenjenog doprinosa oštećenog usled pristanka na vožnju sa licem bez dozvole. Prvostepeni sud je tokom postupka utvrdio doprinos oštećenog od 20%, dok je drugostepeni sud taj doprinos opredelio na 30%. Vrhovni kasacioni sud je potvrdio stav drugostepenog suda nalazeći da je oštećeni imao svest o riziku, jer je bio učesnik u protivpravnom oduzimanju vozila, a inicijalno je i sam upravljao njime bez dozvole, kao i da oštećeni nije bio vezan sigurnosnim pojasom, čime je uvećana težina posledica. Sud je imao u vidu i to da je oštećeni bio maloletnik od 14 godina, te da je njegov stepen zrelosti niži. Dakle, u tom slučaju se naročito vodilo računa o stepenu zrelosti oštećenog i to je bio faktor koji je doprineo da se doprinos utvrdi na manje od 50%.

5. Presudom u predmetu Rev 13044/23[9] Vrhovni sud Republike Srbije potvrđuje da je pristajanje na vožnju sa licem koje nije bilo potpuno sposobno za upravljanje vozilom razlog za utvrđivanje postojanja doprinosa oštećenog nastanku štete i ovaj doprinos opredeljuje na 50%.

6. Apelacioni sud u Beogradu, u predmetu Gž 5085/12[10], doprinos oštećenog usled pristajanja na vožnju sa licem pod uticajem alkohola opredeljuje na 40%.

[7] Dostupno na https://propissoft.profisistem.rs/#.
[8] Dostupno na: https://www.vrh.sud.rs/sr.
[9] Dostupno na: https://www.vrh.sud.rs/sr.
[10] Dostupno na: http://www.propisionline.com/IndOk/Index.

U obrazloženju presude se navodi: „Prema činjeničnom stanju utvrđenom u prvostepenom postupku, a saglasno podacima iz krivičnih spisa, saobraćajnoj nezgodi prethodilo je druženje tužioca sa imenovanim, kojom prilikom su, i to neposredno pred krivični događaj, obojica konzumirali alkohol. Imajući u vidu to da je tužiocu nesumnjivo bilo poznato da je ovaj konzumirao alkohol i da nije posedovao saobraćajnu dozvolu (što je kao oštećeni izjavio prilikom saslušanja u postupku vođenom pred nadležnim Osnovnim sudom protiv okrivljenog), pristajući na vožnju sa njim u takvom stanju – svesno je preuzeo rizik mogućeg nastanka štetnih posledica."

7. Vrhovni kasacioni sud je u rešenju Rev 1261/19 od 16. 10. 2019. godine našao da se u situaciji kada oštećeni suvozač nije bio sa vozačem, dok je ovaj konzumirao alkohol, već ga je vozač sustigao i ponudio mu da ga poveze, te da je do nezgode došlo nekoliko sekundi nakon što je on ušao u vozilo, ne može zaključiti da je suvozač prihvatio vožnju sa alkoholisanim licem i svesno preuzeo rizik mogućeg nastanka štetnih posledica.[11]

Analizirana sudska praksa pokazuje da institut doprinosa oštećenog omogućava proporcionalno umanjenje naknade u skladu sa učešćem oštećenog u nastanku štete, kao i da se doprinos oštećenog dosledno tretira kao faktičko pitanje koje sud u svakom predmetu pojedinačno ispituje. Pristajanje na vožnju s licem pod dejstvom alkohola ili licem koje nije osposobljeno za vožnju, ne mora nužno da znači postojanje doprinosa oštećenog, već sudovi svaki slučaj ocenjuju pojedinačno, vodeći računa o svim okolnostima, a naročito o stepenu svesti i voljnom prihvatanju rizika. Sudovi prave razliku između pukog pristajanja na vožnju i svesnog prihvatanja povećanog rizika, a doprinos oštećenog procenjuje se prema trenutnoj svesti i ponašanju, pri čemu se vodi računa o svim okolnostima slučaja, pa tako npr. i o starosti oštećenog, kao faktoru koji utiče na njegovu zrelost i svest o prihvatanju opasnosti. Takođe, vodi se računa o objektivnim okolnostima, kao npr. o tome da li je medicinski tehničar bio u mogućnosti da tokom prevoza lica kome je potrebna medicinska pomoć bude vezan pojasom.

Praksa nije u potpunosti ujednačena, što potvrđuje razlika u proceni doprinosa u prikazanim presudama. Primećuje se i da sudovi prave razliku između subjektivne svesti o riziku i empirijskih dokaza o nivou alkoholisanosti. Imajući u vidu značaj instituta doprinosa oštećenog, bilo bi korisno da praksa zauzme jasnije standarde u pogledu dokazivanja svesti o riziku i jasnije standarde prilikom opredeljivanja stepena doprinosa u takvim situacijama, kako bi se osigurala pravna sigurnost i dosledna primena načela pravičnosti.

[11] Dostupno na: https://www.lexonline.paragraf.rs/paragrafSRB/.

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Rad mora da sadrži sažetak (apstrakt), sa osnovnim ciljevima istraživanja, metodama, rezultatima i zaključcima rada. Sažetak treba da ima do 150 reči.

Nakon sažetka rad mora da ima ključne reči koje najbolje opisuju sadržaj članka za potrebe indeksiranja i pretraživanja. Broj ključnih reči ne može biti veći od 5.

Rad mora da sadrži listu referenci (literatura) koja obuhvata **samo bibliografske izvore** (članke, monografije i sl.) i daje se isključivo u zasebnom odeljku nakon teksta. Reference se navode na dosledan način, prema azbučnom redosledu prezimena autora, kako glase u originalu.

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Naslov članka se piše na sredini, velikim slovima. Naslovi unutar članka moraju da imaju sledeći format.

1) **Prvi nivo naslova** – na sredini; numeracija: rimski broj (npr. I, II, III, itd.); prvo slovo veliko, a ostala mala.
2) **Drugi nivo naslova** – na sredini; numeracija: arapski broj sa tačkom (npr. 1., 2., 3., itd.); prvo slovo veliko, a ostala mala.
3) **Treći nivo naslova** – na sredini; kurziv (kosa slova, italik); numeracija: malo slovo azbuke sa zatvorenom zagradom (npr. a), b), v), itd.); prvo slovo veliko, a ostala mala.
4) **Četvrti nivo naslova** – na sredini; numeracija: arapski broj sa zatvorenom zagradom (npr. 1), 2), 3), itd.); prvo slovo veliko, a ostala mala.

Primer:

I Pojam
Definicija
Definicija u uporednom pravu
1) Francusko zakonodavstvo

PRAVILA CITIRANJA

Knjige

a) Knjige se citiraju na sledeći način: ime autora, prezime autora, naslov dela naveden kurzivom, eventualno redni broj izdanja, mesto izdanja, godina izdanja, broj strane.

Primer: Nenad Grujić, *Raskid ugovora zbog neispunjenja i pravna dejstva raskida*, Beograd, 2016, 111; Susan Hodges, *Cases and Materials on Marine Insurance Law,* Cavendish Publishing Limited, London, 2002, 74.

Kada se citira tekst sa više strana koje su tačno određene, one se razdvajaju crtom, posle čega sledi tačka. U slučaju da se citira više strana koje se ne određuju tačno, posle broja koji označava prvu stranu navodi se „i dalje" s tačkom na kraju.

Primer: Nenad Grujić, *Raskid ugovora zbog neispunjenja i pravna dejstva raskida*, Beograd, 2016, 111–120.

Primer: Nenad Grujić, *Raskid ugovora zbog neispunjenja i pravna dejstva raskida*, Beograd, 2016, 111 i dalje.

v) Kada se citira knjiga više autora (do tri)njihova imena i prezimena se razdvajaju zarezom.

Primer: Vladimir Kapor, Slavko Carić, *Ugovori robnog prometa,* Deveto izdanje, Centar za privredni konsalting, Novi Sad, 1996, 67.

Katherine B. Posner, Tim Marland, Philip Chrystal, *Margo on Aviation Insurance,* Fourth edition, London, 2014, 429.

g) Ako se citira knjiga sa više od tri autora, navodi se samo ime i prezime prvog autora, uz dodavanje skraćenice reči et alia kurzivom.

Primer: Hugh Beale et al., *Contract Law,* 2nd edition, Bloomsbury Publishing, London, 2010, 54.

d) Knjiga koju je neko lice priredilo kao urednik se citira tako što se nakon njegovog imena i prezimena u zagradi navodi oznaka „urednik" ili skraćenica „ur.", odnosno odgovarajuća oznaka na jeziku na kom je knjiga objavljena.

Primer: Mirko Vasiljević (urednik), *Akcionarska društva, berze i akcije*, Beograd, 2006, 27; Marko Baretić, Saša Nikčević (urednici), *Zbornik Treće regionalne konferencije o obveznom pravu*, Zagreb, 2022, 44.

Fidelis Oditah (editor), *The Future for the Global Securities Market*, Oxford, 1996, 74.

Jürgen Basedow *et al*., (Hrsg.), *Anleger- und objektgerechte Beratung, Private Krankenversicherung, Ein Ombudsmann für Versicherungen,* Band 11, Nomos, Baden-Baden, 1999, 55.

đ) Kada se citira jedna knjiga određenog autora, kod ponovljenog citiranja se navodi prvo slovo imena sa tačkom i prezime, nakon čega se dodaje broj strane.

Primer: N. Grujić, 102.

S. Hodges, 231.

e) Kada se citira više knjiga istog autora, kod ponovljenog citiranja se navodi prvo slovo imena sa tačkom i prezime, potom se u zagradi stavlja godina izdanja, i najzad broj strane.

Primer: M. Vasiljević (2012), 107.

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Primer: *Ibidem*.

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Primer: *Ibid*., 23.

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Primer: Predrag Šulejić, „Pravna priroda sredstava matematičke rezerve u osiguranju", *Pravo i privreda* 5–8/2006, 775.

Ebers Martin, „Information and Advising requirements in the Financial Services Sector: Principles and Peculiarities in EC Law", *Electronic Journal of Comparative Law* 2/2004, vol. 8, 238.

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Primer: Nataša Petrović Tomić, Miloš Radovanović, „Poravnanje o naknadi štete iz sredstava Garantnog fonda", *Harmonius, Journal of Legal and Social Studies in South East Europe*, 2017, 175.

Ako se citira članak sa više od tri autora, navodi se samo ime i prezime prvog autora, uz dodavanje skraćenice reči et alia kurzivom.

Primer: Farines Elise *et al*., , "The Pre-contractual and Contractual Infiormation in Life Insurance Policy", *Insurer's Precontractual Information Duty*, Turkish Chapter of AIDA, Istanbul 2013, 123.

v) Rad, odnosno članak objavljen u okviru zbornika radova ili knjige, koju je neko drugo lice priredilo kao urednik, se citira na sledeći način: ime autora, prezime autora, otvoreni navodnici, naziv članka, zatvoreni navodnici, naziv zbornika radova, odnosno knjige kurzivom, u zagradi oznaka „urednik" ili „ur." („editor" ili „ed."), „redaktor" i sl., i ime i prezime urednika, eventualno redni broj izdanja, mesto izdanja, godina izdanja, broj strane.

Primer: Nebojša Jovanović, „Otvaranje i zatvaranje privrednih društava", *Akcionarska društva, berze i akcije* (urednik Mirko Vasiljević), Beograd, 2006, 307.

Helmut Heiss, "The Common Frame of Reference (CFR) of European Insurance Contract Law", *Common Frame of Reference and Existing EC Contract Law* (ed. Reiner Schulze), Sellier European law publishers, GmbH, München, 2008, 13.

g) Kada se citira jedan članak određenog autora, kod ponovljenog citiranja se navodi prvo slovo imena sa tačkom i prezime, a potom broj strane.

Primer: N. Petrović Tomić, 164.

d) Kada se citira više članaka istog autora, kod ponovljenog citiranja se navodi prvo slovo imena sa tačkom i prezime, potom se u zagradi stavlja godina izdanja, i najzad broj strane.

Primer: N. Petrović Tomić (2014), 122.

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Primer: I. Jankovec (1995a), 16.

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a) Propisi se citiraju na sledeći način:

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Primer: Zakon o privrednim društvima, *Službeni glasnik RS*, br. 36/2011, 99/2011, 83/2014, 5/2015, čl. 13.

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Primer: Zakon o osiguranju – ZO, *Službeni glasnik RS*, br. 139/2014 i 44/2021, čl. 6 st. 3.

v) Član, stav i tačka propisa označava se skraćenicama čl., st. i tač., a paragraf skraćenicom par.

Primer: čl. 24 st. 1 tač. 5 ili par. 14.

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Primer: Zakon o privrednim društvima, čl. 7.

ZPU, čl. 25.

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Primer: nemački Trgovački zakonik iz 1897. godine (*Handelsgesetzbuch*), par. 29. britanski Kompanijski zakon iz 2006. godine (*Companies Act*; dalje u fusnotama: CA), čl. 67.

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Primer: Elisabeth Pollman, The Making and Meaning of ESG, Law Working Paper 659/2022, dostupno na adresi: http://ssrn.com/an+bstarct_id-4219857, 16. 6. 2023, 5.

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Primer: Elisabeth Pollman, The Making and Meaning of ESG, 5.

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Articles should be written in **Times New Roman, 12 pt font, with 1.5 line spacing**. The article in Serbian should be written in Latin script, except for foreign words and words in Latin, which should be written in Latin script and italicized.

The article must begin with the title, the full name and surname (of all) authors, the full (official) name and address (including the country) of the institution where the author is employed. The note at the bottom of the first page should include the email addresses (of all) authors, as well as their ORCID numbers.

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The article must also include an abstract and key words in English. The abstract and key words should be provided at the end of the article, after the References section.

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First-level heading – centered; numbering: Roman numerals (e.g., I, II, III, etc.); first letter capitalized, the rest lowercase.

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Example:
I Concept
Definition
a) *Definition in Comparative Law*
) French Legislation

REFERENCE STYLE

1. BOOKS

a) Books should be cited as follows: author's first name, author's last name, title of the work in italics, edition number if applicable, place of publication, year of publication, page number.

Example: Susan Hodges, *Cases and Materials on Marine Insurance Law*, Cavendish Publishing Limited, London, 2002, 74.

b) When citing a text from multiple pages that are specifically determined, separate the page numbers with a dash, followed by a period. If more than one page is cited from a text, but they are not specifically stated, after the number which notes the first page "etc." is added with a period at the end.

Example: Susan Hodges, *Cases and Materials on Marine Insurance Law*, Cavendish Publishing Limited, London, 2002, 74–80.

Example: Philip Wood, Principles of international insolvency, Sweet &Maxwell, London 2007, 111 etc.

c) When citing a book by multiple authors (up to three), their names are separated by commas.

Example: Katherine B. Posner, Tim Marland, Philip Chrystal, *Margo on Aviation Insurance*, Fourth edition, London, 2014, 429.

d) If citing a book with more than three authors, only the first author's name and surname are given, followed by the abbreviation *et al.* in italics.

Example: Hugh Beale *et al.*, *Contract Law*, 2nd edn. Bloomsbury Publishing, London, 2010, 54.

e) A book edited by someone is cited by adding the designation "editor" or the abbreviation "ed." in parentheses after their name.

Example: Fidelis Oditah (editor), *The Future for the Global Securities Market*, Oxford, 1996, 74. Jürgen Basedow *et al.,* (Hrsg.), *Anleger- und objektgerechte Beratung, Private Krankenversicherung, Ein Ombudsmann für Versicherungen*, Band 11, Nomos, Baden-Baden, 1999, 55.

f) When citing a single book by a specific author, in repeated citations, use the first initial of the first name with a period and the last name, followed by the page number.

Example: S. Hodges, 231.

g) When citing multiple books by the same author, in repeated citations, use the first initial of the first name with a period and the last name, followed by the year of publication in parentheses, and the page number.

Example: M. Vasiljević (2012), 107.

h) If the same page of the same source was cited in the previous footnote, the abbreviation for *Ibidem* should be used, in italics, followed by a period (without quoting the name of the author). (without repeating the author's last name and first name).

Example: *Ibidem*.

If the same source (but not the same page) was cited in the previous footnote, the abbreviation for Ibidem should be used, in italics, followed by the page number and a period.

Example: *Ibid.*, 23.

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a) Articles should be cited as follows:

Author's name, author's last name, title of the article in roman with quotation marks, name of the journal in italics, volume and year of publication, page number

(same rule as in the book citation). If the name of a journal is longer than usual, an abbreviation should be offered in brackets when it is first mentioned and used later on.

Example: Ebers Martin, "Information and Advising Requirements in the Financial Services Sector: Principles and Peculiarities in EC Law", *Electronic Journal of Comparative Law* 2/2004, vol. 8, 238.

b) When citing an article by multiple authors, their names and surnames should be separated by commas.

Example: Nataša Petrović Tomić, Miloš Radovanović, "Poravnanje o naknadi štete iz sredstava Garantnog fonda", *Harmonius, Journal of Legal and Social Studies in South East Europe*, 2017, 175.

If citing an article by more than three authors, only the first author's name and surname are to be cited, followed by the abbreviation *et al.* in italics.

Example: Farines Elise *et al*., "The Pre-contractual and Contractual Information in Life Insurance Policy", *Insurer's Precontractual Information Duty*, Turkish Chapter of AIDA, Istanbul 2013, 123.

c) A paper or article published in a proceedings or book edited by another person is cited as follows:

Author's first name, author's last name, opening quotation marks, title of the article, closing quotation marks, title of the proceedings or book in italics, in parentheses the designation "editor" or "ed.", and the name and surname of the editor, edition number if applicable, place of publication, year of publication, page number.

Example: Helmut Heiss, "The Common Frame of Reference (CFR) of European Insurance Contract Law", *Common Frame of Reference and Existing EC Contract Law* (ed. Reiner Schulze), Sellier European Law Publishers, GmbH, Munich, 2008, 13.

d) When citing an article by a specific author, in repeated citations, use the first initial of the first name with a period and the last name, followed by the page number.

Example: N. Petrović Tomić, 164.

e) When citing multiple articles by the same author, in repeated citations, use the first initial of the first name with a period and the last name, followed by the year of publication in parentheses, and finally the page number.

Example: N. Petrović Tomić (2014), 122.

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Example: I. Jankovec (1995a), 16.

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a) Regulations should be cited as follows:

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Example: Act XXVIII of 2017 on Private International Law of Hungary, *Magyar Közlöny*, 2017-04-11, vol. 54.

b) In case of repeated citations, an acronym should be provided on the first mention of a given statute or other regulation.

Example: Companies Act – CA, *Official Gazette of the Republic of Serbia*, No. 6/2011, 99/2011, 83/2014, 5/2015, 44/2018, 95/2018, 91/2019 and 109/2021.

c) Article, paragraph, and point of the regulation are designated with the abbreviations art. and par..

Example: Art. 8, par. 25.

d) When citing a regulation repeatedly, its full name or the abbreviation introduced in the first citation should be given, along with the abbreviations art. or par. and the provision number.

Example: CA, art. 58.

e) Regulations in foreign languages should be cited as follows:

Full name of the regulation translated into English, year of publication or adoption, opening parenthesis, full name of the regulation in the original language in italics, any abbreviation under which the regulation will continue to appear, closing parenthesis, abbreviation art. or par. and provision number.

Example: German Commercial Code of 1897 (*Handelsgesetzbuch*), par. 29.

4. ONLINE SOURCES

a) Online sources should be cited as follows:

author's first name and surname, or the name of the organization that prepared the text, title of the text, possible place and year of publication, the website address in italics, the date of access, and the page number.

Example: Elisabeth Pollman, "The Making and Meaning of ESG", Law Working Paper 659/2022, available at: http://ssrn.com/abstract_id=4219857, accessed June 16, 2023, 5.

b) When citing an online source repeatedly, use the first initial of the author's first name with a period and the surname, or the name of the organization that prepared the text, the title of the text, and the page number.

Example: Elisabeth Pollman, The Making and Meaning of ESG, 5.

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368

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