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COLLECTION OF THE BANK'S CLAIM UPON THE OCCURRENCE OF THE INSURED EVENT OF THE BORROWER'S DEATH

REVIEW SCIENTIFIC PAPER

Abstract

This paper examines the issue regarding the collection of bank claims in the event of the borrower's death, where the loan agreement is concluded with an insurance policy covering the risk of death, where it is stipulated that the bank is the insurance beneficiary or the policy is assigned in favor of the bank. If, following the occurrence of the insured event – death, it is determined that the borrower's health, i.e. the insured's, had been previously impaired, insurers may refuse the claim for payment to the insurance beneficiary – the bank, citing standard provisions on exclusions under the insurance contract and terms and conditions.

Through analysis of available sources and case law, this paper explores whether, in the event of the borrower's death, the bank is obliged to exhaust all possibilities for collecting the remaining loan debt from the insurer pursuant to the insurance policy, or whether it has the right to choose the order of collection. Specifically, the study examines whether the bank may demand collection of the debt from the borrower's heirs regardless of the concluded insurance agreement and without prior proof that collection from the insurer was not possible.

Keywords: claim collection, bank, insurance, borrower, death.

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I Introduction

The modern lifestyle and market conditions significantly influence the financial needs of the average consumer, who frequently takes out consumer loans to finance planned or unplanned expenses. However, it often happens that a borrower who has been regularly servicing a loan passes away or becomes credit-impaired due to reasons related either to the borrower personally (such as health issues or death, job loss, etc.) but also for other reasons (e.g. financial crisis, pandemic, etc.).[2] One of the instruments that banks often require alongside a loan agreement to enhance the certainty of claim collection is the conclusion of an insurance contract with an insurance company, where the insured is the borrower, i.e. the debtor under the contractual relationship with the bank. These insurance contracts arose as a result of the practical need for adequate loan collection security and represent one of the mechanisms that guarantee the collection of the bank's claims, while simultaneously providing protection to the borrower against future uncertain events to which they may be exposed during the course of what is typically a long-term contractual relationship with the bank. Equally, the insurance company has a clear interest in these arrangements, as it collects significant funds in insurance premiums and, in return, provides coverage against various risks, primarily death, and occasionally permanent disability or job loss.[3] Although coverage for temporary disability and loss of job is often contracted alongside death risk, due to the scope limitations of this paper, the analysis focuses on insurance protection of the borrower against the risk of death.

1. Types of Insurance Contracts for Borrowers

According to the statutory definition, under a loan agreement, the bank undertakes to make a specified amount of funds available to the borrower for a defined or indefinite period, for a specific purpose or without a specified purpose, while the borrower undertakes to pay the agreed interest and to repay the utilized amount of money at the time and in the manner stipulated in the contract.[4] When contracting insurance to protect consumer loan borrowers, there are two interdependent legal relationships that are mutually dependent: the loan agreement and the insurance contract. The loan agreement is concluded between the bank or another credit institution as the lender and the borrower, who is a natural person, i.e.

[2] Loris Belanić, Gabriela Mihelčić, „Određena pitanja iz osiguranja izvjesnosti namirenja tražbine kredita", *Zbornik radova s VI. međunarodnog savjetovanja "Aktualnosti građanskog procesnog prava - nacionalna i usporedna pravnoteorijska i praktična dostignuća"*, 315.

[3] Nataša Petrović Tomić, "Ugovor o osiguranju sposobnosti vraćanja kredita", *Anali Pravnog fakulteta u Beogradu*, year LXV, No. 2/2017, 92.

[4] The Law of Contract and Torts, Art. 1065.

a consumer. The choice of insurance type depends on the credit arrangement. For mortgage loans, it is common to conclude a property insurance contract, where the insured property is real estate (house or apartment) for which the purchase funds are provided through the mortgage loan, so the bank wishes to protect itself from the potential risk of destruction of the property. For purpose-specific loans, such as loans for the purchase of motor vehicles or construction machinery, one of the means of securing claims typically required is a comprehensive (casco) insurance policy, assigned in favor of the bank.

Insurance contracts covering the risk of death of the borrower, which serve as instruments for satisfying the bank's claims, appear in practice in various modalities. The most common are: the loan repayment ability insurance contract, which belongs to non-life insurance (risk type 14.02 – insurance of other types of claims) and the life insurance contract of the borrower (risk type 19.02 – life insurance in case of death).[5]

Within the framework of a thematic survey conducted by the European Insurance and Occupational Pensions Authority (EIOPA), covering 174 insurance companies and 145 banks across Europe over a two-year period (2018–2020),[6] found that the claims ratio for consumer loan borrower insurance amounts to 18%, while for credit card users only 8%. This confirms that credit repayment ability insurance is equally profitable for both banks and insurance companies. In Bosnia and Herzegovina, there is no uniform reporting model by the entity regulatory agencies, making it difficult to determine the exact number of policies and premium amounts for these types of insurance at the national level, as well as theclaims-to-premiums ratio.[7] However, according to publications from the National Bank of Serbia (NBS)[8] and the Croatian Financial Services Supervisory Agency (HANFA),[9] this type of insurance is widespread, particularly in consumer lending, with approximately 100,000 policies contracted annually in these countries.

[5] In the Federation of Bosnia and Herzegovina, the types of risks are defined by the Decision on the Classification of Risk Types by Insurance Groups and Classes, *Official Gazette of the Federation of BiH*, No. 82/17.

[6] EIOPA, Credit Protection Insurance (CPI) Sold Via Banks, study published on 28 September 2022; a thematic review of the study is available at: *https://www.eiopa.europa.eu/publications/thematic-review-credit-protection-insurance-cpi-sold-banks_en, acc,* accessed on 5 January 2026.

[7] The Insurance Supervision Agency of the Federation of Bosnia and Herzegovina does not present data in its reports on the total number of policies and the amount of premiums separately for individual insurance groups (credit insurance, life insurance); instead, the data are provided on an aggregated basis. Consequently, it is not possible to determine the above-mentioned data relating to insurance products that fall under the referenced risk types 14.02 and 19.02. In Republika Srpska, periodic reports include data broken down by risk types within each insurance group. Accordingly, in 2025, premiums collected for term life insurance (risk 19.02) amounted to BAM 13,743,938.00 (approximately EUR 7 million), while claims paid totaled BAM 2,902,162.00 (approximately EUR 1.5 million).

[8] NBS, *https://www.nbs.rs/sr/scripts/showcontent/index.html?id=17992&konverzija=no*, accessed on 25 January 2026.

[9] HANFA, *https://www.hanfa.hr/statistika/drustva-za-osiguranje-i-drustva-za-reosiguranje/,* accessed on 25 January 2026.

1.1. Credit Repayment Ability Insurance Contract

Credit repayment ability insurance contract covers the risk of the borrower's death, as well as the risk of the inability to repay the loan in the event that the borrower loses a job or becomes incapable of working during the term of the loan agreement. If a single contract or policy covers all of these risks, interpretation of the insurance company's terms leads to the conclusion that this is property (non-life) insurance, as its primary function is damage compensation.[10]

Credit repayment ability insurance has its origins in *common law* legal tradition,[11] but over time it has spread as a significant mechanism for protecting borrowers in continental European jurisdictions as well.[12] Although it can be concluded on an individual basis, in practice, credit repayment ability insurance is typically concluded collectively, whereby the contracting party is the bank that concludes insurance policies with the borrowers, provided that they are eligible for insurance within the meaning of the terms, i.e. general rules of the insurance company for the specified type of insurance. The contract with the borrower – the insured – is concluded by signing an accession statement and paying the premium by the insured. This insurance is classified as property insurance because it protects the insured's assets and property interests, namely, it protects them from financial losses to which the insured or their legal heirs may be exposed if one of the insured risks occurs.[13]

The terms and conditions of credit repayment ability insurance predominantly impose certain limitations regarding the insured person, primarily relating to entry age (usually 18 to 65 years) and circumstances related to employment and work status. One of the assumptions frequently included in the terms is that *the insured is in good health and not under medical treatment or supervision*. The terms strictly stipulate that the insurer is not obligated to verify the truthfulness of the information provided in the accession statement (it is presumed that the bank is also not obligated to do so). However, upon the occurrence of an insured event, the insurer may request documentation, including the insured's medical record to verify the truthfulness of health status statements in the accession statement.[14]

[10] N. Petrović Tomić, 94.

[11] Francesco Amici, „Credit Protection Insurance: Too Good to Be True? Actual Challenges and Future Applications", *Dialoghi di dirito dell'economia*, 1/2025, 224.

[12] This type of insurance is referred to in English as *Credit Protection Insurance* (abbreviated: CPI).

[13] N. Petrović Tomić, 95.

[14] See for example: General Terms and Conditions for Group Credit Repayment Ability Insurance for Users of Unsecured Cash Loans, Sava osiguranje d.d., Zagreb, Article 4, available at: *https://www.slatinska-banka.hr/wp-content/uploads/S.O-19.02-2-Grupno-osiguranje-sposobnosti-za-vracanje-kredita-6.9.2022.cdr_.pdf*, accessed on 6 January 2026.

1.2. Life Insurance Contract for the Borrower

Another modality of insurance used as a mechanism to secure loan repayment is a life insurance contract for the borrower, which covers the risk of the borrower's death. In this type of insurance, the survival risk is generally not covered, and no savings component is included. Given that it only covers the risk of death, in insurance terminology it is classified as "term life insurance". Under a life insurance contract, the insurer undertakes to pay the sum insured or annuity to the insured or to a person designated by them in case of death or upon reaching a certain age, while the policyholder undertakes to pay the insurance premium.[15]

A life insurance contract, whether concluded individually or collectively, with a policy assigned in favor of the bank, has the same purpose as credit repayment ability insurance contract, which is to pay the loan borrower's debt to the bank in case of their death. However, in practice, credit repayment ability insurance is much more favorable for the insured, as it also provides coverage in the event of job loss or disability, and unlike life insurance, the procedure for contracting it is maximally simplified, without conducting a medical examination.

The term life insurance provides protection for the borrower against the risk of death with a decreasing sum insured, meaning that the sum insured decreases proportionally with the duration of the credit, i.e. its repayment. Given the classification and the nature of the insurer's obligation, this type of insurance falls under personal insurance, i.e. sum insurance. Unlike credit repayment ability insurance, the terms of term life insurance sometimes contain a very imprecise provision regarding eligibility for concluding a contract, according to which *healthy persons* of entry age from 18 to 75 years who have concluded a loan agreement with the bank can be insured.[16] If a person is not completely healthy, insurance can still be provided under special terms for increased-risk insurance.

II Risk Assessment and Informing the Insured – the Borrower

The disclosure of circumstances relevant to risk assessment is one of the fundamental obligations of the policyholder in all types of insurance contracts. The obligation to disclose circumstances important for risk assessment is of a pre-contractual nature and is based on the principles of good faith (*bona fides*) and conscientiousness and honesty (*Treu und Glauben*).[17] The insurance contract is

[15] Predrag Šulejić, *Pravo osiguranja*, Dosje, Belgrade 2005, 471.

[16] Article 2 of the Terms and Conditions for Life Insurance in the Event of the Borrower's Death with a Decreasing Sum Insured, "Croatia osiguranje" d.d. Mostar (author's archive).

[17] Barbara Preložnjak, „Pravna priroda ugovora o osiguranju života vezanog uz investicijske fondove", *Zbornik Pravnog fakulteta u Zagrebu*, 61, (3) 967-1010 (2011), 975.

often referred to as a contract of utmost good faith (*uberrimae fidei*), which implies maximum transparency between the contracting parties. In insurance contracts, this refers to the policyholder's obligation to provide accurate and truthful information about circumstances material to risk assessment, as well as the insurer's obligation to timely and fairly inform the policyholder about the content of insurance coverage. Thus, in the pre-contractual phase, the policyholder's primary obligation is to disclose to the insurer all circumstances that are material for risk assessment, whether known to them or which could not have remained unknown to them.[18] The insurer, who undertakes an obligation conditional upon unknown circumstances, must rely on the policyholder not to mislead them regarding facts that are decisive for risk assessment.

In credit repayment ability insurance, the pre-contractual duty to disclose circumstances material to risk assessment rests with the borrower – the insured. This is because, despite the undoubted beneficial effect of credit repayment ability insurance, the insurance terms often include numerous exclusions. For example, in the case of death, risks arising from pre-existing health conditions are excluded, while in the case of job loss, the risk is often excluded if it occurs during seasonal or temporary work. However, from the technique of concluding an insurance contract through the so-called bank channel, it is evident that this is a typical accession contract where the insured, by completing the accession statement, provides basic information about their health status, while simultaneously signing authorization for the bank and the insurance company to obtain documentation or information from doctors and health institutions necessary for the insurer to make a decision on acceptance into insurance or on the merit of the claim for payment of the insured sum if an insured event occurs. When contracting insurance, the bank often does not provide sufficient information to the borrower – the insured regarding the content of coverage and conceals circumstances that fall under exclusions.[19]

The terms and conditions of credit repayment ability insurance refer to the provisions of the Law of Contracts and Torts (LoCT) and contain parallel provisions that detail the borrower's obligations regarding disclosure of circumstances material to risk assessment, as well as the consequences of nondisclosure or untruthful disclosure thereof. Nevertheless, analysis of these Terms shows that they **do not contain an obligation for the Bank to inform the insured** about their duties to disclose the mentioned circumstances and the consequences that may arise in the event of an insured occurrence if, in contracting death risk coverage, the borrower fails to disclose or conceals circumstances related to their pre-existing health condition.

[18] The Law of contract and torts, Art. 907.
[19] F. Amici, 231.

1. Avoidance of the Insurance Contract Due to Non-Disclosure of Circumstances Material to Risk Assessment

The terms and conditions of certain insurance companies in BiH prescribe immediate termination, loss of all rights, and automatic nullity of credit repayment ability insurance contracts, granting the insurer the right to claim damages if, after the occurrence of the insured event – death, it is established that some of the information provided when completing the accession statement was inaccurate and incomplete. This provision is problematic for several reasons. Namely, the provisions of the Law of Contracts and Torts (LoCT) regarding the obligation to disclose circumstances material to risk assessment and the consequences of non-disclosure are not of a dispositive nature and therefore cannot be changed by insurance terms, particularly not to the detriment of the insured. On the contrary, these are mandatory norms where, in order to protect the weaker party, preconditions for avoidance and termination of the contract are prescribed if the policyholder has not fulfilled their mentioned pre-contractual obligation. Furthermore, a judicial procedure must be conducted to establish that the contract is void and all consequences that arise therefrom.

In term life insurance, limitations and exclusions from coverage apply only in cases of suicide, intentional homicide, death due to military operations, or the influence of alcohol and narcotic substances. Therefore, in this type of insurance, providing false or incomplete information regarding the insured's health in the application statement does not entail contract nullity. Although not explicitly stated, it can be concluded that the insurer may only establish the inaccuracy and incompleteness of data by reviewing the insured's medical records and other medical documentation, which typically occurs only after the occurrence of an insured event.

The Law of Contracts and Torts (LoCT) distinguishes between intentional and unintentional misrepresentation or concealment of circumstances. In the first case, it gives the insurer the right to request contract avoidance with *ex tunc* effect, whereas in the second case, the insurer may terminate the contract *ex nunc*. Article 908 of the LoCT prescribes the consequences of **intentional** misrepresentation or concealment of circumstances material to risk assessment. If the policyholder intentionally provides false information or intentionally conceals a fact such that the insurer would not have concluded the contract had they known the true state of affairs, the insurer may request contract avoidance. The period for filing an avoidance is three months from the day the insurer becomes aware of the misrepresentation. From the cited statutory provisions, it is evident that the sanction of nullity depends on the insurer's will. If the insurer requests contract avoidance by lawsuit and has compensated the loss to the negligent insured, they may seek return of the executed compensation and retain the collected premium. It is essential that the insured must have had the intention to conceal material facts, and the burden of proof of that

intent rests with the insurer. If the inaccurate disclosure was made **without intent**, the sanction is less severe. According to Article 909 LoCT, if the policyholder has made an inaccurate statement or failed to provide due notification, without intent, the insurer may, at its option, within one month of becoming aware of the inaccuracy or incompleteness, either declare the contract terminated or propose an increase in premium proportionate to the greater risk.

The credit insurance contract cannot be classified as absolutely null and void under Article 103 of the Law of Contracts and Torts, which are contrary to mandatory provisions and public order, and whose nullity can be invoked by any interested person at any time. On the contrary, contract avoidance can be requested by the insurer only in the above-mentioned specifically determined cases and within the prescribed periods. Therefore, such contracts are voidable. Interpretation of Article 908 of the Law of Contracts and Torts leads to the conclusion that this is not a contract without legal effect; rather, the insurer is given the possibility to request avoidance by lawsuit. Thus, the legislator's intention was to treat misrepresentation or concealment of circumstances material to risk assessment as a defect of will, resulting in the voidable nature of the insurance contract. Accordingly, the insurer may file a lawsuit within one year from the day of learning of the reasons for voidability, or within the objective period of three years from contract conclusion (Article 117 LoCT). Here, a statute of limitations problem may arise as a credit insurance contract is typically long-term, and by the time the insurer becomes aware of the misrepresentation, the objective three-year time limit has already expired.

In two cases, the courts of the Republic of Serbia decided on lawsuits for contract avoidance filed by the insurance company against the bank and the heirs of deceased borrowers. In the first case, the insurer filed a lawsuit after reviewing the medical documentation following a compensation claim, before the expiration of the three-month time limit from discovering the concealed circumstances. The court granted the lawsuit under Article 908 and voided the insurance contract, finding that the borrower had concealed a prior diagnosis of malignant disease when entering into the contract.[20] In the second case, the court was guided by general provisions on contract voidability and dismissed the insurer's claim because the subjective period had expired from learning of the reason for voidability had expired, i.e. from the day when the examining doctor's report established that death occurred as a consequence of a disease which the insured had concealed when contracting insurance, and furthermore, the objective three-year time limit from contract conclusion had also passed.[21]

[20] Judgment of the Basic Court in Bečej, Case No. P-135/17, dated 23 April 2018.

[21] Judgment of the Basic Court in Novi Sad, Case No. P-4659/15, affirmed by the Judgment of the Higher Court in Novi Sad, Case No. Gž-1766/2017.

From the above, it can be concluded that provisions in insurance terms stipulating immediate termination, loss of all rights, and automatic nullity of credit repayment ability insurance contract with the insurer's right to compensation, if after the insured's death it is established that some of the data provided when concluding the contract were inaccurate and incomplete, do not produce legal effect automatically as stated therein. Rather, **a court proceeding to avoid the contract must be initiated by the insurer**, with the risk that the claim may be dismissed if the court applies exclusively the general provision on voidable contracts under which the objective three-year time limit from contract conclusion applies.

2. Legislative Basis for the Obligation to Inform the Insured – Credit User

In Bosnia and Herzegovina, the state-level regulation, namely the Law on Consumer Protection in BiH, provides that a bank, as the creditor, is obliged to provide the credit user with a written notice containing information on the costs of insurance concluded in connection with the credit.[22]

The excessive issuance of consumer credits at the beginning of this century was one of the motives for adopting a new entity-level special regulation in the Federation of BiH, namely the **Law on the Protection of Financial Services Users**,[23] which primarily relies on Directive 2008/48/EC on consumer credit agreements.[24] The law proceeds from a restrictive approach in defining the consumer as a natural person and regulates in detail the obligations for pre-contractual and post-contractual information, as well as the right to withdraw.[25] However, the scope of application *ratione materiae* includes banking services, leasing, microcredit, and special financial agreements, but does not cover insurance services.[26]

In terms of informing credit users about the obligation to conclude ancillary service contracts, which particularly include insurance contracts, the aforementioned

[22] Arts. 54 and 55 of the Law on Consumer Protection of Bosnia and Herzegovina, *Official Gazette of BiH*, Nos. 25/2006 and 88/2015.

[23] Law on Protection of Financial Service Users, *Official Gazette of the Federation of Bosnia and Herzegovina*, No. 31/14.

[24] Directive 2008/48/EC of the European Parliament and of the Council of 23 April 2008 on credit agreements for consumers and repealing Council Directive 87/102/EEC, OJ 2008, L 133/66. Article 5 of the said Directive provides that, prior to the conclusion of the contract, the consumer must be given clear information, including any obligation to conclude ancillary services, in particular insurance, their cost, and their impact on the total amount of credit.

[25] For a detailed analysis of the Law on the Protection of Users of Financial Services of the Federation of Bosnia and Herzegovina, see: A. Petrović, "Novo pravno uređenje financijskih usluga u BiH – koliko su korisnici stvarno zaštićeni?", *Zbornik Pravnog fakulteta u Nišu*, No. 70, Year LIV, 810.

[26] Jasmina Đokić, „Pravni okvir zaključenja ugovora o osiguranju na daljinu", *Zbornik 31. susreta osiguravača i reosiguravača – SORS,* Sarajevo, 2021, 171; Nenad Grujić, „Pravne dileme u vezi sa načinima zaključenja ugovora o osiguranju na daljinu – putem mobilne aplikacije i internet prezentacije", *Tokovi osiguranja*, br. 1/2024, 105-118 .

Law prescribes the bank's obligation whereby, if concluding an ancillary service contract – particularly an insurance contract, is *mandatory* for concluding a loan agreement, the existence of such obligation must be indicated clearly and prominently, together with the indication of the effective interest rate. Therefore, the cited provisions relate only to transparency in the pricing of insurance services[27] and the duty to inform the credit user about the obligation to conclude ancillary service contracts.[28] Although these services are predominantly sold by the bank as the insurance company's agent, there is no prescribed obligation to inform the user about the very content of those services.

III European Legal Framework on Linking Credit Agreements and Insurance Contracts

Directive (EU) 2016/97 on Insurance Distribution (Insurance Distribution Directive, hereinafter: IDD)[29] establishes a series of substantive and procedural restrictions aimed at preventing unfair practices and strengthening consumer protection.[30] Based on the fundamental obligation of insurance distributors to act fairly, professionally, and in the best interests of the consumer, the IDD allows linking credit and insurance only under the condition that such practice does not disrupt the balance of contractual parties or impose products on the consumer that are unsuitable for their actual needs.

Special rules on so-called *cross-selling* require insurance distributors to inform consumers clearly and understandably of the possibility of concluding an insurance contract independently of the credit agreement.[31] This limits hidden linking and ensures that the consumer's consent to take out insurance along with credit is real and informed, not merely formal.

The IDD also establishes additional standards of conduct and distributor obligations in the pre-contractual phase.[32] From the bank's perspective as a distributor, this primarily means that the bank is obliged, before concluding the contract, to assess the consumer's needs and propose insurance appropriate to the amount, duration, and risks of the specific credit agreement. Insurance with broad exclusions or whose terms significantly limit the possibility of paying the sum insured cannot be

[27] Law on Protection of Financial Service Users of the Federation of Bosnia and Herzegovina, Arts. 11 and 14.
[28] Law on Protection of Financial Service Users of the Federation of Bosnia and Herzegovina, Art. 15.
[29] Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (recast), Text with EEA relevance, *OJ L 26, 2.2.2016*, 19–59.
[30] Jasmina Đokić, „Customers Protection in Insurance Distribution Directive: an Overview on Harmonization of Legislation in Bosnia and Herzegovina", *Balkan Yearbook of European and International Law,* Springer, 2021, 125.
[31] Article 24 of the Insurance Distribution Directive (IDD).
[32] Article 20 of the Insurance Distribution Directive (IDD).

considered a legitimate means of consumer protection, and forcing such insurance along with credit may constitute unfair linking under IDD.

The problem of insured non-information in credit protection insurance was also addressed in the previously mentioned EIOPA study. Based on the analysis of different types of insurance concluded for housing and consumer loans in member states, along with statistics on claims paid by type of contracting (group or individual), the general conclusion is that in group contracts through the bank with premiums paid alongside other credit costs, the percentage of claims paid is significantly lower than in individual contracts. The high number of rejected claims by insurers is due to poor information provided to insureds during the pre-contractual phase.[33] EIOPA recommendations and guidelines concerning *credit protection insurance* indicate the need to reduce information asymmetry, strengthen the quality of advice, and prevent systematic rejection of compensation claims in group insurance.

1. Bank as Representative of the Insurance Company – the Question of the Duty to Inform

In Bosnia and Herzegovina, the entity-level Banking Laws enable banks to engage in insurance representation activities. In the Republic of Srpska, banks are authorized to perform representation, i.e. intermediation services in insurance,[34] while in the Federation of BiH, banks are allowed to provide only insurance intermediation services.[35] However, given the nature and scope of the insurance sales activities performed by banks, these services cannot be considered mere intermediation services but rather exclusively insurance representation; therefore, the aforementioned legislative formulation in the FBiH is completely incorrect.

Theoretically, a credit user in BiH can conclude insurance individually, but in practice, the user is not so free; rather, the bank assumes the role of insurance policyholder. In this case, the bank's role is threefold: besides being the group insurance policyholder for credit users, the bank also appears as the insurance company's representative and performs agency services for an agreed fee (commission), and at the same time is the insured party in the event that the insured risk occurs. Another specificity of this type of contract is that the bank, as the policyholder, is not obligated

[33] EIOPA, Credit Protection Insurance (CPI) Sold Via Banks, study published on 28 September 2022., a thematic review of the study is available at: *https://www.eiopa.europa.eu/publications/thematic-review-credit-protection-insurance-cpi-sold-banks_en*, accessed on 5 January 2026.

[34] Law on Banks of Republika Srpska, *Official Gazette of RS*, Nos. 4/2017, 19/2018 – corrigendum, 54/2019, 65/2024, and 45/2025, provides in Article 3 that banking activities include insurance representation and intermediary services, in accordance with the regulations governing insurance agency and intermediation.

[35] Law on Banks of the Federation of Bosnia and Herzegovina, *Official Gazette of the Federation of BiH*, Nos. 27/17 and 22/25, stipulate that banking activities include, *inter alia*, insurance intermediation, in accordance with the regulations governing insurance intermediation.

to pay the premium under the general provisions of the Law of Contracts and Torts (LoCT); this obligation rests with the insured, i.e. the credit user.

From the technique of concluding contracts for both types of insurance, it can be concluded that these are adhesion contracts, i.e., accession contracts where, according to currently applicable regulations in Bosnia and Herzegovina, the insured's bargaining power is limited because the contract between the bank and the insurance company disrupts the insured's right to choose whether to conclude an insurance contract at all and with which insurance company they will conclude such a contract. Framework agreements between the bank and the insurer give the bank exclusive right to agency to arrange insurance for an agreed fee.

As the exclusive representative of the insurer, the bank has all the duties prescribed for insurance representatives under the LoCT and the Law on Insurance Intermediation in Private Insurance of the Federation of Bosnia and Herzegovina,[36] i.e. the Law on Insurance Intermediaries, insurance and reinsurance of the Republic of Srpska,[37] which is initiating, preparing, proposing, and performing preparatory work until contract conclusion, or only contract conclusion, on behalf of and for the account of the insurance company.

Since the insurer authorizes the bank to perform all the aforementioned tasks, it implied that the Bank official – in the capacity of insurer's representative, has the duty before concluding the contract to inform the credit user, i.e. future insured, about the content of the insurance coverage, i.e. risks that are covered and those that are excluded, to whom compensation is paid if the risk occurs, etc. Particular attention should be given to explaining the duty to disclose circumstances material for risk assessment. As noted earlier, the disclosure of circumstances material for risk assessment, which are known to the insured or could not reasonably be unknown to them, constitutes the insured's obligation contained in Art. 907 of the LoCT, and also reflects the principle of conscientiousness and honesty in establishing an obligation as a mandatory norm contained in Art. 12 of the LoCT.

However, we shall repeat that the insurance companies' terms do not impose on the Bank the obligation to inform the insured of the duties and consequences of providing false or incomplete information about their health. The burden of guaranteeing the accuracy and completeness of the information lies entirely on the insured. The duty to inform the insured/credit user should consist of familiarizing them with the provisions of the insurance terms.

By giving consent in the accession statement, the insurance policyholder – the bank and the insurer have authorization, but also the duty, to obtain from the

[36] Article 906 of the LoCT and Article 6 of the Law on Insurance Intermediation in Private Insurance of the Federation of Bosnia and Herzegovina, *Official Gazette of the Federation of BiH*, Nos. 22/2005, 8/2010, and 30/2016.

[37] Article 4 of the Law on Insurance Intermediaries, Insurance and Reinsurance of Republika Srpska, *Official Gazette of RS*, No. 47/17.

insured/credit user, and from all doctors and healthcare institutions that the insured has consulted regarding their physical or mental health, documentation or information necessary for the insurer to make a decision on accepting the insured into insurance. The insurer's decision on the acceptability of the credit user for insurance access or possibly access to insurance under special conditions (abnormal risk) should depend on the information collected. However, in practice, credit user insurance contracts are often concluded "automatically", meaning that a bank official does not apply an individualized approach when concluding an insurance contract. On the contrary, if concluding an insurance contract is stipulated as one of the collaterals securing loan collection, the insurance accession statement is given to the credit user with other documents, which the user signs without paying attention to the content or potential consequences, and thus sometimes unintentionally provides false answers to questions about any previously impaired health status.

Given that, as we have seen, the current European regulation largely permits autonomy in contracting insurance, and thereby limits monopolistic conduct of banks and insurance companies, it is necessary to align domestic entity-level Laws on insurance representation and intermediaries with the IDD in the future in order to regulate in more detail the obligation to act in the best interest of consumers, transparent and comprehensive pre-contractual information of all insurance distributors, including banks acting as insurer's agents. Future regulations should explicitly provide for the bank's obligation to provide the loan beneficiary, in a clear and comprehensible manner, with information about the scope of insurance coverage, insurance exclusions, and the consequences of inaccurate or incomplete disclosure of circumstances material to risk assessment.

2. The Law on the Protection of Financial Services Users in Serbia

In the Republic of Serbia, a new Law on the Protection of Financial Services Users was recently adopted,[38] which significantly improves the protection of credit users when loans are concluded with an insurance contract. In doing so, the law distinguishes between the so-called tying of services and the practice of bundling services, where "tying" means concluding a credit agreement in a package with insurance services or other services as a mandatory condition for concluding the contract (the credit agreement cannot be concluded without these additional services). And "bundling" means that a credit agreement can be concluded without the mentioned collateral, but not necessarily under the same conditions as those with tied services. Article 53 of the cited Law concerns the conclusion of insurance policies and aims to achieve a balance between the interests of banks and insurance companies on

[38] Law on the Protection of Financial Services Users of the Republic of Serbia, *Official Gazette of RS*, No. 17/25.

the one hand and credit users on the other. These provisions are clearly drafted to harmonize with the rules of the IDD. Namely, the Law gives the bank the right to require credit users to conclude a certain type of insurance, but it must consider the proportionality between the loan amount and the required insurance policy. On the other hand, it gives credit users the right to choose: they can conclude an insurance policy individually and with another insurer, and are not limited to joining the group insurance contract with the insurer recommended by the bank. The bank is obliged to accept such a policy. The only limitation prescribed to the credit user's previous health condition is that when issuing an insurance policy linked to a credit agreement, personal data regarding cancer diagnoses may not be used if more than 15 years have passed since the end of treatment. Given that insurance companies' accession statements most often include questions about prior cancer diagnoses, it can be expected that the text of these statements and insurance companies' terms will need to be adjusted to this provision. Only information on cancer diseases that occurred within the last 15 years may be used in the risk assessment of the credit user.

The Law still allows tying of services for a credit agreement if the bank can demonstrate that such tying would result in clear benefits for the credit users, provided that the procedure is approved by the National Bank of Serbia (NBS) through a special process established by the NBS. Thus, the Law limits the discretionary imposition of a specific insurance policy on a credit user by the bank, while such tying may be approved if it is in the credit user's interest, with the bank bearing the burden of proof before the NBS. The Law on Protection of Financial Service Users of Serbia is a more recent regulation, so it will certainly be interesting to see whether such a strict regulation will affect the development of bancassurance.

IV Order of Bank Claims Collection in the Event of the Borrower's Death

To determine the order in which a bank may satisfy its claims in the event of the borrower's death, we first proceed from the type and purpose of the insurance contract. In cases of credit protection insurance and term life insurance for the borrower, when a group insurance contract is concluded, the borrower's position is limited because they are required to enter into an insurance contract in order to have the credit approved.

Here we shall pose the question: what would happen if a borrower of a purpose-specific or mortgage loan refused to conclude an insurance contract? Would their credit application be denied? Since one of the contractual obligations under the credit agreement is the payment of a one-time insurance premium, the conclusion is that the credit would not be approved, because the insurance policy is one of the mandatory collaterals specified in the credit agreement. The agreement

clearly specifies the amount of the borrower's financial obligation for the insurance premium, and the method of fulfilling that obligation is clearly and unambiguously stated (e.g. the premium is paid from the approved loan funds or paid in advance).

By reviewing the Terms of credit repayment ability insurance[39] and the Terms of term life insurance for credit users[40] of several insurance companies in the region, similar rules of procedure in the event of the borrower's death can be established. In essence, it can be concluded that, in order to realize rights from the insurance contract, the obligation to report the insured event lies with any person who can prove an undoubted legal interest.[41] This means that the insured event can be reported by the bank as an insurance beneficiary, but also by the insured's heirs, because they have a justified interest in having the remainder of the loan debt be paid by the insurance company.

Although credit protection insurance in any of its forms represents a significant way of protecting the interests of the borrower, since it protects the borrower's heirs from financial burden in case of the borrower's death, enables the bank to collect the remainder of the debt from the insurer as a solvent debtor, and provides the insurance company with substantial premium income, certain disagreements sometimes arise after the occurrence of the insured event, namely the borrower's death. Specifically, during claim processing, the insurer verifies the accuracy and credibility of the borrower's health status by reviewing medical records and other health documentation. If, in the course of this procedure, the insurer determines that the insured's health had previously been impaired, the insurer may deny the claim, relying on policy exclusions in accordance with the insurance contract and the terms and conditions of insurance that are constituent parts of the contract.

Taking into account the purpose and goal of the borrower's insurance, it can be concluded that when joining group insurance is one of the conditions for entering into the credit agreement, and the risk of the borrower's death materializes, the order of application of compulsory measures for the collection of the bank's claim implies priority collection under the insurance policy, with any remaining amount to be collected through other enforcement measures specified in the credit agreement. Accordingly, the bank is required to exhaust all collection options from the insurance company, and may resort to other enforcement measures only if such collection is not achieved.

[39] See, for example: the Terms and Conditions for Insurance of the Repayment of Unsecured Loans, Croatia osiguranje d.d., Zagreb (author's archive).

[40] See, for example: the General Terms and Conditions for Life Insurance in the Event of the Borrower's Death, Lovćen osiguranje a.d., Podgorica; the General Terms and Conditions for Life Insurance of Housing Consumer Loan Borrowers, Generali osiguranje d.d., Zagreb (author's archive).

[41] Loris Belanić, Ugovor o osiguranju sposobnosti vraćanja kredita prema uslovima osiguranja hrvatskih društava za osiguranje, kritika i prijedlozi reforme u poredbenom pravu, *Evropska revija za pravo osiguranja*, No. 1/2012, 74.

1. Case Law on the Order of Bank Claims Collection

We point out the inconsistency in case law in Bosnia and Herzegovina regarding the order of bank claim collection.

In the first example, the bank, as plaintiff in a dispute against the heirs of the deceased borrower, failed to prove that it had filed a claim against the insurance company before filing the lawsuit against the heirs, even though a group credit repayment insurance policy had been concluded alongside the credit agreement. As a result, in the second-instance proceedings, the lawsuit was dismissed with the explanation that the policy was assigned in favor of the bank, which serves as a means of securing loan repayment, to which the bank, as plaintiff agreed. In this situation, the court held that the bank "*was not entitled to seek compensation from the borrower's heirs, but only from the insurance company, since the insurance was ultimately paid for by the borrower for this specific purpose*".[42]

In the second case, there was also a court dispute between the bank and the heirs because the insurance company, in out-of-court proceedings, rejected the bank's claim invoking insurance terms according to which mentally ill persons cannot be insured, and in the process of processing the compensation claim it was established that the borrower had suffered from psychological disorders. However, the court concluded that the heirs were not obliged to repay the remaining debt because the deceased had taken out the insurance policy as security.[43]

As we can see, in the first case, the bank did not prove that it had approached the insurer for claim collection, while in the second case the bank did not exhaust all possibilities of collection from the insurer.

2. Supreme Court of FBiH – Three Different Interpretations

The Supreme Court of the FBiH interpreted the order of bank claims collection in the event of a borrower's death in three recent judgments issued within a short time interval adopted different stances. In the first case, the Court held that

[42] Judgment of the Cantonal Court in Zenica, Case No. 42 0 1 P 019832 23 Gž, dated 5 September 2023.

[43] Judgment of the District Court in Banja Luka, Case No. 71 0 P 314359 22 Gž, dated 8 June 2022, excerpt from the reasoning: *"From the General Terms and Conditions for Personal Accident Insurance arises the obligation of the insurance company to pay the sum insured, i.e. the amount of the remaining debt under the loan agreement concluded between the plaintiff and the defendants' predecessor. The insurance company with which the plaintiff maintains a business relationship had the opportunity to determine the insured's health status, as clearly and expressly explained by the court of first instance. The insurance company is liable to the plaintiff… because the plaintiff itself required the defendants' predecessor, as a means of securing the claim, to conclude an insurance contract, since in the event of the borrower's death the plaintiff would recover claim from the insurance company, in accordance with Article 897 of the LoCT. Given that the insured event has occurred and the insurance contract has not been avoided, there is no liability on the part of the heirs, as correctly concluded by the court of first instance."*

"*when a credit insurance and assignment of the insurance policy in favor of the loan provider, upon occurrence of the insured event-the borrower's death, a primary obligation arises for the lender to enforce its rights under the assigned insurance policy against the insurer, and subsidiarily, if this claim is unsuccessful, may the bank seek repayment from the borrower's heirs. Accordingly, the subsidiary claim cannot be pursued as long as the primary claim arising from the assigned insurance policy is not exhausted...*"[44]

However, shortly after the cited judgment, the Supreme Court of the FBiH issued a different judgment on the same type of legal matter, holding that it is not necessary for the bank to initiate court proceedings against the insurer before attempting collection from the heirs. In case of a negative outcome of out-of-court proceedings conducted against the insurer, the bank may initiate court proceedings against the heirs, but **the bank is obligated in those proceedings to prove that the insurer justifiably rejected the claim**, i.e. that the insured when concluding the insurance policy did not provide accurate data about their health status, whereby there arises a reason for excluding the insurer's obligation to pay the sum insured.[45] However, in the aforementioned judgment, the factual situation was specific, i.e. the insurer justifiably rejected the claim for payment of the sum insured, which was proven in court proceedings initiated against the heirs of the credit user/insured.

We have one more interesting interpretation in a recent judgment of the Supreme Court of the FBiH, where in revision proceedings the bank's lawsuit against the heirs of the borrower was dismissed.[46] This was a dispute regarding the collection of the remaining debt following the borrower's death, and alongside the loan agreement, a life insurance policy had been concluded for the borrower and assigned in favor of the bank. The borrower died from the consequences of COVID-19, and in out-of-court proceedings the insurer rejected the claim, invoking inaccurate disclosure of material circumstances by the borrower in the pre-contractual phase, namely that he had concealed suffering from hypertension and type 2 diabetes. According to the court's reasoning, given the agreed assignment, the heirs could not seek payment of the sum insured from the insurer; only the bank was entitled to do so. Accordingly, the bank has the right to priority payment of the sum insured, and the purpose of this insurance is to protect the borrower's assets and his heirs. Therefore, any other interpretation would call into question the purpose of concluding the insurance contract, since such a contract does not protect only the bank from the risk of the borrower's non-performance, but also serves as a form of financial protection for the borrower's family.

[44] Judgment of the Supreme Court of the Federation of Bosnia and Herzegovina, Case No. 65 0 P 572865 Rev, dated 9 April 2024.

[45] Judgment of the Supreme Court of the Federation of Bosnia and Herzegovina, Case No. 58 0 P 232117 24 Rev, dated 10 December 2024.

[46] Judgment of the Supreme Court of the Federation of Bosnia and Herzegovina, Case No. 33 0 P 092753 25 Rev, dated 1 July 2025.

From the brief overview of recent case law, it is evident that courts generally take the stance that, in the case of borrower life insurance against the risk of death and assignment of such insurance policy in favor of the bank, upon occurrence of the insured event-the borrower's death occurs, the bank assumes a primary obligation to collect the remaining debt under the loan agreement from the insurer based on the insurance contract. Only subsidiarily, if such recovery proves unsuccessful and provided that the bank has exhausted the primary claim under the insurance policy, may it pursue the borrower's heirs.

V Procedural Mechanisms for Bank Claims Collection

In order to avoid harmful consequences for the bank in the form of the statute of limitations on claims, arising from the existence of multiple legal relationships, namely one based on the loan agreement with the borrower/insured and another based on the insurance contract with the insurer and the borrower/insured, and considering that, upon the death of the borrower, the heirs become universal successors in accordance with inheritance regulations, it would be appropriate for both the insurer and the heirs of the deceased borrower to be included in the same legal proceeding.

A possible solution is to submit the claim in the form of subjective alternation, which implies suing multiple defendants so that the Court is requested to alternatively grant the claim against one of them. A legally binding rejection of the previous claim is a condition for a meritorious decision on the following claim; and if the court were to finally accept the previous claim, it would be considered that the following claim was not even filed.[47] Regarding the alternation of claims, it is essential to consider the provision of the Civil Procedure Act of the FBiH, which stipulates that a plaintiff may, in a single lawsuit, sue two or more defendants and request that the claim be granted against the next defendant if it is finally rejected against the defendant listed before them.[48] The plaintiff retains control over the claim by requesting the court to decide according to the order of defendants established in the complaint. This particular form of adversarial procedure is known in legal theory as **eventual or subsidiary adversariality** and serves as a procedural mechanism established solely in the interest of the plaintiff in complex legal disputes where it is uncertain which of the multiple parties is passively legitimized for the claim. It avoids the risk of losing the pending case and having to initiate new proceedings.[49]

[47] Jadranka Stanišić, „Isticanje više tužbenih zahtjeva u jednoj tužbi", *Zbornik radova „Harmonizacija građanskog prava u regionu"*, East Sarajevo, 2013, 502.

[48] Art. 363 (1) of the Civil Procedure Act of the FBiH, *Official Gazette of the Federation of BiH*, Nos. 53/03, 73/05, 19/06, and 98/15.

[49] Senad Mulabdić, „Teorijski i praktični problemi supsidijarnog suparničarstva", *Anali Pravnog fakulteta u Zenici*, Vol. 5, No. 9 (2012), 317.

Prior analysis leads to the conclusion that the order of enforced claim collection requires that the bank must first conduct out-of-court collection proceedings against the insurer, in compliance with the entire procedure prescribed under the relevant insurance terms and conditions. In the event of a negative decision in second-instance proceedings, where the file demonstrates that the insurer's refusal of the claim was unjustified, it is necessary to file a lawsuit against the insurer.

If, based on evidence from out-of-court proceedings, the bank, as the plaintiff is uncertain about the outcome of a potential dispute against the insurer, an appropriate procedural solution would be to file a lawsuit with a stated lawsuit claim against the insurer and the legal heirs, as they constitute formal adversaries under Article 363(1) of the Civil Procedure Act of FBiH. Namely, they are bound by the same or substantially identical factual basis (the death of the insured / legal predecessor) and legal basis, i.e. the obligation to settle the financial liability of the insured / legal predecessor. For the insurer, this entails payment of the sum insured under the insurance contract, while for the legal heirs, it entails liability for the legal predecessor's debts up to the amount of the inherited share. Considering the order of primary claim collection stipulated in the loan agreement, in this case, the insurer should be designated as the first defendant.

V Conclusion

The analysis of the legal nature of borrower insurance, applicable domestic regulations, and case law confirms that the fundamental purpose of insurance contracts concluded alongside loan agreements is to secure the bank's claim collection, but also to protect the property interests of the borrower and their heirs. When the conclusion of an insurance contract is a condition for credit approval and the policy is assigned in favor of the bank, the order of claim collection must adhere to the principle of primary collection from the insurer, whereas collection from the heirs is permitted only subsidiarily, after exhausting all legal and factual possibilities of collection based on insurance. Any other interpretation would call into question the purpose of insurance and undermine the fundamental principles of good fait and the balance between contractual parties.

De lege ferenda, it is necessary to normatively clarify the obligation of the bank, as the policyholder and insurance intermediary, to provide the borrower with clear, complete, and documented information regarding the content of insurance coverage, exclusions, and the consequences of providing inaccurate or incomplete information material to risk assessment. Legislative change is a lengthy process, therefore, joint intervention by insurers and banks would be desirable with the aim of preventive action, i.e. preventing lengthy and expensive court proceedings. This could be achieved by prescribing, in terms of borrower insurance, the obligation of

the bank as the insurance intermediary to provide quality and transparent information to the borrower/insured regarding the consequences of providing inaccurate or incomplete information about their health status when concluding the contract, and by clearer regulation of the insurance acceptance procedure.

Furthermore, as the foundation of a long-term business relationship based on trust, the contracting parties should mutually define the order and procedure for claim collection in the event of the borrower's death, according to which collection under the insurance policy would have primacy over other security means.

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