THE PROCEDURES FOR RECEIVING AND REVIEWING CLAIMS OF CONSUMERS OF JSC INSURANCE COMPANY PRIME

(hereinafter referred to as the PROCEDURE)

(to be validated from October 01, 2018)

ARTICLE 1. GENERAL PROVISIONS

Present Rule determines the forms of receipt and submission of claims of consumers of JSC Insurance Company Prime (hereinafter the COMPANY/INSURER), the procedures for reviewing claims, the person responsible for reviewing claims in the insurance company and other issues related with the reviewing of the claims. The Rule is comprised of the following:

a) Description of the procedures of receiving and reviewing standard hard copies of consumers' claims, and if the insurance service is comprised of the receipt or/and review of claims in electronic forms or/and verbally (by phone, etc.), the procedures for receiving/reviewing the claim submitted in the following form;

b) Standard hard and, if applicable, soft copies of claim to be submitted;

c) The rule of keeping records of consumers by the insurer;

d) Term of review of claim and the rule of providing consumers with a response;

e) The criteria for qualification of consumer's application/expressed dissatisfaction as claim;

f) The rule and terms of reviewing claims and delivering case materials to the consumers;

ARTICLE 2. DEFINITIONS

For the purpose of this Document, used terms shall have the following meanings:

- **Insurance Company** – JSC Insurance Company Prime (ID: 204540274);
- **Website of the Insurance Company** – www.primeinsurance.ge, through which the Insurance Company carries out the part of the insurance activities;

- Consumer – individuals or legal entities receiving insurance service (Insurer, Insured, User);

- Personal cabinet – consumer's portal on the website of the Insurance Company, which may be exclusively accessed by the consumers and through which the relation with the Insurance Company is established, including using insurance products;

- Insurance Agreement/Terms of Insurance/Insurance Police – the agreement, including soft and hard copies, signed by and between the consumer and the Insurance Company for using the insurance product or/and any agreement signed by them in connection thereto;

- Standard terms of using the website – the agreement, including its soft copy, signed by and between the consumer and the Insurance Company for using the website of the Insurance Company, by agreeing by the consumer with the standard terms offered during registration (by ticking special field), posted on the website of the Insurance Company;

- Claim – any written (hard/soft copy) or verbally submitted application submitted by the consumer to the Insurer in perceivable form, by which the consumer presents reclamation, dissatisfaction, disagreement, or claim against the insurer or/and insurance service/insurance product offered by the insurer, which shall not be of apprising nature and there is objective, reliable expectation/demand in regards with the response on the claim by the Insurance Company;

- Applicant – author of the claim submitted to the Insurance Company; if the claim is presented by the consumer – the consumer is at the same time an applicant; submission of a claim is permitted by the person in relation with the consumer (family member, close relative, authorized representative etc.), provided that such person by signing the application confirms that the data stipulated in the Application is reliable and accurate, he/she has due authority for submission of the Application or/and he/she has obtained all required consents/permissions and he/she is fully responsible for any damage caused as a result of submission of the application to the insurance company;

- Responsible person – based on the Order No. 18 dated April 03, 2017, according to this Procedure, the employee determined by the CEO, which, in view of this Procedure, reviews the claims submitted against the Insurance Company including structural companies, keeps records of claims, prepares/fills and, along with the CEO, signs and sends the reporting form/letter to LEPL Insurance State Supervision Service of Georgia;

  For the purpose of present Procedure, Responsible Person is the head of Legal Department, having granted from the accredited university of Georgia the bachelor’s, master's or/and doctor's degree in legal sciences or/and other specializations, considering the certain qualification of Georgian legislation;

- Identification – subject to this Rule, identification of the Applicant, which excludes or significantly reduces disclosure of consumer's personal data;

- **Specification of the claim** – submission of additional data or any other information by the applicant, in connection with the claim;

- **Demand** – demand of the responsible person to the applicant to submit additional data required for identification of the applicant or/and reviewing the claim;

- **Decision** – decision made in connection with the claim;

- **Term** – the period for reviewing the claims under this Procedure;

- **Claims chart** – the registry kept by the Insurance Company, which is comprised of the information about received claims: applicant's data, category of the claim, content of the claim, status of review and outcome of the claim (content of the response), it may also include the claim related with any other, including applicant's contact data;

- **Report** – the report created by the Insurance Company in compliance with this Procedure and the requirement of the legislative acts, which periodically (subject to the Order No. 18) is transferred to LEPL - Insurance State Supervision Service of Georgia.

ARTICLE 3. RECEIPT/REVIEW OF THE CLAIM

1. Subject to this Rule, the claim is consumer's application/expressed dissatisfaction/claim will be qualified to be the claim in all cases, when the application/expressed dissatisfaction/claim touches upon at least one of the demands of following categories:

    1.1. The application touches upon the Insurer's decision on insurance remuneration and its full or partial amendment, submission of corresponding justification or/and review for other reason are requested (1st category);

    1.2. The application is related with dissatisfaction in regards with the elimination of a service-related defect, or/and other related issues, including dissatisfaction for activities of hotline, activities of employee/representative of the insurer or/and the consulting offered by him/her etc. (2nd category);

    1.3. The application is related with the demand for delivery/non-delivery of information/documentation (3rd category);

    1.4. The application is related any other contractual claim (except the cases stipulated in the Subparagraphs 1.1, 1.2 and 1.3 herein and primary demand for issuance of insurance remuneration) (4th category).

2. The claim may be submitted to the Insurance Company:

    a) by phone (verbally) – when talking with the call-center of the Insurance Company. The communication is recorded;

b) in writing (hard copy) – by filling submitting standard form of claim application available via actual location of the Insurance Company (including service-centers) or by scanned copy of the same application, by sending it to the official email of the Insurance Company (info@primeinsurance.ge);

If requested by the applicant, the claim form may be sent to the email stipulated by him/her.

c) electronically – to the official website of the Insurance Company (info@primeinsurance.ge), by filling standard form of online claim application uploaded on the website and receiving automated confirmation from the Insurance Company after sending the application form.

3. When submitting claim to the Insurance Company through any above means, for the purpose of identification of the applicant, reviewing the claim and establishing further communication, the applicant shall stipulate/submit the following:

a) Name and surname;

b) Personal number/passport number – which may be used for identification of the person;

c) Actual address;

d) Email;

e) Phone/mobile number;

f) Relation with the Insurance Company – Its status (is he/she a consumer/union with the consumer); Consumer data (per (a)-(e) Paragraphs);

g) The essence of the Claim – details;

h) Demand.

4. In the event of failing to stipulate/submit mandatory, required data, when it is impossible to identify the applicant, increasing the risk for groundless disclosure of personal data or/and to establish content of the claim, calculation of the term shall not be commenced until elimination of the referred circumstances.

Demand for the additional information/documentation in regards with the reviewing of the claim application, the customer shall be notified within the period of 5 (five) working days from the receipt of the claim application.

5. In the event of failing to submit the determined data, information or/and to satisfy the demand for completing identification within 15 (fifteen) working days from the request by the Insurance Company, the latter is authorized not to review the claim and send corresponding response to the applicant within 30 (thirty) days from the first receipt/submission of the corresponding claim, in the form stipulated in the application.

6. The requests related with the identification are not mandatory, if the applicant is already identified; therefore there is no risk of groundless disclosure of personal data or/and corresponding response on the claim, in view of its general nature, does not require submission of data to the applicant of the claim on personal data.

7. When receiving claim in hard/scanned or soft (through website) copies of the claim, the Insurance Company confirms receipt of the claim by the confirmation commentary of the copy of the claim or via email stipulated by the consumer. In the event of failing to stipulate or incorrect stipulation of the email, the Insurance Company is exempt of the notification obligation, however it shall be liable to provide the consumer with the confirmation via other available means (if any).

8. After completion of reviewing the claim, not later than within 10 (ten) working days from the appeal and identification of the applicant and specification of the claim, the Insurance Company provides the claim applicant (this does not apply the cases submitted by phone (verbally)) electronically, except cases, when the claim is submitted in writing (hard copy) and the applicant of the claim directly requests delivery of the information (response) with the same form, with the response, i.e. notifies the applicant about the outcomes of review of the issue (it shall include reasoned justification and, if possible, terms of its regulation).

9. The Insurance Company is not responsible to the late notification or/and non-notification of the results of the review, if it is caused by the applicant's default or/and the reasons independent of the Insurance Company.

10. The liabilities prescribed herein (receipt of claim, confirmation, review, applicant's notification etc.) does not apply the Insurance Company, provided that:

    a) the Insurance Company has already reviewed in writing or electronically same claim of the same applicant in writing/electronically/verbally (by phone) and no additional significant facts and circumstances exist in regards with the referred issue;

    b) reason of the claim is obstacles or rejecting service, conditioned by the requirements of the applicable legislation of Georgia, including the Law of Georgia on Facilitation of Prevention of Illicit Income Legalization;

    c) the application is not related with the activities of the Insurance Company, its products and consumers' rights.

11. During the term prescribed by the legislation of Georgia for the storage of documentation will permanently data (records) about received claims, which shall be comprised of the following mandatory information: data about the consumers submitting the claim, category/status of the claim, date of submitting the response, content of the insurer's response, date of its submission, content of the insurer's response, activities carried out for solution of the problem stipulated in the claim and final result, as well as other data, as desired by the insurer;

12. The information stipulated in the Paragraph 11 herein and corresponding reasoned grounds, in regards with the procedural or/and contextual issues of the claim (in accordance with the claim), as well as opinion of the expert/specialist (if any), in regards with the description of the procedures and methodology, by using of which the claim was learnt and stipulated circumstances studied, if requested will be submitted to the consumer within reasonable terms or/and LEPL Insurance State Supervision Service of Georgia, by observing the term prescribed by the Service.

13. The Insurance Company is authorized to keep records of the data subject to the legislation about consumers' claims and to provide the Service (subject to the rule prescribed by the Order) with the report signed with the qualified electronic signature of the CEO or the person authorized with managing rights and approved by the person responsible for preparation of the report to the email: cp@insurance.gov.ge.

14. All submitted claims are registered in the chancellery of the Insurance Company (service-centers shall immediately submit the claims to the chancellery)/software of the call-center and shall be immediately transferred to the authorized person and addressee of the claim – head of the department/division/service-center.

15. Head of the department/division/service-center shall prepare written response to the claim and transfer it to the authorized person via corporate email, along with the attached documents, within maximum 5 (five) working days from submission of the claim. If requested by the authorized person, head of the department/division is liable to provide him/her with the additional information/documentation related with the claim at immediate basis.

    The authorized person reviews the documentation/information submitted by the head of the department/division and prepares final version of the response, which shall be mandatorily agreed with the director in charge, signing the hard copy of the response.

    If needed by the Consumer, response is sent to the email from the official email of the Insurance Company.