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Posledice neprijavljivanja bitnih okolnosti kod ugovora o osiguranju života

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Apstrakt

Obaveza prijavljivanja okolnosti značajnih za ocenu rizika predstavlja jedan od ključnih aspekata osiguravajućeg odnosa i ugovorne obaveze između osiguranika i osiguravača. Ugovarač osiguranja dužan je prijaviti osiguravaču prilikom zaključenja ugovora sve okolnosti koje su od značaja za ocenu rizika, a koje su mu poznate ili mu nisu mogle ostati nepoznate. U radu će biti analizirane pravne osnove ove obaveze, njena priroda i značaj, te posledice njenog kršenja prema pozitivnim propisima, uz poseban osvrt na sudsku praksu i tumačenje ove obaveze u savremenom pravu osiguranja. Analizira se normativni kompleks sa specifičnostima i karakteristikama ove teme. Analiza nužno uključuje i zapažanje prednosti, ali i nekih nedostataka normiranja ove obaveze ugovarača osiguranja.

Ključne reči: prijava okolnosti, rizik, poništenje ugovora, raskid ugovora

1. UVOD

U savremenom svetu ugovor o osiguranju života zauzima značajno mesto, jer, po pravilu, uspešno kombinuje osiguranje i štednju. U pravnom odnosu osiguranja obaveze imaju i ugovarač osiguranja i osiguravač. Imajući u vidu da je taj odnos trajan, postoje i različite obaveze s obzirom na pojedine momente u toku samog odnosa. Te obaveze se dele na obaveze koje se preduzimaju prilikom zaključenja ugovora o osiguranju života, tokom trajanja ugovora o osiguranju života i nakon nastupanja osiguranog slučaja (Jovanović, 2016, 156–177). Iz odnosa osiguranja nastaju uzajamna prava i obaveze za osiguravača i ugovarača osiguranja s obzirom na to da obavezama jedne ugovorne strane odgovaraju prava druge i obrnuto. Ugovor o osiguranju života je ugovor dobre vere i na njega se primenjuju načela savesnosti i poštenja i poštovanja zahtevane pažnje. Zato u zakonskim odredbama, kao i u opštim uslovima osiguranja, postoji obaveza ugovarača osiguranja da prijavi okolnosti od značaja za ocenu rizika (Glušac, 2024, 187). Zakon o obligacionim odnosima (u daljem tekstu: ZOO) navedenu materiju reguliše detaljno, a kako je navedeni Zakon iz 1978. godine izostala su moderna rešenja.

Naime, osiguranik raspolaže određenim informacijama, a osiguravač svoju odluku o tome da će da primi u pokriće određeni rizik donosi baš na osnovu tih podataka (Stojiljković, 1995, 491).

2. DUŽNOST PRIJAVLjIVANjA OKOLNOSTI

Osiguravač donosi odluku o preuzimanju rizika u pokriće i o visini premije osiguranja na temelju ugovaračevih podataka. Ti podaci su obično sadržani u ponudi. Po pravilu, ponuda se sačinjava u pisanom obliku na obrascu osiguravača i sadrži bitne elemente ugovora o osiguranju (Opšti uslovi za osiguranje života Wiener Städtische osiguranja a.d.o. Beograd od 6.5.2020, čl. 3, st. 1). Osiguravač može zahtevati popunjen upitnik[1] o zdravstvenom stanju osiguranika. Ponuđač ugovora je dužan da u ponudi navede istinite podatke o svojim godinama starosti i zdravstvenom stanju (Opšti uslovi za osiguranje života OTP osiguranja a.d.o. Beograd od

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Rad je rezultat naučnoistraživačkog rada autora u okviru Programa istraživanja Pravnog fakulteta Univerziteta u Kragujevcu za 2024. godinu, koji se finansira iz sredstava Ministarstva nauke, tehnološkog razvoja i inovacija Republike Srbije.

[1] Medicinski upitnik (izjava o zdravstvenom stanju osiguranika) je formular sa pitanjima koja se odnose na zdravstveno stanje i životne navike osiguranika, koji popunjava i potpisuje osiguranik (Opšti uslovi za osiguranje života OTP osiguranja a.d.o. Beograd od 29.4.2021. godine, čl. 1, st. 2, tač. 10).

29.4.2021, čl. 3, st. 4). To su podaci poznati samo ugovaraču osiguranja i osiguravač pri zaključenju ugovora te podatke uzima u dobroj veri. Prema načelu savesnosti i poštenja, ugovaraču osiguranja nije dozvoljeno da radi dobijanja pogodnosti prilikom zaključenja ugovora prećuti činjenice koje su mu bile poznate na štetu druge ugovorne strane. Na taj način bi osiguravač bio doveden u zabludu u pogledu činjenica relevantnih za zaključenje ugovora (Ćesić i dr, 2005, 140).

Osiguravač može biti doveden u zabludu zbog a) prećutkivanja stvarnog činjeničnog stanja i / ili b) netačnog prikazivanja činjenica (Ćesić i dr., 2005, 1402). Ugovarač osiguranja[2] dužan je prijaviti osiguravaču prilikom zaključenja ugovora sve okolnosti koje su od značaja za ocenu rizika, a koje su mu poznate ili mu nisu mogle ostati nepoznate.[3] Pretpostavka je da su sve važne okolnosti sadržane u upitniku,[4] a na osiguravaču je da dokazuje[5] da je prema specifičnim okolnostima i načelu savesnosti ugovarač osiguranja trebalo da prijavi i neke druge podatke, van onih iz upitnika (Jovanović, 1962, 84). U toj situaciji osiguravač može prihvatiti ili odbiti ponudu za zaključenje ugovora. U vezi sa ovako postavljenom slobodom osiguravača postoje suprotna stajališta. Prema jednima sloboda bi osiguravaču omogućila da arbitrarno obavlja selekciju rizika, dok prema drugima na posao osiguranja utiče tržište, te osiguravaču treba omogućiti da spreči negativnu selekciju rizika (Džidić, Ćurković, 2017, 173). Ovde sintagma „sve okolnosti" podrazumeva činjenice koje su važne prilikom zaključenja ugovora za ocenu težine rizika i one koje su važne za donošenje odluke o sklapanju ugovora. ZOO ne poznaje kriterijume na osnovu kojih se može proceniti da li je okolnost značajna ili nije. Okolnosti od značaja za ocenu rizika su odgovori na pisana pitanja u ponudi za osiguranje (Opšti uslovi za osiguranje života Wiener Städtische osiguranja a.d.o. Beograd od 6.5.2020, čl. 9, st. 2). Prema par. 16 st. 1 nemačkog Zakona o ugovoru o osiguranju, u slučaju nedoumice, bitnom se smatra svaka ona okolnost za koju je osiguravač izričito i pisano postavio zahtev. Uz to, važnim okolnostima se smatraju i one koje nisu obuhvaćene upitnikom, a proizlaze iz opšte dužnosti informisanja. Dalje je potrebno odgovoriti na to šta se podrazumeva pod činjenicama koje „nisu mogle ostati nepoznate", jer ZOO ne sadrži detaljnije obaveštenje. Ta sintagma je objašnjena u čl. 480 st. 2 ZOO, gde se smatra da nisu mogli ostati nepoznati kupcu oni nedostaci koje bi brižljivo lice sa prosečnim znanjem i iskustvom lica istog zanimanja i struke kao kupac moglo lako opaziti pri uobičajenom pregledu stvari. Iako se u ZOO navodi kao „obaveza prilikom zaključenja ugovora", ipak zaključujemo da je ona predugovorne prirode i mora biti izvršena pre zaključenja ugovora.

3. NAMERNA NETAČNA PRIJAVA ILI PREĆUTKIVANJE

Netačna prijava (engl. *misrepresantation*) je davanje izjava koje nisu u skladu sa činjenicama (What is 'Misrepresentation', 2024). Ako je ugovarač osiguranja namerno učinio netačnu prijavu, ili namerno prećutao neku okolnost takve prirode da osiguravač ne bi zaključio ugovor da je znao za pravo stanje stvari, osiguravač može zahtevati poništenje ugovora (ZOO, čl. 908, st. 1). Postojanje ove obaveze ugovarača osiguranja pravda se i putem teorije zablude, prema kojoj ako je ugovarač prećutao neku važnu činjenicu o riziku ili ju je netačno prijavio, uzrokovao je manjkavost u saglasnosti volje osiguravača dovodeći ga u zabludu (Ćurković, 2003, 37). Ovde se postavlja pitanje šta se dešava ako se radi o namernoj netačnosti ili nepotpunosti prijave značajnih okolnosti, a okolnost je takva da ne bi uticala na odluku da zaključi ugovor, ali bi uticala na uslove pod kojima bi ugovor bio sklopljen. Da li bi osiguravač i u ovoj situaciji mogao da zatraži poništenje ugovora? Ako prema čl. 909 st. 1 ZOO on ima pravo izbora između raskida ugovora o osiguranju i povećanja premije osiguranja srazmerno većem riziku, smatra se da se to može priznati i u slučaju kada se radi o namernoj netačnoj ili nepotpunoj prijavi, a činjenica koja nije prijavljena je takve prirode da bi samo uticala na uslove osiguranja i visinu premije (Ćurković, 2009, 102).

U slučaju poništenja ugovora iz navedenih razloga, osiguravač zadržava naplaćene premije i ima pravo zahtevati isplatu premije za period osiguranja u kome je zatražio poništenje ugovora (ZOO, čl. 908, st. 2). Postavlja se pitanje da li osiguravač ima pravo tražiti

[2] Odredbe o posledicama netačne prijave ili prećutkivanja okolnosti od značaja za ocenu rizika primenjuju se i u slučajevima osiguranja zaključenih u ime i za račun drugoga, ili u korist trećeg ako su ova lica znala za netačnost prijave ili prećutkivanje okolnosti od značaja za ocenu rizika (ZOO, čl. 910). Suština proširenja odredbi je u sprečavanju zloupotreba u situacijama kada bi samo ugovarač bio obavezan, a ne zna sve okolnosti od značaja za ocenu rizika.

[3] ZOO, čl. 907. Ugovarač osiguranja je dužan obavestiti osiguravača i o promenama rizika u smislu pokrića osiguranja. O pravnim posledicama neispunjenja obaveze više u nastavku rada.

[4] Prema čl. 16 austrijskog Zakona o ugovoru o osiguranju u slučaju kada ugovarač pismeno ispunjava obrazac koji mu je dao osiguravač i pri tome ne odgovori na pitanje koje mu nije izričito postavljeno, ugovor se ne može poništiti, osim ako se radi o namernoj netačnosti / prećutkivanju.

[5] Kod ugovora o osiguranju života sa lekarskim pregledom, lekar se smatra „pomoćnikom" osiguravača i zato propust lekara ide na štetu osiguravača.

povrat isplaćenih naknada na osnovu poništenog ugovora. S obzirom na to da poništenje deluje *ex tunc* i u skladu sa čl. 119, st. 1 ZOO, smatra se da osiguravač ima to pravo. Hrvatski Zakon o obveznim odnosima je uveo da je osiguravač dužan isplatiti osigurninu ako se osigurani slučaj dogodi do dana podnošenja zahteva za poništenje, i to bez zahteva za umanjenje. Smatra se da je ova odredba suprotna načelu savesnosti i poštenja. Ovo rešenje je čak jedinstveno i u poređenju sa drugim pravnim sistemima. Ova odredba omogućava prevarno ponašanje ugovarača osiguranja i ostaje nejasno amnestiranje nekorektnog ponašanja ugovarača koji namerno ne prijavi ili prećuti važne okolnosti za ocenu rizika (Ćurković, 2005, 35). Prema čl. 21 austrijskog Zakona o ugovoru o osiguranju, odustane li osiguravač od ugovora nakon što je nastao osigurani slučaj, ipak ostaje njegova obaveza na plaćanje osigurnine ako okolnost, s obzirom na koju je i povređena dužnost prijavljivanja, nije uticala na nastanak osiguranog slučaja i obim osiguravačeve obaveze na plaćanje.

Osiguravačevo pravo da zahteva poništenje ugovora o osiguranju[6] prestaje ako on u roku od tri meseca od dana saznanja za netačnost prijave ili za prećutkivanje ne izjavi ugovaraču osiguranja da namerava koristiti to pravo (ZOO, čl. 908, st. 3).[7] Kada protekne tri meseca, prestaje pravo da se zahteva poništenje ugovora jer je u pitanju prekluzivni rok. Ovu nepreciznu odredbu treba tumačiti tako da osiguravač može u roku od tri meseca od dana saznanja tražiti poništenje ugovora (Nikolić, 1983, 49).

Zaključujemo, da bi osiguravač uspeo sa tužbenim zahtevom za poništenje ugovora potrebno je da: 1) dokaže neistinost i / ili nepotpunost prijave, 2) dokaže da je netačno ili nepotpuno prijavljena okolnost značajna za ocenu rizika, 3) dokaže da je ugovarač namerno prećutao ili netačno prijavio značajnu okolnost,[8] 4) da po-

[6] Na osnovu ovako utvrđenog činjeničnog stanja, prvostepeni sud je zaključio da je sada pok. PP bolovao od šećerne bolesti u trenutku zaključenja ugovora o osiguranja života, da mu je to bilo poznato i da nije dao tačne odgovore prilikom popunjavanja ponude za osiguranje. Kako tuženi nije tražio poništaj ugovora o osiguranju u roku propisanom čl. 908, st. 3 ZOO, to je ugovor je konvalidiran i proizvodi pravno dejstvo. Smatrajući da je čl. 12, st. 2 Opštih uslova za osiguranje života izvršeno nedozvoljeno odstupanje od imperativnog načina određivanja uslova osiguranja u smislu čl. 900 ZOO, to je primenjujući ovu odredbu tuženi tužiocima uskratio pravo na isplatu ugovorene svote osiguranja za slučaj smrti. Smrću ugovarača osiguranja, dana 14.1.2012. godine, nastupio je osigurani slučaj. Kako je ugovor ostao na snazi, to su tužioci kao korisnici osiguranja stekli pravo da zahtevaju isplatu osigurane svote od 5.807,80 evra. Prvostepeni sud je, pozivajući se na čl. 395 u vezi sa čl. 414 ZOO, obavezao tuženog da tužiocima solidarno isplati ovaj iznos u dinarskoj protivvrednosti po srednjem kursu NBS na dan isplate, a dosudio je i kamatu na ovaj iznos, počev od dana podnošenja tužbe pa do isplate u skladu sa čl. 277 u vezi sa čl. 324 ZOO. Apelacioni sud smatra da je prvostepeni sud na potpuno i pravilno utvrđeno činjenično stanje pogrešno primenio materijalno pravo kada je usvojio tužbeni zahtev i stavom prvim izreke obavezao tuženog da tužiocima solidarno naknadi premiju osiguranja. Osiguravač je tek posle smrti ugovarača saznao da je ugovarač prećutao i dao pogrešne podatke od značaja za zaključenje ugovora o osiguranju. Osiguravač nije tražio ništavost ugovora, niti je ugovor raskinut, gde bi u konkretnom slučaju bilo mesta primeni čl. 12, st. 8 Opštih uslova, isplatom smanjene osigurane svote čiji bi iznos predstavljao srazmeru između plaćene premije i premije koju bi trebalo platiti prema stvarnom riziku. Međutim, u toku postupka, tužioci na tu okolnost nisu predložili izvođenje dokaza, a drugostepeni sud ne može da na glavnoj raspravi izvodi dokaze koje stranke nisu predložile, a mogle su da ih predlože do zaključenja pripremnog ročišta ili na prvom ročištu za glavnu raspravu. Kako je na tužiocima teret dokazivanja pravnog osnova i visine duga, odnosno visine osigurane svote koja im pripada, a nisu dokazali visinu premije koja bi im pripala primenom čl. 12, st. 8 Opštih uslova, to u smislu čl. 231 Zakona o parničnom postupku nije bilo mesta donošenju odluke kojom bi se delimično usvojio tužbeni zahtev u smislu citirane odredbe (Presuda Apelacionog suda u Beogradu, Gž. 5632/17 od 10. 1. 2019.)

[7] Da je osiguravač znao za namerno prećutkivanje teške bolesti (ciroza jetre) ugovarača osiguranja, koja je nakon sklapanja ugovora i prouzrokovala njegovu smrt, ne bi pristao sklopiti ugovor o životnom osiguranju. Ako osiguravač zbog toga nije zatražio (u sudskom postupku) poništenje ugovora, ne oslobađa se obaveze isplate ugovorene naknade (Županijski sud u Bjelovaru, Gž-1987/2011-2 od 17.11.2011.)

Ugovor o osiguranju života je ništav, a time i polisa osiguranja, ukoliko ugovarač osiguranja namerno osiguravaču da netačnu prijavu za osiguranje života. Predmet spora je da li je pravno valjan ugovor o osiguranju života koji je sklopila sada pok. K. J. sa tužiocem, a temeljem kojeg je izdana polisa osiguranja o životu. Tokom postupka, na temelju medicinske dokumentacije je utvrđeno da je sada pok. K. J. pre sklapanja ugovora o osiguranju bila teški srčani bolesnik, da je imala karcinom maternice i da je operacijom odstranjena joj celokupna maternica, a osim toga da je posle toga išla i na zračenje. Isto tako je utvrđeno da je sada pok. K. J. namerno učinila netačnu prijavu za osiguranje života, jer je na izričit upit da li je imala ili ima kakvu bolest, povredu, operaciju i kada, odgovorila da to nije nikada imala. Na pitanje da li se lečila radioaktivnim zračenjem, takođe je u ponudi za osiguranje života odgovorila da se nikada nije lečila radioaktivnim zračenjem. Osim toga, u ponudi za osiguranje života stoji da je ugovarač osiguranja dužan predočiti i raspoloživu medicinsku dokumentaciju u vezi sa svojim zdravstvenim stanjem, što ona nije priložila iako je s njome očito raspolagala, budući se ta medicinska dokumentacija nalazi u spisu na listu 10 – 28 spisa. S obzirom na tako utvrđeno činjenično stanje, sud prvog stepena je zauzeo stanovište da je predmetni ugovor o osiguranju života K. J. ništav, a time i rečena polisa osiguranja (Županijski sud u Varaždinu, Gž.1618/04-2 od 9.9.2003.)

[8] Nižestepeni sud u Francuskoj propustio je da utvrdi ko je autor lažnog upitnika – osiguranik ili njegova supruga. Ako je autor lažne izjave supruga osiguranika, ugovor neće biti ništav, budući da se pretpostavlja da bi autor trebao biti osiguranik,

štuje propisane rokove, da u roku od tri meseca od dana saznanja izjavi ugovaraču da namerava tražiti poništenje ugovora, a da u roku od godinu dana (subjektivni rok za podnošenje tužbe za poništaj), odnosno tri godine (objektivni rok za podnošenje tužbe za poništaj) od saznanja za razlog rušljivosti, (u skladu sa čl. 117 ZOO) podnose tužbu. Poništiti ugovor može samo sud po tužbi osiguravača (*querella nulitatis*) (Ćurković, 2003, 38).

4. NENAMERNA NETAČNOST ILI NEPOTPUNOST PRIJAVE

Nepotpuna prijava postoji kada je ugovarač osiguranja propustio dati neku relevantnu informaciju ili prema ZOO prećutao neku okolnost (Insight in depth: underinsurance, misrepresentation and non-disclosure, 2024). Ako je ugovarač osiguranja učinio netačnu prijavu ili je propustio dati dužno obaveštenje, a to nije učinio namerno, osiguravač može, po svom izboru, u roku od mesec dana od saznanja za netačnost ili nepotpunost prijave, izjaviti da raskida ugovor ili predložiti povećanje premije srazmerno većem riziku (ZOO, čl. 909, st. 1). Odredbe ovog člana se odnose na okolnosti koje su bile bitne na donošenje odluke o sklapanju ugovora o osiguranju života.

Ugovor u tom slučaju prestaje po isteku četrnaest dana od trenutka kada je osiguravač svoju izjavu o raskidu saopštio ugovaraču osiguranja, a u slučaju osiguravačevog predloga da se premija poveća, raskid nastupa po samom zakonu ako ugovarač osiguranja ne prihvati predlog u roku od četrnaest dana od kada ga je primio (ZOO, čl. 909, st. 2). U oba slučaja raskid deluje samo za ubuduće, *pro futuro*. Kako se osiguravaču ostavlja izbor između dve mogućnosti, pretpostavlja se da će on raskinuti ugovor u onim slučajevima kada je nenamerna netačnost prijave takve prirode da on ne bi sklopio ugovor da je znao za pravo stanje stvari. Ako je u pitanju neka druga, manje značajna okolnost, osiguravač će predložiti ugovaraču osiguranja odgovarajuće povećanje premije, koje teče od početka osiguranja, odnosno predložiće smanjenje osigurane svote u skladu sa plaćenom premijom (Markov, 1998, 11).

U slučaju raskida, osiguravač je dužan vratiti deo premije koji otpada na vreme do kraja perioda osiguranja (ZOO, čl. 909, st. 3). Ovde je primenjeno načelo deljivosti premije *(pro rata temporis*). Primećujemo da ZOO nema posebne odredbe za situaciju ako se radi o namernoj netačnoj ili nepotpunoj prijavi okolnosti, a osiguravač bi se ipak odlučio na sklapanje ugovora pod drugačijim uslovima. U tom slučaju bi se ista mogla tretirati kao kada se radi o nenamernoj netačnoj prijavi okolnosti i prema tome primeniti odnosna zakonska pravila.

Ako se osigurani slučaj dogodio pre nego što je utvrđena netačnost ili nepotpunost prijave, ili posle toga ali pre raskida ugovora, odnosno pre postizanja sporazuma o povećanju premije, naknada se smanjuje u srazmeri između stope plaćenih premija i stope premija koje bi trebalo platiti prema stvarnom riziku (ZOO, čl. 909, st. 4). Razlog smanjenja osigurane svote je plaćanje premije prema riziku koji je osiguravač ocenio prema okolnostima koje mu je saopštio ugovarač osiguranja. Kako težina rizika nije pravilno ocenjena, posledica je niža premija od one koja odgovara stvarnoj težini rizika. Zato ni njegova obaveza ne može biti jednaka kao i u slučajevima kada je primio premiju koja odgovara stvarnom riziku (Ćurković, 2009, 107).

5. SLUČAJEVI U KOJIMA SE OSIGURAVAČ NE MOŽE POZIVATI NA NETAČNOST ILI NEPOTPUNOST PRIJAVE

Osiguravač kome su u času zaključenja ugovora bile poznate ili mu nisu mogle ostati nepoznate okolnosti[9] koje su od značaja za ocenu rizika, a koje je ugovarač osiguranja netačno prijavio ili prećutao, ne može se pozivati na netačnost prijave ili prećutkivanja (ZOO, čl. 911, st. 1). Tu spadaju opštepoznate činjenice, a potom one koje je saznao na drugi način ili preko zastupnika, jer se znanje zastupnika smatra znanjem osiguravača.[10] Osiguravač koji zna stvarno činjenično stanje ne može

kao osoba koja ima primarni interes da eventualno lažira procenu rizika. Ukoliko se u ponovljenom postupku dokaže da je osiguranik taj koji je osiguravaču prećutao ili zloupotrebio određene okolnosti značajne za ocenu rizika zbog kojih osiguravač ne bi sklopio ugovor o osiguranju, da je za njih znao, ugovor će biti ništav (Francuski kasacioni sud, 2. građansko odeljenje, 7.7.2005., br. 535 F-D, obj. u L'Argus de L'Assurance-HORS SÉRIE, mart 2006.)

[9] Nedoumicu izaziva na koji način se može utvrditi, koje okolnosti nisu mogle ostati nepoznate osiguravaču. Trgovački sud u Zagrebu je u rešenju od 11.3.2008. i br. XLIX P 5882/2007 od 8.5.2008. (neobjavljena), u kojima je sud, utvrdivši nespornu činjenicu da ugovarači osiguranja, koji su bili ujedno i osiguranici, nisu osiguravaču rekli istinito činjenično stanje (visok krvni pritisak, posledica smrti zbog infarkta i u drugom slučaju obliterativna ateroskleroza, koronorna bolest i dijabetes), zauzeo stajalište da se osiguravač ne može pozivati na ništavost ugovora zbog toga što osiguranici nisu prijavili potpuno i istinito činjenično stanje, jer su bolesti od kojih su u trenutku sklapanja ugovora bolovali činjenice koje je osiguravač propustio utvrditi, a mogao je to učiniti i posebno pregledati svakoga nastavnika (Džidić, Ćurković, 2017, 180).

[10] Osiguravač se ne može pozivati na ništavost ugovora o osiguranju ako je njegov agent ili zaposleni znao za namernu

se pozivati na netačnost ili nepotpunost prijave, u skladu sa načelom savesnosti i poštenja. Teret dokazivanja činjenice da su okolnosti poznate osiguravaču, odnosno da mu nisu mogle ostati nepoznate je na osiguraniku (Stojiljković, 1995, 496).

Isto važi u slučaju kad je osiguravač saznao za te okolnosti za vreme trajanja osiguranja, a nije se koristio zakonskim ovlašćenjima (ZOO, čl. 911, st. 2). Nekorišćenjem svog prava je konvalidirao ugovor. Konvalidacija ugovora može da se izvrši i konkludentnim radnjama na primer, naplatom premije čak i pre roka u kojem se osiguravač može koristiti svojim pravom.

6. OBAVEZA PRIJAVLjIVANjA STAROSTI OSIGURANIKA

Kod ugovora o osiguranju života pristupna dob, tj. godine života osiguranika u trenutku zaključenja ugovora o osiguranju, osnovna je i najvažnija okolnost za ocenu rizika jer o njoj, kao i o dužini trajanja osiguranja, zavisi i visina same premije koju je osiguravač dužan redovno plaćati osiguravaču. Pristupna starost utvrđuje se tako što se od godine sklapanja ugovora o osiguranju odbije godina rođenja osigurane osobe. O pristupnoj starosti zavisi i visina premije (Ćurković, 2009, 107).

Za netačne prijave godina života u ugovorima o osiguranju života važe sledeća pravila:

1) Ugovor o osiguranju života je ništav, i osiguravač je dužan u svakom slučaju vratiti sve primljene premije, ako su prilikom njegovog zaključenja netačno prijavljene godine života osiguranika, a njegove stvarne godine života prelaze granicu do koje osiguravač po svojim uslovima i tarifama vrši osiguranje života. U tom slučaju ugovor je ništav *ex lege* i na ništavost se može pozvati svaka zainteresovana strana. Samim tim što je osiguravač dužan vratiti sve primljene premije, pravi se razlika između pravnih posledica netačne prijave okolnosti od značaja za ocenu rizika u osiguranju života i drugim vrstama osiguranja. Osiguravač je dužan vratiti bruto premiju, bez obzira na to što je imao određenih troškova oko zaključenja ugovora.

2) Ako je netačno prijavljeno da osiguranik ima manje godina, a njegove stvarne godine života ne prelaze granicu do koje osiguravač vrši osiguranje života, ugovor je punovažan, a osigurana svota se smanjuje u srazmeri ugovorene premije i premije predviđene za osiguranje života lica osiguranikovih godina. Danas osiguravači opštim uslovima osiguranja propisuju da osigurana lica mogu imati i 75 (sedamdeset pet) godina života u momentu prestanka važenja ugovora o osiguranju.

3) Kad osiguranik ima manje godina nego što je prijavljeno prilikom zaključenja ugovora, premija se smanjuje na odgovarajući iznos, a osiguravač je dužan vratiti razliku između primljenih premija i premija na koje ima pravo (ZOO, čl. 944). Ova specijalna pravila su značajna jer se ne pravi razlika između savesnog i nesavesnog postupanja osiguranika, a posledica ništavosti je povraćaj u pređašnje stanje. Poništaj ugovora zbog netačno prijavljenih godina života moguće je kroz sve vreme trajanja ugovora, pa čak i nakon isteka ugovora o osiguranju života.

7. ZAKLjUČAK

Prilikom zaključenja ugovora o osiguranju života ugovarač osiguranja je dužan da obavesti o okolnostima značajnim za ocenu rizika. Naime, ovde može biti značajno pitanje koji stepen pažnje mora imati ugovarač osiguranja prilikom prijave okolnosti. Sledi da se radi o znanju koje ima svaki punoletni građanin. Zakonom su propisane posledice u slučaju namerne netačne prijave ili prećutkivanja. Međutim, ostalo je nerešeno pitanje kada je ugovarač postupio namerno, ali bi uprkos tome osiguravač zaključio ugovor. Takođe, zakonodavac je napravio propust u situaciji kada se se osigurani slučaj dogodio pre nego što je utvrđena netačnost ili nepotpunost prijave ili nakon toga, a pre raskida ugovora, odnosno pre postizanja sporazuma o povećanju premije. Ovo pitanje je regulisano samo kada je učinjena nenamerna prijava ili prećutkivanje, a ne i kada je ugovarač osiguranja namerno učinio netačnu prijavu ili namerno prećutao neku okolnost. Ipak, bez obzira na propust u regulisanju, smatra se da odredbu treba primeniti i kada je ugovarač namerno delovao.

Kako ZOO posebno reguliše posledice netačnih prijavljivanja godina života osiguranika, predviđeno je da u slučaju ništavosti ugovora osiguravač vraća sve primljene premije, odnosno da je osiguravač dužan vratiti razliku između primljenih premija i premija na koje ima pravo. Na taj način se odstupilo od posledica iz opštih odredbi ZOO koje se odnose na namernu netačnu prijavu ili prećutkivanje, gde je predviđeno da osiguravač zadržava naplaćene premije.

U praksi se pored nabrojanih javljaju i druge nejasnoće i pravne praznine, koje pozitivnopravni propisi nisu mogli obuhvatiti. Postojanje pravnih praznina je neizbežnost svih grana prava, te u skladu s tim i Prava osiguranja.

netačnost u izjavama ugovarača osiguranja (Francuski kasacioni sud, odluka br. 941. od 19.05.1999., obj. u L'Argus br. 6638.)

LITERATURA

Knjige i članci

Glušac, D. (2023). *Ugovor o osiguranju života*. Doktorska disertacija. Novi Sad: Pravni fakultet u Novom Sadu.

Džidić, M., Ćurković, M. (2017). *Pravo osiguranja*. Mostar: Pravni fakultet Sveučilišta u Mostaru.

Insight in depth: underinsurance, misrepresentation and non-disclosure, dostupno na https://www.financial-ombudsman.org.uk/data-insight/insight/insight-in-depth-underinsurance-misrepresentation-non-disclosure , 30.9.2024.

Jovanović, S. (2016). *Pravo osiguranja*. Novi Sad: Pravni fakultet za privredu i pravosuđe.

Jovanović, V. (1962). *Osiguranje u privredi*. Zagreb: Informator.

Markov, M. (1998). „Posljedice neispunjenja obveza prijavljivanja okolnosti značajnih za ocjenu rizika u osiguranju života osiguranje", *Osiguranje*, 38 (9), 3-21.

Nikolić, N. (1983). „Obaveza ugovarača osiguranja pri zaključenju ugovora o osiguranju", *Osiguranje i privreda*, 7-8.

Stojiljković, V. (1995). „Prijavljivanje okolnosti značajnih za procenu rizika", *Pravni život*, 44 (11), 489-498.

Ćesić, Z. i dr. (2005). *Komentar Zakona o obveznim odnosima*. Zagreb: RRIF-plus.

Ćurković, M. (2003). „Ugovor o osiguranju=obaveza informiranja o značajnim okolnostima", Izlaganje sa XVII savjetovanja pravnika u Opatiji, 6-8. novembra 2002. godine, *Osiguranje*, 36-43.

Ćurković, M. (2005). „Obaveze stranaka iz ugovora o osiguranju", *Ugovor o osiguranju prema novom ZOO* (29-44). Zagreb: Inženjerski biro.

Ćurković, M. (2009). *Ugovor o osiguranju osoba-život, nezgoda, zdravstveno.* Zagreb: Inženjerski biro.

What is 'Misrepresentation', dostupno na:

https://economictimes.indiatimes.com/definition/misrepresentation , 30.9.2024.

Zakoni i sudske odluke

Austrijski Zakon o ugovoru o osiguranju iz 1958. godine (Bundesgesetz vom 2. Dezember 1958 über den Versicherungsvertrag (Versicherungsvertragsgesetz 1958). StF: BGBl. Nr. 2/1959 (NR: GP VIII RV 102 AB 547 S. 68. BR: S. 140.))

Francuski kasacioni sud, odluka br. 941. od 19.05.1999., obj. u L'Argus br. 6638.

Francuski kasacioni sud, 2. građansko odeljenje, 7.7.2005., br. 535 F-D, obj. u L'Argus de L'Assurance-HORS SÉRIE, mart 2006.

Opšti uslovi za osiguranje života Wiener Städtische osiguranje a.d.o. od 6.5.2020. godine.

Opšti uslovi za osiguranje života OTP osiguranja a.d.o. Beograd od 29.4.2021. godine.

Presuda Apelacionog suda u Beogradu, Gž. 5632/17 od 10. 1. 2019.

Zakon o obveznim odnosima, *Narodne novine*, br. 35/05, 41/08, 125/11, 78/15, 29/18, 126/21, 114/22, 156/22, 155/23.

Zakon o obligacionim odnosima, *Službeni list SFRJ*, br. 29/78, 39/85, 45/89 - *odluka USJ i 57/89, Službeni list SRJ*, br. 31/93, *Službeni list SCG*, br. 1/2003 - *Ustavna povelja i Službeni glasnik RS*, br. 18/2020.

Županijski sud u Bjelovaru, Gž-1987/2011-2 od 17.11.2011.

Županijski sud u Varaždinu, Gž.1618/04-2 od 9.9.2003.

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Consequences of non-disclosure of material facts in life insurance contracts

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Abstract

The obligation to disclose the circumstances material in assessing the risk is one of the key aspects of the insurance relationship and the contractual obligation between the insured and the insurer. A person concluding the insurance shall be obliged to disclose to the insurer, at the conclusion of the contract, all circumstances which are material in assessing the risk, and which were known, or could not have been unknown, to them. The insured's obligation to report all circumstances relevant to risk assessment is a consequence of the fact that the life insurance contract is by its very nature a contract based on good faith. The paper will analyse the legal bases of this obligation, its nature and importance, and the consequences of its violation according to positive regulations, with a special reference to judicial practice and the interpretation of this obligation in modern insurance law. The normative framework, along with the specificities and characteristics of this topic, is analysed. The analysis necessarily includes acknowledging the advantages, but also addressing some disadvantages of standardising this obligation for the insurance policyholder.

Key words: disclosure, risk, cancellation, repudiation

1. INTRODUCTION

In the modern world, the life insurance contract occupies an important place, because, as a rule, it successfully combines insurance and savings. In the legal relationship of insurance, both the policyholder and the insurer have obligations. Bearing in mind that this relationship is permanent, there are different obligations with regard to certain moments during the relationship itself. These obligations are divided into obligations that are undertaken when concluding a life insurance contract, during the life insurance contract and after the occurrence of the insured event (Jovanović, 2016, 156-177). Mutual rights and obligations arise from the insurance relationship for the insurer and the policyholder, given that the obligations of one contracting party correspond to the rights of the other and vice versa. A life insurance contract is a contract of good faith and is subject to the principles of conscientiousness and honesty and due diligence. That is why in the legal provisions, as well as in the general conditions of insurance, there is an obligation of the policyholder to report the circumstances of importance for risk assessment (Glušac, 2024, 187). *The Law of Contracts and Torts* (hereinafter: LCT) regulates the mentioned matter in detail, and since the aforementioned Law dates from 1978, modern solutions were absent in it.

Namely, the insured has certain information at their disposal, and the insurer makes their decision about whether to cover a certain risk precisely on the basis of that information (Stojiljković, 1995, 491).

2. OBLIGATION TO REPORT CIRCUMSTANCES

The insurer makes a decision on the assumption of the risk for coverage and on the amount of the insurance premium based on the contractor's data. This information is usually included in the offer. As a rule, the offer is made in writing on the insurer's form and contains essential elements of the insurance contract (General conditions for life insurance by Wiener

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Städtische Osiguranje a.d.o. Belgrade dated 6/5/2020, Article 3, Paragraph 1). The insurer may request a completed questionnaire[1] on the insured's state of health. The offeror of the contract is obliged to provide true information about his age and health condition in the offer (General conditions for life insurance by OTP Osiguranje a.d.o. Belgrade dated 29/4/2021, Article 3, Paragraph 4). This information is known only to the policyholder and the insurer takes this information in good faith when concluding the contract. According to the principle of conscientiousness and honesty, the insurance policyholder is not allowed to conceal facts known to them to the detriment of the other contractual party in order to obtain benefits during the conclusion of the contract. In this way, the insurer would be misled regarding the facts relevant to the conclusion of the contract (Ćesić et al. 2005, 1402).

The insurer may be misled due to a) concealment of the actual factual situation and/or b) inaccurate presentation of the facts (Ćesić et al., 2005, 1402). The policyholder[2] is obliged to report to the insurer at the time of concluding the contract all circumstances that are important for risk assessment, and which are known to them or could not have remained unknown to them[3]. The assumption is that all important circumstances are contained in the questionnaire[4], and it is up to the insurer to prove[5] that according to specific circumstances and the principle of good faith, the policyholder should have reported some other data, apart from those in the questionnaire (Jovanović, 1962, 84). In that situation, the insurer can accept or reject the offer to conclude the contract. There are opposing views regarding the insurer's freedom set in this way. According to some, freedom would enable the insurer to perform risk selection arbitrarily, while according to others, the insurance business is influenced by the market, and the insurer should be enabled to prevent negative risk selection (Džidić, Ćurković, 2017, 173).

Here, the phrase "all circumstances" means facts that are important when concluding a contract for assessing the severity of the risk and those that are important for making a decision on concluding a contract. The LCT does not recognise the criteria on the basis of which it can be assessed whether a circumstance is significant or not. Circumstances of importance for risk assessment are answers to written questions in the insurance offer (General conditions for life insurance by Wiener Städtische Osiguranje a.d.o. Belgrade dated 6/5/2020, Article 9, Paragraph 2). According to Paragraph 16, Item 1 of the German Insurance Contract Act, in case of doubt, any circumstance for which the insurer has made a request expressly and in writing is considered essential.

In addition, those that are not included in the questionnaire and arise from the general duty of information are also considered important circumstances. Furthermore, it is necessary to answer what is meant by facts that "could not remain unknown", because the LCT does not contain a detailed notification. That phrase is explained in Article 480, Paragraph 2 of LCT, where it is considered that those defects that a careful person with average knowledge and experience of the same occupation and profession as the buyer could easily notice during a normal inspection of things could not have remained unknown to the buyer. Although it is stated in the LCT as an "obligation at the conclusion of the contract", we nevertheless conclude that it is of a pre-contractual nature and must be performed before the conclusion of the contract.

3. INTENTIONAL MISREPRESENTATION OR OMISSION

Misrepresentation is making statements that are not in accordance with the facts (What is 'Misrepresentation', 2024). If the policyholder intentionally made an incorrect report, or intentionally kept silent about a circumstance of such a nature that

[1] The medical questionnaire (statement of the insured's state of health) is a form with questions related to the state of health and life habits of the insured, which is filled out and signed by the insured (General conditions for life insurance OTP Osiguranje a.d.o. Belgrade dated 29th of April, 2021, Article 1, Paragraph 2, Item 10).

[2] The provisions on the consequences of incorrect reporting or the silence of circumstances of importance for risk assessment are also applied in cases of insurance concluded in the name and on behalf of another, or for the benefit of a third party if these persons knew of the inaccuracy of the report or the silence of circumstances of importance for risk assessment (LCT, Article 910). The essence of extending the provisions is to prevent abuses in situations where only the contractor would be obligated, and he does not know all the circumstances of importance for the risk assessment.

[3] LCT, Art. 907. The policyholder is obliged to inform the insurer about changes in risk in terms of insurance coverage. More on the legal consequences of non-fulfillment of obligations in the continuation of the paper.

[4] According to Article 16 of the Austrian Insurance Contract Act, if the contractor fills out the form given to them by the insurer in writing and the contractor does not answer a question that was not explicitly asked, the contract cannot be annulled, unless it is a deliberate inaccuracy/silence.

[5] In life insurance contracts with a medical examination, the doctor is considered an "assistant" of the insurer and therefore the doctor's omission is to the detriment of the insurer.

the insurer would not have concluded the contract if it had known the true state of affairs, the insurer may demand the annulment of the contract (LCT, Article 908, Paragraph 1). The existence of this obligation of the insurance policyholder is also justified by the theory of delusion, according to which if the policyholder kept silent about an important fact about the risk or reported it incorrectly, they caused a deficiency in the agreement of the will of the insurer by misleading them (Ćurković, 2003, 37). The question here is what happens if it is a deliberate inaccuracy or incomplete reporting of significant circumstances, and the circumstance is such that it would not affect the decision to conclude the contract, but would affect the conditions under which the contract would be concluded. Would the insurer be able to request cancellation/repudiation of the contract even in this situation? If according to Article 909, Paragraph 1 of the LCT they have the right to choose between the termination of the insurance contract and the increase of the insurance premium in proportion to the greater risk, it is considered that this can also be recognised in the case when it is a deliberate incorrect or incomplete report, and the fact that was not reported is of such a nature that it would only affect on insurance conditions and premium amount (Ćurković, 2009, 102).

In the case of cancellation of the contract for the above reasons, the insurer retains the collected premiums and has the right to demand the payment of the premium for the insurance period in which it requested the cancellation of the contract (LCT, Article 908, Paragraph 2). The question arises as to whether the insurer has the right to demand the return of the benefits paid on the basis of the canceled contract. Given that the annulment acts *ex tunc* and in accordance with Article 119, Paragraph 1 of the LCT, it is considered that the insurer has that right. The Croatian *Civil Obligations Act* introduced that the insurer is obliged to pay the insurance premium if the insured event occurs before the date of submission of the request for cancellation, without a request for reduction. It is considered that this provision is contrary to the principle of conscientiousness and honesty. This solution is even unique compared to other legal systems. This provision virtually enables the fraudulent behaviour of insurance policyholders and the amnesty of incorrect behaviour of the policyholder who intentionally does not report or keeps silent about important circumstances for risk assessment remains unclear (Ćurković, 2005, 35). According to Article 21 of the Austrian *Insurance Contract Act*, if the insurer withdraws from the contract after the insured event has occurred, their obligation to pay the insurance premium remains, if the circumstance, in view of which the reporting duty was violated, did not affect the occurrence of the insured event and the extent of the insurer's obligation on payment.

The insurer's right to demand the cancellation of the insurance contract[6] ends if they do not declare to the policyholder that they intend to use this right

[6] Based on the established factual situation, the first-instance court concluded that now deceased PP was suffering from diabetes at the time of concluding the life insurance contract, that he was aware of this and that he did not give correct answers when filling out the insurance offer. Since the defendant did not request the cancellation of the insurance contract within the period prescribed by Article 908, Paragraph 3 of the LCT, that is, the contract is validated and produces legal effect. Considering that Article 12, Paragraph 2 of the General Conditions for Life Insurance made an illegal deviation from the imperative way of determining insurance conditions in the sense of Article 900 of the LCT, by applying this provision, the defendant denied the plaintiffs the right to pay the contracted insurance amount in the event of death. By the death of the policyholder, on the 14th of January 2012, the insured event occurred. As the contract remained in force, the plaintiffs, as beneficiaries of the insurance, acquired the right to demand the payment of the insured sum of €5,807.80. The first-instance court, referring to Article 395 in connection with Article 414 of the LCT, obliged the defendant to jointly pay the plaintiffs this amount in dinar equivalent at the middle exchange rate of the NBS on the day of payment, and awarded interest on this amount, starting from the day the lawsuit was filed and until payment in accordance with Article 277 in connection with Artilcle 324 of the LCT. The Court of Appeal considers that the first-instance court wrongly applied substantive law to the fully and properly established factual situation when it adopted the claim and, in the first paragraph of the judgment, obliged the defendant to compensate the plaintiffs jointly and severally with the insurance premium. The insurer only found out after the death of the policyholder that the policyholder remained silent and provided incorrect information relevant to the conclusion of the insurance contract. The insurer did not request the nullity of the contract, nor was the contract terminated, where in the specific case there would be room for the application of Article 12, Paragraph 8 of the General Conditions, by paying a reduced sum insured, the amount of which would represent the ratio between the premium paid and the premium that should be paid according to the actual risk. However, during the proceedings, the prosecutors did not propose the presentation of evidence for that circumstance, and the second-instance court cannot present evidence at the main hearing that the parties did not propose, and could have presented it until the conclusion of the preliminary hearing or at the first hearing for the main hearing. Since the plaintiffs have the burden of proving the legal basis and the amount of the debt, that is, the amount of the insured amount that belongs to them, and they have not proven the amount of the premium that would be due to them by applying Article 12, Paragraph 8 of the General Conditions, in the sense of Article 231 of the Civil Procedure Law, there was no place for making a decision that would partially approve the claim in terms of the cited provision (Judgment of the Court of Appeal in Belgrade, Gž. 5632/17 of the 10th of January 2019)

within three months from the day of learning about the inaccuracy of the report or the silence (LCT, Article 908, Paragraph 3)[7]. When three months have passed, the right to request the annulment of the contract ends because it is a limitation period. This imprecise provision should be interpreted so that the insurer can request cancellation/repudiation of the contract within three months from the day of knowledge (Nikolić, 1983, 49).

We conclude that, in order for the insurer to succeed with the claim for annulment of the contract, it is necessary to: 1) prove the falsehood and/or incompleteness of the report, 2) prove that the incorrectly or incompletely reported circumstance is significant for the risk assessment, 3) prove that the contractor was deliberately silent or incorrectly reported a significant circumstance[8], 4) to comply with the prescribed deadlines, to declare to the contractor within three months from the date of knowledge that they intend to request the annulment of the contract, and to file a lawsuit within one year (subjective deadline for filing a claim for annulment), i.e. three years (the objective deadline for filing a lawsuit for annulment) from learning about the reason for the annulment, (in accordance with Article 117 of the LCT). The contract can only be annulled by the court at the insurer's claim *(querella nulitatis)* (Ćurković, 2003, 38).

4. UNINTENTIONAL INACCURACY OR INCOMPLETE REGISTRATION

An incomplete report exists when the policyholder has failed to provide some relevant information or, according to the LCT, has kept silent about a circumstance (Insight in depth: underinsurance, misrepresentation and non-disclosure, 2024). If the policyholder made an incorrect application or failed to provide the required notification, and did not do so intentionally, the insurer may, at its option, within one month of learning of the inaccuracy or incompleteness of the application, declare that they terminate the contract or propose an increase in the premium proportionately higher risk (LCT, Article 909, Paragraph 1). The provisions of this article refer to the circumstances that were important for making a decision on concluding a life insurance contract.

In that case, the contract ends after fourteen days from the moment when the insurer communicated its statement of termination to the policyholder, and in the case of the insurer's proposal to increase the premium, the termination occurs according to the law itself if the policyholder does not accept the proposal within fourteen days from when it was received (LCT, Article 909, Paragraph 2). In both cases, the termination is effective only for the future, *pro futuro*. As the insurer is left with a choice between two options, it is assumed that they will terminate the contract in those cases where the unintentional inaccuracy of the declaration is of such a nature that they would not have entered into the contract if they had known the true state of affairs. If it is a question of some other, less significant circumstance, the insurer will propose to the policyholder a corresponding premium increase,

[7] If the insurer had known about the deliberate concealment of a serious illness (cirrhosis of the liver) of the policyholder, which caused his death after the conclusion of the contract, he would not have agreed to conclude a life insurance contract. If the insurer therefore did not request (in court proceedings) the annulment of the contract, it is not released from the obligation to pay the agreed compensation (County Court in Bjelovar, Gž-1987/2011-2 dated the 17th of November 2011)

The life insurance contract is void, and thus the insurance policy, if the policyholder intentionally submits an incorrect application for life insurance to the insurer. The subject of the dispute is whether the life insurance contract concluded by the now deceased K. J. with the plaintiff, on the basis of which the life insurance policy was issued. During the procedure, based on the medical documentation, it was established that the now deceased K. J. was a serious heart patient before concluding the insurance contract, that she had uterine cancer and that her entire uterus was surgically removed, and that she also underwent radiation therapy afterwards. It was also established that the now deceased K. J. intentionally made an incorrect application for life insurance, because when asked explicitly whether she had or has had any illness, injury, operation and when, she answered that she had never had it. When asked if she was treated with radioactive radiation, she also answered in the life insurance offer that she had never been treated with radioactive radiation. In addition, the offer for life insurance states that the policyholder is obliged to present the available medical documentation related to her health condition, which she did not attach, although she clearly had it, since that medical documentation is in the file on sheet 10 - 28 of the writings. Considering the established factual situation, the court of first instance took the position that the life insurance contract in question for K. J. is null and void, and thus the said insurance policy (County Court in Varaždin, Gž.1618/04-2 of 9/9/2003)

[8] A lower court in France failed to determine who was the author of the false questionnaire - the insured or his wife. If the author of the false statement is the spouse of the insured, the contract will not be void, since it is assumed that the author should be the insured, as the person who has the primary interest in possibly falsifying the risk assessment. If it is proven in the repeated proceedings that the insured is the one who kept silent or misused certain circumstances significant to the risk assessment, due to which the insurer would not have entered into an insurance contract, had he known about them, the contract will be void (French Court of Cassation, 2nd Civil department, 7/7/2005, No. 535 F-D, published in L'Argus de L'Assurance-HORSE, March 2006.)

which runs from the beginning of the insurance, that is, they will propose a reduction of the insured amount in accordance with the paid premium (Markov, 1998, 11).

In case of termination, the insurer is obliged to return the part of the premium that is due until the end of the insurance period (LCT, Article 909, Paragraph 3). Here, the principle of dividing the premium *(pro rata temporis)* is applied. We note that the LCT does not have special provisions for the situation if it is a deliberate incorrect or incomplete reporting of the circumstances, and the insurer would still decide to enter into a contract under different conditions. In that case, it could be treated as if it were an unintentionally incorrect report of the circumstances, and accordingly the relevant legal rules would be applied.

If the insured event occurred before the inaccuracy or incompleteness of the application was determined, or after that but before the termination of the contract, i.e. before reaching an agreement on increasing the premium, the compensation is reduced in proportion between the rate of premiums paid and the rate of premiums that should be paid according to the actual risk (LCT, Article 909, Paragraph 4). The reason for the reduction of the sum insured is the payment of the premium according to the risk assessed by the insurer according to the circumstances communicated by the policyholder. As the weight of the risk is not correctly assessed, the consequence is a lower premium than the one corresponding to the actual weight of the risk. Therefore, their obligation cannot be the same as in cases where they received a premium that corresponds to the real risk (Ćurković, 2009, 107).

5. CASES IN WHICH THE INSURER CANNOT CALL ON THE INACCURACY OR INCOMPLETENESS OF THE APPLICATION

An insurer who, at the time of concluding the contract, knew or could not remain unaware of circumstances[9] that are important for risk assessment, and which the policyholder inaccurately reported or kept silent about, may not refer to the inaccuracy of reporting or keeping silent (LCT, Article 911, Paragraph 1). These include commonly known facts, and then those that they learnt in another way or through a representative, because the knowledge of the representative is considered the knowledge of the insurer. The insurer who knows the actual factual situation cannot refer to the inaccuracy or incompleteness of the report, in accordance with the principle of conscientiousness and honesty. The burden of proving the fact that the circumstances are known to the insurer, that is, that they could not have remained unknown to them, is on the insured (Stojiljković, 1995, 496).

The same applies in the case when the insurer became aware of those circumstances during the duration of the insurance, but did not use the legal powers (LCT, Article 911, Paragraph 2). By not exercising his right, the insurer invalidated the contract. Validation of the contract can also be carried out by conclusive actions, for example, by charging the premium even before the deadline in which the insurer can exercise its right.

6. OBLIGATION TO REPORT THE AGE OF THE INSURED

In the case of life insurance contracts, the access age, i.e. age of the insured person at the time of conclusion of the insurance contract is the basic and most important circumstance for risk assessment because the amount of the premium that the insurer is obliged to regularly pay to the insurer depends on it, as well as on the length of the insurance period. Access age is determined by deducting the year of birth of the insured person from the year of conclusion of the insurance contract. The amount of the premium also depends on the access age (Ćurković, 2009, 107).

The following rules apply to incorrect declarations of insured's age in life insurance contracts:

The life insurance contract is null and void, and the insurer is obliged to return all premiums received in any case, if the age of the insured was incorrectly reported at the time of its conclusion, and their actual age exceed the limit up to which the insurer provides life insurance according to its terms and tariffs. In that case, the contract is void *ex lege* and any interested party can invoke the nullity. By the very fact that the insurer is obliged to return all premiums received, a

[9] It raises doubts as to how it can be determined which circumstances could not have remained unknown to the insurer. The Commercial Court in Zagreb is in the decision of the 11the of March 2008 and no. XLIX P 5882/2007 of the 8th of May 8, 2008 (unpublished), in which the court, having established the indisputable fact that the policyholders, who were also the insured, did not tell the insurer the true factual situation (high blood pressure, the consequence of death due to a heart attack and in another case obliterative atherosclerosis, coronary disease and diabetes), took the position that the insurer cannot invoke the nullity of the contract due to the fact that the insured did not report a complete and true state of facts, because the diseases from which they were suffering at the time of the conclusion of the contract are facts that the insurer failed to establish, and it could have done so and separately examined each teachers (Džidić, Ćurković, 2017, 180).

difference is made between the legal consequences of incorrect reporting of circumstances important for risk assessment in life insurance and other types of insurance. The insurer is obliged to return the gross premium, regardless of the fact that they had certain costs around conclusion of the contract.

If it is incorrectly reported that the insured is younger, and their actual age do not exceed the limit up to which the insurer provides life insurance, the contract is valid, and the insured sum is reduced in proportion to the contracted premium and the premium provided for life insurance of persons of the insured's age. Today, in the general conditions of insurance insurers stipulate that insured persons can be 75 (seventy-five) years old at the time of termination of the insurance contract.

When the insured is younger than declared when concluding the contract, the premium is reduced to the appropriate amount, and the insurer is obliged to return the difference between the received premiums and the premiums to which they are entitled (LCT, Article 944). These special rules are significant because no distinction is made between conscientious and unconscionable actions of the insured, and the consequence of nullity is a return to the previous state. Cancellation of the contract due to incorrectly reported years of life is possible throughout the duration of the contract, and even after the expiration of the life insurance contract.

7. CONCLUSION

When concluding a life insurance contract, the policyholder is obliged to inform about circumstances significant for risk assessment. Namely, here it can be a significant question of what level of attention the policyholder must have when reporting the circumstances. It follows that this is knowledge that every adult citizen possesses. The law prescribes the consequences in case of intentional misreporting or keeping silence. However, the question remained unresolved when the contractor acted intentionally, but the insurer would still conclude the contract. Also, the legislator made an omission in a situation where the insured event occurred before the inaccuracy or incompleteness of the application was established or after that, and before the termination of the contract, that is, before the agreement on the premium increase was reached. This issue is regulated only when an inadvertent report or silence has been made, and not when the policyholder has deliberately made an incorrect report or deliberately kept silent about a circumstance. Nevertheless, regardless of the omission in the regulation, it is considered that the provision should be applied even when the contractor acted intentionally.

As the LCT specifically regulates the consequences of incorrect reporting of the insured's years of life, it is stipulated that in the event of invalidity of the contract, the insurer will return all premiums received, that is, the insurer is obliged to return the difference between the received premiums and the premiums to which it is entitled. In this way, the consequences of the general provisions of the LCT related to intentional incorrect reporting or keeping silence were deviated from, where it is stipulated that the insurer retains the collected premiums.

In practice, in addition to the ones listed, there are other ambiguities and legal gaps, which positive legal regulations could not cover. The existence of legal gaps is an inevitability of all branches of law, and accordingly also of Insurance Law.

REFERENCES

Books and articles

Glušac, D. (2023). *Ugovor o osiguranju života*. Doktorska disertacija. Novi Sad: Pravni fakultet u Novom Sadu.

Džidić, M., Ćurković, M. (2017). *Pravo osiguranja*. Mostar: Pravni fakultet Sveučilišta u Mostaru.

Insight in depth: underinsurance, misrepresentationandnon-disclosure, available at https://www.financial-ombudsman.org.uk/data-insight/insight/insight-in-depth-underinsurance-misrepresentation-non-disclosure , 30.9.2024.

Jovanović, S. (2016). Pravo osiguranja. Novi Sad: Pravni fakultet za privredu i pravosuđe.

Jovanović, V. (1962). *Osiguranje u privredi*. Zagreb: Informator.

Markov, M. (1998). „Posljedice neispunjenja obveza prijavljivanja okolnosti značajnih za ocjenu rizika u osiguranju života osiguranje", *Osiguranje*, 38 (9), 3-21.

Nikolić, N. (1983). „Obaveza ugovarača osiguranja pri zaključenju ugovora o osiguranju", *Osiguranje i privreda*, 7-8.

Stojiljković, V. (1995). „Prijavljivanje okolnosti značajnih za procenu rizika", *Pravni život*, 44 (11), 489-498.

Ćesić, Z. i dr. (2005). *Komentar Zakona o obveznim odnosima*. Zagreb: RRIF-plus.

Ćurković, M. (2003). „Ugovor o osiguranju=obaveza informiranja o značajnim okolnostima", Izlaganje sa XVII savjetovanja pravnika u Opatiji, 6-8. novembra 2002. godine, *Osiguranje*, 36-43.

Ćurković, M. (2005). „Obaveze stranaka iz ugovora o osiguranju", *Ugovor o osiguranju prema novom ZOO* (29-44).Zagreb: Inženjerski biro.

Ćurković, M. (2009). *Ugovor o osiguranju osoba-život, nezgoda, zdravstveno.* Zagreb: Inženjerski biro.

What is 'Misrepresentation', available at:

https://economictimes.indiatimes.com/definition/misrepresentation , 30.9.2024.

Laws and Court decisions

Austrijski Zakon o ugovoru o osiguranju iz 1958. godine (Bundesgesetzvom 2. Dezember 1958 überdenVersicherungsvertrag (Versicherungsvertragsgesetz 1958). StF: BGBl. Nr. 2/1959 (NR: GP VIII RV 102 AB 547 S. 68. BR: S. 140.))

Francuski kasacioni sud, odluka br. 941. od 19.05.1999., obj. u L'Argus br. 6638.

Francuski kasacioni sud, 2. građansko odeljenje, 7.7.2005., br. 535 F-D, obj. u L'Argus de L'Assurance-HORS SÉRIE, mart 2006.

Opšti uslovi za osiguranje života WienerStädtische osiguranje a.d.o. od 6.5.2020. godine.

Opšti uslovi za osiguranje života OTP osiguranja a.d.o. Beograd od 29.4.2021. godine.

Presuda Apelacionog suda u Beogradu, Gž. 5632/17 od 10. 1. 2019.

Zakon o obveznim odnosima, *Narodne novine*, br. 35/05, 41/08, 125/11, 78/15, 29/18, 126/21, 114/22, 156/22, 155/23.

Zakon o obligacionim odnosima, *Službeni list SFRJ*, br. 29/78, 39/85, 45/89 - *odluka USJ i 57/89, Službeni list SRJ*, br. 31/93, *Službeni list SCG*, br. 1/2003 - *Ustavna povelja i Službeni glasnik RS*, br. 18/2020.

Županijski sud u Bjelovaru, Gž-1987/2011-2 od 17.11.2011.

Županijski sud u Varaždinu, Gž.1618/04-2 od 9.9.2003.