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Укладачі: канд. екон. наук, доцент Р.М. Мамчур

Рецензенти: докт. екон. наук, проф. Навроцький С.А.
докт. екон. наук, проф. Охріменко І.В.
докт. екон. наук, проф. Худолій Л.М.
ст. викладач Дубовик О.М.

INSURANCE

Навчальний посібник

для підготовки до практичних та семінарських занять
з курсу «Insurance»
для студентів освітнього ступеню «Бакалавр»
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Introduction

Insurance business is an important strategic sector of economy. The level of its development in a country is an indicator of population welfare level. Insurance actively assists the development of business and handling numerous social problems.

The insurance market of Ukraine is developing gradually. Various financial and material losses of businesses and regular people are covered by insurance funds. On the other hand insurance payments are used as credit resources and real estate financing.

The major goal of «Insurance» course is to provide the students with the basics of theory and practice of insurance.

A task a course consists in finding out of necessity and insurances with the purpose of creation of the effective system of defense of interests of citizens, businessmen and state, receipt of skills in relation to realization of reinsurances and financial activity of insurer.

The course objectives encompass the following issues:

- basic theoretical principles of insurance, its role and functions in a market economy;
- general trends of the insurance market development and governmental control over insurance business activities;
- conditions and particulars of health, property and responsibility insurance; the notion of reinsurance and its domestic and foreign experience and practice;
- organisation peculiarities of insurance business and companies; ways to improve their financial activities.

The necessary element of successful course mastering is individual student work with special economic literature, legislative acts, regulations and insurance documents.

In the process of studies students get necessary know ledges during attendance of lecture and practical employments. The necessary element of the successful mastering of course is independent work with the special economic literature, legislative and normative acts, insurance documents.

With the purpose of the best mastering of educational material students must to beginning of study of course capture knowledge and skills in industry of economy, finances.

As a result of Insurance course study, the students

should know:

- Principles of insurance, its importance and conditions of application;
- basic insurance market trends;

should be able to:

- identify an insurance risk;
- calculate the sizes of insurance payments and insurance compensation;
- make up the insurance contract for any object from industry, society, property insurance or insurance of responsibility.

Everyone dies. But not everyone really lives.
William W.

Topic 1. INSURANCE IN SOCIAL ECONOMY

Methodical recommendations for studying the topic

By addressing this topic, it is necessary to realize that in the presence of risks in the functioning of any enterprise and risky living conditions of a person, there is an urgent need to protect against various adverse events and to compensate for losses in case of their occurrence.

It is necessary to consider the history of insurance, from ancient times to the present day, as well as the peculiarities of becoming insurance in different countries of the world.

It is necessary to pay attention to the study of insurance as an economic category, the views of theorists and practitioners on the definition of "insurance". Considering the functions of insurance, it is advisable to carry out a comparative description with the category of finance, and while working on the principles of insurance, it is recommended to consolidate their assimilation of concrete examples of modern insurance practices.

When studying the topic, first of all, it is necessary to pay attention to what the necessity of classification of insurance and its basis are determined. It is necessary to realize that without classification ordering, neither theoretical research nor practical activity is possible. In accordance with the purpose of the classification of insurance should distinguish the essential classification characteristics.

Next, you need to read in detail with each type of classification, depending on the criterion, which is based on it.

Particular attention is needed to the sectoral classification, which is the cornerstone of the study and comprehension of the entire course. In particular, attention should be paid to the selection of certain classes of insurance in accordance with international requirements.

It is recommended to thoroughly consider the reasons that lead to the implementation of mandatory insurance, as well as to define the principles of voluntary and compulsory insurance, to conduct a comparative analysis. Summing up the study, it is advisable to draw conclusions about the current state and prospects of the development of voluntary and mandatory insurance in Ukraine on the basis of statistical data in the last few years.

When studying insurance tariffs, it is necessary to learn the structure of the tariff rate, the features of the calculation of tariffs, the value of the correct tariff policy to create sufficient amounts of insurance reserves of the insurer. To consolidate knowledge on the topic is recommended by giving examples based on statistical data from the press materials and brochures of insurance companies.

Mini-lexicon

insurance, insurance protection, natural insurance, insurance fund, centralized insurance fund, self-insurance fund, closed distribution of losses, reversibility of insurance payments, insurer, policyholder, insurance contract, insured, beneficiary of insurance sum, property interest, insurance amount, insurance indemnity, subrogation, franchise, insurance field, insurance policy, insurance system, insurance limit, state insurance, preventive measures, insurance classification, insurance object, insurance industry, type of insurance insurance, voluntary insurance, compulsory insurance, liability insurance, personal insurance, property insurance, liability insurance, insurance case, underwriting, law of large numbers, gross rate, load, actuarial, actuarial calculations, tariff rate, insurance premium.

1. 1. Economic nature and purpose of insurance

Insurance is a specific industry and belongs to the oldest categories of social relations. There was insurance during the collapse of the primitive communal system. Gradually, it penetrated into all new spheres of public life, taking its proper place and confirming its expediency and necessity. Modern life is impossible to imagine without insurance, which became its reliable companion. The most primitive form of loss distribution was natural insurance. At the expense of stocks of grain, forage and other products, the victims' farms were provided with material assistance. With the development of commodity-money relations, the natural form gave way to insurance in cash.

The distribution of losses in cash has created extensive opportunities for so-called mutual insurance, in which the amount of losses was reimbursed by its participants on a solid basis. At the same time, with the increase in the number of entities involved in the distribution of losses, the amount of funds paid by each participant decreases and the amount of financial resources aimed at compensation is increased.

From the point of view of the natural interests of society and its individual citizens, insurance arose as a means of preserving material well-being under the condition of occurrence of random and unpredictable circumstances in order to distribute the damage to the victims of the members of society. The economic nature of insurance protection is explained by the necessity of creating such a kind of human activity, which involves the accumulation and redistribution of financial resources in order to compensate for losses caused by the occurrence of harmful to health and (or) material well-being of events for individuals and legal entities, which creates favorable conditions for an uninterrupted process social reproduction.

Everyone in society is affected by risk in one way or another. Risk arises when there is the possibility of more than one outcome and one of these possible outcomes has negative consequences; e.g., a financial loss. Individuals, businesses and other organizations face various risks in their different activities, and insurance

helps protect them against these risks. Even if someone does not purchase insurance, they may still be the beneficiary of insurance purchased by another.

In the social plan, insurance is a form of participation of the state, employers and citizens in protecting personal interests and creating conditions for ensuring social and political stability in society. Because of its important and pervasive role in the economy, insurance is an industry that is vested with public interest. The economic well-being of every citizen is strongly affected by the adequacy of their insurance protection and how much they pay for it. Consequently, the government has insurance regulation has been subject to increasing external and internal pressures in recent years that have forced the states to respond.

Fundamental changes in the structure and performance of the insurance become closely involved in mandating, providing and regulating insurance. industry have complicated regulators' jobs. Competitive forces have caused insurers to assume increased risk in order to offer more attractive prices and products to consumers. Insurance markets have increasingly become national and international in scope as insurers have widened the boundaries of their operations. High costs in some lines of insurance and the economic impact of natural and man-made disasters have focused greater public attention on regulatory decisions.

These forces have had a dramatic effect on insurance regulatory institutions. Over the past two decades, the states have engaged in an unprecedented program to revamp the framework for insurance regulation. A good share of this effort has been directed at strengthening solvency regulation by establishing higher capital standards for insurers, expanding financial reporting, improving monitoring tools and accrediting insurance departments. A second wave of initiatives has focused on improving the effectiveness and efficiency of market regulation. The states have significantly enhanced the resources devoted to insurance regulation in terms of people, technology and systems to support these efforts.

In accordance with the Law of Ukraine «On Insurance»:

Insurance is a type of civil-law relationship for the protection of property interests of citizens and legal entities in the event of certain events (insurance cases) determined by the insurance contract or the current legislation at the expense of money funds, which are formed by paying citizens and legal entities insurance payments (insurance premiums, insurance premiums).

The main subjects of insurance relations are the insurer and the insured who are involved in the conclusion of the contract, must comply with all its conditions and have the right to change or early terminate the contract. Insurers are financial institutions, which are created in the form of joint-stock companies, full partnerships or partnerships with additional liability, who have received a license for the insurance activity in accordance with the established procedure. The direct business of the insurer can be only insurance, reinsurance and financial activities associated with the formation and placement of insurance reserves. The insurer must have a fully-formed statutory fund of at least 1000000 euros at the NBU exchange rate or 1,500,000 euros in the case of life insurance. The insurer's authorized fund must be paid exclusively in cash.

Insurers are legal entities or able-bodied citizens who have entered into insurance contracts with the insurer, make insurance premiums, or are insured persons in accordance with the legislation of Ukraine.

Insurers are obliged to pay the insurer a premium, and at the onset of an insured event, have the right to demand from the insurer an insurance payment to himself or the insured person. Also, insurers are obliged to comply with the rules of exploitation of property and to take care of life or health. After the insured event, the insured should take measures to reduce the amount of damage, inform the insurer in due time, apply to the competent state authorities (fire supervision, investigating authorities, traffic police, etc.).

A participant in insurance relations may be insured – an individual in favor of whom a contract of insurance in personal insurance has been concluded. In the event of an insured event, the insured person is paid an insurance indemnity. An insured person may be a child when insured by her parents, incapacitated invalid – when insured by his guardian, a worker – when insured by his employer. The insured person, as a rule, must agree with the insurer the terms of its insurance by the insured. The insured person does not pay the insurance, but it can become the owner of the rights and obligations of the insured according to the conditions specified in the insurance contract.

The subject of the insurance contract are property interests related to:

- life, health, disability and pension provision (personal insurance);
- possession, use and disposal of property (property insurance);
- the indemnification by the insured of the damage caused to him or her by the person, as well as damage caused to the legal entity (liability insurance).

The key term in insurance is the insurance risk – a certain event in which case the insurance is carried out and which has signs of probability and accidental occurrence. In this case, an insured event is an event stipulated by an insurance contract or legislation that has occurred and with the onset of which the insurer has an obligation to pay the sum insured (insurance indemnity) to the insured, the insured or another third person.

Insurance amount – a monetary amount, within which the insurer, in accordance with the terms of insurance, is required to pay at the onset of an insured event. The insurance sum in the insurance contract may be established separately for each object and the risk accepted for insurance or for each insured event. The size and procedure for establishing the sum insured can be considered as the most important elements of the contract affecting the price of insurance services, determine the possibility of taking risks for insurance, the need for the conclusion of reinsurance contracts or coinsurance by the insurer.

For mandatory types of insurance, the Ukrainian legislation sets the minimum possible amounts of insurance amounts. When voluntary insurance is carried out, the amount of the insurance amount is determined on the basis of the consent of the parties to the insurance contract – the insured and the insurer. In each branch of insurance, establishing the size of the sum insured and the conditions for its payment as a basis for the implementation of the insurance obligation have their own peculiarities.

The insurance contract will take effect, as a rule, since the first insurance payment has been made.

The content of insurance is disclosed in its functions, the main of which are:

1. Risk function.

It is the responsibility of the insurer for the payment of a certain fee for the consequences of the risk caused by events, the list of which is provided by the current legislation or contract with the insured. In this case, the financial protection of the policyholder from possible property losses and losses is ensured.

2. Function of creation and use of insurance reserves (funds).

Insurance becomes possible only if the insurer has a certain amount of capital sufficient to cover the losses (in case of their occurrence) incurred by the insurer as a natural disaster, accident or other insurance event. To this end, each insurer creates a system of insurance reserves.

3. The function of saving money.

In the first place, in most countries of the world, the volume of insurance premiums is personal insurance (survival, pension insurance, rent, etc.). Insurance payments are made in case of survival of the insured to a certain age or event.

4. Preventive function.

Subjects of insurance insurers and insurers are interested in preventing offensive and reducing the consequences of insurance events. For this purpose, preventive and repressive measures are being taken.

5. Investment function.

With the help of insurance are attracted and economically used money insurer, which by this time forced to capitalize them in the form of a reserve fund of self-insurance. Thus, when making insurance, additional favorable conditions are created for the formation and replenishment of the free capital market, which is essential for a market economy.

6. Underwriting function.

The underwriting function is critical to the efficient operation of insurance markets. It entails the risk assessment, classification and selection of insureds to achieve an insurer's desired portfolio of risks and determine appropriate premiums. Underwriting must be coordinated with an insurer's pricing structure to ensure the insurer collects adequate premiums to support its portfolio of risks. The ultimate objective is to match each risk with an appropriate policy and premium. To the extent that an insurer's rating plan does not fully accommodate all variations in risk, the insurer must decline risks for which its rating plan will not generate an adequate premium or for which its products are unsuitable. In addition, some risks may not meet basic requirements for insurability; i.e., the probability of loss is too high or uncertain to charge an economically feasible premium and provide insurance. All else being equal, insurers with lower prices must have more stringent underwriting standards, while insurers with higher prices can afford to have less stringent standards.

Several principles guide proper underwriting:

1) selection according to standards;

2) proper balance within classifications;

3) equity among policyholders.

Standards are necessary to ensure the application of underwriting decisions to different risks by underwriters and agents consistent with an insurer's business plan. Some standards are fairly objective and clear; e.g., uniform declination of applicants who have been convicted of fraud or arson or who have filed an unusually high number of claims in the past. Others may be more subjective and discretionary; e.g., the apparent care that an applicant has taken in maintaining their home. The appropriateness and fairness of some underwriting guidelines and risk classifications have been a matter of public debate.

The balancing of risks within classifications is aimed at avoiding adverse selection causing an excessive concentration of high-risk insureds within an insurer's portfolio. An excessive concentration of high-risk insureds could tax an insurer's efficiency and financial performance and threaten its solvency. Also, if an insurer writes an increasing concentration of highrisk insureds, it will need to raise its rates and may no longer be competitively priced for low-risk insureds. It is important that insureds are treated fairly from an actuarial or pricing perspective. In other words, insureds should be classified and pay premiums commensurate with their risk. High-risk insureds should pay a higher premium than low-risk insureds. This can be accomplished through an appropriate rate structure or limiting a portfolio to insureds with similar risk characteristics.

Provision of insurance services is based on special principles:

1) Free choice - concerns only voluntary types of insurance. The insured is given the opportunity to choose any insurer licensed for this type of insurance. At the same time, an insurer can not force one or another type of voluntary insurance.

2) Insurance risk is a probable event or set of events for which an insurance is being carried out.

3) Property interest is related to the interest of legal entities and individuals in preserving objects in which the funds and human life and health are invested in the event of adverse events or accidents.

4) Maximum integrity. Reliable insurance is possible only under conditions of high trust between the parties. Neither the policyholder nor the insurer have the right to conceal one or another information relating to the object of insurance.

5) Causal link - involves the insurer identifying the actual cause of the insured event.

6) Subrogation - the transfer to the insurer of an insurer's right to recover damages from third (guilty) persons within the amount paid.

7) Contraction - the right of the insurer to appeal to other insurers who, under the policies sold, are liable to one and the same specific insurer, with the proposal to split the costs of damages.

8) Compensation for actual losses (insurance indemnity) - the main principle of insurance.

Insurance indemnity – insurance payment, which is carried out by the insurer within the insured amount under the contracts of property insurance and liability insurance in the event of an insured event.

The insurance indemnity can not exceed the amount of direct damage suffered by the insured. At the same time, the insurance contract may also provide insurance for indirect damages. On the other hand, the insurance indemnity can not exceed the real value of the property, including in the case when it is insured and paid by several insurance companies. At the same time, each insurer makes a payment in proportion to the size of the sum insured for the insurance contract concluded by him.

In case when the insured amount represents a certain share of the cost of the insured object, the insurance indemnity is paid on the system of proportional responsibility.

The principles underlying risk and insurance are reflected in the design of insurance contracts. Two key concepts are the **principles of indemnity** and **insurable interest**. Under the principle of indemnity, insureds should not profit from a covered loss but should be restored to no better than their financial position prior to the loss. The objective is to ensure that insureds do not gain financially from losses and, in turn, reduce moral hazard. If insureds could profit from insurance coverage of a loss, they would have an incentive to cause losses and a disincentive to take precautions to avoid losses. Most property and liability contracts are contracts of indemnity. Losses in such contracts are typically settled on the basis of actual cash value (i.e., replacement cost less depreciation) or fair market value.

However, there are some insurance contracts that constitute exceptions to the indemnity principle. Avalued policy pays the face amount of insurance regardless of the actual cash value of the loss. Valued policies are sometimes used to insure items for which it would be difficult to determine the actual cash value or fair market value, such as rare antiques. Some states have valued policy laws that require payment of the face amount of insurance in the instance of total losses to real property from certain perils.

Some insurers offer replacement cost contracts, where the cost of replacing the insured property is paid with no deduction for depreciation. For such contracts, insurers typically require a minimum ratio of the market value to replacement cost (e.g., 70 percent) be met to diminish moral hazard. Finally, life insurance contracts are not contracts of indemnity, but rather are valued policies that pay a stated benefit in the event of the insured's death.

The second important concept is the principle of insurable interest. According to this principle, the insured must suffer some form of loss or harm if the insured event occurs. The nature of the loss or harm could be financial or psychological, as in the case of the death of a family member. Insurable interest is necessary to prevent gambling, reduce moral hazard and measure the insured loss. Otherwise, individuals could purchase insurance contracts as a matter of speculation (e.g., insuring another's home in which the insured does not have a financial interest) and/or gain from causing a loss. The same principle applies to life insurance contracts: Purchasing a life insurance policy on a person with whom they have no family relationship or pecuniary interest raises obvious questions

about the insurance buyer's intentions. Insurance contracts reflect a number of other concepts and contain certain standard provisions.

Interesting Facts

The most expensive disaster was the earthquake and tsunami in Japan. The Miyagi, Iwate and Fukushima prefectures have been severely affected by the earthquake. The last accident occurred at the Fukushima-Daiichi nuclear power plant - the largest accident at the NPP since the Chernobyl disaster. As of December 2, 2011 The official number of deaths in the earthquake and tsunami in 12 prefectures in Japan amounted to 15,840 people. The damage to the earthquake in Japan, which occurred on March 11, is estimated at 16-25 trillion. yen ($ 198-309 billion).

In New Zealand, there was an earthquake that killed about 200 people, and insured losses totaled $ 15 billion. The country's government also noted that the country suffered a 30 billion-plus economic loss from two earthquakes in 2010-2011.

Insurance payment – a monetary amount paid by the insurer in accordance with the terms of the contract of life insurance in the event of an insured event. Insurance payments under a life insurance contract are made in the amount of the insured sum (its part) and (or) in the form of regular, successive payments stipulated in the insurance contract amounts (annuity).

The size of the insured sum and the amount of insurance payments are determined by agreement between the insurer and the insured during the conclusion of the insurance contract. The insurance amount is not established for an insured event, in the event of which a regular, successive insurance payments in the form of annuity are carried out.

The contract of life insurance necessarily provides for an increase in the size of the sum insured by the amount of bonuses, which are determined by the insurer once a year based on the results of the investment income from the placement of reserves for life insurance.

In the event that the insured does not pay another insurance premium in the amount and within the terms provided by the rules and the contract of life insurance, the insurer's right to unilaterally reduce the amount of the insured amount may be provided.

The insurance contract, as a rule, provides for a **deductible** – part of the loss that is not reimbursed by the insurer under the insurance contract. The insurer is obliged to give the insurer a certain insurance payment in accordance with the contract, which is called insurance payment (insurance premium, insurance premium). Insurance payment is calculated on the basis of the size of the insurance tariff, which represents the rate of insurance premium per unit of the sum insured for a certain period of insurance.

Insurance rates for voluntary insurance are calculated by the insurer actuarially (mathematically) on the basis of the relevant statistics of the occurrence of insured events. Under the life insurance contracts, the amount of investment

income, which is specified in the insurance contract, is additionally taken into account.

1.2. History of the emergence and development of insurance

The essence, functions and purpose of insurance were historically formed.

he first forms of insurance arose about **3 thousand pp. B.C.** The Phoenician merchants – the owners of merchant vessels entered into collective agreements on the mutual distribution of losses at the loss or damage of the vessel. In Palestine, livestock owners were expected to pay damages in case of theft or death. In ancient Greece, there were pirates-pirates dealings in the distribution of income from trade-robbery operations and the distribution of losses from marine hazards associated with these operations.

2 thousand pp. B.C. – the laws of the Crown of Babylon Hammurabi required the conclusion of an agreement between the participants of the caravan trade in reimbursement of the losses they suffered from the attack of robbers, robberies or other unexpected accidents. The most advanced mutual insurance was in Ancient Rome and was distributed on ritual expenses. The poor Romans accumulated the necessary funds in professional colleges, which, in addition to providing their members with a worthy burial, also served as mutual aid. The funds were not paid in case of suicide or underpayment of insurance premiums.

970-931 pp. B.C. – Egyptian bricklayers at the time of the construction of the pyramids founded a cash aid unit in case of injury or death from an accident.

970-931 pp. B.C. – on the island of Rhodes, the first legal act (ordinance) was adopted, which provides a system for distributing losses in the event of a general maritime accident.

900 BC – Germany has the first firefighting guilds, starting with fire insurance - a risk that is, today, a key to insurance of any kind of property.

1310 – in the city of Bruges, the first insurance house, representatives was founded which carried out operations to protect the property interests of merchant and craft guilds.

18.07.1583 – the first agreement on life insurance was concluded in London.

1699 – the first professional insurance organization for widows and orphans appeared in England, and subsequently an insurance company Eckvatedl, which was engaged in personal insurance, was created.

1752 – in the United States Benjamin Franklin founded the first mutual insurance company in the event of a fire.

December 13, 1971 – in London's Edward Lloyd's coffee shop, 79 merchants signed an agreement on making each of the Bank of England certain amounts for insurance operations, and after five years the members of the London Lloyd Association adopted the "signed Lloyd's Form", a series the provisions of which are still used in international practice. In 1871, by the act of the British Parliament, the association of insurers "Lloyd's" received the official status of a corporation of insurers.

Lloyd's associations are for-profit proprietary organizations in which the underwriter-member is always an individual insurer. Individual members (referred to as "names") write risks on a cooperative basis. Each member assumes risks personally and the organization bears no obligation. Members are individually liable for the risks they assume to the full extent of their personal assets.

Lloyd's of London is the oldest and the most prominent insurance organization. Lloyd's writes property-liability insurance throughout the United States, primarily on a non-admitted basis. The New York Insurance Exchange is a U.S.-based Lloyd's association, which is comprised of groups of underwriters formed into syndicates. Syndicate members' liability is limited to their investment in the syndicate. Only a few states, such as Texas, license U.S. Lloyd's associations that also sell propertyliability insurance.

Historically, Lloyd's associations have tended to write larger, unique and higher-risk insurance policies. This orientation is partly historical, but also may stem from the high potential returns from such business and the flexibility offered by recruiting a number of underwriters to share in the coverage of a particular risk. However, the unlimited liability of Lloyd's of London “names” exposes them to a higher risk. This became an issue in recent years, when Lloyd’s recruited a large number of new names, some of whom did not fully understand their high exposure until their claims obligations became apparent.

This problem is related to financial difficulties Lloyd's suffered in the 1990s due to its accounting procedures and higher-than-anticipated losses from some of the liability coverages it sold, including coverage of U.S. environmental and health liabilities. Hence, it implemented a number of procedural and structural reforms to rectify identified flaws and secure its long-term viability as an alternative source of insurance.

In 1996, Lloyd's moved 1992 and prior business into a new U.K. reinsurance company, Equitas. If Equitas is unable to pay its liabilities in full, the U.K. government will require it to pay a reduced percentage of its total liabilities without being placed in receivership. In response to concerns from U.S. regulators, Lloyd's is required to maintain two $100 million joint asset trust funds, which allow Lloyd's to continue to write business in the United States. U.S. insurance regulators also have required Lloyd's syndicates to provide actuarial reports on their overall losses, as well as the losses represented in their U.S. trust funds.

Lloyd's began requiring its syndicates to file actuarial opinions with their U.K. regulatory filings in 1998.

1.08.1778 – the "Hamburg Asylum Society for the Elders" was founded, having started the now known pension insurance.

1885 – the first "Russian Society for Reinsurance", which was engaged in reinsurance of risks associated with fire, arose.

1891 – a mutual insurance company Dnister was established in Lviv. The insurance was mainly subject to the property of the peasants from the fire and agricultural crops from the hailstones. During the 25 years of its activities, Dnister has implemented about 4 million policies, the insurance indemnity amounted to 50% of the premiums received.

1898 – insurance company of the American city of Hartford (Connecticut) issued the first insurance policy to the car owner. The insured car belonged to Martin Truman of Buffalo, New York.

1901 – the first car was insured under the insurance policy of Lloyd's. Cars at this time were a completely new kind of transport and no special policies, or the conditions of insurance then did not exist for them yet. The Marine Underwriter issued a customary maritime insurance policy for this car on the grounds that it was a ship but was navigating by land.

1911 – in Chernivtsi, an insurance company "Carpathia" was established that carried out life insurance and pensions. The poor people also had the opportunity to be insured, as "Carpathia" offered relatively low tariffs and various variants of mixed life insurance.

November 28, 1918 – the history of the State Insurance Agency of the USSR began with the decree of the People's Commissars "On the organization of the insurance business in the Russian Federation". All private insurance companies and companies have been liquidated. The insurance was declared a monopoly of the state. The State Insurance Fund of the USSR was reorganized into state organizations of the Soviet republics, including Ukrderzhstrakh, which was later renamed into the National Joint Stock Insurance Company "Oranta".

1.3. Evolution of the U.S. Insurance Industry

Dramatic changes have occurred in the U.S. insurance industry since its beginnings in the late 1600s. In its early years, small local and regional carriers, writing primarily fire and traditional life insurance, dominated the industry. Since then, it has grown tremendously in terms of the amount and variety of insurance products and the number of insurers. Today, companies of various sizes selling a vast array of products across state and national boundaries populate the industry. A wide range of insurance services has become available to buyers, reflecting the growing national economy and diversity of buyer needs and tastes for insurance protection. Industry changes have compelled the evolution of regulatory institutions. Regulatory evolution, in turn, has facilitated the development of the insurance industry. That development continues as the industry consolidates, insurers restructure their product lines and companies extend their global operations.

The tremendous growth of the private insurance industry in the United States is plots industry income (premiums and investment income), in constant dollars, relative to gross domestic product (GDP) over the period 1960 to 2000. Total industry income increased from $184 billion (measured in 2000 dollars) in 1960 to $1,168 billion in 2000, a 534 percent rise in real terms. The industry grew considerably faster than the overall U.S. economy. Insurance represented approximately 7.4 percent of GDP in 1960, compared to 11.9 percent in 2000. The number of insurance companies also increased from 4,580 in 1970 to 6,094 in 1990. This figure has since dropped to 4,406 in 2002, reflecting the consolidation of the industry. The fact that the number of insurers has not increased as rapidly as

their real income indicates that the average size of an insurer has increased, which has been furthered spurred by mergers and acquisitions. Industry growth also is reflected in the rise in industry employment from 1.5 million in 1970 to 2.2 million in 2002.

One trend common to all sectors is increasing financial risk. This increased risk, combined with other economic events, caused the number and size of insurer failures to increase significantly in the early 1980s until the early 1990s. Only 20 insurers failed every year, on average, over the period 1976–1984, compared to 70 failures per year for the period 1984-1993. The number of property-liability insolvencies began increasing in 1983 (as the commercial lines market softened) and did not begin to drop until 1993.

Life-health insolvencies did not begin their rise until 1986 and began to decline in 1992. Life-health insolvencies were particularly frequent in the years 1989–1992, when life-health insurers struggled with asset problems. Both property-liability and life-health guaranty fund assessments increased significantly in the latter half of the 1980s, as the number and size of insolvencies increased. It should be noted that these figures are fairly small relative to the size of the industry. The number of insurer failures per year has generally remained less than 0.5 percent of the total companies in operation and annual guaranty fund assessments has not risen above 0.3 percent of total industry premiums in any given year. Still, the increased frequency and severity of insurer failures, coming on the heels of problems in banking and thrift industries, raised concerns about the potential for a more serious crisis and led to the strengthening of insurer solvency regulation in the late 1980s and early 1990s. This is important to understanding the restructuring of insurance regulatory institutions.

After 1994, insurer insolvencies decreased dramatically to prior levels – only to rise again in 2000 in the property-liability sector as a consequence of soft market conditions in the last half of the 1990s and early 2000s. Still, this rise has been fairly moderate and the numbers of insolvencies in both the property-liability and life-health sectors remain considerably below their highs in the early 1990s. It is difficult to determine precisely why the number of insolvencies fell, but there are several potential contributors, including regulatory reforms, improved rating agency procedures, improved financial management of insurers, a generally strong economy and increasing asset values. At the same time, contingencies, such as natural and man-made catastrophes, uncertain asbestos and pollution liability obligations, soft pricing, competition from other financial institutions and cyclical downturns in the economy continue to pose a threat to insurers' financial health. Hence, regulators must be vigilant in detecting and responding to adverse trends to maintain the industry's financial solidity.

The nature of the property-liability insurance business is quite different today than it was 50 years ago. In the industry's infancy, local stock companies and mutual protection associations formed to provide property and fire insurance in a particular community. Over time, property-liability companies have expanded the types of insurance they offer and the geographic area of their operations. Property-liability insurers now cover a wide range of exposures, from residential fire to

managerial liability. The industry continues to innovate in developing new products, as well as retuning old ones. This has increased the complexity of the business and, in some instances, its risk and uncertainty.

One of the significant factors causing increased risk in property-liability insurance is the long payout pattern for commercial liability lines, which makes proper pricing and reserving difficult and subject to manipulation. Shifting liability rules also increase the margin for error and insolvency risk. Cyclical pricing and periodic crises, prompted by severe loss shocks, have plagued the industry. Significant cost inflation in certain commercial lines has induced some buyers to purchase coverage from alternative sources, such as surplus lines insurers and risk retention groups or become self-insured. Another alternative available to some businesses is the formation of a captive insurer or affiliating with other similar businesses to form a group captive insurer. These developments have increased competitive pressure on traditional insurers. Weather changes, severe storms, earthquakes, terrorist risks and extensive building in high-exposure areas have increased catastrophe hazards in property lines. Insurers' profits increased in 2002-2004 due to hard market conditions, but in the long term, greater risk and low profits will continue to pose significant challenges for property-liability insurers.

Historical trends on the portion of the property-liability insurance industry represented by traditional or standard insurers (i.e., insurers domiciled and licensed in the United States). There are still a significant number of small, independent insurers selling property-liability insurance in a limited geographic area. However, large national carriers now account for a larger share of many markets, relegating other insurers to niches they are better positioned to serve. The top 10 property-liability insurers accounted for 46.9 percent of direct premiums written in 2004, compared with 34.4 percent in 1960. Foreign companies also are making increasing inroads into the U.S. domestic market while some U.S. insurers are establishing a significant presence overseas. Fierce competition has forced insurers in all sectors to streamline their operations and abandon unprofitable lines. A number of insurers have sold marginal segments of their business and are concentrating on areas where they believe their core competencies and best opportunities lie. This is reflected in increased market concentration in certain lines of business.

The assets of propertyliability insurers increased from $30.1 billion in 1960 to $1.2 trillion in 2002. Commensurately, total premium and investment income increased from $15.7 billion to $411.4 billion over this same period. At the same time, the industry's leverage, reflected by the ratio of net premiums to surplus, declined from 210.2 percent in 1970 to 99.8 percent in 2002.

Personal auto and homeowners insurance represent approximately one-half of total property-liability premiums. More than 2,400 insurance companies sold property-liability insurance in 2003, with more than 1,000 insurers competing in most major lines. Despite recent market consolidation, most property-liability insurance markets have retained a competitive structure. Two principal measures of market concentration, the 10-firm concentration ratio (the market share of the top 10 insurers) and the Herfindahl-Hirschman Index (the sum of the squared

market shares of all insurers) also reflect competitive market structures in these lines. (The HHI is a summary measure of market concentration that is commonly used by economists. Potential values of the HHI range from near zero to 10,000, the value if there is only one firm in the market. The higher the HHI, the greater the degree of market concentration).

The top 10 insurers accounted for less than 40 percent of the premiums in any given line (with the exception of homeowners), and 20 percent to 25 percent in many lines. Similarly, HHI values ranged from 72 to 367, with most lines falling between 100 and 200. These levels of concentration are considerably below levels that most economists consider necessary for firms to begin acquiring market power. Entry and exit barriers also appear to be low. State fixed minimum capital requirements average in the area of $2 million, which most insurers easily meet.

An insurer's risk-based capital (RBC) requirement will often exceed a state's fixed minimum requirement, but the data indicate that all but a few insurers substantially exceed their RBC requirements. Low entry and exit barriers are reflected in the high percentage of entries into and exits out of these lines since 1990. In most states, non-domestic companies write from 60 percent to 90 percent of the total property-liability premiums, with the weighted average at just under 80 percent. This reflects the interdependence of states in regulating insurers that cross state boundaries and the need to coordinate their oversight.

As in the property-liability insurance markets, dramatic changes have occurred in the accident-health insurance markets. Medical cost inflation and competition have led buyers to search aggressively for savings in their health insurance bills. The sales of standard indemnity policies have declined as insurers have been compelled to redesign their products and services to allow buyers more cost-containment options. Many carriers now offer managed care programs and integrated service networks that involve alliances with doctors and hospitals. The provision of third-party administrative services also is an important market for insurers with the growing number of self-insured risk plans. The traditional dividing lines between insurance companies and other entities in the financing and delivery of health care have become blurred as different firms take on specialized functions and form partnerships to take best advantage of their relative strengths.

For many years, life insurers' "bread and butter" were standard term and whole life policies that emphasized death benefits and offered a modest savings component (for whole life policies). That environment has dramatically changed, as life insurers now offer an expansive menu of life insurance policies, annuities and other interest-sensitive contracts with different risk-return characteristics. This shift is reflected in the fact that life insurers' reserves for retirement-related products (individual and group annuities and supplemental contracts with life contingencies) grew from 27.2 percent of life insurance reserves in 1950 to 69.1 percent in 2000.

The increased significance of interest-sensitive products and insurers' greater exposure to disintermediation (i.e., policy loans, surrenders and lapses) has increased the importance of appropriate asset-liability matching strategies. At the same time, competitive pressures have induced insurers to maintain high crediting

interest rates on their policies. In the 1980s, company investment officers were pressured to increase investment yields and preserve profit margins by lengthening bond maturities and investing in lower-grade securities. Many life insurers assumed greater financial risk while their profitability dropped.

Fortunately, life insurers' profitability rebounded by the mid-1990s as their asset values increased. However, the low market interest rates of the past few years have squeezed the guaranteed interest rates provided in many cash value life insurance contracts, as well as affected the market-linked rates in contracts with interest-sensitive components. Hence, life insurers will continue to face these pressures until market rates rebound to higher levels.

In the 1980s and early 1990s, some insurers invested heavily in noninvestment grade bonds, mortgage loans and real estate to increase their investment returns. When the values of these assets declined in the early 1990s, it created problems for some life insurers and a "flight-to-quality" by some consumers. Insurers were compelled to decrease their holdings of "risky" assets to preserve their financial strength ratings and avoid policyholder runs.

Within the past decade, some life insurers have invested in derivative securities, either to hedge risk or increase investment returns. In concept, the informed and proper use of derivatives should increase insurers' ability to manage their financial risk more efficiently. This is especially important for contracts with embedded options that allow contract owners to withdraw funds for other types of investments. However, regulators are concerned that some insurers might not have sufficient expertise to use derivatives appropriately and could be exposed to increased financial risk.

Consequently, this area has received increased regulatory scrutiny. The number of life-health insurance companies increased from 649 in 1950 to 2,195 in 1990, but then fell to 1,076 in 2002. This parallels the consolidation trends in the property-liability and accident-health sectors. Over this same period, life insurers' assets increased from $64 billion to $3.4 trillion. Total annual income increased from $11.3 billion to $734 billion. The dramatic shift in traditional life to annuity business is evident in the relative shares of income and reserves for these two segments. Hence, the industry has continued to grow in terms of the funds under its control, albeit at a slower pace than other non-bank financial intermediaries.

1.4. Types and forms of insurance

Insurance is carried out in two forms – voluntary and obligatory. The list of types of insurance that can be used by the policyholder is an assortment of insurance market services. All mandatory and voluntary insurance types are included in the Law of Ukraine "On Insurance" and are reflected in Articles 6 and 7.

Insurance activity in the forms of voluntary and compulsory insurance, which is subject to licensing in the Ukrainian insurance market, can be classified depending on the objects of insurance.

Classification of objects of voluntary insurance by branches of insurance is given in the table. 1.

Table 1. Classification of objects of voluntary insurance

№	Insurance industry	The object of voluntary insurance
1.	Personal insurance	- life insurance; - accident insurance; - medical insurance (continuous health insurance); - health insurance in case of illness
2.	Property insurance	- railway transport insurance; - insurance of land transport (except for railway); - air transport insurance; - insurance of water transport (marine inland and other types of water transport); - insurance of loads and luggage (load-carrying); - insurance against fire risks and risks of natural disasters; - insurance of loans; - insurance of investments; - insurance of financial risks; - legal expenses insurance; - insurance of issued guarantees (surety) and accepted guarantees; - medical expenses insurance; - insurance of other property
3.	Liability insurance	- civil liability insurance of land transport owners (including carrier liability); - insurance of liability of owners of air transport (including liability of the carrier); - insurance of liability of owners of water transport (including liability of the carrier); - insurance of third-party liability

Classification of objects of compulsory insurance by insurance industry is given in the table. 2.

Table 2. Classification of objects of compulsory insurance

№	Insurance industry	Object of compulsory insurance
1.	Personal insurance	- medical Insurance; - personal insurance of medical and pharmaceutical workers in case of human immunodeficiency virus infection in the performance of their official duties;

		- personal insurance of employees of departmental and rural fire protection and members of voluntary fire brigades; - insurance of sportsmen of higher categories; - life and health insurance of specialists in veterinary medicine; - personal insurance against accidents in transport; - insurance of employees involved in the provision of psychiatric care, including carries out the care of persons suffering from mental disorders; - insurance of medical and other employees of public and communal health care institutions and state scientific institutions in case of a disease of infectious diseases related to their professional duties in conditions of high risk of infection with pathogens of infectious diseases; - life and health insurance for volunteers for the period of volunteer assistance
2.	Property insurance	- aviation insurance of civil aviation; - insurance of means of water transport; - property risks insurance under a production sharing agreement; - property risks insurance in industrial oil and gas field development; - insurance of objects of space activity (ground infrastructure); - insurance of objects of space activity (space infrastructure) which are the property of Ukraine, concerning risks related to the preparation for the launch of space technology on the space launch site, its launch and operation in outer space; - animal insurance in case of death, destruction, forced slaughter, illness, natural disasters and accidents; - insurance of electric power transmission lines and transformer equipment of electric power transmitters from damage caused by natural disasters or man-made disasters and from unlawful actions of third parties; - insurance of the subject of mortgage from the risks of accidental destruction, accidental damage or damage; - insurance of the property transferred to the concession; - insurance of property risks of the user of subsoil during experimental, industrial and industrial extraction and use of gas of coal deposits
3.	Liability insurance	- insurance of liability of a marine carrier and the performer of work related to the servicing of maritime transport, in respect of compensation for losses incurred

		by passengers, baggage, mail, cargo, other users of sea transport and third parties; - insurance of civil liability of owners of land vehicles; - civil liability insurance of a nuclear installation operator for nuclear damage that may be caused by a nuclear incident; - insurance of civil liability of economic entities for damage that may be caused by fires and accidents at objects of high danger, including fire and explosive objects and objects, which economic activity can lead to accidents of ecological and sanitary-epidemiological nature; - insurance of civil liability of the investor, including for damage caused to the environment, to the health of people, under the agreement on the distribution of production, unless otherwise provided by such an agreement; - insurance of financial responsibility, life and health of the temporary administrator and liquidator of the financial institution; - insurance of the exporter and the person responsible for the disposal (removal) of hazardous waste for compensation for damage that may be caused to human health, property and the environment during the transboundary movement and disposal (removal) of hazardous waste; - insurance of civil liability of subjects of space activity; - insurance of liability for the risks associated with the preparation for the launch of space technology on the space launch site, launch and operation of it in outer space; - insurance of liability of subjects of transportation of dangerous goods in case of occurrence of negative consequences in transportation of dangerous goods; - insurance of professional liability of persons whose activities may cause damage to third parties; - insurance of liability of owners of dogs for damage that may be caused to third parties; - insurance of civil liability of citizens of Ukraine possessing or otherwise possessing legal possession of weapons for damage that may be caused to a third person or its property as a result of the possession, possession or use of this weapon; - insurance of liability of subjects of tourist activity for damage inflicted on the life or health of a tourist or his

		property; - liability insurance of the shipowner; - insurance of liability of producers (suppliers) of products of animal origin, veterinary preparations, substances for damage caused to third parties; - insurance of civil liability of economic entities for damage that may be caused to the environment or human health during the storage and use of pesticides and agrochemicals; - insurance of civil liability of a business entity for damage that may be caused to third parties as a result of blasting operations

To implement compulsory insurance, the Cabinet of Ministers of Ukraine establishes the procedure and rules for its implementation, the form of the model agreement, the special conditions of licensing of compulsory insurance, the size of insurance amounts and the maximum amounts of insurance tariffs (or the method of actuarial calculations).

1.5. System of insurance funds

The economic category of insurance protection is materially embodied in the **insurance fund**, which is a collection of natural resources and financial resources of society, designed to prevent, localize and compensate for damage caused by natural disasters, accidents and extraordinary events.

Historically, the category of insurance arose before the idea of creating an insurance fund. At first, the loss was reimbursed by the participants on solidarity terms after each insured event.

In the form of insurance funds in insurance distinguish self-insurance, centralized and collective insurance.

The insurance fund may be formed:

1) by self-insurance – the creation of insurance reserves directly used by the business entity itself. Self insurance is based on individual responsibility. The disadvantage of this form of insurance is the inability to create an insurance fund of the required size, as it requires the removal of significant funds from the economic turnover. Self-insurance is the first historical form of insurance.

2) at the expense of state funds, which are used on the order of the Government (centralized funds and reserves). Centralized insurance is based on state liability and is financed from national funds concentrated in separate state funds (reserve funds of the Cabinet of Ministers and regional state authorities). The peculiarity of this form of insurance is the limited nature of insurance objects (emergencies) and the formation of both monetary and property insurance funds (the state reserve).

3) at the expense of the insurers themselves, that is, the clients of the insurance company (the insurer's insurance fund). Collective insurance is based on

the joint liability of members of the insurance fund, which they form their contributions. It is collective insurance that is the basis of the insurance market in the form of insurance funds of insurance companies.

Establishing an insurance fund to fulfill the obligations of an insurance organization to the policyholder is the implementation of the basic principle of insurance. For a certain fee, the insured participates in the formation of an insurance fund, receiving a guarantee of compensation for damage, the terms of which are set by the insurance contract. At the same time, the insurer collects cash in the authorized capital of the company, calculated on its further increase. The insurance company does not allocate in the insurance fund the share of each insured in case of occurrence of insured events. The insurance fund serves all the insurers of the company: its purpose is to pay for any insured risk that has come.

The sources of the insurance company's insurance company are:

- authorized capital of the insurance organization, consisting of contributions of the founders (shareholders) of the insurance company;
- insurance premiums paid by insurers under insurance and reinsurance contracts;
- income from investment of insurance reserves and free own funds;
- other income from the activities of the insurer, not prohibited by law.

Insurer's insurance fund is formed at the expense of money deposits of both the insurer and insurers; so both parties are interested in its effective use. At the same time, for insurers, the insurance fund – is primarily a guarantee of the fulfillment of obligations by the insurer in the payment of insurance indemnity in the event of insured events. On the contrary, for the insurer, the insurance fund is the capital through which it can make its growth and profit, and secondly, it is a means to fulfill obligations to policyholders. Thus, the interests of both sides of insurance relations are balanced.

The question for self-control

1. What is the need for insurance coverage against risky circumstances?
2. Name the insurance features as an economic category.
3. History of the emergence and development of insurance.
4. What are the peculiarities of insurance development in Ukraine?
5. Describe the insurance functions.
6. What principles of insurance do you know?
7. What is a franchise and how does it affect the amount of insurance indemnity?
8. The role of reinsurance.
9. Describe the classification of insurance.
10. Name the types of compulsory and voluntary insurance.
11. In what cases does the state establish a mandatory form of insurance?
12. What new types of insurance have been introduced in Ukraine recently?

Topic 2. CONCEPT AND TYPES OF RISKS

Methodical recommendations for studying the topic

Fighting this topic, it should be noted that it is risk that is a prerequisite for the emergence of insurance relations. The risk factor and the need for its coverage determine the need for insurance.

It should be noted that the manifestation of various risks in all spheres of socio-economic life necessitates their specific classification in order to apply systemic analysis and making sound management decisions.

It is advisable to consider in detail the risk management implemented by insurance companies, the techniques and methods used at each stage of this management, to understand that risk management is an objectively necessary and significant element of management, an important prerequisite for business success, since the risk is inevitable in a market management.

Mini-lexicon

insurance risk, insurance case, risk cumulative, amount of damage, net risk, speculative risk, risk management, risk identification, risk analysis, risk assessment.

2.1. Essence and types of risks

In its first and foremost risk is uncertainty. Risk will be recognized only such uncertainty, which can be estimated in quantitative parameters. This is possible if we calculate the probability of its occurrence, that is, to take into account: the frequency of occurrence of the event relative to place and time (the ratio of the number of insurance claims to the number of insurance contracts); the size of the loss, that is, the absolute value of the negative deviation of the actual result from the expected.

The indicator of risk in its content – it's not just the probability of occurrence of a particular event, but also the probability of a negative result. Negative result of the appearance of an uncertain event may be not only direct losses (losses), but also indirect, for example, the lost (lost) expected benefits, which was planned to achieve in the process of effective economic activity. Proceeding from this premise, one can state: risk is the probability of suffering losses of expected economic (financial) benefits or direct losses due to the occurrence of an uncertain (accidental) event regarding the property interest of members of society. The risk and need to cover possible damage as a result of its manifestation cause the need for insurance.

Insurance risk is an event, the occurrence of which is not defined in time and space, independent of the will of the parties, is dangerous, as a result of which there is an incentive for insurance. This is a risk that can be estimated from the

point of view of the probability of occurrence of an insured event and the size of possible damage.

The concept of insurance risk has several meanings, namely:

1) the probability of occurrence of an event that is out of control;

2) the probability of occurrence of damage as a result of damage (loss) of property, damage to health, death (death) of the insured (insured person) as a result of the insured event;

3) an event in case of occurrence of which insurance is being carried out;

4) insurance objects that act as carriers of risk.

The classification of risks is shown in Fig. 1.

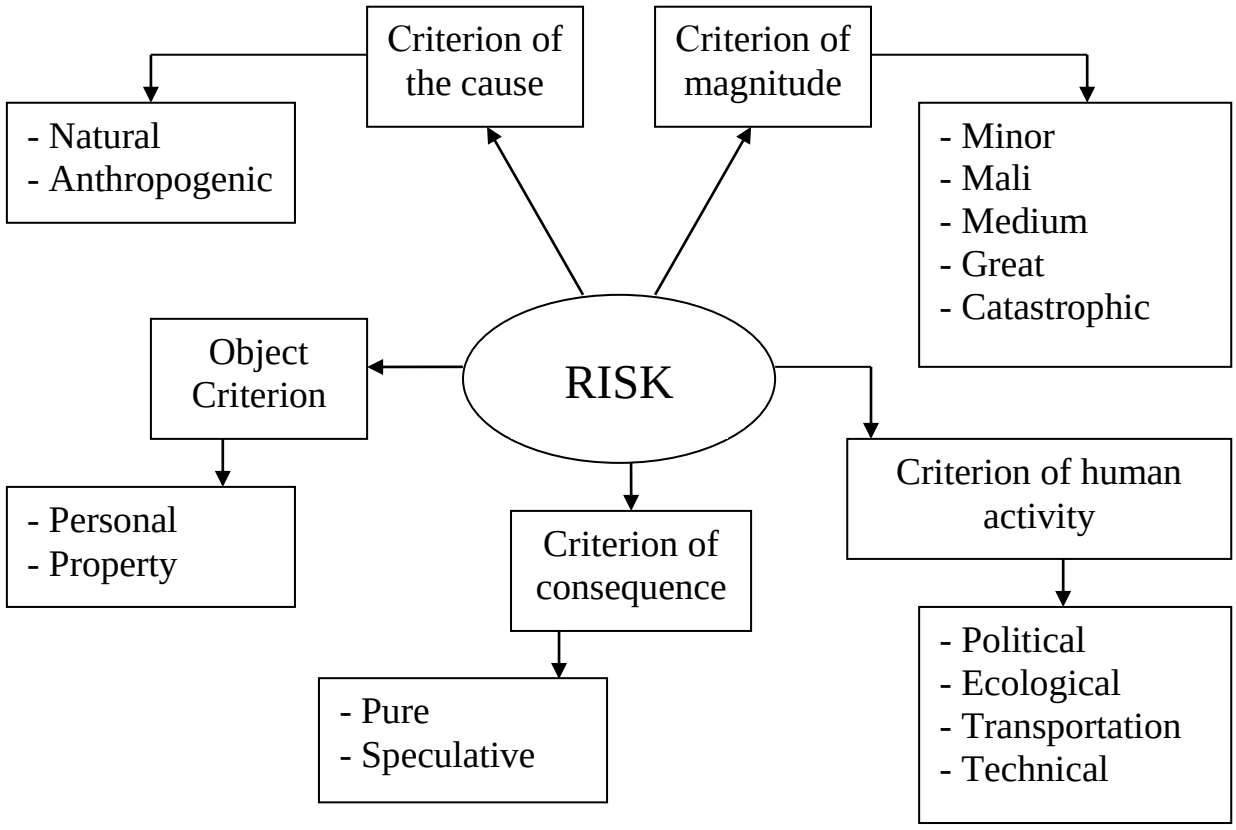

Fig. 1. Classification of risks

Originally, risks are divided primarily into natural and anthropogenic. The natural origin of risks is characterized by the complete independence of causes – accidental events and natural phenomena. In contrast to the risks of natural origin, anthropogenic risks arise only as a result of diverse economic and scientific and technical activities of people. A person as an object of risk is much more complex than a property object, and therefore it is capable of generating a wider range of risks. This feature stems from the fact that each person is known to be a physical, physiological, and social body at the same time. Depending on which of the specified properties will be harmed by an accident, personal risks can be manifested as risks of physical, physiological and social origin.

Under the criterion of the object risks are divided into property and personal. Regardless of the accidental event, property risks are manifested in property and

property interests of their owners, and personal – on persons of people. Consequences of random events, primarily of anthropogenic origin, may be not only negative, but also positive results.

Risk is endemic to life and business and something that risk-averse individuals and firms have good reason to manage. Broadly defined, **risk** is a condition in which more than one outcome is possible. Uncertainty refers to the perception of risk, which may or may not correspond closely to reality. That is, situations in which the possibility of one or more negative outcomes may or may not occur. Individuals and firms face a number of perils that threaten them with financial losses and other adverse consequences. A peril is an event that causes a loss, such as hostile fires, earthquakes, windstorms and premature death.

Insurance texts distinguish between "pure risk" and "speculative risk". Pure risk involves no chance of economic gain and uncertainty about whether a financial loss will occur and possibly how much that financial loss will be. Speculative risk involves the chance of gain or loss and, in theory, is not insurable. Gambling is an example of speculative risk. The chance of damage to one's home from a fire or storm is an example of a pure risk. The cause of such a loss is accidental and uncertain. Homeowners do not know whether they will have such a loss, when it would occur and how severe it would be. Homeowners only know that a loss might occur because of a random act of nature or other event outside of their control. Moreover, homeowners have nothing to gain from losing their home.

Interesting Facts

In the capital, the Netherlands is invited to conclude an insurance contract for people who do not see their lives without lottery games. Those persons who have played at least 52 times in the lottery and have never won anything, receive from the insurer 2,500 euros. The odds for the insurance case are 1: 4900, which is quite good, given that the odds of winning the main prize in the six-digit lottery are 1:14 million. The cost of insurance is 12-28 euros per year.

By the criterion of magnitude, risks can form a certain number and be divided into catastrophic, large, medium, small and minor. The assignment of risk to any of these categories depends on the likelihood of occurrence of greater or lesser material losses that may arise in each particular case. It is obvious that losses at catastrophic risks are the largest, and for the smallest – the smallest. However, the incidence of catastrophic risks is much lower than that of ordinary or minor ones.

Interesting Facts

In 2002, the world's largest reinsurance company Munich Re (Germany) proposed for the first time to assess the threat of a meteorite falling to Earth.

Depending on the sphere of human activity, there are: political (connected with illegal actions of the governments of foreign states in relation to the sovereign

state, entrepreneurs, citizens), environmental, transportation (casco, kargo) and technical risks (construction and assembly, electrical engineering, operation of machines and equipment).

In theory, risk exposures should meet several conditions to be insurable in a private market. In reality, few risks meet these conditions exactly, but the further they diverge the less insurable they become.

The four conditions for insurability are:

- many independent and identically distributed exposure units;
- the premium should be economically feasible;
- losses should be unintentional and accidental;
- losses should be easily determinable.

Independence means that there is no correlation between an event causing a loss to one exposure and an event causing a loss to another. Identically distributed means each exposure faces the same probability distribution of potential losses. The law of large numbers works most effectively in the pooling and diversification of risk exposures when they are independent and identically distributed. This condition is violated when a significant number of exposures could suffer losses because of one or a series of related events, such as a hurricane or a deadly epidemic. Insurers can use devices such as reinsurance or catastrophe bonds to cope with this problem, but there are practical limits to how much risk can be diversified through these instruments.

An economically feasible premium is sufficient to cover an insurer's cost of providing insurance (i.e., expected loss, necessary expenses and cost of capital), but still low enough to be attractive to potential insureds. Economically feasible premiums are most achievable when the probability of loss is relatively low and insurers' loading for expenses and profit would not exceed the risk premium that an insured would be willing to pay. When the probability of loss reaches higher levels, the corresponding premium will approach or exceed the potential loss. In such a situation, the cost of insurance is so high that a person would be better off if he or she kept the money to pay for a loss that is very likely to occur or find other ways to avoid the loss.

The third condition for insurability is that losses should be unintentional and accidental. There are several reasons for this. One is that insuring intentional losses may give rise to moral hazard, a problem explained further below. When moral hazard is present, losses are more likely to occur. Also, from a social point of view, insuring intentional losses would encourage deliberate destruction of property or loss of life. In addition, losses that occur naturally over time (e.g., the depreciation of an automobile) and are not accidental tend not to be insurable. Such losses are essentially certain and it would be more efficient to budget for them than to purchase insurance.

The final condition is that losses should be easily determinable. If it is impossible to determine whether a loss has occurred or its severity, then the insurer will have no objective information to determine if a claim should be paid or how much the payment should be. If determining a loss is difficult but not impossible,

the cost of adjusting a claim may be so high that it is not possible to offer insurance at an economically feasible premium.

2.2. Features of insurance risk management

The term "management" means managing, rational management. It combines the concept: management system, management conditions, organization. Insurance management is a set of principles, methods, tools and forms of insurance management in order to increase the efficiency of its work and increase profits. It should be remembered that management is not just a managerial activity. It combines the study, analysis, planning, forecasting and formation of the insurance market.

A characteristic feature of the insurance market is the unpredictability of possible outcomes in the implementation of insurance services, that is, its risky nature. In this regard, the main task of insurance management is to anticipate the risk and reduce possible negative consequences to the minimum level. The ultimate results of operating and financial activities reflect the insurance company's reporting. The reporting data, certified by external auditors, is the basis for regulating the activities of insurance companies by the State Insurance Supervisory Committee, tax authorities, potential insurers, banks, etc.

The results of the insurer's activities are also used for analysis and control in order to manage and correct their own position in the insurance market. This control is divided into current and strategic ones. The current management allows you to respond quickly to changes in the environment and the internal state of the insurer, and includes financial management and risk management.

Financial management provides for the development of measures to manage the insurer's financial flows in order to:

- tax planning (optimization of tax payments and management of own financial resources);
- management of deviations, which mean deviations from the average planned values, as well as the actions of the structural units of the insurance company, which allow adjusting the current financial condition.

The overall objective of financial management is to achieve a stable financial position of the company in order to improve the volume and range of insurance services offered.

Risk management involves the use of such methods as:

- regulation of tariff policy at the expense of the change of the gross rate (insurance tariff);
- regulation of the composition and structure of insurance reserves;
- reinsurance of a part of risks for increase of financial stability of the insurer.

The ultimate goal of risk management is the formation of a balanced insurance portfolio. The planning process as an element of management includes the following stages: the choice of purpose; assessment of income and expenses

related to the achievement of the goal; sequence of actions to implement the plan; verification and evaluation of the plan.

Today, the following methods of planning are used in insurance: balance, normative, program-target, economic-mathematical modeling. Particularly important insurance companies provide the regulatory method of planning in connection with the peculiarities of the formation of insurance tariffs. In developing the program-target plan, first of all, take into account: ensuring the financial stability of the insurance company, expanding the range of insurance services. With the help of economic-mathematical modeling, an analysis of the dynamic number of numbers of existing insurance contracts in advance of the planned period is conducted in order to identify the trend of development and its further extrapolation. The data received is adjusted to take account of possible changes in the future.

Regardless of the chosen method of planning, particular attention should be paid to the analysis of the activity of receipt of insurance premiums, which are the source of the primary income of the insurer and the financial base for all subsequent activity of the insurance company. Thus, insurance planning is a means of predicting the size of an insurance fund. At the same time, the volume of insurance payments depends directly on the number of contracts, the list of insurance services and their quality.

Another important element of management is the prognosis of insurance activity. The purpose of the forecast is to identify the main trends and patterns of insurance activity of this company. Modern science has sufficiently developed general theoretical economic and mathematical methods and models of forecasting and management with calculations on the computer.

Insurance requires management, like any economic activity. However, the insurance business has some features, due to which differs from other types of management. These features are that insurance activity is defined in Ukraine as an exclusive activity. In countries with a developed market economy, insurers make a significant part of their profits not from insurance activities, but from investment. The main task for the insurer is to increase the number of insurers and use the collected insurance premiums for investment activity.

All this was made possible by a well thought-out and well-considered management policy. Insurers began to approach the issue of taking risks more balanced, more efficiently earned the institution of reinsurance, more attention began to focus on preventive measures, learned to manage risks. Insurance – one of the branches of business, the most dependent on information provision. Each insurer feels the need to constantly analyze changes in external and internal factors that can affect the company's business. Therefore, electronic data processing is an important moment in the strategy of the insurance company's development. It is necessary to develop integrated computer information support systems of the company.

Another important aspect of insurance company management is the amount of insurance payments. Almost all insurers in Ukraine are based on the collection of insurance payments. From this money formed the insurance reserves, payment

of insurance sum and insurance compensation, expenses of the company. Therefore, issues related to the management of insurance payments and their planning become more acute. The requirements to increase financial stability encourage insurance companies to increase the number of insurance contracts.

Another way to increase financial stability can be the balance of the insurance portfolio – an increase in types of insurance and redistribution of liability between insurers. There is a kind of insurance, where the loss-making is almost 100%, but it is popular with the population and is mandatory. In order not to work at a loss insurers are forced to develop other types of insurance and at their expense to cover their losses.

An important aspect of insurance management is the insurer's investment activity. The best way to place insurance reserves is to make an investment strategy. In countries with a developed market economy and strong competition, insurance companies are not aiming to receive large profits from insurance activities. The main task of insurance companies is to maximize insurers and, as a consequence, collected insurance premiums for investment purposes. And in this regard, the insurance company is a participant in the investment process and is forced to know all the intricacies of its market. This is the other side of the investment market, where insurers can act not as investors but as subjects of the insurance market, that is, to insure investment risks for the development and strengthening of investors' positions. This aspect of insurance management is important to consider as an extension of the sphere of influence on the insurance market.

Risk management is a deliberate action by the insurer to limit or minimize risk. The process of risk management is reflected in the development of a situational plan that describes the concrete actions of each participant in insurance relationships and their consequences, which allows you to act quickly in unforeseen circumstances, while reducing the risk of making unreasonable decisions. In addition, special funds of deferred payments, called insurance reserves, technical provisions and life insurance reserves, are created in order to reduce the risk of risks.

The specific risk management method is chosen depending on its type. Let's consider them in more detail.

1. Risk of main activity. There is the risk of an insurer as an entrepreneur. The reasons for its occurrence are loss making insurance operations, increase of labor costs for insurance agents, and decrease of cash receipts.

2. The risk is financial. The reasons for its occurrence are the sphere of relations with external partners (banks and other institutions).

3. The risk is commercial. Appears in the process of implementing insurance services. The reasons for its occurrence are increase of tariff rates, reduction of the list of insurance services by types of insurance, reduction of proceeds from sales.

The specifics of insurance include the following classification of risks at the level:

- admissible – the risk that does not go beyond the net premium;

- critical – the risk at which the full use of the insurance fund takes place while retaining equity capital;

- catastrophic – a risk that leads to the loss of all property (bankruptcy).

When calculating tariffs, a more detailed classification of risks is used: catastrophic, large, medium, small, insignificant.

In insurance practice, the value of risk is taken to be expressed through the indicator of loss-making insurance operations, as well as through the analysis of elements that allow determining the magnitude of risk and completeness of the damage.

Such elements are:

- probability of occurrence of an insured event under one insurance contract;
- average insured amount under one insurance contract;
- average compensation under one insurance contract.

In this regard, before the alignment of risks, it is necessary to analyze the loss index of its three elements. Difficulties in the practice of insurance causes the distribution of risk with a uniform increase in loss-making. It requires a constant review of insurance tariffs based on the average loss of the sum insured. Stages of the risk management process: goal setting, risk identification, risk assessment, choice of risk management methods, use of the selected method, evaluation of results. The steps of the risk management process are reduced to a set of risk management measures that involve regulating the principal activities of the insurer through methods of adjusting policies: bonus, loss, insurance portfolio formation and transfer of risks to reinsurance. Much attention is paid to the marketing activities of the insurer.

2.3. Forms of risks limitation and elimination

Individuals and firms can reduce the pure risks they face through insurance mechanisms designed to transfer and diversify risk across a wider base of exposures and/or over time. This is accomplished by pooling losses for a group of individuals or firms in some manner. Members of the group share all losses that are incurred by its members. In effect, members of the group exchange a smaller, more certain financial contribution for protection against a larger, uncertain loss. Combining losses for a group and sharing them in some manner among group members makes this possible.

Uncertainty and the law of large numbers make insurance valuable, as well as feasible. As the number of members of an insurance pool increases, the random or uncertain aspect of the occurrence of accidents and claims for benefits is reduced, and there is greater certainty about the total losses that the pool will suffer. This allows the pool to allocate its costs among members in the form of smaller, certain premiums or assessments. In essence, pool members exchange their fair share of total pool costs in return for protection against the risk of a potentially much larger loss that they would otherwise face individually.

Risk and uncertainty is reduced through sharing all losses among the group members and the greater predictability of losses achieved by increasing the number

of members of the pool. As the size of a pool increases, its actual losses will tend to come closer to its expected or predicted losses based on the risk levels of its members. Assuming that pool members are risk averse – i.e., they value greater certainty and the reduction of risk – pool members will be willing to pay some additional premium over their expected loss to cover the costs of administering the pool in return for the reduction in risk. This is called a **risk premium**.

It should be stressed that pooling losses does not necessarily mean that every pool member will make an equal contribution to the pool. In theory, equal contributions only make sense if every member of the pool has the same risk of loss. In practice, most pools contain members whose risk varies. Individual pool contributions can be based on each member's relative degree of risk, so that individuals with greater risk pay higher premiums. As explained below, this maintains low-risk pool members' incentives to remain in the pool. Pools can be organized in various ways (e.g., group self-insurance, insurance companies, etc.), but the basic concept is the same.

For many years, socio-economic practice has developed a number of methods and forms of effective counteraction to risks and the elimination of their negative consequences.

The forms of limitation and elimination of risks were as follows:

1. Prevention of the occurrence of accidental events that form risky situations in public life.

2. Overcoming (repression) of random events, the appearance of which, however, could not be prevented.

3. Satisfaction of needs arising from the risk (compensation of losses, losses).

How does the risk management system consist of a series of successive stages, which, in turn, consist of a variety of organizational and financial measures.

The mentioned stages acquire the following content:

1) risk analysis.

2) risk control;

3) risk financing.

Risk analysis is a complex step during which it is assumed:

• diagnostics, or identification, risks (qualifications);

• risk assessment by quantitative methods (quantification);

• determining the sequence of follow-up actions based on a general risk assessment in this particular situation.

Risk control is carried out in different ways:

• avoiding risk;

• reduction (minimization) of risk;

• limitation (localization) of risk;

• distribution (division) of risk.

Avoiding risk is the most effective and at the same time the most difficult to implement by the method. Avoidance means the actual avoidance of risk-taking activity or the way of being. Of course, avoidance can only be made with alternative solutions that are less risky.

In a situation where the possibilities of rational risk avoidance are exhausted, there is a need to use other methods of anti-risk nature. One of these methods is preventive (risk) activity aimed at reducing risk. The implementation of effective preventive activities requires significant financial costs for the purchase of various technical means and organizational and technical measures that could counteract the emergence of risks.

In a situation where, despite all the preventive efforts, the risk comes, they take measures aimed at limiting it (localization). These measures are mostly repressive.

In order to limit the effects of risk, it can be divided. The division of risk as a form of control is that business entities can exchange shares of shares, thus giving part of their own risk and taking part of someone else's. Such operations are known as operations to diversify the portfolio of assets of an economic entity. All of the above methods of controlling risks are applied simultaneously. But there is a requirement to adhere to the optimal correlation between these methods in terms of their effectiveness.

The main stage of the risk management process is to cover their negative consequences (losses) by financial means. The financing of risks is carried out by two methods: self-financing and transfer of risk to another economic entity in accordance with prior mutual agreement. Self-financing of risks, also known as self-insurance, is a form of direct independent coverage of losses by own funds.

Rendering (transfer) of risks can be carried out in two basic forms:

• risks are transferred under the financial guarantee of another entity;

• risks are transferred to professional insurers on the basis of the insurance contract for the corresponding fee.

The first form is widely implemented by concluding bail-out agreements, according to which under certain conditions the risk is transferred by one entity to another. This form has limited application, because it requires extremely high trust in the mutual relations between actors.

The most common form of risk transfer is the transfer to their professional insurers. Insurer, unlike the guarantor, taking on the obligations of risks, is able to align their redistribution among many entities. Alignment of risks with the help of an insurance mechanism has the advantage that it is carried out not only in time, but also in space, that is among the subjects of a certain environment. However, alignment can only be applied to a particular risk category. These are, as a rule, net risks that are consistent with the criteria below.

1. The criterion of complete randomness.

This means that the event that causes the damage should be extraordinary, and the magnitude of the damage is unpredictable.

2. Criterion of uniqueness.

The unequivocal requirement is that, in spite of the accidental event between it and the end result (losses), an explicit causal relationship must be traced. Consequently, we always need to be sure that the amount of funds to cover losses at this accidental event is well-known.

3. Valuation criterion in monetary units.

Since insurance is based on the formation of funds of funds, then the needs that arise when servicing the risks must have a cost, monetary value.

4. The criterion of independence.

Independence of risks is characterized by the fact that they should not be deliberately caused, and also risks should not be easily accumulated, while exposed to other risks.

5. The criterion of magnitude.

The most insured, both in terms of the amount of damage and the probability of their onset, are average risks.

Consequently, according to the tasks performed in the process of risk management, such management should be perceived as a process of choosing the optimal, that is, the most cost-effective structure of tools for influencing risks and their consequences.

Efficiency is a concept that is more often discussed by economists than insurance experts, but it is relevant to all markets and insurance systems. The highest level of efficiency is achieved when resources are used in the best way possible to maximize social welfare (i.e., the combined utility of all members of society). In other words, there is no other possible allocation of resources that would produce a higher level of social welfare. This implies that the benefits of an activity should at least equal its cost or the activity should not be undertaken and that all activities are performed at the lowest cost possible. When this occurs, society reaps the maximum value from the employment of its resources. With respect to insurance, this means individuals and firms are managing risk in the best manner possible from their perspectives, as well as society's perspective. Managing risk efficiently requires selling and purchasing optimal insurance contracts, as well as retaining and controlling losses to the extent that it is cost-effective to do so.

Equity is another word for "fairness", and both terms can imply different things to different people. Some might interpret equity to mean that all insureds should pay the same premiums or receive the same benefits from insurance contracts, regardless of their relative risk. Avariation of this view of equity is based on ability to pay; i.e., those with greater resources would be expected to pay more than those with fewer resources. Alternatively, others define equity to mean that individuals should pay costs according to the benefits they receive. Based on this interpretation, equity in insurance markets is achieved when individuals pay premiums commensurate with their relative risk; i.e., high-risk insureds pay higher premiums than lowrisk insureds.

There is a tradeoff between the first interpretation of equity and efficiency. Equal premium payments among insureds with different levels of risk will reduce efficiency. Low-risk insureds will be induced to buy too little insurance and high-risk insureds will be induced to buy too much. Incentives to mitigate losses also will be distorted by equalizing premium payments. Individuals who do not pay the full cost of their insurance will have less incentive to reduce their risk to lower their premiums.

The second interpretation of equity is consistent with maximizing economic efficiency. Allocating the full costs of activities to their beneficiaries will

encourage insurance and loss-control expenditures that maximize social welfare. Individuals and firms will be induced to reduce their risk of loss if the resulting savings (from lower insurance premiums or retained losses) exceeds their cost of reducing risk (e.g., investing in loss prevention). Consequently, there is no tradeoff between this notion of equity and efficiency.

Moral hazard is another type of market failure that occurs when having insurance causes insureds to change their behavior; i.e., either to intentionally cause losses or expend less effort to avoid losses. Insurance experts draw a distinction between "moral hazard" and "morale hazard". In this lexicon, moral hazard occurs when the insured stands to gain from causing an accident and filing a claim. For example, this could occur if a homeowner could insure a home for more than its market value and gain financially from its loss. Morale hazard arises when an insured has diminished incentives to prevent losses but would not gain financially from an insured event; for example, an insured homeowner who is more careless in preventing losses, such as failing to repair faulty electrical wiring.

Economists tend to use the term moral hazard to cover both phenomena, which will be the convention used in this text. Insurance is impractical in the extreme case of moral hazard, as losses would be intentional and certain. In the less severe case, moral hazard can create significant problems but is not necessarily fatal to a market. If insurers must assume that insureds will act less safely, then they will charge a higher premium to cover higher expected losses. This is still an inefficient result if the cost to insureds of taking more precautions (e.g., fixing faulty wiring in their home) is less than the extra premiums they are charged for not taking the precautions. This problem can be remedied if insurers can restore insureds' incentives to avoid losses.

Insurers combat moral hazard through cost-sharing with insureds, offering premium discounts or credits for safety measures, setting certain policy terms and conditions, and declining to provide coverage in situations where moral hazard is a serious concern. Cost-sharing can take the form of deductibles, policy limits and co-insurance provisions that cause the insured to bear some portion of his or her loss. Retaining some portion of the potential loss increases the insured's incentive to decrease the chance of loss. While such measures have a desirable effect on insureds' incentives, they result in incomplete insurance and diminish the amount of protection.

Alternatively, insurers may seek to improve incentives by offering discounts for loss-prevention measures and declining to sell insurance to individuals who do not demonstrate a commitment to safety. Again, regulators may find some of these measures acceptable and others to be problematic.

2.4. The potential impact of climate change on insurance regulation

Although market regulation issues and strategies to mitigate the impact of climate change will vary by line of business, solvency-related risks remain central to all insurers and lines of business. As such, the threat that climate-change-driven weather-related risks pose to insurer solvency is of universal concern for insurance

regulators, especially considering that insurer financial stability is heavily dependent on its investment portfolio. So it is imperative we examine how climate change will impact the investments insurers hold and establish applicable regulatory standards for the investment practices of insurers.

Direct and indirect investments in real estate represent a portion of all assets held by insurers. While much of this direct investment is held by life insurers, most insurers hold some direct real estate investments for their own operations and some indirect investment for production of income or sale. Many of these properties are located within coastal areas with increasing risk from climate-change-influenced weather perils such as hurricanes and flooding.

Gradual changes like rising sea levels influenced by climate change also pose a risk to structures in these areas. As investors in these properties, insurers may be exposed to greater investment risk. Insurance regulators need to recognize that the risk of weather-related losses on real estate is complex. It can arise not only from declining asset values, but also the costs of fortification, physical damage to structures, and associated business interruption.

Insurers hold reserves funded by investments in assets that are secured in part by real estate. These indirect investments in real estate include mortgage-backed securities and pass-through securities. Climate change poses a risk to these assets as well. In the event of climate-influenced catastrophes, increased mortgage defaults may be expected as owners of property struggle to make mortgage payments under these stressful circumstances.

Premium increases or market withdrawal that results in a lack of affordable insurance coverage could trigger technical mortgage defaults. These technical mortgage defaults due to non-availability of property insurance will impact mortgages in which insurers have invested. This leads to concerns that mortgage lenders may become a property insurer of last resort, as they are required to obtain insurance on property on which they hold mortgages.

Aside from risks to investments in real estate, insurers also face risk from investments in sectors of the economy that have heavy exposure to the effects of global warming. Insurer investments in bonds, preferred stocks, and equities with firms of substantial exposure to climate-change-influenced catastrophes become increasingly problematic. These firms not only face direct weather-related losses to property and potential business interruption, but possibly product and environmental-liabilityrelated losses from possible litigation over pollution emission. As the court system establishes the parameters of legal accountability for climate change to individual sectors of the economy, exposure to such liability may present new challenges for those industries. Municipal bonds, a significant investment holding for many insurers, are another potential source of risk as municipalities face increasing pressure and ultimately costs to adapt to the impacts of climate change.

Working intensively with their domestic insurers, regulators have an opportunity to help insurers address the challenges to insurer solvency posed by climate change. Domestic regulators should begin a dialogue on an insurer’s financial exposure to loss resulting from a catastrophe and small weather extremes.

Regulators should encourage insurers to examine their business to consider the impact of climate change.

As part of this examination, insurers who have not yet done so already should be encouraged to undertake an analysis of geographic spread of property exposures, including a review of the controls in place to assure that the insurer is adequately addressing its net exposure to catastrophic risk. This analysis should also consider different time frames that take into consideration the expected useful life of the assets being insured. Regulators should review studies made by or on behalf of the insurer using catastrophe modeling. Insurers should review the limits, cost and terms of catastrophe reinsurance, including reinstatement provisions.

As climate change is a challenge of unprecedented scope for insurers, regulators should encourage and work with insurers to consider creative methods of risk distribution such as catastrophe bonds and other alternative capital sources, including lines of credit and other appropriate instruments.

Regulators should work with insurers to see that the insurer has a reasonable contingency plan to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event. This contingency plan should give consideration to an insurer's enterprise risk, such as the potential for an event triggering both problematic and correlated insurance and investment losses.

Working together, regulators will need to develop new solvency regulatory tools to meet the challenges of climate change. For example, regulators may consider a requirement of a statement of catastrophe or extreme weather risk by the enterprise risk manager, actuary and risk modeler. The development of an information collection tool that prompts an insurer to analyze and disclose climate risks faced by the insurer and potential responses of the insurer to those risks would allow regulators, investors and consumers to evaluate the insurer's climate change knowledge and planning. Such an information collection tool should provide information to the public but provide insurers the opportunity to keep legitimate trade secret information confidential.

Given that climate change is global, that the number of catastrophic losses is increasing internationally, and that some emerging economies are generating increased properties and increased values, regulators must begin to consider whether there will there be enough capital in the international marketplace to finance the risk. They also need to recognize that some U.S.-domiciled insurers may have cross-border or international insurance exposure in emerging markets where climate-change-influenced risks are high and preparedness is low. States should also strongly consider catastrophe reserving as means to encourage sound enterprise risk management to help ensure adequate capital is available for catastrophic loss potential impacted by climate change.

Alternative risk transfer vehicles need to be explored, and this industry needs to improve its educational outreach. Regulators could assist with the development of common terminology and encourage the development of a more transparent marketplace. However, alternative risk transfer methods are not

necessarily applicable to addressing the full spectrum of climate change risk exposure, especially the impacts from smaller scale, diffuse and gradual events.

The impact of climate change on insurers is ultimately borne in large part by policyholders. Reductions in coverage availability of personal and commercial property insurance have been predicted as a likely outcome of global warming.

Insurers facing the near certainty of losses that exceed premium for coastal regions may be limited in the magnitude of their rate increases on a temporary basis. Recent experience in the southeastern and northeastern U.S. has shown that changing expectations of the long-run risk profiles have made it difficult for insurers to price their products on an actuarially sound basis. Likewise, policyholders face uncertainty as to the real risk, and hence cost, of building in a particular location. As obtaining financing for real estate acquisition requires property insurance protection, further economic development of coastal regions, western forests and other environmentally fragile locations will require a commitment to understand and mitigate the risk that arises as a result of global warming.

Before insurance coverage becomes unaffordable or unavailable, consumers, politicians, realtors, builders and other interested stakeholders, will demand regulators and insurers become even more involved in understanding changes in underlying risks and communicating that understanding to policyholders and the public. Regulators should work with the insurance industry to educate these groups about the increased risks associated with climate change and the associated factors that contribute to the cost of insurance. Insurers have long understood that the only way to achieve sustained stability or reduction in insurance costs is to reduce the level of risk. If insurance costs are to be controlled, policyholders need to become active partners in this effort, which means that insurers must continue to push in this direction.

Life insurance issues

While property and casualty insurers may face the greatest impact of climate-change-related catastrophic events, life insurers face challenges as well. Life insurers manage products that American families rely on for financial security during retirement and in the event of premature death. Because life insurers hold long-term assets and enter into long-term contracts, actions taken today may have significant implications for future solvency. Life insurers have an obligation to their policyholders to fulfill all contracts, and must be prudent when managing investments and issuing policies. Not preparing for the possible effects of climate change may indeed have serious repercussions for both life insurers and policyholders.

Unlike many other industries, the primary business of life insurers is to underwrite and manage long-term risk, including mortality-linked risk. Life insurers pool, diversify and hedge their risk in preparation for catastrophic events and any resulting change in mortality. In order to be prepared for climate change, life insurers need to keep abreast of changes in the frequency and/or severity of weather-related events, and should try to determine the degree to which an individual catastrophic event can be attributed to climate change as opposed to

other factors. Life insurers should also monitor scientific advances in forecasting, storm tracking and communications; improvements in federal, state and local disaster mitigation and management; and changes in public awareness and attitudes, all of which may lower fatalities associated with catastrophic events.

As the public becomes aware of the danger posed by extreme weather, it will be more proactive and will be more likely to follow mandatory and voluntary evacuation orders or take other life-saving actions. Paradoxically, it is possible that increased public awareness, coupled with technological and logistical advances, may ultimately result in an overall reduction in mortality related to catastrophic events, even in an environment of climate change.

Life insurers must consider all these variables when anticipating future changes in mortality resulting from the possible effects of climate change. Like other industries, life insurers should also prepare for the impact of climate change on investments. Since they are in the business of managing long-term financial risk, this is something they currently do, and the expectation is that this will continue. Climate change is one of numerous risk factors considered by life insurers when they make investment choices, with the impact of risk varying according to the type of investment made.

Health insurer issues

At a very basic level, human health will be impacted by climate change in ways that are not yet fully understood nor anticipated. There are a host of possible events and associated consequences – some of which will compound already existing health issues such as asthma – that will require regulators to better understand and evaluate their effect on public health and the health insurance industry.

Among the possible events are:

- hurricanes and other flooding events where people are exposed to flood waters. The flood waters from Hurricane Katrina provide a perfect example. People were exposed to many bacteria (e-coli and others) and hazardous chemicals as they fled their homes. Many were made sick over the short term, including protracted mental health issues. Only time will tell if there are significant long-term consequences.

- health issues associated with heat waves. The 2003 European heat wave not only killed many, but severely strained the ability of European nations to deal with the immediate health consequences. There were some nations where the summer holiday (vacation) schedule left few trained medical personnel available to deal with the influx of those affected by the heat wave.

- climate change can also adversely impact the prevalence of vector-borne diseases, food poisoning, water quality, aeroallergens, and the health of natural systems that can cause economic losses for humans, sometimes insured.

- the combination of more airborne allergens, rising temperatures, greater humidity, more wildfires, and more dust and particulate pollution may considerably exacerbate upper respiratory disease (rhinitis, conjunctivitis, sinusitis, asthma) and cardiovascular disease.

Coverage of Disclosure

In the absence of detailed mandatory reporting requirements there are several groups that may wish insurers to increase disclosure of their response to climate risk. Various interest groups and bodies have the ability to encourage and in some situations force disclosure. Insurers could be faced with a variety of differing reporting requests. In the interests of uniformity and regulatory certainty, regulators and industry that are proactive in disclosure will have greater control over the final forms of disclosure.

Some of these groups and bodies that have been active in encouraging and trying to force disclosure are:

- investors, particularly institutional investors and organized groups of individual investors,
- insurer management, who may wish to be seen as leaders or who are personally interested in climate risk, or who lead insurers that are particularly vulnerable to climate risk,
- professional bodies involved in establishing accounting standards, auditors, and actuaries, who as professionals may see climate risk as poorly understood and/or measured, and hence a vulnerability to the integrity of their work.

Global warming and the resultant climate change will have impacts across multiple lines of insurance. Whether it is property and casualty, health, or life insurance – the impacts will be felt across many sectors of the economy that depend on insurance to provide financial security.

Insurance regulators, working together, must continue to develop tools to evaluate these risks. Regulators, like companies, are operating under conditions of uncertainty with regard to the extent of climate change risk and the models used to study those risks. Nonetheless, regulators have the duty to protect consumers, despite knowing that companies will not have complete information and therefore, not be able to report with certainty. Under these circumstances, the framing of questions and evaluation of responses must take the inherent uncertainty into account.

There are many things discussed in the white paper that call for further concerted action by insurance regulators as they consider how best to encourage or even require insurers to thoroughly address growing climate change risk in order to

protect consumers and insurer solvency. Regulators also have a role to play in ensuring that environmental benefits claimed by insurers are authentic and reasonably quantified to lend credibility to these efforts.

The question for self-control

1. Give the definition of insurance risk.
2. What is the difference in insurance risk from an insured event?
3. What criteria are used to classify risks?
4. What is meant by "risk management"?
5. What methods of risk management do you know?
6. Name the causes of catastrophic risks.

7. What is the feature of unique risks?
8. How do you determine the probability of a risk?

Topic 3. INSURANCE MARKET

Methodical recommendations for studying the topic

Before you begin studying this topic, try to independently determine the insurance market and indicate the objective need for its existence.

In the process of mastering the material, particular attention should be paid to the fact that one of three subjects of the insurance market, together with the insurer and the insured, is an insurance intermediary. Since Ukraine has two main types of intermediaries - insurance agents and insurance brokers, it is necessary to clearly identify their main functions and differences between them. To do this, you need to familiarize yourself with the current instructional and regulatory material.

Having studied the general characteristics of the insurance market, it is advisable to analyze its current state and prospects of development, using statistical materials and reports in the press. It is recommended to pay attention to the procedure for the establishment and operation of mutual insurance societies, to identify their differences and common features compared with the activities of insurance companies.

After mastering this topic, one should consider the functions, principles of activities and the main tasks of professional associations of insurers established in Ukraine.

By studying this topic, one must realize that the activity of an insurance company always depends on the economic environment in which it exists. It is worth paying attention to the fact that insurance companies are divided into types depending on the criterion laid the basis for their classification (according to the form of organization, the nature of the operations performed, the size of the authorized capital).

It is necessary to study the activities of foreign insurers in the domestic market, as well as the organizational structure of the insurance company and pay attention to the fact that the activities of the insurer can not be carried out without the availability of labor, financial and information resources.

For better understanding and assimilation of the material is mandatory independent processing of the current instructive and normative acts concerning the activities of insurers.

When considering the issues of marketing in insurance it would be expedient, using the information of the advertising character and materials periodicals, to find out the main objectives of marketing in practice.

Concluding the study of the topic of the insurance contract, it is necessary to process it, in accordance with the Law of Ukraine "On insurance" and forms of contracts for certain types of insurance.

It is necessary to understand the necessity of state regulation of insurance as a sphere of business.

It is advisable to consider in detail the history of the creation of a state control body for insurance activities in our country, its work over the years, as well as the National Commission for the Regulation of the Financial Services Market, its functions and structure.

It is recommended to consider existing similar structures in other countries. It is necessary to familiarize with the Law of Ukraine "On Insurance" and normative and instructional documents, which reveal peculiarities of control over insurance activity, appointment of procedures for registration and licensing of insurers, the procedure for conducting inspections of insurance companies.

It is advisable to thoroughly elaborate articles in the press, in particular, Ukraine-Business, Business, Insurance, and Financial Services, on specific measures by state authorities that regulate insurance activities.

Mini-lexicon

insurance market, insurance market infrastructure, the insurer, the insured, the insurance service, insurance products, insurance agent, insurance broker association of insurers, League of Insurance Organizations of Ukraine, mutual insurance, insurance office, insurance pool, the insurance company, joint stock insurance company, private partnership, captive insurance companies, representative offices, branches insurance company, insurance marketing, insurance rules, insurance contract, insurance policy, accreditation, registration of insurance companies, licensing of insurance activity, legislation on insurance business, comprehensive inspections, order.

3.1. Insurance market and its characteristics

Formation of a financially stable insurance market in Ukraine is intended to ensure the safe functioning of economic entities, their protection from existing and potential threats under the influence of possible negative factors and maintaining social stability of society. In addition, insurance companies must accumulate free funds on an equal footing with banking institutions, as well as pursue an active investment policy.

In developed countries, insurance is one of the most important sectors of the national economy and provides a redistribution of up to 15% of gross domestic product. The total volume of revenues to these countries' budgets from the insurance industry equals to the revenues from the banking system. As a result, money accumulated through insurance is a source of significant investment in the economy.

The insurance market represents the whole set of economic relations regarding the purchase and sale of insurance services. A prerequisite for the existence of an insurance market is the need to provide cash assistance to victims in the event of unforeseen insurance events. Only insurance companies whose

activities are subject to mandatory licensing can offer insurance services on the market. The main economic law of the functioning of the insurance market is the law of supply and demand.

Features of the development of the insurance market of Ukraine:

1. High level of concentration of insurance companies in the regional dimension. In Ukraine, there are about 450 insurance companies, of which almost two thirds are concentrated in five cities: Kyiv, Odesa, Dnipro, Kharkiv, Lviv.

2. Low level of coverage of individuals and legal entities by insurance coverage. Today, Ukraine's share of the national insurance market accounts for only 0.01% of the volume of insurance services provided on the world insurance market, and 0.05% – in Europe.

In general, the insurance market in Ukraine covers approximately 10% of the risks, while in most developed countries – at least 90-95%. The indicator for insurance premiums per one citizen in Ukraine is approximately $ 70. In developed economies, this figure is: in Austria – $ 1845, Germany – $ 2073, France – $ 2720, the United States – $ 3635, Japan – $ 3764, the United Kingdom – $ 4105, Switzerland – $ 5569, for comparison, in Russia – $ 100.

Despite the significant growth rates of the main indicators of the activities of insurers and insurance intermediaries, the Ukrainian insurance market has a number of unresolved problems that can be attributed to:

1) low interest in insurance due to low solvency of the population and the existence of certain distrust of insurance;

2) imperfect legislation on obligatory types of insurance;

3) insufficient development of long-term life insurance, retirement annuities and other types of accumulation insurance;

4) small financial capacity of the domestic insurance market, insufficient capitalization and low liquidity of insurers, which results in the receipt of significant amounts of insurance premiums in the form of reinsurance premiums, to foreign companies under reinsurance contracts.

The main subjects of the insurance market are insurers and insurers, which enter into an insurance contract, as well as insurance intermediaries, the main among them are insurance agents and insurance brokers.

Depending on the specifics of the insurance market, distinguish the other participants in the insurance relationship: insured persons, associations of insurers, reinsurers, mutual insurance companies, the state supervision of insurance activities, professional risk assessors, professional appraisers of losses. The general structure of the insurance market is shown in Fig. 2.

The activities of insurance agents and insurance brokers are similar, but they have different legal status. In accordance with Article 15 of the Law of Ukraine "On Insurance", insurance agents are citizens or legal entities acting on behalf of and insurer and carry out part of its insurance activities, namely: conclude insurance contracts, receive insurance payments, perform work, associated with the implementation of insurance payments and insurance reimbursements, as well as collect information about the respective types of insurance services and insurance companies – competitors, conduct a market environment analysis.

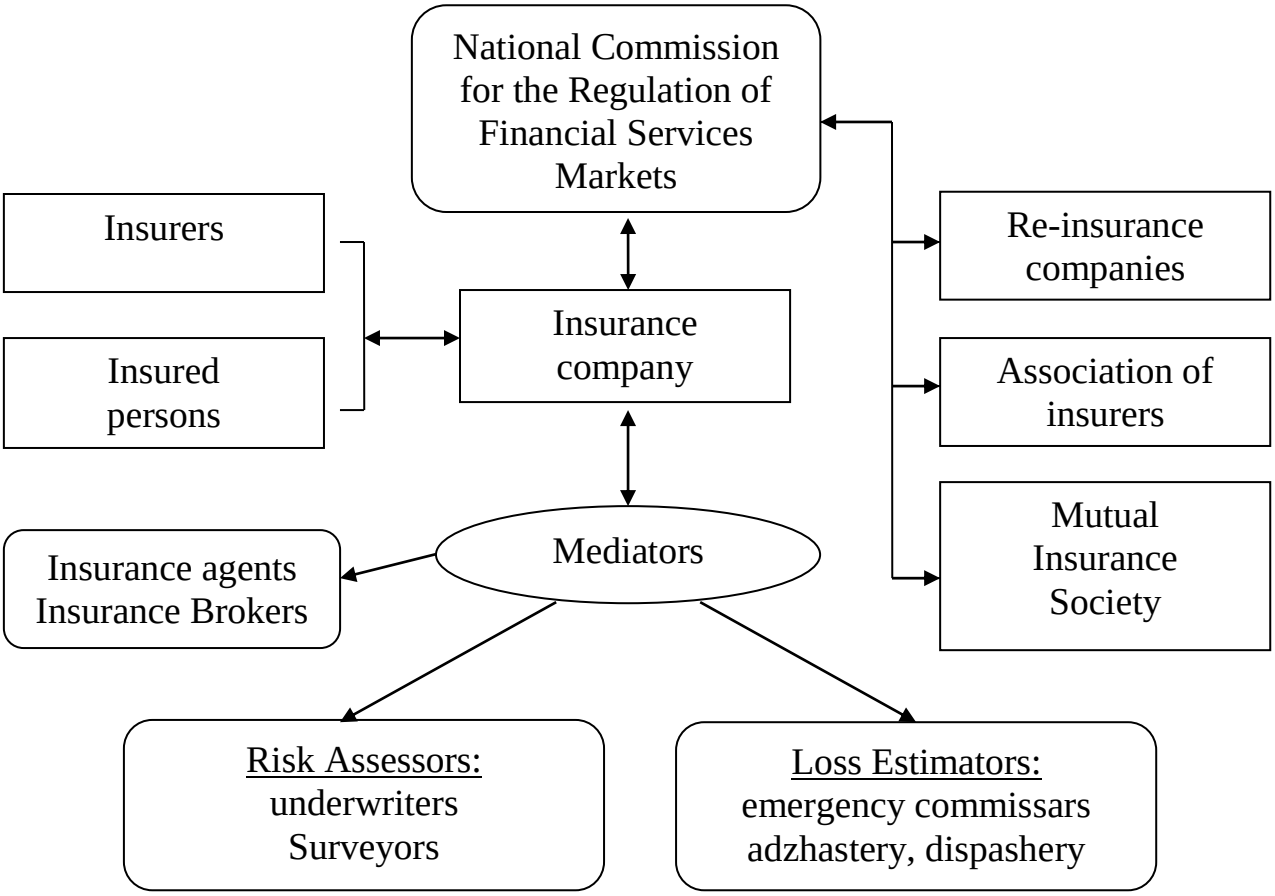

Fig. 2. General structure of the insurance market

Insurance agents are representatives of the insurer and act in their interests for a fee on the basis of a contract of commission with the insurer.

Insurance brokers are legal entities or citizens who are registered in the established order as subjects of entrepreneurial activity and reimburse intermediary insurance activities on their own behalf, based on a brokerage agreement with a person who needs insurance as a insured. The insurance broker is an authorized person of the insured.

An insurance agent and insurance broker can be both physical and legal entities, such as insurance agencies with a certain number of agents or brokerage offices with a certain number of brokers.

Depending on the specifics of insurance activity, there are several groups of insurance agents – legal entities:

1) by geographical distribution:

- Republican (APPB Aval, State Savings Bank, Pravex-Bank, Kyivstar, UMC, Ukrposhta);
- regional (service stations, border crossing points);

2) by type of insurance:

- those who are engaged in life insurance (public associations, trade union committees);
- those engaged in personal insurance, in addition to life insurance (travel agencies, medical institutions);

- those engaged in property insurance (car dealerships, banks, credit unions, leasing companies);

- those responsible for insurance of liability (cargo carriers);

3) with participation in the insurance process:

- insurance agents directly providing insurance services (banks, bus stations, railway stations);

- insurance agents, contributing to the conclusion of insurance contracts (notary offices, auditing firms);

4) according to the organizational-legal form:

- insurance agents established on the basis of contractual relations between the insurance agent and the insurance company;

- insurance agents through the joint creation of a separate legal entity;

- subsidiaries of the insurer;

- insurance companies created by an intermediary, such as a bank.

Insurers put forward certain requirements for candidates who want to work as insurance agents, such as: the level of insurance culture, communication skills, external attractiveness, responsiveness, secondary or higher education, as well as credibility of the candidate.

Tasks facing insurance agents:

- find a customer;

- interested in the client and sign an insurance contract with him;

- accompany risks.

For the realization of their task, they receive from the insurer a certain commission, the size of which depends on the insurance industry, which includes the proposed insurance object, as well as the amount of insurance premiums received.

Insurance companies regulate the activities of insurance agents. At the same time, the insurer's inadequate control over the activities of its agents qualifies as a violation of the insurance law.

The functional duties of insurance or reinsurance brokers are: consulting, expert information services, work related to the preparation, conclusion and maintenance of insurance contracts (reinsurance), including for the settlement of losses in terms of receiving and transferring insurance premiums, insurance payments and insurance indemnities in agreement with the insurer or reinsurer, as well as other intermediary services in insurance and reinsurance on the list established by the National Regulatory Commission tion of Financial Services Markets of Ukraine.

Insurance or reinsurance non-resident brokers can provide services only through permanent representations in Ukraine, which should be registered as taxpayers in accordance with Ukrainian legislation and included in the state register of insurance or reinsurance brokers.

The registration of insurance and reinsurance brokers is carried out by the National Commission for the Regulation of Financial Services Markets of Ukraine (until April 26, 2003, this function was exercised by the Ministry of Finance of Ukraine). At the same time intermediary activity in the territory of Ukraine for the

conclusion of insurance contracts with foreign insurers is not allowed, except for reinsurance contracts with observance of the requirements of Article 30 of the Law of Ukraine "On Insurance".

It should be noted that, in contrast to the requirements of Ukrainian legislation regarding the minimum size of the statutory fund of an insurer and the procedure for its formation exclusively in cash, insurance brokers do not have a similar requirement. Taking into account the absence of direct norms, the formation of statutory funds of insurance brokers may be carried out by other assets than cash, incl. property, intellectual property, etc.

In some countries, insurance brokers make the vast majority of all types of insurance, while others only insure small, new and little-known risks. In Ukraine, this kind of activity is in the stage of development.

The broker's activities include:

1) customer search;

2) determining the needs of the client in order to meet them.

If an insurance broker does not know his client and his business, he can not effectively fulfill his obligations to him. The services that a broker provides to your client can be grouped together as "best advice." At this stage, the broker plays the role of a risk management consultant. He studies risks, compares insurance policies, processes statistics and develops a special client risk management program. The latter contains the type of contract and the name of the insurer, the types of risks that warrants, the objects that are appropriate to insure, the possible franchise, the size of the insurance premium, the duration of the contract and the conditions for its termination.

3) offering a risk broker in the insurance market and the beginning of negotiations for the conclusion of a contract;

4) sending a formal message to your client and underwriter in the event of a complete risk placement.

In the event of an insured event, the policyholder notifies the insured event, both the insurer and the broker. Assisting the client in preparing the required documents for making a claim is a very important broker's service, and when the client is not aware of the intricacies of formal procedures, it is absolutely necessary. Large brokers have an impact on the market and can use it, for example, to make a satisfactory insurance indemnity.

An insurance broker may contact his client with a proposal to renew the contract for a new term in case of approaching the expiration of the existing insurance policy.

An insurance broker has a certain number of customers whom he represents on the market and spends considerable research and forecast money. Commission agent remuneration has the same components as insurance agents.

The main functions of insurance intermediaries are given in Table. 3.

Table 3. Functions of insurance intermediaries

Insurance agent	Insurance broker
1. The insurer concludes insurance contracts and sells insurance policies on behalf and on behalf of the insurer	1. Determine the object of insurance and insurance risks that must be insured by the client
2. Draw up the insurance documentation, helping the insured to receive insurance payments	2. Performs a comparative analysis of services, financial status of insurers, chooses the best insurance option and draws up an insurance contract.
3. Provides timely transfer of insurance payments to the insurer	3. Carries out control over timely receipt of insurance payments

In insurance practice, intermediary functions can also be performed by banks, travel agencies, transport companies, branch offices, notary offices, supermarkets, etc.

Underwriter is a specialist in the field of insurance, which has the authority on the part of the insurer to assess the degree of risk, take on insurance risk, determine the tariff rates and other terms of the insurance contract, based on the economic feasibility, economic and insurance policies of the insurer and based on the rules of insurance law and ordinary rights.

Surveyor – an independent expert who reviews the property taken for insurance, determines the probable degree of occurrence of the insured event and draws up a survey report, which results in the insurance company deciding on the conclusion of the insurance contract.

The **Emergency Commissioner** is a person with special skilled knowledge about the assessment of the damage caused and the causes of the insured event. On the instructions of the insurer determines the reasons, the nature of the insured event and the size of the damage caused as a result of the accident, as a rule, an accident.

Rights and obligations of emergency commissars:

- carrying out an overview of the accident site (using modern technical means: photography, audio and video, etc.);
- determination of the nature of vehicle damage;
- giving a conclusion as to whether this event belongs to an insured event;
- determining the size of the damage;
- collection of necessary documents.

The result of the work of the Emergency Commissioner is an emergency certificate, which in the future is evidence of an accident, and serves as a solid evidence in court.

Adjuster – represents the interests of the insurer in resolving and settling the claims of the insured associated with the insured event. The functions of the adjester include investigation of all circumstances of the declared event in order to establish the fact of the occurrence of the insured event, its compliance with the

terms of the insurance contract, determining the amount of insurance indemnity, drawing up an expert opinion for the insurer, taking part in the settlement of losses with a representative of the opposite party.

The **dispatcher** is an official expert authorized to carry out a dispensary; a specialist in the field of maritime law, which calculates the losses in the general accident, distributed between the shipowner and the cargo owner in proportion to the cost of the ship, cargo and freight. Abroad, dispatcher, as a rule, is appointed by the shipowner. The functions of the discharger can be performed by the adjester.

Mutual Insurance Society (MIS) is an association of individuals or legal entities created on the basis of a voluntary agreement between them for the insurance of their property interests.

The essential difference between mutual insurance companies from insurance companies is that they conclude insurance contracts in relation to the property interests of the members of the partnership, which are both its insurers and co-owners. The essence of MIS and its main principle is solidarity responsibility of everyone before each within the partnership.

During the fiscal year, MIS carries out current insurance payments and, at the reporting date, determines the size of insurance reserves both for certain types of insurance and for all types of activities, and also calculates the solvency of the company.

The activity of the fuel and energy complex includes not only insurance, but also financial support of its members through investment of funds, preferential crediting of the participants of the company.

In recent years, the insurance market of Ukraine is a process of consolidation of insurers. The most influential and mass association of insurers is the League of Insurance Organizations of Ukraine. It is believed that the first association of insurers was established in 1791. It was called "Union of Fire Insurance Societies of London".

3.2. Marketing research of the insurance market

Insurance marketing is an integrated approach to the management of sales activities of the insurance company, aimed at providing quality insurance services that meet the potential demand of customers.

The primary task of the insurer's marketing service is to search for a potential client, to form his needs for insurance protection and to determine his solvency. Next, the marketing service determines the parameters of the insurance product, proposals for its implementation, collects information among the actual consumers of insurance products, develops recommendations aimed at improving the insurer's activities in order to consolidate and develop the categories of customers, the search for new potential market segments.

The insurer must strive to form a balanced insurance portfolio (a set of insurance premiums accepted by the insurance company from the policyholders), which means the presence of its various insurance contracts.

From the point of view of marketing applied to the insurance market, the formation of demand for insurance services contains a number of measures to attract potential insurers to insurance companies. The main ones are: persuasion with the help of targeted advertising, a set of measures for the conclusion of insurance contracts, differentiation of tariffs for insurance services, etc. If the demand for insurance services decreases, the insurer must identify its causes and take appropriate measures.

Despite a number of positive developments over the past five years, the growth of the classic insurance market in Ukraine still suffers from the lack of a broad audience of insurance culture and trust in insurance. Particularly negative is the attitude of Ukrainians towards compulsory insurance, given their low level of solvency.

The problem of negative attitude to insurance has a comprehensive socio-psychological and informational character, so it is groundless to expect its solution at the state level through the mechanism of compulsory insurance. Today, leading insurance companies in Ukraine are trying to effectively solve this problem through the introduction of the existing mechanism of insurance marketing. First, insurance marketing is a system of interaction between the insurer and the insured, aimed at the mutual consideration of interests and needs. Secondly, insurance marketing – a method of studying the insurance market and influence it in order to obtain the insurance company as much profit as possible.

The term "**marketing**" comes from the English "Market gain" – the conquest (seizure, achievement) of the market. It was first used by its American farmers in the 30's of the XX century. Officially, the term "marketing" was first introduced by the National Association of Teachers of the US Economy (1935 p.). Subsequently, the term is used more and more and today is one of the dominant and most used in a market economy.

In insurance, the term "marketing" began to be used in the early 60's. Thus, marketing in insurance is a complex of measures aimed at the formation and continuous improvement of the insurer's activities, namely:

- conducting marketing research, segmentation and positioning on their results;
- development of new or adaptation of existing insurance products (services) taking into account market requirements;
- formation of competitive prices (tariffs) for insurance products;
- formation of an effective system of distribution (distribution) of insurance products, management of this system;
- implementation of measures to promote insurance products (advertising, promotions FOSSTIS);
- implementation of communication PR-policy.

Marketing is based on the following principles:

1) a thorough study of the state of affairs of the insurance market;

2) segmentation of the insurance market (sector allocation – personal insurance, property insurance and liability insurance);

3) flexible operational response to insurer requests;

4) innovations in accordance with market requirements.

The main tasks of marketing in insurance are:

1) achieve the maximum possible consumption of insurance products;

2) achievement of the maximum demand for satisfaction of demand for insurance products;

3) the offer of the widest choice of insurance products;

4) maximizing the quality of life (average consumption, medical care) – the quality of life is higher if guaranteed compensation in case of insurance.

The organization of marketing can be carried out for:

- types of insurance;
- a complex of insurance services;
- the geographical division of the insurance market segmentation.

Insurance marketing covers the following functional elements:

- research of the market of insurance products;
- development of insurance products;
- the implementation of insurance products.

Marketing insurance is a marketing service that is viewed as a think tank, a source of substantiated information and recommendations on the current and future activities of the insurer. The activity of the marketing service is aimed at satisfying the requirements for insurance protection of the central figure of the insurance market – the insured.

The primary task of the insurance company's marketing service is to search or select an insurer's potential client, to formulate the immediate needs of this client in insurance coverage and to determine its solvency. Next, the marketing service determines the parameters of the insurance product, proposals for its implementation, collects information among the actual consumers of insurance products, develops recommendations aimed at improving the insurer's activities in order to consolidate and develop the categories of customers, the search for new potential market segments.

Also, the tasks of the marketing service are:

1) collection, processing and analysis of information on the insurance market, the demand for insurance services and its competitors, that is conducting of information-analytical researches;

2) forecasting the state of the insurance market;

3) studying the potential of insurance companies;

4) planning of the insurer's own business strategy in accordance with the conditions of the insurance market (determination of the priority directions and principles of the insurer's work).

The marketing service provides all the structures of the insurer with the necessary and reliable information, determines their activity in the future. It can have a horizontal or vertical structure.

Marketing is constantly in active dynamics and produces information and advisory assistance primarily to the top officials of the insurer, namely: underwriting, aquisition and public relations units. Such complex of actions is

carried out according to the programs of three elements of marketing: strategic, operational and organizational.

Strategic marketing activities include:

- investigation of the insurance market and its segmentation;
- definition of indicative indicators of insurance products;
- development of proposals and projects concerning the strategy of further development of the insurer.

Operational marketing involves:

- analysis of the current status of the implementation of insurance services;
- professional training of specialists and insurance intermediaries;
- organization of conducting of advertising measures and public relations;
- development and implementation of additional services for insurers.

Within the limits of organizational marketing the following tasks are solved:

- monitoring of organizational interrelations in the structure of the insurance company;
- increase of efficiency of interaction of structural units of the insurer;
- introduction of measures to strengthen the corporate culture of the insurer's staff.

From the list below, it follows that the task of the marketing service can be, in particular, in one of the following forms:

1) in the form of a problem – when a specific problem is formulated in the activities of the insurer and it is proposed to develop options for its solution or elimination of the reasons that led to it;

2) in the form of the task – to choose the optimal option from the available options, on specific issues in the activities of the insurer;

3) in the form of requests (they usually come from certain departments or specialists of the insurer) – for obtaining an expert assessment on a specific issue (insurance tariffs of similar products from competitors, the effectiveness of the new introduced by the form of advertising section, grading requests of a specific group of regular customers, evaluation quality of instructional materials for insurance agents).

At the same time, with the marketing service there should be a clear agreement on the appropriate research depth, timing, amount of expected materials and specific assistance to be provided.

In addition to information and analytical materials, the advantage of which is the ability to add, reuse, accumulate and distribute in departments, marketing services can submit their products and in the form of demonstration developments.

The main ones include:

- business games – one of the most effective methods of preparation for important negotiations by working out options and coordination of actions of participants on the part of the insurer; acquiring practical skills in the activities of specialists (or insurance intermediaries), if, in accordance with their functional responsibilities, the latter are involved in working with clients;
- simulation and analysis of specific situations, demonstration and evaluation of various options of actions of the insurer's specialists in working with clients;

- provision of visual materials (layouts of policies, methodological developments, promotional materials, etc.) from their own research, practice of competitors or other business entities.

One of the most important conditions for the preparation of the marketing service of the final products of its activity is the display of a reasonable initiative, based on a deep awareness of the specialists of the service of the priority directions and principles of the insurer's work, and aims at full and full use in the interests of the governing bodies and units of the insurer of collected and systematic information , which is being processed by the service.

The criteria for engaging in the collection of information from one source or another are the rules of the current legislation and the moral and ethical requirements of associations of insurers (for example, the League of insurance organizations of Ukraine).

Performers of marketing research in work must be guided by such principles as objectivity, completeness, conciseness and timeliness.

Almost all marketing research of domestic insurance companies, as a rule, is associated with the solution of a specific problem that suddenly faces the firm, or is associated with the adoption of a specific management decision. At the same time, marketing research should be understood as a systematic determination of the data cycle, collection, analysis and compilation of the results report.

The main sources of receipt and receipt of information for marketing research in insurance are as follows:

- the insurer's specialists and insurance agents, including those that are not directly related to the research topic put before the marketing service;
- third-party insurers, which are partners, including foreign ones;
- competent third-party specialists involved in labor contracts;
- materials of the target customer survey, both actual and potential;
- results of communication with insurance brokers and clients of other insurers;
- available to the insurer scientific and methodological literature and documents from the archive;
- work with special literature in libraries and training centers;
- analysis of advertising and informational products for similar types of activities or insurance products, etc.

Work on the collection of information is planned and conducted as a logical link of the marketing research algorithm.

Performers of marketing research in work must be guided by such principles as objectivity, completeness, conciseness and timeliness.

First of all, based on the data of previous marketing researches the insurer chooses variants of possible strategic directions of its activity. To analyze the expected effectiveness of their implementation, he, in each of the options, forms his marketing policy. As a rule, this policy includes a number of prerequisites, reservations and intentions regarding the final indicators. They, in turn, depend on the real possibilities of the insurer or the goal.

Marketing policy is traditionally divided into the following main types:

1) is focused on the choice of the potential insurer, that is, to search for certain categories of citizens on certain grounds, namely:

- by type of labor activity;
- the relation to the property;
- region of residence;

2) focused on certain types of insurance or groups of insurance products, namely:

- medical,
- from accidents,
- when traveling abroad,
- for the comparative value of insurance products,
- for service at their realization,
- assistance provided.

3) oriented towards specific implementation channels.

At the same time at one or another stage of marketing necessarily need to address the question of the subjective attitude of the client to insurance as an institution of social protection or offered to him specific insurance products. These questions are combined with the concepts of the formation of consumer demand (insurance culture).

In the field of marketing, it is advisable to highlight the following objects of primary importance:

1) insurance field (categories of potential clients of the insurer and objects of insurance);

2) qualitative indicators of insurance products;

3) channels for the implementation of insurance products;
4) formation of consumer demand.

A number of moments that are directly related to the marketing service:

- explanation of the specifics of the type of insurance that interests the client, assistance in determining the real need for insurance of specific risks and providing legal advice on related problems;
- high service;
- material and moral forms of promotion of regular clients, including by means of a bonus or assistance in qualitative prevention of insurance cases;
- as wide as possible realization of "packages of insurance policies" to clients for various types of insurance and for several family members;
- attraction of priority clients to the circle of shareholders of the insurer;
- formation of the "trademark" of the insurer, which should be understood as containing the concept of its authority and business reputation and loyalty to the best traditions.

Depending on the size of the insurer's cadre, the functions of the marketing service can be relied directly on a separate unit of several employees or one specialist. It is expedient to subordinate this service to the executive officers of the insurer (for example, the first deputy chairman of the board), taking into account his powers regarding the collection, compilation and analysis of information relating to the strategic directions of the insurer's development, control and work to

determine the effectiveness of specific activities and activities of specific specialists and subdivisions. This service, within the limits of its functions or specific tasks, should have the opportunity to access the necessary information and to survey relevant specialists from other departments.

The professional level and business qualities of the specialists of the service must meet the following basic requirements:

- devotion to the cause and sincere interest in the development of financial strength, profitability and strengthening the credibility of the insurer;
- high level of theoretical training and practical skills on the main types of insurance on which the insurer specializes;
- the ability to purposefully collect, accumulate and analyze information and develop appropriate conclusions and proposals on its basis;
- initiative, communicative, executive discipline ability to focus on the main, broad, general erudition.

The development of marketing services in insurance companies in the post-Soviet area, including in Ukraine, now corresponds to the place of marketing that he has taken in insurance. However, it should be noted that this way was also the marketing services insurers in economically developed countries during 70-80 years of the last century. Only in the 1990s they became more or less standardized units with a methodologically grounded structure.

Today, insurance companies continue to be involved in the sale of insurance products without the help of marketing departments. Thus, at the first stage of the formation of insurance marketing its service, as a rule, separated from the units working on the implementation of insurance products. At the same time, sales units themselves partly perform marketing functions in the process of selling insurance products.

Among the main problems of creating marketing services can now be the lack of financing of marketing services and incomplete awareness of the leadership of enterprises in the role of marketing in the modern system of effective sales of goods and services, the inability to adequately attract marketers to the insurance industry with knowledge of the specifics of the enterprise, etc.

Expansion of the practice of using marketing tools in the process of commercialization of insurance products and the transition to the systematic use of marketing by insurance companies entails the need for the creation of organizationally independent units with the competence of strategic marketing and marketing departments dealing with practical applied marketing.

In this case, operational marketing should provide:

- support for the sale of insurance products to assist agents or other insurers;
- advertising of insurance products in the place of sale.

Operational marketing can enter the system of sales of insurance products or remain independent, working closely with the system of sales and subjecting the strategic marketing unit.

Further development of marketing necessarily leads to the creation of a subdivision in the structure of the insurance company responsible for organizational marketing. The functions of this unit should include analysis of the

internal environment of the insurance company – state control and optimization of the insurer's structure, organization of interactions of different units, internal communications, support of "corporative culture", etc.

Thus, insurance marketing should turn into a triangle, which will include strategic, operational and organizational marketing. The implementation of such an approach to insurance marketing turns it into an element that is at the center of the insurer's activities on the market, and the marketing service is a structural unit that performs a number of different functions in the intranets of all divisions of the company.

Marketing services are directly responsible for the entire complex of relations between the enterprise and the buyer.

In view of this, the manager and leading marketing specialists must meet certain requirements:

- systematic knowledge;
- broad erudition and outlook;
- communication;
- striving for a new, high degree of dynamism;
- diplomacy, ability to resolve conflicts.

Effective human resources policy contributes to the effective marketing of the enterprise. The most effective way to find personnel for a marketing department is to allocate among the employees of the managerial company the most consistent with the above requirements, subject to additional education from a special training course in the marketing specialty.

With the attraction of highly skilled personnel to the marketing service and the establishment of the permanent work of the latter increases, on the one hand, the level of marketing communications of the enterprise with the customers, and thus the efficiency of delivery through better understanding of the nature of demand. On the other hand, marketing functions are complicated as the essence of the latter is the systematic development and offering of new products and services, new quality and terms of service to the company and clients.

It is obvious that in order to ensure success, the marketing service should organize a clear interaction of all elements of its own system and effective cooperation with other structural units of the insurer. The lack of interaction between operational, strategic and structural marketing leads to a sharp increase in the share of unsuccessful marketing campaigns. In full interaction successful shares make up about 90% of the total, and because of the absence of effective interaction – no more than 50%.

Thus, the effective activity of the insurance company's marketing service should ensure:

1) reliable, reliable and timely information about the market, structure and dynamics of concrete demand, tastes and preferences of buyers, that is, information about external conditions of the firm's operation;

2) the creation of such a service, a set of services (assortment) that most fully meet the requirements of the market compared with the services of competitors;

3) the necessary impact on the consumer, demand and the market, which will ensure the maximum possible control of the scope.

The insurance market research covers the following main tasks:

- analysis of the external economic environment;
- segmentation of the insurance market and analysis (research) of various segments of the market;
- analysis of competitors activity;
- analysis of internal capabilities;
- development of relations with clients (insurers).

The ultimate goal of such a study is to select a specific segment of the insurance market in which the insurance company will work, that is, the definition of specific types of insurance (insurance products).

For the study of demand, inspecting insurers, communicating with business people can be conducted. On the basis of the collected information a scientifically grounded concept of analysis and accounting of demand for the requirements of policyholders is created.

It is important to study the demand for insurance services exactly in the area where the insurance company is expected to work: studying the socio-demographic composition of insurers, their solvency, economic, natural, scientific and technical, political, cultural environments, etc.

In each case, you need to focus on one or another medium.

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composition of insurers, their solvency, economic, natural, scientific and technical, political, cultural environments, etc. In each case, you need to focus on one or another medium.

Basic principles of segmentation of the insurance market:

- horizontally – by groups of insurers' income;
- vertical (insurance by categories of policyholders);
- by geographical features;
- by demographic characteristics;
- on psychological grounds;
- for social and ethical behavior, etc.

The analysis may also cover the study of the following clientele markets:

- the consumer market of insurance services;
- market of insurance service providers;
- the market of insurance intermediaries;
- market of state insurance institutions;
- non-state insurance market;
- the international insurance market (there is an international division of labor in the insurance business, for example, the United Kingdom is a leader in maritime insurance, Germany – in insurance of property and buildings, etc.).

After that, the process of direct development of insurance products begins, which includes the following steps:

1) definition of the insurance product (name of the type of insurance);

2) development of product specification (insurance terms);

3) determination of the procedure (procedure) for the conclusion of insurance contracts;

4) determination of the value of the product;

5) determination of the price of the product (insurance tariffs);

6) approval and obtaining permission of state regulatory bodies for insurance activities (obtaining a license for insurance).

Insurance products are developed independently by the insurer, only from the obligatory types of insurance the insurance conditions are developed by the Cabinet of Ministers of Ukraine. Requirements to the Insurance Rules are set forth in the Law of Ukraine "On Insurance".

The insurance process starts with creating **products** (i.e., policies or contracts) that specify the obligations between insurers and insureds. It is in this process that insurers determine consumers' risk-management and transfernneeds and develop insurance contracts that will meet those needs consistent with the basic insurance principles. Insurance contracts must provide value to the insured in terms of coverage against specified perils while protecting the insurer against moral hazard and other problems that would expose the insurer to uncontrollable or unanticipated losses that could not be fairly priced. Insurance contracts typically include provisions for covered perils, coverage amounts and limits, deductibles/retentions, co-insurance provisions, coverage exclusions, the basis of loss settlement and additional coverages. These provisions provide coverage for

losses, administrative efficiencies and loss mitigation incentives in response to insureds' desired level of risk retention.

From another viewpoint, an insurance contract represents a bundle of services provided to insureds that includes but is not limited to risk transfer. These additional services encompass risk assessment, loss prevention, claims management and investment management, among others. In response to consumer demand and within regulatory constraints, competition compels insurers to develop differentiated products that meet various insureds' needs and preferences.

Pricing involves determining the amount the insured must pay to finance the loss protection or the potential insurance benefits the insured will receive, as well as necessary administrative expenses and the insurer's cost of capital. For the most part, insurance pricing is prospective, because it is necessary to determine in advance what insureds must pay to cover losses incurred and benefits that will be paid in the future, in addition to insurers' expenses.1 Because of its prospective nature and the uncertainty associated with predicting future events and losses, insurance pricing is complex.

Insurers must use extensive data and various actuarial methods to determine appropriate rates or premiums. At the same time, the competitive nature of insurance markets introduces additional strategic considerations into insurers' decisions on what to charge insureds.

For the purposes of this discussion, the price of insurance or the **gross premium** is divided into two components: the **pure premium** and **expenses**. The pure premium is the amount of losses or benefits that insurers expect to pay, on average, on a given insurance contract. Expenses comprise all of the additional costs incurred by insurers in providing coverage and servicing a policy. These costs include provisions for acquisition of business; administering policies; adjusting and paying claims; taxes, assessments and fees; general overhead; and profit or the cost of capital.

Allocating expenses to specific insurance contracts and determining an appropriate profit-loading require considerable analysis and judgment, as does projecting expected loss or benefit payments. Setting a profit margin necessitates calculating a fair rate of return on invested capital. A fair rate of return should be equivalent to what insurers could earn on alternative risk-free investments, plus a provision for the risk that insurers' actual earnings will be less than expected. Because insurers collect premiums in advance of paying claims, they must discount premiums for anticipated investment income on funds held in reserve, net of any expected investment expenses. Determining the appropriate discount rate requires projecting the timing of cash inflows and outflows and earnings on investments.

The above principles generally apply to all forms of insurance, but different approaches are employed for the major types of insurance products. Property-liability insurance pricing and accident-health insurance pricing are somewhat similar in concept, although they use different types of data and specific methods. The pricing of life insurance and annuity contracts is approached differently

because of the different nature of the risk that is insured and the structures of these contracts.

Rates can be determined for groups or classes of risks as well as individual risks. For property-liability insurance, class rating involves applying various rating factors to a base rate according to the insured's characteristics. For auto insurance, for example, an insurer determines the appropriate average premium for all drivers that it insures and adjusts this premium for a particular insured using factors for the insured's selection of coverage provisions, type and value of vehicle, geographic location, use of vehicle, age, marital status, driving record and other variables.

Rating factors are expressed in terms of relativities to a base rate so that the class rate or premium paid by each insured sum to the total premiums required to fund the expected losses and expense costs for all insureds.

Various adjustments may be applied to class or "manual" rates to further customize the premiums for an insured. These adjustments include experience rating, schedule rating, discounts, retrospective rating, dividend plans and judgment rating. Experience rating adjusts an insured's premium based on the insured's historical claims experience. Schedule rating provides credits or debits for certain qualitative factors, such as whether the insured has an established loss-prevention program.

Discounts may be offered to larger risks to reflect the fact that some insurer expenses to service a policy increase less than proportionately with the amount of the premium. Retrospective rating effectively adjusts an insured's premiums after the policy period based on the losses that the insured actually incurred. Judgment rating, as the term suggests, involves a subjective determination of an insured's premium when standard rating plans and other objective information are insufficient to determine an appropriate price.

All of these measures represent attempts to refine insurance prices to reflect the underlying costs of a policy as closely as possible. Rates also must be changed over time to reflect new experience, as well as anticipated changes in factors affecting future benefit payments.

Alternatively, **individual risk rating** involves developing premiums for specific risks based on their particular characteristics and policy provisions without the use of a class rating plan. In effect, the insurer determines the necessary premiums to fund the expected losses for a particular insured rather than a group of risks. Individual risk rating tends to be used for large commercial risks of sufficient size and experience to develop an individualized premium without reference to the expected losses for like risks.

A property-liability insurer typically uses a combination of its own historical data and industry historical data in the rating process. Insurers with a larger volume of business in a particular line will tend to place greater reliance on their own data, while insurers with less volume use industry experience more heavily, as their data alone is less statistically credible (i.e., more subject to random fluctuations) because it is based on fewer exposures. Insurers also may use a combination of data from different sources in class rating, employing credibility weighting to

determine the relative effect of each source on determining the rate for a particular class.

State regulators authorize statistical and advisory organizations to collect and analyze pooled data from insurers and disseminate this information to assist the rating process. Advisory organizations also may file full rates or loss costs for approval by regulators and use by insurers.

Life insurance policies can be purchased with a single premium payment or periodic premium payments. The net single premium is not common, but it provides a basis for understanding how life insurance pricing works. The net single premium can be defined as the present value of the future death benefit. The premium, combined with compound interest, must be sufficient to pay all death claims. The gross premium is equal to the net single premium, plus a provision for expenses.

More common is the net level premium, which consists of a periodic premium payment that remains the same throughout the duration of the policy or some other defined period. The calculation of the premium must consider the probabilities that death benefits will be paid and when they will be paid, as well as the premium payments that will be made and that will cease if the insured dies during the policy period. The premium calculation also must consider the compound interest that will be earned on accumulated reserves. It is anticipated that, for the average policy or a group of policies, premium payments in the early years of a policy will exceed the death benefits paid. In the later years of a typical policy, death benefits paid are expected to exceed the premium payments received.

Hence, insurers must establish a reserve that reflects the accumulated difference between premium payments received and death benefits paid. This reserve is used to pay death benefits when they begin to exceed the premiums received. In order to calculate appropriate premiums, insurers must rely on mortality tables and other information to determine the probabilities associated with if and when death benefits will be paid and premium payments will cease. In essence, insurers must project cash inflows and outflows, as well as investment income on accumulated reserves, to determine the proper premium for a given insured.

The probability of death increases with age. Consequently, the net premium for a given death benefit increases with the age of the insured at the time the policy is purchased, as well as the length of the policy period. Other factors, such as gender and whether the insured is a smoker, also affect mortality projections and premiums.

Various provisions, such as the accumulation of a cash value, renewability guarantees, etc., also have cost and pricing implications for life insurance contracts. The pricing of an annuity contract is based on similar concepts, except the insurer must determine the amount of annuity payments it will likely pay over the duration of the policy, given its specific provisions. Consequently, premiums for annuities that cease payments when the annuitant dies will be lower than premiums for annuities that continue to make payments to the annuitant's spouse or other beneficiaries after the annuitant dies. As with life insurance policies, various

other annuity contract provisions affect their cost to insurers and their price to consumers.

Production and Distribution

Production and distribution involve the marketing and sale of insurance contracts and related transactions and activities. Most insurers use producers (generally known as either agents or brokers) in some capacity as intermediaries to transact business with insureds; however, a few insurers market directly to consumers. Typically, a producer will contact or be contacted by potential insurance buyers and assist buyers in determining their insurance needs and selecting an insurer and the appropriate coverages.

Agents act on the behalf of insurers and do not represent the interests of consumers. The agent submits policy applications and premiums to an insurer and may have authority to bind coverage under certain conditions. Agents may provide further services to insurers and insureds, such as assisting in the filing and adjusting of claims and changing policy provisions.

Independent agents can represent more than one insurer and "own" their book of business. Independent agents generally must be appointed by the insurers they represent.

Exclusive or **captive** agents represent one insurer and do not own the business they generate. They may be employees of the insurer or independent contractors.

A few insurers transact business directly with buyers without the services of an agent. Generally, insurers that use exclusive agents or directmarketing systems are called direct writers. Some insurers also are beginning to use a mixture of distribution systems and, hence, cannot be classified purely as independent agency companies or direct writers.

Agents receive a commission (typically a percentage of the premium) or a salary to perform these functions. Acquisition costs are generally lower for exclusive agency insurers and direct writers, who maintain greater control of their sales force and the compensation they receive. Agents for these insurers also may provide fewer services directly to buyers and receive more logistical support from their insurers, requiring additional expenditures by these insurers.

Alternatively, **brokers** represent and advise buyers and seek coverage from insurers on behalf of buyers. Brokers are more common in commercial lines of insurance; however, there are brokers who sell personal lines coverage. Brokers typically provide a broader range of services, including risk-management advice, for their clients. Brokers are compensated by their clients on a commission or fee-for-service basis. Other production/distribution services performed by insurers include activities related to marketing and advertising; processing applications, renewals and cancellations; verifying the information submitted on applications; writing policies; and collecting premiums. Insurers also must establish and maintain distribution systems and provide information to their agents. These activities tend to be more extensive for direct writers, who undertake more responsibility and costs in supporting agents and sales offices.

3. 3. Analyzing Insurance Markets

The insurance industry is described here according to principles of market function commonly used by industrial organization economists. Economists postulate a theoretical relationship between market structure and market outcomes that is labeled the structure-conduct-performance hypothesis. The basic hypothesis is that market structure determines market conduct, which determines market performance. A market with easy entry and exit and a relatively large number of firms causes firms to behave independently and competitively, which, in turn, leads to good market performance. Exceptions to these conditions and other structural flaws can cause market problems that require regulation or other remedies, if feasible, to protect consumers and produce market outcomes more consistent with the public interest.

Regulators need to be familiar with these concepts in assessing whether market forces and competition are working in the best interest of consumers, particularly under competitive-rating systems where regulators are required to monitor competition as a substitute for prior review and approval of rates.

Market structure encompasses the number of buyers and sellers and their size distribution, the height of barriers to entry into (and exit from) the market, cost structures, the degree of vertical integration, the character of buyer and seller information, and the degree of product differentiation.

Market conduct refers to the actual behavior (e.g., degree of independence) of firms in setting prices and output levels, product design, advertising, innovation and capital investment. Market performance comprises price, profit and output levels; the efficiency of production and allocation; the rate of technological progress; and equity. The solvency of firms and the availability of coverage also are important aspects of performance in insurance markets.

Analyzing industries like insurance is complicated by the presence of regulation and other forms of government intervention that affect market conditions. Hence, it is important to identify and evaluate government institutions and policies that may significantly influence market behavior, along with other factors. For example, regulatory requirements for admission and exit can have a significant impact on the number, type and size of insurers in a market and their behavior. Analyzing government's influence on the market is often a difficult task, given the complex interaction between regulation and market forces, but it is necessary to understanding all of the relevant determinants of market outcomes.

Supply of and Demand for Insurance

The economics of insurance markets are driven by the supply of and demand for insurance coverage (see Varian, 1992). Insurance markets, like other markets, tend to settle at a price and quantity where the amount of insurance that insurers are willing to supply equals the amount that consumers demand at a price agreeable to both. Changes in the supply of and/or the demand for insurance will change this point of equilibrium.

Regulation or other external interventions in the market also can affect supply and demand, changing the point of market equilibrium or causing an

imbalance between the amount of insurance that insurers are willing to sell and the amount that consumers would like to purchase.

When economists use the term **supply**, they think in terms of a schedule of the quantities of a product that firms are willing to supply at different prices. The supply function for a market is the sum of the supply functions of individual firms. The supply of insurance is determined primarily by the cost of providing coverage (i.e., the present value of expected claim costs or benefits paid to insureds, expenses and the cost of capital). Insurers' costs include a "risk load" or "risk premium" to reflect the cost of uncertainty about their future liabilities. In the short run, the supply function for insurance is likely to be upward sloping; i.e., insurers require higher prices to provide larger quantities of insurance coverage, because their per-unit costs increase with the quantity of insurance they provide.

In the long run, the supply function for most insurance markets should be relatively flat, or **price elastic**. That is, the quantity of insurance that insurers are willing to supply should expand to meet increased demand without a significant increase in average cost that would require an increase in the market price. In the long run, insurers' costs are generally variable; i.e., fixed investments in their facilities can be adjusted to produce a given amount of insurance at the most efficient scale of operation.

This assumes that, ideally, there are no significant barriers to entry and that capital can flow easily into a market to meet increased demand for insurance without an increase in per-unit costs. (The demand for and supply of catastrophe reinsurance illustrate these principles). When the demand for catastrophe reinsurance significantly increased after Hurricane Andrew in 1992, the price of reinsurance rose significantly because of short-term capacity constraints. However, the increased demand and price attracted additional capital into the market and the price of catastrophe reinsurance subsequently fell.)

The **demand** for insurance is determined principally by consumers' risk (actual or perceived), degree of risk-aversion, income and assets, other options for managing risk and compulsory insurance requirements. Generally, the greater risk an individual or firm faces, and the lower their ability to reduce or finance potential losses using other means, the greater will be their demand for insurance. To the extent that consumers are riskaverse (i.e., they gain additional utility from reducing their risk), they will be willing to pay a premium that exceeds their expected loss (without insurance) that is necessary to cover insurers' expenses, transaction costs and cost of capital. The demand for insurance would be expected to be somewhat sensitive to price; i.e., the higher the price, the less insurance consumers will want to purchase, all else being equal. At the same time, this price sensitivity or elasticity may be somewhat low for certain coverages that consumers perceive to be essential or are mandated by governments or lenders (e.g., auto and homeowners insurance).

The price (P) and cost (C) of a unit of insurance are plotted on the vertical axis and the quantity of insurance (Q) is plotted on the horizontal axis. The downward-slanted line D represents the market demand curve for insurance, indicating the total number of policies or amount of insurance demanded at various

premium levels (It can be somewhat difficult to define and measure the quantity of insurance. Possible measures might include the amount of "insurance" (i.e., the policy limit minus any losses retained by the insured) or the expected losses for a block of policies).

The downward slope of the demand curve indicates that less insurance is demanded at higher prices. In other words, higher premiums cause some buyers to drop out of the market or buy less insurance. The short-run supply curve is indicated by the line SS. The long-run market supply curve is represented by the flat line LS, which assumes that, in the long run, insurers can provide increased insurance without increasing its price.

Under perfect competition, in the long run, the market price or rate, PC, will equal average and marginal cost, and the number of policies or amount of insurance sold will equal QC. In other words, the market price will be justnsufficient to cover insurers' costs, operating at an efficient level, and thenquantity of insurance sold will equal the quantity of insurance that consumers demand at that price. Total premiums will equal total cost, which is equal to the area OPCAQC and "economic profits" will be zero.

This means that consumers will receive any "surplus utility" reflected in the difference between the price of insurance and what they would be willing to pay for it. The income earned by insurers will be just sufficient to cover their costs, including the cost of capital, and no more.

The impact of market competition is reflected in the market loss ratio. The loss ratio is equal to total losses divided by total premiums, which is equivalent to average loss, Cl, divided by market price, P. The loss ratio reflects the dollar amount of loss-protection policyholders receive for a dollar's worth of premiums. Under perfect competition, the loss ratio will equal the ratio Cl/PC; i.e., average loss divided by competitive market price.

It should be noted that if insurers' claims costs or expense costs rise (e.g., due to higher accident rates), this will push up the supply curve, LS, and result in a higher market price and less insurance being purchased.

Competition and Alternative Market Structures

Theory of Competition

The characteristics of a competitive market provide a benchmark for comparing alternative market structures and evaluating markets in the real world. Competition is considered desirable from society's standpoint because it ensures resources are being used in the best way possible. An industry is considered perfectly competitive when the number of firms selling a homogeneous commodity is so large, and each firm's share of the market is so small, that no firm is able to affect the price of the commodity by varying its output. In addition, perfect competition requires that there be no barriers to the entry and exit of firms and resources be perfectly mobile in and out of the market.

The long-run equilibrium outcome of a competitive market possesses three desirable properties:

1. The incremental or marginal cost of producing the last unit of output will be equal to the price that consumers are willing to pay for it.

2. There will be no excess or economic profits. Investors will receive a return just sufficient to induce them to maintain their investment at the level required to produce the industry's equilibrium output efficiently.

3. Each firm will be producing at an output level where its average cost will be at a minimum; i.e., maximum efficiency.

In essence, a large number of firms and the lack of barriers to entry and exit lead to independent and competitive pricing, which results in optimal market performance. (This principle is taken to its logical limit under the theory of contestable markets, which argues that even high concentration may not permit firms to maintain a price above the competitive price if entry and exit are costless and can occur rapidly). However, the reality may be that very few markets, if any, have costless entry and exit; empirical support for the theory of contestable markets has not been forthcoming. Still, the disciplinary effect of potential entry into markets cannot be disputed. For a discussion of the theory of contestable markets.

Conversely, high market concentration and entry barriers will tend to constrain competition and cause suboptimal performance. Perfect competition also requires complete and perfect knowledge. All firms should know the relevant technologies, and buyers and sellers should be fully informed about all aspects of the product and the market. Conditions with respect to consumer information and consumer choice may be more relevant when other conditions for perfect competition are violated. When entry is significantly constrained, the fact that buyers lack information about prices and/or are forced by law to buy a product, could result in higher prices or diminished product quality or service.

Insurance markets are subject to a number of imperfections, which compels the use of a model of workable competition to analyze their structure and performance in a dynamic context. If a market is relatively unconcentrated, entry barriers are low, profits appear to be in line with other industries of similar risk and there is no evidence of gross inefficiency, then it is unlikely that government intervention could significantly improve performance. On the other hand, if a market is highly concentrated, entry is restricted and long-run profits substantially exceed those in other industries, then some form of regulatory action may be beneficial. Workable competition does not require that all firms in the market operate at maximum efficiency at all times or that no sale is ever made at a price above the "competitive price" or insurers' average cost. What is relevant is whether the market, over the long run, rewards efficient firms and punishes inefficient firms. When this occurs, then a market will be driven to greater efficiency over time to the maximum benefit of consumers.

Alternative Market Structures

The main alternatives to a structurally competitive market are monopoly and oligopoly. A monopoly occurs when there is only one seller of a commodity for which there are no close substitutes. Amonopolist possesses market power that allows it to constrain the quantity of a good supplied in order to raise the market price. In other words, under a monopoly, the quantity of a good sold and purchased is lower – and the price paid is higher – than under perfect competition.

The monopolist sets quantity and price to maximize profits and consumer surplus is reduced to zero. Hence, consumers are disadvantaged by a monopoly and social welfare is less than what would be achieved under perfect competition. For this reason, governments seek to break up monopolies or regulate them closely if they offer significant economies of scale or other advantages.

Oligopoly occurs when there are only a few relatively large sellers and each possesses a share of the market sufficient to cause them to recognize the interaction of their decisions in determining the market price and output. This recognition creates a basis for cooperative behavior and limits on competition, explicit or implicit, for the purpose of increasing profits. Entry barriers further facilitate explicit and implicit cooperative behavior by preventing new firms from entering the market and undermining existing price and output agreements among firms already in the market. Entry also can be deterred if exit from the market would be costly.

Monopolistic competition is another possible market structure. Under monopolistic competition, there are numerous firms, but they do not sell a homogenous commodity. Their products are sufficiently differentiated so that each firm effectively faces a separate demand curve for its product. At the same time, the firms' products are highly substitutable, so they must compete on price as well as the features of their products. Because consumers will switch for a small difference in price or quality in such a situation, firms are forced to compete, be efficient and charge prices that just cover their costs, as is the case with perfect competition.

The market for home loans might be a good example of monopolistic competition. Because insurers vary their products and quality of service to some degree but also compete aggressively on price, insurance markets also might be compared to monopolistic competition. The above comments with respect to workable competition also would apply to monopolistic competition. In other words, a monopolistically competitive market also could be workably competitive.

Synopsis of Key Points

1. The structure-conduct-performance hypothesis provides a basic framework for analyzing insurance markets.

2. The supply of insurance is determined largely by the cost of providing coverage and should be relatively price-elastic over the long run.

3. The demand for insurance is determined principally by consumers' risk and degree of risk-aversion and will be somewhat less sensitive to price, particularly for essential or mandatory insurance coverages.

4. The concepts of perfect competition and workable competition provide a benchmark for evaluating the structure and performance of insurance markets. A competitive market structure leads to competitive conduct and good market performance that maximizes the value of insurance to consumers.

5. Market power reflected in monopolistic or oligopolistic market structures can result in higher insurance prices, excessive profits or inefficiency, and the purchase of less than an optimal amount of insurance.

6. Many insurance markets may be characterized by a monopolistically competitive structure, where insurers compete on price and product features. This structure will generally be efficient, assuming that consumers value the product differentiation provided by insurers.

7. There are instances where insurers may engage in excessive competition, underpricing and cyclical pricing. Underpricing should be a short-run phenomena but may require regulatory intervention if it persists and threatens insurers' solvency.

The question for self-control

1. Give the definition of the insurance market.
2. Describe the formation and development of the insurance market of Ukraine.
3. What is the role of intermediaries in the insurance market?
4. Mutual insurance company.
5. Association of insurers, their functions and tasks.
6. Determine the role of each element of the insurance market infrastructure in the development of insurance relationships.
7. Types of insurance companies.
8. Strategy of the insurance company.
9. What criteria determine the organizational structure of the insurance company.
10. Bodies of management of an insurance company.
11. Name the marketing features in insurance.
12. Marketing research and marketing policy of the insurer.
13. Advertising of insurance services.
14. Realization of insurance services.
15. Calculation of tariff rates.
16. Identify peculiarities of actuarial calculations.
17. What is included in the insurance tariff?
18. What is the bonus system?
19. How to calculate an insurance payment?
20. What factors influence the cost of insurance services?
21. Concept, content and basic requirements for insurance contracts.
22. Rights and obligations of the parties to the insurance contract.
23. Procedure for preparing and concluding an insurance contract.
24. Settlement of disputes.
25. Termination of insurance contracts.
26. What factors are determined by the need for state regulation of insurance activities?
27. What is the licensing of insurers?
28. What documents are submitted for obtaining a license?
29. Public insurance supervisory authorities and their functions.
30. Insurance supervision in the countries of the European Union.

Topic 4. PERSONAL INSURANCE

Methodical recommendations for studying the topic

Prior to studying this topic, repeat the functions, principles and classification of insurance.

It is necessary to understand the purpose of life insurance and pensions, the need for its implementation and distribution. It is recommended to find out: the terms of life insurance specified in the contract; factors affecting the size of insurance premiums; options for their payment; rights and obligations of the parties; the order of payment of the redemption amount. When studying the issue of mixed life insurance it is necessary to determine the options of insurance, the conditions for the implementation of insurance payments.

It is advisable to get acquainted with the insurance products that are offered on the domestic insurance market, as well as to process the statistics and provide actual examples of press materials for the life insurance abroad.

Before examining the issue of retirement insurance, it is recommended to familiarize yourself with the concept of rent, to consider the types of pension insurance.

It is necessary to understand the difference in the sources of pensions for state and non-state pension provision and pension insurance with the help of insurance organizations. It is advisable to pay attention to the various pension insurance programs offered by insurers, as well as to study the foreign experience of realization of pension insurance.

It is worth repeating the functions, principles and classification insurance.

It is necessary to understand the purpose of personal insurance, its necessity and development in our country. Then it is recommended to master the classification criteria used in personal insurance.

It should be noted that the long-term types of personal insurance - life insurance and pensions are discussed in the previous section. This topic is a description of the risk types of personal insurance.

Considering accident insurance is required pay attention to the peculiarities of voluntary insurance from accidents of certain categories of policyholders, the conditions for the conclusion of contracts and insurance payments, a list of documents that must be provided for their receipt.

The potential insurer must realize the importance of personal insurance to protect his or her family and their family in everyday life. It is recommended that you familiarize yourself with certain types of personal insurance that are mandatory.

It is advisable to consider the insurance products offered on the domestic insurance market, as well as to process the statistics and present actual examples of periodicals on the implementation of personal insurance by insurance companies abroad.

It is recommended to repeat the tasks that are being solved due to personal insurance, paying attention to its social significance.

It is necessary to understand the purpose and essence of health insurance and its necessity.

It is recommended to determine the peculiarities of compulsory and voluntary medical insurance, the categories of insured persons, the conditions of concluding contracts and payment of insurance indemnity, as well as to learn the principles of medical insurance, the state and prospects for its development in the coming years.

It is advisable to get acquainted with the insurance products developed and offered on the domestic insurance market, as well as to work out statistical data and to find examples, facts about realization of medical insurance in Ukraine and other countries of the world.

Mini-lexicon

life insurance, insured, receiver insured amount, mixed life insurance, redemption amount, duration table life, terms of the insurance contract, annuity, rent, pension insurance, beneficiary, personal insurance, insured, insured, accident, personal insurance, personal insurance, collective insurance, injury, disability, comprehensive insurance, insurance payments, insured, health insurance contract, medical service, health insurance program, contract for providing medical services, medical insurance contract, medical examination, assistive company.

4.1. The role of personal insurance in providing social protection

At the current stage of development and formation of market relations, one of the main directions of our state's activity is solving the issues of social protection of citizens. Social insurance as an integral part of social protection plays a significant role in the lives of Ukrainian citizens, especially those who have lost the ability to provide themselves on their own. However, the system of social protection has not yet received the final form and is in the process of continuous reform.

Social protection in Ukraine has the following main objectives: ensuring the living standards of the working population is not lower than the subsistence minimum established by the state; counteracting social tension in society, which may be due to property, ethnic, religious or other inequality.

The current system of social protection in Ukraine is depicted in Fig. 3.

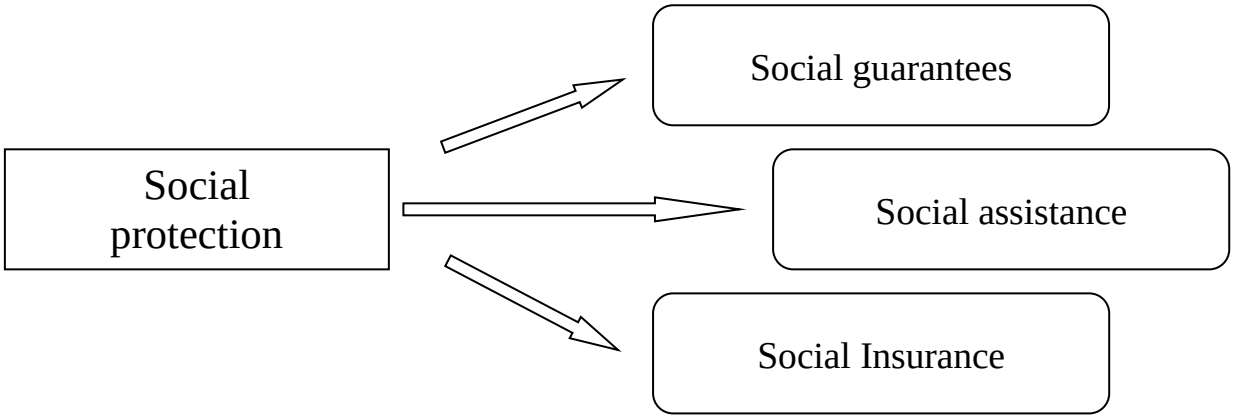

Fig. 3. The general structure of social protection of population in Ukraine

The main organizational principles of social security include: insurance, provision and care (assistance).

A characteristic feature of the insurance policy is that the financing of social payments is carried out at the expense of contributions to social insurance, as well as the close interdependence between contributions and the amount of social benefits. Thus, the principle of insurance, applied both in private insurance companies and in the social insurance system, best suits the market principles of fairness remuneration in accordance with personal contribution and personal responsibility.

The principle of social insurance provides that financing of social protection mechanisms is carried out at the expense of insurance premiums of members of the insurance association, who receive insurance payments upon the occurrence of an insured event. The financing of social security payments may also be partly financed through state subsidies or loans.

The social insurance principle plays a significant role, first of all, in Germany, Austria, France, Italy and the Netherlands, where the financing of social protection systems is based either on the tripartite participation of workers, employers and the state (Germany, Austria), or mainly at the expense of employers and the state (Italy, France).

The application of the social insurance principle is based on the rules of equivalence and redistribution. In a generalized sense, the social insurance system solves two important social and economic tasks, namely:

1) the preservation and complete restoration of the working capacity of the active part of the population of the country;

2) the guaranteed material security of citizens who have lost their ability to work in connection with retirement or did not have it at an able-bodied age for one or another reason.

4.2. Essence, classification and life insurance options

Life insurance is a special kind of insurance, which at the same time combines protective and accumulation functions. An important distinction between life insurance and other types of insurance is that the event that life insurance covers (death) is uncertain in any given year, but certain in the long term. The risk of premature death poses undesirable financial consequences for the insured's survivors. The probability of death generally increases over the term of life insurance policies (i.e., the insured ages) and, hence, insurers must accumulate funds to pay claims that will eventually occur. Life insurers use mortality tables to chart the probability of a death claim over time based on the age and gender of the insured and set appropriate reserves to pay the claims expected to occur from the insurers' portfolio of policies during a given period.

Life insurance is a sub-branch of personal insurance in which the object of insurance relations is the property interests that do not contradict the legislation of Ukraine related to the life and health of the insured on the basis of a voluntarily entered into agreement between the insurer and the insured. The risks that exist in life insurance are related to the uncertainty of the duration of the last for each individual insured.

Life insurance involves the liability of the insurance company in the form of a one-time or delayed payment of the sum insured if one of the following events occurs:

1) survival of the insured before the expiration of the insurance contract;

2) the death of the insured for any reason during the period of the insurance contract;

3) reaching the insured for a certain age: pension (pension insurance) or age specified by the insurance contract.

The terms of the life insurance contract stipulate the insurer's obligation to make an insurance payment in the event of an accident that has occurred with the insured person and (or) the insured person's illness.

The policy of life insurance provides, in addition to the payment of a full sum insured on the fact of survival or death, the payment of a share of the sum insured on the fact of temporary or permanent disability.

If on the occurrence of an insured event, a regular consecutive life insurance payments are provided for (life annuity insurance), then the insurance contract must necessarily include the risk of death of the insured person during the period between the commencement of the insurance contract and the first insurance payout from the life insurance premiums.

An insurance contract is considered an accession agreement, since its general terms are made only by the insurer. The insurer agrees to the conditions offered by the insurer.

Interesting Facts

The first client who opened the fashion for exotic insurance, became the actor of a silent movie Ben Terpin. He insured in 1922 for 20 thousand dollars his eyes. Ben arranged insurance for the case if his congenital strabism, which gave particular expression to the person of the Hollywood comedian, for any reason disappeared.

A bottle of insurance worth £ 3900,000 was ordered by the wine maker Chateau de la Garde Ilya Gort from Bordeaux. London Lloyd, famed for the most unusual insurance, pledged to pay the specified amount in case of loss of a wine smell.

Today, the most common types of life insurance are:
- mixed life insurance,
- child insurance,
- insurance before marriage,
- supplementary pension insurance.

Mixed life insurance is one of the most popular types of personal insurance. Mixed insurance is a type of life insurance that combines in one contract and one person several separate types of insurance, namely: life insurance and insurance in case of death of the insured.

Thus, mixed life insurance combines two risks that contradict each other: on the one hand it is a survival to a certain date or event, and on the other – death. However, there is actually only one risk: a person will either survive the end of the contract or not.

The terms of the insurance contract may include liability of the insurer and in the event of an accident with the insured person, which led to a permanent loss of overall capacity for work. For temporary disability (for example, due to light wounds, burns), the insurance company does not pay the sum insured. Inclusion of liability of the insurer for the consequences of accidents contributes to the increase of tariff rates.

Mixed life insurance contracts are long-term and can be concluded for different lengths of time. For example, in Ukraine, as practice shows, mixed-life insurance contracts can be concluded for a term of 3, 5, 10, 15 and 20 years. This takes into account the age of the insured. It is set up from 18 years old. The insurance conditions are limited and the maximum age for the conclusion of the insurance contract. This restriction is also stipulated by the insurance company. Along with the restriction of the minimum and maximum age limits for the acceptance of insurance, the age of the insured person is clearly established at the time of the expiration of the insurance contract according to the average life expectancy.

When entering into an insurance contract, the state of health of the insured is important, as the insurance contracts, as a rule, do not conclude with the disabled disabled Group I. Other restrictions (for persons with disabilities in group II,

patients with oncological, chronic diseases or on AIDS) may also be envisaged, as these illnesses may lead to premature death of the insured person.

As a rule, in a mixed life insurance, the insured who pays contributions and the insured is one and the same person. Also, the policyholder is given the right to identify the person (s) who is entitled to receive the insured amount if the insured died. In addition, the person appointed by the insured person may be replaced by another before the time of the occurrence of the insured event.

Insurance companies when concluding contracts for this type of insurance take into account the following circumstances: the state of health of the insured, his age, profession, sex, place of residence, working conditions, livelihoods, genetic heredity. All this in aggregate determines the mortality rate of insured persons. For the conclusion of an insurance contract, the person who intends to insure submits to the insurance company a statement of the prescribed form. An application for insurance is an important legal document, which is filled in by the insurance agent (inspector) from the words of the insured. An insurance statement is not accepted if it is not signed by the person on behalf of the insurance, because in this case the insurance contract is invalidated.

The insured amount is set by the insured at the conclusion of the insurance contract, but the insurance company limits the size of the minimum and maximum insurance amount. The insured may be granted the right during the validity of the insurance contract with the consent of the insurer to change the amount of the sum insured. At the same time, changes in the insurance contract are made. The insurance contribution payable by the insurer to the insurer depends on the size of the insurance amount and the rate, which, in turn, depends on the insurance period and the age of the insured. The contribution is paid once, annually, quarterly or monthly, through cashless payments or cash. Under child insurance contracts, the amount of contributions depends on the age of the child, the sum insured, the insurance period and the length of payment of contributions.

The action of the insurance contract begins at the time the insurer pays the first payment to the cash employee of the insurance company or from the day the contribution to the account of the insurance company in the institution of the bank. In case, if by the term established in the insurance contract, the insurance contribution (completely or in a certain share) will not be paid, the insurance contract is considered invalid and the insurance contributions received are returned to the policyholder.

The fact of entering into an insurance contract is certified by an insurance policy (certificate). The insurance policy specifies the term of the insurance contract, the beginning and end of the contract, the insurance amount, the amount of insurance premium, as well as the person (person) who, in case of death of the insured, is entitled to receive the insurance sum.

Under the terms of the insurance contract, the insurer is given the right to terminate the insurance contract ahead of schedule. In this case, the insured receives a redemption amount, which depends on the amount of insurance premiums paid and the duration of the insurance contract, taking into account the investment income. At the same time, the insured is given the opportunity to renew

the insurance contract if the redemption amount has not been paid to him and the insurance contract has not yet expired.

When the insured lives before the expiration of the insurance contract, the insurance company pays him the sum insured specified in the contract. If during the term of the contract the insured died, this also entails the duty of the insurer to pay the amount stipulated in the contract.

The insurance amount is not paid if:

- the death of the insured person occurred during the first 6 months of the treaty on malignant tumors or cardiovascular disease;

- the death of the insured person is the result of an intentional crime or is related to the self-propelled control of an internal combustion engine or electric motor, a boat or a motor boat in the state of alcohol, narcotic or toxic intoxication, or suicide.

In these cases, a redemption amount is paid, which depends on the actual contributions paid by the insurance period on the day of death of the insured. The redemption amount is the sum of the accumulation of insurance payments, minus the costs of conducting the case, which is returned to the policyholder in the case of early termination of the life insurance contract.

If the insurance contract establishes the liability of the insurer in case of damage to the body by the insured as a result of an accident, then payment at the same time forms part of the sum insured, which depends on the degree of loss of health. The percentage of loss of health is determined by a special table developed by the insurance company. In order to confirm the fact of an accident and determine its consequences, the insured must submit to the insurance company a certificate from the medical institution. The full insured amount is paid for the total loss of general disability from an accident.

Accidents, the consequences of which will be paid insured, include:

- injuries received by the insured due to the influence of external factors: natural disaster, unlawful actions of third parties;

- accidental acute poisoning by poisonous plants, chemical substances, low-quality food products with medicines taken by the appointment of a doctor;

- accidental fractures, bone dislocation, burns.

In case of survival before the expiration of the insurance period or when the health is lost, the insured person is an insured person or another person, in accordance with his or her order, drawn up in notarial manner. In cases where the insured dies before the receipt of the insured amount for life or in connection with the loss of health, the insured amount is paid to the person or heirs assigned to him, if they are not involved in his death.

The terms of the mixed-life insurance contract may also include the right of the policyholder to obtain a loan at a rate not exceeding the redemption amount, calculated on the basis of the reserve formed for fulfillment by the insurer of the obligations to pay in connection with the insured event of survival of the insured before the expiration of the term insurance, at the time of the loan. In the event of an insured event, it is necessary to notify the insurance company, the relevant competent authorities (police, police, medical institution, etc.) within

three days. Within fifteen days, collect and transfer to the insurance company all necessary documents for drawing up an insurance certificate and making an insurance payment, namely: application, insurance policy and a receipt for the payment of the last installment, if it was paid in cash. In addition, other documents may be filed in accordance with a particular insurance case.

In the event of the death of the insured, the beneficiary or heir must submit to the insurance company a copy of the death certificate of the insured, his identity card or certificate of inheritance. The payment of the sum insured is based on the statement of the insured (the beneficiary, the heir) and the insurance certificate within the terms defined in accordance with the concluded insurance contract, cash, postal transfer, receipt for receipt of the amount in the bank, transfer to the deposit at the name of the recipient.

In addition to mixed life insurance, insurance companies may individually provide life insurance and death insurance.

Life insurance means that the person who pays insurance premiums and has lived to a certain predetermined age, receives the insured amount from the insurer; In the opposite case, in case of death of the insured during the period of the contract, the insurer pays 100% of the sum insured to the heirs. Therefore, the insurer according to the mortality table determines the probability that the person (insured) will live to a certain age and on the basis of this calculates the insurance premium so that, taking into account the increase in capital, it is possible to issue an insurance sum. Reliable mortality table is important for every insurance company, because it depends on it on the size and reserves of the premium. Death insurance provides that for an insurance premium that is made by the insured during his life or at any given time, the insurer undertakes to pay the established pre-insurance amount, if it does not occur.

The expediency of such insurance became reasonable with the appearance of a mortality table. Knowing the average life expectancy for each age, you can determine the amount of insurance premium, sufficient to ensure that in case of death, pay the insurance amount.

Interesting Facts

Since 1999, the list of insurance services provided in the United States includes insurance "for various damage caused by the newcomers, including theft. One of the British brokers begins to sell the appropriate insurance to women who are afraid of getting pregnant from an alien.

When insuring children, insurers are parents and other relatives of the child who enter into insurance contracts, pay insurance premiums, and the insured is a child aged from birth and up to 16 years. As a general rule, the age, state of health of the insured does not matter when entering into an insurance contract, but in some cases, insurance companies can stipulate it. In addition, contracts for child insurance may be concluded by legal entities – enterprises, institutions, organizations.

Insurance companies are offered several options for child insurance:

- types of long-term savings insurance, associated with cash accumulation for various purposes (insurance of children in orphanages, wedding insurance);
- types of short-term insurance, which make it possible to compensate temporary or permanent loss of health in connection with an accident;
- various programs of voluntary medical insurance, which include not only material support in the event of emergencies, but also the medical service and assistance specified in the contract.

The insurance contract combines the conditions of survival of the insured child up to 18 years of age, death during the period of the contract, as well as loss of life, health due to an accident.

Contributions to be paid by the policyholder during the duration of the insurance contract depend on the age of the child, the amount of the insured sum and the period of insurance.

In case of death of the insured, any other relative of the child can assume his obligations. Otherwise, the insurance contract stops, and the insured child returns the amount of paid contributions by converting to a personal bank deposit.

Interesting Facts

The Hullberry Insurance Company (Amsterdam) has received official approvals from its supervisors to provide its extravagant insurance services. A man who does not trust his partner can be insured against the risk that he is not the father of a child. In this case, he will receive 500 euros. The cost of insurance is 12-28 euro per year.

Marriage insurance is a guaranteed payment of insurance coverage to the insured, even if during the period of the insurance contract the payment of insurance premiums will be interrupted due to the death of the insured. The greatest interest in this type of insurance manifests itself in grandparents, who are satisfied with the payment of insurance for grandchildren when entering into marriage, regardless of whether the insured survived the expiration of the insurance period and did not pay all the contributions in full in accordance with the contract.

Interesting Facts

The person who was told "no" at the altar can get from the insurance company 100 euros. Such insurance is offered in Germany for uncertain newlyweds. Its cost is 12-28 euro per year.

Insurers under this type of insurance are relatives of a child aged 18 to 80 years who have entered into a contract in favor of children – insured persons. Insurance contracts can be concluded with respect to children from birth to a maximum of 21 years at the time of the expiration of the insurance contract. In

favor of one child, you can conclude several insurance contracts. There are no contracts for the insurance of disabled persons of group II. The insured amount can be set at the request of the policyholder and paid in connection with the registration of the marriage.

Interesting Facts

Insurance from Love has drawn one of the famous photographers on its model. An insured amount of $ 100,000 will be paid if the model falls in love and gets married during the policy period.

The insurer's liability expires when the child reaches the age of majority, but the payment is made only after a certain period of time. From 18 to 21 or before registration of a marriage the amount of the insurance sum increases for additional interest income.

An insurance contract prior to marriage may include the insurer's liability at the death of the insured during the term of the contract or in the event of loss of health due to an accident. In case of death of the insured in the first 6 months, the insured person is paid a redemption amount if it is provided for in the insurance contract. Upon the death of the insured person, the insured returns all paid contributions, and the validity of the insurance contract is terminated.

The insurance premium is determined depending on the age of the insured and the insured person, the sum insured, the term of insurance and other terms of the contract and is paid in cash or non-cash, one-time, annually, quarterly, monthly.

Rents and **supplementary pensions** are a specific form of insurance. In insurance, the rent is about the use of existing capital by turning it into annual rent. Rents insurance is a combination of types of insurance, under which the insurer undertakes to pay the insured person with the period of life under the contract period of regular insurance, life or temporary. In case of death of the insured person, the contract may provide for the return of the insured part of the insurance premiums paid to the heirs or the payment of the contractual amount of rent minus already received by the insured.

Rent insurance may include the payment of insurance coverage to two or more persons (the head of the family and his dependents), and maybe (in case of death of the insured) – the widow's husband (wife) or dependents.

The obligations of the insurance company begin with the life of the insured until the certain age or the term specified in the insurance contract. At the same time, the insured pays a sum of money to the insurance company at one time or by installments, which she uses for investment purposes.

Rents insurance contracts differ from other insurance contracts by the fact that the insurer's sum insured will be paid to the insured by shares and periodically after a certain time. In addition, the insurer must perform his duties to the insured (insecure) only when the latter, in accordance with the insurance contract, will pay the full amount of contributions and not before.

The insured amount is determined by the size of the due pay rent in the year. Tariff rates are higher than life insurance.

In foreign practice, rent insurance is also called annuity. The main types of insurance rents include insurance for an additional pension. Rents and supplementary pensions are a specific form of insurance. With mixed life insurance, child insurance and marriage insurance, the goal is to create a new capital, and when it comes to insurance, the rent refers to the use of existing capital by turning it into annual rent.

Rents insurance is a combination of types of insurance, under which the insurer undertakes to pay to the insured person (s) at the time of life under the contract period of regular insurance, life or temporary. In case of death of the insured person, the contract may provide for the return of the insured part of the insurance premiums paid to the heirs or the payment of the contractual amount of rent minus already received by the insured.

Rent insurance may include the payment of insurance coverage to two or more persons (the head of the family and his dependents), and maybe (in case of death of the insured) – the widow's husband (wife) or dependents.

The obligations of the insurance company begin with the life of the insured (insured) to a certain age or the term specified in the insurance contract. At the same time, the insured pays a sum of money to the insurance company at one time or by installments, which she uses for investment purposes. After the insurance contract specified in the insurance contract (age), the insured receives certain payments himself (if alive) or they are received by the person in whose favor the insurance contract (or heirs) was entered into.

Rents insurance contracts differ from other insurance contracts because the insured amount represents the amount that the insurer will pay to the insured (insured) shares and periodically after the occurrence of a certain time (age). In addition, the insurer must perform his obligations to the insured (insured) only when the latter, in accordance with the insurance contract, will pay the full amount of contributions and not earlier than, for example, in the case of mixed life insurance. At the same time, the obligation to start payment of certain amounts may be related to the moment when the payment of all contributed deposits ends. But there may be some period between the expiration of the payment of contributions and the beginning of the payment of rent.

Unlike life insurance contracts, when the insured payment is made after the survival of the insured before the expiry of the insurance period or in the event of his death during the period of the contract (with the legal relationship of the parties involved in the contract, are terminated), the insurance rents begin to be paid after the survival of the insured until the term established by the agreement, when the necessary insurance fund is created, intended for payment of rent. At the same time, the insurer's obligation regarding regular payments to the insurer is only commencing. The specificity of rent insurance is also that it is intended to create an additional regular source of income for the survivor (for example, survivors' death annuity).

Taking into account this specificity, tariff rates are calculated that are higher than that of life insurance.

The insured amount is determined by the size of the due pay rent in the year. The rent can be paid at any frequency, which is established by the agreement – monthly, quarterly, annually. The term of insurance is divided into the period of payment of contributions (the question of the frequency of payment of insurance premiums is decided upon the conclusion of the contract) and the period of payment rent.

During the insurance contract the policyholder is given the right to change the size (increase or decrease) and the periodicity of payments. In addition, if desired, subject to the terms of insurance, he may terminate the contract and receive a redemption amount.

There are several types of rent insurance: lifetime or temporary; immediate or delayed. It all depends on the timing of the payment of contributions and the terms of payment of regular security. An insurance contract for rent can also be concluded with liability for the payment of insurance coverage (rent) in case of death of the insured. The most promising is rent insurance, which has such a special direction: creating a source of additional income for the elderly, providing material assistance to children in the event of loss of parents, disabled people who have lost the opportunity to work, persons of working age, unemployed in connection with child care, etc.

In foreign practice, rent insurance is also called annuity. There are various types of annuities. Annuity forms are:

- term deposit, which provides that the insurance contribution will be paid at one time and, in return, the insurer (insured) throughout his life, the insurance company will make annual payments. This form of annuity is popular with retirees who intend to provide themselves with regular income;

- annuity with deferment of payments is characterized by the fact that the insurer makes payments on a certain date in the future, that is, it provides for a period of delay between the conclusion of the insurance contract and payments. In this case, the insured is given the opportunity to pay payments in one installment or regularly during the specified period of delay;

- a temporary annuity stipulates that the contract between the parties stipulates a specific date after which the contract is terminated;

- the guaranteed annuity is a fixed annuity which is not associated with the death of the client and is guaranteed for a minimum period of time;

- an annuity of common life is intended to provide a payment to one of the spouses at the retirement age (the surviving one). After the insurer's death, payments may be continued in full or in a reduced amount;

- an indexed annuity allows you to reduce the impact of inflation and increase the value of annuity. At the same time, the amount of initial contributions is lower compared to the fixed benefit annuity;

- the annuity of the protection of capital is more expensive than the term, and provides for providing the guarantee to the client of the insurance company or its heirs to receive the full amount of paid contributions.

The main types of insurance rents are pension insurance, that is, the insurance of an additional pension, which is intended to protect the material interests of citizens, in particular, to stabilize their level of life.

Pension insurance is a type of personal insurance and, at the same time, a type of rent, in which the insurer undertakes to pay the insured to a certain amount and with a certain periodicity of a pension during the life or time period, and the insured – to pay insurance premiums.

Insurance contracts are concluded individually, as well as with a group of individuals. Individual insurance contracts for supplementary pensions are made with able-bodied citizens, taking into account age, sex and regardless of the state of health.

Pension insurance assumes that the insurance company makes payments to the insured person associated with the retirement (supplementary pension insurance) or the age established by the insurance contract. The liability of an insurance company under supplementary pension insurance contracts may be extended by agreement of the parties. Thus, in addition to the terms of the contract for supplementary pension insurance, the insurance company may assume responsibility for payment in the event of an accident or death of the insured (insured). The insurance company may provide the policyholder with an opportunity to conclude an insurance contract in favor of another person.

The sum insured is determined at the conclusion of the insurance contract. When determining it, the amount of current payments to be paid by the insurance company is taken into account. In addition to these basic payments, the insurance contract may also provide for additional payments that are the result of the insurer's participation in the profit of the insurance company. The policyholder is entitled to pay insurance premiums at one time or periodic payments. The amount of insurance premiums depends on the sum insured, age, sex of the insured or the insured person.

An additional pension depending on the content of the insurance contract may be paid by the insurer during the life of the insured or during a specified period. There may be cases when the insured did not live up to the time of payment of the pension or received it only during a very short period. In this case, in accordance with the terms of insurance, the insurance company or pays the beneficiary (heir) the appropriate number of pensions, which is determined when entering into an insurance contract, or the difference between the specified amount of pensions and the amount that has already been paid to the insured for his life. When entering into an insurance contract, the procedure for paying pensions is established (monthly, for each year, etc.). In this case, the terms of the insurance contract may provide that during the life of the insured he personally receives an additional pension, and in case of his death - the beneficiary, which is defined by the insured, in full amount of the additional pension provided for the insured, or in a certain part of life.

The conditions for the insurance of an additional pension may include the provision of benefits to insured persons. So, after a certain period of time, the

insurer can provide the insured with the opportunity to obtain a loan secured by the time accumulated before the call for a loan reserve.

Pension provision in most countries of the world is carried out at the expense of state pension systems (within the framework of social insurance), pension funds and insurance companies and other financial organizations.

The main problem of pension insurance, as well as life insurance, is to ensure the protection of citizens' savings in the event of inflation. Therefore, it is necessary to calculate the additional amount of pension, which is payable in a certain number of years. The task is complicated by the fact that during the period of payment of contributions, and for the period of payment of pensions should be charged the amount of the additional amount of pension. In this case, the amount of the additional amount must be different depending on the period of payment of contributions and the period of payment of pensions, the order and frequency of contributions.

Annuities are designed to systematically liquidate a principal sum. Under an annuity contract, the insurer agrees to pay the annuitant a certain sum for a specified period of time that could be a number of years or the life of the annuitant. The objective is to protect the annuitant against the contingency that he or she will outlive other sources of income. Immediate annuities are paid with the commencement of the contract, while deferred annuities are paid after some specified period of time has elapsed. Annuities with life contingencies only obligate the insurer to pay benefits as long as the annuitant is alive. Annuities without life contingencies require payment of the benefit to the annuitant or the annuitant’s beneficiary for a specified period of time, regardless of when the annuitant dies.

Immediate annuities are always funded by single premiums, while deferred annuities can be funded by single or flexible premiums. The single premium is equal to the present value of the anticipated benefit payments that will be paid under the contract plus a provision for the insurer's expenses and profit.

Guaranteed investment contracts are a form of single-premium deferred annuities that provide a guaranteed return to the policyowner or contract holder without exposing the insurer to any mortality or morbidity risk. The contract only guarantees a rate of return for a specified period of time and pays the accumulated contract value on the death of the contract holder, minus appropriate charges.

Variable annuities pay the current value of a fixed number of annuity units. The current, or dollar, value of each annuity unit depends on the investment earnings of a special account, which is typically invested in equity securities. This type of contract is intended to provide a more stable value or purchasing power in response to inflation.

4.3. Accident insurance

Accident insurance refers to risky types of personal insurance, whose purpose is the insurance of citizens in the event of loss of health or death due to an accident. Unlike accumulative long-term life insurance, accident insurance

provides for the payment of the insured amount only at the onset of an insured event (in full or in part). The provision of accident insurance services is carried out in accordance with the insurance rules developed by the insurer. The object of insurance under this type of insurance is property interests that do not contradict the legislation of Ukraine related to the life, health and ability to work of the insured (insured person).

Insurers for this type of insurance may be legal entities or able citizens who have entered into an insurance contract with the insurer. The insurance contract does not conclude with cancer patients, patients with severe forms of cardiovascular disease, AIDS, which are registered in narcological, psycho-neurological, tuberculosis, skin and venereal dispensaries.

There are the following types of accident insurance:

- individual – the insured is an individual, the payment of contributions is carried out at its expense;
- collective – the insured is a legal entity; payment of insurance payments is made on the account of the funds of enterprises and organizations where there are workers who are exposed to life-threatening conditions of work – firefighters, pilots, rescuers, etc., who are insured in case death or loss of health in the performance of official duties.

Insurance cases, upon occurrence of which the insurer must fulfill taken at the conclusion of the insurance contract on accidents, are:

- temporary loss of the insured person of general working capacity (at least seven days);
- permanent loss of general working capacity (establishment of a disability group);
- death of the insured person as a result of an accident.

An event occurring as a result of:

- intentional or unlawful actions of the insured, which led to the occurrence of an insured event;
- actions of the insured who was in a state of alcohol, narcotic or toxic intoxication;
- suicide or attempted suicide of the policyholder, except in those cases where the insured (insured person) was brought to such a state by unlawful actions of third parties;
- intentionally causing a personal injury to the insured person, including under the influence of actions of third parties;
- commission by the beneficiary of an intentional crime that led to the death or death of the insured.

The size of the insured sum is determined by agreement between the insurer and the insured at the conclusion of the insurance contract. For each day of delay in payment of the sum insured, the insured shall be paid arrears (fine, fine), the amount of which is determined in the insurance contract.

The amount of the insurance contribution depends on the occupation of the insured, sports, time and place of the insurance contract, the geographical area of

the insurance contract, the number of simultaneously insured persons, the order of payment of contributions, etc.

The insured amount is paid by the insurer in the following cases:

- the death or death of the insured (insured person) as a result of an accident to the beneficiary or heir – in the amount of 100% of the sum insured;

- receiving an injury from the accident as a result of an accident and establishing a disability in Group 1 – 100% of the sum insured, Group II – 75% of the sum insured, III group – 50% of the sum insured;

- temporary loss of the insurer of work ability, he is paid for every day 0,5% of the sum insured, but not more than 50% of the sum insured.

When entering into an insurance contract for third parties (except for children under the age of 16), the written consent of the insured person is required. When submitting an application for the conclusion of an agreement, the insurer must provide the information required by the insurer regarding the health status of each person in whose favor the contract is concluded (sometimes the insurer requires a medical report from the person who insures health and in whose favor the contract is concluded). The term of the insurance contract is determined by agreement of the parties from one to twelve months, unless otherwise provided by the insurance contract.

Upon occurrence of an insured event, the insured must:

- to inform the insurer about the occurrence of an insured event within three working days from the moment of its occurrence;

- provide the insurer with the necessary documents stipulated by the rules and insurance contract;

- provide the insurer with reliable information about the state of health of the insured person, as well as other necessary information at the request of the insurer. To obtain the sum insured, the policyholder submits documents confirming the occurrence of the insured event.

In accordance with the Law of Ukraine "On Insurance", accident insurance may be compulsory or voluntary.

The purpose of the mandatory form of insurance, set by the state, is to protect the interests of individual insurers and society as a whole. Legislative acts determine the list of objects of insurance, the amount of insurance liability, the rules of insurance, the procedure for payment of insurance payments, the rights and obligations of insurance participants, insurance organizations that carry out compulsory insurance.

According to Article 7 of the Law of Ukraine "On Insurance", compulsory Personal Accident Insurance covers the following types of insurance:

1) personal insurance of medical and pharmaceutical workers (except for those working in institutions and organizations financed from the State Budget of Ukraine) in case of human immunodeficiency virus infection in the course of performing their official duties;

2) personal insurance of departmental employees (except for those working in institutions and organizations financed from the State Budget of Ukraine) and rural fire brigades and members of voluntary fire brigades (teams);

3) insurance of sportsmen of higher categories;

4) life and health insurance of specialists in veterinary medicine;

5) personal insurance against accidents in transport;

6) insurance of employees (except for those working in institutions and organizations financed from the State Budget of Ukraine) involved in the provision of psychiatric care, including caring for persons suffering from mental disorders;

7) insurance of financial responsibility, life and health of the temporary administrator and liquidator of the financial institution;

8) insurance of medical and other employees of public and communal health care institutions and state scientific institutions (except for those working in institutions and organizations financed from the State Budget of Ukraine) in case of an illness for infectious diseases related to their implementation professional duties in conditions of high risk of infection with pathogens of infectious diseases.

Personal insurance of medical and pharmaceutical workers in case of human immunodeficiency virus infection when performing their official duties. This insurance is subject to workers who provide medical care to the population, carry out laboratory and scientific research on human immunodeficiency virus and produce viral drugs.

The size of the insured sum payable upon infection with the human immunodeficiency virus or disability due to AIDS is regulated by the size of the minimum wage, and in case of death of the insured person as a result of the AIDS disease, his insured person is paid the insured amount depending on the amount of money spent by the deceased for the last occupied by his post.

The insurance of employees of departmental and rural fire brigades and members of voluntary fire brigades (teams) provides protection of their life and health while performing their duties at the expense of funds provided in the estimates for their maintenance of enterprises, institutions and organizations where they were created, and workers of rural fire brigade - at the expense of legal entities that hold units of this protection, or at the expense of the local budget.

Insurance for this type of insurance are:

- death of the insured during the performance of his duties;

- injuries, contusions, injuries, injuries or illnesses obtained during the elimination of the fire or the consequences of the accident by the insured, who has performed his duties in accordance with an order or order.

In order to carry out this type of insurance, the legislation of Ukraine provides that the insurer must be a joint-stock company "Ukrainian fire and insurance company" or another insurance organization that has received a corresponding license in the Authorized Agency, and the insured – an employee of the departmental and rural fire guard, a member of the voluntary fire brigade (team), which performs fire fighting and emergency response functions in accordance with the current legislation.

The maximum amount of liability of an insurance company is set in the amount of ten-year salary insured on his post on the day of insurance. The maximum insurance rate is 2% of the insured amount for each insured. The insurance contract is, as a rule, one year.

If the insured, as a result of performing his duties on the suppression of fires or the elimination of the consequences of the accident, is established:

- and the disability group (or there is the death of the insured person) - the insurer is obliged to pay 100% of the sum insured;
- II group of disability - 90% of the sum insured;
- III group of disability - 70% of the sum insured;
- in case of temporary loss of ability to work due to an insured event, the insured shall be paid 0.2% of the sum insured for every day, but not more than 50% of the sum insured.

In order to receive an insurance indemnity in case of temporary loss of ability to work due to an insured event, the insured person or his heir must submit to the insurer a statement in the prescribed form and present a document certifying the person, and in the case of death or death of the insured, a copy of the death certificate of the insured and a certificate right to inheritance, with loss of insured ability to work - a copy of the certificate of the medical and social expert commission on the degree of disability, certified notarially.

Insurance of sportsmen of higher categories applies only to athletes of national teams of Ukraine and is conducted in case of death or death of the insured during preparation or participation in competitions, as well as loss of insured ability to work due to injury, contusions, injuries or injuries, illness, disability that occurred during preparation or participation in competitions. Given this, a special procedure for the formation of insurance payments is also defined.

Insurance amounts are paid in cases of death or death of the insured depending on the amount of money held by the last position occupied by the insured, and in case of loss of capacity or invalidity, the insurance amounts are paid in the amount determined on the basis of the calculation of the average wage in proportion to the period of loss disability or depending on the established disability group.

Life and health insurance of specialists in veterinary medicine is carried out at the expense of extrabudgetary revenues of state veterinary medicine institutions in case of death (death), fatalities or occupational diseases that have arisen in connection with the performance of official duties, in the fight against diseases and with immediate manipulations with animals.

Insurers are subject to doctors, paramedics and veterinary medicine who carry out diagnostic, preventive, health, medical treatment in animal husbandry, veterinary and sanitary examination of livestock products and provide other veterinary services to animal owners.

Insurance payments for compulsory insurance of specialists in veterinary medicine are paid by state veterinary medicine institutions with extrabudgetary revenues. The annual insurance premium for each insured is set at 8% of the minimum wage.

Mandatory personal accident insurance in transport is introduced to reduce the danger to persons who use vehicles and passengers who use them. This type of insurance applies to:

- passengers of rail, sea, inland waterway, automobile and electric transport (except internal city) during the trip or stay at the station, in the port, at the station, the wharf;

- employees of transport enterprises, irrespective of the forms of ownership and types of activities directly engaged in transport operations, namely:

- drivers of cars, electric vehicles, drivers and assistant train drivers;

- drivers of underground trains, conductors of passenger cars, heads of trains;

- electric trainers;

- conductors;

- employees of restaurant cars and rolling stock units;

- mechanics of refrigerated sections;

- workers of the brigade of medical aid.

Passengers are considered insured since the announcement of landing in one or another form of transport until the completion of the trip, and drivers – only for the duration of travel.

The policyholders are passengers who pay an insurance payment additionally when paying a travel ticket. Passengers entitled to free travel in accordance with current legislation are subject to compulsory personal insurance without payment of an insurance payment and without receiving an insurance policy. Drivers' insurers are owners of vehicles that have entered into insurance contracts with the insurer and insure drivers for travel time.

The action of compulsory personal insurance against accidents in transport does not apply to passengers:

- marine and inland water transport on pleasure lines;

- inland waterway transport inside the city and crossings;

- automobile and electric transport on city routes.

The insurance payment is withheld from the passenger by the transport organization, which has agency agreement with the insurer, on the lines of rail, sea, inland waterway, automobile and electric transport on interregional and long-distance routes within one region of the Autonomous Republic of Crimea up to 2% of the fare, on the routes suburbs – up to 5% of the cost of travel, and is taken into account in the cost of the ticket.

Insurance payments are transferred to transport organizations by insurers who have received a license for compulsory personal insurance and have concluded an agency agreement with them. The insurance payment for compulsory personal insurance of drivers for rail, road and electric transport is determined in the amount of up to 1% of the insured amount for each insured person. The transport organization gives each insured an insurance policy, which is located on the back of the ticket, or issued on a separate form.

The insurance policy states:

- kind of compulsory insurance;

- name, address, phone number of the insurer;

- the size of the insurance payment and the sum insured.

If the ticket for travel is fully purchased for the currency of another state, then the insurance payment is included in the ticket price and is kept from the passenger in the same currency.

Insurers pay insured amounts:

1) in case of death or death of the insured as a result of an accident in the transport of his family or heir in the amount of 100% of the sum insured;

2) in case of receipt of an insured injury as a result of an accident at the time of establishment of a disability:

- group I – 90% of the sum insured;
- group II – 75% of the sum insured;
- group II – 50% of the sum insured;
- in case of temporary loss of insured working capacity for every day – 0.2% of the sum insured, but not more than 50% of the sum insured.

For every accident that has occurred with the insured in transport, the transport organization must:

- to draw up an act about an accident with the insured driver (Form H-1, stipulated by the Regulation on investigation and registration of accidents, occupational diseases and accidents at enterprises, institutions and organizations, approved by the decision of the Cabinet of Ministers of Ukraine dated August 10, 1993, N 623);
- draw up an act about an accident with the passengers of the industry sample;
- issue a certificate to the victim (who was entitled to free travel in accordance with the current legislation) with the information about the insurer (name, address, telephone).

Payment of the insured sum to the insured is carried out by the insurer on the basis of the statement of the insured (his family or heir) on its payment, an accident certificate, a letter of disability or a certificate from the specialized institutions on the establishment of a disability, in case of death or death of the insured as a result of the insured event – copies of the certificate death and succession documents for the heirs, as well as the insurance policy or a replacement document (for privileged categories of passengers, a document confirming the right to lhy).

The insurance amount is paid not later than 10 days from the date of receipt of the required documents. These insurance payments are made regardless of the amount to be received by the recipient for state social insurance and social security, and the amount that should be paid to him as compensation.

Obligatory state insurance of other categories is made in case of death or death of the insured during performance of official duties, loss of insured ability to work as a result of injury, contusions, injuries or injury, illness or disability that occurred during the performance of official duties. The amount of the insured amount depends on the amount of money for the last post and the degree of disability. Other conditions are similar.

Despite the fact that the Law of Ukraine "On Insurance" provides for compulsory insurance of risky occupations of national economy from accidents, its

practical implementation is constrained by the lack of a clear list of relevant professions and insurance conditions.

The main purpose of voluntary insurance against accidents is the reimbursement of losses inflicted on the life and health of the insured as a result of an accident that can not be reimbursed under compulsory forms of personal accident insurance.

Voluntary insurance of citizens from accidents is carried out on the basis of conditions and rules that take into account the features of both individual insurance of citizens and collective insurance of employees from accidents at the expense of enterprises. Special conditions can be applied in the case of insurance of children of school age and pupils of specialized educational institutions in the event of an accident as a result of an accident, as well as of servicemen. They reflect the peculiarities of the risk of these categories of insured persons.

Insurers can be both legal persons and able citizens, who have entered into insurance contracts with insurers. Insurers may enter into agreements with insurers on insurance against accidents of third parties (insured persons) who may acquire the rights and obligations of the insured under the insurance contract. At the same time, policyholders have the right, when concluding insurance contracts, to appoint citizens or legal entities to receive insurance premiums, as well as to replace them before the occurrence of an insured event.

Important conditions of insurance of citizens from accidents are:

- limitation of the term of insurance;
- limitation of the age of the insured;
- limitation of the amount of insurance liability caused by the consequences of accidents that occurred with the insured during the period of the contract;
- the proportional amount of the payment of the sum insured depending on the degree of loss of health, working capacity or the time of treatment;
- a specified list of documents confirming the occurrence of an insured event;
- the specified period of payment of the sum insured;
- determination of the three-year limitation period from the date of the decision of the insurer regarding the insurance payment or refusal to pay for the application of the policyholder regarding the payment of the sum insured for loss of health due to an accident.

Insurance cases are:

- temporary loss of the insured person of general working capacity (at least seven days);
- permanent loss of general working capacity (establishment of a disability group);
- death of the insured as a result of an accident.

In this case, an accident is interpreted as an unexpected unforeseen event that actually occurred and resulted in physical damage or as a result of which a health disorder or death of the insured occurred and confirmed by a medical institution. Each insurance company defines its own list of insurance events.

The main ones are:

- injury;
- drowning;
- burns, lightning or electric shock;
- frostbite, hypothermia;
- accidental acute poisoning with chemicals, medicines;
- bites of animals, poisonous insects, snakes.

Persons who are recognized as incapacitated in accordance with the established procedure, invalids I and disabled II group invalids, as well as patients with severe nervous and mental illness and AIDS can not be insured. The age limit is also applied.

Non-insurance cases:

- injury to the insured in connection with the commission of actions in which the investigating authorities or the court established the signs of intentional crime;
- injury of the insured, caused by his actions, connected with the management of a vehicle in the state of alcohol, narcotic or toxic intoxication;
- injuries or deaths associated with intentional self-inflicted injuries, etc.

Depending on the degree of risk in one or another profession, all insured are divided into risk groups:

- group I includes employees, engineers and other categories of citizens who are not directly involved in the production process, the working conditions of which are not associated with an increased risk of injury; artists of dramatic and musical theaters, pop artists, ballets and dance ensembles; employees of banks (except for persons engaged in collection and transportation of money); household and communal services workers; pedagogical staff of out-of-school children's institutions, teachers and students of higher educational establishments, colleges; housewives; medical workers; shop chain and food; postal and telegraph workers; library staff; hotel staff; wipers; kiosks; press workers;
- group II – the remaining categories of workers (workers, employees, agricultural workers and others) directly engaged in the production process; personnel of airfield service; cashiers and cashiers; workers of veterinary hospitals; gas welders; locksmith; workers of the manufacturing industry; artisans; food industry workers; printing enterprises; fire protection; servicemen, officers of internal affairs bodies (except for employees of the criminal investigation, traffic police, drivers); workers of construction, engineering, glass industry; agricultural workers; transport workers (except for air); workers of power stations and expeditions;
- group III – persons whose work is associated with a special risk in the event of an accident: employees of the criminal investigation, traffic police, civil aviation; Testing of motor vehicles and aircraft; circus performers who perform tricks on ropes, trapezes, acrobats, gymnasts, car mechanics, trainers of wild animals, horse riders, stuntman; drivers of vehicles; in the mining industry - persons who perform work in underground conditions, drillers of oil and gas wells; those whose work places are mining and gas service; workers involved in the production, storage, testing of explosives, poisonous substances; divers; a person whose work is related to hunting, fishing in the seas and oceans, hovercraft,

roofing work; installers of concrete, reinforced concrete structures; cavalrymen Rescuers of Mining and Water Reservoir stations.

Charges for the insurance of citizens from accidents are applied depending on the risk group, which includes the insured and the type of insurance (full insurance coverage, or protection only in production). Tariffs are set on the basis of actuarial calculations and vary in the range from 0.5 to 2.0%.

In the case of insurance against accidents, the insurer's employees – a legal entity may be provided with a group discount on the calculated insurance premium depending on the number of insured persons.

In the case of children under the age of 16, a special rate may apply. When it comes to insurance of tourists and accompanying persons, as well as athletes, contracts can be concluded for a term up to 1 year with the corresponding tariff adjustments. Depending on the degree of risk, both raising and lowering factors are used.

The fact of the conclusion of the insurance contract is certified by an insurance certificate (policy, certificate), which is a form of insurance contract and issued after payment by the policyholder of an insurance payment by cashless payments - through the accountancy of the company or organization, from the account in the institution of the bank or cash – to the insurer or insurance agent's cash desk.

If the insured is a legal entity, then the insurance contract of the corresponding form is executed in duplicate. Each contract is accompanied by a list of persons who are accepted for insurance, indicating the amount of the sum insured for each person. The list is certified by a signature of the head and seal. One copy of the contract is kept by the insured, the other – by the insurer. By agreement between the insured and the insurer, the insurance policy may be issued to each insured person.

If the policyholder is an individual, then on the basis of the application for insurance after payment of the insurance payment, the insurer is issued an insurance policy, a copy of which is stored by the insurer. The insurance contract is, as a rule, one year. Insurers, who during the period of validity of the insurance contract entered into for a term of one year, were not paid for insurance cases, when concluding a new contract for the same term, a benefit in the form of a reduction in the amount of insurance payment may be granted.

The insurance contract comes into force from 00 hours of the day specified as the beginning of the insurance contract but not before the insurance payment is received on the current account of the insurer or not earlier than the day after payment of cash payment to the insurance agent (inspector) and ends at 24.00 the day specified in insurance contract (insurance policy) – as the expiration of the insurance contract.

The validity of the insurance contract is terminated if:

- the insurer has fully fulfilled the obligation to the insured;
- the policyholder did not pay insurance payments in the terms specified by the contract;
- the insured went to a permanent place of residence outside Ukraine;

- the death of the insured took place;

- liquidation of the insurer - a legal entity in accordance with the procedure established by the legislation of Ukraine;

- the court decision on recognition of the insurance contract is invalid;

- there have been other cases stipulated by the legislation of Ukraine.

In the case of early termination of the insurance contract upon request of the insured, the insurer shall return insurance payments to him for the period remaining before the expiration of the contract, less statutory costs of conducting the case and actual insurance payments made under the insurance contract. At pre-term termination of the insurance contract on demand of the insurer, the insured shall return fully paid insurance premiums. If the insurer's claim is conditioned by the non-fulfillment by the insured of the terms of the insurance contract, the insurer shall return to the policyholder insurance payments for the period remaining before the expiration of the contract, less statutory costs of conducting the case and actual insurance payments made under the insurance contract.

The insurer (the insured, the beneficiary) shall notify the insurer in writing about the occurrence of the insured event, not later than one year from the date of the insured event.

List of documents confirming the occurrence of an insured event for the receipt of the sum insured:

- written statement of the established form;

- insurance certificate (contract or policy);

- a certificate (or copy) about the death of the insured in case of death of the accused;

- a certificate of the medical and social expert commission on the establishment of a disability group or a certificate of disability (a copy thereof) issued by a medical institution (in case of impossibility to receive a letter of non-availability, a certificate of the medical institution is submitted);

- an accident statement or a document from the competent authorities confirming the fact of an accident;

- passport of the recipient (or identity document);

- for the heirs – also a certificate of the right to inheritance issued by a notary office.

The term of payment of the sum insured is determined by the rules of insurance and is, as a rule, a weekly period.

Insurers pay insured amounts:

- in the case of death or death of the beneficiary or heir in the amount of 100% of the insured amount insured as a result of an accident;

- in case of receipt of an insured injury as a result of an accident at the time of establishment of a disability:

groups I – 90% of the sum insured;

group II – 75% of the sum insured;

group II – 50% of the sum insured;

- in case of temporary loss of insured working capacity for every day – 0,5% of the sum insured, but not more than 50% of the sum insured.

Cases in which the insurer may refuse to pay the sum insured:

- intentional actions of the insured or the insured, aimed at the occurrence of an insured event;
- submission by the insured of knowingly false information necessary for the conclusion of an insurance contract;
- notice to the insured on the occurrence of an insured event after one year has elapsed since the day of the occurrence of the insured event without grave for the said reasons;
- creating an obstacle to the insurer in determining the circumstances and nature of the accident.

Under the same conditions, voluntary insurance against accidents of school-age children and pupils of special educational institutions and military personnel is carried out, but taking into account certain characteristics.

In the case of **insurance for school-age children** and students of special educational institutions, insured persons may be children aged from 6 to 17 years old, and the insured are both parents and relatives of the child with whom he lives, or his guardians (trustees). Collective insurance contracts for students of general education schools, lyceums, gymnasiums, vocational schools, secondary specialized schools can also be concluded. The size of the tariff rate for child insurance depends on the insurance period.

The size of the rate for child insurance depends on the age of the child and the period of insurance. There is also a discount on the size of the insurance tariff, depending on the number of children accepted for insurance. The peculiarity of this insurance is the definition of the insurance cover of a moral injury to the insured child as a result of her kidnapping or rape, which provides for a payment of 50% of the sum insured.

In the case of **insurance of servicemen**, an insured person may be any individual who is called for a regular service to the Armed Forces of Ukraine, other military formations provided for by the current legislation of Ukraine, as well as an individual who studies in a military educational institution of the Ministry of Internal Affairs of Ukraine, The Security Service of Ukraine or at a higher educational institution with a military unit. Another person who is an officer of the Armed Forces of Ukraine or other military formations may also be insured and who is in regular service either on a long-term basis or on a contract basis. The size of the insurance rate depends on the insurance coverage program.

Recently, widespread use has been made of voluntary **insurance for citizens traveling abroad**, from accidents or in the event of a wound illness or other assistance.

The peculiarity of this insurance is that concluded insurance contracts can be complex and operate outside Ukraine and do not apply to the country of permanent residence of the insured or the country of which he is a citizen. The most important element of the insurance of citizens traveling abroad is emergency insurance, where it is not just about damages, but the provision of services in the form of

immediate assistance. In recent times, technical assistance on roads in case of car breakdown may also be involved.

Thus, the insurance of citizens traveling abroad can be carried out in two forms: compensatory and service.

In the first case it is said that the insured person pays for medical services on his own, and upon returning to his country on the basis of the documents submitted receives from the insurer the reimbursement of expenses included in the insurance coverage, which is not always satisfied with the policyholder.

That is why the widespread insurance of citizens who travel abroad, in service form. The guarantor of this form of insurance protection of citizens is the possibility of a round-the-clock connection with the operational center and the availability of an operational center of an extensive network of service providers that can provide insurers with a full range of services – from emergency care and hospitalization to returning to their country. Of course, operational centers and service providers are not kept by every insurance company, but by a limited number of highly specialized organizations – insurance or service companies. Relationships, including the distribution of costs between the insurer and the company – the organizer of the provision of services, is determined on contractual terms, which provides for payment for the services provided to the organizer, and the procedure for payment of medical services.

The amount of the insurance amount is set in a hard currency with the consent of the insured and the insurer.

The size of the premium is determined by the rates of the insurer, which depend on the insurance period, the set of insurance cases, the geographical area and the sum insured.

At insurance of tourists can be applied reduced tariff rates. This is due to a smaller amount of guarantees provided to them.

The peculiarity of the **insurance of credit card holders** is that an individual can be an insured person – the owner of a plastic bank card, irrespective of citizenship and age, and the amount of the insurance amount and payment depends on the type of card. At the same time for the owner of each card due to a certain set of insurance events.

A kind of voluntary insurance of citizens from accidents traveling abroad is insurance under the terms of the "Annual Policy". An insurance contract is for one year for an unlimited number of trips abroad, but provided that each trip lasts no more than one month, with the definition of a certain amount of the insured amount for each trip.

In case of **insurance of athletes and other participants of sporting events**, the insurance period is determined from the date of the arrival of the participants of the sporting event to the venue, but not earlier than for a certain number of days before the official opening of the event, and ends at 24.00 on the day of its official closing (ending).

The size of the rate for the insurance of athletes who participate directly in competitions, as well as spare players, is determined depending on the group to which the sport belongs and the insurance period.

If the insurance contract is concluded for a period of one year, the policyholder is granted a discount on the insurance payment, determined by tariff rates.

Interesting Facts

Insurance of body parts is a fairly common type of insurance amongst stars, and there are really many examples here. Jennifer Lopez's jacket draws $ 27 million, Meraii Carey's feet are $ 1 billion, Daniel Craig's body is £ 5 million.

4.4. Medical Insurance

Health insurance is a health insurance for any reason, including due to illness and accident.

Medical insurance combines all types of insurance related to the reimbursement of expenses incurred by the insured in connection with the illness and the need for treatment. The peculiarity of health insurance is the availability of long-term and short-term types of insurance. Long-term types include continuous health insurance, the contract of which the policyholder may conclude for an indefinite period. Similarly, the short-term types of health insurance (health insurance for sickness, medical insurance for tourists traveling abroad, insurance for the period of pregnancy and childbirth, etc.) can not be classified as short-term accident insurance.

A broad range of coverages is available to protect individuals against the wage loss and medical costs associated with illness and disability. These coverages have many similarities with property-liability coverages, including the application of the indemnity principle. There are two primary types of health insurance: disability income insurance and medical expense insurance.

A significant proportion of health insurance is sold under group contracts. Under a group contract issued to someone other than the insured, coverage is provided to a number of persons affiliated by employment or some other association. Large groups are often rated at least partially on their own experience. Members of groups are generally not subject to individual underwriting and the underwriting is focused on the characteristics of the group. This is intended to minimize adverse selection and administrative costs.

The main feature of health insurance is that, paying a one-time insurance contribution, significantly lower than the cost of all medical services, the insured is able to use the complex of medical services of qualified specialists in paid services clinics free of charge for a year.

In addition, an insurance payment may be made by the insurer in two ways:

- directly to the insured (insured) in the form of a full sum insured or its share;

- in the form of payment to the medical institution of the cost of treatment of the insured (including payment for stay in the hospital, physiotherapy procedures, consultations of leading specialists, costs for the purchase of medicines, etc.). Just like in insurance against accidents, insurers can be physical and legal persons

here. The insured and the insured may be one and the same or two different persons.

The subjects of medical insurance are:

- insured persons – individual able citizens, enterprises representing the interests of citizens, as well as charitable organizations and foundations;
- insurers – insurance companies licensed for this type of insurance;
- insured – citizens in whose favor insurance contracts are concluded;
- medical institutions that provide medical insurance assistance and also have a license for medical and preventive activities.

The object of medical insurance is the life and health of citizens. Medical insurance can be carried out in a compulsory and voluntary form. Distinguish the concept of insurance medicine and health insurance. With the help of insurance medicine, the issues of guarantee and availability of medical services for the general population, attraction of additional resources in the sphere of health care are solved.

The development of insurance medicine is one of the promising directions for solving health financing problems. Insurance medicine covers the financing of scientific research, training of medical personnel, expenses for the development of material and technical base of medical institutions, provision of medical care to the population.

Insurance medicine is based on certain principles, including the provision of economic and social protection of the middle and low-income groups of the population, the guarantee of the rights of every citizen for quality medical care, the obligatory contribution of both individuals and legal entities. From the economic point of view, insurance medicine is a medicine that is funded specifically for this purpose money funds.

An important element of the system of insurance medicine is medical insurance – it is produced by the world practice of the insurance business mechanism for the formation and spending of funds, which provides:

- the reasonableness of the size of the contributors' cash contributions and payments from the fund to actuarial calculations, that is, a specific system of mathematical, statistical and economic calculations;
- minimization of insurers' contributions by means of a joint distribution of expenses between all the participants of insurance, as well as by generally accepted practice in the insurance business for receiving profit from reserve, other temporarily free funds and reinvesting it into the main activity of funds;
- ensuring, respectively, the targeted mobilization of funds and targeted and targeted spending on the basis of a specific system of work with the categories of insurance risk, insurance case and insurance coverage, control of the cost of medical care;
- separation of funds from health insurance funds from the state budget and reduction of administrative and command influence of the state on funds in favor of intensification of public control and outflow.

An insured event in medical insurance is the application of the insured (insured) during the validity period of the insurance contract to the medical

institution with complaints about health, provided that the symptoms of the disease correspond to those listed in the contract for cases considered insurance.

The insured amount within the limits of which the insurer is liable for payments is determined by the value of the program of voluntary medical insurance chosen by the insurer. The selected program is an integral part of the insurance contract. The programs proposed by the insurer differ in circumstances in which the insured will receive medical aid: outpatient, in-patient, by calling medical assistance or doctor's home. In addition, programs can only be designed to help children or adults, and also differ in the list of medical institutions involved in the implementation of health insurance services. And, finally, the programs differ in value, which is influenced by all the above mentioned moments.

Disability income insurance provides periodic payments when the insured is unable to work because of illness, disease or injury. This coverage is intended to replace a significant portion, but not all, of the income lost from the incapacity to work. The partial replacement reflects the expectation that a worker's income needs are reduced when they are not working. It also guards against moral hazard and gives an incentive to incapacitated workers to return to work. Short-term disability policies typically provide benefits for periods of less than a year. Long-term disability policies provide benefits for longer periods (e.g., one to two years), up to age 65.

Medical Expense Insurance

Medical expense coverage, also referred to as indemnity plans, provides benefits for various medical services, including physician services, nursing serves, hospital services, supplies and equipment. Typically, benefits are structured along the lines of these services, supplemented by major medical benefits that cover costs for hospital and surgical services that exceed the benefits provided for these specific services. These benefits are subject to a number of limits to encourage insureds to use these services judiciously and contain costs. These limits typically take the form of deductibles, coinsurance provisions and maximum caps. Medical expense policies also limit reimbursement of provider charges to what are considered customary and reasonable fees for different procedures.

Health insurers also offer managed care programs that utilize preferred provider organizations (PPOs) or health maintenance organizations (HMOs). HMOs provide their members defined health care services in return for fixed periodic premiums. The enrolled members usually live within a given geographic area. Managed care providers used by the HMO are carefully screened. Contract terms specify the services to be rendered and the form of compensation. HMO providers also are subject to quality assurance programs, case-management and utilization-review procedures.

Providers can either be an employee (or facility) of the HMO or contract with the HMO as a separate entity. HMOs require members to choose a primary care physician who serves as a gatekeeper to specialists and other health services for which there must be a referral in order for the member to be covered. The primary care physician typically receives a salary if directly employed by the HMO or, if retained on a contractual basis, a capitated reimbursement on a

permember and per-month basis, regardless of the amount of actual services provided. Other providers are paid on a fee or capitated rate basis.

Providers receive the capitated rate regardless of the amount of services provided to the insured. This is intended to give providers an incentive to minimize expenditures by treating patients in the most cost-efficient way, with an emphasis on preventive care, to avoid more costly services if illness occurs or worsens.

PPOs combine some features of a standard indemnity policy with some features of HMO plans. PPOs contract with screened groups of providers selected by the insurer who have agreed to a negotiated fee schedule in return for prompt payment and a larger volume of patients. Insureds can obtain care from non-affiliated providers but may be subject to additional charges if they do so. PPO providers also are subject to quality monitoring and utilization controls.

HMOs and PPOs also offer point-of-service (POS) plans that allow enrollees to choose providers outside the plan, with the imposition of larger deductibles and co-pays – thereby increasing the cost to insureds who exercise this option. This arrangement allows insureds greater flexibility in choosing providers while maintaining some incentive to use in-plan providers.

Some insurers market special limited-benefit or "dread disease" policies. These policies only provide limited reimbursement for medical expenses (e.g., $10 a day for hospital expenses) or cover only certain illnesses, such as cancer. While these policies may appear attractive to consumers because of their low premiums, they are expensive relative to the amount of coverage they provide, which is generally inadequate to meet the full health-care needs of consumers. Hence, they tend not to be a good buy and their aggressive marketing, especially to low-income and elderly consumers, is a matter of regulatory concern. Still, there has been resurgence in the sale of disease-specific policies – labeled as "catastrophic" or "critical illness" policies – that provide a lump sum benefit for a limited list of serious, life-threatening medical conditions.

A recent development is the introduction of consumer-directed health plans. These plans come in two varieties: First, is a high-deductible health plan issued with a health savings account; second, is a high-deductible health plan issued with a health reimbursement account. The health savings account and health reimbursement accounts allow the consumer to use taxfree dollars for health care expenses. The consumer-directed health plans are generally less expensive for employers, but more costly for employees.

The object of **compulsory medical insurance** is the property interests of the society related to the health and working capacity of its citizens. Compensation is charged for the organization, development and implementation of medical care to the population in the amounts provided by the appropriate state-guaranteed insurance programs.

The principle of compulsory insurance operates in France, Canada, Germany, the Netherlands, Sweden, Belgium and other countries. In Israel and Switzerland, voluntary health insurance prevails, and compulsory state insurance exists only for servicemen and police officers. Mandatory form is used, as a rule, in

those countries where public health is predominant, and voluntary – in those countries where private insurance programs are distributed.

Insurance premiums are set in the amount necessary to meet the obligations of the state. They are levied on insurers in the form of taxes or other deductions, the difference between which for enterprises or the population is insignificant, since these and other payments for them are obligatory. Regarding some contingents insured by the insurer is the state, allocating in the funds insurance premiums from its budget.

For compulsory health insurance, it is characteristic that the insurers pay contributions at the set amounts and at the appointed time, and the level of insurance coverage is the same for all insured persons. Compulsory health insurance stipulates that the payment of insurance premiums may be imposed on both entrepreneurs and employees. The share of each party depends on the specific economic conditions of such insurance and the cost of medical care.

Compulsory health insurance is based on a system of contracts between insurance companies that reflect the rights, responsibilities and responsibilities of the parties. An insured or insured, an insurance medical organization, issues an insurance medical insurance policy for compulsory health insurance. Insurance policy is a document that guarantees the insured the provision of medical care within the framework of compulsory or voluntary medical insurance.

Compulsory medical insurance is based on compulsory health insurance, which determines the scope and conditions for the provision of medical and medical care to the population. The program covers the minimum necessary list of medical services guaranteed to every citizen who has the right to use it.

Therapeutic and prophylactic institutions as subjects of compulsory medical insurance are those medical institutions that have a license for the right to provide medical care and services in accordance with the program of compulsory health insurance. The license is a state permit for a medical institution to perform certain types of activities and services under the compulsory health insurance program. A license must be obtained from any medical institution, regardless of the form of ownership. In addition, she must be accredited for compliance with established professional standards.

Medical institutions perform their activities on the basis of an agreement with insurance medical organizations, which provides for the medical organization to provide the insured contingent with medical assistance of a certain amount and quality within a specific time frame (within the framework of the compulsory medical insurance program). The contract establishes the volume of medical and diagnostic assistance and norms of reimbursement of expenses. For medical services, medical organizations receive a fee.

Medical institutions are responsible for refusing to provide medical care to the insured party, inconsistency of medical services by volume and quality with the terms of a contract with an insurance medical organization. Medical care in the health insurance system can be provided by self-employed physicians who have the right to do so.

Payments with health care institutions are carried out by insurance organizations for the actual provided health care or service provided to the insured person. This ensures control over the quality of medical care and the use of funds, provides an opportunity to create economic incentives for improving the service of insured citizens in health facilities.

A health insurance fund may be the subject of health insurance, which is created by the state together with other subjects of insurance relations to exercise control over the activities of insurance companies and medical institutions, the use of funds, etc.

The compulsory health insurance system obliges policy holders to enter into relevant contracts, according to which they are entitled to receive medical services, the list and volume of which is established by the program of compulsory medical insurance, in medical institutions included in the system of compulsory health insurance. When entering into an agreement, the insurer gives the insurer an insurance contract, and the insured – an insurance policy that has the force of the contract. The contract of compulsory medical insurance determines that the insurance organization undertakes to pay medical and other services that were provided to the insured in accordance with the program of compulsory health insurance.

In turn, the policyholder undertakes to pay contributions to the insurance organization. The contract stipulates the amount, terms and procedure for making insurance premiums, the validity of the contract, the liability of the parties in case of non-fulfillment of the terms of the contract, as well as the procedure for resolving disputes. The insurance policy for compulsory medical insurance confirms the right of a citizen to receive medical assistance under the program of compulsory medical insurance.

Interesting Facts

In 2001, Marina Khlebnikova became the first Russian artist to arrange insurance from meeting with aliens. Her policy is literally the following: "If the UFO comes in contact with Marina Khlebnikova in order to establish a relationship with the earthly civilization, the insurance company will pay a premium of $ 1 million." The insurance contribution was only 1 ruble, and the insurance itself is valid for 20 years.

Voluntary health insurance involves paying for medical services over the program of compulsory health insurance. It provides the policyholder (insured) with the guarantee of full or partial compensation by the insurer of additional expenses associated with applying to a health care institution for a service provided under a voluntary health insurance program.

Voluntary health insurance programs vary according to the list of health services; contingent of insured persons (children or adults); the list of medical institutions offered by the insurance company for implementation of the program of voluntary medical insurance; of the value of the services provided.

The voluntary form of health insurance involves the use of types of insurance in which the insurer's liability arises on the fact of illness or treatment. The payment for these types of insurance company carries out in the form of a fixed sum insured or per diem. The voluntary form covers also those types of insurance, according to which the insurance company's liability arises in the case of appeal of the insured (insured) to the health care institution for receiving medical assistance or services in accordance with the terms of the insurance contract. Payment is a form of compensation for the cost of the treatment needed. The emergence of voluntary forms of health insurance is due to the fact that the scope of services and conditions for the provision of medical care under the program of compulsory medical insurance are limited.

The object of voluntary medical insurance is the property interests of the insured or the insured, which are related to the cost of receiving medical care. Voluntary health insurance is based on attracting free funds from enterprises, organizations and the public to health care.

Subjects of voluntary medical insurance are insurers, insured persons, insured and health care institutions. Insurers in the field of voluntary health insurance are independent insurance companies that have the status of a legal entity and a license to carry out voluntary health insurance.

Insured persons in the system of voluntary medical insurance are capable natural or legal persons. Insurers – individuals have the right to conclude insurance contracts in their favor or in favor of third parties. The main insurers for voluntary health insurance are enterprises that conclude collective insurance contracts in favor of all their employees or individual professional groups. Enterprises pay insurance premiums from profits.

Insured persons are individuals in whose favor insurance contracts are concluded. If an individual concludes an insurance contract with respect to herself, then the insured and the insured is one person.

Therapeutic and prophylactic institutions are medical institutions that have a license for the right to provide medical care and services in the system of voluntary medical insurance and have been accredited for their compliance with established standards for the provision of medical care and services. Insurance medical organizations conclude agreements with medical treatment institutions on cooperation in providing medical care and treatment of insured under the terms of contracts of voluntary medical insurance. The contract usually involves monitoring the quality of the provision of insured health services, compliance with the latest list, which is guaranteed by the voluntary health insurance program.

Voluntary health insurance is carried out within the limits of the rules established by the insurance company and may be individual or collective. For a collective form of insurance characterized by the fact that insurance premiums are paid at the expense of legal entities. In individual form, the source of payment of contributions is the incomes of individual citizens.

Voluntary health insurance is divided into individual and collective. Individual policyholders are individuals who have entered into an agreement with the insurer to insure themselves or a third person (children, parents) at the expense

of their own funds under the terms of the rules of voluntary medical insurance. In case of collective insurance, the insurer is an enterprise, an organization, an institution that concludes an agreement with the insurer to insure its employees or other natural persons (members of the families of workers, pensioners) at the expense of their funds.

By the terms of the contract, voluntary medical insurance may be short- or long-term.

According to the classic scheme, voluntary health insurance in countries with a developed insurance system involves a long-term insurance contract that provides a significant amount of insurance coverage (payment of various insurance services, including expensive ones) at the expense of monthly or annual insurance contributions accumulated over the years.

In Ukraine, two forms of voluntary health insurance have become widespread:

- continuous health insurance;
- health insurance in case of illness.

Continuous health insurance is a type of health insurance in which the insured person is provided with medical services with the subsequent payment by the insurance company (on the accounts submitted by the medical institution and within the sum insured). Contracts of continuous health insurance are concluded for a period not less than three years. An insured event for this type of insurance is the insured person's illness, which lasts for at least two weeks. Upon the occurrence of an insured event, the insurer carries out a sequence of insurance payments (insurance annuities) to the insured person during the period of the disease within the term and place of the insurance contract. The calculation of insurance rates is based on the relevant statistics on the incidence, taking into account the individual characteristics of the insured person: age, sex, occupational activity, place of residence, housing conditions, genetic features, state of health.

Health insurance for a sickness is a type of insurance, in which the treatment of a particular illness, which is taken for financing by an insurance company (ie insurance), is valued in monetary terms. Upon the occurrence of an insured event, the insured sum (its part) is paid to the insured person. In the case of medical insurance, an insured person's application during the validity of the relevant contract to the medical institution (as provided for in the insurance contract) in the case of an acute illness, exacerbation of a chronic disease, injury or other accidents with the aim of obtaining advisory, prophylactic or other assistance, which requires the provision of medical services within the limits of their list, stipulated by the insurance contract.

The contract of voluntary medical insurance is concluded on the basis of the claim of the insured. The fact of entering into a contract of voluntary medical insurance is certified by an insurance policy. The duty of an insurance medical organization is not only to familiarize the insured (insured) with the rules of insurance, but also to add insurance rules to the insurance policy. At the same time, the insurance organization may add to the insurance policy an excerpt from the

insurance policies that are of interest to the insured, but not included in the insurance policy.

Mandatory terms of the contract of voluntary medical insurance are:

- the name of the insured, the insured, the number of insured persons;
- object of insurance;
- the amount of insurance liability (including the list of medical services under the voluntary medical insurance program);
- the sum insured;
- term of the insurance agreement;
- the order of payment of insurance coverage;
- tariff rates;
- the size of insurance premiums and the procedure for their payment;
- the possibility and procedure for changing the initial conditions of the insurance contract;
- rights and obligations of the parties, other conditions.

Voluntary health insurance involves providing the insured (insured) with a wider right to choose specialized doctors, as well as institutions for obtaining the necessary assistance; improved retention in a hospital, medical treatment institution; increased by terms of post-hospital patronage and home care, etc. The volume of obligations of the insurer under the contract of voluntary medical insurance is determined by the list of insurance cases, in case of which the insurer has a duty to make an insurance payment. At the conclusion of the contract, the policyholder chooses a voluntary health insurance. The sum insured in voluntary medical insurance is the limit of insurance coverage, which is determined in accordance with the list and cost of medical services provided by the insurance contract.

The insurance contributions paid by the insured depend on the chosen program of voluntary medical insurance, the level of insurance coverage under the insurance contract, the insurance period, the tariff rate and other conditions stipulated by the insurance contract. The wider the list of events for which the insurance company is liable, the higher the amount of insurance premium. Tariffs for medical and other services of voluntary health insurance should be established with the consent of the insurer and the medical institution that provides the relevant services. The tariff rate is calculated by the insurer on the basis of statistical data on the application for medical aid and the duration of treatment. Sometimes, the rate is differentiated depending on the sex, age, and state of health of the insured person.

Insurance premiums under the insurance contract may be paid by the insured once for the entire period of insurance or paid periodically during the term of insurance in cash, or be transferred to the account of the insurer without cash. The insurance contract comes into force on the terms established in it. During the term of the contract the insured has the right to change the terms of insurance or to terminate the contract ahead of time.

The insurer has the right to refuse to pay the insurance indemnity to the insured person in case of her appeal to the health care institution, if any:

1) a disease which is the result of the use of alcohol, drugs, toxic substances and medical preparations by the insured person without the appointment of a doctor (except for the cases of violent use of such substances in relation to the insured person by third parties), self-medication;

2) illness or injury resulting from:

- suicide attempt, except for cases when the insured person was brought to such a state officially confirmed by unlawful actions of a third party, deliberate self-inflicted injury;

- the commission of an intentional crime by the insured person;

- attempts by the insured person to perform actions in which the structure of the crime has been established by law enforcement agencies;

- management by the insured person of a vehicle in the state of alcohol, narcotic or toxic intoxication, and also voluntarily transferring it to a person who was in a state of alcohol, narcotic or toxic intoxication, as well as to a person who did not have the rights of the driver of the corresponding category;

3) receipt of the insured person not provided for in the contract of health insurance or health care and in health care facilities not provided for in the insurance contract without prior agreement with the insurer (assisting company).

If the insured person has received health care in a health care institution not provided for in the insurance contract and has not previously agreed with the insurer (assisting company), but paid the cost of this assistance or purchased the prescribed drugs for treatment, then the insurance company carries out payment in the terms stipulated by the terms of the agreement, or refuses to pay the insurance indemnity in these terms with the obligatory written substantiation of the reasons for the refusal. The decision on the refusal to pay is taken by the expert commission of the insurer on the basis of conclusions of the health care institution.

Voluntary health insurance services can be divided into types:

- group I – provides for payments not related to the cost of treatment (insurance in case of diagnosis of the disease, accident insurance in connection with the injury, insurance of daily allowances, etc.);

- group II – provides compensation for the cost of treatment (insurance of expenses for hospital stay, insurance of surgical expenses, insurance of expenses for post-surgical care, etc.).

For the insured, the greatest interest is the types of contracts that guarantee not only payment but also the opportunity to get medical care. Insurance costs that are not related to treatment are simpler, since its implementation does not need to be aligned with the cost of medical expenses. Payment under such contracts may be made in the form of a certain sum insured, specified in the insurance contract, or in the form of daily payments. In the implementation of types of insurance, which include reimbursement of costs for the treatment of the insured, there are significant difficulties associated with the establishment of liability, the calculation of tariff rates, the definition of the amount of the sum insured.

In the case of loss of health insured in connection with illness or accident, the insurance company pays the bills of the medical institution, based on the actual

number of days of treatment of the insured according to the daily rates of treatment established in the contract.

Medical and prophylactic institutions, as well as with compulsory medical insurance, should be economically responsible for the provision of medical services to insured citizens, the volume and quality level of which is provided for in the insurance contract. In case of failure by the medical and preventive institution of medical and economic standards, the insurance organization may partially or completely not pay the cost of medical services.

As foreign experience shows, insurance companies can offer insurance policyholders specialized and universal insurance policies for health insurance. The universal policy of health insurance as an insurance provides for those cases (health condition), medical care which does not require special treatment or consultations of doctors of narrow specialties. How insurance can be considered cases that require a local doctor to call home if there is a malaise, fever, acute respiratory disease, and so on. The list of insurance cases can be unified, and can be determined by agreement between the insurer and the insured with possible participation of the clinical service base. The organization of insurance coverage under a universal policy may consist of applying for a family doctor. Such doctors are trained by special medical institutions.

Specialized insurance policies allow you to take advantage of the medical services of doctors from the narrow specialization or to take only a certain state of health (pregnancy, childbirth, HIV infection, etc.) for insurrectional protection. Specialized medical policies are mostly provided to individuals who are already ill or those who are prone to such illness.

If universal insurance policies are targeted at individuals, specialized medical services are often provided under collective insurance contracts – firms insure their employees from the most possible occupational risks. In order to serve clients under specialized insurance policies, the company concludes a contract with either individual specialized doctors or specialized clinics.

Voluntary medical insurance enables citizens traveling abroad to enter into insurance contracts (assistance) in the event of a sudden illness, bodily injury due to an accident, death while staying abroad.

The main purpose of the assistant is immediate response in extraordinary circumstances, providing the client with moral, medical, and technical assistance. The insurance contract may include the insurer's liability for the organization of medical transportation of the patient to the nearest or specialized hospital, transportation to the country of residence medical support, repatriation of the body of the insured, early repayment, emergency stomatologic help, etc.

The rules of insurance for citizens traveling abroad do not provide for reimbursement of expenses in the case of the treatment of chronic diseases, prosthetics of teeth. When entering into an insurance contract, insurance companies set the maximum amount of the insured amount, which may be paid to the insured in the event of an insured event and set the amount of the franchise. The insurance policy for voluntary medical insurance determines the scope of

provision of medical services, the possibility of choosing the conditions for obtaining health care, etc.

Ukrainian insurance companies offer standard health insurance programs to their clients, which differ in the set of services and the price and, as a rule, include:

- ambulatory-polyclinic and consultative diagnostic medical aid, including ultrasound, X-ray and tomography;
- surgical operations;
- doctor's call at home and hospitalization;
- treatment in outpatient settings and at home;
- full payment of medicines;
- issuance of medical records, medical reports, certificates;
- full individual nutrition taking into account the medical diet insurance contract, in accordance with the chosen programs of voluntary medical insurance.

After the end of the treatment, the insured person provides the insurer with an application for payment and original documents: accounts of the health care institution, documents confirming the occurrence of the insured event (primary medical records or extracts from the history of the disease, specifying the department's profile, nosologies, a list of diagnostic procedures, therapeutic measures , a list of medicines with indication of the form of release, dosage, as well as the period and frequency of application, their cost). The amount of the payment is calculated, outflow from the size of actual costs, previously agreed with the insurer.

The insurance indemnity is paid by the insurer under the terms of the concluded insurance contract due to the payment of the medical institution or assisting company the cost of the health care provided to the insured person in connection with the occurrence of the insured event within the insured amount specified by the insurance contract.

The health institution or assisting company must inform the insurance company about the occurrence of the insured event within two days, provided that the other is not specified in a specific contract with the health care institution or assistive company.

The payment of insurance indemnity is made if an insurance certificate of the corresponding sample is drawn up and the health care institution which provided health care to the insured person has issued an application for payment and documents confirming the occurrence of the insured event: primary medical records or an extract from the history of the disease indicating the department's profile, nosologies, a list of diagnostic procedures, therapeutic measures, a list of medicinal products with indication of the form of release, dosage, as well as the period and frequency of application ting their value.

If the insurer fails to pay the insurance indemnity, then every day of such a delay, a fine is paid in the amount specified in the insurance contract or agreement with the health care institution (assisting company), depending on who the payment is made to.

The insurance contract shall cease to be valid in the case of: the death of the insured person; absence of payment by the insured of the insurance payment in the insurance contract established by the term.

The question for self-control

1. What is the essence of life insurance?
2. What do you know about life insurance options?
3. Describe mixed life insurance.
4. What are the main risks are possible with mixed life insurance?
5. What is the essence of survival insurance?
6. Features of death insurance.
7. What are the main conditions for child insurance?
8. Features of the insurance before marriage.
9. What do you know about the basic features of rendering insurance and pension insurance?
10. How are the tariffs for life insurance contracts determined?
11. For what purpose are mortality tables used in insurance?
12. What is the insurance of children and the insurance of a wedding different from mixed life insurance?
13. The main purpose of rent and pensions insurance.
14. Who is the recipient of the sum insured for life insurance?
15. What insurance cases are provided for life insurance?
16. From what age can I enter into a life insurance contract?
17. What is an accident?
18. What are the consequences of an accident for the insured person?
19. Accident insurance, its types and forms of implementation.
20. Name the types of compulsory personal insurance.
21. Personal insurance of medical and pharmaceutical workers.
22. Insurance of employees of departmental and rural fire brigades and members of voluntary fire brigades (teams).
23. Insurance of sportsmen of higher categories.
24. Life and health insurance of specialists in veterinary medicine.
25. Compulsory personal insurance against accidents in transport.
26. Individual and collective voluntary insurance against accidents.
27. Insurance of children of school age and pupils of special educational establishments.
28. Insurance of servicemen.
29. Voluntary insurance of citizens traveling abroad.
30. Insurance of holders of credit cards.
31. Insurance of athletes and other participants of sporting events.
32. General characteristics, features and forms of health insurance.
33. Compulsory health insurance.
34. Voluntary health insurance.
35. Medical insurance of citizens traveling abroad.

36. Practice of medical insurance.
37. What is assistive and what tasks do assistive companies do?
38. Under what conditions do legal expenses insurance cover medical expenses?
39. Who is the insured, the insured and the recipient of insurance payments for medical insurance?
40. What medical services can be provided to the insured person?
41. What kind of health insurance institutions do insurance companies conclude?
42. Voluntary health insurance.
43. What factors depend on the insured amount and the insurance premium when voluntary health insurance?
44. What is the difference between continuous health insurance and sickness insurance?
45. What is an accident insurance in case of sickness insurance?
46. From what factors depends on the insured amount and insurance premium in the case of voluntary medical insurance?
47. What is the difference between continuous health insurance and sickness insurance?
48. What is an accident insurance case in case of illness?
49. Practice of medical insurance.
50. What services are provided by assistive companies?

Topic 5. PROPERTY INSURANCE

Methodical recommendations for studying the topic

Starting the study of the topic, it is expedient to repeat the issue of insurance compensation systems, franchise, the obligations of insurers under the insurance contract.

It is necessary to realize the necessity of insurance of property belonging to legal and natural persons, to study property insurance objects and the threats that they are threatened with.

Particular attention should be paid to: the definition of the value of property taken for insurance; insurance rates in each type of insurance; risks from which the object is insured; conditions for providing benefits to insured persons.

When considering the issue of insurance of agricultural property Enterprises are advised to determine the specificity of the objects of insurance in this type and the conditions under which it is carried out.

It is necessary to consider in detail the insurance of technical and transport risks, since they occupy a significant place in the activities of most economic entities and, unfortunately, often manifest themselves in real practice.

Since almost every individual possesses certain property, which protection by insurance is very necessary. When studying the issue of personal property insurance it is expedient to clearly understand that it can be insured that – no, and which objects are counted on certain conditions. It is necessary to pay attention to

the obligations of the parties in the event of an insured event and compliance with the terms of the insurance contract for property insurance.

Mini-lexicon

property insurance, types of property insurance, insurance object, main contract, additional contract, property valuation, FLExA, franchise, benefits to insured persons, car insurance, casco insurance, insurance cases, insurance indemnity insurance, insurance case, title insurance, regress.

5.1. Essence and features of property insurance

Interesting Facts

In 2011, humanity spent more on disaster management than ever before in history. The largest amounts were spent on the restoration of Japan after the earthquake and tsunami in March. The cost was about 380 billion dollars - it is almost two thirds more than the cost of recovery after the 2005 Katrina hurricane in the United States. In general, 2011 was the most active in the disaster list, including 253 events, which resulted in a total economic loss of $ 435 billion. 60% of all cataclysms fall into earthquakes, with 85% of all natural disasters happening in Asia. Over the past 10 years, the world has registered nearly 4 thousand natural disasters, in which at least 780 thousand people died. The damage incurred is estimated at approximately 960 million dollars.

Also, the total amount of insurance payments ($ 107 billion), as a result of natural disasters in 2011, became the second largest in history, giving way only 120 billion dollars of insurance cases registered in 2005, of which 90 billion dollars were paid as a result big hurricanes Katrina, Rita and Wilma. The catastrophes in Japan, New Zealand and Thailand cost the insurance industry 108 billion euros. The economic damage from natural and man-made disasters in 2011, which resulted in the deaths of more than 30 thousand people, is estimated by the German insurer Munchener Re about 350 billion dollars.

Property insurance – an insurance business in which the object of insurance is property interests that are related to:

- possession;
- use;
- disposal of property.

Property insurance policies protect insureds against losses stemming from damage to or loss of property and legal liability. Many lines of propertyliability insurance have evolved over time to meet the needs of a growing and increasingly diverse economy. These lines can be divided into four basic categories: fire, marine, casualty and surety. Property-liability insurance covers direct losses from damage to property, indirect losses resulting from direct losses (e.g. loss of income due to damages to a business facility) and

loss of possession Homeowners multi-peril insurance and commercial multiperial insurance package various property and liability coverages for homeowners and businesses, respectively.

The economic purpose of property insurance is to compensate for the damage caused to the policyholder as a result of an insured event with the insured property. Under property, property insurance means means of transport, goods, property of any legal entity, group of things and items, as well as financial risks.

Property insurance is divided into:

1. Depending on the owner:

- insurance of property of legal entities (property of enterprises, goods, means of transport);
- property insurance of individuals (personal property - buildings, apartments, pets, transport).

2. depending on the type of insurance events:

- property insurance against fire and natural disaster;
- insurance of agricultural crops against drought and other natural phenomena;
- insurance of animals in case of death due to illness and accidents;
- insurance of means of transport from accidents, theft and other hazards.

This classification is used to develop harm reduction and insurance methods for each of the following groups.

The types of property insurance for which the corresponding licenses are issued are: insurance of railway transport; insurance of land transport; air transport insurance; water transport insurance; insurance of cargoes and luggage; insurance against fire risks and risks of natural phenomena; insurance of loans; insurance of investments; insurance of financial risks; legal expenses insurance; insurance of issued and accepted guarantees; other property insurance.

Comparative characteristics of insurance of property of individuals and legal entities are shown in Table. 4.

Table 4. Comparative characteristics of property insurance individuals and legal entities

Insurance objects	
Property of individuals	Property of legal entities
- residential buildings and separate living quarters; - household buildings; - engineering equipment of buildings and dwellings; - decoration of buildings and dwellings; - objects of unfinished construction; - interior and furniture; - electrical appliances, audio, video, photo, electronic equipment;	- fixed assets and working capital; - means of transport; - cargoes; - electronic devices; - machines and mechanisms; - equipment; - objects of unfinished construction; - inventory; - finished products; - raw materials

- articles of precious metals, stones, antique items, collections	
Property not accepted for insurance	
Property of individuals	Property of legal entities
- cash; - securities, certificates, credit cards, card indexes, books; - technical information carriers; - precious metals in ingots and precious stones without frames; - food, alcoholic beverages, tobacco products; - explosives; - buildings, structures that are in an emergency or located in a zone threatened by landslides, landslides, floods and other natural phenomena	
Insurance terms	
Property of individuals	Property of legal entities
- under the general contract (except for articles made of precious metals, precious stones, paintings collections); - for certain household items; - by separate groups of subjects	- under the main contract (all property belonging to the company); - for additional contracts (property acquired by the enterprise in accordance with the contract of property lease or accepted for processing, repair, transportation, storage, commission, etc., property for the duration of experimental, research and exhibitions at exhibitions
Calculation of the amount of damage inflicted	
Property of individuals	Property of legal entities
- is determined on the basis of the actual value of the property; - calculated separately for each item and for each risk of destruction or damage to home property	- is determined on the basis of the full book value or contract value, and in case of damage to the objects – on the basis of the cost of repair (repair), which takes into account: the cost of purchasing materials and spare parts for repairs, repairs, delivery of materials to the repair site, etc.

The property is accepted for insurance only if it is properly preserved. If after the conclusion of the insurance contract with the insured property there have been changes, they must be reported to the insurance company.

Services for the insurance of property of individuals and legal entities are provided in a voluntary form in accordance with the insurance rules developed by the insurers. Insurance policies can vary significantly from different insurers, but they are characterized by the following conditions:

- property insurance contracts of individuals and legal entities are short-term (up to 1 year);

- payment of insurance payments can take place in cash or non-cash form, once for the entire period of insurance or in several terms;

- during the validity of the insurance contract, the insured may enter into an additional contract for the period remaining until the end of the main contract;

- for certain categories of insurers, insurers may be granted benefits.

5.2. Basic terms of insurance of citizens' property

Interesting Facts

In 2000, Iranian authorities first introduced in the history of the country a state-owned camel insurance. Owners will be able to insure their animals from a variety of risks - from earthquakes and bites to snakes, from collision with a car or with another camel and from abduction.

Among property belonging to individuals can be identified real estate, domestic farm animals and everyday items. Property insurers may be citizens of Ukraine residing in Ukraine.

The object of insurance is the property interests of the insured, which do not contradict the current legislation of Ukraine, related to the possession, use, disposal of property belonging to the private property of the insured and members of his family who live with and live with the common household with him, and also the property that the insurer disposes of under a contract of employment, if such property is not insured by its owner.

The following may be insured:

- residential buildings and separate living quarters;
- household buildings;
- engineering equipment of buildings and dwellings;
- decoration of buildings and dwellings;
- objects of unfinished construction;
- interior and furniture;
- electrical appliances, audio, video, photo, electronic equipment;
- carpets, clothes, shoes;
- articles of precious metals, stones, antique items, collections (taken for insurance in the amount of their full value in accordance with an expert assessment).

The property is accepted for insurance only if it is properly preserved.

Not subject to insurance:

- cash;
- securities, certificates, credit cards, card indexes, books, etc.;
- technical information carriers;
- precious metals in ingots and precious stones without frames;
- food, alcoholic beverages, tobacco products;

- explosives;

- property that is in the zone of increased probability of natural disasters.

According to the Law of Ukraine "On Insurance", services on citizens property insurance are provided in a voluntary form in accordance with the insurance policies developed by the insurers.

Insurance policies can vary significantly from different insurers, but they are characterized by the following conditions:

- property insurance contracts of citizens have a short-term character (up to 1 year);

- payment of insurance payments can take place in cash or non-cash form, once for the entire period of insurance or in several terms;

- during the validity of the insurance contract, the insured may enter into an additional contract for the period remaining until the end of the main contract;

- for certain categories of insurers, insurers may be granted benefits.

Citizens' property may be insured:

1) under the general contract (except for articles made of precious metals, precious stones, paintings collections);

2) for certain household items;

3) by separate groups of objects, for example, furniture, rugs, precious metal products, collections, paintings.

Especially valuable property can be taken on insurance under a special contract.

The calculation of the amount of damage inflicted has certain features:

- the amount of damage is determined separately for each item of home property;

- the size of the damage is determined separately for each risk of destruction or damage to home property, because the losses in both cases will be different.

If the property is insured by several insurers and the total insured amount exceeds the real value of the property, then the insurance indemnity paid by all insurers can not exceed the real value of the property. At the same time, each insurer makes a payment in proportion to the size of the sum insured for the contract concluded by him.

The property can be insured on the basis of the system of real value, which guarantees full compensation of losses in case of their occurrence, or on the basis of the system of proportional liability, under which the insurance indemnity will be such a proportion to the amount of damages, as the sum insured to the insurance estimate.

A contract of insurance may provide for a franchise (conditional or unconditional), which is determined by agreement of the parties as a percentage of the sum insured or in absolute amount.

The property is considered to be destroyed if it became completely unusable for use at its original destination, and damaged – if the quality of the item has deteriorated, but repair is possible through its maintenance and its further exploitation.

Property insurance conditions include the following risk groups:

- "fire" – damage to or destruction of property by fire (including lightning strikes, electric power grills, explosion), as well as products of combustion, hot gases, means of fire fighting, and because of high temperature;

- "arson" – damage or destruction of property as a result of fire caused by arson;

- "explosion" – damage or destruction of property as a result of an explosion (except for unlawful actions of third parties);

- "natural disaster" – damage to or destruction of property as a result of storms, hurricanes, tornadoes, storms, floods, earthquakes, subsidence of soil, mountain shear, mudflows, heavy rain, snow, strong frost;

- "action of water" – damage or destruction of property as a result of accidents plumbing, sewage, heating and other hydraulic or fire systems, or penetration of water from adjacent premises;

- "extraneous influence" – damage or destruction of property as a result of the onslaught of land vehicles, the impact of water vehicles, falling on the insured property of aircraft, helicopters, spacecraft, etc., trees or other objects provided for by the insurance contract;

- "illegal actions of third parties" – damage to or destruction of property as a result of intentional actions of third parties, namely theft, burglary, robbery, deliberate destruction or damage to property by arson, etc.;

- "breakdown of glass" – damage to or destruction of property as a result of accidental splitting or breaking as a result of deliberate acts by third parties of windows, stained glass windows, window and door glass, etc.

The contract can be concluded in aggregate of all the above-mentioned insurance risks, or "in the event of a fire" and any other risks.

Fire insurance covers losses to buildings and personal property from fire. Individual homeowners can purchase dwelling or residential fire insurance or, more commonly, buy fire protection for their home as part of a homeowners multi-peril policy. Homeowners insurance provides protection for a person's home and belongings against a specified number of perils.

Four basic types of coverages are typically included in a homeowners policy:

1) property damage to the dwelling, other structures and personal property;

2) additional living expenses;

3) personal liability;

4) medical payments.

Policyholders can choose to insure their home and contents for either replacement cost or actual cash or market value, as well as choose different deductible amounts and coverage limits. Dwelling fire insurance covers damage to the structure of a home caused by a more limited set of perils, including fire. Homeowners also can buy extended coverage on the contents of their home as a supplement to coverage of the structure.

Businesses can insure against fire and other property risks through a commercial fire policy, with or without extended coverage. Small businesses also can obtain fire protection as part of a businessowners multi-peril policy.

Commercial fire insurance is class-rated or individually rated depending on the size and value of the structure. This coverage protects against damages to buildings, machinery and equipment, inventories and other goods. Supplementary coverages can be purchased to protect against indirect losses from fire, such as those stemming from business interruption.

The contract is issued on the form of the insurance certificate of the established form. The contract on this type of insurance comes into force the next day after payment of the insurance premium in cash, and in the case of non-cash payment, from the day the insurance payment is transferred to the accounting of the enterprise or institution. The contract is valid only on the territory indicated in the insurance contract (actual location of the property).

Insurance payment can be made:

- cash or non-cash through the accountancy of the organization where the insurer operates;
- one time or parts for several terms in the manner prescribed by the insurance contract.

In case of an insured event, the insured must:

a) take measures to prevent and reduce losses incurred as a result of an insured event;

b) immediately (within two days) inform the insurer about the insured event;

c) in case of theft, damage due to intentional actions of a third person to the police, in the case of a fire, to the bodies of fire supervision, in the event of an accident to the relevant emergency services;

d) make a list of destroyed, damaged or stolen home property;

e) keep the insured company representative insured before the arrival of a damaged item in the list or the remaining balances from them, to show them for inspection during the drawing up of the act.

The insurance company, upon receipt of the application for an insurance case, undertakes to make an act of the corresponding form within the three-day period (with the participation of the insured and two witnesses). Insurance indemnity is paid only after the causes and amount of damages are fully established. In this case, the insured is obliged to provide the insurer with all necessary documents confirming the reasons and the amount of losses, among which should be:

- statement of the insured to the insurer;
- a list of destroyed, damaged or stolen home property;
- documents issued by the competent authorities confirming the occurrence of an event that may be qualified as an insured event;
- documents on the initiation of a criminal case, if there is a presence of unlawful actions;
- insurance certificate;
- estimate of losses (determined by the insurer through examination).

The insurance certificate shall be drawn up within ten working days from the receipt of a written application from the insurer regarding damages and other

documents. The indemnity is paid within five working days from the date of signing the insurance certificate.

If the case is not considered an insurance, the insurer shall notify the policyholder in writing within two working days from the day the insurance certificate is signed.

Losses are reimbursed:

- upon destruction, the theft of property at its actual value at the time of the conclusion of the insurance contract, minus the depreciation for the duration of the contract;

- at complete destruction in accordance with the sum insured, which is stipulated by the insurance contract of property;

- in case of damage, as the difference between the value of the property indicated by the insured and the value, taking into account the impairment (loss of quality and value) caused by the insured event;

- if the damaged item can be returned after repair, then the cost of repairing this object is considered a loss. The cost of repairs is calculated at current rates.

The insurance indemnity is paid by the insurance company within three days after receipt of all necessary documents. If the insured has received compensation from third parties, the insurer pays only the difference between the amount payable under the insurance terms and the amount received from third parties. After payment of the insurance indemnity, the insurer's liability is reduced by the amount of the insurance indemnity paid. If the insurance indemnity is paid in the amount of the full sum insured, the validity of the insurance contract shall be terminated from the day the insurance certificate is drawn up.

Insurance indemnity is not paid if:

- the insured event was the result of intentional actions of the insured or a member of his family;

- the representative of the insurance company has not been shown damaged items or their remains;

- things of home property, damaged as a result of wear of certain parts, technical defects, exceeding the term of use.

The amount of the insured amount may be chosen by the policyholder at its discretion, but it should not be greater than the actual value of the insured property. The size of the tariff rate is determined as a percentage of the sum insured per year and depends on the extent of the insurer's liability, the selected risks, the type of household property, the conditions of storage of property, the presence of fire and security signaling, the type of building in which the property is, the conditions of observance of safety rules, etc.

The insurance contract is concluded for one year. When insuring home property, the size of the franchise is of paramount importance (the percentage of the amount of damage, and in some insurance companies it is a percentage of the amount of the liability limit). Its size is stipulated in the insurance contract.

If the limits of liability (amount of insurance amount) are low, the insurance company can insure the property without examination and evaluation. When an insured event occurs, insurers offer their clients additional services:

- consultations on registration of documents (certificates from operational services, law enforcement agencies, etc.);

- determining the size of the damage caused;

- repair works, including the purchase of construction materials;

- compensation for the value of stolen property by the established fact, regardless of the duration and results of the investigation.

Insurers are offered several options for the provision of insurance services: insurance of buildings, animals, household property, property in the yard, in case of repair, etc.

Buildings by degree of importance belong to the priority property. Destruction or damage to any building causes its owner huge losses. Therefore, every owner of a building or a building should take care in advance that in case of such losses it is possible to cover them.

Individuals, owners of buildings or their elderly members of families, as well as individuals who temporarily use or dispose of buildings legally, may be insured persons and enter into voluntary insurance contracts.

The list of objects subject to insurance protection includes various buildings: residential, garden and country houses, household (sheds, cellars, garages) and external (sidewalks, terraces, fences, gates) buildings, built on a permanent place, in that including those on the mortgage of which the insured has received a loan in an institution of the bank (in this case they are subject to compulsory insurance on the amount of their actual value, regardless of the amount of the loan). Simultaneously with the buildings, additional equipment is added to them for insurance (gas pipeline, water, gas counters, lattice windows, etc.). The contract can provide insurance of civil liability of the insured and members of his family for the damage that can be caused by the use (disposal) of buildings.

The policyholder has the right to freely choose an insurance object. That is, he can insure:

- all buildings located on its land plot;

- separate buildings (only a dwelling house or a garage);

- separate structural elements (only windows, doors or roof);

- buildings under construction.

Exceptions to the list of insurance objects are buildings that are subject to demolition, very old, emergency, as well as those contained in the zone of increased natural danger (landslips, landslides, floods or other natural disasters, if declared in accordance with the established procedure).

Individually insured items of home furnishings, household and personal consumption, building materials that are in the building, or as an additional option to the main property group, which is the building.

The insurer's liability for building insurance is to compensate for losses incurred as a result of:

- natural disaster (storm, hurricane, lightning, rain, hail, collapse, landslide, mud, outflow of groundwater, soil deposition, flood, earthquake);

- fires;

- an explosion;

- crash of the heating system, water supply or sewage network;
- penetration of water from an adjoining room;
- gas release;
- unlawful actions of third parties.

When building insurance, damage caused by rotting, wear, damage to the house fungus is not compensated; repair works, structural defects of buildings, which were known to the insured until the occurrence of an insured event; intentional actions of the insured; conduct of hostilities, emergence of civil unrest, confiscation of property, environmental disasters.

The insurance contract is concluded on the basis of a written statement of the insured for a term of 1 year or any shorter term.

In order to conclude an insurance contract, the insurer:

1) verifies the ownership of the building of the person with whom the contract is concluded;

2) find out whether a threat of collapse, flood or other natural disaster has been declared or not in a given area. If such threat is declared, the contract does not conclude (except for renewal for one more term);

3) must inspect the building in the presence of the insured;

4) find out whether secured buildings (especially garden, country houses) are properly cared for (permanent residence, regular visits, supervision of relatives, neighbors, etc.);

5) provides an insurance assessment of the building in order to correctly determine the amount of insurance.

Providing insurance assessment is the most important stage of the insurer's work, since it is on its basis that the amount of insurance sum, insurance payment is determined, and in the case of destruction or damage to buildings – the amount of damage and insurance indemnity. In addition, the accuracy of the definition of insurance assessments affects the overall financial results of the insurer.

To determine the value of buildings, insurers use the services of independent experts or relevant evaluation documents of the Bureau of Technical Inventory, public utilities, which each owner owns. Valuable documents are made on the basis of inventory documents, based on the cost of a certain unit of measurement (meter square, cubic meter, meter of running length) of the new building. The valuation documents shall indicate the original and actual value of the buildings. Initial cost is the cost of a new building, calculated in accordance with existing valuation norms in the given region. The actual value is calculated by deducting the original value of the amount of the wear.

In insurance practice, two variants of definition of insurance estimation of buildings are used:

1) at the actual value of the building at the time of conclusion of the contract;

2) at the market price of the building in the given region (occurs in case of exceeding the market value over the actual).

The insurance amount is determined separately for each building that is accepted for insurance, according to the agreement of the insured with the insurer,

but can not exceed the cost of the insurance assessment of the building. When the contract is concluded for an insurance sum that is less than the insurance grade, the insurer shall be proportionally liable, that is, the insurance indemnity shall be paid in such percentage of the amount of the loss, which percentage of the insurance amount is from the value of the building.

If the policyholder intends to increase the sum insured during the period of validity of the insurance contract, an additional contract is concluded for the term remaining until the expiration of the main contract. In this case, the total insured amount under the main and supplementary contracts should not exceed the actual value of the buildings.

Insurance payments are determined by the size of the insured sum, the term of insurance and the degree of risk with the simultaneous use of the maximum amount of tariff rates: for buildings in rural areas – from 0,2 to 0,45% of the sum insured; for a building in urban areas – from 0.18 to 0.4% of the sum insured. In case of building insurance, an early cancellation of the insurance contract on the initiative of the insured is possible (in case of loss of ownership in case of sale or donation of buildings, etc.). At the same time, if during the period of insurance there was no insurance case, the insured returns the share of paid payment. It is calculated in proportion to the unused period for which the insurer must be liable, with a reduction for a certain amount used to conduct the affair of the insurance company.

In order to encourage insurers to further cooperate, insurers provide for various benefits. As a rule, permanent insurers, who during the time of insurance did not receive an insurance indemnity, in the case of renewal of the contracts, discounts are provided at a certain amount from the insurance payment.

In the event of an insured event, the insured should take measures to reduce the damage caused by the insured accident:

- to inform the competent authorities within 24 hours (depending on the event, fire control, police authorities, etc.);
- to notify in writing any case of the insurer;
- to enable the insurer's representative to inspect the damaged buildings without performing repair work.

In case of non-fulfillment of the specified requirements by the insurer, the insurer has the right not to pay the insurance indemnity.

The insurer must:

- to accept and register the claim of the insured on destruction or damage of buildings;
- to invite the person responsible for the harm (if any) for the drawing up of the insurance certificate;
- make an insurance certificate;
- request the competent authorities or independently find out the reasons and circumstances of the insured event;
- calculate the amount of damages and insurance indemnity;
- pay the insurer insurance indemnity;

- on the amount of the insurance indemnity paid to the guilty person (if any) a recourse.

The size of the insurer's loss and insurance indemnity is determined on the basis of the insurance certificate in which the insured participates, two witnesses and the guilty person (if any).

In the insurance certificate, which consists in the place of the insurance event, as a result of a thorough inspection of the damaged (destroyed) building, the characteristic of the incident occurred; the size of the building and building materials of its structural elements are indicated; Information is given about the size of destroyed or damaged buildings; listed rescue works; the presence of remnants of a destroyed or damaged building, suitable for further use, shall be noted.

These data are the basis for calculating the amount of damage. It distinguishes between total and partial damage. Total damage, or destruction of a building, shall be stated when the cost of the restored works, taking into account the value of the balances and expenses incurred by the insurer in order to prevent damage or reduce it, exceeds the real value of the building.

For partial damage (damage to buildings), the basis for determining losses is the cost of repair (repair) of the building, taking into account the amount of wear and value of the remainder of the damaged (destroyed) structural elements. The cost of restoring the building is the costs necessary to bring the building to a condition when it is suitable for use, similar to the one in which the building was before the insured event.

The insurance indemnity is paid to the policyholder during the period stipulated by the contract after receipt of all necessary documents. In case of payment of the insurance indemnity in the full insurance amount, the validity of the contract is terminated. If only a part of the sum insured is paid, the validity of the contract is prolonged until the end of the term specified therein, with the following losses will be covered by the difference between the sum insured and the amount of the insurance indemnity paid.

Interesting Facts

In 1999, John Dow of Charlotte, North Carolina, bought a box of very rare and extremely expensive cigars, and, among other things, insured them from the fire. A month later, having smoked all his cigars, John sued the insurance company. In a statement, he wrote that cigars were lost "in a series of small fires". The insurance company refused to pay compensation, basing it on the fact that John used cigars naturally. However, he filed a lawsuit and won the case.

At the announcement of the verdict, the judge stressed that John had an insurance policy in which it was written "black on white" that the insurance company insured cigars, including from the fire, without specifying, in the event of ignition, she would not pay compensation. Therefore, the company must pay back to John compensation. In order not to burden itself with long and expensive appeals, the insurance company agreed with the court decision and paid John

Dow $ 15,000 for the loss of his rare, expensive cigars, destroyed as a result of fire. After receiving the money by check, John was arrested on charges of 24 arsonists. His own statement of claim and testimony at the first court were used against him. He was found guilty of deliberate arson of the insured property and sentenced to 24 months imprisonment and a fine of $ 24 thousand dollars.

Animal insurance is a type of property insurance that provides insurance protection to owners of animals in case of their death, incident or forced slaughter. Voluntary animal insurance contracts are concluded with natural persons who are owners of animals.

When concluding animal insurance agreements, it is mandatory:

1. The object of insurance is determined. The sick, depleted animals, as well as those who are in the area where the quarantine is declared, are not accepted for insurance. Only healthy animals of a certain age are subject to insurance, namely:

- cattle, horses – from 1 month old;
- pigs – from 6 months;
- mules, sheep, goats, donkeys – from one year;
- fur animals (nutria, rabbits) – from 45 days of age;
- dogs – from 6 months to 10 - 12 years;
- bees, cats, decorative birds;
- Exotic animals (monkeys, snakes), etc.

2. Certain groups of animals are accepted for insurance only if certain requirements are met (for example, dogs - if they are registered in the Association of Amateur Dogs, Ukrainian Society of Hunters and Fishermen, or in the Society for the Promotion of the Defense of Ukraine; bee-seed – after verifying the veterinary and sanitary passport of the apiary (characteristics of the apiary, veterinary and sanitary condition).

3. Owners of any group of animals are obliged to strictly adhere to the recommendations established in the area for the care, feeding and maintenance of animals, as well as to take all measures to prevent their disease and death, otherwise the insurance company may refuse to accept such a insurance policy.

Risks arising from animal insurance:

- death or death of animals from illness or natural disaster (flood, collapse, lightning, storm, hurricane, hail, earthquake), electric current, freezing, strangulation, grass poisoning, snake bites or poisonous insects, drowning, falling under the means of transport, getting into the gorge and other traumatic injuries;
- forced slaughter of an animal if it is injured due to an accident and this prevents its further use. Or if a forced slaughter (as directed by a veterinary specialist) involves the use of measures aimed at combating epizootics or incurable illness, which also excludes further use of the animal;
- treatment of an animal from an illness or injury received as a result of an accident (losses incurred in the form of additional costs for the maintenance of an animal are subject to compensation);
- abduction or intentional unlawful actions of third parties.

The insurance contract is concluded on the basis of a written statement of the insured, usually for a term of 1 year, with a mandatory inspection of animals. For insurance, all available on-farm animals of a certain type. When there are animals of different species (eg cattle, pigs, rabbits), at the request of the insured, animals of all kinds or only one species (eg pigs) may be insured. Only those animals that are located at the address indicated in the insurance certificate are covered under insurance protection. If the animals are not at the place of insurance, insurance protection is terminated.

The insurance amount is set for each animal separately, and its maximum size can not exceed the market value of the animal (insurance assessment). For all animals of the same species and age group, the sum insured should be the same. Animal insurance is a rather dangerous risk, because each species requires a different level of insurance liability. These and other factors determine the use of different tariff rates, which may range from 1 to 10% of the sum insured. At the same time, insurance of bovine animals is carried out at the maximum amount of insurance rates from 2 to 5% of the sum insured; insurance of horses from 3 to 7%. The insured payment may be paid by the insurer in cash to the representative of the insurer at the same time as the conclusion of the contract or non-cash through the accountancy of the enterprise where he works, at the expense of the insurer in the institution of the bank.

For this type of insurance, the insurer's liability for the payment of insurance indemnity for the death of animals from the disease occurs, as a rule, one month after the payment of the insurance payment. Such a deferral makes it possible to avoid payments for animals that, when entering into a contract, were sick and should not have been accepted for insurance.

For permanent insurers, insurance companies may offer benefits similar to benefits for building insurance.

Upon occurrence of an insured event, the insured must:

- take measures for the reduction of losses incurred as a result of an insured event;
- within a day, declare the death of the animal to a specialist in the veterinary service;
- during the day, make a statement to the police in case of the abduction of the animal, destruction or injury as a result of intentional unlawful actions of a third person;
- within 24 hours in writing, apply to the insurer for the occurrence of an insured event.

Upon receipt of the claim of the insured on the insured event, the insurer makes an insurance certificate in the presence of the insured and two witnesses, indicating the species and age of the dead animal, its suit and signs, when the animal died (when the disease was committed), when and to whom it was declared, reasons and circumstances, which resulted in her death (forced slaughter, abduction, illness), as well as the amount of damage and insurance indemnity.

In order to establish the fact and causes of the death of the animal, the insurer uses the conclusion of specialists of the veterinary service, a certificate of the bodies of the hydrometeorological service, fire supervision, police, court, etc.

The amount of damage is determined by:

- in the event of the death or abduction of animals – in the amount of market value of an animal that has developed in the given region;

- when forced slaughter:

a) cattle, horses, pigs, sheep, goats – in the amount of the difference between the market value of the animal and the cost of fit for meat consumption;

b) fur animals – in the amount of the difference between the market value and the cost of skins and fit for eating meat. If the veterinarian specializes in recognizing meat as completely unfit for food, the amount of damage is determined as the death of the animal;

- in the case of treatment of an animal from illness or injury – in the amount of the cost of treatment indicated in the certificate of the veterinary expert.

Insurance for animal insurance is based on the system of the first risk, that is, the insurance indemnity is paid to the policyholder in the amount of the amount of damage within the sum insured.

The insured receives insurance indemnity on the basis of an act of death (forced slaughter) and certificates of the competent authorities confirming the insured event.

The insurer may refuse to indemnify, if:

- the animal is slaughtered for economic reasons (for the implementation of meat, due to old age, etc.);

- the policyholder violated the term for filing an application for an insurance case;

- the fact of the insured event is not confirmed by the competent authorities;

- the death of an animal is the result of hostilities, radioactive contamination, intentional actions of the insured or an adult member of his family.

Under the conditions of home property insurance, any property belonging to the policyholder's private property and members of his family who live with him and lead a joint venture may be insured.

The object of insurance is: furniture, radio, video and TV equipment, electrical appliances, carpets, clothes, linen, footwear, articles of precious metals, household and consumer goods, household and sports equipment, books, fine art objects, etc., building materials, fodder, fuel, agricultural crops, elements of decoration and equipment of residential and commercial premises in buildings, etc.

Insurance can be accepted:

- all household goods that are in the household;

- separate groups of objects (for example, furniture, clothes, radio, television, video equipment);

- separate subjects.

Particularly valuable property (precious metal products, precious, semiprecious stones, paintings, collections, unique and antique items) can be taken on insurance under a special contract.

The risks for home property insurance are:

- natural disaster: flood, storm, hurricane, rain, hail, collapse, landslide, groundwater discharges, soil subsidence, flooding, unusual long rains and heavy snowfall for the area, earthquake, lightning, earthquake;

- fire, explosion, accident of the heating system, water supply or sewerage network, penetration of water from the adjacent premises, gas release, sudden destruction of the main constructions of residential or utility premises;

- abduction or illegal actions of third parties.

The amount of insurance liability does not include losses incurred as a result of military operations, the introduction of martial law, wear, technical defect, technical failure, exceeding the term of exploitation of domestic property, intentional actions of the insured or a member of his family.

Covered by insurance protection home property is subject to insurance only for the address specified in the insurance contract, that is, at the place of residence of the insured or the location of the garden (cottage) home. If the property is moved to another address, the validity of the insurance contract is terminated, except as provided in the contract.

The insured amount of each insured item of household property must correspond to the insurance estimate for the actual or market value of the property, taking into account the cost of its salvation or bringing it to order during the insured event. At the insurer's request, homeowners can be insured at full value or at a fraction of the cost. Only collections, paintings, unique and antique items are accepted for insurance in the amount of their full value, according to an expert assessment of the relevant competent authorities.

If separate groups of property or separate objects are accepted for insurance, then the insurance amount is established, based on the value of each group of property or an item separately.

The insurance contract is concluded on the basis of a written statement of the insured, as a rule, per year and provides for an overview of the property performed by the insurer's representative in the presence of the insured. The size of the tariff rate is determined as a percentage of the sum insured and depends on the extent of the insurer's liability, the type of household property, the type of building in which the property is contained, the conditions of housing security and other factors.

In case of an insured event, the insured must:

- take measures to prevent and reduce losses incurred as a result of an insured event;

- in the case of the theft, destruction or damage to property as a result of intentional unlawful actions of a third person - to notify the authorities of the police, in the case of a fire, to the bodies of fire supervision, in the event of an accident or explosion, to the appropriate authorities of the emergency service, etc.;

- immediately inform the insurer of any insured event;

- submit a list of the destroyed, damaged or stolen home property to the insurer;

- to preserve damaged objects of property or available remnants from them and to show them to the insurer's representative when drawing up the insurance certificate.

The damage is determined by:

- upon the destruction of property - in the amount of the real value of the insured property, taking into account the balances (if any). If the property by way of repair can be brought into a suitable state of use, the amount of damage is determined on the basis of the cost of repair of these items;

- upon destruction or damage to the elements of decoration or equipment of residential and commercial premises - at the cost of repairs (renovation) of premises at the rates applicable on the day of the insured event and applied by construction organizations for providing services to the population.

Insurance indemnity is paid for destroyed (stolen or damaged) property in the amount of the amount of damage, but not higher than the sum insured. The insurer pays the insurance indemnity on the basis of the received statement of the insured on the insurance case, a list of destroyed, stolen or damaged household items, an act on the destruction (damage) of property, certificates of the competent authorities, confirming the fact and circumstances of the insured event.

In the case of theft (destruction, damage) of domestic property taken under the protection of internal affairs by means of signaling, from the amount of insurance indemnity deduct the amount that the insured received from the internal affairs bodies. The Insured loses the right to receive compensation if the damage is fully compensated by the person responsible for the damage. If the damage is not compensated by the guilty person, the insurer pays the policyholder compensation, and the guilty person on the amount of the indemnification paid a recourse action. This is most often the case of damage to property as a result of a fire, penetration of water from adjacent premises, as well as theft of property.

In the event that after payment of the insurance indemnity to the insured was returned stolen home property, he must, within the specified terms of the insurance period, after returning him, to return to the insurer the insurance indemnity received for the property, with the exception of the expenses related to the theft of repairs and the ordering of returned items. In practice, home property and buildings are insured, as a rule, in a complex.

5.3. Basic conditions property insurance by entrepreneurial activity subjects

Casualty insurance provides protection against damages to property and losses from legal liability that are not covered under the policies describe above. A wide range of lines of insurance fall into this category, including:

- auto insurance;
- commercial multi-peril;
- medical malpractice;
- workers’ compensation;
- general liability;

- mortgage and financial guaranty;
- aircraft;
- glass;
- burglary and theft;
- boiler and machinery.

The most widespread and even traditional type of business risk insurance is the insurance of property of industrial enterprises from fire. Fire insurance consists in the reimbursement of losses from sudden and unpredictable fire or explosion events, as well as some other related phenomena. Under this type of contract are the main and additional insurance contracts.

Under the main contract, all property belonging to the enterprise is subject to insurance:

- buildings, constructions, transmission equipment, power, working and other machines, equipment, vehicles, fishing vessels, guns, objects of unfinished construction, inventory, finished goods, raw materials, goods, materials and other property.

Under additional agreements can be insured:

- property acquired by the enterprise in accordance with the contract of property lease (if it is not insured by the lessor), or taken from other enterprises and the population for processing, repair, transportation, storage, commission, etc.
- property for the time of conducting experimental or research works, exhibitions at exhibitions.

Apart from own property, fixed assets leased to other enterprises and organizations may be insured.

Not accepted on voluntary insurance terms:

- cash in cash;
- shares, bonds and other securities;
- manuscripts, drawings and other documents, bookkeeping and business books;
- precious metals;
- technical carriers of information, computer and similar systems (magnetic films, cassettes, magnetic disks, etc.);
- property that is located in the insured premises, but does not belong to the policyholder;
- buildings, structures that are in an emergency or located in an area threatened by landslides, landslides, floods and other natural phenomena.

The standard fire insurance policy covers the following risks:

- fire;
- lightning strike;
- gas explosion.

If the insured has suffered losses in the course of taking measures aimed at rescuing property, preventing a fire, etc., such losses shall be compensated.

Under an additional insurance contract, potential losses may be insured as a result of:

- natural disasters – earthquakes, storms, tornadoes, floods, floods, mountain shifts, etc.;

- explosion of steam boilers, gas storage facilities, units, cars, etc.;

- damage to the insured property as a result of the accident of the electric network and the influence of electric current;

- damage to the insured property as a result of the accident of the water supply, sewage and heating system, fire extinguishing systems;

- burglary theft;

- glass beads, mirrors, showcases.

The insurance contract is concluded on the basis of a written statement of the insured. The policyholder submits a separate application for voluntary insurance of property belonging to the enterprise and a statement on voluntary insurance of property in accordance with the contract of property tenancy. In the application, the insured must give a reliable description of the property, describe it, indicate the location and destination, indicate the losses that have occurred previously and their causes. Such information is necessary for the correct determination of the degree of risk, the size of the insurance premium, the settlement of disputes concerning the amount of damages.

If after the conclusion of the insurance contract with the insured property there have been changes, they must be reported to the insurance company. If the insurer insures property that is already insured in other insurance companies, he must notify the new insurance company of the current contracts and indicate the insurance amount, since the insured amount must not exceed the insurance value. The insurance contract is issued by the policyholder of the insurance policy and begins to act the next day after paying the accrued payments.

Property insurance contracts can be concluded for 1 year or indefinitely with an annual recalculation of the value of the property and the amount of annual payments.

If the activity of the enterprise ceases due to its liquidation, the contract will expire on the day established for liquidation, and in case of reorganization (merger, division, separation) – within 15 days from the day of reorganization. Payments remaining after the termination of the contract until the end of the insurance period are returned (only for full months).

In case of death or damage of insured property during the period of work of the commission on reorganization of activity or liquidation of enterprises, insurance indemnity shall be paid to the enterprise or successor organization. Benefits for insurers who continuously insured property at full value and during one, two, three, four or more years did not receive an insurance indemnity, the annual amount of insurance premiums decreases respectively by 15, 20, 25 and 30 percent.

The insured, who insured property during the year, is given a monthly grace period for the conclusion of a new contract. It shall come into force from the date of expiry of the previous agreement. From this day, insurance payments under the new agreement are calculated. If during the grace period an insurance case will

occur and the new agreement will not be concluded at this time, the indemnity will be paid according to the conditions established by the last insurance contract.

For full compensation of losses incurred by fixed and circulating funds, their evaluation is necessary.

The basis for determining the sum insured is the actual value of the insured property at the time of signing the contract, which is determined by the book value and cost of acquisition, taking into account the depreciation. The insurance amount must not exceed the insurance value. If it is smaller then the policyholder has the right to reimburse only the part of the loss attributable to the total amount of damage, such as the insured amount to the insurance value.

Insurance value is determined by:

- for the goods manufactured by the insured (unfinished construction and finished products) – these are the costs of their manufacture;
- for goods that the insurer sells, the raw material used by the insurer for the production of goods and natural resources is the purchase price of the replacement;
- for machinery and equipment – costs for the purchase or restoration of an insured object similar to the lost (with the exception of wear);
- for buildings and structures – at the cost of building a completely identical building or structure that is destroyed, taking into account the location, technical and operational condition of the building and its wear;
- for objects under construction in progress – in the amount of material and labor costs actually committed at the time of the insured event;
- for fixed assets – their full balance value, less the amount of wear.

The main factors determining the size of the premium rate: the probability of an insured event; probable size of a defeat. Having set the values of these two values, we will get an integral predicate, which is the basis for the premium rates. When calculating the tariff rate, the insurance company proceeds from the conditions that the collected funds from the insurers should be sufficient for the insurance payments to all insured persons.

For the insurance of property of non-state enterprises and organizations, rates are used, differentiated by types of management and types of property. From the insurance of property of religious organizations, museums, etc., different rates are applied depending on the level of fire protection of buildings.

Upon occurrence of an insured event, the insurance indemnity is paid after the causes and extent of the damage are fully identified. The amount of damage in the event of death (destruction) of buildings, structures and other property belonging to fixed assets, is determined on the basis of the full book value or contract value at which they are insured, and in case of damage to these objects, on the basis of the cost of restoration (repair) and within the sum insured.

Recovery costs take into account:

- expenses for the purchase of materials and spare parts for repair;
- expenses for repairs;
- expenses for the delivery of materials to the repair site and other expenses necessary for bringing the damaged property to the state that was before the occurrence of the insured event.

The amount of damage also includes loss from property damage as a result of the measures taken to save it, to store and arrange the insured property after the occurrence of an insured event, expenses for the preparation of estimates for the repair of damaged objects, conducting of examinations, etc.

The amount and value of the property available at the time of the occurrence of the insured event, is determined by the accounting and reporting data and on the basis of the primary documents on receipts and expenditures, inventory balances of unused materials. After calculating the amount of damage, determine the amount of insurance indemnity.

Interesting facts

The submission of the largest insurance claim in the world, amounting to almost $ 2 billion, took place in 1978. The initiator of the suit was a large British shipowner, the defendant - the German shipbuilding company. The reason for the suit was a catastrophe chartered by the British tanker "M. T. Amoco Cadiz ", which took place on the coast of England on March 16, 1978. The Germans are still reimbursing losses under the insurance contract.

The method of determining the damage and insurance compensation depends on the object of insurance (buildings, means of production, goods, etc.), the subject of insurance (state enterprise, collective, etc.), natural disaster (fire, earthquake, flood, etc.).

The amount of damage and payment of insurance indemnity are determined in the following sequence:

1) establish the fact of an insured event;

2) determine the size of the damage and the insurance indemnity, make a insurance certificate about the insured event;

3) make an insurance payment.

If the property is damaged, lost or stolen, the insured has to submit an application for an insurance case within one to three days, indicating in it, when, where, under what circumstances and what property was lost or damaged or stolen. The insurance company verifies the compliance of the above facts and conditions of the insurance contract. So the question is whether an insurance or non-insured event exists.

It is also necessary to establish whether the property was insured at the moment of the occurrence of the insurance event, as the insurance contract could not yet come into force or be already terminated. Next, it is necessary to check whether insurance claims and other risks from which the insurance has been made are within the scope of liability. The relevant authorities must provide the policyholder with the following documents:

- in the event of a fire – a certificate (certificate) of the fire authority;

- in the case of a natural disaster – a certificate of the authorities of the hydrometeorological service;

- in the case of theft or destruction of property connected with theft – a corresponding decision of the investigating authorities with a mandatory list of property that was stolen or destroyed.

When the event that has arisen has not been stipulated in the contract, it is not an insurance case and the insurer is exempted from compensation for the damage sustained.

The insurance company, recognizing that an event that led to the death or damage of property, is an insurance case, within five to ten days from the receipt of the application from the insurer, must draw up an insurance certificate, reflecting in it the fact, the causes and consequences of the insured event, as well as determining the amount of damages and insurance indemnity.

After calculating the amount of damage, determine the amount of insurance indemnity. Insurance indemnity is defined as the loss multiplied by the sum insured and divided by the value of the property. Most companies reimburse the insurance indemnity within 15 days from the day of the drawing up of an act about the death (damage) of the insured property and the receipt of all necessary documents from the competent authorities. If the fact of destruction or damage to property opened a criminal case, then the insurer pays 30% of the insurance indemnity, and the rest – after the investigation.

Insurance indemnity is paid:

- in the case of complete destruction of property – in the amount of the real value, less depreciation and the value of the balance of property suitable for future use, but within the sum insured;

- in case of partial damage to property, the difference between the claimed sum insured and the value of the balance of property suitable for subsequent use, and in the case of insurance at replacement cost, in the amount of expenses for its restoration, but not more than the sum insured.

The insurance institution, which paid out the insurance indemnity for the property damaged or lost, acquires the right to nominate (within the amount paid to the policyholder) the claims which the enterprise has to the person responsible for the harm.

The insurance contract for which the insurance indemnity was paid shall remain in force until the end of the period specified therein in the amount of the difference between the sum insured specified in the contract and the amount of the insurance indemnity paid. If the insurance indemnity is paid in the amount of the full insured amount, the validity of the contract is terminated.

Not subject to damages:

- caused as a result of processes which can not be avoided in the work or those that naturally follow from them (corrosion, natural excitement and other natural properties of individual objects);

- caused due to the fact that the insured did not take appropriate measures to rescue the manna, ensure its storage and prevent further damage or destruction;

- incurred as a result of theft of property, if the theft has not been confirmed by the police or other law enforcement agencies.

Automobile Insurance

Adetailed description of each of these coverages is beyond the scope of this text, but it is useful to describe several of the more prominent lines of casualty insurance that occupy a good share of regulators' attention. Of these lines, personal auto insurance often receives considerable attention. In states in which accident victims can sue in tort to collect damages, auto liability insurance typically covers liability for bodily injury and property damage, as well as uninsured/underinsured motorists losses.

Bodily injury liability coverage indemnifies the insured against claims for damages to others from accidents caused by the insured. These damages include medical expenses, lost wages and pain and suffering. Property damage insurance covers damages caused by the insured to the property of others. Uninsured and underinsured motorists coverage protects the insured directly for damages the insured suffers because of accidents caused by other drivers who do not have sufficient liability insurance. These coverages are subject to specified benefit limits and many states mandate minimum limits for these coverages.

In the 1970s, a number of states enacted no-fault auto insurance laws intended to lower costs and expedite benefit payments to accident victims. Under the purest form of no-fault, insureds would have no legal right to sue in tort for damages caused by another driver.

In this system, accident victims would be covered by their own insurance policy for medical expenses and wage loss, regardless of who was at fault. In actuality, no state has implemented a pure no-fault system, and restrictions on lawsuits vary widely among the states. For those states that restrict lawsuits, damages are required to meet a certain threshold – verbal or monetary (more common) – in order for the victim to sue.

In states with some form of no-fault law, drivers purchase personal injury protection insurance to cover their medical expenses and wage losses from auto accidents. They also purchase residual liability insurance to cover any damages they are obligated to pay to others for accidents caused by their own negligence.

In some states, it is also possible to buy personal injury protection coverage even hough there are no or very limited restrictions on lawsuits (these are typically referred to as add-on systems). More recently, a few states have experimented with choice no-fault systems whereby the insured, at the time of purchase, elects the type of system they wish to have govern their rights and obligations.

Collision coverage pays for physical damage to the insured's vehicle caused by its collision with another vehicle or object. Comprehensive coverage pays for damages to the insured's auto from most other causes, including weather, theft and vandalism. These property insurance coverages are purchased with various deductibles that lower the required premiums. Other incidental coverages can be purchased for items such as medical payments, rental reimbursement and towing.

5.4. Features of insurance of agricultural property enterprises

Interesting Facts

The magnitude of the impact of catastrophic events on agricultural production in recent years varies annually from 3 to 7 billion UAH.

Agriculture – the oldest and traditionally one of the most important and at the same time the most risky sectors of the economy, which is constantly under the influence of natural forces of nature. In the conditions of Ukraine, agriculture is one of the key sectors of the economy and at the same time the most risky, as it is constantly under the influence of natural forces of nature. In agriculture, about 3% of risks are insured, while in most developed countries this indicator reaches 70-80%. At the same time, in Ukraine yield losses from unfavorable weather conditions in some years can reach 45-50%.

The economic mechanism of insurance for agricultural production consists in the creation and use of an insurance fund in order to compensate for unforeseen losses caused to agricultural enterprises by natural disasters, other unfavorable events that violate the normal reproduction process.

Insurance of agricultural enterprises is characterized by complexity. The objects of property insurance of agricultural enterprises are:

- a crop of crops and perennial fruit-bearing plants, except for the harvest of natural hayfields and pastures, crops sown on green fertilizers, crops that the farm sowed for 3-5 years, but never received a crop;
- trees and fruit and berries growing in the gardens, and vineyards (long-term planting, wear or liquefaction of which is more than 70%, as well as those to be written off from the balance, are not accepted for insurance);
- farm animals, poultry, rabbits, fur animals, bees, other than farms, where animals are subject to quarantine or other restrictions due to infectious diseases;
- buildings, structures, agricultural machinery, objects of incomplete construction, transmission equipment, power, working and other machines, vehicles, raw materials, materials. Fisheries can also insure vessels and fishing gear.

Insurance of agricultural enterprises can be carried out only by insurers with sufficient insurance reserves, an extensive network of branches and representative offices, as well as specialists well acquainted with the peculiarities of agrarian production.

World experience proves that significant and ever-increasing investments in the agro-industrial complex as well as increasingly sophisticated modern agricultural production technologies put the world in the world to the necessity of creating national systems of crop insurance insurance.

In most countries of Western Europe, only voluntary forms of risk insurance in crop and livestock production are applied. In this case, insurance policies are

bought by virtually all farmers in the UK, the Netherlands, France, Italy, Austria and Germany and many other countries.

At the same time, the state plays a significant role in insurance of property of agricultural enterprises. So, in the United States, when insurance for agricultural crops is insured, the state subsidizes insurance payments; covers the administrative costs borne by the private insurance sector; provides reinsurance services.

Spain and Portugal have so-called "public-private partnership" systems, where the role of the state is to provide subsidies on insurance payments and reinsurance. Private companies are integrated into this system and are involved in administering programs and cover part of the risks that are not covered by the state. The European Union member states have their own special insurance programs for agricultural producers, which differ in the degree of state participation in the insurance process.

The most risky is the cultivation of crops and perennial crops.

Crop production is the activity conducted mainly in the open air, and the results of management are significantly influenced by fluctuations in climatic conditions and other natural factors that can not be accurately predicted.

Adverse environmental and climatic conditions are divided into two groups:

- permanent, that is, ordinary factors for a given locality – short vegetative period, average annual fluctuations of air temperature, low quality of soil, etc.;
- unusual, random deviations from normal conditions of development of plants: early freezing, hail, drought, flood, long-term absence of precipitation.

The action of the first group of factors is neutralized by financing the necessary costs for growing varieties of grains and other rapidly growing ripening crops, implementing costs for soil quality improvement, influencing the price through the mechanism of surcharges and other methods. As for the second group, then the system of monetary funds, which is created directly by insurance companies, plays an important role.

At the time of the occurrence of an insurance case in the insurance of the crop, the problem of determining the damage caused to the economy is quite complicated. Therefore it is accepted to compare the actual harvest of the current year with the average yield that the farm has received in the previous five years. In some cases (the plowing of new land areas, irrigation of new lands) it is possible to calculate the loss on the basis of the forecast yield, which an economy could obtain in the absence of an insured event (under normal weather conditions). Insurance of agricultural crops can be all legal entities and individuals who use land.

The object of insurance in plant growing is the property interests connected with the non-receipt or non-receipt of the crop of any kind of agricultural crops (grain, leguminous, technical, vegetable, fodder, melons, orchards, vineyards, greenhouses, etc.).

Together with losses from loss or damage to the crop, the costs associated with cutting or sowing crops after a natural disaster are also reimbursed. Insurance risks include hail, drought, freezing, flood, fire, rain, storm, frost, plowing, roasting, sprouting, natural disaster, wind and water erosion, landslides,

rotting of seeds, damage to birds, loss of crops in closed soil, cause which are the termination of the supply of electricity, caused by natural elements, fires, technical or technological accidents.

The insurance amount is determined in the amount of the value of the agricultural product crop for insurance purposes, which is calculated by multiplying the planned area of sowing of a particular crop by the average annual yield (per hectare) for the last five years and at the price agreed with the insurer per unit of production. The sum insured should not exceed 70% of the cost of the crop (50% – in the case of compulsory insurance of the crop). The rest of the cost of production in case of its destruction at the onset of insurance conditions is covered at the expense of the resources of the economy.

Insurance premiums are calculated for each culture by multiplying the value of the crop from the total area sown to the tariff rate and are paid in full or at least 25% of the annual amount for insurance of crops.

The contract of insurance of crop crops shall be concluded not later than the designated agronomic services of the optimal period of sowing (planting) for the given region, and for perennial plantings – until the cultivation is stopped. To insure crops grown in sheltered soils, the contract must be concluded before the start of the production cycle (sowing, landing). If after the conclusion of the contract the policyholder changes the size of the sown area to the side of its increase, then he is given the right to conclude an additional contract. For all agricultural crops, the crop insurance begins on the day they are sown (landing) and ends on the day the harvest is completed.

A non-harvest crop is not considered an insurance case when the natural and climatic circumstances common to the area took place. When, after a certain natural disaster (for example, late frosts), crops can yield a crop within the average for previous years, then the insurance case is absent.

In the event of damage to or loss of crops, the size of the damage shall be determined on the basis of the cost of the quantitative losses of the crop of the main products of the insured crop or group of crops. The damage is calculated by multiplying the difference between the cost of the actual yield of the given year and the average yield of the previous five years from one hectare for the entire area of sowing.

If on the whole area where the damaged or damaged crop died or a part of such area was transplanted (subspecies) then the damage is determined taking into account the cost of the actually gained gross crop of the main crop (at the prices agreed upon at the conclusion of the insurance contract) and the actual cost harvest on the cutting area (sowing) at the prices of sales of these products. When cutting or sowing of damaged plants, the size of the damage is determined taking into account the associated additional costs and the cost of the crop of the newly sown plants.

The damage is compensated, which is expressed in less quantity of received products in comparison with the average yield of 1 hectare in the last five years. The loss amount is calculated on the basis of the purchase (contractual, realization, market) price, which is fixed in the insurance contract.

Upon the occurrence of an insured event, the policyholder in writing within the term specified by the contract shall draw up an insurance case and shall inform the insurer within a period of one day. In the act, he indicates the crops that were killed or damaged, the date and type of natural disaster, its duration, intensity, the nature of the damage to each crop, the phase of development of the plants at the time of damage, the size of the area of damage, as well as the area of the crops intended for cutting. In turn, the insurer verifies the reliability of these data on the materials of the meteorological service, identifies the causes and circumstances of the insured event.

The insurer must take a decision on payment of insurance indemnity or refusal to pay it within 10 days from the date of receipt of all necessary documents, and within 10 days – to make a payment.

Insurance indemnity is not paid if:

- the crop has died due to intentional actions of the insured;
- damage caused is a result of mismanagement.

An insurer shall notify the decision on refusal to pay the insurance indemnity in writing within three days from the moment of its acceptance. The insurance company has the right to bring a recourse action against the perpetrators of the death or damage to agricultural crops.

Farmers can be insured by all legal entities and individuals who have animals. The object of insurance in animal husbandry is property interests related to destruction, destruction, forced slaughter of animals belonging to the insured, as a result of illness, natural disaster and accidents.

The fundamental feature of **agricultural animal insurance** is the reimbursement of losses only in case of death of the animal. Insurance risk is death, destruction, forced slaughter of animals due to infectious diseases, fire, hurricane, electric shocks, lightning, freezing, earthquake, flood, landslide, hurricane, storm, hail, bite snakes, poisonous insects, injuries, poisoning herbs or substances falling under vehicles and other traumatic injuries.

The insured amount is determined by the book value of the animal. The rates for insurance of farm animals is lower than the rates for insurance of crops and depend on the insured entity, including compliance with technical requirements of maintenance and feeding of animals, veterinary and efficiency of preventive and other measures.

Based on the difference in the amount of insurance liability, the whole set of insured animals is divided into three groups:

- productive cattle;
- young animals;
- tribal and highly valuable animals.

Livestock is the main group and is insured in case of death due to natural disasters, infectious diseases, fire and electric current.

Young animals need special care and can be insured only from natural disasters, fires and electric currents. For tribal and highly valuable animals, a higher level of insurance liability is used, taking into account the drop in animals from infectious diseases, general diseases and accidents.

The insurance contract becomes effective after the payment of insurance premiums by the insured in whole or in part, of at least 50% of the respective amount, but no later than 30 days after its signing.

The contract comes into force:

- in case of cash payment – from the day following payment;
- in the case of cashless settlement – from the date of receipt of the insurance payment to the insurer's account.

In the event of an insured event, the insured must, within a one-day period, declare the death of the animals to a specialist in the veterinary service, the insurer, and in case of theft, to the police.

Upon receipt of the application, the insurer, on the basis of the conclusions of the specialist and the two witnesses, within a three-day period makes an act for f. No. 26-TV, which is the basis for the payment of compensation. The insured shall be compensated only for direct damage (death, death or forced slaughter), but not loss of production, which is indirect damage.

In case of death of animals, this damage is equal to the book value of the dead animals. If the individual accounting of the book value of animals is not conducted, then it is defined as the average for all animals of this species. In the case of forced slaughter of cattle, sheep, goats, pigs, horses, camels, and poultry, the damage is determined in the amount of the difference between their book value and the amount received from the sale of meat suitable for eating. If the meat is completely unsuitable for use, then the damage is calculated as at the case. In case of a case or forced slaughter of fur animals, damage is determined taking into account changes in the cost of the skin as a result of an infectious disease, natural disaster or fire. The price of the sold peel is determined on the basis of relevant certificates of the procurement organization.

The insurance of productive farm animals, which is the private property of citizens, is carried out in a voluntary form. Animals are accepted for insurance in a contractual amount, but not higher than the book value. Insurance risks for animal insurance are infectious diseases, fires, accidents, explosions, natural disasters, landslides, agricultural lands, accidents, ice-colds, falling under mobile transport, under the influence of electric current and forced slaughter (destruction) by order of the veterinary service.

The insured amount is established on the application of the insured, but not more than the market value of the animal on the day of the contract or book value. Insurance of buildings, structures and other property is carried out in case of destruction or damage due to fire, explosion, lightning strike, flood, flood, earthquake, storm, hurricane, rainfall, hail, landslide, unusual snowfall, village, stoppage of electric power supply (caused by insurance event). Means of transport are insured in the event of an accident. In addition, equipment, machinery and other property may be insured in the event of theft and unlawful actions by third parties.

The insurance contract is concluded on the basis of a written application of the agricultural enterprise, which describes the property that is accepted for insurance, its location and destination, and the losses that have occurred and their

causes are indicated. These data make it possible to correctly determine the degree of risk, the size of the insurance premium and settle the disputed issues of compensation.

The contract can be concluded on all property or on its separate kind. Under the main contract, all property owned by the enterprise is subject to insurance, namely: buildings, structures, transmission equipment, power, working and other machinery, equipment, vehicles, fishing vessels, fishing gear, objects of incomplete construction, inventory, finished products , raw materials, goods, materials and other property.

Under additional agreements, the property received by the enterprise under the contract of property lease (if it is not insured by the lessor) may be insured or taken from other enterprises or the population for processing, repair, transportation, storage, commission, etc.; property for the time of experimental or research work, exhibitions at exhibitions.

A property insurance contract can be concluded on the book value, on the contract value or on a certain share of the value.

The property received by the insured during the period of the contract is considered automatically insured, and the fact that he left – withdrawn from insurance coverage without changing the sum insured and insurance payment. If the property is insured for the time of conducting experimental or research work or exhibit at an exhibition, then it is considered insured from the moment it is taken from a permanent place of residence for packing and transportation to a test or exhibit. Insurance cover for such property extends to the period of its temporary warehousing, testing, exhibition and return transportation until a permanent place of stay is established in a clause specified in the contract.

For the valuation of fixed assets, their full book value, net of the value of wear, is used. Inventories of own production, as well as purchased by the enterprise, are valued at the amount of actual cost or in the prices that acted on the day the contract was concluded, taking into account depreciation, and objects of incomplete construction – in the amount of material and labor costs actually incurred at the time of the insurance case.

The policyholder submits a separate application for voluntary insurance of property belonging to the enterprise and a statement on voluntary insurance of property in accordance with the contract of property tenancy. If the insurance contract is concluded for a part of the property, the description of the corresponding property shall be attached to the application.

Provided that after the conclusion of the insurance contract with the insured property there were changes (for example, reconstruction, replacement of equipment, etc.), about them it is necessary to inform the insurance company. If the insurer insures property that has already been insured in other insurance companies, he must inform the new insurance company of the current contracts and indicate the insurance amount, since the insured amount must not exceed the insurance value.

The insurance contract is concluded, as a rule, for a year and is issued by issuing to the policyholder an insurance policy, which begins to act the next day

after payment of accrued payments (the whole amount or a specified part of a contract). The insurer may refuse the insured in payment of an insurance indemnity if the insured has submitted false information about the object of insurance.

5.5. Vehicles insurance

Vehicle insurance is an insurance type where the facility is mechanized and other vehicles. Depending on the type of route, transport insurance is divided into ground, river, sea and air.

Ground transport as an object of increased danger poses a risk to the environment, especially to the life and health of people, and at the same time it itself becomes quite often and easily the object of damage.

Insurance of vehicles is referred to as "CASCO", and insurance of goods – "CARGO" insurance.

Land transport insurance is provided only on a voluntary basis (with the exception of traveling abroad). Vehicles are subject to insurance, which are subject to registration in the traffic police.

The insurer carries out voluntary insurance of motor vehicles belonging to legal and natural persons and trailers to these means, corresponding accessories and equipment. As a rule, a motor vehicle and trailers are accepted for insurance in a technically normal condition.

For this type of insurance, insurance risks are:

- damage, destruction of the object of insurance as a result of an accident and other damages that occurred during the movement process;
- damage, destruction of the object of insurance as a result of unlawful actions of third persons during his stay or in any place, either in the guarded parking lot or in the garage;
- damage, destruction of the object of insurance as a result of natural disasters (storm, hurricane, tornado, rain, hail, avalanches, landslides, outflow of groundwater, flood, flood, field, lightning, pounding, earthquake), fall of a tree, an animal attack, as well as a fire or an explosion in a motor vehicle;
- theft or theft of a motor vehicle and trailers to it, as well as theft of appropriate accessories and additional equipment when staying or in any place, or in a guarded parking lot or in a garage.

Vehicles are insured against the following risks:

- in case of damage or loss of the vehicle as a result of an accident; - in the event of damage or loss of the vehicle, its components, parts, equipment, in case of theft or attempted abduction, damage due to intentional actions of third parties;
- in case of damage due to a natural disaster (storm, flood, earthquake, etc.);
- in the case of theft of a vehicle and trailers to it, as well as theft of the equipment in case of stay or in any place, either in the guarded parking lot or in the garage.

The main risk of destruction or damage to a vehicle is an accident (traffic accident).

Interesting Facts

There is a rather interesting dependence of the probability of an accident occurring on the driver's experience and the color of the car. For example, drivers with an experience of up to one year go cautiously and make less than all accidents. Drivers with an experience of 6 to 10 years are more than twice as likely as newcomers, due to a decrease in vigilance and attention. The rest of the drivers occupy a middle position between these two groups, but drivers with a 10-15 year experience go a bit better. Cars of bright colors (red, yellow) are less likely to be involved in road accidents than gray and black.

In determining the probability of an accident, other factors are also taken into account. Yes, it is noted that cars of bright colors (red, yellow) are less likely to get into road traffic accidents than gray and black.

All these factors should be taken into account when determining the fare in case of conclusion of an insurance contract in case of damage to a vehicle as a result of an accident. The probability of an accident rather than unlawful actions is offset by a small loss-making effect of this risk, which is on average 2-5 thousand UAH, therefore the average rate for this risk is 1.5-3.5%.

Other significant damage is caused by unlawful actions of third parties, theft and robbery of vehicles. Note that when concluding an insurance contract with a full cashier, the rate of abduction is more than half in the share of the insurance tariff and reaches about 4 - 6%. This is explained by almost 100% of the loss of the insurance amount. That is, in case of an insured event, it is necessary to pay the entire insurance amount. In addition, such an insurance case is quite easy to falsify. Therefore, most insurers do not generally take on vehicle insurance against theft. In the case of this risk, however, large amounts of franchise (10%) are used. This risk has its own peculiarities. The risk of robbery lies primarily in the prestige of the car, its storage location, the presence of security devices and signaling, the life of the vehicle.

Another group of risks is natural disasters. Here subjective factors do not affect the probability of occurrence of losses. A significant place in this issue is the region of operation of the vehicle. The tariff for natural disasters does not exceed 1%. The list of insurance cases can include one, several or all of the just listed events and specify them in the insurance contract.

Not accepted for insurance:

- motor vehicles and their trailers, whose term of use has been exceeded by 10 years since the date of issue by the manufacturer;
- from the theft – motor vehicles of all brands, not equipped with anti-theft devices;
- baggage of the vehicle;
- glass of motor vehicles with any damage and defects.

No damages are incurred for:

- damage (destruction) of tires of a vehicle and tires mounted on trailers to it, caused by traffic and did not cause an accident;

- theft of wheels, including spare parts mounted on a motor vehicle and its trailers, if the theft of wheels has taken place separately, without theft or theft of a vehicle or trailer;

- the use of a motor vehicle and trailers to him in a pre-known insurer in a state of emergency;

- military actions or military actions and their consequences, damage or destruction of mines, bombs and other weapons of war, and as a result of civil war, popular unrest and strikes, confiscation, arrest or destruction, at the request of military or civilian authorities;

- direct or indirect effects of atomic explosion, radiation or radioactive damage associated with any use of atomic energy and the use of radioactive materials;

- transportation of a motor vehicle by sea, rail and other modes of transport;
- rot, corrosion, destruction and (or) loss of natural properties of materials used in a vehicle, due to storage in unfavorable conditions, natural chemical processes, etc.;

- natural wear of the vehicle as a whole, as well as its individual parts and units, loss of merchantability, factory defects;

- damage to the tires caused by the poor condition of the anterior part, running on sharp objects;

- driving by a person who does not have a driver's license;

- driving by a driver who is in a state of alcohol, narcotic or toxic intoxication;

- disobedience to the authorities (escape from the scene, persecution by the traffic police), actions (other than those punishable by a criminal offense) connected with violation of the Rules of the road;

- violation of rules of fire safety, transportation and storage of flammable, explosive substances and objects that are easily engaged;

- gross negligence of the insured or his representative, as well as violation by any of them of the established rules of operation of motor vehicles;

- the transfer by the insurer of the vehicle control to a person who is in a state of alcohol, narcotic or toxic intoxication, as well as to a person who does not have a driver's license with the permissible category of the relevant vehicle.

Ukrainian insurers offer a variety of insurance conditions for land transport. But it is rare to find an insurance company that would take insurance against a car from all risks, regardless of the country of its production and its lifetime. The insurance contract is, as a rule, one year. It is possible to conclude an insurance contract for shorter periods, for example, when traveling abroad, or at the time of driving a vehicle.

The insurance amount is determined on the basis of the submitted applications for insurance and documents confirming the cost of the vehicle, trailers to it and additional equipment and forms a full or part of the cost of the vehicle. The cost of a vehicle is determined by the certificate of the trading organization, the exchange price or on the basis of the conclusions of the insurance merchant's merchandise. The insured amount must not exceed the current cost of

the vehicle on the day of conclusion of the contract, taking into account the depreciation.

In case of an insured event, the insured must notify the traffic police and insurance company.

After receipt of the application, the insurer inspects the object of insurance within a three-day period, draws up an insurance case in the presence of the insured, the guilty party and two witnesses.

Insurance payments depend on the life of the vehicle, from the driver's seniority. The insurance premium is calculated by the insurer depending on the sum insured and the insured cases chosen by the insurer – factors influencing the probability level of the occurrence of the insured event: the car's mark, the year of its issue, seniority and age of the driver, the presence of the security alarm system and the device against theft and the size of the franchise.

The insurance contract is made according to tariffs, as a rule, for a year and may be concluded both in favor of the policyholder and in favor of another person specified by the policyholder who has the rights established by the legislation to use the motor vehicle.

The question for self-control

1. Features, essence and basic conditions of insurance of property of citizens.
2. Insurance of buildings of citizens.
3. Pets insurance.
4. Home insurance.
5. What types of business property insurance exist?
6. Insurance of the risk of loss of property by business entities.
7. Specificity, mechanism, objects and forms of insurance in agriculture.
8. Insurance of crop production.
9. Insurance of farm animals.
10. Insurance of buildings, structures and other property in agriculture.
11. Expand the main terms of compulsory insurance.
12. When does the insurer initiate and terminate the liability for compulsory insurance of the crop?
13. Expand the methodology for calculating damages under compulsory insurance of the crop.
14. What is the percentage of insurance coverage when obligatory insurance of the crop?
15. How is the insurance estimate for each type of agricultural property calculated?
16. In what cases can the insurer refuse the insured in payment of insurance indemnity?
17. Expand the objects and risks of car insurance insurance.
18. Land transport insurance.
19. What expenses are not reimbursed to the policyholder when insuring vehicles?

20. On the basis of which documents will be paid insurance indemnity?
21. What powers does the Motor Transport Insurance Bureau of Ukraine have?
22. How is damage calculated in case of damage or loss of a vehicle?
23. What is the reason for the large number of restrictions on motor vehicle insurance?

Topic 6. INSURANCE OF LIABILITY

Methodical recommendations for studying the topic

Beginning the study of this topic, it is necessary to find out that insurance liability is a specific group of types of insurance that has significant differences from other types of insurance.

One of the most massive types of this group is civil liability insurance of vehicle owners, which is usually carried out in mandatory form. It should be explained why this is due. It is necessary to pay attention to the main tasks and principles of the international system "Green Card", as well as the Motor (Transport) Insurance Bureau of Ukraine (MTIBU).

Considering the insurance liability of haulage companies, it is advisable to clearly indicate the importance and characteristics of this type of insurance. By studying the liability insurance of employers and liability insurance for producers for the quality of the product, we must consider foreign experience, since these species are not common in domestic practice.

In the process of mastering the issue of professional liability insurance, it is necessary to clarify the meaning of this type of insurance in a market economy, and also the fact that the nature of losses, risk assessment and the development of insurance conditions depend on the type of activity that falls under the insurance protection.

Particular attention should be paid to environmental insurance, which should be considered as one of the economic and legal instruments of the security of Ukraine's economy.

Mini-lexicon

liability insurance, administrative liability, civil liability, professional liability, insurer's liability limit, Green Card, Motor (Transport) Insurance Bureau of Ukraine, emergency commissioner, retroactive date, environmental insurance.

6.1. Features of liability insurance

Liability insurance is a form of protection against risks that threaten a third person (her health or property).

Specific features of liability insurance:

- the subjects of insurance relations are three parties: the insurer, the insured and the insured - the third party to whom the insurance indemnity will be paid and which is not predetermined;

- the cost of the insurance object is unknown;

- the insured amount is established in the contract as the limit (limit) of the liability of the insured, which may arise when the insured causes harm.

Liability insurance is classified:

- in the form of implementation;
- by types of insured subject of insurance relations;
- for the object of insurance (table 5).

Table 5. Classification of liability insurance

№	Criterion of classification	Види страхування відповідальності
1.	In the form of implementation	- voluntary; - required
2.	By types of insured subject of insurance relations	- entities; - individuals
3.	By the object of insurance	- insurance of debts (insurance of loans, deposits); - compensation insurance (professional liability insurance of doctors, lawyers, builders, etc.); - liability insurance of vehicle owners; - liability insurance of the carrier; - insurance of civil liability of enterprises – sources of increased danger

When insuring liability, the policyholder is not exempt from administrative and criminal liability.

6.2. Civil liability insurance of vehicles owners

A vehicle is a source of increased danger to the life and health of citizens, their property. One of the forms of protection of the material interests of citizens in damaging their lives, health and property as a result of a road accident is the civil liability insurance of vehicle owners, which is mandatory in most countries of the world. The victim receives compensation for losses incurred in the shortest terms regardless of the financial condition of the driver.

The purpose of insurance of civil liability of owners of vehicles is to provide guarantees of compensation of losses of the insured – the owner of the vehicle, which arose as a result of the obligation to compensate for the damage inflicted by the insured third party.

From January 1, 2008, civil liability insurance of owners of vehicles is compulsory.

The object of insurance is civil liability of owners of motor vehicles for damage caused to third parties as a result of road traffic accidents. In order to realize the civil liability insurance of owners of vehicles in 1994. The Motor Transport Insurance Bureau (MTSBU) was established, the purpose of which is to compensate victims in the event that the damage is caused by an unidentified vehicle, and also in cases where the insurer can not fulfill insurance obligations due to insolvency.

Obligations of such insurance apply both to residents and non-residents – owners of vehicles. Under the owner of a vehicle means a legal or physical person who operates a vehicle owned by him on the right of ownership, full economic management, operational management or on other grounds, which do not contradict the current legislation (lease, commission, etc.). These means of resident residents are subject to state registration and registration in the relevant bodies of the Ministry of Internal Affairs of Ukraine.

The subjects of compulsory insurance of civil liability are insurers, insurers, MTIBU and third parties – legal entities and individuals who have suffered damage to the vehicle as a result of road traffic accidents.

The object of compulsory civil liability insurance is the civil liability of owners of vehicles for damage caused to third parties as a result of road traffic accidents. It is about life or health of citizens, their property and property of legal persons.

Insurance coverage covers direct damage to a third party during vehicle traffic when there is a causal link between the vehicle's traffic and the damage it inflicts.

As an insurance case, a road transport accident is considered, which occurred with the participation of the insurer's vehicle and the liability of which is incurred for the damage caused by this transported vehicle to the property, life and health of a third party.

There are two types of compulsory civil liability insurance contracts:

- the usual agreement, which is concluded with the owner of the vehicle, registered in Ukraine or temporarily imported into the territory of Ukraine for use;

- an additional agreement in force on the territory of the states specified in the insurance policy on the terms established in those states, in accordance with the agreements concluded by MTIBU with the respective authorized civil liability organizations of vehicle owners and operates in the territory of Ukraine. If at the time of conclusion of the usual insurance contract the franchise is applied, then the insurance policy must be made a note on the established amount of the franchise.

In case of entry into the territory of Ukraine, the owner (driver) of the vehicle must conclude an ordinary contract of compulsory insurance of civil liability, except in cases when the owner of the vehicle insured civil liability in the state, with the authorized organization for civil liability insurance of vehicle owners who MTBB entered into an agreement on the mutual recognition of contracts for such insurance.

In case of departure outside Ukraine, the insured is obliged to conclude an additional contract of compulsory insurance of civil liability under the conditions established by MTIBU, if the use of a vehicle outside Ukraine rents mandatory insurance of civil liability on the terms of visiting countries.

In accordance with the basic principles of insurance for the conclusion of a contract of compulsory insurance of civil liability, the policyholder has the right to choose the insurer (insurance organization), and the insurer can not refuse any insurer in the conclusion of the contract of compulsory insurance of civil liability. For this type of insurance are eligible solvent and financial stable insurance companies that have passed the licensing and are members of MTIBU.

The insured amount under the contract of this type of insurance is defined as the monetary amount within which the insurer, in accordance with the terms of insurance, is obliged to pay to a third person or third parties (in case of victims in road accidents several) after the occurrence of an insured event. Under the obligatory insurance of civil liability, the insured amount and the amount of insurance payments are set by the Cabinet of Ministers of Ukraine.

An accident is an accident that occurred with the participation of a vehicle of the policyholder and as a result of which his civil liability for damage caused to a vehicle by property, life and health of a third party arises.

In case of accident insurance (which means bodily injury or death of the driver and passengers of the insured car by the number of seats) resulting from an accident, the company pays in the event of an injury 0.1% of the sum insured for each day of the hospital (but no more than 120 days)

When making a contract, the client must pay the insurance premium to the insurance company. In this case, the size of the insurance tariff depends on the brand, car model, terms of the contract, the amount of insurance liability and other data specified by the applicant.

A client who during the year did not apply to the insurance company for receiving a refund has the right to discounts from the insurance premium in the amount of 10% for each year of trouble-free operation. In turn, the insurer has the right to reduce the amount of insurance payments for such customers, as well as increase the amount of insurance payments to owners of vehicles due to which insurance cases occurred (under the conditions established by MTIBU, but not more than 50% of the amount of insurance payment in both cases).

In order to compensate for the losses caused by an accident, the insured or a third person (her successor, assignee of the insured) are obliged (depending on the case) to apply to the insurer (insurance organization) or to MTIBU.

The payment of insurance indemnity to a third person is carried out by the insurer on the basis of the following documents:

- applications for payment of insurance indemnity;
- certificates of the bodies of internal affairs about the circumstances of the commission of an accident;
- certificates (conclusions of examination, insurance certificate, emergency certificate, etc.), which confirms the amount of property damage in case of its occurrence;

- certificates of medical establishments on the term of temporary disability or a certificate of the specialized institutions on establishment of disability in case of its occurrence;

- copies of the death certificate (for those killed in an accident or died as a result of this incident) and the succession rights.

Payment of insurance indemnity is made to a third person or heirs within 15 working days from the date of receipt by the insurer of the indicated documents, except in cases when disputes related to the payment of insurance indemnity are considered by court.

Provided that several road vehicle owners are the perpetrators of the road accident, the insurers will reimburse third parties, in proportion to the guilt of the policyholder, as determined by law. In this case, the third person has the right to contact one of these insurers, who is obliged to compensate for damage in accordance with the provision.

If an accident is caused by a third-party property damage, then, as a rule, a conclusion of the examination, which is carried out at the expense of the insurer, is required to pay the insurance indemnity. If such expertise is carried out by subjects of entrepreneurship who have a special permit (license) for forensic expert activity, and subjects of this type of insurance have not agreed on the amount of damages, additional examination is carried out at the expense of the insured.

The amount of the deductible for the reimbursement of losses incurred by the property of third parties is set at two percent of the sum insured.

The insurer does not indemnify damages:

- in case of damage to the life and health of the owner of the vehicle responsible for the accident;

- for any damage (damage) or destruction of any property (cargo) contained in the vehicle of the insured, guilty of an accident;

- for a damaged or destroyed vehicle to its owner, guilty of an accident;

- for the consequences of a fire that arose outside the border of the roadway on the territory adjacent to it;

- for damaging or destroying antique items, articles of precious metals, precious or semiprecious stones; objects of religious worship, collections of paintings, manuscripts, banknotes, securities;

- if an accident occurred as a result of deliberate actions of a third person recognized as such in the prescribed manner;

- if an accident occurred as a result of massive disturbances and group violations of public order, military conflicts, natural disasters, an explosion of ammunition, vehicle fires not related to this adventure.

The contract of compulsory civil liability insurance is concluded on the basis of the claim of the insured and comes into force from the moment specified in the insurance policy, but not before the insurer makes an insurance payment in favor of the insurer, which is certified by the relevant documents. After payment of the insurance payment, the insured receives from the insurer an insurance policy, which is a contract (written agreement) of compulsory insurance of civil liability. An example of an insurance policy is established by MTIBU in agreement with the

insurance supervisory authority. The insurance policy may have sections providing for the voluntary insurance of a vehicle, the driver and the passengers' lives and health.

The insurance policy contains:

- name and address of the insurer;
- type, vehicle brand;
- the state license plate and the place of registration of the vehicle;
- engine numbers, chassis (body);
- the beginning and end of the contract of compulsory civil liability insurance;
- the size of the insurance payment and the sum insured;
- for the insured – a legal entity – its name and address, for the insured – an individual – the last name, first name, patronymic of the owner of the vehicle, home address;
- signatures of the Parties.

Limit of liability of the insurer:

- for the damage caused to the victims of the victim – 100000 UAH. per victim;
- for the damage caused to the life and health of the victims – 200000 UAH. per victim.

In the event that the total amount of damage in one insured event exceeds five times the limit of liability of the insurer, the compensation to each victim is reduced proportionally.

The amount of the deductible for the compensation of damage caused to the property of the victim is 0, 500, or 1000 UAH, in case of compensation for the damage caused to the life and health of the victims of the franchise, does not apply. In accordance with the Decree of the Cabinet of Ministers dated December 11, 1996 (N 1501), invalids – owners of vehicles with the appropriate distinguishing signs "disabled" (when they personally manage their car) – do not conclude with the insurers a contract of compulsory motor third party liability insurance , but are considered insured by the Motor (Transport) Insurance Bureau, which compensates for the damage caused to them by third parties, under the conditions specified by the provisions. Insurance policy is not issued at this time. Other drivers who operate such a vehicle are obliged to conclude a contract of compulsory civil liability insurance on a general basis.

Upon the occurrence of an insured event, the insured (a driver of a vehicle that has committed an accident) is obliged:

- adhere to the rules of the road, established by the current legislation;
- take all measures to reduce the amount of harm;
- provide third parties with the necessary information for identification of the insured and the insurer (insurance organization);
- inform the insurer (insurance organization) within three working days about the occurrence of the insured event, provide him with a written explanation on the circumstances of the road accident, the insurance policy and, if necessary, present a vehicle for inspection and examination. If the Insured was not able to

perform the specified actions for valid reasons, he must prove it in a documentary way.

When completing the relevant documents on the road accident, the officers of the internal affairs bodies in accordance with the current legislation establish and record the necessary information on compulsory insurance of civil liability of the participants of this incident.

Control over the presence of an insurance policy for compulsory insurance of civil liability from the owner (driver) of a vehicle during its operation is carried out by the internal affairs bodies in accordance with the current legislation. Persons operating a vehicle without an insurance policy are liable in accordance with applicable law. An interesting fact is that in most countries in the event of an accident, if the car owner does not have an insurance policy, the system of compulsory insurance of civil liability is still working. In such cases, the Motor Bureau pays the insured amount to the victim, and with the owner of uninsured transport regulates the relations in court.

The validity of the contract of compulsory civil liability insurance may be terminated prematurely at the request of the insured or the insurer, if it is stipulated by the terms of the contract, which any party is obliged to inform the other not later than 30 days before the date of termination of the insurance contract, unless otherwise provided by this agreement.

After Ukraine's accession to the Green Card system, the Motor (Transport) Insurance Bureau of Ukraine is obliged to pay compensation for losses caused by our drivers to foreign citizens in their territory.

International insurance system "Green Card". The introduction of civil liability insurance for car owners is one of the main conditions for Ukraine's accession to the International Insurance System "Green Card". The Green Card is an insurance policy for civil liability of vehicle owners, recognized by all Member States of this international system.

If an accident occurred due to the fault of a resident of one country in the territory of another country, the claims of the victims are settled through the national motor insurance bureau.

6.3. Insurance of carriers' civil liability

Carrier liability insurance is a relationship to protect the property interests of persons who have suffered losses in connection with the carriage of passengers or goods. It is conducted on the basis of contracts concluded in favor of third parties, whose property interests were damaged by the actions of the policyholder during the operation of vehicles associated with the carriage of passengers or goods. Insurers under the insurance contract of carriers' liability can be legal entities of any organizational and legal form possessing ownership, lease, leasing, operational management of means of transport, engaged in their operation in order to carry passengers or cargo on the basis of a license (certificate), or received in the legislative procedure an official permit for such transportation.

Carriers' liability insurance includes types of insurance that can be distributed according to the types of vehicles covered by the insurance, and by the category of persons, in case of damage which the insurer is liable for. Thus, first of all, it is possible to allocate insurance of liability of carriers of water transport (it is called liability insurance of shipowners), insurance of liability of air (first of all aviation) carriers, insurance of liability of car carriers and insurance of liability of railway carriers.

At the same time, each of the above-mentioned carriers may cause damage to different groups of individuals, and therefore insurance contracts are concluded in the following cases:

- damage to the lives and health of passengers;
- causing damage to passengers' luggage;
- loss, damage or mis-sending of the cargo transported for carriage;
- causing losses to third parties who are outside the vehicle and have no contractual relationship with the carrier.

The terms of the insurance contracts may differ depending on which insurance coverage, domestic or international, is applicable to the carriage. Under the insurance contract, the insurer receives insurance premiums from the policyholder for expenses and losses incurred or to be incurred by the policyholder in connection with causing damage to third parties during the validity of the insurance contract. Moreover, liability arises from the exploitation of those belonging to him, and specified in the contract of vehicles. The contract stipulates insurance cases in which losses to third parties are reimbursed in accordance with the norms of legislation of Ukraine, other states or international law.

The insurance risk in the event of the onset of insurance is the causing damage to third parties as a result of the insurer's activity as a carrier. In accordance with the insurance case, in the insurance of carriers' liability, there is a documented event that entails the causes of the resulting damage to third parties and is the basis in accordance with the rules of law for the presentation to third parties of claims to the policyholder for the reimbursement of this loss, and is directly related with the operation of the insurer and specified in the contract of insurance of means of transport.

In particular, under an insurance contract, insured events may include:

- bodily injury, illness or death of passengers who are on the insured transport in connection with accidents, accidents and other cases connected with the operation of such means of transport;
- loss or damage to baggage of passengers as a result of the consequences for which the insurer is liable in accordance with the legislation;
- loss, shortage or damage to the cargo destined for the carriage carried or transported in the insured mode of transport for the reasons for which the insured is civilly responsible;
- delay in the delivery of cargo or the arrival of passengers for reasons for which the policyholder is liable in accordance with the legislation;

- the delivery of the goods by the policyholder in the event of inconsistency with the instructions and delay in issuing or without receipt of the corresponding document, which testifies to the possession of the right of ownership for the cargo;

- death or damage to the health of individuals who are outside the vehicle, or loss or damage to their property in connection with the operation of the insured vehicle.

There are no insurance payments caused by:

- special actions of the insured and his representatives, violation of any of them rules and requirements of operation of the means of transport, against fire protection, storage of fire and explosive materials of materials;

- known circumstances to the insured, about which the insurer was timely brought to the notice;

- use of means of transport for training, participation in competitions, verification of technical characteristics and other actions not related to the activities of the insured as a carrier;

- exploitation of insured means of transport in conditions not provided for their purpose;

- use of insured means of transport outside the area agreed in the insurance contract, if it is not included in the list of force majeure circumstances;

- transportation of a large number of passengers and a greater weight of the cargo than is provided by the norms of technical exploitation;

- the operation of vehicles after the adoption by the court of decisions on the suspension of activities;

- participation of insured vehicles in smuggling or other illegal transactions;

- by force of circumstances of force majeure;

- military actions, maneuvers, other military measures;

- operation of mines, torpedoes, bombs, missiles, etc.;

- arrest, seizure, condition or detention of the insured vehicle as a result of hostilities, strikes, etc.;

- civil wars, revolutions, uprisings, etc.;

- acts of sabotage or terrorist acts committed on political grounds;

- confiscations, requisites or similar means of state bodies or organizations;

- ionizing radiation, toxic, explosive and other dangerous properties of nuclear fuel or radioactive products or waste, and transported as cargo on the insured means of transport, and those that are outside of it;

- intentional actions of the victim aimed at the occurrence of an insured event.

Insurance contracts are concluded on the basis of a written statement of the insured, which should contain the following data:

- name, address of the insured, his bank details;

- data on the means of transport claimed for insurance (their number, types, types, marks, age, load capacity, passenger capacity, technical condition, etc.);

- data on crew qualifications;

- area, nature and intensity of operation;

- the characteristics of the goods being transported;

- list of insurance risks claimed for insurance;

- terms of insurance and limits of insurance liability.

The insurance contract may be concluded for a certain period or at the time of the specified flight.

Insurance premiums under the insurance contract are established in a differentiated way by type of means of transport, taking into account cargo and passenger traffic, distance and routes of transportation, characteristics and condition of vehicles, the nature of goods and other factors that affect the degree of insurance risk.

Upon occurrence of an insured event, the insured must:

- take all possible and expedient measures to reduce possible losses. In this case, the insurer has the right to make recommendations aimed at reducing the damage and which the policyholder must comply with;

- to immediately notify the insurer about the insured event or his representative;

- urgently notify the insurer of all claims made to him in connection with the insured event, to provide the insurer with a copy of the claims of the victims about the indemnification by the insured of losses, to inform the insurer about the beginning of actions of the competent authorities on the fact of causing losses;

- ensure the participation of the insurer or its representatives in determining the circumstances and causes of the insured event, the size of the damage caused;

- provide the insurer with all available insurer information and documentation, which allows to talk about the causes, course and consequences of the insured event, the nature and extent of the damage caused. In this case, the insurer has the right to make an insurer's request for any information and documents relating to the insured event;

- to provide the full assistance of the insurer in judicial and extrajudicial protection. In this case, the insurer has the right to speak on behalf of the insured in litigation;

- apply all measures to obtain from third parties the reimbursement of their expenses and losses, which are paid by the insurer under the terms of the insurance contract;

- inform the insurer of all monetary amounts and other material values received from third parties for the reimbursement of expenses for claims that are subject to indemnification by the insurer.

In turn, the insurer must:

- make an insurance certificate;

- to pay the insurance indemnity for the damage caused by the insured in the terms specified in the insurance contract;

- in case of refusal to appoint its experts, advocates and other persons for claims and litigation or settlement of losses in connection with an insurance case – to compensate the insured actual expenses for the payment of the activity of these persons.

The amounts of the insurance indemnity are determined by the insurer after the agreement with the insured on the basis of the insurance case certificate, taking

into account the official claims of the victims about the damages caused, other necessary documents on the facts, the consequences of the damage, as well as confirmation of the costs incurred.

The insurance contract sets the monetary amount (which is called the liability limit for the whole term of the contract), within which the insurer is obliged to pay the insurance indemnity under the contract.

The policyholder is obligated to conclude an agreement prior to the beginning of activities related to the carriage of dangerous goods. Without it, police, for example, will not issue permission for the carriage of such goods by road. If the carrier carries out the functions of the sender or the receiver, he must also insure his liability in full.

Overseas carriers' liability insurance is based on the legislation in force in each country on compensation of victims (including to a third person) caused during the period of operation of vehicles, including the carriage of passengers and goods. Thus, the responsibility of the carrier of the cargo begins from the moment of acceptance of the cargo to the carriage and is prolonged until its delivery to the destination with the indication of the consignee, who must be informed about the delivery of the goods.

6.4. Manufacturers and employers' liability insurance

Civil liability insurance enables the company to avoid additional financial costs caused by the necessity to compensate for damage caused to other legal entities and individuals in connection with the norms of civil law.

Workers' compensation insurance differs from other insurance lines in that benefits are set by state law and most employers are required to have coverage. Insurance texts classify workers' compensation as a form of social insurance because of its compulsory nature and other characteristics.

The workers' compensation system is designed to provide a statutory-based set of benefits that must be accepted by employees as their exclusive remedy for work-related injuries. The basic benefit structure is the same among the states but there are differences in the types of injuries covered and the amount of benefits paid. In all states, workers' compensation will pay for accidental injuries and occupational diseases that arise in the course of employment.

Medical benefits are essentially unlimited and are not subject to deductibles or co-insurance provisions. Indemnity or disability benefits cover wage loss from work-related injury, subject to limits and co-insurance provisions intended to give injured workers an incentive to return to work. Coverage requirements for rehabilitation expenses vary among the states. More recently, some states have experimented with allowing insurers and risks to coordinate workers' compensation insurance with medical insurance plans through variations of managed care, medical fee schedules and 24-hour coverage. Insurers also sell excess risks liability coverage for suits that workers are still allowed to file against employers. Because workers' compensation benefits are set by law, insurers compete on price and different services associated with workers' compensation

coverage, such as loss prevention and case management. Insurers also offer different pricing arrangements that vary the amount of risk retained by the insured in return for lower premiums or make other adjustments to reflect variations in risk. These pricing arrangements include retrospective rating plans, experience-based dividend plans, schedule rating and largedeductible policies.

Distinguish insurance: civil liability of enterprises exploiting hazardous production facilities; responsibility for pollution of the environment; producer responsibility for the quality of manufactured products; civil liability of owners of vehicles; liability to third parties during construction and installation work; liability insurance for non-fulfillment of obligations; responsibility of employers, etc.

Insurance of producer responsibility for the quality of manufactured products. The manufacturer can insure himself in case of harm to the life or health of the consumer of his products. The size of the sum insured, as a rule, is determined by the producer himself. Some insurers may set a minimum or maximum amount of such liability. Tariffs range from 0.1% to 2% of the insured amount, depending on the level of technological equipment and technical condition of the enterprise, the reliability of the storage of products, the type of packaging, etc.

The entrepreneur may additionally insure himself of the amount of legal expenses for the conduct of proceedings or to stipulate in the insurance contract compensation for the moral damage inflicted to third parties. Insurance companies responsible for liability insurance for the quality of products (works, services) must have highly professional personnel in insurance and quality management, which will guarantee a high level of service and efficiency.

Employer's liability insurance. An entrepreneur may not reimburse the damage that may be caused to workers during the working hours of life or health. The insurance company may, for a fee, make the necessary payments to employees who have been injured or died as a result of a fire, accident, heat stroke, poisoning, electric current, burns, etc. The insurer can assume an average of 0.11% to 3.8% of this amount. This range is explained by the fact that insurance companies significantly reduce or increase the tariff rate depending on the risk of a particular profession. Thus, in one and the same insurance company, the insurance policy of the employer's liability in the case of causing physical damage to the firefighter is 2,55%, and the librarian – 0,3%.

Insurance of trust loans offers entrepreneurs protection from unsatisfactory financial consequences, losses incurred by their own personnel, who, in view of their duties, need to trust property values.

The said insurance enables:

- avoiding unnecessary worries about tangible assets, which consists in the emergence of special instructions and instructions;
- to prevent direct losses and losses;
- to avoid in each case the need to obtain proof of the integrity of material values.

The insurer shall reimburse the policyholder for damage to property caused to him by his authorized persons by way of or as a result of the commission of

unlawful actions. Consequently, this insurance is a specific type of liability insurance for civil servants.

In recent years, a special kind of trust insurance has become the insurance of computer abuses. It protects the owners of computer systems from the losses they incur as a result of the use of electronic processing of information through external invasion of the computer system in order to damage the media, change programs, making fictitious accounts, withdrawals from them and their subsequent appropriation. The amount of insurance liability in these cases is established by agreement between the insurer and the insured.

Environmental insurance – is the insurance of civil liability of production that is a source of increased danger to the environment caused by harm that can be inflicted on citizens and legal entities as a result of accidental pollution of the environment.

The object of environmental insurance is the environmental interests that require insurance protection. Under the environmental interests understand the natural and social needs of the population in the use of natural resources, environmental protection and environmental security. As you know, the territory of Ukraine is recognized as an area of environmental disaster. Therefore, an effective direction in solving environmental problems is the introduction in Ukraine, taking into account global experience, environmental insurance as a mechanism for ensuring the country's environmental security. One of the options for implementing an effective environmental policy is the introduction of compulsory liability insurance for enterprises with a high environmental risk (first of all, enterprises of the chemical, oil and gas industry, metallurgical complex, which exert considerable pressure on the country's ecosystems). All other enterprises can carry out environmental insurance on a voluntary basis.

To date, there are a number of legislative acts regulating certain issues related to environmental insurance (environmental risk insurance, liability for damage caused by pollution of the environment, from the risk of radiation exposure). The right to make compulsory environmental insurance is granted to national insurers who have received a license for this type of insurance or an insurance company with the participation of the state.

Article 49 of the Law of Ukraine "On Environmental Protection" provides for voluntary and compulsory state and other types of insurance of citizens, their property, property and income of enterprises, institutions and organizations in the event of damage caused by pollution of the environment and deterioration of the quality of natural resources. Such a wording is rather general, and therefore requires further specification and development of the legal mechanism for its implementation. In addition, this law does not define the definition of environmental insurance.

The Law of Ukraine "On Insurance" does not classify environmental insurance as compulsory insurance. The obligatory environmental insurance includes:

- insurance of civil liability of the operator of a nuclear installation for damage that could be caused by a nuclear incident;

- insurance of civil liability of economic entities for damage that may be caused by fires and accidents at objects of high danger, including fire and explosive objects and objects, the economic activity of which may lead to accidents of environmental and sanitary-epidemiological character;

- insurance of civil liability of the investor, including for damage caused to the environment, to the health of people, under the agreement on the distribution of production, unless otherwise provided by such an agreement;

- property Risks Insurance in Industrial Oil and Gas Field Development; - liability insurance of the exporter and the person responsible for the disposal (disposal) of hazardous waste, in respect of compensation for damage that may be caused to human health, property and the environment during the transboundary movement and disposal (disposal) of hazardous waste.

Obligatory environmental liability insurance of owners of sources of increased environmental hazard is a prerequisite for obtaining a permit for the operation of high-risk objects.

Compulsory insurance is also subject to enterprises and organizations whose activities are related to accidental pollution of the environment. Insurance funds under compulsory environmental insurance can be created and accrued at the expense of insurers' contributions; at voluntary – at the expense of contributions from profits (income) of enterprises, organizations and institutions that remain at their disposal.

When voluntary environmental insurance of individuals, insurance premiums are formed at the expense of their funds, as well as funds of enterprises. As the losses caused by damage to the environment and penalties imposed on companies that give rise to environmental accidents often exceed their financial capacity, then reserve funds and compensation for losses due to environmental disasters may be by mutual insurance industry.

To align risk and increase the sustainability of insurance companies, it is necessary to attract as many clients as possible, in particular with different responsibilities. This reduces the risk of loss and allows you to more accurately calculate such a risk using the law of large numbers. For the further development of the environmental insurance system, it is necessary to develop an effective legal mechanism that will enable intensification of the environmental transformation in the country.

Various other coverages have been developed to protect individuals and businesses against their liability exposures from their activities. Individuals can purchase personal liability insurance separately or as part of their homeowners coverage. They also can buy umbrella policies that provide broad liability coverage at relatively high limits (e.g., $1 million) in excess of the liability coverage provided by their auto and home policies.

Different business liability coverages also are available to cover specific risks, such as product liability, professional liability or errors and omissions, directors and officers liability, and employment practices liability. Commercial general liability policies offer broad coverage for liability exposures arising from commercial activities. Coverage can be purchased on an occurrence basis or a

claims-made basis. The trigger for occurrence policies is bodily injury and property damages that occur during the policy period. The trigger for claims-made policies is the filing of a claim during the policy period. Insureds also can purchase tail coverage separately if they purchase a claims-made policy. Tail coverage provides insurance against claims reported after the end of the policy period.

The question for self-control

1. Expand the objects and risks of car insurance insurance.
2. Land transport insurance.
3. Insurance of civil liability of owners of vehicles.
4. International insurance system "Green Card".
5. Insurance of civil liability of carriers.
6. What expenses are not reimbursed to the policyholder when insuring vehicles?
7. On what basis will the insurance indemnity be paid?
8. What powers does the Motor Transport Insurance Bureau of Ukraine have?
9. How is damage calculated in case of damage or loss of a vehicle?
10. What is the reason for the large number of restrictions on motor insurance insurance?
11. Insurance of producer responsibility for the quality of manufactured products.
12. Insurance of employer's liability.
13. Insurance of credit of trust.
14. Ecological insurance and its main types.

Topic 7. BASES OF REINSURANCE AND CO-INSURANCE

Methodical recommendations for studying the topic

At the beginning of the topic, it should be clear that reinsurance is a "secondary" risk insurance that is taken by itself.

After that you need to define the purpose, specific features, functions and principles that rely on reinsurance.

Important in assimilating material is understanding of the mechanism of transferring insurance risk to reinsurance. Particular attention should be paid to the methods and forms of reinsurance.

It must be understood that in each individual case, reinsurance contracts have their own particular features, differing in the shares of the parties' participation, the rates of the premium, their own maintenance. It is advisable to pay attention to the disadvantages and advantages inherent in the types of reinsurance contracts.

For a more profound mastering of the topic, it is recommended that you familiarize yourself with current legislative and guidance material, statistical data describing the amount of reinsurance.

For a better understanding of the issue of coinsurance, it is advisable to make comparative characteristics of this category with insurance and reinsurance, to determine their common features and differences.

Mini-lexicon

reinsurance, co-insurance, assignment, cession, cession, retrocession, reinsurance contract, blind, reinsurance commission, quota, excerte, immit of insurer's liability, own maintenance, reinsurance contract, bonus, disproportionate reinsurance, proportional reinsurance, optional reinsurance, obligatory reinsurance.

7.1. Peculiarities of reinsurance in insurance activity

Reinsurance is a component of the insurance market and is quite a common branch of financial and economic activity. He is considered "secondary" insurance. Reinsurance comes and depends on insurance. The insurer, giving one or more reinsurers a part of the risk that exceeds its financial capabilities, achieves a reasonable homogeneity of risks and ensures the balance of its insurance portfolio.

Reinsurance features:

- makes it possible to take on insurance very expensive and unique risks;
- promotes the introduction and distribution of new types of insurance.

The need for reinsurance comes from the objective impossibility of one, even the largest and most powerful, insurance company to take on the insurance of particularly dangerous and significant volume risks.

Reinsurance operations are a prerequisite for ensuring insurers' solvency and reliability, safety and diversification of the insurer's insurance reserves placement if:

- the insurer undertakes insurance liabilities in volumes that may exceed their ability to execute at the expense of their own assets;
- the insured amount for a particular object and type of insurance exceeds 10% of the amount of paid charter capital and created insurance reserves at the last reporting date.

The basis for reinsurance is an agreement under which one party - the insurance company (the assignor) transfers the insurance risk in full or in part to the other party – the insurance or reinsurance company (reinsurer), which, in turn, undertakes to pay to the assignor the relevant part of the insurance indemnity in the event of an insured event.

It should be noted that by handing over to the reinsurer some of the responsibility from the assumed insurance risks, the assignor gives him a certain part of the insurance premiums received.

The process of transferring risk is known as risk tracing or reinsurance cession. A risk-taking insurance company is called a trustee or reinsurer, and a risk-taking reinsurer is a cession holder.

However, the risk adopted by a certain reinsurer from the assignor is often subject to further transfer to a fully or partially another reinsurance company, which has received the name of the retrocession. In such a case, the reinsurance company, which pays the risk of reinsurance to a third party, is called a retroclient, and the one who takes the risk is a retrocessional.

The mechanism for the transfer of insurance risk is shown in Fig. 4.

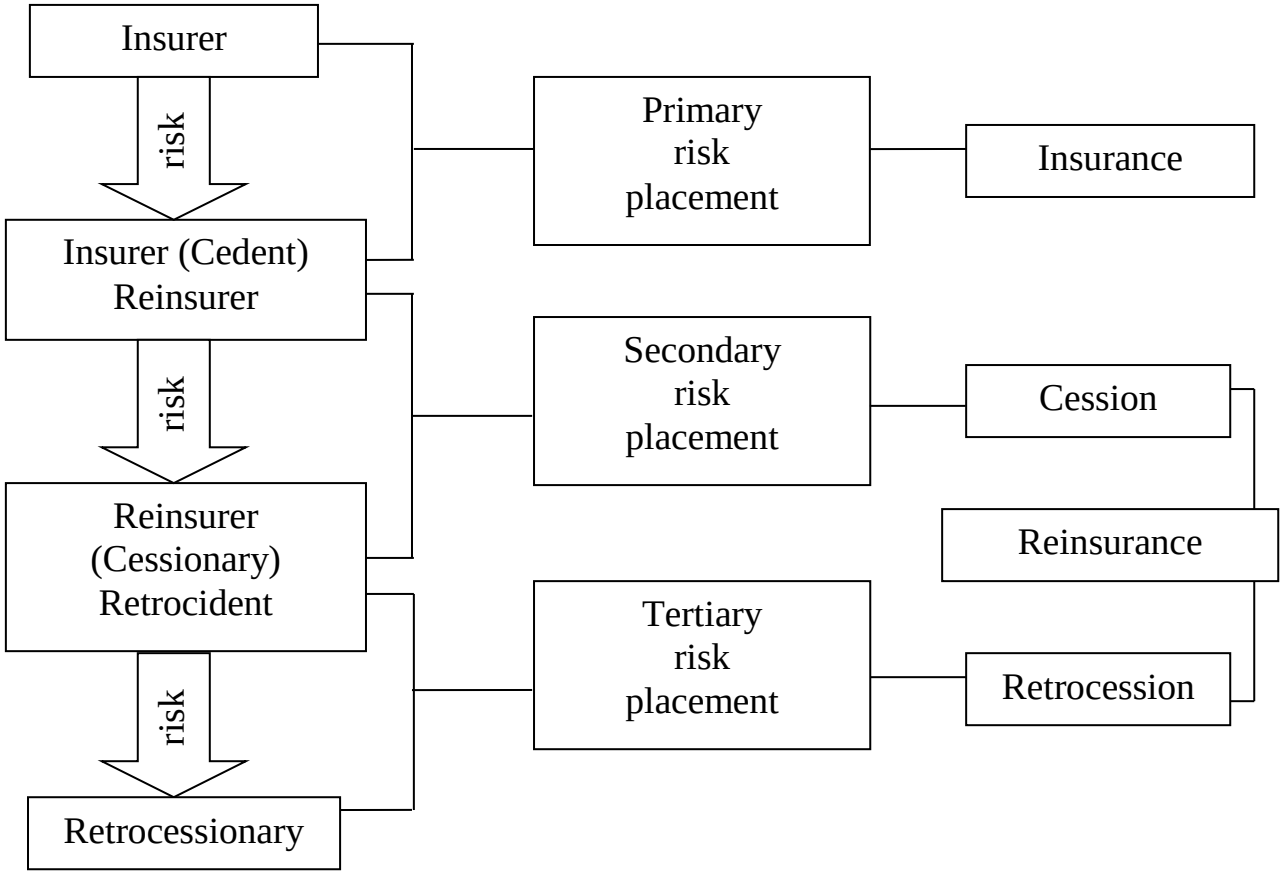

Fig. 4. The mechanism of insurance risk transfer

The insurer himself decides which part of the risk to be transferred to reinsurance, and which to leave on their own maintenance. For each type of risk, insurance companies make tables of their own retention limits. Actual retention is a definite part of the sum insured, which the insurance company leaves or "holds" on its own responsibility and within the limits of which it considers it expedient to compensate for probable losses. Shares of risks exceeding a certain level are transferred to reinsurance.

Uniform reinsurance contract does not exist today. The main types of insurance, the responsibility for which is today reinsured in Ukraine, is insurance of property of legal persons, insurance of cargoes, casco (air, sea, automobile), civil liability. The largest reinsurance markets in the world are London, European and American.

An Obligatory Reinsurance Agreement is an agreement that covers the entire insurer's insurance portfolio for a particular type of insurance or a significant part of it.

In the process of long-term development of reinsurance relations, certain methods of transferring risks to reinsurance have been developed. Reinsurance can be carried out by an optional method (optional) and by obligatory method (obligatory). There is also an optional obligatory or mixed reinsurance method. These methods differ from each other by the obligations of the parties arising from the terms of reinsurance contracts.

The optional reinsurance method is characterized by the full freedom of potential parties to the reinsurance contract: the assignor – in deciding which part of the risk to leave on their own maintenance; the reinsurer – in resolving the issue of accepting a risk in one or another volume.

An optional reinsurance contract is an individual agreement, which in most cases relates to one risk. The insurer, offering the risk of optional reinsurance, must provide the reinsurer with as much information as possible about this risk. He prepares for the reinsurer the blind (a document proposal that contains the main characteristics of the risk) and transmits it directly or through a broker to one or more reinsurers.

Obligatory reinsurance obliges the assignor to transfer to the reinsurer within the limits of a certain share all risks of the same kind of The transfer takes place only when they are the insured amount exceeds the insured's own participation. An obligatory reinsurance agreement is an agreement that covers the entire insurer's insurance portfolio for a particular type of insurance or a significant part of it.

In practice, there is also an optional bond agreement, which gives the assignor the freedom to make decisions: what risks and in what amount should be transferred to the reinsurer. In turn, the reinsurer must accept hedged parts of risks in advance of specified conditions. So thus, the option is provided for the insurer, and obligatory – for the reinsurer. Reinsurance payments are determined on an individual basis with the consent of the parties or in proportion to the insurance payments received at the conclusion of the original insurance contract.

Efficient insurance markets require insurers to further diversify their risk through reinsurance, investments and other vehicles to lower the risk of insolvency and increase their capacity to write insurance on a primary basis. Reinsurance is the purchase of insurance by an insurer to cover all or a portion of its loss payments on its insurance contracts. The insurer buying reinsurance, in effect, cedes premiums and losses from its book of business to a reinsurer. The reinsurer assumes these premiums and losses and pays a commission to the ceding insurer to cover transaction costs incurred by the primary insurer.

The reinsurer, in turn, may cede premiums and losses to a retrocessionaire, which is a company that sells reinsurance to reinsurers. In this way, the reinsurance market helps to further diversify risk and allows ceding insurers to retain higher amounts and concentrations of exposures. This yields efficiencies for primary insurers in terms of economies of scale and scope. Insurers purchase reinsurance to reduce their risk and drain on surplus from unearned premium and loss reserves, increasing their capacity to write more business. This is particularly helpful to rapidly growing insurers. Reinsurance also helps protect an insurers' surplus

against higher than anticipated underwriting losses and benefit payments and the impact of catastrophes on underwriting results.

There are several types of reinsurance contracts, which are all designed to reduce or limit the ceding insurer's risk. Facultative reinsurance contracts are used on specific risks on a case-by-case basis when the primary insurer wants to write a risk that exceeds the amount of exposure that it wishes to retain. Facultative contracts are most frequently used for a large amount of insurance on a single risk. This type of contract is flexible in that it can be tailored to a specific risk.

However, it is negotiated and written on a caseby-case basis, which delays issuing the primary policy. The alternative is an automatic reinsurance treaty contract under which the reinsurer agrees in advance to assume a portion of the business of the primary insurer. The primary insurer also is obligated to cede this business. This type of contract offers efficiencies in terms of timing and lower transactions costs. It is most suitable for a large number of small risks that are more homogeneous in terms of their characteristics and coverage than large, more unique risks.

Reinsurance is used in the life-health and property-liability insurance sectors, but the nature of their contracts in these sectors differ somewhat, reflecting the different types of coverage that are provided. Property-liability reinsurance agreements may require the reinsurer to share every loss with the ceding insurer or only pay after a loss reaches a certain dollar amount. A ceding insurer may arrange several different contracts on the same risk or group of risks with different reinsurers.

In a quota share treaty, the assuming and ceding insurers share losses and premiums according to some agreed proportion. In the example the assuming and ceding insurers each pay 50 percent (or $100000) of a $200000 loss. The reinsurer and primary insurer share premiums at the same rate, but the reinsurer also pays a ceding commission to the primary insurer to compensate for the first-year acquisition expense incurred on writing the primary policy.

In a surplus share treaty, the reinsurer assumes some amount of insurance on each risk in excess of a specified retention limit. The amount of insurance under the limit is retained by the primary insurer. Typically, the reinsurer agrees to assume some multiple of the retention limit or "line" that establishes a maximum amount the reinsurer is obligated to pay. Using the example, if the line is $15000 and the multiple is three: On a $200000 loss, the reinsurer will pay $45000 and the ceding insurer will pay $155000. Primary insurers may purchase several layers of this type of reinsurance in order to reduce their risk of large losses.

Under excess-of-loss contracts, the reinsurer pays losses in excess of the retention limit, up to specified maximums for a specific risk and occurrence; e.g., a hurricane. For example, if a primary insurer suffers losses of $200000, with a retention limit of $20000 and a maximum of $80000, the reinsurer would pay $80000. Again, the primary insurer may purchase additional layers of this type of reinsurance beyond $80000 from other reinsurers for large risks.

Life insurers use a term insurance or a coinsurance approach to reinsurance. Under the former, the primary insurer purchases yearly renewable-term insurance

on the difference between the face value of a policy and the reserve. This approach can be used on either one large policy or a number of policies to avoid large losses or fluctuating operating results. Under the coinsurance approach, the primary insurer cedes a portion of the face amount of the policy, as well as the reserve, for a death claim. This allows the ceding insurer to reduce its policy reserves and write additional business.

A reinsurance agreement is a contract between insurance companies. A ceding insurer transfers risk to an assuming reinsurer, the insurance company (or companies) that assumes all or part of the risk of one or more insurance policies issued by the cedent. Reinsurance agreements may be negotiated either directly with a reinsurer or arranged through the use of a third-party, a reinsurance broker or intermediary. Reinsurers, themselves, also purchase reinsurance protection, principally for the purposes of further spreading risk and reducing the impact of catastrophic loss events. This is called retrocession.

Reinsurance agreements are contracts of indemnity in that the reinsurer's obligation arises only when the company's liability under its original insurance policy or reinsurance agreement has been incurred. The extent of that obligation is defined by the specific terms and conditions of the applicable reinsurance agreement. Absent specific agreement to the contrary (for example, a "cut-through" provision in which the obligations of the reinsurer will be paid directly to the insured or claimant under the original policy), there is no privity of contract between the reinsurer and any party other than the company defined as the "reinsured" in the reinsurance agreement.

Reinsurance transactions in the insurance industry are becoming increasingly complicated. Companies may employ numerous reinsurance transactions with a variety of specific details, but typically, there are seven basic explanations to account for the companies' desire to engage in reinsurance:

1. Expand the insurance company's capacity – insurance company capacity is the maximum amount of risk the insurer can undertake in accordance with the company's surplus. By engaging in reinsurance transactions, companies are able assume more risk and obtain premium income while transferring a portion of the insurance risk to assuming companies.

2. Stabilize underwriting results – significant individual losses have the capacity to worsen the insurance company’s overall underwriting results. By engaging in reinsurance the insurance company has the capability to limit the impact of these individual large losses on its overall underwriting results by transferring a portion of the risk to other companies.

3. Financing – statutory accounting rules prohibit the capitalization of acquisition expenses. Although the revenue from the insurance policy is earned over the policy term, the commissions paid to agents for new or renewed insurance policies must be recognized immediately. As this directive could put a financial strain on insurance companies, the commission allowances permitted under specific types of reinsurance transactions may assist in alleviating the strain on the company's surplus.

4. Provide catastrophe protection – insurance companies may provide insurance for various types of perils in which one act may significantly impact numerous insurers for extensive amounts. It is vital for insurance companies to remain solvent by minimizing the financial impact of a single catastrophic loss occurrence (e.g., 1 in 250 year storm event).

5. Withdraw from a line or class of business – insurance companies may decide to stop writing a particular line or class of business. The insurer can transfer, or retroactively cede, risks to reinsurers that will assume the obligations of the primary insurer.

6. Spread of risk – reinsurance permits companies to lessen surplus strain and improve their capacity levels. It also enables companies to increase the amount of risks assumed and policies written as well as provides opportunity to engage in various types of risks among classes and businesses. This provides the company with the opportunity to improve the stability of underwriting risks and overall performance.

7. Expertise – insurance companies may look to reinsurers for advice and counsel concerning underwriting guidance and information on forms, rates and loss experience on lines of business the company is considering entering. Companies may also look to their reinsurers for guidance concerning investments, personnel recruiting, claims reserving, engineering and acquisition of other companies.

Reinsurance, reduced to fundamentals, is therefore a contractual promise to pay, which depending on the type of insurance business ceded will not be presented for collection until long after the contractual obligations are created (primarily with respect to casualty/liability lines of business). As the primary insurance is not relieved from its obligation to its policyholder, the ceding entity is compelled to indemnify its policyholder irrespective of whether the reinsurance fulfills their contractual "promise to pay".

Long-term continuity has historically been an important element in reinsurance relationships. The reinsurance agreement entered into today is quite likely to have a financial impact on both parties that may persist over many years. The ultimate underwriting result on the contract may not become fully apparent until long after the agreement itself has expired or been terminated. However, the reinsurance arena is increasingly becoming more transaction-driven rather than relationship-based, which increases the importance of ensuring that adequate protections are explicitly and clearly incorporated into the contract at the outset.

Close attention must be paid to the nature and structure of the company's reinsurance arrangements, since they can have a substantial impact on the company’s operating results and overall financial condition. Evaluation of the quality of reinsurance partners and the degree to which the company's surplus is leveraged by reinsurance recoverables should be given a high priority in every regulatory examination.

The U.S. regulatory community has long-recognized the need for both U.S. and non-U.S. reinsurance capacity to fulfill the needs of the U.S. marketplace. Consequently, the U.S. has developed a system of reinsurance regulation that has

led to the development of an open but secure reinsurance market where nearly half of the reinsurance premiums are reinsured outside the U.S.9 According to 2004 NAIC statistical data, reinsurance premium was ceded to approximately 2,300 reinsurers. Approximately 60 countries receive U.S. premiums, although 96.4% of reinsurance premiums ceded outside of the U.S. go to the top 10 countries and 85% to the top 4 countries10.

EU Directive on Reinsurance

In October 2005, the European Union adopted a Directive on reinsurance. The Directive extends to reinsurance undertakings the existing system for EU insurance undertakings under which the authorization and financial supervision is the responsibility of the supervisory authority of the Member State in which the reinsurance undertaking has its head office (home country control) in accordance with harmonized reinsurance supervision rules. On this basis, reinsurance undertakings are able to operate throughout the EU ("single passport"), either by establishing themselves in other Member States, or by providing services directly from their home or another Member State.

The EU Reinsurance Directive sets out minimum regulatory requirements that Member States agreed amongst themselves were essential, necessary and sufficient for mutual recognition purposes and that are consistent with internationally agreed standards produced by bodies such as the IAIS (International Association of Insurance Supervisors). The EU Reinsurance Directive prohibits Member States from introducing or keeping rules requiring EU reinsurers to post collateral. Rules requiring reinsurers to post collateral were prohibited, because it was felt that they represented both a barrier to the creation of an internal market and because a system based on mutual recognition was more appropriate for today's international reinsurance markets than a system that relies primarily on the posting of collateral.

Under the Directive, the home Member State will require every reinsurance undertaking seeking a license to limit its object to the business of reinsurance and related operations, to submit a scheme of operations and to possess the capital to fulfill the minimum guarantee fund requirement. The persons running the reinsurance company shall be of good repute and with appropriate professional qualifications or experience. The Directive also sets out prudential rules for the supervision of reinsurance undertakings. These prudential rules are similar to those already applied in the Insurance Directives.

It contains rules on the establishment of technical provisions, including the use of accepted actuarial methods for the purpose of calculating (mathematical) provisions, and rules on the investment of assets covering those technical provisions. It also lays down rules on required solvency margins and minimum capital requirements as well as rules on measures to be adopted by regulators if reinsurance undertakings are in financial difficulties. Reinsurance companies are obliged to report regularly to the supervisory authorities in accordance with their instructions. They shall ensure that they have sound administrative and accounting procedures and adequate internal control mechanisms. Furthermore, under EU law, the financial statements of reinsurance undertakings have to be audited and

auditors are required to communicate to competent authorities any possible infringement to the rules they may find whilst carrying out their duties. Also, under the EU Reinsurance Directive, reinsurers as part of an insurance group are subject to supplementary supervision in accordance to the EU Directive dealing with Insurance Groups. Under the directive dealing with the supervision of financial conglomerates reinsurance companies are also included in the supplementary supervision.

France

Insurance and reinsurance companies in France are supervised by the Commission de Contrôle des Assurance, des Mutuelles et Institutions de Prévoyance (CCAMIP). The CCAMIP ensures that undertakings are in a position to meet (financial supervision) and do meet (performance supervision) their underwriting liabilities.

Direct insurers assuming reinsurance are subject to full direct supervision of their whole business. French direct insurers are subject to licensing requirements, minimum solvency (i.e. capital requirements), reporting requirements and investment restrictions (based on EU directives – coverage of technical liabilities with admitted assets).

French reinsurers are submitted to authorization and are supervised by the CCAMIP. In the present regulation, the supervision and solvency requirements applying to reinsurers are lighter than those applying to direct insurers. However these requirements will be reinforced by the implementation in France of the EU Reinsurance Directive.

Germany

Pure reinsurers have to meet the same standards as primary insurers concerning capital requirements. A respective amendment (sec. 119 to 121e and sec. 123b) of the German Insurance Supervision Law (Versicherungsaufsichtsgesetz - VAG) has been adopted at the end of 2004. Pursuant to sec 53c in connection with sec 123b VAG, reinsurance companies have to have an amount of unattached equity capital, which enables them to fulfill their contractual obligations at any time.

This amount has to be, as a minimum, at least as high as the required solvency margin; the overall business volume determines the solvency margin. With respect to defining solvency margin requirements, sec. 121d VAG refers to the respective European Community Directive (Solvency I). Insurance undertakings that carry on both reinsurance and primary insurance business have to subject their entire technical insurance and reinsurance business to the solvency requirements applicable to primary insurers – also based on the above-mentioned sections of the VAG and on the Solvency I Directive.

Moreover, reinsurers are to be taken into account in the calculation of the adjusted solvency margin of an insurance group and of a financial conglomerate. The supervisory authority may take any precautions and orders which are necessary to ensure that reinsurance undertakings are able to meet their obligations arising from reinsurance relationships at all times. The funds of reinsurers have to

be adequate in order to fulfill all obligations under the existing reinsurance contracts.

United Kingdom

The FSA requires that a firm must at all times maintain overall financial resources, including capital resources and liquidity resources, which are adequate, both as to the amount and quality, to ensure that there is no significant risk that its liabilities cannot be met as they fall due. The UK does not differentiate between insurers and reinsurers for these purposes. Firms must, as a minimum, meet the European Community Directive requirements. The EC requirement is based on the higher of a percentage of premiums or a percentage of claims calculation, with a minimum.

In addition, the FSA requires firms to make their own assessment of the capital it needs given the nature of risks and risk mitigation that the firm has. The FSA reviews these firm assessments and may then give guidance to the firm as to the amount of capital the FSA considers it should hold. If the firm does not meet this level of capital, the FSA is able to restrict the amount of business the firm writes, or take other regulatory action. In addition firms are required to report the result of a risk based capital calculation with percentages applied to premiums, claims, and assets, with the percentages depending on the line of business, and generally expected to explain how their own capital assessment differs from this risk based calculation.

Lloyd's is also subject to the capital assessment framework described in the previous paragraph. For Lloyd's, the same principles apply, but the nature of this unique market means that there are differences in application. Each member has to hold a level of capital as assessed by Lloyd's annually. Each managing agent is required to assess, for each of the syndicates, the amount of capital required to support the risks that the syndicate is exposed to. The level of capital is subject to the EC minimum and regulatory review by the FSA.

Italy

Reinsurance companies are authorized and supervised by the Istituto per la vigilanza sulle assicurazioni – ISVAP. Currently the solvency requirements for primary insurers are not applicable to pure reinsurers that undertake exclusively reinsurance business. However the reinsurance undertakings are required to own a minimum capital requirement that varies from a minimum of $1 million Euros to a maximum of $5 million Euros according to the classes pursued. Moreover the submission of a scheme of the operations that the reinsurance undertaking intends to pursue is one of the conditions for granting the authorization.

The scheme of operations shall be accompanied by a technical report explaining the criteria according to which the scheme has been drawn up. The members of the board of directors and supervisory board (Italian collegio sindacale) as well as managing directors must meet fit and proper requirements i.e. they must be of good repute and possess adequate professional experience and qualification. Shareholders are subject to the requirements of good repute and financial soundness. The reinsurance undertakings are obliged to set up technical provisions and to cover them with appropriate assets even though current

regulations do not envisage any quantitative or qualitative limit for assets representing technical provisions. ISVAP has the same powers of supervision and sanction as for insurance undertakings and – based on the examination of the annual accounts of reinsurance undertakings – may request information and documents, make remarks, raise objections and conduct inspections on the reinsurance companies' premises and on all aspects of their activity. The regulations in force do not require collaterals to the reinsurance undertakings that operate in Italy in freedom of establishment or freedom of services.

Japan

Japan adopts a risk-based approach to regulatory capital requirements, which focuses on the major risks: insurance risk, assumed interest risk, asset management risk and operational risk (life and non-life business), and additionally catastrophe risk (non-life business).

Insurers are expected to maintain a regulatory minimum of 200% of the estimated value of the risks.

Switzerland

Pursuant to Art. 10 of the Insurance Supervisory Law (1978, as of 2000), Swiss reinsurers should provide necessary guarantee to the insured, in particular as regards their solvency and the organization and conduct of their business.

Accordingly, Swiss supervision procedures and industry practices require that a reinsurer's eligible or free capital amount to at least 20% of net premiums earned, but no less than CHF 10 million.

Draft regulations, currently being discussed, include detailed solvency margin and target capital requirements for Swiss reinsurers.

United States

In the U.S., individual states require reinsurers to maintain a minimum level of capital and surplus in order to establish and continue operations. In addition, the NAIC has adopted a risk-based capital approach, which applies to both direct insurers and reinsurers, and requires a risk-based capital ratio of not less than 200%. Financial solvency is also monitored through the use of financial profile reports, prioritization tools and financial analysis.

Separate risk-based capital formulae exist for life (re)insurers, property/casualty (re)insurers and health (re)insurers, using a four-tier system to indicate the severity of any capital deficiency. These formulae include components to assess risks related to reinsurance. Where the risk-based capital requirement is lower than a state's minimum capital requirement, the higher figure is required.

A study was carried out to look at the public disclosures of a sample of groups including significant reinsurance operations, covering the jurisdiction represented within the global reinsurance market statistics. Reference was made to publicly available consolidated financial statements and website information. This has been supplemented by further information from national supervisors within participating jurisdictions, including comments relating to regulation of reinsurers generally as well as specifically to disclosure.

It may be noted that EU listed groups will need to prepare consolidated financial statements in accordance with International Financial Reporting Standards with effect from January 1, 2005. This is significant because traditionally the different national accounting regimes for insurance companies have varied considerably. Following the need for a global standard in the field, the IASB has launched its project for an international financial reporting standard for insurance contracts.

The valuation of insurance liabilities (technical provisions) is at the very center of an on-going discussion. Since insurance liabilities represent the insurer's obligations vis-à-vis the policyholders, the valuation of those liabilities is crucial for a true and fair view and proper assessment of an insurer's overall financial position and the determination of capital requirements.

Bermuda

There are five classes of license under the Insurance Act comprising Long-Term insurers and four nonlife classes. The table below summarizes the different classes of license and the relevant key requirements of the Insurance Act. In Bermuda, companies falling into the Class 4 category undertake the most significant professional reinsurance business.

Under the Insurance Act, every Class 4 insurer is required to file annually a statutory financial return and statutory financial statements within four months of the insurer’s financial year-end. Penalty fines may be incurred if filings are not made as required. The statutory financial return includes:

Audit opinion from an auditor approved by the Supervisor, stating that the auditor carried out a proper examination of the insurer’s statutory financial statements, and that the examination was conducted in accordance with an accepted auditing standard. Cover sheet describing the types of business conducted, whether it is written on a direct/reinsurance basis, premium by related/unrelated categories, description of stop loss reinsurance cover, and whether loss reserves are discounted.

A declaration of statutory ratios, which includes a premium to statutory capital and surplus ratio, a five-year operating ratio, and a change in statutory capital and surplus ratio. A Loss Reserve Specialist Opinion from a fully qualified actuary in respect to the insurer's loss and loss expense provisions. Schedule of Ceded Reinsurance, a list of the reinsurers the company has contracts with, including their jurisdiction, rating, premium ceded, amounts owing to the reinsurer and a listing of aged recoverables owed from the reinsurer.

Form 1 – Statutory Balance Sheet – general business, a prescribed line-by-line listing of all assets, liabilities and statutory capital & surplus.

Form 2 – Statutory Statement of Income – general business, a prescribed line-by-line listing of all revenues and expenses.

Form 8 – Statutory Statement of Capital and Surplus, a detailed breakdown of the amounts that make up the statutory capital and surplus. Notes to the Statutory Financial Statements.

The regulations do not require any of the information submitted to be made available to the public. However, most of the Class 4 companies licensed in

Bermuda are publicly traded in the U.S. stock markets, and file extensive financial disclosure statements with the U.S. Securities Exchange Commission (SEC). The generally high level of financial security in Bermuda, coupled with very stringent solvency margin requirements for the Class 4 sector, has allowed most of the Class 4 companies to achieve A ratings from the internationally recognized rating agencies.

All prepare audited financial statements and obtain A M Best's, Standard & Poor's, Moody's, and/or Fitch Ratings to which they submit extensive financial disclosure materials including both material quantitative and qualitative information.

Reinsurers present consolidated financial statements (balance sheets, income statements, cash flow statements, and statements of changes in equity). In addition, SEC rules require the comprehensive disclosure regarding the use of financial instruments including their use of derivatives and other hedging activities. Further, the publicly traded companies are required to provide "market risk" disclosures, both quantitative and qualitative about all financial instruments presented "outside" the financial statements.

Moreover, market analysts such as Goldman Sachs and Merrill Lynch review detailed financial data and provide extensive reports on company performance and forecast for the future.

France

The current supervisory framework for reinsurance and insurance companies in France is based on a single set of accounts that is used for both accounting and supervisory purposes. These accounts – balance sheet, profit and loss account and annex, including a detailed list of investments – are public documents. Firms usually provide financial statements (balance sheets, income statements, cash flow statements and the complete list of investments with their localization, market and book value) with notes, which provide details on their premiums, assets, investments, liabilities and debt.

Some information is also provided in the annual report (technical result with premiums, claims, provisions and expenses by class of business, and also premiums and claims by region, information on risk management, business strategy corporate management and retrocession). Some firms also disclose information on their share capital, alternative risk transfer, derivative financial instruments, and claims development triangle.

Parent companies also have to publish consolidated financial statements with notes on their consolidation methods and list of consolidated entities.

More detailed information is reported to the supervisor in the form of CCAMIP returns, referred as "C reports" (annual) and "T reports" (quarterly), which are not publicly available. The information provided by insurers and reinsurers in these returns includes:

C1: detailed technical results by insurance category and sub-category,

C2: liabilities and technical results by country,

C3: reinsurance accepted and ceded (with a distinction between intra-group and external reinsurance),

C4: premiums per type of guarantees,

C5: insurance liabilities and assets backing those liabilities (not for pure reinsurers),

C6: solvency margin: required margin and eligible equity components (not for pure reinsurers),

C7: projection of the solvency requirement of the society for the next 5 years (not for pure reinsurers),

C8: description of the reinsurance covers (not for pure reinsurers),

C9: detailed list of the reinsurers and stress testing of the reinsurance cover (not for pure reinsurers),

C10-C11-C12: loss development triangle by insurance category and sub-category (non-life),

C20-C21: detailed information per contract (life).

T1: information on activity (premium, number of contracts sailed, amount and number of claims occurred),

T2: list of investment by class of assets (at book value and market value),

T3: stress testing analysis on assets and technical provisions.

A: solvency report where the society demonstrate its future solvency (where the society have to explain both their internal control and process to maintain their solvency but also the results of their balance sheet projection under different scenarios).

A: report on the investment politics.

A: report on reinsurance politics (not applied to pure reinsurers).

Germany

External Accounting

Reinsurers and insurers have to prepare financial statements in accordance with general rules and specific regulations. These financial statements are based on the German accounting standards set forth in the German Commercial Code and other regulations. These focus very much on the creditor and not on the investor. The principle of prudence has top priority. Within 10 months of the financial year end, reinsurers have to draw up their annual accounts as well as an annual report. This generally happens much earlier. These documents must be submitted to the supervisor as soon as they have been drawn up, i.e., before they are made public.

The consolidated financial statements (balance sheet, income statement, cash flow statement, stockholder equity, comprehensive income, and retained earnings) include informative notes with details on their assets, market value investments, and liabilities; premiums, investment results and expenses. For the sample of reinsurers reviewed, companies offer information on their financial products business, including useful comments on their market, credit and liquidity risks, including ratings. Fair value of financial instruments is also available.

According to the Corporate Sector Supervision and Transparency Act (KonTraG) reinsurers have to set up a risk management system which identifies potential risks. Companies have an obligation to disclose information about such risks and the structure of the system. Additionally all reinsurers have to meet the requirements of the German Accounting Standard 5-20. Reinsurers have to prepare

a risk report under the rules of this standard. For the sample of reinsurers reviewed, disclosure includes details on the type, maturity, currency, and regional allocation of their assets and investments. Information on their provisions, debt (with some information on the characteristics of the instruments), and other liabilities is provided. Details on the class, claims, ratios, and regional allocation of premiums are available. General information on their risk management, business strategy, affiliated and subsidiary companies and principal officers can be found.

Auditor's report Reinsurers and insurers must have their annual accounts and the annual report audited by an auditor. BaFin has to be informed before his appointment and before the audit takes place. The contents of audit reports is stipulated in the 'regulation on auditor's reports' published by BaFin. Two copies of the audit report are to be sent to BaFin, together with the relating comments of the managing and the supervisory boards. Finally, the auditor's report on the managing board's statement about the relations with affiliated companies also needs to be presented.

Internal accounting

The term internal accounting refers to information an insurer has to submit to the supervisory authority only. The provisions applying to internal accounting are similar to the provisions for non-life insurers. They were laid down in a regulation in 199524 and last amended in 2005. The changes are part of a continuous improvement process at the BaFin aiming at a reduced administration effort and further risk oriented supervision. For this purpose some statements were omitted (compare the Global Reinsurance Market Report 2003) and some newly introduced (see below).

The present provisions require all reinsurers to submit the documents mentioned below, which have to have a certain format. The documents, which insurers have to put forward, provide not only a more detailed breakdown of the external accounts. They also allow a closer look into the reinsurer's business.

The documents that are to be submitted:

- Balance sheet (statement 100).
- Profit and loss account (statement 200) − (excerpts for the technical account): for the entire insurance business, for the entire reinsurance business accepted by domestic ceding insurers, for the entire reinsurance business accepted by foreign ceding insurers, for each class of insurance (very detailed split).
- Development of investments (statements 101).
- Income from and expenses for investments (statement 201).
- Statement 203 (newly introduced) additional information with respect to reinsurance, including details about individual technical profits and losses relating to the accepted reinsurance business (former statement 250). And information on inward and outward reinsurance business, by every direct insurer and reinsurer dealt with (former sample 1).
- Statement 251 (newly introduced) information about covering technical provisions.
- Statement 252 (newly introduced) information about the insurance-business and the contracts, and in particular details about technical claims

provisions. Moreover, information about individual technical profits and losses relating to the accepted reinsurance business (former statement 250).

- Statement 604 (newly introduced) quarterly information about the technical reinsurance business.

- Statement 671 (newly introduced) every six months information about technical provisions and details about the assets of reinsurers.

- Statement 688 (newly introduced) forecasting with a yearly cut-off date (30.06.) the respective development of the following months in advance. Finally, reinsurers also have to supply informal statements such as an outline of the methods they use for setting up the provision for claims outstanding.

Where applicable, the reinsurer has to present the consolidated financial statements, which may be prepared on the basis of either IAS or U.S. GAAP, including an auditor's report. The reinsurer is subject to the rules applicable to group supervision, if a primary insurer is involved also. In addition to information delivered on a regular basis, the supervisor may request from the reinsurer any other information it requires.

Italy

The primary information concerning reinsurance undertakings, available to any stakeholder is, generally speaking, contained in official company acts (accounts, annual report, internal and external auditors' reports, etc), regularly published by undertakings in conformity with existing domestic legislation. Reinsurers as well as insurers must have their financial statements checked by an auditor.

As concerns financial statements, based on the Civil Code, insurance undertakings are obliged to file their financial statements with the Chamber of Commerce and also, based on sector regulations, to file the audit report from the auditor. The deadline for the approval of the balance–sheet for pure reinsurers is 30 June (i.e. six months after the end of the year. On a reinsurance undertaking’s request based on specific reasons, the deadline may be postponed up to 30 September.

Japan

Insurance companies in Japan, including reinsurance companies, are subject to the disclosure requirements of the Insurance Business Law and relevant Enforcement Regulations. The industry association sets out further standards on disclosure. These result in highly comprehensive and standardized disclosures by Japanese insurers, including reinsurers.

In addition to the primary consolidated financial statements (balance sheets, income statements, cash flow statements, statement of retained earnings), companies disclose general information on business strategy, organizational structure, senior management and shareholders, as well as detailed information on investment activities, insurance activities, risk and solvency.

Information on investment activities includes, for example, asset management policy (qualitative), investment by class of asset, return on investment by class of asset, information on maturity (for securities and loans), information on debtors (for loans) etc. Information on insurance activities includes, for example,

details, by line of business, on policy liabilities, premiums, claims paid, insured amounts, underwriting profit, etc.

Also disclosed is information on derivatives such as the policy on the use of derivatives (qualitative) and notional and market values of derivatives by type of transactions. Information on risk includes a description on the risk management system and risk management policy. As for quantitative information, insurance risk, assumed interest risk and asset management risk are calculated and disclosed based on a formula set by the Financial Services Agency. The overall risk based capital adequacy ratio (solvency margin ratio) is also disclosed.

Details of the reports insurance companies are required to submit in connection with their financial results are included in "Financial statements" and "Business reports" as well as "Periodical monitoring" requirements.

1) Financial statement (required half yearly), which includes:

Overview of business result (summarized business result, ratios related to company management, statement of profits / losses, statements of assets, liabilities and capital). Balance of major accounts (state of securities, etc., insurance policy reserve, claims provisions, liability reserve), requiring a detailed breakdown by type of security or by class of business line. Business expenses (including claims expenses), requiring a detailed breakdown by type of expense Business result (business result of primary insurance, number of business contracts, amount of claims payment by class of business line, net business result, direct net premiums, direct net claims paid by class of business line).

Schedule of asset management (situation of asset management, proportion of assets invested with the same insurance company). State of risk-monitored loans (schedule required). Conditions of solvency adequacy for claims payment – Solvency Margin Ratio (Calculation of amount by type of risk is required). State of transaction with major shareholders.

2) Business report (required annually), which includes:

Overview of business situation and result. Indicators showing business result. A detailed breakdown or information for the above items is required. Shareholders' meetings, etc. (report on shareholders' meetings, dividend and surplus distribution, other matters to be reported). Balance sheets. Profit-loss statements. Statement of cash flows. Report on fund depreciation. Report on payment of fund interest. Report on profit appropriation. Report on loss disposition. State of securities (securities held for trading purposes, securities held for other purposes). Conditions of solvency adequacy for claims payment (Solvency Margin Ratio).

3) Periodical monitoring (required: (A) Monthly (B) Quarterly (C) Half yearly (D)Yearly), including:

Current situation of insurance business (balance of insurance business (B), state related to the third filed business (B), state related to new business by way of subscription (B). Liquidity risk (liquidity index (A), liquidity reserve (B)). Market risk (state of securities by purpose of holding (B), risk analysis table by category (B), state of derivative transaction (B), index related to securities retained (B),

interest rate risk related to reserved account (B), equity holding state by type of industry (C), list of top 20 shareholding balance in Japan (C).

Credit risk (basic information by rating (C), list of top 20 loaned companies (C), state of assets for largely-loaned companies (C)). Others (situation of invested assets (B), balance sheet by asset remaining period (C).

Switzerland

Swiss reinsurers publish balance sheets, income statements, shareholders' equity statements, and cash flow statements with informative notes to them. The consolidated information is complemented with information on business segments. These notes include information on investments (type of instrument, country, currency and maturity), derivative financial instruments (interest rate contracts, equity and index contracts, foreign currency and other instruments), acquisitions and dispositions, and debt in some detail.

Premiums are detailed by geographic allocation and line of business. Additional information on subsidiaries and equity investments is also available. General notes on the firms' risk management and business strategy complement the quantitative information.

United Kingdom

The Financial Services Authority (FSA) in the UK regulates both insurers and reinsurers, as well as Lloyd's, which is subject to the same requirements. For regulatory reporting purposes, no distinction is drawn between an insurer and a reinsurer.

The FSA's principal supervisory tool in monitoring UK authorized insurers and reinsurers is the requirement on these entities to complete and submit an audited return on an annual basis (the regulatory return). The regulatory return enables the FSA to monitor an insurer or reinsurer's solvency and also to assess any other risks and exposures the entity may face.

Each year an authorized insurer or reinsurer must prepare a regulatory return comprising, among other things, the revenue account, profit and loss account and balance sheet at the end of the year together with the annexed notes, statements, reports and certificates and it must be audited. The regulatory return must be submitted to the FSA within 2 months, 15 days of the year-end or if submitting electronically (on FSA Approved software) within 3 months.

The regulatory return is very detailed and comprises a number of standard forms, which must be completed.

Forms 9 to 17 report the detailed assets and liabilities (including derivatives) and profit and loss figures and compare these with solvency requirements.

The general business revenue (forms 20 to 39) largely comprises analyses of premiums and claims by class of insurance business. There are eleven accounting classes, broken down into eight classes for direct and facultative business and three classes for treaty reinsurance.

Accident year accounting is the normal basis of accounting for these forms. However the underwriting year accounting basis is also permitted and where this is adopted, a supplementary note must be included in respect of each accounting class, stating:

a) the reason for accounting for such business on an underwriting year basis,

b) the basis for distinguishing between such business and any other business falling within the same class accounted for on an accident year basis,

c) the accounting policy adopted for determining the provision for claims outstanding,

d) if the information provided in a to c differs in respect of risks incepted in the financial year in question from risks of a similar description incepted in previous financial years, the reason for the difference.

Information given for each accounting class is also further subdivided as follows:

a) direct and facultative business is broken down by risk group within each country or reported on a reconciliation basis,

b) treaty reinsurance business is broken down into business categories.

This information included in the revenue forms above is to allow the FSA to analyze, compare and monitor the performance by class of business and to assess the adequacy of claims provisions by comparing actual claims movements with technical provisions.

Companies writing long-term insurance business are required to complete forms 40 to 45, which give fuller details supporting the revenue forms and forms 46 to 61 give details supporting the valuation report by the appointed actuary.

The following details must also be provided:

1. additional information on general insurance business reinsurance ceded,

2. statements of major treaty reinsurers and cedants and facultative reinsurers (general insurers),

3. statement of additional Information on derivative contracts,

4. statement of information on controllers (UK insurers only),

5. statement of information about the appointed actuary (life insurers),

6. supplementary notes to the return to amplify the information given on the forms,

7. the certificates and auditors' report required by the regulations.

Companies in the UK generally adopt UK GAAP, which requires a significant amount of disclosure (detailed in Schedule 9a to the Companies Act 1985) and comply with applicable accounting standards, the ABI SORP as well as the Combined Code on Corporate Governance. In addition to the substantial information publicly available in the FSA returns, a considerable amount of information is also provided in the annual report (such as the segmental analysis usually provides an analysis of premiums, claims and expenses by region and major class of business). Information on assets and investments is normally summarized in the CEO's report, and details of the type of assets, their currency and investment returns are provided in the notes to the accounts. Information on risk the management framework and the management of key risk areas is included in the Statement of Corporate Governance.

United States

In the United States, from a regulatory standpoint, reinsurers are subject to the same regulatory template as employed for direct writing insurers. That means

that they are required to disclose the same level of extensive information as direct writers and that information is completely available to the public.26 The statement templates and instructions are specific to property and casualty insurance, life insurance, and health insurance.

The disclosures include a balance sheet, income statement, statement of cash flows, underwriting schedules showing direct, assumed and ceded premiums, losses and loss adjustment expenses by line of business (about 30 lines of business are included). Many of the financial schedules also include subtotals for affiliated/non-affiliated, authorized/unauthorized and pooling arrangements.

Investments schedules detailing each investment held as of a reporting date by type of investment (i.e., real estate, mortgage loans, bonds, preferred stocks, common stocks, other invested assets and derivative type investments with approximately 30 data items per investment, including statutory values and fair values), historical paid and incurred loss and loss expense development experience by line of business including reserve performance and detailed reinsurance information showing the source of all assumed premiums and the destination of all transferred business through cessions (facultative and treaty).

In addition, the disclosures require answers to numerous regulatory questions and detailed and formatted footnote disclosures. The statements disclose all investment activity in the interim of reporting periods and those interims are quarterly. Profit and loss per investment transactions are readily discernible.

Additionally, companies are required to file statements prepared by independent certified public accountants that disclose differences between their findings and those presented by companies in their filed statements. Also, companies are required to file, in the case of life companies, actuarial opinions and memoranda, and in the case of property/casualty insurers, loss reserve opinions, from qualified actuaries. The independent certified accountants' reports and the actuarial opinions are publicly available.

Publicly traded companies are also required to file additional information of the type noted above with the securities regulators. This information is also publicly available.

The regulatory system in the United States also provides that all material holding company transactions require filing prior to engagement. Some of those transactions above a relatively modest threshold actually require prior approval. Such transactions are disclosed to the public in the filed statutory statements. Mergers, acquisitions, changes in domicile, changes in form of an entity, changes in control, etc. all require prior regulatory approval. Sales of blocks of business require prior approval and appropriate disclosures. Dividends to stockholders are limited.

7.2. Features of co-insurance in insurance business

Co-insurance is an insurance in which two or more insurers take part in certain risks in the insurance of one and the same risk by issuing joint or individual

policies, each for the sum insured, which he has to pay at the onset of an insured event.

One company issues a policy and agrees with the insurer, but does not assume all the risk, but only part of it, determined in percentage terms. In the future, this company, called the "parent organization", offers other insurance organizations to take on risks that remain outside insurance coverage until they are fully deployed.

Co-insurance provides significant benefits when taking particularly large and dangerous risks. The entire operation is often carried out by a broker who receives a commission from the principal insurer.

Following the principle of proportionate liability, each insurer meets its part of insurance obligations directly to the policyholder. As a rule, the insurer, who accepts a smaller portion of insurance risk for insurance, is subject to conditions agreed with the insurer, which holds a larger share of its liability.

Each co-insurer has a direct contractual relationship with the policyholder. The so-called "main" insurer is liable only for its share of risk, regardless of what happens to other insurers. If one of the co-insurers is not able to pay their share of the insurance indemnity, other insurers are not liable for this.

In coinsurance, the policyholder receives a policy that contains the names of all insurers involved in this process, indicating the shares that they have taken on their responsibility.

The question for self-control

1. The essence and theoretical basis of reinsurance.
2. Methods of reinsurance.
3. Forms of reinsurance operations.
4. Features of reinsurance of risks from non-residents.
5. Compensation and the mechanism of its application.
6. Conditions of reinsurance of risks in countries of the world.

Theme 8. BASES OF FINANCIAL ACTIVITIES OF THE INSURER

Methodical recommendations for studying the topic

When studying this topic, it is mandatory to familiarize with the current legislative and regulatory documents that relate to formation of income, expenses and profits of the insurer.

It is necessary to distinguish between the insurer's income, which he can receive directly from insurance, investment and financial activities.

After the definition of "income" to find out how the insurer formed, the composition and structure are determined by two interrelated processes: repayment obligations to policyholders and funding of the insurer. It is advisable to understand the specifics of determining the cost of insurance operations.

It is necessary to realize that by comparing incomes and expenses the insurer for a certain reporting period calculates the financial result of his activity, which is determined by the insurance operations as a whole.

It should be noted that the financial result of the activities of insurers may acquire a form of profit or loss.

Particular attention should be paid to the fact that under current tax law, insurers, as well as any entity paying national and local taxes and fees. For a more detailed consideration of the issue of taxation of insurance activities, it is recommended to work out the relevant articles of the Tax Code of Ukraine.

The theme should be started with the clarification of the notion of financial reliability in accordance with the Law of Ukraine "On Insurance".

Particular attention should be paid to insurance reserves, their formation and directions of use; get acquainted with the current normative documents, understand the difference of the technical reserves from the mathematical ones. It is advisable to consider examples of domestic insurance practice.

It is recommended to determine the purpose and sources of creating centralized insurance reserves.

Study of the investment activity of the insurance company it is advisable to begin with the meaning of the development by the insurance company clear investment strategy, familiarization with legislative documents, which defines the directions of investment of funds. Then consolidate real examples from periodicals, proving that insurers are real and potential domestic investors.

It is recommended to determine the preventive measures that insurers recommend to insurers.

Mini-lexicon

gross income of the insurer, income from insurance activities, expenses insurer, the cost of insurance services, financial performance of the insurer earned premiums, income from insurance business, the return on investment, profit rate of financial reliability, insurance reserves, reserves for life insurance technical reserves, the equity share capital, insurance portfolio, early warning, solvency, liquidity, free reserves, guarantee fund, placement of technical reserves, preventive measures.

8.1. Financial resources of insurance organizations

To provide the insurer with the provision of insurance protection, he must form and use the funds of the insurance fund in order to cover the losses of insurers, compensation of own expenses for conducting insurance operations, as well as the receipt of profits. In conditions of developed market relations, the insurance company, as a rule, invests temporarily free funds in investment activities. Therefore, the movement of cash and cashless funds of the insurer is quite complex and includes two relatively independent cash flows: the turnover of

funds, which is the source of insurance protection, and the turnover of resources associated with the conduct of insurance operations. Certain features are inherent in the movement of part of the funds of the insurance fund, which are invested in order to profit.

The most important feature of monetary turnover associated with the provision of insurance protection is the risk nature of the movement of funds. If the basis of the formation of an insurance fund is the probability of damage, which requires the study of statistical data and the application of the relevant sections of the theory of probability, then the use of funds from the insurance fund depends on the actual losses of policyholders in a particular year. The difference between the volume of the formed insurance fund and the needs for the payment of insurance indemnity also generates specific features of the organization of the insurance company's finances.

The possible discrepancy between the expected and actual loss causes certain requirements, first of all, to the size and structure of the tariff. In its main part (net-rate) must include a risk premium, which reflects the probability of a deviation of the magnitude of the actual loss from the expected – both in time and in space.

The higher the probability that a fund established by the insurance organization will be sufficient to fully compensate the insurers, the higher its financial stability.

As well as for any business structure, the activity of an insurance company is directed not only to the reimbursement of expenses, but also to profit. At the same time, the insurer should not seek to obtain an excessive profit from insurance operations, because such practice violates the principle of equivalence of its relations with the policyholder. In general, in the application of insurance, the notion of "profits" is rather arbitrary, because it does not create a national income, but only its redistribution occurs. For the insurer, the profit is such a positive financial result, which ensures the excess of its income over costs.

Income from insurance activities include:

1) insurance payments (insurance premiums, insurance premiums) under insurance and reinsurance contracts;

2) commission fees for reinsurance;

3) the share of insurance premiums and insurance reimbursements paid by reinsurers;

4) returned amounts of special insurance reserves of previous periods;

5) other income from insurance activities.

Expenditures of the insurer, in addition to the cost of insurance, is the payment of insurance premiums and insurance compensation, deductions in insurance reserves and for preventive measures.

The object of taxation of insurers is the profit received from insurance, reinsurance and financial activity, which can be carried out in accordance with the legislation. The insurer's profit remaining after the payment of taxes (net profit) is its property, and the procedure for its use is set by the insurer on its own. An important sphere of the movement of funds of an insurance organization is

connected with the formation of insurance reserves. They are foreseen for future insurance payments and insurance indemnities. Reserves are formed separately under contracts of life insurance, health insurance and risk insurance. Reserves are created by insurers by means of deductions from insurance premiums (insurance premiums, insurance premiums), as well as from revenues received from the allocation of temporarily free funds.

The reserves include:

a) technical reserves – insurance reserves that are created to ensure the fulfillment by insurers of their obligations under signed insurance contracts (from the compulsory types of insurance, technical reserves are created separately from other types of insurance);

b) free reserves – insurance reserves that act as additional insurers' solvency and are not bound by specific obligations under signed insurance contracts. In the case of insufficient reserves for insurance payments, they should be replenished at the expense of profits.

We draw attention to the fact that it is prohibited to pay out on risky types of insurance at the expense of life insurance and health insurance reserves. It is not allowed to use (reduce) volumes of republics for any purpose other than the insurer of payments.

For insurers there are certain obligations. They should create such technical reserves from market types of insurance:

- reserves of premiums (reserves of unearned premiums) – under contracts whose validity has not expired;
- loss reserves (reserved amounts of insurance indemnity under known insurers' claims).

Insurers may also independently create other reserves in accordance with the accepted technology of forming an insurance portfolio.

For insurers there are obligations to create such technical reserves for life insurance and health insurance:

- reserves of long-term liabilities (calculated separately for each contract);
- reserves of due insurance payments.

At least once a month, insurers are obliged to independently carry out the necessary redistribution of established reserves in accordance with the insurance events that have come.

When carrying out a reinsurance operation with an insurer (assignor), the amount of insurance reserves does not decrease after the transfer of the risk to the reinsurer. When making insurance premiums for reinsured risks, the corresponding reserves are reduced by the amount of the payments.

When reforming the balance sheet at the reporting date, insurers are obliged to replenish the corresponding provisions and reflect their use for insurance payments.

The conditions for ensuring the fulfillment of its obligations by the insurance organization are the availability of paid charter capital, the creation of insurance reserves, as well as the system of reinsurance.

The minimum amount of the authorized capital, in accordance with the Law of Ukraine "On Insurance", is set at an amount equivalent to EUR 1 million (EUR 1.5 million for the UK, which carry out life insurance) at the rate of the National Bank of Ukraine.

Insurers are obliged to adhere to normative relations between the amount of their authorized capital and insurance reserves and the volume of assumed insurance liabilities.

Insurance obligations, depending on insurance (перестрахування), except for obligatory, in relation to the amount of the authorized fund and insurance reserves, shall not exceed:

- from personal insurance, except for life insurance – 40-fold its value;
- insurance of all types of liability – 20-fold and value;
- from reinsurance – 10 times its value.

We draw attention to the fact that the maximum amount of insurance liabilities under a separate insurance contract can not exceed 10% of the amount of the authorized fund and insurance reserves.

In order to ensure life insurance, insurers must create separate reserves according to the methodology.

Insurers, who have assumed insurance collateral in volumes exceeding the limits of their ability to perform their own funds, should insure the risk of fulfilling their obligations to reinsurers.

Reserve funds are formed by the insurance company in order to provide future payments and necessary insurance compensation depending on the types of insurance (reinsurance) by deducting up to 50% of insurance payments for these types of insurance and other incomes. Insurance funds are formed in the currency in which insurers are liable for their insurance obligations. Reserves for life insurance are formed separately from reserves for risky types of insurance. Insurance organizations have the right to create reserve assets for the financing of measures for the prevention of accidents, losses and damages of the insured property, as well as by deductions from insurance payments within the limits established by regulatory enactments.

The duty of insurers is the placement of insurance reserves, other temporarily free funds, taking into account safety, profitability and liquidity. Reserves can not be placed (invested) in securities and the rights of participation of other insurers.

Loans to individuals-insurers who have concluded life insurance contracts must be within the limits that do not exceed the insurance premiums made under these contracts.

The costs of an insurance company reflect the use of its funds to secure its activities and determine two interrelated processes:

- fulfillment of obligations to policyholders;
- financing of the insurance company's activities.

Expenses insurer divided by the economic content of the following groups:

- payment of insurance sum and insurance reimbursement under insurance and reinsurance contracts;

- expenses for insurance business;
- costs of financing preventive measures;
- expenses in the course of investment activity.

The insurer's income reflects the entire amount of income and is divided into groups of activities:

- income from insurance activities;
- income from investment activity;
- other income.

Revenues from insurance activities are income from operating activities, including all revenues from insurance and reinsurance. These include insurance premiums under insurance and reinsurance contracts, commission fees, share of insurance premiums and insurance reimbursements paid by reinsurers. These revenues are formed at the expense of the insurance premium, which is based on gross-tariff.

The insurer's funds are "earned" after the expiration of the insurance contract, if during the period of this contract no insurance cases occur. By economic content, the insurance premiums earned are the result of the implementation of the insurance service.

The amount of insurance premiums earned depends on the amount of insurance payments and the change in the balance of unearned premiums. The above is expressed by the formula:

$$EIP = RIP + RUPb - RUPe,$$

where EIP – earned insurance premiums;

RIP – receipt of insurance payments, less insurance premiums paid to reinsurers under reinsurance contracts in a certain period;

RUPb – reserve of unearned premiums at the beginning of the reporting period;

RUPe – reserve of unearned premiums at the end of the reporting period.

Unearned premiums is part of the technical reserves of the insurer, are the insurance premiums received by the insurer, saved him before the expiry of the contract, not with the property insurer.

Reserves for unearned premiums are calculated on a quarterly basis depending on the amounts of insurance premiums for certain types of insurance in each quarter preceding the reporting date.

The difference between income and expense creates the financial result of the activity of the insurance. The financial result includes two elements:

- profit (loss);
- growth (departure) of the reserve of deposits.

The growth of deposit reserves during the period of storage on the accounts of an insurance company can be used as a source of investment in the state's economy. The main indicators of the effectiveness of the financial and economic activities of the insurer are financial stability, solvency, profitability and reliability.

Solvency means the ability, ability of the insurer to meet their obligations. In practice, insurance is assumed that if the assets of the insurance company are larger than the commitments, then it has a sufficient level of solvency.

The level of solvency of an insurance company is an indicator that is subject to constant monitoring by:

- the financial service of the insurer himself;
- the state authorized control body;
- audit services;
- under certain conditions – rating agencies.

8.2. Managing receipts and disbursements in insurance companies

The volume of collected insurance payments is the most lagging indicator of the insurer's activity, which is influenced by the size, structure and quality of the insurance portfolio, the volume and range of insurance services, and the size of the insurance fund. Given that the amount of payments – the magnitude of the absolute, for the adoption of managerial decisions, it is analyzed, or compared with the volume of revenues in the region, district, or in dynamics. The dynamics of the amount of received payments determines the process of formation of the insurance fund, the quantity and quality of the services rendered to the policyholders. Depending on the task, the changes in the structure of payments are studied both in general and in the branches and types of insurance.

The number of active contracts that the insurance broker has assumed, indicating the number of insurances, characterizes not only the insurance portfolio, but also the demand for insurance service. Along with the indicator of the volume of received payments, the figure of the number of existing contracts is analyzed in the dynamics in order to regulate the structure of the insurance portfolio in the direction of increasing the share of the most profitable operations.

Indicators of the average insured amount and average payment per contract reflect the essential aspects of insurance contracts, and the insurance amount characterizes the level of insurance coverage for one insurance, and the average payment for one contract – the amount of costs of the insured for one contract. In order to determine the average tariff, which is important in managing the insurer's activity, it is necessary to compare the average payment with the average insured amount. These indicators are generally studied in comparison with the previous period or the average values that are characteristic of the insurance companies-competitors.

Receipt of payments for voluntary insurance depends on a number of factors of social and eco nomic character. These include the number of contracts concluded, the average payment for one contract. The number of contracts concluded, in turn, is influenced by the size of the insurance field and its coverage, the number of insurance agents and the load on each of them by the number of contracts. The average payment for one contract depends on the average insured amount under the contract and the average insurance rate.

Determining the policy of an insurance organization will be more balanced, if attention is paid, to take such factors as the change in the value structure of the insurance portfolio in property insurance and the growth of real incomes in personal insurance. The volume of the insurance tariff is influenced by the change in the level of risk of the structure of property insurance objects, the change in the risk and age structure of the insurance portfolio of personal insurance, the growth or reduction of the share of dangerous occupations in insurance against unfortunate costs.

Significant peculiarities inherent in the analysis and subsequent managerial decisions on the receipt of payments and the growth of contracts for life insurance, which stems from the long-term nature of contracts in this area of insurance. In particular, the growth of insurance premiums affects their payment in advance, and the increase in the number of contracts, taking into account the above factors, has a deterrent effect on their early termination and natural causes (the expiration of life insurance, death of the insured, change fear of the place occupants residence).

While approving the decision on the directions of improving the work of the insurance company, it should be taken into account that the number and dynamics of existing contracts to a large extent depend on the burden on one insurance agent. Therefore, when analyzing the trends of life insurance, a significant place should be devoted to studying the work of insurance agents for the conclusion of new and extension of existing contracts, ensuring a net increase in the amount of the monthly contribution, reducing the number and reducing the share of prematurely terminated contracts. To find out the reasons for early termination of contracts, counter-checks are carried out directly from policyholders.

One of the main directions of insurance operations management is control over items of the insurer's expenses, in particular, payment of insurance sum and insurance indemnity. Initially, dynamic series of payouts are being developed and revealed. Then the rates of growth and increase of these values, chain and basic indices are determined. It is important here to establish the branches and types of insurance, payouts which grow at the highest rates. This is necessary for sound financial planning, drawing up a plan of incomes and expenses of the insurance company.

By managing personal insurance, one needs to consider that one kind of it can provide several forms of liability. For example, mixed life insurance has the following forms of liability: for survival, in case of death, in the event of a loss of health; Individual accident insurance involves liability of the insurer in the event of death and loss of health. In this regard, we should not only limit ourselves to studying the dynamics of payments in general by type of insurance (although it is necessary to establish trends in the dynamics of risk), but also examine the dynamics of payments for each form of liability, which will determine the amount of financial the results and the loss-making amount of the insurance amount for this type of insurance.

A prerequisite for a sound management of insurance operations is the calculation of the average payout per contract for each type of insurance and for each type of liability. The dynamics of this indicator reflects, first of all, the growth

of the sum insured (ie, insurance), and in property insurance, in addition, also the degree of damage to the object. The average payment due to the loss of health indicates the level of injury, and in the case of death - about the average insurance amount for this type of insurance.

The dynamics of payments can be analyzed with the help of calculating relative indicators, primarily, the level of payments and rates of payment. The level of payments is set in percentage terms by dividing the amount of payments by this type of insurance for the tariff period into the amount of payments for the same type of insurance for the same period. Despite the fact that the indicator of the level of payments is fairly stable, however, when calculating it, it is necessary to keep in mind the requirements of territorial distribution of damage. When introducing the level of payments for life insurance it is necessary to take into account that in insurance premiums there are provided contributions to the reserve of reserves.

Paid insurance payments represent a set of gross rates. Insurance same sum and insurance indemnity are paid only at the expense of net stakes. Therefore, in addition to the indicator of the level of payments, in the management of insurance operations, the payment rate is calculated.

This relative indicator refers to the share of net-rate in gross-rate, expressed in percentages. In the process of making managerial decisions, the level of payments is commensurate with the rate of payment. If the first indicator exceeds the second one or tends to do so, it is necessary to establish the reasons for the high level of payments.

To this end, an analysis of the loss-making nature of the insurance sum and its elements is carried out.

For deductions in reserve funds the normative structure of the tariff rate is used. The same principle determines the amount of deductions for preventive measures in the event of an insured event. The management of this group of expenses of the insurer involves studying its expediency, efficiency, as well as the main directions, the use of funds.

An important area of management of insurance operations is the creation of conditions for achieving steadily increasing financial results, which determines the constant attention to their analysis.

One such result is the insurer's expenses on insurance transactions, that is, their cost price in the narrow sense. Investigating the costs of conducting a case involves finding out the dynamics of this indicator and its structure in the main items of expenditure. Note that the cost structure (grouping of articles, level of detail) depends on the specific task that needs to be solved. It is important to compare the actual cost of insurance operations for a certain type of insurance with the regulatory, which is provided by the tariff.

The study of the cost of insurance operations relies on studying the dynamics of relative cost indices per unit of insurance payments. These indicators reflect the cost of operations for the formation of the insurance fund and are calculated by dividing the total expenses of the insurer for the provision of insurance operations per year or expenses related to insurance of a specific type to

the receipt of insurance payments for the same period, all or only for this type of insurance.

Reducing the cost of a particular insurance contract or transaction is possible only with a reduction in the cost of its individual elements. Obviously, a significant result in reducing the cost is possible by reducing them to the most significant item of expenditure. It is known that a very large share in the cost of insurance companies reflects the cost of maintaining insurance companies. Therefore, the costing of insurance operations must be complemented by an analysis of the rationality of the use of labor resources of the insurance company. For this purpose, the dynamics of the number of insurance employees (the ratio of full-time and non-staff insurance agents, their qualification composition), the load on one insurance agent according to the number of concluded contracts is analyzed.

The volume of insurance payments (per one insurer agent and one contract) are studied in dynamics and in comparison with insurance companies-competitors. The most important result of a financial result of an insurance organization, like any other business entity, is profit. For insurance operations, the profit is calculated by comparing the corresponding income and expenses. Profit management involves establishing a relative indicator - the profitability of insurance operations. It is calculated by comparing the value of profit received during the year from insurance operations, with their cost.

To make managerial decisions that would increase the profitability of insurance operations, it is necessary to analyze some processes. First, the dynamic series of the indicator of profitability in general for insurance operations and for each type of insurance are investigated. In this approach, the analysis of profitability in time allows us to establish trends in its dynamics.

Secondly, valuable information provides a comparison of the indicators of profitability of individual insurance operations or branches and sub-sectors of insurance for periods with levels of the same indicators, achieved by insurance companies, competitors. It will provide the necessary information base for making managerial decisions as a tactical and strategic plan.

The objective of **loss settlement** is to pay claims or benefit obligations arising out of the insurance contract according to the provisions of the contract. It is essential that claims-settlement practices are consistent with insurance contract provisions and the assumptions underlying an insurer's pricing and financial structure. Otherwise, an insurer could incur much higher losses than expected, with negative financial consequences. While insurers must pay appropriate attention to cost-containment and proper loss-settlement procedures, they are obligated to pay claims and benefits that are provided for under their contracts.

There are several steps in the settlement process. First, the insurer must determine that a covered loss has occurred, that a specific person or property is covered under the policy and the extent of the coverage. Second, the company must provide for fair and prompt payment of valid claims under its contracts. This requires the company to determine an appropriate payment that is neither excessive nor inadequate under contract provisions. If the insured disputes the settlement

offered by the insurer, the insurer and insured may negotiate a settlement to avoid litigation.

Otherwise, the insured may file a complaint with the insurance department and/or sue the insurer in court. It is in the interest of an insurer to resolve claim disputes amicably and maintain a positive reputation among its insureds and potential insureds. Hence, insurers may use their discretion to pay benefits that are not clearly required under a policy if they believe it will avoid disputes and increase goodwill.

Insurers may provide other services related to loss settlement if they are effective in reducing loss costs or are otherwise valued by insureds. Companies may provide advice and additional assistance (e.g., temporary housing) to an insured struck by a calamity, using their experience in similar matters and contact with the insured to ease the insured's adjustment. Some insurers will provide case-management services, such as in workers' compensation insurance, to help speed the recovery of individuals who have been injured and encourage the efficient use of medical and rehabilitation services. In some areas, insurers work closely with insureds in managing claims.

Investment

The reserves that insurers hold for unearned premiums, unpaid losses or benefits to be paid and other contingencies must be invested along with a company's surplus to recover the time-cost of money and promote efficiency. The income earned on appropriate investments allows insurers to discount premiums and/or improve benefits on insurance contracts.

For insurance products that include a savings or cash accumulation component, insurers provide an additional service in managing underlying investments to achieve a good return for an acceptable level of risk. These functions require prudent investment policies that match liabilities and assets, manage cash flows and achieve an appropriate balance of risk and return.

Because of their fiduciary responsibilities and the market's valuation of their financial strength, insurers tend to invest in assets for which there is a relatively low risk of default. They also tend to avoid high concentrations of investments with particular issuers that would jeopardize an insurer's solvency in the event of default. Ideally, the timing or duration of liabilities and assets will be coordinated to avoid potential losses when assets have to be liquidated to pay claims or other obligations.

For example, an insurer that writes property insurance predominantly, for which claims are paid relatively quickly in relation to the policy period, will invest more heavily in short-term bonds and blue-chip stocks. These investments can be liquidated quickly to pay claims without incurring substantial losses due to fluctuations in interest rates and the economy. On the other hand, life insurers tend to invest in a greater portion of long-term bonds and other securities to match the long-term nature of their contracts.

8.3. Financial stability of insurance companies

Growth of profitability and profitability of the insurance organization is achieved through constant consistency of its incomes and costs in general on the insurance fund. Particularly attractive is the stable excess of income over expenditure, which achieves the financial stability of all or the vast majority of insurance operations. At the heart of its support are, first of all, the rational values of tariff rates (profitable insurance and acceptable to policyholders), as well as the necessary level of concentration of funds in the insurance fund. It is under this condition that the necessary distribution of damage is achieved – territorial and in time.

The concentration of funds of the insurance fund is indirectly affected by the ever-increasing number of insured and insured objects.

Ensuring the financial stability of the insurance fund can be analyzed by establishing the likelihood of insufficiency of funds for insurance payments in a given year and in the aspect of the ratio of income and expenses of the insurer during the reporting period.

The financial stability of insurance operations increases with the increase in the number of insured objects and increase the size of insurance tariffs. In order to assess the financial stability of the insurance fund as a whole, it is necessary to compare the total amount of income of the insurer during the tariff period and the amount of funds in the stock funds with the amount of expenses for the same period is considered normal when the result of such comparison will exceed one.

It is obvious that for a steady income surplus over expenses of the insurer during the tariff period (with the use of optimal tariffs) a significant concentration of funds of the insurance fund, as well as funds in the emergency funds, is required. It allows you to recover even extraordinary damage, ensuring its placement in time.

Indicator of the loss-making amount of the sum insured is the ratio of payment of insurance indemnity or insurance amount to the insured amount of all insured objects. The given indicator allows comparing the expenses for the insurer's payment with the assurance received by him.

The study of the dynamics of indices of losses of the insurance amount pursues the goal of establishing the correspondence of actual loss rates to the tariff level. If it is determined that the actual loss rate exceeds the norm included in the tariff rate, then it is necessary to establish the role of these separate elements of the loss-making.

When insuring the property, the contents of the elements of the loss-making amount of the sum insured gives a wide opportunity to find out the reasons for increasing the loss-making. For example, an increased level of frequency of emergency cases associated with a fire indicates, first of all, the lack of quality of fire-prevention measures. The unprofitableness of the insurance amount for the insurance of crop crops and the effect of this indicator on the financial stability of

insurance operations is determined by the ratio of insurance indemnity to a certain cost of the crop. This indicator can be compared to the tariff level.

The analysis is conducted for each agricultural crop and homogeneous groups of crops. To determine the financial sustainability of insurance operations for the insurance of crops, it is possible to determine and analyze the synthetic rate of loss and the percentage of lack of standard yield. Comparison of these indicators is carried out both in time and in the regional aspect. Analysis of their dynamics in a few years allows us to draw conclusions about the reasons for increasing the loss-making of individual insurance operations.

Certain peculiarities in providing financial stability of insurance operations on insurance of farm animals. Here the synthetic indicative loss-making amount of the sum insured can be studied by categories of properties, types and forms of insurance. Elements of loss to some extent change. So, the frequency of insurance cases reflects the ratio of the number of insurance cases to the number of insured objects. If this indicator exceeds the average level in the area, this indicates an unsatisfactory veterinary and zootechnical support of animals, about unsustainable maintenance. Such an element of unprofitableness as devastation, indicates how much an average animal dies from the onset of an insured event. Based on the level of this indicator, it is possible to draw conclusions about the effectiveness of measures to localize the consequences of insured events.

In work to ensure the financial sustainability of insurance operations for animal insurance, it is necessary to delimit the total percentage of the case from the percentage of the insurance case of animals. The limited amount of insurance liability on the terms of specific types of insurance may lead to the fact that with a general high rate of death, the death of insured animals will be negligible. Importance is the study of the indicator of the ratio of risks. It shows the ratio of the average amount of insurance indemnity for one object to the average insurance amount per animal. If this figure exceeds one, this indicates a decrease in more valuable animals compared to the overall average level of their insurance grade. The ratio of risks to the death of non-breeding prods of livestock in agricultural enterprises may indicate the degree of malnutrition of meat for the consumption of people. In this case, the indicator is less than one.

In the study of the loss-making amounts of personal insurance-baths, it is necessary to calculate this indicator separately for each type of insurance liability. Then the received data are compared with the average net rates, which are laid down in the tariffs. If the indicators of loss-making do not significantly differ in the net rates or exceed them, it is necessary to analyze the elements of the loss-making. It establishes factors that determine a high level of unprofitableness. As a result, they receive the necessary data to increase the financial sustainability of insurance operations.

The concept of "insurance portfolio" is used to set up the actual number of insured objects or operating contractscontracted in a certain territory. Under the insurance portfolio in personal insurance can also be taken into account the amount of monthly insurance contributions under existing long-term life insurance contracts on a specified date in a certain territory. All current and prospective

activity of the insurance organization is based on an insurance portfolio, the structure of which ultimately determines the financial stability of insurance operations. Indeed, the size and quality of the insurance portfolio depends on the amount of insurance payments, volumes and fluctuations in payments of insurance sums and insurance indemnity.

The structure and quality of the insurance portfolio can be analyzed using a number of indicators. However, it is expressed either in the number of insured objects, or in the total insurance amount, that is, the amount of insurance liability. The structure of the insurance portfolio is characterized by the ratio of individual types of insurance, as well as between voluntary and mandatory forms. The structure of the insurance portfolio can be analyzed in the aspect of the specific weight of the existing contracts and again concluded contracts with the minimum (low) and maximum (high) insurers, the amounts, collective and individual insurance. The structure of the insurance portfolio is influenced by the range of insurance services, that is, the system of types and forms of insurance. Of particular importance for ensuring the financial stability of insurance operations has an operational response to the satisfaction of demand in those insurance services, which, in market conditions, are in line with the interests of policyholders.

When analyzing an insurance portfolio, it is necessary to pay attention to its dynamism, which is characterized by a relationship between contracts that are already expiring and contracts that are re-concluded. In order to ensure long-term financial sustainability of insurance operations, it is important to strive to achieve and maintain a portfolio equilibrium. This condition is characterized, at a minimum, by compensation of newly concluded contracts of those whose term expires. However, such compensation should apply not only to the number of contracts and the amount of contributions on them, but also to be consistent with the sum insured, the term of insurance and not to differ significantly from the likelihood of a loss that prevailed in previous contracts.

Certain features are inherent in the insurance portfolio under life insurance contracts. In this type of insurance the structure of the insurance portfolio is affected by the so-called "reverse". Under it means the refusal of the policyholder to fulfill the terms of the contract before the expiration of his term of action. Reversal in the social aspect shows that the insurer's demand for a particular insurance service by the given insurance agent can not be satisfied.

For a balanced insurance portfolio as a basis for ensuring the financial stability of insurance operations, its uniformity in terms of the volume of the insurance sum of objects and the corresponding set of risks is important. By the size of the sum insured homogeneity of the insurance portfolio is established quite simply – in terms of money in terms of insurance sum of various objects. With regard to the likelihood of damage, calculations are required based on the dispersion of the sum insured, which reflects the proportion of contracts with a maximum and minimum amount.

The effectiveness of an insurance company's activities is determined by indicators such as financial sustainability and profitability of insurance operations.

The peculiarity of the insurance process lies in the fact that the insurers' money resources are paid in advance in the formation of insurance reserves and are temporarily delayed by the insurer, which places them and uses them to provide insurance payments and receive a certain income. Therefore, a certain guarantee is required regarding the ability of the insurer to meet their obligations within the limits of the risks assumed and the amounts of liability for them. Such a basic guarantee is the financial stability of the insurer, which is connected with its tariff, financial, investment and reinsurance policy. Under the financial stability of insurance operations understand the constant advantage of income over costs within the calculation of the insurance fund.

Evaluate the financial stability of the insurance company with the following indicators:

- the size of the authorized capital;
- availability of a guarantee fund;
- size of own funds;
- the size of the created insurance reserves, sufficient for future payments;
- ratio of assets and liabilities;
- implementation of standards for the allocation of insurance reserves;
- profitability of insurance operations;
- loss-making insurance sum.

In Ukraine, the League of Insurance Organizations of Ukraine is engaged in the analysis of the status of performance indicators of insurance companies and brokers. Information that is subject to monitoring and analysis is provided by the insurers voluntarily.

The analysis is carried out in the following directions:

- indicators of activity;
- assets;
- business activity;
- equity;
- insurance premiums;
- received insurance payments;
- received reinsurance payments;
- insurance payments;
- insurance reserves;
- share of insurance payments due to reinsurers;
- regional network;
- the insurer's balance sheet profit.

One of the objectives of this text is to explain how differences in regulatory policies can affect market structure and performance. As noted above, more stringent solvency requirements will tend to limit entry into insurance markets, as well as the range of prices and products that insurers can offer. For example, regulators would not allow an insurer to invest 100 percent of its assets in high-risk non-investment grade bonds to support life and annuity products with relatively high crediting interest rates. Consumers, presumably, are willing to accept some

solvency restrictions on insurers' financial risk to protect their interest in insurers' ability to meet their obligations.

Regulatory requirements are of little value if there is no mechanism to monitor insurers' compliance with those requirements. Fundamentally, the objective of solvency monitoring is to ensure that insurance companies meet regulatory standards and alert regulators if actions need to be taken against a company to protect its policyholders. Solvency monitoring encompasses a broad range of regulatory activities, including financial reporting, early-warning systems, financial analysis and examinations. The annual and quarterly financial statements filed by insurers serve as the principal source of information for the solvency monitoring process, but there are a number of other special reports that are filed and used in regulatory monitoring. Insurance commissioners also may require insurers to provide other information as necessary to assess their financial condition.

Insurers are required to file annual financial statements for the previous calendar year by March 1 with their domiciliary state, every state in which they are licensed to do business and the NAIC. Statements for the first, second and third quarters must be filed 45 days after the close of the quarter. On a quarterly basis, insurance departments subject statements to a bench or desk, audit by an in-house financial analyst or examiner who assesses the accuracy and reasonableness of the information that is filed and determines whether the insurer requires further investigation before its next regularly scheduled on-site examination. The NAIC, through the Financial Analysis Working Group of the Financial Condition Committee, also scrutinizes insurers' financial statements and disseminates its analysis to insurance departments.

Ideally, regulators should monitor indicators of excessive financial risk and hazardous financial condition and mitigate the causes of insolvency. Studies indicate that the most common causes of property-liability insurer failures are deficient loss reserves, inadequate rates and rapid growth. Other factors involved in property-liability insolvencies include fraud, overstated assets, significant changes in business, reinsurance failure and catastrophe losses. The most frequent causes of lifehealth insurer failures have been inadequate pricing and rapid growth, followed by problems of affiliates, overstated assets, fraud, significant changes in business, reinsurance failure and new management.

Direct regulation of insurers' prices, products and market practices also can affect market conditions, positively or negatively. If insurers are able to exercise market power to raise the market price above the competitive price, then regulators can improve market performance by setting a price ceiling at the competitive level. In practice, this is rarely necessary as the competitive structure of most insurance markets prevents insurers from acquiring significant market power. If regulators set a price ceiling below the competitive market price, then insurers will offer less insurance than consumers will want to buy, causing availability problems. In the long run, insurers will be induced to leave the market if they cannot charge a premium that covers their costs and believe that they will sustain losses for the foreseeable future.

The rate structure (i.e., the relative rates between different risks) and the rate level are regulated in some property-liability lines, such as auto insurance, workers' compensation insurance and health insurance. Ideally, the premium should approximate the expected cost of insuring a given risk, but there are inherent limitations to the precision of any insurance-pricing system, regardless of regulatory constraints. Regulators seek to ensure that rate differentials are not unfairly discriminatory. However, that principle may be interpreted and applied differently among states.

In practice, insurers may perceive regulatory price constraints to be more binding for some risks than others. Insurers will be disinclined to discount rates that are already perceived to be inadequate for a given risk and may decline to offer coverage for such risks. Consequently, the more binding regulatory price constraints are perceived to be for a given group of risks, the less likely those risks will be able to obtain coverage in the voluntary market.

This principle also applies to the regulation of residual market rates. If residual market rates are insufficient to cover residual market costs, the operating deficit will be assessed back to the voluntary market, forcing a subsidy from voluntary market risks to residual market risks. This, in turn, further discourages insurers from accepting risks in the voluntary market, which increases the growth of the residual market.

Holding rates below cost can have other adverse effects on the market besides causing insurers to exit and decreasing the availability of coverage. Insurers might lower the quality of service they provide by increasing the stringency of their claims-settlement policy. A tighter claims policy will result in fewer claims being paid as well as lower settlements on some claims that are paid. This is more difficult to do in lines where benefits are set by law. Alternatively, insurers might lower quality and their costs by delaying claims payments, premium refunds and dividends to policyholders. Also, insurers might lower their expenses by reducing other services they provide to insureds.

Regulators can potentially assist consumers by increasing the information they have and preventing market abuses by insurers and producers. For example, if an insurer fails to meet its obligation to pay a claim under an insurance contract, the insured can sue the insurer, but such action can be costly in terms of time and money. An insurer may have more resources to sustain litigation than the insured. Regulators can help balance the relative positions of the insurer and insured by taking enforcement action against the insurer. Similarly, regulators may find it more efficient to simply disallow policy provisions they believe to provide inadequate coverage or are misleading, rather than rely on consumers to determine this for themselves.

Increasing consumer information offers an effective substitute or complement to regulatory activities. Greater information enables consumers to make better insurance decisions, which increases competition among insurers and market efficiency. Regulators improve consumer information by educating consumers on how to purchase insurance and publishing information on insurers' prices, products and quality of service.

8.4. Principles of insurance regulation

Economists, political scientists and legal scholars have offered various theories to explain regulation and regulatory behavior. Some of these theories are normative in nature (i.e., what regulation should be) and some are positivistic (i.e., how regulators actually behave). Traditional **public interest theory** analyzes the role of regulation in correcting market failures (defined below) and improving economic performance. This traditional view has been challenged by **economic and political theories of regulation** that examine how economic interests, bureaucracy, political elites and ideology affect regulatory policy.

It is not necessary here to provide a comprehensive review of the different theories of regulation, but the reader should know that there is such a literature. The emphasis here will be the on principles governing insurance regulation that serve the public interest, rather than on other factors that influence insurance regulatory policy.

The term "regulation" is often used as if there is a common understanding of its meaning, but it can often be defined differently. Most analysts use the term narrowly to refer to government restriction of private actions to achieve particular public goals. With respect to insurance, the scope of regulation so defined might encompass such areas as licensing of companies and agents, other entry and exit restrictions, solvency, prices, trade practices and products. However, the full scope of government involvement with insurance markets is not confined to these areas.

Other areas of government action that affect insurance include public insurance programs; antitrust policy; taxes; public expenditures; property, contract and tort law; and international trade policy, among others. The narrower concept of regulation is the primary frame of reference for this text, but it is important to note the interrelationship between various areas of public policy that affect insurance. Regulators' efforts to achieve particular market outcomes in insurance can be affected by other government actions.

The economic foundation for regulation is based on the concept of market failure. Market failures constitute violations of the conditions of workable competition outlined in Chapter 6, such as entry and exit barriers, firm market power and lack of information. Market problems (e.g., high prices, unavailability of coverage, insolvencies) can be a consequence of a market failure or other factors that affect a market that is structurally competitive.

In other words, not all conditions perceived as market problems are necessarily caused by a market failure. For example, high insurance prices may be the natural result of increasing risk driven by external factors, and not the malfunctioning of the market per se. It is important to determine the underlying cause of market problems to determine the appropriate regulatory response.

Under public interest theory, regulation is primarily intended to remedy market failures – not necessarily market problems caused by other external forces. The basic premise underlying the need for regulation is that market failures can diminish the efficiency and equity of market outcomes and harm the public interest. The purpose of regulation, then, is to correct market failures, or at least

minimize their negative effects, and improve allocative efficiency and equity. This assumes that regulators have perfect information and can determine and implement the correct market solutions.

The principal market imperfections that regulation is intended to address are barriers to entry and exit, externalities (where transactions create costs for third parties) and internalities (where the costs and benefits of transactions are not reflected in the terms of exchange). To correct or counteract these problems, regulators may impose controls on entry, exit, prices, product quality, inputs to production, refusal to serve and other private activities.

Insurance regulation is principally targeted toward correcting market failures that would otherwise cause insurers to incur an excessive risk of insolvency and/or engage in market abuses that hurt consumers. The public interest argument for the regulation of insurer solvency derives from inefficiencies created by costly information and principal-agent problems. Owners of insurance companies have diminished incentives to maintain a high level of safety to the extent that their personal assets are not at risk for unfunded obligations to policyholders that would arise from insolvency. It is costly for consumers to properly assess an insurer's financial strength in relation to its prices and quality of service. Insurers also can increase their risk after policyholders have purchased a policy and paid premiums.

This represents what economists call a principal-agent problem, in that the principals (policyholders) have difficulty in monitoring and controlling the behaviour of their agents (insurers) when there is a conflict between their interests/incentives. Thus, in the absence of regulation, imperfect consumer information and principal-agent problems would result in an excessive number of insolvencies. Solvency regulation is intended to limit insurers' insolvency risk in accordance with society’s preference for safety. Regulators limit insolvency risk by requiring insurers to maintain a minimum amount of capital and meet other financial requirements.

Limiting insolvency risk is a different objective than preventing insolvencies. Limiting insolvency risk implies that some insurers will become insolvent. This is inherent in a competitive market where firms must have the opportunity to fail. In order to guarantee that no insolvencies would occur, the government would have to impose extremely high capital requirements and significantly constrain insurers' investments and other transactions to reduce the probability of insolvency to zero. The result would be high insurance prices and inefficient markets. This is impractical, and public officials have chosen a more reasonable objective to reduce the cost of insolvencies to some acceptable minimum that represents an acceptable tradeoff with the cost and availability of insurance.

The traditional explanation for regulation of insurance prices also involves costly information and solvency concerns. Insurers' incentive to incur excessive financial risk and even engage in go-for-broke strategies may result in inadequate prices. Some consumers will buy insurance from carriers that charge inadequate prices without properly considering the greater financial risk involved. In this scenario, poor incentives for safety could induce a wave of destructive competition

in which all insurers are forced to cut their prices below costs in order to retain their market position. Thus, it is argued that regulators must impose a floor under prices to prevent the market from imploding.

This view essentially governed insurance rate regulation until the 1960s, when states began to disapprove or reduce price increases in lines such as personal auto and workers' compensation. The rationale that some might offer for government restrictions on insurance price increases is that consumer search costs impede competition and lead to excessive prices and profits. Further, constraints on consumer choice and unequal bargaining power between insurers and consumers, combined with inadequate consumer information, can make some consumers vulnerable to abusive marketing and claims practices of insurers and agents. It also might be argued that it is costly for insurers to ascertain consumers' risk characteristics accurately, giving an informational advantage to insurers already entrenched in a market and, therefore, creating barriers to entry that diminish competition.

According to this view, the objective of regulation is to enforce a ceiling that will prevent prices from rising above a competitive level and to protect consumers against unfair market practices. In addition, the public may express a preference for regulatory policies to guarantee certain market outcomes consistent with social norms or objectives.

The question for self-control

1. The composition and economic content of the insurer's income and expenses.
2. Determination of the insurer's profit.
3. Taxation in insurance companies.
4. The concept of financial instability of the insurer.
5. Name the conditions that ensure the financial reliability of the insurer.
6. What principles should be followed by the insurer when forming a balanced insurance portfolio?
7. Insurance reserves.
8. Determine the specifics of the formation of insurance reserves for life insurance.
9. Insolvency of the insurer and conditions of its provision.
10. Investment activity of insurers.

Synopsis of Key Points

1. The public interest theory of regulation provides a foundation for the principles that should govern insurance regulatory policies intended to serve consumers and the general public.

2. Regulation, narrowly defined, is the government restriction of private action to achieve public goals.

3. Regulation is intended to remedy market failures, which represent violations of the conditions for workable competition.

4. Solvency regulation is intended to limit some insurers' tendency to incur excessive financial risk because of consumers' limited information and difficulty in controlling insurers' actions.

5. Market regulation of insurers' prices, products and trade practices is intended to prevent prices from rising too high (because of insurers' market power) or too low (because of overly aggressive price competition) and other abuses that might arise from consumers' lack of information and unequal bargaining power.

6. Solvency regulation will necessarily restrict market entry and may limit the range of insurers' prices and products, which constitutes a tradeoff with reduced insolvency risk.

7. Regulation can improve market performance if insurers exploit any market power that they are able to acquire. However, in most instances, competition prevents insurers from acquiring significant market power. Regulation also can distort market forces and hurt efficiency if it suppresses prices below costs.

8. Insurance serves an essential role in diversifying risk and reducing uncertainty by pooling losses among a group of individuals or firms.

9. Social welfare is maximized when insurance markets function efficiently and the costs of different activities are equal to their benefits.

10. Equity can be defined in different ways, but it is consistent with economic efficiency when individuals pay insurance premiums commensurate with their relative risk of loss.

11. Risk exposures may not be insurable if they fail to meet four conditions:

- many independent and identically distributed exposure units;
- economically feasible premiums;
- losses are unintentional and accidental;
- losses are easily determined.

12. Adverse selection arises when high-risk individuals are more likely and low-risk individuals are less likely to buy insurance. Adverse selection can be diminished by risk-based pricing, proper underwriting selection and policy design.

13. Moral hazard arises when insureds stand to gain from causing a loss and/or have diminished incentive to prevent losses. Insurers combat moral hazard by having insureds bear a portion of their losses and declining to offer insurance in situations where the insured would gain financially from having a loss.

14. Insurance contracts embody various concepts, including the principles of indemnity and insurable interest. Under the principle of indemnity, in the event of a loss, insureds should not gain financially from insurance and should be restored to no better than their prior position. Under the principle of insurable interest, the insured must suffer some harm or loss if the insured event occurs.

15. Insurers design and sell insurance contracts (i.e., policies) intended to cover insureds against insurable perils or contingencies.

16. Pricing involves determining an appropriate premium for a given risk and insurance policy. For property-liability insurance and accidenthealth insurance, premiums may be based on a rating manual or be determined and negotiated individually for certain risks. For life insurance and annuities, insurers use

mortality tables and other information to determine the necessary premiums to cover their projected premium and investment income receipts and benefit payments over the duration of their policies.

17. Production and distribution involves marketing and selling insurance contracts to consumers. Insurance contracts can be sold through independent agents, exclusive agents and brokers or marketed directly to buyers.

18. Underwriting entails the risk assessment, classification and selection of insureds to appropriately match insurance products and price to the risk.

19. In settling losses and paying benefits, the insurer determines whether a covered loss has occurred or a benefit is payable and the appropriate benefit payment under the terms of the insurance contract.

20. Insurers invest their reserves for liabilities and surplus to manage their cash flow and recover the time-cost of money, which enables them to offer policyholders greater value for the premiums they pay. Insurers' investments tend to be conservative with respect to credit risk and should be coordinated with the timing of their liabilities.

21. Reinsurance is the purchase of insurance by an insurer and is intended to further diversify risk, support growth and cushion surplus against larger than anticipated losses or benefit payments.

22. Insurers provide a diverse range of products and services that are continuing to evolve to serve consumers' needs.

23. Property-liability insurance policies protect insureds against losses stemming from damage to or loss of property and legal liability. The principal lines are fire, marine, casualty and surety.

24. Life insurance covers an event – death – that is uncertain in any given year, but certain in the long term.

25. Term life insurance pays the face value of the policy upon the death of the insured during a specified number of years, but does not accumulate a cash value or pay anything if death does not occur during the policy term.

26. Whole life policies pay the face value of the contract when the insured dies, regardless of when this occurs. Whole life policies accumulate a cash value, which the insured might utilize in different ways.

27. For certain other types of life insurance policies, such as universal life and variable life, the rate of cash accumulation will depend, at least in part, on the investment earnings of supporting assets, and offer various options to policyowners to adjust their coverage.

28. Annuities are designed to systematically liquidate a principal sum over a specified period of time, with or without a life contingency. The value of variable annuities is based on the investment earnings of assets supporting the contract.

29. Disability income insurance provides periodic payments when the insured is unable to work.

30. Medicare supplement insurance covers retirees for certain medical expenses that are not covered by Medicare. Long-term care insurance provides extended medical or custodial care that is not typically covered by medical expense insurance.

31. Insurers design and sell insurance contracts (i.e., policies) intended to cover insureds against insurable perils or contingencies.

32. Pricing involves determining an appropriate premium for a given risk and insurance policy. For property-liability insurance and accidenthealth insurance, premiums may be based on a rating manual or be determined and negotiated individually for certain risks. For life insurance and annuities, insurers use mortality tables and other information to determine the necessary premiums to cover their projected premium and investment income receipts and benefit payments over the duration of their policies.

33. Production and distribution involves marketing and selling insurance contracts to consumers. Insurance contracts can be sold through independent agents, exclusive agents and brokers or marketed directly to buyers.

34. Underwriting entails the risk assessment, classification and selection of insureds to appropriately match insurance products and price to the risk.

35. In settling losses and paying benefits, the insurer determines whether a covered loss has occurred or a benefit is payable and the appropriate benefit payment under the terms of the insurance contract.

36. Insurers invest their reserves for liabilities and surplus to manage their cash flow and recover the time-cost of money, which enables them to offer policyholders greater value for the premiums they pay. Insurers' investments tend to be conservative with respect to credit risk and should be coordinated with the timing of their liabilities.

37. Reinsurance is the purchase of insurance by an insurer and is intended to further diversify risk, support growth and cushion surplus against larger than anticipated losses or benefit payments.

Glossary

A

Accident – A loss-causing event that is sudden, unforeseen, and unintentional.

Actual Cash Value – The value of property at the time of its damage or loss, which is equal to its replacement cost minus depreciation.

Adverse Selection – The tendency of persons with a higher-than-average risk of loss to seek insurance at standard (average) rates.

Advisory Loss Costs – Prospective (fully developed and trended) loss costs filed by advisory organizations for property-liability insurance.

Advisory Organizations – Organizations that develop and file advisory loss costs and standard policy forms and provide other services for propertyliability insurers, regulators and others.

Agent – Someone who legally represents the insurer in insurance transactions and has authority to act on the insurer's behalf.

Alien Insurer – An insurance company that is domiciled in a foreign country.

Alternative Market – A term used to generally describe non-traditional markets and risk management mechanisms for various forms of property-liability insurance that encompass non-admitted insurers but not licensed insurers.

Annuitant – A person who receives the periodic payment of an annuity.

Annuity – A periodic payment to an individual that continues for a fixed period or for the duration of a designated life or lives.

Assessment Mutual – A mutual insurance company that is authorized to assess policyowners for losses and expenses.

Asset Valuation Reserve (AVR) – A new asset reserve requirement for lifehealth insurers, instituted in 1993 with the Interest Maintenance Reserve (IMR), that extended and refined reserve requirements for all major asset classes and replaced the prior Mandatory Security Valuation Reserve (MSVR) requirement.

Automobile Insurance – A form of insurance that provides liability and physical damage coverage for personal and commercial vehicles.

Automobile Insurance Plan – A term used to generally describe the various residual market mechanisms for automobile insurance.

B

Binder – Authorization of coverage by an agent given before the insurer has formally approved a policy. Provides evidence that the insurance is in force.

Blue Cross Plans – Non-profit, community-oriented prepayment plans that provide health insurance coverage primarily for hospital services.

Blue Shield Plans – Non-profit, community-oriented prepayment plans that provide health insurance coverage primarily for physician services.

Broker Someone who represents the insured in insurance transactions, soliciting or accepting applications for insurance that are not in force until the insurer accepts the policy.

Businessowners Policy (BOP) – A package commercial insurance policy containing coverages designed to meet the typical property and liability insurance needs of small businesses.

C

Captive Insurer – An insurance company established and owned by a parent firm (or association) to insure its loss exposures (or those of the association members).

Cash Surrender Value – The amount payable to the owner of a whole-life insurance policy if the policyowner decides to terminate the policy.

Casualty Insurance – An area of insurance that encompasses risks not covered by fire, marine and life insurance.

Ceding Insurer – An insurer that writes an insurance policy or group of policies initially (i.e., on a primary basis) and that subsequently transfers all or portion of the risk to a reinsurer.

Chance of Loss – The probability that a loss-causing event will occur.

Choice No-Fault – A system under which auto owners can elect to be covered under their state's no-fault law or retain the right to sue under tort liability law.

Claims-Made Policy – A liability insurance policy that only covers claims that are first reported during the policy period, provided the losscausing event occurred after the retroactive date (if any) stated in the policy.

Class Rating – A method of insurance pricing in which groups of similar insureds are effectively placed in the same risk classification and each is charged the same rate. In class rating, the rate for a particular insured is determined by the application of a set of class rating factors to specified insured risk characteristics.

Coinsurance – An approach to determining insurance claims payments or benefit payments in which the insured is required to retain a certain percentage of the covered losses they incur.

Collision Loss – Damages to an automobile caused by upset of the vehicle or its impact with another vehicle or object.

Competitive Market – A term used by economists to define markets where the lack of entry and exit barriers and a large number of firms promotes competitive behavior and good market performance.

Competitive Rating – A term used to generally describe regulatory systems under which insurers are not required to obtain prior approval for rates before they go into effect. Regulators typically rely on market forces to determine rates under competitive rating systems. The term "open competition" also is used to label such systems.

Compulsory Insurance Law – A state law requiring owners and operators of automobiles to carry certain amounts of auto liability insurance to license a vehicle and drive legally within the state.

Concentration Ratio – A measure used to quantify the degree of market concentration which is equal to the combined market share of some specified number of the leading firms.

Coordination of Benefits – A provision in insurance contracts that prevents an insured from receiving duplicate or excessive claims payments when the insured's losses are covered by more than one policy.

D

Direct-Response System – A marketing system in which an insurer sells insurance directly to consumers without using the services of an agent.

Direct Writer – A term typically used to label an insurer that uses a directresponse system or exclusive agents to sell insurance.

Disintermediation – The outflow of funds from a financial entity, such as an insurer, in response to changes in interest rates or other developments. This poses a

risk to life insurers in that they are forced to sell assets at current market prices (which may be less than their book or amortized value) to cover policyowners' demands on their funds.

Distribution – The marketing and sale of insurance.

Diversification of Risk – The process of transferring, spreading or pooling risk.

Domestic Insurer – An insurance company that is domiciled and licensed in the state in which it sells insurance.

Dwelling Property Insurance – A form of residential property insurance that covers dwellings, other structures and contents on a named-perils or open-perils basis. Dwelling property insurance does not include certain insurance coverages, such as liability coverage, that are provided in homeowner multi-peril insurance policies.

E

Efficiency – A term used by economists to characterize market outcomes where resources are employed to their best possible use and social welfare is maximized.

Electronic Commerce – Transactions conducted over the Internet or other electronic networks.

Employers Liability Insurance – A form of insurance that covers employers for their legal liability stemming from work-related employee injuries and illnesses that are not covered under workers' compensation insurance. Such liability is limited in most states because workers' compensation is intended to be the exclusive remedy for injured workers.

Endorsement – A written provision that adds to, deletes, or modifies the provisions of the insurance contract to which the endorsement is attached.

Equity – A term used to characterize "fair" or "equal" distributions of the costs and benefits of various activities.

Excess Insurance – An insurance arrangement in which the insurer is not obligated to pay any losses that fall below a certain threshold. Typically, a firm will purchase excess insurance to cover large losses above a significant amount retained by the firm.

Exclusions – A listing of perils, losses and property that are not covered in an insurance contract.

Exclusive Agent – An agent who represents only one insurance company or group of companies under common ownership.

Exclusive Remedy – A legal principle which holds that the workers compensation system should be the sole source of compensating workrelated injuries and illnesses and that employers should not be subject to tort liability suits for such injuries.

Expenses – The costs incurred by an insurer in servicing insurance policies beyond the payments it makes to insureds to cover losses. The cost of capital or normal profits can be considered an expense, but is typically distinguished from expenses in analyzing insurers' financial performance.

Expense Ratio – The ratio of expenses to premiums.

Experience Rating – A method of insurance pricing which determines or adjusts the rate for an insured on the basis of the insured's past loss experience.

Exposure Unit – A unit of measurement used to quantify the amount of risk exposure in pricing insurance.

Externality – Costs or benefits of an activity borne or received by thirdparties who do not control the activity.

F

Facultative Reinsurance – A type of reinsurance contract written on individual risks, on a case-by-case basis.

Fair Access to Insurance Requirements (FAIR) Plan – A federal property insurance plan that provides basic property insurance to property owners unable to obtain insurance in the voluntary market. Under this system, such insureds are assigned to insurers through a central placement facility in each state that has a FAIR plan. This is the principal residual market mechanism used for property insurance.

File-and-Use Rating – A law for regulating insurance rates under which insurers are required to file their rates with the state insurance department before they go into effect, but prior approval is not required.

Financial Regulation – The regulation of insurers' financial risk, financial condition or solvency. Synonymous with the term "solvency regulation".

Fire Insurance – A form of property insurance that covers damages to a structure and its contents caused by fire and certain other specified perils such as windstorms.

Flex-Rating Law – Alaw for regulating insurance rates under which insurers are required to obtain prior approval for rates that exceed a certain percentage above or below the rates previously filed.

Foreign Insurer – An insurance company that is licensed to do business in a state but is domiciled in another state.

Fraternal Insurer – A mutual insurance company that provides life and health insurance to members of a social organization.

G

Group Insurance – A term used to describe various form of insurance provided to the employees of a firm or the members of an association under a single contract.

Guaranteed Investment Contract – An investment contract with an insurer under which the insurer guarantees both principal and interest on a pension contribution.

H

Hazard – A condition that creates or increases the risk of loss.

Health Expense Associations – A term used to describe organizations that provide pre-paid health services to their members, such as Blue Cross Blue Shield plans and HMOs.

Health Maintenance Organization (HMO) – An entity that provides comprehensive health care services to its members for a fixed prepaid fee and uses managed care measures to control costs.

Herfindahl-Hirschman Index (HHI) – A measure of market concentration that is equal to the sum of the squared market shares of firms in the market. A higher HHI indicates higher market concentration.

Homeowners Multi-Peril Insurance – Insurance provided through a package policy that combines property and liability coverages for homeowners.

I

Incurred-But-Not-Reported (IBNR) – A term used to label unpaid losses for property-liability insurance from covered events which have occurred but for which claims have not been filed.

Indemnification – Compensation to the victim of a loss, in whole or in part, by payment, repair or replacement.

Indemnity Principle – The principle that insurance should restore an insured to approximately his or her financial position before a loss, but should not allow the insured to gain financially from the loss.

Independent Agent – An insurance agent who represents one or more insurers as an independent businessperson. An independent agent owns the expiration or renewal rights to the business the agent writes and is compensated through commissions.

Inland Marine Insurance – Transportation insurance that provides coverage for goods shipped on land, means of transportation, and personal and commercial property floaters.

Insurable Interest – The principle that the insured must suffer some form of loss or harm if the insured event occurs.

Insurance – The pooling of fortuitous losses through transfer of risk to insurers who agree to indemnify insureds for such losses, to provide other pecuniary benefits on their occurrence, or to render services connected with the risk.

Insurance Services Office (ISO) – A major advisory organization that provides various services to property-liability insurers, regulators and others, including standard policy forms and advisory loss costs.

Interest Maintenance Reserve (IMR) – Anew asset reserve requirement for life-health insurers, instituted with the Asset Valuation Reserve (AVR) in 1993, that requires insurers to amortize interest-related gains and losses over the remaining life of a disposed asset.

J

Joint Underwriting Association (JUA) – A type of residual market mechanism that collects premiums from and pays the losses of its insureds. Operating losses incurred by a JUA are shared by insurers proportionately according to their voluntary market premiums.

L

Law of Large Numbers – The concept that as the number of exposures increases, the closer actual results will approach the probable results expected from an infinite number of exposures.

Legal Reserve – The liability life insurers are required to establish on their balance sheet for excess premiums received and interest earned from life insurance policies in their early years under the level-premium method.

Loading – The amount that must be added to the pure premium for expenses, profit and contingencies.

Lloyd's Associations – A for-profit proprietary organization composed of underwriter-members who cover special risks on a cooperative basis.

Long-Term Care Insurance – A form of health insurance that pays benefits for extended medical or custodial care received in a nursing facility, hospital or at the insured's home.

Loss Cost System – A system in which advisory organizations file advisory loss costs but not full rates. Insurers may file multipliers which adjust the loss costs to full rates or file full rates.

Loss Frequency – The probable (or actual) number of losses that may (or have occurred) during some given time period.

Loss Ratio – The ratio of losses to premiums.

Loss Reserve – The amount that insurers set aside to cover claims incurred but not yet paid.

Loss Severity – The probable (or actual) size of losses that may occur (or have occurred).

Loss Settlement – The process by which insurers verify, measure and pay losses covered under their insurance contracts.

M

Major Medical Insurance – Health insurance designed to pay a large portion of the covered expenses of a catastrophic illness or injury.

Managed Care – A general term for medical expense plans that provide covered services to insureds/members with more extensive cost-control measures than found in traditional, fee-for-service indemnity plans.

Manuscript Policy – An insurance policy designed for a firm's specific needs and requirements.

Market Conduct – The behavior and market practices of firms.

Market Failure – A violation of the conditions for perfect or workable competition which results in inefficient or suboptimal market outcomes.

Market Performance – The dimensions of market outcomes in areas such as profits, efficiency, equity and quality of service.

Market Power – The ability of firms to exercise some influence over the market price and output to increase profits and/or protect inefficiency.

Market Regulation – The regulation of firms' products, prices and market practices.

Market Structure – Supply and demand functions, the number and size distribution of firms, entry and exit barriers, the quality of information, and other dimensions that affect market conduct and performance.

Merit Rating – An insurance pricing method in which class rates are adjusted upward or downward based on the individual insured's loss experience.

Monitoring Competition – A process by which regulators monitor market conditions to ensure that competition is working and serving consumers' interests.

Monopolistic Competition – A market structure in which numerous individual firms sell differentiated products and each face different market demand functions. Because of a high degree of substitutability among their products and consumers willingness to switch for relatively small differences in price, monopolistically competitive markets are workably competitive and maximize consumer welfare.

Monopoly – A market structure in which there is only one seller of a product who is protected from entry and competition from other firms.

Moral Hazard – As utilized by insurance experts, this term refers to dishonesty or character defects in an individual that increase the chance of loss. Economists use this term more broadly to refer to the diminished incentives of insureds to avoid or prevent losses because they have insurance.

Morale Hazard – As utilized by insurance experts, this term refers to carelessness or indifference to loss because of the existence of insurance.

Mutual Insurer – A non-profit insurance company owned by its policyowners.

N

Named-Perils Policy – An insurance policy that only covers perils specifically listed in the policy.

National Association of Insurance Commissioners (NAIC) – An association of the chief insurance supervisory officials in each state, the District of Columbia and five U.S. territories.

Negligence – The failure to exercise the standard of care required by the law to protect others from harm.

Net Amount at Risk – The difference between the face amount and the legal reserve of a life insurance policy priced under the level-premium method.

No-Fault Insurance – A concept under which persons injured by the negligence of another collect benefits from their own insurers rather than sue the negligent party to recover their damages under tort law.

Non-Admitted Insurer – A term used to characterize insurers who are authorized or permitted to sell certain lines of insurance on a nonlicensed based in a state.

Nonforfeiture Law – State law requiring insurers to provide at least a minimum nonforfeiture value to policyowners who terminate insurance policies that have accumulated cash values.

O

Objective Risk – The relative variation of actual losses from expected losses.

Occurrence Policy – A liability insurance policy that covers claims arising out of loss-causing events that occur during the policy period, regardless of when a claim is filed.

Ocean Marine Insurance – A form of insurance that covers ocean-going vessels, their cargoes, and the legal liability of owners and shippers.

Oligopoly – A market structure in which there are a limited number of sellers who recognize the interdependence of the pricing and production decisions. This

recognition can create the basis for explicit or tacit cooperation to raise market prices and limit output to increase profits and/or protect inefficiency.

Open-Perils Policy – A policy which covers all perils unless specifically excluded. This type of policy is sometimes called an all-risk policy.

Ordinary Life Insurance – A type of whole life insurance that provides protection throughout the insured's lifetime and for which premiums are paid throughout the insured's lifetime.

P

Peril Something that can cause a loss, such as fire or windstorms.

Personal Umbrella Policy – An insurance policy designed to provide protection for an individual or family against a catastrophic lawsuit or judgement. This insurance is intended to provide excess coverage over liability coverage provided in personal auto and homeowners insurance policies.

Point-of-Service Plan – A health insurance plan that allows the insured the option to use providers in an HMO network or providers outside the network. A larger portion of the insured's expenses are reimbursed if they use a provider within the network.

Policy Loan – An option that allows the owner of a life insurance policy to borrow its cash value, at interest.

Policyholders' Surplus – The difference between an insurer’s assets and its liabilities.

Pooling – The spreading of losses incurred by the individual members of a group over the entire group. Each member pays the average loss incurred by the group rather than his or her actual loss.

Preferred Provider Organization (PPO) – A network of screened and closely-controlled group of providers selected by an insurer who have agreed to a negotiated fee schedule in return for prompt payment for services provided and a larger volume of patients.

Pricing – The process by which insurers determine the rate or premium they will charge for a given insurance contract and insured.

Principal-Agent Relationship – A relationship in which an agent acts on behalf of a principal. A principal-agent relationship is established by an insurance contract in which the principal is the policyowner and the agent is the insurer. Principals may

have some difficulty in monitoring and controlling the behavior of their agents which can lead to problems if they have conflicting incentives.

Prior-Approval Law – A state law requiring that insurers file and receive approval for their rates from the state insurance department before they go into effect.

Product Design – The process by insurers develop insurance contracts or policies and related services to meet the needs and preferences of insureds.

Products Liability – The legal liability of manufacturers, wholesalers, and retailers to persons who are injured or who incur property damage from defective products.

Profit – The difference between the costs incurred by firms and the income they receive.

Provider-Sponsored Organization (PSO) – A pre-payment plan for health services owned by providers.

Purchasing Group – A type of entity established by the federal Liability Risk Retention Act of 1986. A purchasing group is authorized to purchase commercial liability insurance on behalf of its members and must be domiciled in at least one state.

Pure Premium – The portion of the insurance rate needed to pay losses and loss-adjustment expenses.

Pure Risk – The situation in which there only the possibilities of loss or no loss and there is no possibility of gain.

R

Rate – The price per unit of insurance.

Receivership – Ageneral term that refers to the legal seizure of an insurer by regulators in the event of financial difficulty or insolvency for the purposes of the rehabilitation, sale or liquidation of the insurer.

Reciprocal Exchange – An unincorporated mutual insuring organization in which insurance is exchanged among members and which is managed by an attorney-in-fact.

Regulation – The restriction of private activities by government to promote the public interest or other public objectives.

Reinsurance – The transfer of risk initially underwritten by one insurer to another insurer.

Replacement-Cost Insurance – A form of loss settlement for property insurance in which the insured is indemnified on the basis of the replacement cost of the insured property with no deduction for depreciation.

Residual Market – A term used to generally describe non-voluntary market mechanisms to cover persons or firms that cannot obtain insurance in the voluntary market.

Retention – A term that refers to the amount of potential losses retained by an insured and not subject to reimbursement by an insurer.

Retrocession – A process by which a reinsurer obtains reinsurance from or transfers risk to another reinsurer.

Retrospective Rating – A form of merit-rating in which the insured's loss experience during the policy period determines the premiums paid by the insured for the policy period.

Risk – A situation in which more than one outcome is possible.

Risk-Based Capital – A flexible, minimum capital standard developed by the NAIC which varies by insurer according to a formula applied to an insurer's financial structure.

Risk-Retention Group – A risk-bearing entity established by the federal Liability Risk Retention Act of 1986 to provide commercial liability insurance. A risk-retention group must be chartered and licensed as an insurer in at least one state but may operate in other states without a license.

S

Schedule Rating – A form of merit-rating which adjusts an insured's rate upward or downward according to a schedule of credits and debits applied to certain risk characteristics of the insured.

Self Insurance – A term used to describe a program in which an individual or firm pays a portion or all of its losses.

Separate Account – A variation of the deposit administration pension plan arrangement in which pension funds are segregated so that account assets are not commingled with an insurer's general assets and can be invested separately.

Speculative Risk – A situation in which either profit or loss are possibilities.

Stock Insurer – A profit-making insurance company funded by an initial capital investment by the owners or stockholders of the company.

Stop-Loss Limit – A modification of the coinsurance provision in major medical insurance plans that sets a maximum limit on the amount of medical expenses the insured must pay out of his or her own pocket.

Structure-Conduct-Performance Framework – A conceptual framework used by economists to explain the relationship of market structure, market conduct and market performance.

Surety Bond – A bond that provides monetary compensation if the bonded party fails to perform certain acts.

Surplus Lines Broker – A specialized insurance broker licensed to place business with a non-admitted insurer.

T

Term Life Insurance – A type of life insurance that provides temporary protection for a specified number of years.

Total Adjusted Capital (TAC) – A specific calculation of an insurer's capital and surplus with certain modifications which is compared against the insurer's RBC requirement to determine whether regulatory or company action is needed.

Treaty Reinsurance – A form of reinsurance arrangement or contract in which the primary insurer must automatically cede and the reinsurer must automatically assume certain risks as defined by the terms of their contract.

Twisting – An illegal insurance sales practice that induces a policyowner to drop an existing policy in one company and take out a new policy in another through misrepresentation or incomplete information.

U

Underinsured Motorists Coverage – A coverage that may be added to a personal auto insurance policy that pays bodily injury damages to the insured caused by the ownership or operation of an underinsured vehicle by another driver.

Underwriting – The selection and risk classification of insurance applicants by an insurer.

Underwriting Cycle – A term used to characterize the cyclical movement in the supply and price of certain lines of insurance over time.

Unearned Premium Reserve – A liability reserve of an insurer that represents the unearned portion of gross premiums written on all outstanding policies at the time of valuation.

Uninsured Motorists Coverage – A coverage that may be added to a personal auto insurance policy that pays bodily injury damages to the insured caused by an uninsured motorist, a hit-and-run driver, or a driver whose insurer is insolvent.

Universal Life Insurance – A flexible whole-life insurance policy that provides lifetime protection under a contract that separates the protection and savings components. The policyowner can vary the timing and amount of premium payments and can earn interest in excess of the guaranteed crediting rate based on the investment performance of the insurer.

Use and File – A regulatory system under which insurers are allowed to put rates into effect before they are filed.

V

Valued Policy – An insurance policy that pays the face amount of insurance, regardless of the actual cash value of the insured's loss, if a total loss occurs.

Valued Policy Law – A state law requiring payment of the face amount of insurance if a total loss to real property occurs from a peril specified in the law, even though the policy may state that only actual cash value will be paid.

Variable Life Insurance – A whole-life insurance policy in which the death benefit and cash surrender value vary according to the investment experience of a separate account maintained by the insurer.

W

Workable Competition – A standard for evaluating the competitiveness and performance of markets under real world conditions. A market is workably competitive when it approximates the conditions for perfect competition and government intervention cannot feasibly improve the market's performance.

Workers' Compensation Insurance – A form of insurance that covers the payment of all workers' compensation and other benefits that an employer must legally provide to covered employees who suffer a work-related illness or injury.

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