



# Your social security rights

*in Bulgaria*

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The information provided in this guide has been drafted and updated in close collaboration with the national correspondents of the Mutual Information System on Social Protection (MISSOC). More information on the MISSOC network is available at: <http://ec.europa.eu/social/main.jsp?langId=en&catId=815>

This guide provides a general description of the social security arrangements in the respective countries. Further information can be obtained through other MISSOC publications, all available at the abovementioned link. You may also contact the competent authorities and institutions listed in annex to this guide.

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## Chapter I: Introduction, organisation and financing

### Introduction

The scope of social protection in Bulgaria includes both the classic contribution based social insurance, non-contributory social security schemes and social assistance, including the system of social services. It contains targeted programs for social assistance and care, creating employment for disadvantaged groups, family allowances for children, etc. The non-contributory social security schemes and the social assistance scheme are financed by the state budget. A set of criteria, including means tests, is applied to these schemes in order to assess entitlement. The social insurance schemes are financed through special budgets of the social insurance funds.

The public social insurance administered by the National Insurance Institute provides cash compensations, benefits, and pensions for:

- temporary incapacity to work;
- maternity;
- temporary reduced ability to work (reassignment);
- unemployment;
- invalidity;
- old age;
- death.

The compulsory health insurance, as well as the healthcare financed by the budget, provide a basic package of healthcare activities, financed either by the budget of the National Health Insurance Fund or by the state budget depending on the scheme.

The social assistance, as defined in the national legislation, covers benefits in cash or in kind, which supplement or replaces income up to the basic living needs or satisfies an incidental need of the supported persons and families.

### Organisation of social protection

The Bulgarian health model comprises both insurance based and tax financed schemes.

The public social insurance schemes provide cash benefits and pensions against the risks of: sickness; invalidity; maternity; occupational disease and accidents at work; old age; and death. Beside the social security schemes, the system of social assistance provides for protection against the risk of poverty, which also covers the family benefits under the Bulgarian legislation.

The Bulgarian pension model consists of three pillars. Since 2000, in addition to the pay-as-you-go scheme, a compulsory supplementary old-age scheme has been in operation– the second pillar. It covers all compulsory insured persons under the state public insurance, born after 31 December 1959 (universal scheme) and workers in hazardous conditions of work (professional pension funds). The third pillar comprises the voluntary pension insurance, within which occupational schemes regulated by the IORP directive were also introduced. The second and third pillar schemes are administered by private insurance companies under the supervision of the Financial Supervision Commission (*Комисия за финансов надзор*).

The institutions and the activities of social security are subject to statutory regulation, which is implemented by the Parliament and the Council of Ministers in cooperation with the representative organisations of workers and employers and other organisations of civil society, e.g. organisations for the protection of patients, and are supervised by the Judiciary.

The Minister of Labour and Social Policy elaborates and enacts the policy in the field of public social insurance, compulsory and supplementary pension schemes and social assistance.

The Minister of Health elaborates and enacts the policy in the field of healthcare, in both the insurance based and tax financed systems.

The National Revenue Agency (*Националната агенция по приходите*), established in 2005, is responsible for the creation and control of both taxes and social insurance obligations and their collection.

The National Social Insurance Institute (*Национален осигурителен институт*), established in 1995 organises the membership of the public insurance schemes for cash benefits.

The National Health Insurance Fund (*Националната здравноосигурителна каса*) has operated since 1999 and began contracting health services with providers on July 1, 2000.

The Employment Agency (*Агенцията по заетостта*), established in 1990, implements proactive measures for the employment of job seekers regardless of their insurance affiliation.

The Social Assistance Agency (*Агенцията за социално подпомагане*) manages activities related to the provision of sufficient funds, social care and family benefits.

In 2005 the Agency for people with disabilities (*Агенция за хората с увреждания*) was created and implements different activities in the field of the integration of people with disabilities.

## **Financing**

The social security system is financed from national insurance contributions paid by employers, employees, self-employed persons and in part from the State budget. The social assistance system is financed only by the state budget.

## **Contributions**

Insurance contributions are a percentage of the contributory income. They are divided between the insurer and the insured in the ratio of 60:40 (only the "General Sickness and Maternity" and "Unemployment" funds). The total pension insurance contribution for the third category of labour is 17.8% (9.9% for the insurer and 8.0% for the insured). If the insured was born after 31/12/1959, the pension insurance contribution is 12.8% (7.1% for the insurer and 5.7% for the insured). Since 01/01/2009, the state budget makes transfers to the "Pensions" fund, amounting to 12% of the sum of all contributory income of all insured persons for the calendar year.

Personal contributions for civil servants, judges, prosecutors, investigators, state bailiffs, court officials, and military staff are covered by the state budget.

Self-employed persons pay the full amount of contributions due at their own expense.

Contributions for accidents at work and occupational diseases vary, according to the working conditions, from 0.4 to 1.1% and are entirely at the employer/insurer's expense.

The contribution to the Guaranteed Claims of the Employees Fund is entirely at employers' expense (0.1% in 2010). In 2012, contribution payments to the Fund were temporarily suspended.

Workers in the first and second category of labour are mandatorily insured with the professional pension fund for supplementary mandatory pension insurance (SMPS). The amount of contribution for the first category of labour is 12% and for second is 7%. Contributions are fully covered by the employer. The employer is obliged to submit another 3% of contributions to the "Pensions" Fund at his or her own expense. An additional 4.3% is paid on the behalf of teachers to the teacher's pension fund at the expense of the insurer. For persons born after 01/01/1960, the contribution to the "Pensions" Fund is reduced. The difference of 5% is credited to the individual's account in a universal pension fund for supplementary mandatory pension insurance.

The maximum monthly amount of the contributory income is BGN 2,000 (€ 1,023). Social security contributions are due on received, including accrued and unpaid, gross monthly wages. Contributions cannot be less than the minimum contributory income as defined by the main economic activities and qualification occupational groups.

For individuals for whom no minimum contributory income has been defined, contributions are due on the national minimum monthly wage.

The minimum contributory income for self-employed persons varies from BGN 420 (€ 215) to BGN 550 (€ 282) depending on their taxable annual income for 2010. For persons who did not undertake lucrative activity in 2010 and for the self-employed persons who have started their economic activity in 2011 and 2012, the minimum amount of the contributory income is BGN 420 (€ 215).

## Chapter II: Healthcare

### When are you entitled to healthcare?

#### Within the scope of tax financed healthcare schemes

1. Bulgarian nationals;
2. Foreigners with permanent residence in Bulgaria;

NB - other EU nationals are not foreigners within the meaning of the BG legislation, EU nationals have the same rights and obligations as Bulgarian nationals on the basis of Treaty on the Functioning of the European Union.

#### Within the scope of compulsory health insurance

The compulsory health insurance scheme in Bulgaria is managed by the National Health Insurance Fund (NHIF). NHIF provides a basic healthcare services package, on the basis of contribution payments to the compulsory health insurance.

The following are subject to the compulsory health insurance system:

1. all Bulgarian citizens who are not also citizens of another country;
2. Bulgarian citizens who are also citizens of another country and permanently reside on the territory of the Republic of Bulgaria;
3. foreign citizens or persons without citizenship who have permission to stay permanently or long-term on the territory of the Republic of Bulgaria, unless otherwise stipulated by an international agreement to which the Republic of Bulgaria is a party;
4. persons with a status of refugee, humanitarian status or who have been granted the right to asylum.
5. foreign students and doctoral students admitted to universities or science organizations in the country by the order of the Decree of the Council of Ministers No. 103 of 1993 for the Implementation of Educational Activities Among the Bulgarians Abroad and Decree of the Council of Ministers No. 228 of 1997 for Admittance of citizens of the Republic of Macedonia in the state universities of the Republic of Bulgaria;
6. persons, who fall outside of the scope of the ones referred to in items 1 through 5, with regards to whom the legislation of the Republic of Bulgaria is applied in compliance with the rules for coordination of the social security schemes.

Persons who are subject to health insurance in another Member State shall not be obligatorily insured by the National Health Insurance Fund, according to the rules for coordination of the social security schemes.

The health insurance rights of persons who are required to pay health insurance contributions at their own expense shall be suspended if they have failed to pay more than 3 due monthly contributions in a period of 36 months, up to the month preceding the month in which the healthcare services were rendered. The persons concerned can recover their insurance by paying the outstanding health contributions for the past 36 months. Their health insurance rights shall then be reinstated as from the date of



payment of the due contributions. Amounts paid for healthcare provided shall not be refunded. When it is the obligation of the employer or another person to pay the contribution, non-payment of contributions does not deprive the person of his/her health insurance entitlement.

## What is covered?

### The scope of the tax financed healthcare scheme

The following treatment is provided by the tax funded scheme for Bulgarian nationals and some categories of foreign nationals with a long-term residence permit:

- medical aid in emergency cases;
- obstetric aid for all women without health insurance, regardless of the manner of birth, within the scope determined by an ordinance of the Minister of Health which shall also determine the procedure;
- psychiatric hospital aid;
- the provision of blood and blood products;
- the transplantation of organs, tissues and cells;
- mandatory treatment and/or mandatory isolation;
- expert opinions and reports on the degree of disability and long-term loss of the ability to work;
- payment for the treatment of diseases under the terms and conditions set out by the Minister of Health;
- medical transport under the terms and conditions set out by the Minister of Health.

### The scope of compulsory health insurance

Compulsory health insurance shall guarantee to the insured persons free access to medical care by means of a package of health-care activities of a specific type, scope and amount, as well as the free choice of a care provider, who or which has concluded a contract with a Regional Health Insurance Fund.

The right of choice shall apply to the entire territory of Bulgaria and may not be restricted on geographic and/or administrative grounds.

The National Health Insurance Fund shall pay for the following medical services:

1. medical and dental services for the prevention of diseases;
2. medical and dental services for the early discovery of diseases;
3. out-patient and hospital medical care for diagnostics and the treatment of diseases;
4. further treatment, long-term treatment and medical rehabilitation;
5. emergency medical care;
6. medical care for pregnancy, labour and motherhood;
7. medical care under Art. 82, Para 1, Item 2 of the Law of Health.
8. abortions carried out for medical reasons and for pregnancy as a result of rape;
9. dental services;
10. medical care in cases of home treatment;
11. prescription and dispensing of permitted medicines for home treatment on the territory of the country;
12. prescription and dispensing of medical products and dietetic foods for special medical purposes;
13. medical expertise for the capacity to work;

14. transport services for medical reasons;
15. health activities under Art. 82, Para 2, item 3 of the Law of Health (inpatient psychiatric care).

The medical care covered under the preceding paragraph, with the exception of Items 11, 12 and 15 shall be defined as a basic package guaranteed by the budget of the National Health Insurance Fund. The basic package shall be determined by an ordinance of the Minister of Health.

For carrying out the activities provided for in this law, NHIF and the Bulgarian Medical Association shall adopt and sign the National Framework Contract for medical activities, and the NHIF and the Bulgarian Dental Association shall adopt and sign the National Framework Contract for dental activities. The National Framework Contracts shall contain:

1. the requirements to be met by the providers of medical care, as well as the procedure for concluding contracts with them;
2. the particular types of medical care as per the basic package;
3. the conditions and the procedure for providing the care in the basic package;
4. the quality and accessibility criteria of the care;
5. the documentation and document flow;
6. the obligations of the parties to provide informational services and exchange information;
7. other issues of importance for health insurance.

The Minister of Health shall issue an ordinance determining a list of diseases for which medicinal drugs, medical goods and dietetic foods for special medical purposes for treatment at home shall be fully or partly reimbursed by the National Health Insurance Fund. The NHIF pays fully or partially for up to 3 listed pharmaceutical products per listed illness. The NHIF together with the associations of doctors and dentists determines the prices of the products with the producers and wholesalers. The extent of the National Health Insurance Fund payment towards the listed products is included in the annual National Framework Contract.

Upon every visit to a GP, a specialist physician in outpatient care, or a dentist, the insured person shall pay a user fee of 1% of the minimum wage.

Should an insured person require hospitalisation, he/she must pay 2% of the national minimum wage for each day of hospitalisation where this amounts to less than 10 days per year. After the 10th day, the patient is not required to pay the user fee.

The user fee for the provision of outpatient and inpatient health and dental care shall not be paid by:

- persons with diseases specified in the annex to the National Framework Contract;
- minors and unemployed family members;
- victims of, or connected with, the country's defence;
- war veterans and war invalids;
- detainees and prisoners;
- poor people receiving state aid;
- people without income, living in care homes;
- health professionals;
- pregnant and young mothers, up to 45 days after birth;
- insured persons with severe invalidity who are in addition suffering from specified diseases;

- patients with malignant neoplasm.

Persons with discontinued health insurance rights shall pay for the healthcare services rendered.

## **How is healthcare accessed?**

### **Choice of a GP**

Insured persons are entitled to freely choose a GP for primary outpatient care, and dental practitioners (dentists) throughout the country. Insured persons can change their GP every calendar year, during the periods running from 1st to 30th June and from 1st to 31st December. In the case of a change of residence, the insured person is entitled to choose a new GP at any time of the year.

### **Dental care**

Insured persons are entitled to receive dental care upon the presentation of their health insurance record to the dentist of their choice, throughout the country.

### **Outpatient care**

Specialised outpatient care can be provided to insured persons who were issued a "Medical referral for consultation or joint treatment" by their GP. This referral can be used within 30 calendar days of its issuance. The insured person can choose a specialist in any hospital which has signed a contract with the Regional Health Insurance Fund upon presentation of the referral.

### **Access to establishments for inpatient care**

Doctors and dentists can refer the patients to a chosen health establishment for inpatient care throughout the country. The hospital (or dispensary) is required to have signed a contract with the Regional Health Insurance Fund. From 2011 there has been the possibility for patients to choose a team of doctors and nurses within the health establishment.

## Chapter III: Sickness cash benefits

### When are you entitled to sickness cash benefits?

The public social insurance provides social insurance benefits and cash allowances to insured employees for periods of temporary incapacity, when they are in the process of recovering their health and have no employment income.

### What is covered?

Insured persons are entitled to benefits for temporary incapacity to work in the case of:

- sickness;
- accidents – with the exemption of labour-related accidents;
- examination due to sickness;
- quarantine;
- pregnancy;
- maternity;
- reassignment - sickness;
- reassignment - pregnancy;
- sanatorium-resort treatment for sickness;
- accompanying a child of up to 3 years of age to the hospital;
- caring for a child under the age of 18;
- caring for a sick person over the age of 18.

The daily cash benefit for temporary incapacity to work due to general sickness shall be calculated at the rate of 80%, and for temporary invalidity due to labour accidents or occupational diseases - up to 90% of the average daily gross wage or average daily contributory income for the last 18 months, on which insurance contributions are paid or are due.

Cash benefits for temporary incapacity to work due to general sickness, labour accidents and occupational diseases are payable from the first day of the event up to recovery or the establishment of permanent invalidity.

Until 31 December 2012, the employer shall pay the sickness cash benefit for the first, second and third day of the temporary inactivity in an amount equal to 70% of the average gross wage of the employee. Afterwards, the benefit shall be 80% of the contributory income and is paid by the National Social Insurance Institute.

### How are sickness cash benefits accessed?

Leaves for temporary incapacity to work are authorised by means of a sick leave paper issued by the authorities responsible for assessing working capacity. The sick leave paper is issued on the day of the establishment of the incapacity, whereas the leave may begin the previous day, the same day, or the day following the examination. The sick leave paper shall indicate the type of incapacity, the need, and type of treatment and the duration of the leave. The sick leave paper must be

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submitted to the employer or the latter should be informed about it immediately after its issue, in any case, no later than two business days thereafter.

The employer shall grant the leave, with no right to discretion, upon the presentation of the sick leave paper. For the first business day of the temporary invalidity, the employer shall pay the insured person the gross average daily wage for the month in which the temporary invalidity occurred.

Cash benefits for the second and subsequent days of the temporary invalidity are calculated and paid by the National Social Insurance Institute to the insured person's declared bank account.

## Chapter IV: Maternity and paternity benefits

### When are you entitled to maternity or paternity benefits?

Insured persons are entitled to a cash benefit for pregnancy and birth in replacement of their wage if they have completed 12 months of insurance towards this risk.

#### Maternity benefit (MB)

Mothers insured for general sickness and maternity are entitled to a cash compensation for pregnancy and birth for a period of 410 calendar days, beginning 45 days before the determined date of child birth. If the birth occurs before the expiry of the 45 days from the beginning of the use of compensation, the remainder of the 45 days can be used after the birth.

A father who has been insured in the "General Sickness and Maternity Fund" for at least 12 months, is entitled to statutory paternity pay for a period of 15 calendar days upon the birth of his child. The amount of the benefit is 90% of the father's contributory income for the last 24 months. With the consent of the mother (or adoptive mother), when the child reaches 6 months old, the father (or adoptive father) may use any remaining of the 410 days instead of the mother, receiving the relevant benefit instead of the mother.

After the expiration of the pregnancy and birth leave, mothers who have been insured for general sickness and maternity for at least 12 months have the right to receive a benefit for taking-care of small children who are under the age of 2 years.

#### Maternity allowance for uninsured mothers

Pregnant women, whose average monthly income per family member is lower or equal to a certain level, shall be entitled to a one-time allowance during pregnancy if not entitled to a pregnancy and childbirth benefit under the Social Insurance Code and if permanently residing in this country. This allowance will be fixed annually with the State Budget of the Republic of Bulgaria Act for the respective year, but will not be lower than the amount fixed in the previous year.

Where a pregnant woman is insured in respect of common disease and maternity, but is not entitled to a pregnancy and childbirth benefit due to the failure to complete the required length of insurance participation under the Social Insurance Code, the one-off allowance shall be paid in an amount proportionate to the number of days from the start of the maternity and childbirth leave and the time of reaching the required length of insurance participation under the Social Insurance Code, but not in excess of 45 days.

The one-time pregnancy allowance shall be payable 45 days prior to the determined expected date of child birth.

#### What is covered?

The daily cash benefit during pregnancy and childbirth is set at 90% of the average gross wage or contributory income for the last 24 months, on which contributions have been paid or are due. The amount of the benefit cannot be lower than the statutory minimum wage and cannot exceed the average net remuneration.

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The amount of the benefit for the taking-care of a small child of up to 2 years of age is fixed by the Public Social Insurance Budget Act and amounts to BGN 240 (€ 123).

If the child is given up for adoption, or placed in a nursery school with full state subsistence allowance, the benefit shall be terminated starting the next day.

### **How are maternity and paternity benefits accessed?**

To qualify for this benefit, a leave should be authorised. The health authorities shall issue a sick leave paper. The employer shall grant the leave without right to discretion, upon the presentation of a sick leave paper.

## Chapter V: Invalidity benefits

### When are you entitled to invalidity benefits?

#### Invalidity pension

Insured persons are entitled to an invalidity pension when they have wholly or partially lost their working capacity for a long period of time or permanently.

Insured persons acquire the entitlement to an invalidity pension according to the following contribution requirements:

- up to 20 years of age: no period of insurance is required;
- up to 25 years of age: one year of insurance is required;
- up to 30 years of age: 3 years of insurance is required;
- over 30 years of age: 5 years of insurance is required;
- those who are disabled at birth or who become disabled before starting work will acquire the entitlement to an invalidity pension after a one-year period of insurance.

An invalidity pension is granted to persons with permanently reduced working capacity of 50% or more. Entitlement to the pension arises from the date the invalidity occurred.

For persons blind at birth and blind before entering the labour market - the invalidity pension is paid from the date of application. The pension is granted for the duration of the invalidity.

#### Invalidity allowance

Insured persons are entitled to an invalidity allowance due to general sickness, when they have not acquired the necessary period of insurance for the granting of an invalidity pension.

### What is covered?

#### Invalidity pension

The amount of the general-sickness invalidity pension is determined by multiplying the income on the basis of which the pension is calculated by the total sum of 1.1% for each year of the period of insurance. In addition, the time counting as a period of insurance is multiplied by a coefficient which depends on the degree of invalidity as follows:

- degree of invalidity over 90%: 0.9;
- degree of invalidity between 71% and 90%: 0.7;
- degree of invalidity between 50% and 70.99%: 0.5.

Pensioners who have lost over 90% of their working capacity and who are constantly in need of external assistance, receive a pension supplement of 75% on the social old-



age pension. The supplements are added to every pension regardless of the type. Supplements are paid to the retired person and not to the person providing the assistance.

### **Social Invalidity Pension**

The right to a social pension for disability is granted to persons who have reached 16 years of age and have a permanently reduced capacity to work/type and degree of inability of more than 71%.

The amount of the social pension for disability for persons with a permanently reduced ability to work/type and degree of inability over 90% is 120%. Persons with a permanently reduced ability to work of between 71 to 90% receive 110% of the social pension for old age.

### **Invalidity allowance**

The amount of the allowance for invalidity due to general sickness, when the insured person does not have the necessary periods of insurance to be granted an invalidity pension due to general sickness, is calculated by multiplying the daily amount of the allowance for temporary invalidity by 60.

Similarly to the invalidity pension, an external assistance supplement is granted for the duration of the incapacity, as assessed by the Territorial Expert Medical Board (TEMB) or by the National Expert Medical Board (NEMB), if the person has not reached retirement age in that year. When, within the period specified in the expert decision, the person reaches retirement age, the external assistance supplement is paid for life.

The payment of the external assistance supplement ends when the grounds for the entitlement no longer exist, e.g. death of the pensioner, change of the invalidity group, etc.

### **How are invalidity benefits accessed?**

#### **Invalidity pension**

The invalidity pension is granted upon an application to the NSII. The application shall be accompanied by an expert decision by the TEMB (NEMB), determining the degree of incapacity.

#### **Invalidity allowance**

When the insured person does not have the required periods of insurance for the granting of a general-sickness invalidity pension, the invalidity allowance shall be granted on the grounds of an application to the territorial unit of the National Social Insurance Institute (NSII). The following documents should be enclosed with the application:

- documents for the contributory (employment) service up to the date of invalidity;
- documents about the gross wage or income on which insurance contributions have been paid;
- an expert decision of the Territorial Expert Medical Board TEMB or the National Expert Medical Board (NEMB).

## Chapter VI: Old-age pensions and benefits

### When are you entitled to old-age benefits?

State old-age pension can be claimed once you reach the State pensionable age and have accumulated a certain number of years of insurance periods:

- men are entitled to an old-age pension at the age of 63 years and 4 months and with 37 years and 4 months years of insurance periods;
- women are entitled to an old-age pension at the age of 60 years and 4 months and with 34 years and 4 months years of insurance periods;
- persons who have not acquired sufficient periods of insurance are entitled to a pension at the age of 65 years and 4 months, upon the existence of 15 years of insurance periods.

As of 31/12/2011, the required length of insurance will start increasing by 4 months per calendar year until reaching 40 years for men and 37 years for women. As of 31/12/2011, the retirement age will start increasing by 4 months per calendar year until reaching 63 years of age for women and 65 years of age for men. Also as of 31/12/2011, the retirement age for persons not having acquired the necessary length of insurance will start increasing by 4 months per calendar year until reaching the age of 67 years.

For workers and employees, the period of insurance is the time during which they have worked full-time according to the statutory working hours, if contributions have been paid or are due on the remuneration received, which may not be less than the minimum contributory income. The period of insurance is calculated in hours, days, months, and years. For part-time workers and employees, the period of insurance is calculated by dividing the hours worked by the statutory work hours.

The insurance legislation gives the opportunity for some periods to be recognized as a period of insurance without the need to pay contributions. Periods of insurance with no contributions cover periods of paid and unpaid leave for the raising of a small child, paid and unpaid leave for temporary incapacity to work, paid and unpaid leave for pregnancy and child birth, and unpaid leaves of up to 30 working days within a calendar year and the time during which the person has received unemployment allowance.

The insurance legislation provides the opportunity, under specific conditions, to purchase insurance periods.

### Social old-age pension

A social old-age pension may be granted at the age of 70, to persons for whom the annual income per family member is less than the guaranteed minimum income (BGN 65 (€ 33)). The social old-age pension is a special type of pension that is not linked to employment. Entitlement to such a benefit is granted to persons who are not entitled to an old-age pension because their period of insurance is insufficient. This pension is not paid by the insurance funds but by the state budget. The social old-age pension is a type of social support, which is defined as a pension payment due to its regularity (monthly) and its management by the administration of the Social Assistance Agency.

## What is covered?

The calculation basis for the statutory old-age pension is determined by multiplying the national average monthly contributory income (over the 12 calendar months preceding the granting of the pension) by the insured person's individual coefficient. The individual coefficient is determined on the basis of the insured person's average monthly contributory income.

The calculation basis is then multiplied by 1.1% for each year of insurance and a proportional amount for each additional month of insurance. In addition, the calculation basis is multiplied by 4% for each year of insurance for persons who have acquired a period of insurance of 37 years and 4 months for men and 34 years and 4 months for women but still continue working after reaching the retirement age and are not yet receiving their pension.

The amount of the old-age pension cannot be lower than a fixed amount and cannot exceed a maximum threshold. The minimum amount of the old age pension is determined by the Public Social Insurance Budget Act and amounts to BGN 145 (€ 74). The maximum pension amount (for all pensions) is determined as 35% of the maximum contributory income for the preceding year. In 2011, the maximum contributory income was BGN 2,000 (€ 1,023), and in 2012, the maximum pension amount is BGN 700 (€ 358).

Any pensions granted until 31 December of the preceding year shall be updated on an annual basis as from 1 July by decision of the Supervisory Board of the National Social Security Institute through adjustment by a percentage equal to the consumer price index for the last preceding calendar year. Due to budget restrictions, pensions have not been adjusted since 1 July 2009.

The supplementary old-age scheme is based on the amount saved on each individual's personal account.

## How are old-age benefits accessed?

In order to receive a pension, the insured person shall file an application with the regional unit of the National Social Insurance Institute (NSII). The following documents should be enclosed:

- a work record book and/or insurance record book and/or certificate of length of service; or
- the gross wage or income on which insurance contributions have been made for a period of three consecutive years from the last 15 years of insurance periods by 01/01/1997 as chosen by the person or the income on which the insurance contributions have been made for the period after that date until the retirement of the person.

If the application to the NSII has been submitted up to 6 months before the date of the termination of insurance, the pensions will be granted as of that date. If the application has been submitted six months after the date of the termination of insurance, the pension is granted as of the date of the application.

Following the application, a minimum pension is granted within one month, and the actual pension is calculated and granted at a later stage.

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## **Social old-age pension**

Documents to be submitted for the granting of a social old-age pension:

- an application for the granting of a social old age pension, based on a model approved by the NSII;
- a declaration for family and property status;
- a declaration of the annual income of family members for the 12 months preceding the application.

When defining the annual income of family members, family members include husbands, wives, and children up to 18 years of age if not married, as well as children above that age if disabled, and who are not receiving any other income and who are not married.

The social old age pension is for life. The entitlement ends upon the death of the entitled person.

## Chapter VII: Survivors' benefits

### When are you entitled to survivors' benefits?

The right to a survivor's pension is granted to the children, the surviving spouse and the parents of the deceased insured person.

The children shall have the right to a survivors' pension until reaching 18 years of age. After reaching 18 years of age, if studying, the children of the deceased insured have the right to receive the survivors' pension for the term of study up until 26 years of age. Surviving children of the deceased insured person who have become disabled under the age of 18 are also entitled to receive the survivors' pension until reaching 26 years of age.

The surviving spouse shall be entitled to a survivors' pension 5 years earlier than the age for entitlement to an old-age pension (63 years and 4 months for men and 60 years and 4 months for women) or before that age, if he or she has lost his or her working capacity.

Parents shall be entitled to a survivors' pension upon the death of their children if they have attained the age for entitlement to an old-age pension.

### Survivors' pension for old-age and invalidity

Upon the death of the insured person, the heirs shall be given a pension equivalent to the type of the personal pension (i.e., pensions for general diseases, labour accidents, or professional diseases) that the deceased would have received as a disabled person who had lost more than 90% of his or her ability to work.

When the deceased has acquired the right to a pension due to his or her completed insurance periods and age, the heirs shall be given a survivors' pension as calculated from the pension due as a result of completed insurance periods and age if this is more favourable for them.

In the case of the death of a pensioner who has been receiving a pension for disability due to a general disease or a personal pension calculated on completed insurance periods and age, the survivors' pension shall be released in the percentage mentioned below, according to the type of the received pension.

### Survivors' allowance

Retired persons whose spouse is deceased are entitled to receive a pension supplement, the so-called survivors' allowance. Survivors' supplements are only paid in addition to another granted pension: persons who are not already entitled to a pension on other grounds are not entitled to this supplement.

The survivor must therefore meet several conditions in order to receive the pension supplement:

- the survivor must be receiving a personal or survivors' pension, regardless of the type;
- the survivor must not have remarried after the death of the spouse; upon remarrying the supplement is terminated as of the date of marriage;

- the survivor must not be receiving a survivors' pension from the deceased person.

This allowance is defined as a percentage of the pension of the deceased spouse and is paid to assist the surviving spouse. The pensioner is entitled to a supplement of 20% of the pension or pensions, received by the deceased spouse (to reach 40% by year 2015). For the calculation of this supplement, any supplements to the pension of the deceased spouse are not taken into account. If the deceased spouse has never received a pension, the supplement is determined on the pension, or the sum of pensions, to which the deceased would have been entitled.

### What is covered?

The survivors' pension shall be determined as a percentage of the due personal pension of the deceased insured person as follows:

1. one heir - 50%;
2. two heirs - 75%;
3. three and more heirs - 100%.

Upon the death of both of the parents (or adopters), the children shall have the right to a survivors' pension as determined from the sum of the pensions of the deceased.

### How are survivors' benefits accessed?

The survivors' pension is granted on the application to the relevant regional unit of the National Social Insurance Institute (NSII). The following documents should be enclosed:

- certificate of heir;
- declaration by the school providing that the children continue to learn;
- expert decision for children that have become disabled before the age of 18, or before the age of 26 if disability occurred during training or military service;
- expert decision for surviving spouses who have not reached the [required age](#) and are unable to work;
- declaration providing that the children are not adopted and certificate proving that the surviving spouse has not remarried;
- declaration for the parents, certifying that they do not receive a personal pension and they are not deprived of parental rights and a document certifying they are parents;
- a document issued or certified by the respective military department providing that the death occurred during military service - for the parents of a person who died during the military service;
- documents proving the deceased person's periods of insurance – work record book, insurance record book, and certificate of periods of insurance if the deceased person was not a pensioner.

## Chapter VIII: Benefits in respect of accidents at work and occupational diseases

### When are you entitled to benefits in respect of accidents at work and occupational diseases?

All persons working under labour contracts, service contracts, elected positions, cooperatives or management contracts are compulsorily insured under the Labour Accident and Occupational Disease Fund for accidents at work and occupational diseases. This covers invalidity, death, temporary incapacity to work, and temporary incapacity due to labour accidents and occupational diseases.

The amount of social insurance contributions paid by the insurers is determined as a percentage of the monthly contributory income of the insured person.

### What is covered?

Regardless of the length of period of insurance, insured persons are entitled to:

- cash benefits in cases of urgent medical examinations, tests and treatments;
- sanatorium resort treatment;
- cash benefits for temporary invalidity due to labour accident or occupational disease;
- cash benefits for prevention and rehabilitation;
- invalidity pensions due to labour accidents or occupational diseases;
- cash benefits for technical aids related to invalidity.

The daily cash benefit for temporary invalidity due to labour accident or occupational disease is calculated at the rate of 90% of the average daily gross wage or average daily contributory income for the last 18 months, on which contributions have been paid or are due. It is payable from the day the event occurred until recovery or the establishment of an invalidity pension. If the temporary invalidity occurred within 30 calendar days of the termination of the employment contract or the insurance, the cash benefit is paid for the period of incapacity but for not more than 30 calendar days.

### How are benefits in respect of accidents at work and occupational diseases accessed?

In order to become entitled to benefits, temporary invalidity leaves must be authorised, by means of a sick leave paper. The sick leave paper shall be issued on the day of the establishment of the invalidity; however the starting date of the leave may be the preceding day, the same day, or the day following the examination. The sick leave paper shall indicate the type of incapacity, the need, and type of treatment and duration of leave.

The sick leave paper shall be submitted to the employer or the latter shall be informed about it immediately after it is issued, not later than two work days thereafter. The employer has no discretion whether to grant such leave or not and shall and pay the

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insured person a gross average daily wage for the first working day of temporary invalidity.

Cash benefits for second and subsequent days of temporary invalidity are calculated and paid by the National Social Insurance Institute to the account declared by the insured.

Until the end of 2012, the first, second and third day of the temporary incapacity to work will be paid by the employer at 70% of the average gross wage. From the fourth day onwards, the National Social Insurance Institute (NSII) will cover the payment of cash benefits at 90% of the average gross wage.



## Chapter IX: Family benefits

### When are you entitled to family benefits?

Family allowances and some of the maternity benefits are considered family benefits for the purposes of the EU coordination regulations.

Family allowances are cash or in kind benefits, aimed at providing financial support for pregnancy, birth and the raising of children. They are one-off or monthly payments.

The following categories are entitled to family allowances:

- pregnant women - Bulgarian citizens;
- families of Bulgarian citizens – for children they raise in the country;
- families in which one parent is a Bulgarian citizen – for children with Bulgarian citizenship, raised in the country;
- families of relatives or foster families – for children placed within these families under the Law on Child Protection;
- pregnant women – foreigners and families of foreign nationals who permanently reside and raise their children in the country, if the entitlement to such benefits is provided in another law or international treaty to which Bulgaria is a party.

To be entitled to family allowances, the average monthly income per family member for the previous 12 months, must be less or equal to the income designated for that purpose in the law for the state budget of the Republic of Bulgaria for the relevant year (BGN 350 (€ 179)). The means-test is applied only for the monthly allowance for children until their completion of secondary education, but not after reaching 20 years of age; the targeted allowance for the raising of children under one year of age and the targeted allowance for children enrolled in 1st grade.

### What is covered?

Family benefits include:

- lump-sum allowances for pregnancy;
- lump-sum allowances at childbirth;
- lump-sum allowances for raising twins under the age of one year;
- lump-sum allowances for raising a child under the age of one year for mothers that are full-time university students;
- monthly allowances for children until the completion of their secondary education, but not after reaching 20 years of age;
- monthly allowances for raising a child under the age of one year;
- targeted allowances for children enrolled in 1st grade;
- targeted assistance for free domestic travel by rail and bus transport for mothers with many children;
- monthly allowances for children with a permanent invalidity under 18 years of age and until the completion of secondary education, but not after reaching 20 years of age.

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## **How are family benefits accessed?**

Family allowances for children are granted by the Social Assistance Directorates (SAD), based on an application by means of a form, approved by the Minister of Labour and Social Policy. The application shall be filed by the mother or other legal representative of the child.

Applications for a lump-sum allowance for childbirth must include the following documents:

- original birth certificate of the child for whom assistance is requested;
- copies of the birth certificates of all children born to the mother.

Entitlement arises on the date of birth of the child, unless it was left for care in a specialised institution for children. This benefit may be requested within three years from the end of the month in which the child was born.

Applications for family allowances for children under the age of 18 must include:

- a certificate for the gross monthly family income for the six calendar months preceding the month of application (for workers in employment or in a civil service relationship). It must specify income from pensions, benefits, and scholarships.
- an official certificate from the school that the child is enrolled in declaring that the child is a student and attends classes regularly.

Applications for monthly allowances for children under the age of one year must include:

- a certificate for the gross monthly family income for 6 calendar months before the month of application;
- a copy of the birth certificate of the child.

## Chapter X: Unemployment

### When are you entitled to unemployment benefits?

Any person for whom the employer pays insurance contributions for unemployment is insured against the risk of unemployment. Employers are obliged to pay contributions from the date of receipt of the employment, management or control contract.

Persons who have paid contributions to the Unemployment Fund for at least 9 months during the 15 months preceding the end of the insurance are entitled to unemployment benefits on the condition that they:

- have registered as unemployed at the Employment Agency;
- have not been granted a period of insurance and old-age pension or occupational pension for early retirement;
- are not employed.

### What is covered?

Insured persons are entitled to:

- information on job vacancies;
- assistance for finding a suitable job;
- unemployment benefits and allowances.

Unemployment benefits are paid from 4 to 12 months, depending on the length of the person's total period of insurance as follows:

- for contributory income up to 3 years, benefits are paid for 4 months;
- from 3 to 5 years, benefits are paid for 6 months;
- from 5 to 10 years, benefits are paid for 8 months;
- from 10 to 15 years, benefits are paid for 9 months;
- from 15 to 20 years, benefits are paid for 11 months;
- over 25 years, benefits are paid for 12 months.

The daily unemployment benefit amounts to 60% of the average wage or average contributory income on which unemployment fund contributions are paid or are due for the 24 calendar months preceding the month of termination of insurance. It shall not be lower than a fixed minimum amount. The minimum daily amount of unemployment benefit is determined annually by the Public Social Insurance Budget Act (BGN 7.20 (€ 3.68)).

Unemployed persons who left their job at their own request, with their own consent or because of their own inappropriate behaviour, receive the minimum amount of unemployment benefit for a period of 4 months.

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## **How are unemployment benefits accessed?**

The unemployment benefit shall be granted upon application to the regional unit of the National Social Insurance Institute (NSII). The application shall be submitted personally based on the permanent or present address. The unemployment benefit is paid from the date of termination of the insurance, if the application is filed within 3 months from that date. If the application is submitted after that date for unacceptable reasons, the cash benefit is paid for the specified period, reduced by the period of the delay.

Cash unemployment benefits are paid by the National Social Insurance Institute to the bank account declared by the person.

## Chapter XI: Minimum resources

### When are you entitled to benefits regarding minimum resources?

Social benefits in cash or in kind supplement or provide an income to guarantee the basic living needs or meet incidental needs of individuals and families. Social benefits are provided to persons having exhausted all other possibilities for self-support and support by their relatives.

Persons or families whose income for the previous month is lower than a predefined differentiated minimum income are entitled to a monthly benefit.

### What is covered?

The Council of Ministers defines the monthly amount of guaranteed minimum income (GMI), which serves as a basis for determining the amounts of social assistance. The GMI amounts to BGN 65 (€ 33).

Individuals and families with low income have the right to monthly social assistance, targeted social assistance benefits for covering specific needs associated to travel, ill-health, medical treatment abroad, housing, etc., or lump-sum social assistance benefits for the fulfilment of extraordinary needs.

In addition, individuals and families whose income is below a certain level, could receive a heating allowance for a period of 5 consecutive months (November – March). The amount of the monthly heating allowance is determined by the Minister of Labour and Social Policy.

### How are minimum resources benefits accessed?

Social benefits are granted upon an application submitted by the needy or their authorised representatives. The aid is granted after the following aspects are taken into consideration:

- the person's or family's income;
- the person's property status;
- the person's family status;
- the person's health status;
- any working and/or educational engagements;
- age;
- other circumstances.

Social benefits are exempt from taxes and fees.

Unemployed persons of working age who receive a monthly allowance and are not included in employment programs, shall be obliged to perform community work for a period of 14 days, 4 hours a day, based on programs organised by the municipal administration for the provision of social services, environmental programs, development and sanitation of settlements and other programs for community activities.

## Chapter XII: Long-term care

### When are you entitled to long-term care?

Long-term care is needed when a person becomes ill or suffers from an invalidity that makes them unable to carry out their normal daily activities, with the probability that this invalidity will continue over the long term. In the case of elderly people, this is typically caused by an increasing frailty due to ageing or the chronic aftermath of acute conditions such as a stroke, a fall, or severe arthritis. Long-term care can also be required if a person is mentally impaired. The most common form of impairment for elderly people is Alzheimer's disease.

In Bulgaria, long-term care falls under the social assistance sector. The social security sector, based on the contributory principle of the payment of contributions for a set of social risks, does not currently provide social protection for long-term care.

### What is covered?

Long-term care is provided according to one of the following state programs:

- pension supplements for external assistance are provided to pensioners who have lost over 90% of their capacity to work and who are constantly in need of external assistance. They receive a pension supplement of 75% of the social old-age pension.
- the National Programme "Assistants to the disabled" provides care in a family environment to people with disabilities or who are severely ill. The programme aims at providing unemployed persons with a job either as a personal or a social assistant. Personal assistants help families in which there is a person with disabilities in need of constant care. Social assistants help disabled, seriously ill, sick or lonely people with their daily activities, organising their leisure time and carrying out activities for their social inclusion. The programme is funded through the State budget.
- the programme "personal assistant", implemented by the Social Assistance Agency and municipalities, encourages the social inclusion of disabled children and of persons suffering from severe diseases by providing permanent care enabling them to fulfil their daily needs. The programme is funded by the European Social Fund.
- the programme for "social assistant" and "home assistant" activities funds projects of the municipalities and NGOs, who have applied to perform these activities. The programme is funded by the European Social Fund.
- specialised institutions for social services under the Social Assistance Agency provide social services in boarding-type homes where people are separated from their home environment. These include homes for children, for adults with disabilities, social educational professional establishments, retirement homes and homes for temporary accommodation.

A personal assistant cares for the elderly and children with severe disabilities, needing care throughout the day. Possible beneficiaries are:

- individuals in need of constant care, having 90 or more than 90% permanent invalidity, who are entitled to external assistance;

- children with 50 and over 50% reduced capacity for social adaptation, who are entitled to external assistance;
- individuals or children dismissed from specialised institutions for people with disabilities.

A social assistant may work part-time and the service can only be used for cases of medium severity, where the person cared for shall be taken out for socialising, taken to rehabilitation or the work place, if performing economic activities. Possible beneficiaries are:

- individuals with 90 or over 90% permanent invalidity, who have been prescribed external assistance;
- children with 50 and over 50% reduced capacity for social adaptation, who are entitled to external assistance;
- seriously ill and lonely people who are unable to care for themselves;
- individuals/children who have been dismissed from specialised institution for people with disabilities.

Persons who are eligible to receive the services of both a personal assistant and a social assistant must choose one of the two.

A home assistant does not have any special qualification and performs routine care tasks.

## **How is long-term care accessed?**

### **External assistance supplement**

Entitlement to an external assistance supplement is assessed by the Territorial Expert Medical Board (TEMB) or National Expert Medical Board (NEMB). They issue a decision specifying that the person is unable to care for him/her self and needs the assistance of another person. When claiming an external assistance pension supplement, the following documents should be enclosed:

- the application form;
- the TEMB decision containing all the necessary data about the medical condition of the pensioner, the degree of lost working capacity and data about the period of supplement entitlement;
- the decision of the medical committee of the regional unit of the National Social Insurance Institute (NSII).

### **Social services, provided in the community**

Persons, who wish to use social services shall file an application in writing respectively to:

- the Director of the Social Assistance Directorate – for social services that are delegated by the state;
- the Mayor of the municipality – for social services that are rendered by the municipality;

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- the management body - if the service provider is an individual registered under the Company Law or a legal entity.



## Annex: Useful addresses and websites

A detailed table on social security arrangements in Bulgaria and in other Member States can be found on the [MISSOC](#) network web page:

*For social security issues concerning more than one EU country, you may search for a contact institution in Europe on the Institutions' directory maintained by the European Commission and available at: <http://ec.europa.eu/social-security-directory>*

### **National Revenue Agency**

52, Kniaz Dondukov Blvd.  
1000 Sofia, Bulgaria  
phone: (+359 2) 9859 3037  
E-mail: [infocenter@nra.bg](mailto:infocenter@nra.bg)  
<http://www.nra.bg>

### **National Social Insurance Institute**

1303 Sofia  
62-64 Alexander Stamboliiski Blvd.  
tel.: (+359 2) 926 10 10  
E-mail: [noi@nssi.bg](mailto:noi@nssi.bg)  
<http://www.noi.bg>

### **National Health Insurance Fund**

1407 Sofia  
1 Krichim Street  
Information to citizens: tel.: (+359) (0) 800 14 800 - national telephone line  
<http://www.nhif.bg>

### **Ministry of Labour and Social Policy**

Sofia 1051  
2 Triaditsa Street  
tel.: (+359 2) 8119 443; fax: (+359 2) 988 44 05; 986 13 18  
E-mail: [mlsp@mlsp.government.bg](mailto:mlsp@mlsp.government.bg)  
<http://www.mlsp.government.bg>

### **Financial Supervision Commission**

1303 Sofia  
33 Shar Planina Street  
operator: (+359 2) 94 04 999  
press centre: (+359 2) 94 04 582; fax: (+359 2) 829 43 24  
E-mail: [bg\\_fsc@fsc.bg](mailto:bg_fsc@fsc.bg)  
<http://www.fsc.bg>