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Legal Analysis of the OJK's Role in Rejecting Insurance Policy Claims by Customers

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Abstract
Insurance is an institution that functions to mitigate various risks that may occur in the future. Therefore, insurance plays a crucial role in providing protection to policyholders. One of the challenges that frequently arise in insurance practice is the rejection of claims submitted by customers to insurance companies, which are usually accompanied by various reasons from the company. In this case, the existence of the Financial Services Authority (OJK) is very helpful for customers in resolving issues related to claim rejections. Based on Law Number 21 of 2011 concerning the Financial Services Authority, this institution not only serves as a facilitator of consumer protection and mediation, but also plays an active role in legal defense for customers. The OJK's role in resolving disputes over insurance claims rejected by insurance companies includes acting as a mediator in the deliberation process to reach a consensus between the customer and the insurance company, as well as acting as a supervisor to ensure the outcome of the agreement. However, in carrying out its functions, the OJK faces a number of non-legal obstacles, both internal and external. This research uses literature review and legal analysis to help provide results in addressing this issue. Some of these obstacles include the lack of clarity in customer complaints, incomplete supporting documents, and minimal information that can be obtained.

I. INTRODUCTION

Insurance is a mechanism for transferring the risk of loss from one party to another, which is done by distributing the risk burden through proportional premium payments.(Saputra, Listiyorini, and Muzayanah 2021). Basically, insurance is a contract between an insurance company and a policyholder, in which the company provides protection against objects or activities that have the potential to cause losses.(Sigalingging, Sagala, and Gultom 2022)Through risk management stipulated in the agreement, insurance companies can expand their business activities, strengthen their vision, and build trust with their customers. Collected premiums serve not only as a protection fund but also as capital for company development. Ultimately, customers benefit from this system. Insurance is chosen because it provides coverage against losses, both individual and collective, depending on the agreed-upon agreement. However, the variety of insurance products in circulation does not all align with the promised protection, particularly in the context of legal certainty. A common problem is when customers experience difficulty in disbursing claims even though the risks as insured have occurred. This contradicts the primary expectation of customers, who want compensation for unforeseen events.

In this case, the insurance company should be subject to legal obligations which are manifested in the form of a written agreement, namely a policy, which functions as legal evidence when a claim or dispute arises.(Ridho 2020). Customer rights as consumers are guaranteed by Law Number 8 of 1999 concerning Consumer Protection, which provides legal protection and improves customers' bargaining position against companies. One real example can be seen in the legal dispute between a customer and PT Prudential Life Assurance based on the Decision of the South Jakarta District Court Number

309/Pdt.G/2016/PN.Jkt.Sel, which was strengthened by the Decision of the DKI Jakarta High Court Number 582/Pdt/2017/PT.DKI. In this case, a customer named Ratua Artha Uli sued the company for rejecting claims related to benefits from health insurance products despite major changes in premium values and policy provisions.

This case demonstrates how a lack of transparency by insurers can lead to serious legal disputes. Many insurance companies fail to provide transparent explanations before the agreement is signed. This results in losses for customers and raises doubts about the legal validity of the agreement itself, particularly when viewed under Article 1320 of the Civil Code. Issues such as unclear information regarding the insured object—for example, in health insurance without a preliminary examination of the prospective insured's condition—can lead to a discrepancy between the contents of the contract and reality. In this case, companies often reject claims on the basis that the illness existed before the agreement was entered into, even though it was not explicitly stated in the contract. Furthermore, this creates a legal vacuum regarding the obligation for a preliminary medical examination by the insurer. Uncertainty about when and under what conditions an illness can be used as the basis for a claim causes the contract to fail to meet the objective elements of a valid contract, potentially making it void. If the object of the agreement is not fully explained or turns out to be different from what was promised (for example, only covering partial health coverage), this can be categorized as a substantive error (error in substantia), which can render the agreement voidable.(Womb 2022). In addition, Article 18 paragraph (1) of the Consumer Protection Law expressly prohibits companies from including standard clauses that are difficult to read, unclear, or difficult for consumers to understand. The practice of drafting policies that are not transparent has the potential to give rise to legal conflicts, not only concerning the validity of the agreement, but also the rights and obligations of the parties that are not explained in a balanced and open manner.

Every element of human life considered essential is not always secure; instead, it is often faced with various dangerous threats. This state of uncertainty creates a sense of insecurity about potential losses, known as risk. Simply put, risk is an event that can cause loss and create insecurity.

To deal with threats to human interests resulting from unpredictable events, there are generally four approaches that can be taken.(Manik et al. 2025):

1. Acceptance (assumption or retention): Avoidance means doing or not doing an action to avoid loss.
2. Prevention, namely taking certain steps to reduce the impact of losses.
3. Transferring and sharing (transfer or distribution), namely transferring potential losses to other parties.

Risk management can be achieved by transferring it to another party, ultimately giving rise to the concept of insurance. Insurance emerged as a result of a risk transfer agreement, known as an insurance contract or coverage. In the insurance world, risk is defined as the uncertainty associated with loss, which contains two main elements: uncertainty and loss, with the emphasis on uncertainty.

The need for insurance protection or coverage stems from the desire to overcome uncertainty. This uncertainty encompasses a variety of potential threats that could affect individuals and businesses. This creates a need to mitigate potential losses resulting from the inability to address these risks. These risks can be caused by natural disasters, accidents, illness, negligence, errors, failures, or other factors that are difficult to predict, including riots, sabotage, and terrorism.(Adi 2025).

From an economic perspective, insurance is a method for reducing risk by transferring and combining the uncertainty of financial losses.(Adelia et al. 2024). Indonesia as a state of law, as stated in Article 1 paragraph (3) of the 1945 Constitution of the Republic of Indonesia which reads as follows, "The State of Indonesia is a state of law". The meaning of the contents of this article is that the state upholds the supremacy of

law to uphold truth and justice, and there is no power that cannot be accounted for.

Legal protection is providing protection to human rights that are harmed by other people and this protection is given to the community so that they can enjoy all the rights granted by law or in other words legal protection is a variety of legal efforts that must be provided by law enforcement officers to provide a sense of security, both mentally and physically, from disturbances and various threats from any party.(Agustini, Rachman, and Haryandra 2021)This study proposes an innovative approach to addressing insurance policy claim rejection issues by maximizing the role of the Financial Services Authority (OJK). Based on previous studies, the focus of this research lies not only in analyzing OJK regulations and authorities under Law Number 21 of 2011, but also in evaluating the actual implementation and challenges faced by OJK in providing legal protection for the insured. This study also proposes a more active intervention model from OJK in the insurance dispute mediation process. This model involves utilizing information technology to increase transparency in the claims process, as well as implementing regular training for insurance companies related to operational standards and professional codes of ethics. It is hoped that this innovation will strengthen legal protection for customers while increasing public trust in the insurance industry.

This approach is highly relevant given the ever-growing complexity of insurance disputes in Indonesia. Therefore, this research significantly contributes to improving the quality of supervision and regulation in the financial services sector, while also enriching the literature on law and consumer protection in the insurance sector. The purpose of this research is to understand and analyze the efforts and obstacles faced by the Financial Services Authority (OJK) in resolving disputes related to rejected insurance policy claims, as well as to examine the OJK's authority to provide legal protection to insured parties in such cases.

II. RESEARCH METHODS

The method used is normative juridical, which focuses on the study of norms within positive law. This normative juridical method is guided by legal regulations or legislation, court decisions, and binding social norms related to societal customs. This research uses a legislative approach, a case study approach, and a literature review approach. Several articles, books, and magazines can be used as research tools to achieve the research results.(Jonaedi Efendi, Johnny Ibrahim, and Se 2018).

III. RESULTS AND DISCUSSION

A. Rights and Authorities of the Financial Services Authority in Legal Protection

1. Financial Services Authority Legal Protection for Insurance Claim Rejection

The Financial Services Authority (OJK) is an independent institution free from interference by other parties. It has the functions, duties, and authority to regulate, supervise, inspect, and investigate. The OJK serves as the organizer of the regulatory and integrity oversight system for all activities in Indonesia's financial services sector.(Excerpt 2019).

The authority held by the Financial Services Authority (OJK) over insurance companies is explicitly regulated in Law Number 21 of 2011. In Articles 8 and 9, it is stated that the OJK is tasked with regulating and supervising all activities in the financial services sector, including the insurance sector.

Preventive legal protection is a supervisory measure taken to protect the insured by preventing violations by the insurer in administering insurance.(Suryamizon 2017)The goal is to ensure the insured's rights are protected before any violations occur. In this regard, the Financial Services Authority (OJK) has a mandate to protect the interests of the public and consumers from potential violations of financial sector regulations within its jurisdiction. One concrete form of preventative legal protection by the OJK is through financial education and literacy

activities, consumer services, consumer protection policies, and market conduct monitoring.(Excerpt 2019).

Preventive legal protection efforts by the Financial Services Authority (OJK) include several instruments as follows:(Ridho 2020):

One form of legal protection is through the issuance of official regulations. This is evident in OJK Regulation No. 1/POJK.07/2013 concerning Protection of Consumers of Financial Services. This regulation provides guidance for policyholders in understanding their rights, the form of supervision by OJK, as well as the procedures and types of complaints that can be submitted by the public. Supervisory measures are regulated in Chapter V, Articles 51 and 52 of POJK No. 1/POJK.07/2013, which emphasizes the OJK's role in overseeing the activities of financial service providers to prevent losses, especially for policyholders. This supervisory function is an important part of preventative legal protection. As a step to support complaint resolution, OJK also regulates coaching for business actors through training that pays attention to risk management aspects. This is stated in OJK Circular Letter No. 2/SEOJK.07/2014 concerning Consumer Services and Complaints, which requires financial service providers to provide internal training.

The Financial Services Authority (OJK) Regulation on Dispute Resolution in Financial Services is a regulation established by the Financial Services Authority (OJK) to regulate the mechanism for resolving disputes between financial services businesses and consumers or the public in a fair, fast, and efficient manner. This regulation aims to protect consumer rights and maintain public trust in the financial services sector.(Ansa 2023).

Some important points of this regulation include(Ansa 2023):

1) The OJK's Dispute Resolution Mechanism provides non-litigation dispute resolution channels, such as mediation and arbitration. This aims to expedite the process and reduce settlement costs for both parties.
2) Alternative Dispute Resolution Institution (LAPS)Regulations stipulate the establishment of LAPS which is facilitated or recognized by the OJK as a mediator or arbitrator in resolving financial services disputes.
3) Rights and Obligations of the PartiesThe regulations regulate the rights and obligations of both financial services business actors and consumers in the dispute resolution process, including the right to clear information and fair treatment.
4) Supervision and EnforcementOJK plays a role in supervising the implementation of dispute resolution and can impose administrative sanctions if financial services business actors violate applicable provisions.
5) Registration and Reporting of DisputesConsumers can submit complaints to the OJK or LAPS in accordance with established procedures, and business actors are required to report the resolution of disputes carried out.

B. Legal Consequences Arising from Losses Suffered by Customers or Insured

The legal consequences of insurance contracts can result in losses for one or even both parties to the contract. The Financial Services Authority (OJK) has issued regulations regarding the standardization of insurance policies. However, in practice, these regulations have not been fully implemented in the clauses or content of insurance policies. One major problem is the use of standard clauses that do not comply with statutory provisions, giving rise to the perception that insurance companies are exploiting the situation to limit their responsibilities to customers, both in paying claims and in waiving obligations (exemption). This situation is exacerbated by weak government oversight of insurance companies as policy issuers.(Rachmanto 2018).

In addition, the OJK can provide preventive legal protection by establishing obligations that must be complied with by business actors in running their businesses and prohibiting certain practices that are detrimental to consumers.(Ananto, Idayati, and Taufik 2024). Most insurance policies are known to violate Law

Number 8 of 1999 concerning Consumer Protection, particularly regarding the lack of transparency in existing contract clauses. This places customers in a weak position because they often do not fully understand the content and consequences of these clauses. This lack of clarity is most often found in health insurance policies, which essentially shift the company's responsibility to the customer. The failure of an insurance company to pay out claims will result in losses for the customer. In this case, the company can be sued in civil court for breach of contract and demanded to provide compensation for the losses suffered. Such a lawsuit can be filed if one party violates the agreed contract, thereby harming the other party.(Dwinanto 2021).

Further problems arise from the legal aspects of contracts, particularly under Article 1320 of the Civil Code, which governs the legal requirements of contracts. One common issue is the lack of clarity regarding the insured object, such as when health insurance is issued without a preliminary medical examination of the prospective insured. For example, someone might insure their health without undergoing an examination and then file a claim for a long-standing illness before the policy took effect. However, the claim is rejected on the grounds that only illnesses that arose after the contract is in place can be claimed. This situation demonstrates a legal vacuum regarding the requirement for a medical examination before a person becomes an insured or policyholder. The lack of clarity regarding the category and timeframe for the insurance object to be claimed renders the contract ineligible for objective purposes and can therefore be deemed null and void.

According to applicable regulations, proof of the insurance agreement between the insured and the insurer is generally based on the policy document.(Ridho 2020). However, if the policy has not yet been issued, evidence can be in the form of notes, records, telegrams, calculation letters, or other documents as stipulated in Article 258 paragraph (1) of the Commercial Code which permits the use of all types of evidence as long as there is initial written evidence. This provision provides a stronger position for the insured as a relatively weaker party compared to the insurer, so that legal protection for the insured is more guaranteed. The creation of a policy as a deed of agreement also implicitly provides the insurer with the opportunity to accept or reject the agreement. The clauses written in the standard policy function as rules that bind both parties after mutual agreement. If the customer accepts the contents of the agreement, then he can sign the contract. Conversely, if he rejects, then the contract is not considered to exist because there is no signature from the customer. This requires the insured to carefully read all the terms, conditions, and clauses in the policy. All of these clauses are drafted by the insurer, namely the insurance company, which aims to make a profit. Usually, large insurance companies use policy document formats that are adjusted for their own interests. Basically, the contents of the policy contain everything agreed upon in the insurance contract, and general rules regarding the contents of the policy are regulated by law.(Sigalingging et al. 2022).

The omission of an insurable interest element renders an insurance contract less legally valid and voidable. Individuals are considered to have an interest in the insurance object if they experience financial loss due to damage, loss, or other risks covered by the policy. The principle of insurable interest requires a real interest for an insurance contract to be valid; if it is not met, the contract is void. The purpose of this principle is to prevent insurance from being used as a gambling tool. The insurer is not obligated to pay compensation if the insurance is made without the insured's interest in the insured object, as stipulated in Article 250 of the Commercial Code.(Dhini, Maharani, and Amarulloh 2016).

Despite numerous insurance consumer protection provisions, rights violations are not limited to insurance companies. Customers are also at risk of fraudulent conduct, such as providing incomplete or inaccurate information (misrepresentation). This can influence the insurer's decision to accept risks or determine premium amounts. Conflicts in insurance are unavoidable and can originate from both customers and insurance companies. Therefore,

legal regulations and effective dispute resolution mechanisms are needed. Legal protection for customers is regulated not only by Law Number 40 of 2014 concerning Insurance, but also by Law Number 8 of 1999 concerning Consumer Protection. This regulation provides legal certainty for customer safety and comfort in receiving insurance products or services, and also regulates the insurance company's responsibility to provide information that could impact policyholder losses.

These various disputes can actually be minimized if both parties fulfill their rights and obligations as agreed upon before signing the contract. Customers are required to disclose important facts regarding the insurance object, while insurance companies must be transparent in conveying risks and coverage. This principle, known as Utmost Good Faith, is crucial in insurance policy agreements. If the Utmost Good Faith principle is not met, it will affect the claim disbursement process. Many insurance companies generally reject insurance claims because the insured conceals material facts (which could increase the risk) that should be disclosed to the insurer.(Saputra et al. 2021).

C. The Impact of Inaccurate Information in Health and Loss Insurance Policies on Customer Legal Protection

Legal protection for customers with health insurance policies is a crucial aspect that needs to be examined. In practice, health insurance companies often use standard clauses in policy agreements that favor the insurer, placing the insured in a legally weak position when signing the contract. This imbalance often results in losses for customers when filing claims, who frequently face complicated procedures and are denied for various reasons.

Due to a breach of the insurance policy contract, the customer automatically suffers a loss because they are not receiving the benefits they should have received from the policy they purchased. The customer must then choose a dispute resolution path, either through court proceedings or alternative out-of-court settlements. Referring to POJK No. 1/POJK.07/2013 concerning Consumer Protection in the Financial Services Sector, this regulation focuses more on legal protection for customers as consumers than for insurance companies.(Sigalingging et al. 2022).

When disputes arise between customers and insurance companies, the Financial Services Authority (OJK) is responsible for managing dispute resolution through litigation (court or arbitration) and non-litigation (negotiation, mediation, and conciliation). The primary focus is ensuring effective legal protection for customers. Amriani explained that conflict resolution can be pursued through two approaches: adversarial litigation and cooperative mediation or negotiation.(Ananto et al. 2024).

In practice, dispute resolution typically involves proving that the insurance company applied biased standard clauses, weakening the policyholder's position. Hospitals sometimes reject claims due to insurer error. Therefore, it's crucial to understand preventive and repressive health insurance legal protections to prevent claims failure due to a lack of transparency in policy information.

Legal protection for customers who experience failed claims due to unclear information in the policy can be divided into two types. First, preventative protection involves drafting an insurance contract with fair clauses, involving elements such as equal bargaining power, open negotiation, and proportionality between the two parties. Second, repressive protection is provided through mediation facilitated by the Indonesian Arbitration Mediation Board, the Consumer Dispute Resolution Agency, or through the courts.(MUNIROH 2021).

This protection aims to ensure fairness in the contractual relationship between the insured and the insurer, where the agreement is made voluntarily and without coercion. Legal protection for customers is regulated in several important aspects as a basis for fairness in insurance contracts.

1. Reviewing the validity of the agreement, in accordance with Article 18 paragraph (1) letter g of Law Number 8 of 1999 concerning Consumer Protection.

2. Customers are obliged to pay premiums past the due date, in accordance with Article 18 paragraph (1) letter g of Law Number 8 of 1999 concerning Consumer Protection.
3. The customer dies after the grace period, according to Article 18 paragraph (1) letter a of Law Number 8 of 1999 concerning Consumer Protection.
4. The customer has not paid the premium and does not have any cash value, according to Article 18 paragraph (1) letter f of Law Number 8 of 1999 concerning Consumer Protection.
5. Termination of premium payments and the policy has a cash value, in accordance with Article 18 paragraph (1) letter f of Law Number 8 of 1999 concerning Consumer Protection.
6. The customer carries out policy recovery, in accordance with Article 18 paragraph (1) letter g of Law Number 8 of 1999 concerning Consumer Protection.
7. The customer requested compensation that was due, in accordance with Article 18 paragraph (1) letter a of Law Number 8 of 1999 concerning Consumer Protection.
8. The material for submitting a claim for compensation, in accordance with Article 25 letter a of the Decree of the Minister of Finance No. 422/KMK.06/2003 concerning Insurance Business Organizers and Reinsurance Companies and Article 18 paragraph (1) letter a of Law Number 8 of 1999 concerning Consumer Protection.
9. The company's responsibility for customer losses, according to Article 18 paragraph (1) letter a of Law Number 8 of 1999 concerning Consumer Protection.

In principle, customers are guaranteed legal protection through statutory regulations that stipulate certain prohibitions. Meanwhile, insurance companies are required to comply with these regulations and not implement policies that conflict with the law. Thus, customers receive adequate legal protection.(Rafika 2022)This protection is specifically related to the standard clauses listed in the health insurance policy, which include:(Sigalingging et al. 2022):

1. Bargaining Position

When customers apply for a policy, they must follow the rules set by the insurance company without any room for negotiation, including premium amounts, payment terms, payment methods, and other provisions. The economic capabilities of both parties also influence this bargaining position. Therefore, the bargaining position in the contract must take the customer's financial situation into account so that their roles as parties to the contract can be clearly and inseparably identified.

2. Negotiation

Negotiation plays a crucial role in reaching an agreement or contract. Through the negotiation process, both parties can understand each other's rights and obligations. Negotiation occurs because each party has its own goals and interests, leading to a mutual agreement. The primary principle of negotiation is finding a win-win solution. However, in standard contracts unilaterally established by the company, the scope for negotiation is very limited. This is evident in the numerous predetermined clauses, leaving customers with the option to accept or reject.

3. Proportionality

In contract clauses, the principle of proportionality is reflected in the balanced exchange of interests between the two parties, namely the customer and the insurance company. This proportionality can be seen in the content of each clause in the contract, which must reflect a balance between the rights and obligations of both parties. However, its implementation can be fair or burdensome for one party. Furthermore, transparency of information related to clauses in the contract must align with the objectives of consumer protection laws.

4. Balance

The balance in an insurance policy contract clause can be assessed based on the conditions of the parties before the agreement is reached. The main principle that must be considered to achieve balance is the attitudes and actions of all parties related to the object of the contract. A contract is considered valid if both parties are jointly bound by it. The legal actions of the parties can be seen from their intention to fulfill or ignore existing

legal obligations. If all parties are in a balanced position, the resulting contract will be better. However, if one or both parties are not aligned in carrying out legal actions, the contract is considered unbalanced. Therefore, balance in an insurance policy clause depends heavily on the awareness and mutual agreement of the parties involved.

When a dispute arises between a policyholder and an insurance company, the Financial Services Authority (OJK) exercises its functions, duties, and authority to resolve consumer disputes through two mechanisms: litigation and non-litigation. However, the issue lies in the extent to which policyholder protection is actually implemented. According to Nurnaningsih Amriani, theoretically, there are two methods of dispute resolution: adversarial or litigation methods such as arbitration and court proceedings, and cooperative methods, including negotiation, mediation, and conciliation.

Since the signing of the insurance agreement already includes elements of a standard agreement or standard contract that has the potential to be detrimental, and coupled with the implementation of the contents of the insurance agreement which is also complicated and tends to be complicated, the position of the policyholder becomes weaker and powerless. When a dispute arises with the insurance company, according to Law No. 30 of 1999 concerning Arbitration and Alternative Dispute Resolution, it is stipulated in Article 2 that:

"The law regulates the settlement of disputes or differences of opinion between parties in a certain legal relationship that all disputes or differences of opinion that arise or that have entered into an arbitration agreement that expressly states that they may arise from the legal relationship will be resolved by arbitration or through alternative dispute resolution." Dispute resolution, usually taken through litigation and non-litigation, or in other words, through the courts or outside the courts. Law No. 30 of 1999 is an effort to resolve disputes outside the courts. In contrast to civil trials at the district court level, in the arbitration process it is preceded by the submission of an arbitration application accompanied by a request for the appointment of an arbitrator who will be chosen by the applicant to handle the dispute in arbitration until the evidence that will be submitted by the applicant to support his application (statement of claim).

POJK No. 1/POJK.07/2012 regulates dispute resolution known as consumer complaint resolution. In the event that an agreement cannot be reached on complaint resolution, consumers can resolve the dispute outside the court or through the court. Dispute resolution outside the court as referred to in paragraph (1) is carried out through an alternative dispute resolution institution. In the event that dispute resolution is not carried out through an alternative dispute resolution institution as referred to in paragraph (2), consumers can submit a request to the financial services authority to facilitate the resolution of complaints from consumers who have been harmed by actors in financial services businesses.

Consumer disputes in the event of default by the insurance company regarding insurance claims or demands that cause problems, can be resolved through the courts or outside the courts (Indonesian Arbitration Mediation Agency and Consumer Dispute Resolution Agency).

IV. CONCLUSION AND SUGGESTIONS

A. Conclusion

Contracting parties are generally not bound by a specific format, and this relates to standard clauses and the actions that can be taken. To achieve fairness in contractual agreements, the government has a role in providing guidance and supervision, as stipulated in Article 29 of Law Number 8 of 1999. Problems often arise when standard clauses in contracts do not align with applicable legal regulations, giving rise to the perception that insurance companies exploit loopholes to reduce their responsibilities to customers, including in terms of claim payments or waivers (exoneration). This is possible due to weak oversight by the competent authorities. To provide legal protection to health insurance customers whose claims are rejected due to a lack of transparency in the policy content, justice efforts can be carried out through two approaches.

First, preventively, namely by ensuring transparency in the contract content so that customers receive fair treatment. Second, repressively, namely by resolving conflicts between customers and insurance companies, either through the courts or alternative dispute resolution outside the courts.

B. Suggestion

Strengthening the OJK's Role in Non-Litigation Mediation: The OJK should be more active in encouraging dispute resolution through non-litigation channels such as mediation and conciliation. These methods are typically faster, more efficient, and can reduce the burden on the courts and costs for both customers and companies. Improving Customer Education and Outreach: To better understand their rights and obligations, the OJK and insurance companies need to provide transparent education regarding policy content and claims procedures. This can prevent misunderstandings that often lead to disputes. Standardizing Fair and Transparent Policy Clauses: The OJK needs to ensure that standard insurance policy clauses meet the principles of fairness, balance, and transparency, so as not to burden either party, especially the customer. Stricter Supervision and Law Enforcement: To reduce the practice of policy clause abuse and unfounded claim rejections, OJK supervision must be strengthened, and the application of sanctions against insurance companies that violate regulations must be more consistent. The development of the OJK's Digital Information System can utilize information technology to simplify the complaint process and monitor insurance claim disputes, making the process more transparent and accountable. Facilitating Effective Negotiations: The OJK can provide a dedicated platform or forum to facilitate negotiations between customers and insurance companies, ensuring a cooperative dispute resolution process that prioritizes win-win solutions. These measures can optimize legal protection for insurance customers and increase public trust in the insurance industry.

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