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Legal Analysis of Rejection of Life Insurance Claims By Insurance Companies Based on the Principles of Good Faith and Consumer Protection

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Abstract
One of the most common causes of disputes between insured and insurance companies is the rejection of life insurance claims. Life insurance is essentially a contract that offers protection against the possibility of death or other perils stated in the policy. However, in reality, many insurance companies refuse to pay claims for various reasons, including policy limitations, discrepancnies in the coverage data, alleged violations of the principle of absolute good faith, or other administrative reasons. As parties entitled to insurance benefits, this situation often results in legal confusion for the insured and their heirs. This study aims to investigate the legal justification for life insurance claim rejections by insurance companies, examine the legal protections for the insured, and investigate the legal consequences of claim rejections that violate legal requirements. The research methodology used is normative legal research using statutory, conceptual, and case study approaches. The findings indicate that insurance companies can only reject claims if there is a strong legal basis in accordance with the policy provisions and relevant laws and regulations. Unilateral rejection of claims without a valid reason can be considered a breach of contract (default) or possibly an illegal act requiring compensation. Alternative Dispute Resolution Institutions in the Financial Services Sector, insurance companies' internal dispute resolution procedures, or court litigation can all be used to seek legal protection for insured parties. Therefore, to provide legal certainty and preserve the rights of insured parties, it is crucial to increase transparency in insurance claims procedures and strengthen oversight by the Financial Services Authority (OJK).

I. INTRODUCTION

In recent years, the Indonesian insurance industry has grown rapidly. Insurance is now seen as a vital tool for protecting the public from various risks, no longer a luxury. Life insurance, a contract between an insurance company and a policyholder that offers benefits in the form of compensation or cash payments if the agreed-upon risks materialize according to the policy's terms, is one of the most popular products.

Under Articles 1320 and 1338 of the Indonesian Criminal Code (KUHP), a legally binding agreement between the parties creates a legal relationship between the insurance company and the insured. Furthermore, the KUHP, Law No. 40 of 2014 concerning Insurance, and other implementing regulations issued by the Financial Services Authority (OJK) govern how insurance companies operate.

Although the practice of life insurance has a strong legal basis, disputes still frequently arise, particularly regarding claims payments. Conflicts typically arise when insurance companies reject claims submitted by the insured or their beneficiaries, citing policy violations, false information in the Life Insurance Application Form (SPAJ), risks covered by exclusion clauses, or other administrative requirements. Numerous investigations have shown that not all claim rejections are supported by valid legal arguments. In fact, insurance companies have been found in breach of contract in numerous court decisions when they failed to provide a valid reason for denying claims.

Because it relates to protecting the rights of insured persons as consumers of financial services, the issue of claim denial is crucial. In reality, there is an imbalance between policyholders and insurance companies. Many policyholders struggle to

understand policy provisions, which use complex phrases and clauses that can lead to differing interpretations, as insurance companies typically have more expertise, experience, and access to information than the insured. When claims are filed, this often leads to disputes.

However, insurance companies can still reject claims if they can demonstrate that the policyholder did not act in the highest good faith. This principle, which requires both parties to provide honest, accurate, and comprehensive information from the outset of the insurance application process, is essential to insurance contracts. However, to prevent harm to the insured or their beneficiaries, the application of this principle as a basis for rejecting a claim must be supported by sufficient evidence and applied proportionately.

II. RESEARCH METHODS

The legal standards governing the denial of life insurance claims by insurance companies are the main topic of this study, which uses a normative legal research method. Because this study focuses on examining statutory provisions, legal doctrines, principles, and court decisions related to the issues under study, this approach is used.

Several methods were used in this study, including:

The Statutory Approach is conducted by examining various legal provisions that form the basis for insurance companies in Indonesia. The Civil Code (KUHP), the Civil Code (KUHD), Law Number 40 of 2014 concerning Insurance, Law Number 8 of 1999 concerning Consumer Protection, and several regulations issued by the Financial Services Authority (OJK) concerning consumer protection in the financial services sector are among the regulations examined.

Various legal ideas and concepts related to insurance contracts, the notion of supreme good faith, default, illegal activities, and consumer protection are examined using the Conceptual Approach.

A case study approach was employed by examining various court decisions related to disputes regarding rejected life insurance claims. The purpose of analyzing these decisions is to understand the basis for judges' decisions in situations involving insurance claims.

This research uses primary, secondary, and tertiary legal sources. Relevant laws and court decisions are examples of primary legal materials. Secondary legal documents can be found in various places, including books, insurance law papers, and scholarly journals. Legal encyclopedias and legal dictionaries are sources of tertiary legal materials.

Various written sources related to the research object were examined to gather legal material through library research. To gain a comprehensive understanding of the research subject, all legal material was then examined using descriptive-analytical techniques with a qualitative approach.

III. RESULTS AND DISCUSSION

A. Concept and Legal Basis of Life Insurance in Indonesia

In the case of risks listed in the policy, life insurance is a type of financial protection that aims to offer financial benefits to the insured and their heirs. Today, life insurance serves more purposes than simply transferring risk; it has become a tool for long-term financial planning and social welfare. Life insurance is becoming increasingly important as people realize the importance of being protected from the possibility of death, accidents, and other events that could impact a family's financial stability (Aris, 2022).

Legally, life insurance is a contract between the insured and the insurance company. Unlike general insurance, which focuses on compensation, life insurance benefits are determined by the policy's face value, regardless of the extent of the beneficiary's loss (Agoes, 2024). Therefore, the object covered by life insurance is the right to a person's survival, not a physical object.

From a civil law perspective, a life insurance contract must meet the requirements outlined in Article 1320 of the Civil Code (KUHP) to be considered a valid contract. The validity of an agreement is based on the agreement of the parties, their legal capacity to act, a clear purpose, and a justification that is not unlawful. Furthermore, every legally made agreement binds the parties as a matter of law, according to Article 1338 of the KUHP. Consequently, an insurance policy is legally

binding, and both the insured and the insurance company must comply with it (Junaidi, 2003).

The Indonesian Civil Code (KUHD) also has specific regulations relating to insurance. Article 246 of the KUHD defines insurance as a contract that obligates the insurer to pay the insured for losses, damages, or lost profits that may arise from unforeseen events in exchange for premiums. The provisions of the KUHD continue to serve as one of the legal foundations for establishing insurance companies in Indonesia, although its formulation was originally intended for general insurance.

With the enactment of Law No. 40 of 2014 concerning Insurance, broader regulations have emerged as a result of the growth of the financial services sector. The Financial Services Authority (OJK)'s oversight mechanism, corporate governance, insurance company institutions, scope of business activities, and policyholder protection are all regulated by this law, which serves as the primary basis for regulating the implementation of insurance businesses. According to Article 1, number 1 of the law, insurance is an agreement that gives the insurance company the right to collect premiums and, in the event of an uncertain event, to offer benefits to the policyholder or insured in accordance with agreed terms.

The Financial Services Authority (OJK) has issued several regulations offering protection to policyholders in addition to the Insurance Law. The OJK is an organization that ensures the implementation of consumer protection principles and acts as a supervisory body within the national insurance system. Consequently, insurance companies must provide accurate, clear, and easy-to-understand information to prospective policyholders regarding their rights, responsibilities, benefits, risks, and the claims process (Oscar, 2024).

Several legal principles defining insurance law form the basis for the implementation of life insurance contracts. The highest level of good faith is one of the most fundamental values. According to this principle, each party must honestly and completely disclose all relevant information about the insured object. This obligation is fulfilled by completing the Life Insurance Application Form (SPAJ). Insurance companies can refuse to pay claims if the information is false or misleading, as long as the legal basis for the refusal can be proven.

The concept of insurable interest, which recognizes the existence of a legal interest between the policyholder and the insured, is in addition to the standard of good faith. A person may have an inherent interest in the insured's survival due to family, business, or other legal ties. The purpose of this approach is to prevent insurance abuse that subjects individuals to speculation about their lives.

The explanation above makes it clear that the implementation of life insurance in Indonesia is supported by a number of complementary legal instruments, such as the Indonesian Criminal Code (KUHP), the Indonesian Penal Code (KUHP), Law Number 40 of 2014 concerning Insurance, and various regulations issued by the Financial Services Authority (OJK), in addition to the contractual relationship between insurance companies and policyholders. All of these regulations aim to provide legal certainty in the implementation of life insurance contracts and to create a balance between the rights and obligations of the parties. Therefore, understanding the concept and legal basis of life insurance is an important starting point for evaluating the legitimacy of claim denials by insurance companies.

B. Legal Reasons for Rejection of Life Insurance Claims by Insurance Companies

One of the most common causes of conflict in insurance practice in Indonesia is the rejection of life insurance claims. Insurance companies, in theory, cannot unilaterally reject any claim. Rejection is only permitted if there is a valid legal justification, either based on the policy provisions agreed upon by the parties or under statutory provisions. Consequently, any rejection decision must be supported by objective and reasonable justification and must not conflict with consumer protection values or good faith.

Violation of the highest principle of good faith is one of the most frequently used legal grounds for rejection. According to this principle, all

relevant information about the insured risk must be disclosed by the prospective insured. Health issues, medical history, type of employment, and lifestyle choices that may affect the level of risk are examples of material facts in life insurance. Insurance companies can reject claims under Article 251 of the Commercial Code if it is proven that the insured intentionally provided false information or omitted important information when completing the Life Insurance Application Form (SPAJ).

Several court decisions have shown that claims can be rejected on the grounds that the good faith criterion has been breached. However, the insurer is still required to demonstrate that the omitted information was a significant factor in the decision to insure the risk. Therefore, if a claim is not supported by sufficient evidence, the principle of supreme good faith cannot be used as a justification for avoiding payment (Rahmadhani dkk, 2022).

Furthermore, the existence of exclusion clauses in policies is a common reason given by insurance companies to reject claims. These provisions address a number of situations not covered by insurance coverage, such as suicide within a certain timeframe, drug abuse, the insured's involvement in criminal activity, or death caused by terrorism or conflict. Exclusion clauses agreed upon by the parties can provide insurance companies with legal justification for rejecting claims, as the policy is legally binding under Article 1338 of the Civil Code.

However, exclusion provisions must be clearly and precisely written to eliminate the possibility of conflicting interpretations. In reality, disputes often arise from insurance companies' overly broad interpretations of these provisions, to the detriment of policyholders. Therefore, protecting the less vulnerable party (the insured or policyholder) should be prioritized in any ambiguity within the policy (Maulana, 2024).

Failure to comply with requirements related to the waiting period or denial period is another frequently cited legal reason. Certain insurance benefits are not available during the waiting period, which is a specific period of time from the inception of the policy. Meanwhile, the denial period gives the insurance company an opportunity to ensure that the information provided by the insured at the time of policy conclusion is accurate. The insurance company can cancel coverage and deny claims if it discovers materially false information or concealment of facts during this period (Christian, 2023).

Failure to comply with the policy's administrative requirements can also result in a claim denial. For example, failure to comply with other administrative procedures, failure to complete supporting documentation, or delays in reporting risks. As part of the claims review procedure, insurance companies are legally permitted to confirm that administrative requirements have been met. However, if the claim largely meets the standards and its validity can be proven, this condition should not be the sole basis for waiving the insured's rights.

In reality, denials can also occur if an insurance policy has expired or is no longer valid due to unpaid premiums. As a result of the insurance contract, the policyholder has a fundamental obligation to pay premiums. Generally, the insurance provider is no longer responsible for paying benefits for risks arising after the policy's inactive status if this requirement is not met, resulting in the policy's termination. Therefore, before a company decides whether to accept or reject a claim, the policy's validity is always a factor to consider.

Not all claim denials are legally justifiable, as evidenced by developments in Indonesian judicial practice. Courts have found insurance companies to have breached their contracts in a number of decisions when they denied claims without good cause or failed to provide legal justification. Insurance companies may be obligated to provide insurance benefits and compensation to the insured and their beneficiaries in some situations. This demonstrates that the insurer's authority to deny claims is still limited by legal provisions and must therefore be applied fairly, honestly, and with the policyholder's interests in mind (Hasnan, 2023).

C. Legal Protection for the Insured Against Rejection of Life Insurance Claims

A crucial component of insurance company operations in Indonesia is providing legal protection to the insured. Insureds are positioned as customers of financial services in legal interactions arising from insurance contracts, with the right to legal certainty, open communication, and fair treatment from the insurance provider. Consequently, an insurance company's decision to deny a claim must be supported by a valid legal basis and be legally responsible (rastuti, 2021)

Law No. 40 of 2014 concerning Insurance regulates the basis for legal protection for the insured. According to this regulation, all insurance companies must prioritize safeguarding policyholder interests and build their business operations based on the values of prudence and good corporate governance. Furthermore, several regulations from the Financial Services Authority (OJK) enhance consumer protection in the financial services industry. These regulations require insurance companies to provide accurate, understandable, and truthful information about the rights, obligations, benefits, and provisions stated in the policy (Mujiyantod kk, 2022).

The law provides insured parties with the opportunity to resolve disputes outside of court or within the legal system if they feel aggrieved by a claim denial. The first step in non-litigation action is to file a complaint with the insurance provider. The Alternative Dispute Resolution Agency for the Financial Services Sector (LAPS-SJK) can be consulted if amicable settlement fails to produce the desired outcome. Compared to the legal process, this mechanism is intended to offer a simpler, more effective, and relatively inexpensive resolution (Dwi Tatak dkk, 2024).

In addition to out-of-court settlements, if the insurance company is accused of default or engaging in illegal activities during the claim denial process, the insured can also file a lawsuit (Syaifuddin, 2024). The court will review the case and determine whether the company's refusal complies with the policy terms, the principle of utmost good faith, and relevant laws and regulations. The insurance company may be required to pay insurance benefits and compensate the injured party if it determines the refusal lacks a valid legal basis.

Therefore, in addition to the various requirements stipulated in laws and regulations, legal protection for the insured is also achieved through dispute resolution procedures that ensure the fulfillment of policyholder rights. The existence of this protection system is crucial for creating legal clarity, maintaining a harmonious relationship between the insured and the insurance company, and increasing public trust in the insurance sector in Indonesia.

IV. CONCLUSION AND SUGGESTIONS

A. Conclusion

According to research, life insurance claims cannot be arbitrarily rejected by insurance companies. Rejection can only be made if there is a valid legal basis, both from the policy content and from relevant laws and regulations. Violations of the principle of the highest good faith, risks included in policy exclusions, non-compliance with administrative requirements, and evidence of material facts that were not disclosed or misrepresented by the insured during the insurance coverage process are some of the common reasons for rejection. On the other hand, rejection of a claim without a clear legal basis by an insurance company can be considered a breach of contract or an illegal act that causes harm to the insured. Law Number 40 of 2014 concerning Insurance, several regulations of the Financial Services Authority (OJK), the Alternative Dispute Resolution Institution for the Financial Services Sector (LAPS-SJK), and court litigation all regulate legal protection for the insured. These various legal instruments are intended to ensure a balance of rights and obligations between policyholders and insurance companies, provide legal certainty in claims settlement, and increase public trust in the Indonesian insurance sector and system.

B. Suggestion

When developing and communicating policy materials to prospective policyholders, insurance companies should prioritize transparency, particularly regarding exclusion clauses, claim submission criteria, and the rights and obligations of the parties. Clear and easily understood

information is expected to reduce misunderstandings that could lead to conflict. To ensure the protection of the insured's rights, insurance companies must also carry out professional claim verification and settlement procedures while upholding the values of prudence and good faith. Furthermore, the Financial Services Authority (OJK) is expected to raise public

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