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Refusal Of Lıfe Insurance Claım Based On The Absence Of The Insured's Utmost Good Faıth

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Abstract

Insurance is a product used by the community with the aim of transferring risks from the insured to the insurer, namely the insurance company. In general, insurance is divided into 2 (two), namely loss insurance (general insurance) and life insurance. The problem that generally occurs in the insurance sector is the rejection of claims, especially in life insurance products, one of which is the absence of good faith by the insured, which is also one of the principles in life insurance, namely utmost good faith. The purpose of this research is to know and understand the things included in utmost good faith in life insurance. This research was conducted using normative research with data collection through literature study. Based on the results of the research, it is known that the rejection of life insurance claims based on the principle of utmost good faith is closely related to the assessment of whether the information is the main cause of the onset of coverage and is submitted clearly, correctly and accurately.

Keywords: Life Insurance and Utmost Good Faith

1. INTRODUCTION

Insurance is one of the products of the financial services sector that has existed for so long, so basically the public understands that insurance is a way of transferring risk by paying several costs, namely premiums to insurance companies. The existence of insurance has a positive impact on society, companies, or development. The benefits of insurance in providing a sense of security so they get protection from the possibility of an unexpected event or event make people want to have the insurance. As for insurance companies, the premiums will be used and managed by, for example, investing in the capital market by

considering investment instruments that are in accordance with the company's risk profile or by managing funds in other fields whose purpose is to make a profit. The management of these funds, either directly or indirectly, plays a role in encouraging the development and economy's country. This is what makes the existence of insurance products until now still exist and are needed.

The definition of insurance is regulated in Article 246 of the Indonesian Commercial Code (KUHD), but taking into the principle of lex specialist derogate legi generali, the definition of what insurance is refers to Article 1 number 1 of Law of the Republic of Indonesia Number 40 of 2014 concerning Insurance (Insurance Law). However, what is meant by the life insurance can be seen from the definition of life insurance business Article 1 points 6 of Insurance Law. In general, the definition of insurance is an agreement between an insurance company and a policyholder (insured) which is the basis for receiving premiums by the insurance company in return for providing compensation or payment for an event or risk that occurs. In additions, there are some essential elements of insurance which are legal subject, agreement, object of insurance, purpose of insurance, risk and premium, events, compensation or payment of benefits, terms and conditions, and insurance policies.

As explained that insurance aims to transfer risks to insurance companies, so that if a situation or event occurs of the object insurance, the insured or other entitled parties get replacement of lost (compensation) or payment of benefits from the insurer (insurance company). In addition, from an economic point of view, insurance is a form of risk management, especially used to hedge against the risk of loss from a person or entity to another entity. So that compensation for losses or payment of benefits is essential and necessary to obtain legal guarantees and protection.

Insurance based on the form or business can be divided into 2 (two), namely general insurance (loss insurance) and life insurance. The definition of life insurance can be understood by referring to Article 1 number 66 of the Insurance Law. But in simple terms, life insurance is insurance that aims to bear people against unexpected financial losses caused by dying too soon or living too long. In life insurance, there are several parties who can receive benefits, namely the insured himself, the policy holder, or other entitled parties if the insured dies (policy holder).

Based on statistical data from the Financial Services Authority (OJK) from the period January 2022 to June 2022 there were 2,987 (two thousand nine hundred and eighty seven) complaint services received by OJK related to insurance. The most complaint services are

claims issues. One of the most frequently encountered issues regarding claims is the rejection of claims by insurance companies. As has been described, filing a claim made by the insured is the main goal of the insured wants. Furthermore, the payment of benefits is the right of policyholders who have bound themselves by paying premiums (a sum of money) that determined by the insurance company or insurer.

The rejection of premiums by insurance companies is based on the circumstances that are regulated or included in the insurance policy or not. An insurance policy is an agreement that forms the basis of the engagement between the insurer and the insured. Some points that are regulated in the policy include the extent of coverage, things or risks that are not guaranteed or excluded and general requirements and special requirements. The contents of the insurance policy, especially regarding matters or risks that are guaranteed or not and also about the special requirements that needed, are the basis for the insurance company to reject claims. The agreement about the matters regulated and excluded from insurance policy is a form of mutual agreements and acceptance which is seen by the closing of the insurance policy by the policyholder or insured.

On the other hands, even though the insured has carried out and fulfilled the conditions for closing the insurance policy including the Life Insurance Closing Letter (SPAJ), health checks by doctors/clinics/laboratories appointed by the insurance company have been fulfilled by the insured, the life insurance claim still get rejected by the insurance company. The problem is not related with the failure of paying the life insurance premium. But it happened because the insurance company believed there is bad faith of the insured by covering up or not submitting information on his illness to the insurance company, even though the disease was not the cause of the insured's death. In additions, probably the illness also can not detected when the insured do the medical checkup.

Based on this description, it is necessary to conduct a more in-depth study and discussion regarding the rejection of claims based on the absence of utmost good faith in the delivery of information by the insured and what is the scope of the application of the principle of utmost good faith that needs to be considered by the insured. This is important because the main purpose or benefit of life insurance is the payment of benefits while the asymmetrical information situation towards understanding the contents of the policy can be the cause of the absence of information disclosure. This research aims to increase public knowledge and understanding of the things that need to be considered in the utilization of life insurance and the importance of applying utmost good faith when using life insurance products.

1.1 Problem

Based on this background, the main problem is about the legal considerations regarding the rejection of life insurance claims on the basis of the absence of utmost good faith by the insured.

2. RESEARCH METHODS

The research method in this study is normative legal research conducted by researching and tracing library materials through secondary data. The legal materials used consist of primary legal materials using laws, OJK regulations and other related regulations. While secondary legal materials are books, research journals and others. The data collection was carried out by literature research with a statutory approach and a conceptual approach with deductive analysis.

3. DISCUSSION

The insurance agreement has the purpose of transferring risk by obtaining compensation or benefit payments. Not all risks can be covered by insurance, there are several requirements so that a risk can be insured, namely:

1. The amount of loss due to risk must be measurable in money.
2. Risk are not speculative (can provide profits or losses such as gambling, trade risks and the like).
3. Risk occurs without any intentional action by the insured.
4. Risk does not occur massively in the sense that risk occurs to certain property or people.
5. Risk is not against the law in this case applicable regulations and the public interest.

Before the insurance products are released, the insurance companies will make some considerations related to the risks that can be borne or made into insurance products, for example whether the insurance object has a population or the possibility of a risk occurring in a particular population or object. This is usually done by using statistical data or certain research results. The purpose of research is so that insurance product that are marketed can be utilized and purchased by the public.

When discussing insurance products that sell well or widely purchased by the public, it's impossible when we say that this is not in line with the image and ability of insurance companies to gain trust from the public. The ease of submitting and disbursing claims is often

being the main reason consumers choose certain insurance companies. However, it needs to be understood that insurance products have different characteristics. Consumers who want to utilize insurance products must at least generally understand at least the principles of insurance to avoid conflicts in the future. Moreover, in insurance, there are events or uncertain events that cause risks to arise which become the object of coverage so that matters relating to the insured event need to be considered as much as possible on the principles of insurance. The principles of the insurance agreement are:

1. Insurable interest

Insurable interest is an absolute requirement that must be owned by the insured. If the insurable interest does not exist, in principle, the insurer has no obligation to compensate for any loss. This is as regulated in Article 250 of the KUHD, which stipulates if a person enters insurance for himself or the interests of a third party, but at the time the agreement is mad e the insured or third party has no interest in the object of loss, then the insurer has no obligation to compensate for any loss.

The interest in questions is financial interests. This financial interest can be measured by taking into the account if the loss or damage of the object brings financial loss to the person or not. Such interests can arise for example due to ownership, employment relationship, marriage relationship, debt-debt relationship, and agreement appointment relationship.

2. Good faith

The principle of upmost good faith is a principle that requires actions to disclose accurately and completely all material facts about object of insurance. This principle is closely related to fair dealing; therefore, the existence of good faith is an essential element in contract. The principle of good faith binds the parties, both the insurer and the insured to do so. The insurer must clearly explain the terms and conditions of the insurance, on the other hand, the insured should provide a clear and correct information about the object or interest insured. Good faith should have existed since the pre-contract phase (filling out the insurance application (SPAJ or SPPA) until the implementation of the contract (claim disbursement).

3. Proximate cause

This principle being used to determine whether someone needs to compensate or not. In determining the actual cause and effect, we need to use the principle of unbroken chain of events to see the full cause of the loss. Thus, we can determine the proximate or the ultimate cause of the loss. The expansion of matters covered by insurance also extend the event of proximate causes that are stipulated on insurance agreement.

4. Indemnity

The principle of indemnity is a principle that provides compensation for actual losses, meaning that there will be no payment for a planned loss (volenti nonfit injuria). The principle of indemnity puts the insured back in the original financial position before the loss or at least close to the original financial position. Indemnity payments can be made by cash payments, repairs, replacements, and reinstatements.

5. Contribution

This principle is usually used if the insured uses more than 1 (one) similar insurance.

6. Subrogation

In essence, the principle of subrogation is to replace or put oneself in the place of another person. In insurance, the principle of subrogation can simply be defined as the insurer replacing the position of the insured to collect on third parties after the insurer pays compensation to third parties.

In addition, it should be noted that insurance agreements are one of the special types of agreements regulated in the KUHD. Insurance agreements have special properties and characteristics, among others:

1. It is an *aletoir* agreement. The performance of the insurer is given for an event that has not necessarily occurred. The implementation of the performance by the insurer has a time gap between the payment of the premium and the receipt of benefits and depends on the presence or absence of the promised event;

2. It is a one-sided agreement. This means that only one party makes a promise if an event occurs, namely the insurer, while the insured does not promise anything.

3. Insurance agreements are agreements that are attached to the insurer's terms. In practice, this is because the terms and conditions for reimbursement of losses or payment of claims are almost entirely determined and created by the insurer.

The insurance agreement is the basis of an agreement between the insurance company and the insured that gives rise to the rights and obligations of each party. Therefore, the fulfillment of the validity of an insurance agreement remain an important element. The regulation regarding the validity of an agreement as regulated in Article 1320 of the Civil Code remains a requirement for the validity of an insurance agreement with the additions of the obligations which are stipulated in the KUHD. Article 1320 of KUHPer regulates the legal requirements of an agreement as follows: agreement to bind oneself, capacity to make an agreement, a certain thing that becomes the object of the agreement and a halal cause. Meanwhile, in trade law there are several additional requirements

1. The principle of insurable interest;
2. The principle of perfect honesty;
3. The principle of indemnity; and
4. The principle of subrogation.

Noting about the conditions of the validity of the agreement as stipulated in the KUHPer and KUHD are the conditions of the insurance agreement. So, automatically the things that are generally regulated in the KUHPer and KUHD about the reasons for canceling the agreement still apply. If the policyholder has the opinion that the occurrence of the insurance agreement is due to misdirection, coercion and fraud from the insurer, the policyholder can take efforts to apply for the cancellation of the agreement through the court. If the cancellation of the agreement is accepted by the court, the policyholder is entitled to a refund of the premium paid as stipulated in Article 281 of the KUHD with a note that the agreement was made by the insured in good faith.

3.1 Insurance Policy

The insurance agreements must be a written agreement, based on Article 255 of the KUHD. However, this does not mean that if the insurance agreement is closed before the policy is issued, then if an event as agreed occurs as promised, the insured cannot accept the right of the compensation. As stipulated in Article 257 of the KUHD that the insurance agreement exists after the insurer and the insured have carried out their obligations, in this case the insured has paid the insurance premium.

So based on this description, the insurance policy is more intended as written evidence to state that there has been an insurance agreement between the insured and the insurer. Article 255 KUHD states that insurance must be carried out by deed, namely the insurance policy, however, this does not mean the policy is the only evidence, because in an insurance agreement there are other written documents such as SPAJ, insurance agreement closing notes, welcome letters and others. This can be used as written evidence and is accommodated in Article 258 of the KUHD or known as the beginning of writing evidence.

The contents of the insurance policy or agreement are regulated in Article 11 of the Financial Services Authority Regulation Number 23 /POJK.05/2015 concerning Insurance Products and Marketing of Insurance Products (POJK Insurance Products and Marketing) which at least contains provisions regarding:

1. When coverage applies;
2. Description of the promised benefits;
3. The method of payment of Premiums or Contributions;
4. Grace period for payment of Premiums or Contributions;
5. The exchange rate used for Insurance Policies if the payment of Premiums or Contributions and benefits are linked to the rupiah currency;
6. The time recognized as the receipt of payment of Premiums or Contributions; the Company's policy established if payment of Premiums or Contributions is made past the agreed grace period;
7. The period when the Company cannot review the validity of the insurance contract (incontestable period) on long-term Insurance Products;
8. Cash value table, for Insurance Products marketed by Life Insurance Companies that contain cash value;
9. Calculation of Insurance Policy dividends or similar, for Insurance Products marketed by Life Insurance Companies that promise Insurance Policy dividends or another that has similarity;
10. Termination clause, whether from the Company or from the policyholder, insured or participant, including the conditions and causes;
11. Terms and procedures for submitting claims, including supporting evidence that is relevant and necessary in submitting claims;
12. Procedures for claim settlement and payment;

13. Dispute settlement clauses which, among others, contain in-court and out-of-court settlement mechanisms and the selection of the seat of dispute settlement; and
14. Language used as a reference in the event of a dispute or difference of opinion, for Insurance Policies printed in 2 (two) or more languages.

In addition, POJK Insurance Products and Marketing also regulates that insurance policies must be written clearly and can be read easily. It is intended that the insured can clearly read and understand the contents of the insurance policy including clauses that may cause claims to be unacceptable to the insured, for example related to pre-exiting periods. However, if there is an understanding in the insurance policy that is ambiguous or multiple interpretations, the principle of contra preferentem will apply, namely the understanding that applies is favorable to the insured party. The insurer, who is the party that instinctively has a stronger position than the consumer, cannot get or take advantage of the ambiguity.

The insured's understanding of the insurance policy is very important, especially regarding the exclusion or limitation of the causes of risks that can be covered as well as the reduction, limitation, or exemption of the insurance company's obligations to avoid consumer disputes. Therefore, Article 19 paragraph (2) POJK Insurance Product and Marketing Regulates the formulation that can be interpreted as mentioned above must be written or printed in bold or italicized letters so that it can be easily known that there are exclusions or restrictions on the causes of risks or the reduction, limitation, or exemption of the Company's obligations.

In an insurance agreement, the insured has the obligation to pay a premium or a sum of money determined by the insurer and approved by the insured. It is important to understand that the amount of premium correlates with the amount of the insured's ability to bear the risks that arise in the future. Low premiums are usually offered for simple products or features. Premium determination is usually done by underwriting by looking at the risk of the insured object. POJK Insurance Products and Marketing generally provides guidelines regarding premiums or contributions must be set at a level that is sufficient, not excessive, and not applied in a discriminatory manner. The insured in principle can request quotes from other insurance companies to see and compare the premiums and product features offered.

The importance of upmost good faith in insurance

Insurance is not a profit and loss agreement, an insurance agreement is an agreement made with the aim of transferring risk from the insured to the insurer balanced by the payment of premiums by the insured. In the insurance agreement, the principle of risk transfer applies if the premium is paid. If an event occurs and the insurer does not pay, the insured can file a lawsuit to the district court based on default or the insured can settle it through an out-of-court dispute resolution institution for the financial services sector, namely the Financial Services Sector Alternative Dispute Resolution Institution (LAPS SJK).

The absence of good faith by one of the parties or parties in an insurance agreement can indicate fraud which is the beginning of a dispute. Whereas in principle the insurance agreement is an agreement based on trust. Although usually to prove the motive for fraud in insurance or the definition of insurance fraud is difficult to prove. But usually the motive for financial gain is the most commonly encountered motive. Activities that can be categorized as fraudulent generally have 3 (three) elements, namely:

1. Conceal, falsify, or lie not to convey data or information that is material (material misrepresentation).
2. Purpose or intention to deceive or trick.
3. Aims to gain unauthorized benefit.

In every agreement the existence of good faith is very important, especially since it cannot be denied that there is information asymmetry in every activity, especially in the financial services sector. Information asymmetry can simply be interpreted as an imbalance of knowledge of certain information. In life insurance, for example, the insurer does not have sufficient information about the insured outside of the things conveyed at the time of the product offering regarding the health condition or disease of the insured. Based on this information, the insurer will then calculate and offer the type of insurance product that suits the insured's health condition and ask the insured to complete the requirements. Likewise, the insurer has limited information about what matters are in the agreement and its clauses, although there is usually a free look provision given by the insurance company to the insured to read and understand the contents of the policy.

The implementation of upmost good faith principle is the obligation for both parties. However, seeing how the regulation have regulated in more detail and rigidly about the things that may and may not in the business process performed, also the duties of business actors is more rigid and detailed, then consumer good faith is very essential in fulfilling the

agreement. Furthermore, in Article 5 of Financial Services Authority Regulation No. 6/POJK.07/2022 (POJK Consumer Protection) gives businesses the right to ensure the good faith of consumers and obtain information and/or documents about consumers that are accurate, honest, clear, and not misleading. This is especially true for financial products that are highly dependent on the profile and capabilities of the consumer.

Based on this definition, it can be seen that there are 3 (three) things regarding the absence of good faith, namely:

1. Providing false information.
2. Providing incorrect information.
3. Does not provide information about things that are known.

The responsibility to submit information correctly is important for the insurer as a basis for calculating the amount of risk it bears which is related to the cost of the premium to be paid by the insured. There are several mistakes in providing information as follows:

1. Not disclosing material information correctly and completely (non-disclosure) which is done unintentionally.
   Material information is important information that can cause an application for coverage to be rejected or accepted but with different terms of coverage or premiums. Determining whether information is material or not is difficult to do, therefore the insured should submit all information about the insured object. Not disclosing material information correctly and completely is the reason for the rejection of the insured's claim.
2. Hiding information (concealment).
   This is usually a deliberate attempt to hide material information.
3. Information disclosed is innocent misrepresentation.
   Misinformation usually occurs because there is a lack of knowledge or understanding of the questions presented.
4. Providing false information for the purpose of fraud (fraudulent misrepresentation).

There is no qualification for the submission of incorrect information, so the submission of incorrect information in any form can be a condition for canceling insurance or rejecting insurance claims. Moreover, one of the principles of the insurance agreement is the proximate cause principle. In insurance agreement policies, it is usually stated what causes can be guaranteed. In addition, if you pay attention to Article 251 of the KUHD, the

process of canceling an insurance agreement does not mean that the agreement is immediately considered canceled, but the cancellation need to be submitted by the insurer to the court to be canceled. However, usually if the insurer after analyzing and considering on humanitarian grounds, the insurer can provide compensation in the form what we called as ex gratia.

However, for life insurance, it needs to be understood that there are no causes of death listed in the insurance policy. The truth that every living creature must die does not need to be doubted or it is a certainty event. What is uncertain is when someone dies, so that the evenemen (uncertainty event) in the life insurance agreement is only 1 (one), namely the uncertainty of when someone dies. So that if the insured until the time limit does not die, the insured is entitled to get a sum of money from the insurer whose amount has been determined in the insurance policy.

Furthermore, the principle of good faith is essential to provide fair dealing with premiums and the amount of coverage. Thus, information that is not conveyed, for example regarding diseases that have been experienced either chronic or acute, needs to be conveyed even though it is not an event of life insurance. The information about medical record is material information especially if the disease suffered is a high-risk disease.

Fair dealing or fairness in dealing with material information submitted by the insured is done by re-under writing or re-selection of insurance acceptance. This is done to determine the level of materiality of the information that is not submitted. Whether the fact that the insured has a history of the disease or a history of treatment for the disease, the insurer will still provide or accept the insurance application. In addition, if the insurer accepts the insurance application, it is likely that there will be changes to the requirements in applying for life insurance, for example, the examination requested is not an ordinary health examination but a special examination. So that the insured can be said to have bad faith, by making misrepresentations (non-disclosure of material facts).

Consumers also need to be wise and smart consumers. The SPAJ often done by insurance agents because prospective consumer are lazy enough or tired to filled it by themselves. So that conditions sometimes used as an excuse, so consumers claim do not know the existence of clauses that are a requirement for claim disbursement. SPAJ, which is an integral part of the insurance policy, thus why reading and understanding the contents of the SPAJ is an obligation to consumer himself. In addition, it's a common thing in insurance business process to market their products through insurance agents who had certificated. In short, it is legal.

Based on Article 48 POJK Insurance Products and Marketing Products, it is stated that companies that market Insurance Products through insurance agents must ensure that the insurance agent meets the provisions of laws and regulations regarding insurance agents. Provisions regarding insurance agents, namely having an agency certificate in accordance with their field of business and registered with the OJK as stipulated in the Financial Services Authority Regulation Number 69 /POJK.05/2016 concerning Business Implementation of Insurance Companies, Sharia Insurance Companies, Reinsurance Companies, and Sharia Reinsurance Companies (POJK Insurance Business Implementation). In addition, based on Article 29 of the POJK on Consumer Protection, there are provisions regarding the responsibility of Financial Services Business Actors (PUJK) for consumer losses arising from errors and / or negligence of employees, management including third parties working for the benefit of POJK.

Although there are regulations related to the responsibility of the PUJK (insurance company) for the actions of third parties including insurance agents working for the benefit of the insurer, but the actions of insurance agents need to be classified first. Whether the insurance agents that filling the agreement of insurance act on behalf the insurer or the insured. In author's opinion, the insurance agent acting in filling out the insurance quote proposal is representing the interests of the insured. Therefore, accordance to the principle of granting the power of attorney, the insured remains responsible for the actions or contents of the form even though it is filled out by the insurance agent, as long as the insured willingly gives power of attorney to the agent for that. The lack of knowledge about what the insured do is the negligence that he committed may cause disputes in the insurance sector. The insured must be a wise consumer by understanding his rights and obligations including reading the contents of the insurance policy carefully and acting on their behalf.

4. CONCLUSION

Policyholders or insureds who experience an event that causes a claim to be filed for the risk that covered by insurance policy needs to pay attention to the ultimate cause of an event. The ultimate cause must be in a series of events or an unbroken chain of events from the risk borne. In addition, by paying attention to the provisions in Article 251 KUHD which regulates the consequences of the absence of good faith or upmost good faith of the insured by not conveying the information clearly, correctly, and accurately, it may result the cancellation of the agreement. The awareness of the insured to convey relevant information

is a form of good faith that must be carried out by the insured. The up most good faith act by the insured is essential in insurance agreements especially in life insurance because it is the basis for the insurer or insurance company in determining premium costs and considering the type or insurance product that suits with the conditions and wishes of the insured. This is a part of *fail dealing* in insurance agreement.

4.1 Advice

1. The insured should carefully read the contents of the SPAJ and fill in the information themselves honestly and correctly in accordance with the existing reality or facts before closing the insurance.
2. The insured must carry out a very well documentation during the process undertaken for the dealing until the issuance of the insurance policy. The documentation could be both in written form and media recordings. In Additions, the insured must ensure to provide complete access or information to prospective heirs.
3. Insurance companies must ensure that their agents convey clear, correct, and complete information including matters that are special for the insurance application or claiming.

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