REJECTION OF INSURANCE CLAIMS DUE TO THE INSURED'S DISHONESTY REGARDING THE HISTORY OF ILLNESS

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Abstract

This study examines and analyzes the rejection of insurance claims because the insured does not honestly disclose the history of illness he has experienced. The research method used is a normative juridical method with secondary data in the form of insurance legislation, insurance policies, and insurance literature, data analysis is carried out qualitatively. Insurance is an agreement to transfer risk from an insured or policyholder to an insurer or insurance company. The insured or policyholder should pay a certain amount of money as a risk transfer fee called the insurance premium. If there is a risk that has been agreed, the insurer must pay insurance benefits or claims whose amount has been stated in the policy which is referred to as the sum insured. Good faith in the form of honesty in filling out and answering questions at the beginning of the insurance closing process, especially medical history or illness that has been or is being suffered or experienced by the prospective insured is very important because it will have an impact on the claim settlement process. If the prospective insured or insured does not have good faith and does not honestly fill in and answer questions about the history of his health condition, it will have an impact on every claim that occurs and is submitted by the insured becomes not guaranteed by the policy, meaning that the insurer has no obligation to pay claims or policy benefits because the policy becomes null and void or void by itself as stipulated in Article 251 of the KUHD. To avoid disputes, and disappointment with the insured / policyholder in the claim, it is recommended that everyone who wants to buy an insurance policy always have good intentions, namely honestly in submitting data, information, and information about his medical history when filling out and answering questions in the Life Insurance Application Letter (SPAJ) form.

Keywords: insurance, good faith, Medical History, SPAJ, claims

INTRODUCTION

Every human life always coexists with the dynamics of existing problems, starting from economic, social, and cultural problems. Along with the times, the problem is getting more and more variations, and it is all inseparable from risks and uncertainties, therefore to avoid this in their lives, humans try to do maximum prevention. Someone who understands and cares about these risks will try their best to reduce, eliminate, and even transfer all risks to an unexpected threat of danger. According to Man S. Sastrawidjaja and Endang said that:[1]

"*The possibility of humans facing loss or loss is a risk. The risks faced by each person can affect both his own life and his wealth. Therefore, regarding this risk, there are economic ones such as burning houses, loss of depositor funds in banks, and others. There are also non-economic ones such as death and others*".[2]

[1] Djoko Prakoso, 2000, *Indonesian Insurance Law,* Rineka Cipta:Jakarta, 4th printing, p.15.

[2] Man S. Sastrawidjaja and Endang, 1997, *Insurance Law*, Alumni:Bandung, 2nd Edition, 1st printing, p.1.

Risk can also occur because the action costs money and the person cannot afford to provide it, so he surrenders to the risk. Risk in this case is a possibility of an event that befalls a person or someone's property, and if there is a risk it will cause physical suffering, death, or financial loss to the person who experiences the risk event. The risk that can befall a person is also in the form of bodily injury, disability, and the risk of illness that requires large medical costs if you have to be hospitalized or require surgery in the hospital. Therefore, efforts that can be made to overcome the impact of these risks are by insurance.

Insurance is an agreement to transfer risk from an insured or policyholder to an insurer or insurance company. The insured or policyholder should pay a certain amount of money as a risk transfer fee called the insurance premium. If there is a risk that has been agreed, the insurer is obliged to pay insurance benefits or claims whose maximum amount has been stated in the policy which is referred to as the sum insured.

Insurance is an agreement based on a principle or principle called the principle of good faith or *utmost good faith.* The principle of good faith teaches and states that the insured and the insurer in the insurance agreement must be in good faith. Good faith for the insured means that submitting data, information, and facts about the insurance object must be done honestly, and must not lie, or provide data, information, or facts that are not true. The insurer believes that the insured will provide true information about the insurance object, while the insured believes that the insurer will provide insurance benefits or compensation if the insured experiences the risk or event that has been agreed upon. The role of the insurance company here is as a protection institution, which is an institution that protects the form of guarantees to the insured, under the agreement contained in the policy.[3]

Based on the role of the insurer as a protection institution, the insurer is an institution that is trusted by the community, because it can overcome the risks faced by the insured, where to gain the trust of prospective insured or prospective insurance customers is to offer various benefits from the insurance company concerned. The insurer guarantees that the management claims faced by policyholders can be managed or disbursed easily when experiencing risks under the contents of the insurance agreement.

Article 1 point 6 of Law Number 40 of 2014 concerning Insurance states that the Life Insurance business is a business that provides risk management services that provide payments to policyholders, insured, or other entitled parties if the insured dies or remains alive, or other payments to policyholders, insured, or other entitled parties at a certain time stipulated in the agreement, whose amount has been determined and/or based on the results of fund management.

In the practice of implementing life insurance policies, the insured party is still often disappointed, and/or disputes occur in the claim settlement process. The submission of the insured's life insurance claim is rejected by the insurer because the insured has violated the principle of good faith. This at least dilutes public trust in the insurance company or insurer, because it seems to make it difficult to disburse claims.

Reasons Rejection of claims from the insurer often uses the insured party or policyholder has violated the principle of good faith when filling out the Life Insurance Application Form or abbreviated as SPAJ. In the SPAJ form that must be

[3] Agus Prawoto, 1995, *Insurance Law and Health Insurance Companies*, BPFE Publisher, Yogyakarta, hIm. 6.

filled out by the insured when becoming a prospective customer, some questions must be filled in, namely related to medical history and diseases that have been suffered in previous years or that are being experienced by the prospective insured. In filling out and/or answering questions contained in the SPAJ form, the prospective insured must be honest, and must not lie. The insurance agent must also explain that there are consequences if the prospective insured is not honest in submitting information, data, and information including the medical history of the prospective insured. Here the role of a life insurance agent is important, and the agent should not facilitate the filling of the SPAJ form, especially not let the agent fill out the SPAJ form himself. Dishonesty in providing information, information, data and medical history of the prospective insured in the SPAJ form will result in a claim not being required to be paid by the insurer. An insurance agent is certainly expected to play an optimal role in the implementation of the principle of good faith for prospective insured or policyholders. The orientation of the agent should not be solely to get as many customers or insured as possible but in the end, if there is a risk it will cause problems in the claim settlement process.

The purpose of this paper is to provide an overview and further information about the position of analyzing conditions in legal systematics at the time of the insurer's refusal of the insured for alleged indirectness about the insured's disease history.

RESEARCH METHODS

The research method used in research is normative juridical. Whereas the normative juridical itself focuses more on library materials as sources such as books, laws, and regulations related to this research. This research approach is carried out by looking at insurance laws and regulations [4], insurance policies, and insurance literature. This research refers to the Civil Code, Law Number 40 of 2014 concerning Insurance *Jo* Law Number 2 of 1992 concerning Insurance Business and Commercial Law Code.

The analysis method used is a qualitative analysis method where this research refers to rules, principles, and legal theories to obtain further views which will eventually be analyzed for research. The form of this research is descriptive-analytical, which is research that emphasizes secondary data which includes norms and legal regulations related to the refusal of the insurer's refusal to the insured for alleged indirectness about the insured's disease history.

RESULTS AND DISCUSSION

a. Legal Responsibility Carried Out by the Insurer to the Insured for Alleged Dishonesty about the History of Disease

The running of the wheel of life of every human being must always have the lowest point in his life such as illness and death will always loom, this is what we usually call risk. Risk in insurance contains two concepts, namely uncertainty, and loss.

One way to minimize risk is to entrust our finances to financial institutions. The institution in question is insurance. This claim for compensation by the insured to the insurer is usually called a claim. In entering into any agreement, although efforts have been made to write all the words and formulations in the agreement concisely, simply, and unequivocally, in its implementation it still often causes problems.[5]

There are often obstacles when

[4] Muhammad Abdul Qadir, *Law and Legal Research*, (Bandung: Citra Aditya Bakti, 2004), p. 201.

[5] Agus Prawoto, *ibid* p. 133.

implementing insurance claim settlement, one example is the obstacle to settling insurance claims caused by incomplete documents that must be fulfilled when submitting a claim. Errors can also occur in the marketing process, namely the lack of understanding of each party who makes an insurance agreement on the application of insurance principles that must exist since the implementation of the insurance agreement or contract. If in the future the consumer feels that the product he bought is not as promised, then the consumer can promise a lawsuit or cancel.[6]

A claim is a submission of rights made by the policyholder to the insurer to obtain his rights in the form of coverage for losses based on an agreement or *contract* that has been made.

There are several cases of rejection of insurance claims that cause legal uncertainty, there is even a possibility that this is quite problematic from the beginning of the submission process as a prospective customer. In general, insurance company agents are tasked with being intermediaries between customers and insurance companies, Law Number 40 of 2014 concerning Insurance Article 31 paragraph (1) and paragraph (2) state that:

"Insurance agents are obliged to provide true, non-false, and/or non-misleading information to policyholders, insureds, or participants regarding risks, benefits, liabilities, and charges related to insurance products or Islamic insurance products offered. "

Understanding the essence of this legal basis, the orientation of the company is a comprehensive data validation of the information submitted by prospective insurance insured and can be accounted for, not just looking for as many customers as possible.

If there is an error in customer data regarding his disease history where this process is a formal form that must be accounted for in registration, it must be investigated whether the customer hides his health condition or the insurance agent who manipulates the insured, of course, this will harm both parties, especially the insured who has entrusted the risk to the selected insurance company. This is the responsibility of the insurance company in tracing customers which is an important part of the functions and objectives of the insurance institution. The responsibility of the insurance company regarding the insured's indirectness regarding the history of illness must start from the investigation of the claim needs a more complete investigation, including:

a) Ensure that indeed the facts submitted in the evidence of loss
b) Determine whether the actions of the insured invalidate his claim. Whether the actions of the insured fulfill the obligations stated in the insurance contract
c) Determining the amount of loss, if the insured has reported the amount of loss, then the adjuster will examine the claim and compare it with his estimate of the amount owed to the insured under the policy.[7]

If this amount does not match, the adjuster will explain to the insured how he arrived at the estimate. The insured will also explain the calculation to the adjuster. They can devise a solution that is satisfactory to both parties.

The loss settlement process may require the adjuster to determine if his insurance company can recover some of the money that has been paid for the claim. If the insurance company has paid a claim, then up to the amount of payment of that claim, it has the right of *subrogation* (the

[6] Ketut Sendro, *Easy Insurance Claim*, Cet.3, Jakarta: BMAI, PPH, 2009, p. 52.

[7] A. Hashim Ali, *Introduction to Insurance*Cet. I, (Jakarta : Bumi Aksara, 1993), p. 266

right to replace) the insured's claim against the guilty party responsible for the loss. Although in general the adjuster and the insured can reach an agreement on the settlement of losses, each insurance policy sets the conditions for the settlement of claims if no agreement is obtained, for this reason, an *Arbitration* (referee) is held to act as an arbitrator. Then after signing the policy and handing it over to the insured, as stated in Articles 259 and 260 of the KUHD, which reads:[8]

Article 259 of the Criminal Code:

"*If a liability is closed directly between the insured, or the person he has ordered to do so or has the power to do so, and the insurer, the policy shall be within 24 hours after it is requested to be signed by the latter, unless in the provisions of the Act in a particular case, a longer term is established*."

Article 260 of the Criminal Code:

"*If a cover is closed through the intercession of a realtor, then the signed policy must be handed over within eight days after the closing of the agreement*."

Provide compensation to the insured, if the agreed event occurs, as stated in Article 246 of the KUHD, Return the restorno premium to the insured, if the insurance is void or void, as stated in Article 281 of the KUHD as follows:

"In all cases where the liability agreement is wholly or partially void or void, and the insured has acted in good faith, the insurer is obliged to refund the premium in full, or in part."

b. Arrangements regarding policy claims for diseases suffered by the insured outside the history of illness submitted at the time of insurance registration

The insured realizes that there is a threat of danger to his property or his life. If such harm befalls his property or his soul, he will suffer loss. Material loss, loss of life, or physical disability will affect the course of a person's or his or her heirs' lives. The insured as a party threatened with danger feels heavy to bear the burden of risk that can occur at any time. In life insurance, if until the end of the insurance period, no death or accident befalls the insured, then the insured will get a refund of the amount of money from the insurer under the contents of the insurance agreement.[9]

It may occur between the insurer and the insured in life insurance. If the insured feels that his rights such as claims are not paid by the insurer or it could be that the dispute occurs because the insured makes an incorrect claim. [10]

The obligations of the insured as a consumer can refer to Article 3 of the Financial Services Authority Regulation Number: 1/POJK.07/2013 concerning Consumer Protection in the Financial Services Sector that

"Financial Service Institutions have 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."

In this case, what is meant by Financial Service Institutions according to Article 1 paragraph (1) POJK No. 1 / POJK.07 / 2013 is

"Commercial Banks, Rural Banks, Securities Companies, Investment Advisors, Custodian Banks, Pension Funds, Insurance Companies, Reinsurance Companies, Financing Institutions, Pawn Companies, and Guarantee Companies, both those that carry out their business

[8] *Ibid.*, p. 269

[9] Komaruddin, *Encyclopedia of Management,* Bumi Aksara, Jakarta, Cet. 1st, 1994, pp. 789-790.

[10] Article 8 point M, Decree of the Minister of Finance No: 422.KMK.06/2003, concerning *Business Operation of Insurance Companies and Reinsurance Companies*.

activities conventionally and sharia-compliant."

Based on the provisions of these regulations, prospective insureds who due to their dishonesty when filling out the SPAJ form regarding disease history will result in the Insurance Policy becoming void and claims are not guaranteed by the policy so the insurer is not obliged to pay claims.

If there is an error in data regarding the prospective insured regarding his disease history when filling out the SPAJ form where this process is a formal form that must be accounted for, it will result in the Insurance Policy becoming void and the claim is not guaranteed by the policy so that the insurer is not obliged to pay the claim.

While in insurance protection held by the insurer. Explained in Article 8 point L of the Decree of the Minister of Finance No. 422/KMK.06/2003 it is stated that the *policy must contain the terms and procedures for submitting* a claim, including supporting evidence needed to file a claim. The existence of supporting documents to file a claim is needed by the insurer to know in detail the risks experienced by the insured and the claims submitted by the insured for the risks suffered really by the insured. It can be concluded that to submit a health insurance claim there are several things needed, including:[11]

a. Health insurance policy;
b. The name of the police insurer;
c. No police;
d. Name of the insured;
e. An insurance claim form completed and signed by the policyholder or insured and the attending physician and surgeon (if there is surgery);
f. Original receipt from the hospital during treatment;
g. Details of hospital treatment costs;
h. Copies of diagnostic test results and summaries of medical records from doctors who examined or treated the insured starting from hospitalization or surgery;
i. Other documents required by the insurer;

In the event of an insured risk, the insured must immediately file a written notification to the insurer. As for the form of solving these obstacles, if all the documents described above have been fulfilled and accepted by the insurer, then if there is no need for an examination or investigation of the risks that occur, the insurer will make a claim payment to the insured. The hospital will still assist if there are obstacles in managing claims that are considered unclear and incomplete problems with the required documents both with the hospital and with insurance companies that cooperate with the hospital. The hospital will try to take a middle ground to help in solving the problem by approaching the insurer so that it can be resolved in a familial way for mutual interest. Continuing with its function, the hospital provides health services to participants or insured by the provisions in the agreement with the insurer, according to the agreement of both parties, which are stated in the agreement and which are not listed in the agreement.

CONCLUSION

Life Insurance is insurance whose object is life and the human body as a unit. The purpose of Life insurance is to transfer the cost risk from the insured to the insurer so that the insurer must pay insurance benefits or claims whose amount has been stated in the policy which is referred to as the sum insured. Regarding the history of the disease, if there is an error in the customer's data regarding the history of his illness when he has become a customer,

[11] Amin Suma, *Sharia Insurance & Conventional Insurance*, (Jakarta: Kholam Publishing, 2006), p. 53.

where this process is a formal form that must be accounted for at the time of registration, it must be investigated whether the customer is hiding his health condition or the insurance agent is manipulating the insured, of course, this will harm both parties, especially the insured Insurance that has entrusted its risk to the selected insurance company. The risk that will be faced by the prospective insured is that the Insurance Policy becomes void and the claim is not guaranteed by the policy so the insurer is not obliged to pay the claim.

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