Due to the Legal Failure to Pay by the Insurance of the Insurance Policy of the Insured

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Abstract: This Paper Discusses Due To The Legal Failure To Pay By The Insurance On The Insurance Policy Of The Insured. The agreement between the two parties insured (insurance company) and the insured (policy holder) at the time of making an insurance policy is important, because insurance or coverage is a form of agreement. In recent years, Indonesia has been shocked by the number of insurance cases, which has made policyholders from any insurance company to be wary or worried about their money that has entered the insurance company. These policy holders (insured) seek justice and legal certainty by taking various legal methods. This normative research uses the method of legislation and a conceptual approach. This paper aims to analyze the legal consequences of the insurer failing to pay on the rights of the insured and the legal protection for the insured affected by the default. The results of this study indicate that legal remedies that can be taken by the Insured to minimize losses are one of them by paying attention to the time limit for granting claims and benefits that have been agreed in the Insurance Policy which is generally 30 (thirty) days after the agreement. The Financial Services Authority has the authority to ask the Insurer to stop activities if it has the potential to harm the community. It is also authorized to facilitate the settlement of consumer complaints that have been harmed by actors in financial service institutions (Insurers).

Keywords: Failure to pay; Insurance Company; Insurance Policy.

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INTRODUCTION

In this modern era, people are often faced with existing problems. Problems can come in terms of finance, health, business, and others. This problem arises because of the risks that exist in every decision taken by the community. These risks are mild to severe, depending on the cause. As we know, these problems can actually be suppressed or minimized in various ways. One of them that is familiar to our ears is insurance. Between the insurance company and the policyholder, there is an insurance agreement that forms the basis for obtaining premiums for the insurance company.

According to Article 246 of the Commercial Code or abbreviated as (KUHD) what is meant by insurance or coverage is an agreement of an insurer who bind himself with the policyholder in order to get a premium whose function is to provide compensation for losses, damage or loss of profits due to unspecified events.

Uncertain event in the sense of insurance are events against which insurance is held, cannot be ascertained to occur and are not expected to occur\(^1\). So it can be concluded that insurance consists of several elements, namely\(^2\):

- a. Is an agreement;
- b. There is a premium;
- c. There is an obligation of the insurer to provide reimbursement to the policyholder;
- d. The existence of an event that has not occurred (anzekesvoorval).

The agreement between the two parties insurer (insurance company) and the policy holder at the time of making an insurance policy is important, because insurance or coverage is a form of agreement. The existence of insurance companies in Indonesia aims to realize the stability of the country’s economy and create a just and prosperous society. Therefore, in order to achieve good national development, it must be seen from various aspects in order to create harmony or balance, including in the investment economy.

The policy brought by the policyholder is a form of agreement that should be obeyed by both parties. The fact that often occurs in default insurance cases is that the insurer cannot fulfill the policy agreement and this has its own legal consequences for the policyholder. Policyholders who experience a default case will lose their rights, because they have paid the premium as stated in the policy but cannot use it when it is due.

The existence of insurance can actually help us when things happen that are not desirable in the future, such as illness, accident, fire or other natural disasters that can damage building assets and others. By paying a premium that has been agreed between the policy holder and the insurance company is actually the same as saving. The difference is that if you save at a bank, the funds can be taken by the customer at any time, but if the insurance premium can only be taken when the things covered in the policy occur.

Insurance companies exist with the aim of providing solutions to the problems faced by policyholders, at least being able to ease their burden by providing compensation according to the agreement so that policyholder avoid bankruptcy so that they can stand as before and return the policy to its original state. Position before the problem.\(^3\) With this aim, it is

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3 Radiks Purba, *Getting to Know Land Transportation Insurance and Air*, (Jakarta: Djambatan, 2012), 15.
hoped that the welfare and legal certainty can be obtained by policy holders, because the problems that occur have been taken over by the insurance companies.

To be able to know the things covered by the insurance company can be known from the type of insurance chosen. There are many types of insurance and each insurance company has a different type of insurance products and a different systems for policy holders. The insurance policy has also included a time limit for the coverage claimed, which if it’s past that time limit, but the funds cannot be received by the policy holder, this is where the problem of the origin of this difficulty will arise. This kind often experienced by policy holders, so they feel safer keeping their money in the bank rather than having to pay insurance premiums which often fail to pay when they fall due.

In recent years, Indonesia has been shocked by the number of insurance cases that have made policy holders from any insurance company to be wary or worried about the money that goes to the insurance company. Because many insurance companies in Indonesia are bankrupt and unable to pay the policy holders’ benefits that have matured. As a result, these policy holders seek justice and legal certainty by taking various legal methods. There are many reasons that make the insurer fails to pay (default) to the policyholder’s funds or benefits.

One of them is the performance of insurance companies that are getting worse day by day and in the end need to be restructured. Things that can make an insurance company’s performance become unfavorable can be caused by the lack of implementation of Good Corporate Governance, fundamental problems, and can also be the result of liquidity pressure from saving plan products.\(^4\)

There are various types of insurance programs, benefits and systems tailored to the needs of prospective insurance customers. One of the insurance programs that are currently experiencing many problems is a saving plan products. This insurance product system is almost the same as a term investment, only in the form of insurance policy benefits with a disbursement period.

This program was originally intended to address the liquidity of insurance companies, but over time, it become a problems due to the weak implementation of Good Corporate Governance. If the implementation of Good Corporate Governance is weak, the portfolio of guidelines that serve to regulate maximum investment in high risk assets will be imperfect or even non-existent. Giving high interest on the saving plan program causes the obligation borne by the insurance company (the insurer) to pay the policy benefits to default. Insurance companies (insurers) form teams to accelerate restructuring in order to minimize existing problems and save policy holders funds. Actually the insurance company (the insurer) who failed to pay has paid some of the benefits to te policyholder, but still, because the amount is large, it cannot be settled in its entirety.

The case of insurance default that occurred in the near future is the case of PT. Asuransi Jiwasraya (Persero). The policyholder is a member of the Jiwasraya Victim Forum who want to claim some of their rights to the insurance company. Some of the rights they asked for include; requesting the issuance of a decree regarding the disbursement of the Jiwasraya Savings Plan insurance funds which

are the rights of our customers, requesting that the government also intervene in solving this problem, and so that policy holders do not want to be forced to be transferred to another insurance company.

The default case of PT Asuransi Jiwasraya (Persero) began in October 2018. Until now, the saving plan claim process has not been carried out properly, so there are still many policyholders who claim the losses they have suffered. Since the case of default, many policy holders have lost their lives, especially during the current pandemic, they depend on savings and other forms of savings.

Several other steps have also been taken, from selling some of the company’s assets to conducting a *repurchasing agreement* (repo), namely the sale of securities.\(^5\) If this kind of incident is allowed to continue without a good solution, it can harm consumers and make other more distrustful of insurance or financial services coverage. However, the insurer must continue to prioritize the rights of policyholders and provide legal certainty for them. This default insurance problem occurs because of weak supervision from the regulator. This causes a gap between strict regulations and weak supervision in the field by the Financial Services Authority (OJK).\(^6\) Meanwhile, the policy holder has the right to get coverage from what has been agreed between the two parties contained in the policy. For companies that are entangled in financial or debt problems, Postponement of Debt Payment Obligations (PKPU) or Bankruptcy can be a way out where both applications are submitted to the Commercial Court. PKPU and bankruptcy are two solutions to problems that occur in the business world.\(^7\)

If PKPU becomes an barrier in making insurance payments, at least the insurance company (insurer) does not ignore the interests of the policy holders. As we know that according to Article 1 number 1 of Law Number 8 of 1999 concerning Consumer Protection (Consumer Protection Law) it is stated that Consumer Protection is an effort to guarantee legal certainty and also provide protection to consumers. Like it or not, the government must participate in resolving this dispute so that it can provide a good and appropriate solution and minimize the people who have been harmed a lot.

To be able to minimize the legal consequences and losses experienced by policyholders in cases of a default, legal remedies and legal protection are needed to ensure certainty between the two parties. For example, the case of default insurance that occurs in Jiwasraya insurance. The insurance company failed to pay the policyholders’ policies due to poor corporate governance, especially in the company’s financial management. This is what causes when the policyholder’s policy has matured, the company cannot fulfill it properly because the existing funds are not clearly managed.

Based on the problems above, the formulation of the problem can be drawn: What are the legal consequences of the insurer failing to pay on the rights of the policyholders? and What are the legal protection measures for policyholders who are affected by default? The purpose of this paper is to provide knowl-

\(^5\) Ibid.

\(^6\) Ibid.

edge or insight to the public so that policyholders do not feel aggrieved and unprotected without legal certainty. This is because many policyholders have paid premiums of hundreds of millions to billions of rupiah, which until now have not yet received the benefits of the policy, because company accounts are blocked and detained by the state so that companies cannot make payments to policyholders.

METHOD

The type of legal research is normative, namely research that is focused on examining the application of rules or norms in positive law. The research approach uses a statutory approach, namely Law Number 40 of 2014 concerning Insurance, a conceptual research approach that has been selected and becomes a reference for discussion. Finally, using the case approach (case approaches).

The legal materials used are primary legal materials and secondary legal materials. Primary legal materials consist of statutory regulations, namely the Commercial Code, the Consumer Protection Act, the Insurance Act, POJK No. 1/POJK.07/2013 concerning Consumer Protection in the Financial Services Sector, POJK No. 27 of 2018. Secondary legal materials consist of legal papers in the form of books, journals and articles.

The technique of collecting legal materials used in this paper is literature study. Literature studies are carried out by reading, reviewing, taking notes, making reviews of legal materials that have to do with insurance rules and concepts.

After collecting primary legal materials and secondary legal materials, an analysis was carried out using a systematic interpretation method. Systematic interpretation is interpreting statutory regulations by linking them with other laws, because the formation of a law is essentially part of the overall system of applicable laws and it is impossible for a law to stand alone without being related to other regulations.

ANALYSIS AND DISCUSSION

The Legal Consequences of Insurers Failing to Pay Against the Rights of Policyholders

Insurance means having a backup income in case of an accident in the course of life that causes the main income, for example due to an early death. To be able to solve insurance problems, it is necessary to do some correct and appropriate legal efforts. However, before taking legal action, it is important to know the general concept of insurance. To provide protection for the object of coverage, the concept of risk in insurance is very necessary.

C.S.T Kansil states that risk is an uncertainty which means the possibility of a loss in the future. Insurance risk is a Statement of the kind of risks and the extent to which a company will expose itself to risks. Meanwhile, what is meant by standard risk is a pure risk that is normal or common and can be insured

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10 CST Kansil, Pokok-Pokok Pengetahuan Hukum Dagang Indonesia, (Jakarta: AksaraBaru, 2014), 33.
at standard premium rates. Risks related to insurance have several types of risk classifications including; Pure Risk when something happens that causes a loss and if it does not happen it will not cause a loss or profit, Speculative Risk is a chance risk which when it occurs will cause a profit, loss or no loss, no profit, Particular Risk (Special Risk) a risk that is personal or local in nature, both cause and effect, Fundamental Risk is a risk that is caused by one particular party or certain center but has a fairly broad effect.

So that when a loss occurs, the insurance company can provide compensation to the policy holder, to realize an uncertainty into a certainty. The risks in this insurance are divided into two types, including; pure risk and speculative risk. What makes the difference is the pure risk of possible loss or no loss. Meanwhile, in speculative risk, the possibility that arises is not only the possibility of a loss or no loss, but there is also a possibility that one party can benefit and the other party suffers a loss.

The duty of the insurance company is to transfer the risk that may occur or be experienced by the policy holder. Where the obligations of the insurer are in accordance with the agreement with the policyholder listed in the policyholder’s insurance policy. The subject and object of insurance or coverage can provide certainty to the insurance policy holder and become clear to the parties and the object. The subjects in insurance are the parties who are active in the insurance activities, namely: Insurers and Policyholders. The insurer is the party who accepts the transfer of risk where by receiving a premium, promises to compensate for the loss or pay an agreed amount of money. The policyholder is the party who transfers the risk to another party by paying a premium. The insurer also has binding rights, namely: receiving premiums, obtaining information from the policyholder based on the principle of good faith based on Article 251 of the KUHD, and the right to receive compensation from the policyholder’s obligations.

In addition to the rights of the insurer, the insurer also has obligations that must be fulfilled, including the obligation to apply all skills, attention, and accuracy in serving or interacting with policy holders, the Insured, or participants. Obliged to provide correct, not wrong, and/or not misleading information to Policy Holders, the Insured, or Participants regarding the risks, benefits, obligations and charges related to insurance products or sharia insurance products offered. Mandatory to handle claims and complaints through a process that is fast, simple, accessible, and fair (Article 31 Paragraph 1, 2, and 3 of Law Number 40 of 2014 concerning Insurance).

Giving the policy to the policyholder, in the event that the policyholder suffers an insurance loss or requires life insurance compensation, the insurer is obliged to pay compensation for it. Similar to the insurer, the policyholder also has rights and obligations, where the policyholder is entitled to receive an insurance policy according to the type of insurance he chooses, and receive compensa-

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14 Ibid.
tion in the event of an unexpected event as guaranteed condition of the policy. The policy holder also has obligations that must be fulfilled while holding the insurance policy, namely; pay insurance according to the percentage contained in the insurance policy, minimize losses that will occur in future, carry out other obligations contained in the policy provisions, carry out the principle of utmost good faith. The principle of Utmost Good Faith implies that every person is obliged to clearly and thoroughly disclose all important facts relating to the insured object. This principle is a foundation in the insurance agreement, so if this foundation is not constructed properly it can be fatal in the implementation of the agreement to provide information to the insurer.\textsuperscript{16}

Based on Article 1 number 25 of Law Number 40 of 2014 concerning Insurance states that:

“The objects of insurance are life and body, human health, legal liability, goods and services, and all other interests that may be lost, damaged, lost, and/ or reduce in value.

In addition, the object of insurance is also regulated in Article 268 of the KUHD which states that:

“Insurance can be based on all interests, which can be valued in money, threatened by a danger, and by law is not excluded.”

The existence of a clear subject and object in insurance is expected to provide clarity to both parties, namely the insurer and the policy holder. Considering that there are often problems in insurance financial services, especially what has happened in the last few years which has caused a lot of losses for policyholders. So they demand justice and legal certainty regarding their rights that they should get. should be able to carry out their obligations properly and always remember the purpose of establishing an insurance company. The policyholder should avoid the losses he suffers and be able to return to his original position, but with the problem that the insurance company fails to pay, it can make the policyholder suffer a very large loss.

Policyholders can obtain insurance claims and benefits from their policies when their insurance agreements expire. The termination of an insurance agreement can occur because:\textsuperscript{17}

a. Event Occurs

The death of the policyholder in life insurance is one of the events that becomes the burden of the insurer. If the policy holder dies, the insurer is obligated to pay compensation to the heirs appointed by the policy holder, or to his heirs. In the insurance agreement there is an agreed time period. The life insurance agreement ends as soon as the insurance company pay the indemnity. Or in other words, at the time of settlement of an event claim, the life insurance agreement ends immediately.

b. Term Expires

event period is not always the burden of the insurer even until the end of the insurance period. The insurer’s risk burden ends when the the life insurance period ends. If until the end of the agreement there is no event, then the insurer will return some money to the policyholder.

c. Fall Insurance

Fall insurance is regulated in Article 306 of the KUHD and Article 307 of the KUHD. Article 306 of the KUHD states that:

If the person whose life is insured at the time the insurance is given turns out to

\textsuperscript{16} Ibid., 21.

\textsuperscript{17} Ibid., 26.
be dead, then the insurance is void, even though the policyholder does not know about the death unless agreed otherwise. Article 307 of the KUHD states that: “If the person who insures his life commits suicide, or is sentenced to death, the insurance will be invalid.” The two articles can still be distorted by the parties, such as when the policy holder really does not know when the policy holder dies, the insurance he has remains valid.

Cases of insurance companies that fail to pay the rights of policyholders are caused by several reasons. One of them is the investment system in life insurance products which has caused the insurance industry to become chaotic. Insurance companies should only guarantee life insurance for policyholders, there is no obligation to guarantee fixed returns through insurance products with investment models. The yield promised on this insurance investment product promises higher interest rates from the bank. Initially, this insurance product was held to attract people to buy the product.

However, over time these products are abused by promising high profits. With promises that have already been given to policyholders, many insurance companies end up placing policyholder funds in high-risk and volatile stock instruments because there is no guarantee. Investments through investment managers and direct investments are distributed evenly to be allocated to certain stock instruments on the Indonesia Stock Exchange (IDX). Giving high interest is very burdensome for insurance companies, especially when the current capital market conditions are not good. Insurance companies in Indonesia have received supervision from the Financial Services Authority (OJK), but unfortunately the OJK in this case seems negligent, and does not provide supervision and inspection of investment products offered by insurance companies.

In fact, it is clear what the insurance company has done has violated the law. OJK should have been able to predict before this case happened, that this would be dangerous and would be a ticking time bomb for insurance companies. Insurance companies in offering investment insurance product also does not provide clear information to prospective policy holders (customers). Whereas Article 251 of the Commercial Code states that:

All false or incorrect notifications, or all concealment of circumstances that are known to the policy holder, even though they are carried out in good faith, of such a nature that the agreement will not be made, or is not held under the same conditions, if the insurer knows the actual situation of all these things, the insurance is void.

Returns are clearly unknown in the insurance business world and this violates Law Number 40 of 2014 concerning Insurance, and Financial Services Authority Regulation (POJK) Number 27 of 2018 (updated from POJK Number 71 of 2014) regarding Financial Health Insurance Companies and Reinsurance. In addition to the problems mentioned above, there are also basic problems that affect the performance of insurance companies. These problems have existed for many years but due to limited resources they have gotten worse over time. These problems include; low asset management performance, poor corporate governance, weak corporate control systems, loss-making products, lack of liquid investment and non-investment assets, unreliable information systems, unpro-
ductive branch offices, inefficient operating costs, limited access to capital, conventional work facilities and infrastructure, lack of innovation products and services, and lack of quality of Human Resources in the insurance sector.

All of this is the cause of insurance companies being unable to develop and increasingly experiencing a slump.\textsuperscript{18} With the problems that often occur in insurance companies and cause losses to policyholders, the law regulates good efforts in order to provide solutions and minimize losses borne by policyholders. Several ways can be done in order to avoid insurance products and insurance companies that are not credible, namely:\textsuperscript{19}

1. History of the insurance company

Prospective policy holders should first look at the history of the insurance company that he wants to choose. This is important so that the funds are not already placed and then they find out that the insurance company they choose has a bad history of managing their finances or has a myriad of unresolved legal cases. In the end, customers also feel the loss and regret in the end. The history of the establishment of insurance companies can be seen through electronic media, economic newspapers, the website of the Financial Services Authority and others.

2. Risk Based Capital (RBC)

Try to find an insurance company that has a Risk Based Capital (RBC) above 120% according to the rules of the Financial Services Authority (OJK). This is to be able to provide certainty and security to prospective customers, in this case policy holders. This RBC can also be a benchmark for the level of solvency level or the capital adequacy ratio of a company. The higher percentage of RBC value, the stronger the insurance company in paying the Sum Insured to the policyholder.

3. Multinational Insurance Companies

Multinational insurance companies have branches in many countries, so they are stronger in dealing with existing financial problems. Considering that life insurance products have a long period of time, don’t let when the program is running suddenly the selected insurance company closes. This clearly endangers the future of the policyholder.

4. Understand the contents of the insurance policy

Before determining the type of insurance product you want, Prospective policy holders should ask for help from an insurance agent to make an illustration of a minimum offer to do the same thing for three different companies. So you can find out with the same benefits, but with the cheapest premium value. Because the quality of an insurance product is not necessarily of good quality and cheap premiums are not necessarily of poor quality, because the quality of an insurance product is not necessarily judged by the premiums to be paid, but there are other comparative factors as well.

After getting the right type of product, the policyholder can really understand the rights and obligations of the policyholder and the insurance company. This is important when a dispute occurs in the future the parties will remember and be bound by the rights and obligations of each party.


\textsuperscript{19} Junaedy Ganei, \textit{Hukum Asuransi Indonesia}, (Jakarta: Sinar Graphic, 2016), 29.
in the insurance policy agreement.

5. Choosing the right insurance product

There are various types of insurance products depending on customers needs. For example, there are two types of life insurance, namely traditional life insurance and unit-linked life insurance. Traditional life insurance has *term life*, *whole life*, and *endowment*. Unit-link life insurance has an investment feature, where there will be cash return in line with the investment growth made by policyholder customers. This type of unit-linked insurance is more suitable for people who have long-term life insurance needs.

In addition, unit-link premiums are higher when compared to *term life* insurance and the like. This is comparable to the facilities offered in unit-link insurance along with health insurance, accident insurance, and/or critical illness insurance.

The insurance policy also regulates the claim payment period, generally 30 (thirty) days from the date of agreement. However, in the current case, many insurance companies fail to pay or default because they cannot pay claims and insurance benefits from policyholders or have exceeded the agreed time limit. This is what ultimately causes great losses for the policyholders, and they have to claim their rights to the insurance company. Insurance companies are prohibited from being late in paying insurance claims, as regulated in Article 37 Paragraph 1 Financial Services Authority Regulation Number 69/POJK.05/2016 concerning Business Conduct of Insurance Companies, Sharia Insurance Companies, Reinsurance Companies, and Sharia Reinsurance. Companies stating that the company or Sharia Units are prohibited from taking actions that can delay the settlement or payment of claims, or not taking action that should have been taken so as to result in delays in the settlement or payment of the claim. Article 23 paragraph 1 of Government Regulation Number 73 of 1992 concerning the Implementation of Insurance Business which reads:

An Insurance Company or Reinsurance Company is prohibited from taking actions that can delay the settlement or payment of claims, or not taking actions that should have been taken which could result in delays in the settlement or payment of claims.

In relation to the period of payment of insurance claims, it is regulated in Article 27 of the Decree of the Minister of Finance Number 422/KMK.06/2003 concerning Business Conduct of Insurance Companies and Reinsurance Companies which reads:

“The Insurance Company must have paid the claim within 30 (thirty) days after the agreement between the policyholder and the insurer or certainty regarding the amount of the claim to be paid.”

The sanctions imposed when an insurance company violates the provisions are regulated in Article 37 of Government Regulation Number 73 of 1992 which reads:

Any Insurance Company that does not comply with the provisions of this Government Regulation and its implementing regulations concerning business licensing, financial health, business operations, submission of reports, the announcement of the balance sheet and the calculation of profit and loss, or regarding direct examination, is subject to warning sanctions, sanctions for limiting business activities, and sanctions for revocation of business licenses.

If after 30 (thirty) days the insurance company does not have good intentions to pay the
claim and insurance benefits from the policy holder, the policy holder can send a summons 3 (three) times at different times or between the first, second, and third summons. The summons contains a warning for the non-compliance of the insurance company’s obligations as well as other demands of the policyholder.

If they do not want to pay or the funds are not immediately disbursed, then the policyholders can act individually on behalf of themselves or in groups to file a civil breach of contract on the basis of Article 1243 BW, this is because the basis of insurance is an agreement as regulated in Article 1 Number 1 Law Number 40 of 2014 concerning Insurance.

Legal Protection for Policyholders Affected by Failure to Pay

Functions of Financial Supervisory Institutions in Cases of Insurance

Insurance is an insurance business engaged in the insurance business sector, namely a financial services business which by collecting public funds through the collection of insurance premiums provides protection to members of the public using insurance services against the emergence of losses due to an uncertain event or to the life or death of a person, reinsurance businesses, and insurance business supporting businesses that provide intermediary services, assessment of insurance losses and actuarial services\(^\text{20}\). Insurance companies are general insurance companies and life insurance companies (Article 1 point 1 of the Financial Services Authority Regulation Number 55/POJK.05/2017 concerning Periodic Reports of Insurance Companies).

The Financial Services Authority (OJK) is an institution that is independent and free from interference from other parties, which has the functions, duties, and authorities of regulation, supervision, inspection, and investigation (Article 1 point 1 of Law Number 21 of 2011 concerning the Financial Services Authority). OJK functions to organize an integrated regulatory and supervisory system for all activities in the financial services sector\(^\text{21}\). OJK carries out regulatory and supervisory duties on\(^\text{22}\): a. Financial services activities in the banking sector; b. Financial services activities in the Capital Market sector; c. Financial service activities in the insurance sector, pension funds, financing institutions; and d. Other Financial Services Institutions.

The authority of the Financial Services Authority over insurance companies in Article 8 and Article 9 of Law Number 21 of 2011, it is stated that the authority of the Financial Services Authority to carry out regulatory tasks and supervision of activities in the financial services sector, one of which is insurance activities\(^\text{23}\).


\(^{21}\) Article 5 of Law Number 21 of 2011 concerning the Financial Services Authority.

\(^{22}\) Ibid.

\(^{23}\) Paulus Jimmytheja Ng et al., “Eksistensi Otoritas Jasa Keuangan Dalam Memberikan Perlindungan
Legal Protection for Policy Holders

*Saving plan* is a traditional insurance product. In the *saving plan*, the customer cannot determine the risk profile or in what instrument the funds are invested. However, the customer pays the premium at the same time at the beginning and will get a refund according to the agreed amount at the end of the policy period. Saving *plans* are also a non-unit-linked investment whose risks are fully borne by the insurance company. If the insurance company declares a default, it will result in the termination of the sale of the saving plan will also affect the level of public confidence in the insurance company in the future. Insurance companies have their own characteristics because the products sold here are not real because they cannot be seen and touched.

When an event occurs to the policy holder, the insurer (insurance company) will be responsible by paying the sum insured according to what was previously agreed. Insurers who are trusted by the community because they are able to accumulate public capital to help finance national economic development. The insurance agreements uphold the principle of trust in which mutual trust between the insurer and the policyholder is very important. The form of the principle of trust is the implementation of the principle of good faith which must be implemented in every agreement including in the insurance agreement (Article 1338 BW). In *Title II of the United States Bankruptcy Code* 1994 which was updated in 1998, the requirement “in a state of being unable to pay” known as “insolvent” is one of the requirements of the petition for a declaration of bankruptcy. In the Bankruptcy Code, insolvency defined, among others, as:

> “financial condition that the sum of such an entity’s debts is greater than all of such entity’s property”; “unable to pay its debts as they become due.”

In Article 1 number 1 of Law Number 8 of 1999 concerning Consumer Protection explains that consumer protection is all efforts that guarantee the existence of a legal certainty to provide protection to consumers. In addition to the Consumer Protection Law, there is a regulation that specifically addresses consumer protection, namely POJK No. 1/POJK.07/2013 concerning Consumer Protection in the Financial Services

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26 Pratama, “Pertanggungjawaban Otoritas Jasa Keuangan Dalam Kasus Gagal Bayar Polis Asuransi PT Jiwasraya (Persero).”

Associated with the case of failure to pay by the Insurer which is the point of the problem, so that the consumer (policy holder) will request a claim application to the insurance (the insurer) for the loss he has experienced, then with the existence of Law Number 8 of 1999 as the basic law of consumer protection in Indonesia. Indonesia and as a reference from POJK No. 1/POJK.07/2013. Referring to Article 40 of POJK No. 1/POJK.07/2013 regulates the rights of consumers to obtain consumer protection, the rights of consumers are:

a. Consumers can submit complaints indicating a dispute between Financial Services Businesses and Consumers to the Financial Services Authority; and

b. Consumers or the public can submit complaints indicating violations of the provisions of laws and regulations in the financial services sector to the Financial Services Authority.

Articles in the KUHD that can be used to protect policyholders, among others:

a. Article 254, prohibits the parties to the agreement, both at the time the agreement is entered into and during the duration of the insurance agreement from declaring the release of things that are required by law.

b. Article 257 and Article 258. The insurance agreement is issued immediately after closing, the mutual rights and obligations of the policy holder and the insurer come into effect from that time. The policy holder must prove that the insurance agreement has been closed with other evidence, such as correspondence between the insurer and the policy holder, the insurer’s record, closing notes, and others.

c. Article 260 and Article 261, insurance covered by a broker or agent. In Article 260, if the insurance agreement is closed through a broker, the signed policy must be submitted within eight days of being signed. Whereas Article 261, if there is negligence in the matters stipulated in Articles 259 and 260, then the insurer is obliged to provide compensation.

Law Number 40 of 2014 concerning Insurance specifically regulates legal protection for policy holders, policy holders or insurance participants, namely Article 53 (policy guarantee program) and Article 54 (mediation agency). Looking at Law Number 21 of 2011 concerning the Financial Services Authority, insurance customers or policy holders are consumers. OJK’s efforts as an insurance supervisory agency provide preventive and repensive legal protection.

First, preventive legal protection, namely regulating the overall obliga-

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28 Inayah and Marsitiningsih, “Perlindungan Hukum Atas Kerugian Nasabah Asuransi Terhadap Kasus Gagal Bayar Ditinjau Dari UndangUndang Nomor 8 Tahun 1999 Tentang Perlindungan Konsumen.”
tions that must be fulfilled by business actors in running a business, regulating things that are prohibited from being done by business actors and for consumers, they are required to have good faith and provide honest information to business actors. And also done by arranging the organizers of the insurance company.

Second, repressive legal protection is the final protection in the form of sanctions such as fines, imprisonment, and additional penalties given if a dispute has occurred or a violation has been committed. Repressive legal protection occurs if there has been a dispute between the public (consumers) and financial service business institutions, the OJK is given the authority to take certain legal actions, such as conducting investigations, written orders, taking certain legal actions to insurance companies and also has the right to impose sanctions.

Sjachran Basah stated that legal protection for the aggrieved party is a natural urgency, appearing and occupying a leading position in realizing the path of equal opportunity to obtain justice. In Article 28 letter b and Article 29 letter c of the OJK Law, it is stated that OJK has the authority to represent the interests of the community who have suffered losses. It is emphasized in paragraph (2) for compensation only to those who are harmed in question are the policyholders. After analyzing the Consumer Protection Act, Insurance Act, OJK Law and POJK No. 1/POJK.07/2013 really helps consumers as policy holders to ask for their rights to the insurer concerned and consumers feel protected.

CONCLUSION

There are several ways that policyholders can do to minimize their losses, one of which is by paying attention to the deadline for granting claims and benefits that have been agreed upon in the Insurance Policy, which is generally 30 (thirty) days after the agreement. Policyholders can also choose an insurance company that is multinational in nature with branches in several countries, so that when a branch in one country experience a loss, funds can be provided from branches in other countries. This is important because the insurance company must have good faith to pay on time and avoid late payments. And in accordance with the provisions of the Minister of Finance Number: 422/KMK.06/2003

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30 Paul Jimmytheja Ng, JemmyRumengan, et al, _loc. cit._, 207.
32 Sjachran Basah, _Perlindungan Hukum terhadap sikap-tindak Administrasi Negara_, (Bandung: Alumni Publisher, 1992), 11.
concerning the Operation of Insurance Companies and Reinsurance Companies.

When an event occurs to the policy holder, the insurer (insurance company) will be responsible by paying the sum insured accordance with what was previously agreed.

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Financial Services Authority Regulation Number 69/POJK.05/2016 concerning Business Conduct of Insurance Companies, Sharia Insurance Companies, Reinsurance Companies, and Sharia Reinsurance Companies.


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