PROTECTION LAW TO EXPERT THE HEIRS ARE LIABLE FOR THE CLOSURE OF THE POLICY INSURANCE SOUL CREDIT WITHOUT MEDICAL CHECK UP

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Abstract

This research focuses on a normative study of the regulations for closing life insurance policies according to Indonesian laws and regulations. This is followed by an analysis of legal protection for the insured's heirs as policy holders regarding the practice of closing credit life insurance policies without medical check-ups, as well as an analysis of the Judge's considerations and decisions regarding the importance of medical check-ups before closing credit life insurance policies using Decision Number 38/Pdt .G/2023/PN Date as object of study. In this case, the judge considered that the insurance company should have carried out a medical examination before closing the policy, to ensure that the insured provided accurate information about his health. This research will analyze the judge's considerations in this decision, as well as its impact on insurance practices in Indonesia, especially in protecting the interests of policy holders from unilaterally detrimental policy closures. This research is descriptive normative legal research, with a statutory, conceptual and case approach. The data used is secondary data, which was collected using library study data collection tools using document study techniques. The data was then analyzed using qualitative data analysis methods and drawing conclusions deductively. The research concludes that the arrangements for closing life insurance policies in Indonesia are transparent and provide protection for the insured. OJK requires insurance companies to ensure prospective insureds understand the terms and risks, including the importance of health checks. Legal protection for the insured's heirs is regulated in Article 22-26 POJK No. 20/2023 concerning Insurance Linked to Credit, which highlights the importance of information transparency. If the claim is rejected due to the absence of a medical examination, the insured's heirs can file a lawsuit in District Court. Decision Number 38/Pdt.G/2023/PN Tgl emphasizes the importance of a medical examination before closing a policy, reflecting the principle of prudence and utmost good faith. This decision provides justice, certainty and benefits for policyholders by guaranteeing claim payments according to the provisions. It is recommended that there be detailed regulations regarding mandatory medical check-ups and transparency of information in credit life insurance.

***Keywords**: Credit Life Insurance, Medical Checkup, Claim Rejection*

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INTRODUCTION

Every action or activity carried out by humans in their lives always involves risk. Risk is the possibility of experiencing loss due to danger that may occur, although it is not known for sure when or how it will occur. The risk can come from various factors, including actions and events. These factors can result in profit or loss. Therefore, a company is needed that is willing to take risks to reduce unwanted risks in the future, such as loss of property, fire, or problems with bank credit loans. The company is an insurance company, which is ready and able to bear all the risks faced by its customers, both individuals and companies (Kasmir, 2018)

Insurance as a concept aims to share the risk of loss fairly, insurance is considered an effective tool to control risk by sharing and transferring the risk to other parties so it is reasonable to call it a risk management tool (Mulhadi, 2022). Insurance or coverage, according to the definition of the Law Code. The Commercial Law (KUHD) in Article 246 states that "an agreement in which the insurer, by paying a premium, binds himself to the insured to provide him with compensation for losses, damages, or profits that cannot be obtained which may be suffered as a result of an uncertain event." Furthermore, according to Article 255 of the KUHD, the existence of a policy is proof of the existence of an insurance agreement, but Article 257 of the KUHD states that the policy only functions as evidence, without a policy, the insurance agreement has been deemed to have occurred.

The provisions in Article 257 of the Commercial Code can cause polemics. The polemic that has the potential to arise is the existence of insurance coverage without a clear policy, vague, and not detailed requirements that are important to be fulfilled by the insured. The polemic is exacerbated by the phenomenon where insurance companies in Indonesia are trapped in the stigma of seeking the highest premiums. In order to collect these premiums, insurance companies through their agents do various ways to attract prospective customers to meet the premium achievement and this results in incomplete insurance information that will be used by the insurance customers, both prospective insured, policyholders, and insurance beneficiaries.

In the insurance system, especially credit life insurance, it is important to understand the different roles and legal relationships between the various parties involved, namely:insurer, insured, policyholder, and beneficiary. In this context, the insured is the party that receives protection against the risk, while the policyholder is the party that purchases the insurance and has administrative control over the policy. These two parties have different positions, although in practice the policyholder can also act as the insured. In addition, there are also beneficiaries who are entitled to insurance claims.

The primary notification obligation concerns facts already known to the prospective Insurance Company or facts that should be known to the prospective Insurance Company about the health of the prospective Policyholder. In addition, the Insurance Company is required to notify the prospective Policyholder of the obligation to provide complete information regarding the risks. An Insurance Company that does not remind the Policyholder of the obligation is not entitled to reject a claim based on misrepresentation/non-disclosure, except in cases where the misrepresentation/non-disclosure has been carried out by the Policyholder fraudulently (Nanda, 2021). Honest information is very important for insurance institutions because from this information, the risk of potential insurance customers can be analyzed so that the amount of premium to be paid can be determined. Honest information from the insured is one of the requirements that must be met before an insurance agreement is made concretely in the form of a policy, known as the principle of utmost good faith, namely "the principle of good faith or the principle of perfect honesty, namely that every insured is obliged to clearly and accurately inform all important facts related to the insured object and not to profit from the insurance". The insurance agreement that has been agreed upon by both parties is a legal act (das sein) in which both parties must comply with the provisions contained in the insurance agreement (das sollen).

One of the consequences of incomplete information provided by the insurance underwriter to the insurance customer is the emergence of cases of default/breach of promise by the insurance company in providing coverage to the insured on the grounds that the insured did not fully convey the history of the illness that was suffered, where the information was obtained by the insurance company through tracing the insured's medical history. The tracing of the medical history was also carried out after a lawsuit from the insured. It is unreasonable if the tracing of the insured's medical history is carried out after a lawsuit. It should have been done long before there was an insurance policy agreement between the insurance company and the insured. This is what is mentioned in order to pursue premiums, the insurance company does not consider all important aspects and managementthe risk of an insurance agreement that will be implemented between the insurance company and the insured.

Conceptually, insurance is basically a risk transfer. In this case, there is a risk transfer from the

policyholder or customer to the insurance company, where the policyholder or customer is required to pay insurance premiums according to the insurance agreement to provide compensation to the insured if an event or loss occurs. The program held by the insurer, namely the insurance company, has quite an influence on the increasing number of policyholders in Indonesia. Moreover, currently many insurance companies are competing to offer various insurance products that aim to attract the interest of the insured community (Indra, 2021).

The massive products offered by insurance companies are not accompanied by a guarantee of legal protection for insurance policyholders. The need for the presence of insurance businesses is also felt by the business world, considering that on the one hand there are various risks that are consciously and rationally felt to be able to disrupt the continuity of their business activities, on the other hand the business world often cannot avoid a system that forces it to use insurance business services (Sri, 2017)

Furthermore, in addition to the non-transparency of the insurance company in providing or requesting information from the insured, the life insurance policies of customers (insured) are also often unilaterally canceled by the insurance company on the grounds that after conducting a medical history investigation, the data provided when initially applying for the policy differed from the results of the insurance company's investigation. This unilateral cancellation or closure of the policy is very detrimental to the insured.

The problem of insurance practices as above, occurred as in Decision Number 38/Pdt.G/2023/PN Date, the case of which concerned the unilateral cancellation of a life insurance policy by the insurance company PT. AsuransiJiwa Manulife Indonesia on the pretext of a violation of the principle of perfect good faith as in Article 251 of the Commercial Code, where there was a difference in the health history of AsepHendraIndrawan as the insured, where before the insurance policy and after the insurance policy with Number 4299345605. In this case, PT. AsuransiJiwa Manulife Indonesia as the insurance company did not provide information to AsepHendraIndrawan as the insured or to his wife, SitiSujati, to conduct a medical check-up to find out the medical history and health of the life insurance insured. This caused a problem when a claim was made for the death of AsepHendraIndrawan as the insured of the life insurance which caused PT. AsuransiJiwa Manulife Indonesia not to pay the claim on the grounds of a difference in the medical/health history ofinsured. The incident certainly harmed the insured's heirs, because the insurance policy was agreed upon without a medical check-up first.(Tegal District Court Decision Number 38/Pdt.G/2023/PNTgl)

Based on the description above, this research is important to conduct considering the following things:

1. This study needs to examine how laws and regulations in Indonesia regulate the closing of life insurance policies. There are provisions in the Commercial Code and other related regulations that regulate the obligations and rights of insurance companies and the insured. However, there is often ambiguity in the application of these rules, especially regarding the obligation of insurance companies to provide clear and complete information to prospective policyholders. By understanding these regulations, it can be seen to what extent the law protects the interests of the insured from detrimental practices such as unilateral policy closure by insurance companies that are detrimental to the insured.
2. Legal protection for the insured's heirs is an important aspect that must be considered in this study. The practice of closing a policy without a medical check-up carried out by an insurance company causes losses to the insured's heirs, especially if the credit life insurance claim is rejected for unfounded reasons.
3. Court Decision Number 38/Pdt.G/2023/PN Date is a relevant case to analyze the importance of medical check-ups before closing a credit life insurance policy. In this case, the judge considered that the insurance company should conduct a medical check-up before closing the policy, to ensure that the insured provides accurate information about his/her health. This study will analyze the judge's considerations in the decision, as well as its impact on insurance practices in Indonesia, especially in protecting the interests of policyholders from unilateral policy closures that are detrimental.

Based on the explanation above, the study will discuss exploratively related to this matter in the ideal realm in the form of a thesis entitled "Legal Protection for the Insured for Closing a Credit Life Insurance Policy Without a Medical Check-up (Study of Decision Number 38/Pdt.G/2023/PN Date)".

RESEARCH METHOD

The research type isnormative juridical, namely "legal research that places law as a building of a norm system. The norm system that is built is about the principles, norms, rules of laws and regulations, court decisions, agreements, and doctrines (teachings), and refers to legal norms"[50]Thus, this research emphasizes secondary sources of material, both in the form of regulations and legal theories, in addition to examining legal rules that are of a scientific theoretical nature and can be used to analyze the problems discussed.The nature of this research is descriptive analysis. The approaches used in this study are the statute approach, the conceptual approach, and the case approach. The case approach is used for cases related to the issues faced that have become court decisions that have permanent legal force namely in this case the Tegal District Court Decision registered with Number 38/Pdt.G/2023/PN Date.The data collection technique used in this research is through library research which has been collected to determine its relevance to the needs and problem formulation.The data analysis used in this study is a qualitative data analysis method, namely by interpreting the legal materials that have been processed.The use of this interpretation method aims to interpret the law, whether there are gaps in legal norms, antinomies of legal norms and unclear legal norms in the legal material, especially primary legal material.

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RESULTS AND DISCUSSION

Credit Life Insurance Products in Insurance Practice

As is known, providing credit often raises various complex problems. One of the main risks is failure to pay debts, for example due to disasters that cannot be controlled by the debtor, such as the death of the debtor. Given this, banks need to find ways to eliminate or at least reduce the risks that may arise from each credit transaction. One effective solution is to transfer the risk to a third party, which is legally and business-wise possible, namely through insurance.(Atikalina, 2023) Financial Services Authority Regulation Number 23/POJK.05/2015 concerning Insurance Products and Marketing of Insurance Products has regulated every insurance product marketed by Insurance Companies and Sharia Insurance Companies. Insurance products associated with Credit are one of the insurance business lines that provide coverage for the financial obligations of Credit recipients.*Suretyship*is an expansion of the business scope of a General Insurance Company aimed at guaranteeing the financial obligations of the insured (Sovia, 2025). In its development, insurance products associated with Sharia Credit or Financing have become one of the products with the largest portfolio in General Insurance Companies. The underwriting process for risks carried out by Insurance Companies and Sharia Insurance Companies is important in maintaining the level of claim ratios and liquidity of Insurance Companies. The high level of risk exposure borne by insurance products associated with Sharia Credit or Financing makes this product must be managed prudently (Rika, 2025). In implementing the precautionary principle, insurance companies must consider the determination of premiums/contributions, risks covered, and time periods based on the capabilities of the Insurance Company and Sharia Insurance Company as stated in the insurance agreement or policy, which the Financial Services Authority then prepares the Financial Services Authority Regulation regarding insurance products linked to Sharia Credit or Financing.Conceptually, it can be seen that credit life insurance consists of 2 (two) words, each of which has a different meaning, namely 'life insurance' and 'credit'.Life insurance generally only recognizes the insurer, the insured and the beneficiary/designated party, usually the heir of the insured. In life insurance on a credit agreement, the designated beneficiary is the bank/creditor, while the debtor remains the insured party (Sri, 2017)

Article 1 paragraph 20 of POJK No.20/2023 states that "Credit Life Insurance is a life insurance product that provides at least coverage for the risk of death and is linked to the fulfillment of the Debtor's financial obligations to the Creditor in accordance with the Credit agreement."According to AtikalinaAuliaSidabariba and Muhammad HendraPratama, credit life insurance is "a type of life insurance, where the insured is the life of the debtor/borrower from the policyholder and the insurance company provides compensation in the amount of the remaining debt that has not been paid off according to the repayment schedule, if the debtor dies during the insurance period.

This is in accordance with Article 1 number 6 of Law No. 40/2014, where the purpose is none other than "to protect customers from financial losses due to unexpected disasters and to provide guarantees to customers in the future. Article 12 of POJK No. 20/2023 also states that "Life Insurance Companies are prohibited from implementing subrogationor Credit Life Insurance products." The provisions of Article 10 of POJK No.20/2023 limit the scope of Credit Life Insurance only to the risk of death, permanent disability due to accidents, and critical illness, to ensure relevant protection for debtors. In addition, Article 12 of POJK No.20/2023 prohibits the application of subrogation to this product, so that insurance companies cannot claim compensation from third parties after paying

claims. This regulation aims to protect debtors from additional burdens, increase transparency, andensuring fair relationships between insurance companies, financial institutions and customers, in accordance with consumer protection principles.

In credit life insurance, there are 3 (three) parties, namely the insurer, the insured (the debtor who is responsible for his life), the beneficiary (heir or the promised). Credit life insurance is one example of insurance with a certain cost where the risk replacement will not be in accordance with the risk experienced. Death is an event in life insurance, which gives rise to rights and obligations for the parties. In general, when the insured dies, the insurer has an obligation to provide compensation to the beneficiary (heir) unless otherwise agreed. For example, the insured/debtor agrees to the clause provided by the bank, containing cooperation with the life insurance party to overcome the risks that occur. So in this case the bank acts as the policyholder (recipient) of compensation.

Credit life insurance claims are rights granted by the insurer to the insured if a risk or disaster occurs to the insured, then the insured has the right to request the right to payment of insurance claims in accordance with the agreement that has been made. Credit life insurance claims themselves cansubmitted by the insured if the insured experiences a disaster or risk such as an accident, total permanent disability, or death. When a credit life insurance contract is made between the insurer and the insured, further care and understanding of the standard clauses, especially information regarding the payment procedures or settlement of credit life insurance claims stated in accordance with the provisions of each life insurance company, is needed.

The provisions regarding the benefits of credit life insurance claims, in addition to being regulated in the policy provisions at the time of the agreement, are also regulated generally in Law No. 40/2014 concerning claims relating to the protection of policyholders. In Article 31 paragraph (3), what is meant by "fast" is that the process of handling claims and complaints is carried out immediately, within a certain time.as briefly as possible. Furthermore, “simple” means that the process of handling claims and complaints is straightforward and uncomplicated, and “easily accessible” means that the process of handling claims and complaints is carried out at the company office or other places that are easy to visit, or is carried out using technology that makes it easy for people to submit claims or complaints and get responses. The meaning of “fair” is that the process of handling claims and complaints is carried out by adhering to the truth, impartially, and not arbitrarily.

The settlement of insurance claims in general which is also related to credit life insurance claims can be seen as in the Financial Services Authority Regulation Number 69/POJK.05/2016 concerning the Implementation of Insurance Company Business, Sharia Insurance Company, Reinsurance Company, and Sharia Reinsurance Company (POJK No.69/2016) namely in Article 36 and Article 37 paragraph 1 which states that:

Article 36

Sharia Companies or Units are required to have claim settlement guidelines for marketed products, which reflect that claim handling has been carried out through a fast, simple, easily accessible and fair process and in accordance with generally accepted insurance practices.

Article 37

(1) Companies or Sharia Units are prohibited from taking actions that could delay the settlement or payment of claims, or not taking actions that should be taken, resulting in delays in the settlement or payment of claims.
(2) The Company or Sharia Unit may appoint an insurance loss assessment company to carry out an assessment of the submitted claim.
(3) In the event that the Company or Sharia Unit uses an insurance loss assessment company as referred to in paragraph (2), the Company or Sharia Unit is prohibited from ignoring the results of the loss assessment without being based on strong arguments.”

In Article 38, the insurance company can only request documents as a requirement for submitting a claim in accordance with those stated in the policy, and the inclusion of the document must be relevant to the coverage and reasonable in the claim settlement process, and the insurance company is also prohibited from making claim payments through third parties unless it has obtained approval from the beneficiary. That in Article 40 paragraph 1 explains the period for payment of claims or benefits stipulated in the insurance policy or a maximum of 30 (thirty) days since the agreement between the policyholder, insured, or participant and the Insurance Company.A credit life insurance policy agreement can be implemented if it has been approved by both parties executing the insurance agreement. So before implementing the agreement, the policy holder needs to read and understand the policy book regarding the benefits obtained and this needs to be explained by the partycompanies regarding matters concerning credit life insurance policies, especially claim benefits, to avoid misselling. The process flow for handling or settling insurance claims is through 7 (seven) stages, namely:

1. An event occurs that causes a loss to the insured object.
2. The insured contacts the insurance company to provide information regarding the occurrence of a loss experienced. The insured can contact via telephone, email, SMS, and others.
3. The insurance company asks the insured to make a written statement regarding the loss experienced. The statement contains, among other things, the location of the incident, chronology of the incident, and others.
4. The insurance company asks the insured to complete the documents required in the claims process.
5. The insurance company conducts a survey of the insured object and determines whether the claim is approved or not. If the claim is approved, the insurance company determines the value of the claim loss. If the claim is rejected, the insured object that experiences a loss is not guaranteed in the pattern.
6. The insurance company informs the insured of the claim loss value.
7. The insured receives compensation for claims submitted in accordance with the insurer.

Credit life insurance claims in their settlement or disbursement of insurance claims themselves cannot be easily disbursed directly, but must be analyzed first and the requirements must be seen whether they are in accordance with the provisions or not. Because each insurance company usually before entering data to the center for disbursement of claim costs, the branch company will trace and analyze the policy before being submitted to the center so that there is no claim rejection (Haris, 2022). In practice, the application of credit life insurance claim provisions is sometimes not fully implemented firmly. The imbalance between the terms and conditions in the credit life insurance agreement clause tends to burden customers, so that the hope for strengthening the customer's bargaining position and providing encouragement of responsibility to the insurance party is not or very lacking. Although sometimes due to the customer's own ignorance regarding the procedure for submitting a claim.(Wetria, 2019)

Decision Court Constitution Number 83/PUU-XXII/2024 related Conditionally Unconstitutional Article 251 KUD

The Constitutional Court (MK) granted the application for a judicial review related to Article 251 of the Commercial Code (KUHD) filed by the applicant MaribatiDuha, which was registered under case number 83/PUU-XXII/2024. In its ruling, the Constitutional Court determined that insurance companies may not reject insurance customer claims due to incomplete disclosure of information. The Constitutional Court ordered a court decision if the insurance company rejects based on this rule. The Constitutional Court in its ruling stated that "the norm of Article 251 of the Commercial Code (Staatsblad 1847 Number 23) is contrary to the 1945 Constitution of the Republic of Indonesia and has no legal force conditionally binding as long as it is not interpreted as including in relation to the cancellation of insurance which must be based on an agreement between the insurer and the insured based on a court decision. Based on the Constitutional Court's ruling, which stated that the norm of Article 251 of the Commercial Code requested by the applicant is conditionally unconstitutional. Thus, it was decided that insurance companies cannot unilaterally cancel claims. The article is the basis applied in the insurance industry so far or known as the basic principle of Utmost Good Faith. With the Constitutional Court's ruling, Irvan Rahardjo said, "Article 251 of the Commercial Code no longer has the power to prevent dishonest actions from insurance customers in filling out insurance contract agreement forms. So the impact of the Constitutional Court's ruling is very broad. Insurance is required to be more professional and careful in implementing the principle of good faith. (Ferry, 2025). Based on this, insurance companies must implement mitigation efforts by conducting a comprehensive and detailed assessment of each customer's risk history. Plus, do not simply entrust policy registration to agents. Because agents are only oriented towards sales to earn commissions and are not interested in the level of risk.

According to the Applicant in his judicial review application, the provisions of the norms in the article open up a very large space for insurance companies to take advantage of statutory regulations for the company's personal interests. The provisions of the norms of Article 251 of the Commercial Code can also be used to avoid responsibility for errors or negligence made by the internal team of the insurance company itself. The negligence in question includes re-underwriting or risk selection, which is the process of estimating and classifying the level of risk that exists in a prospective insured. Underwriting is often re-done and is almost always done by insurance companies if the heirs file a claim for the benefit value promised in the policy. This is what the Applicant experienced when filing a claim with Prudential. The company's actions are a motive or trick to cancel the policy or at least

reduce the value of the benefits that can be claimed as experienced by the Applicant.This motive seems to be valid in the eyes of the law because of the application of Article 251 of the Commercial Code which gives the insurer exclusive rights to cancel without considering the legal defenses made by the insured (Anggara, 2025)

Legal Protection for the Insured's Heirs as Policy Holders Regarding the Practice of Closing Credit Life Insurance Policies Without a Medical Check Up

As explained above, a credit life insurance product is basically a life insurance product that provides coverage for the risk of death related to the fulfillment of the debtor's credit obligations to the creditor in accordance with the credit agreement, and the insurance company provides compensation in the amount of the remaining debt that has not been paid if the debtor dies during the insurance period.Based on this, if we pay attention to the regulations regarding insurance, it basically does not regulate the relationship between three parties, but two parties, namely the insurer and the insured or policyholder, because of the issue of insurance interests (insurable interest), namely if there is a risk to the debtor that affects the loss of the banking company as the credit provider, so that the debtor needs to be insured and becomes a requirement for credit disbursement by the bank (Agus, 2023) However, of course because the insurer does not have a direct relationship with the insured whose position is weak, it can cause the insurance interest relationship to be unbalanced and unfair. This unbalanced and equal relationship can cause a conflict of rights and obligations, so that inUltimately, the insured requires adequate legal protection within the scope of a three-way relationship like this (Rahmat, 2021)

Conflicts and obligations in credit life insurance arise because the insured, who is also the debtor, is required by the policyholder in this case a banking company to insure his life as a condition of credit disbursement to the insurer (insurance company) which should have a direct relationship and freedom in conducting risk selection (underwriting). Meanwhile, the insured himself also does not have the freedom to guard his interests until the end of the contract, even if the error is made by the policyholder.The three-party or three-tier relationship in the credit life insurance process shows that the insurance company does not deal directly with the insured party as the insured, but rather the insurance company deals and relates directly with the banking company as the policyholder, so that in terms of consumer protection, benefits, justice, balance and legal certainty and its purpose for the creation of a consumer protection system that contains elements of legal certainty and openness of information and access to obtain information (Article 3 of the UUPK) is not achieved. In fact, the insured's obligation to follow existing procedures, to have good intentions in conducting transactions,paying according to its value (premium) and following appropriate dispute resolution efforts have also been carried out.

The policyholder or bank's interest in insurance often only serves as a credit condition (bank clause). When this condition is met, namely the debtor's premium is deducted and deposited to the insurance company, it is as if the insurance company is obliged to cover the remaining credit if the debtor dies.On the other hand, insurance companies need accurate information about the insured's condition to conduct risk selection or underwriting. Ideally, this information is obtained through direct interaction with the insured, not just based on administrative forms managed by credit staff at the bank. This condition raises questions about whether the interests of the two parties are truly fair to the insured, especially when a risk occurs. The absence of a direct relationship, a weak position, or an imbalance of information can cause errors or omissions from the bank to be misinterpreted as statements by the insured, while the insured himself is often not involved in the process until the end of the contract.

Legal protection according to Muchsin is "an activity to protect individuals by harmonizing the relationship of values or rules that are manifested in attitudes and actions in creating order in social interactions between fellow human beings." Muchsin emphasized that legal protection is"something that protects legal subjects through 2 (two) things, namely preventively, namely through protection provided by the government through laws, and repressively, final protection in the form of sanctions such as fines, imprisonment, and additional punishments through the courts (Muchsin, 2003)

Protection provisions in Law No. 40/2014 are regulated in Chapter XI, concerning Protection of Policyholders, Insured, or Participants in Articles 53 and 54, which are essentially a policy guarantee program that is similar in spirit to the Deposit Insurance Corporation (LPS) in banking. However, Article 54 only provides space for the formation of a mediation institution that functions to resolve disputes between insurance companies, sharia insurance, reinsurance and sharia reinsurance with policyholders, insured, participants or other parties entitled to receive insurance benefits, where insurance and reinsurance companies are required to be members. The institution is independent and impartial, has written approval from the OJK, and is final and binding on the parties (Rahmat, 2021)

Thus, Law No. 40/2014 does not seem to provide a deep understanding of legal protection for the insured, especially when the insured acts as a third party in an agreement between the insurance company as the insurer and the bank as the policyholder. Although there are mediation institutions or policy guarantee institutions, the legal protection provided byprovided by the state to the insured, especially in the context of credit life insurance, is still inadequate.Regarding preventive legal protection for parties insured under credit life insurance, this has actually been widely regulated in regulations, both in the Insurance Law (vide Article 26, Article 28), the Consumer Protection Law (vide Article 4, Article 5, Article 6, Article 7, Article 19, Article 23), the Civil Code.(vide Article 1320, Article 1338, Article 1253, Article 1262, 1266, Article 1267, and Article1365), , KUHD (vide Article 254, Article 257, Article 258, Article 260, Article 261), or in POJK, such as OJK which carries out the mandate of the Law as a supervisory institution in the financial services sector, which provides legal protection for insurance policyholders from the issuance of regulations, namely Financial Services Authority Regulation Number 6 / POJK.07 / 2022 of 2022 concerning Consumer and Community Protection in the Financial Services Sector. This regulation is a reference for insurance policyholders to know what is included in the supervision by OJK and also to know what types of complaints the public can submit and what stages in the complaint and its requirements (Kania, 2023)

In addition, as of January 3, 2025, the Constitutional Court in its Decision 83/PUU-XXII/2024 determined that insurance companies may not reject customer claims. insurance caused by incomplete disclosure of information, this is a preventive legal protection for the insured party of credit life insurance. Because the decision reduces the risk of imbalance in legal power between the insured and the insurance company. So far, the clause that gives exclusive rights to the insurance company to cancel claims without going through the courts is often used to avoid paying claims. With the Constitutional Court decision, every claim cancellation must go through the court mechanism, thus providing preventive legal protection against abuse by the insurance party.

The Constitutional Court's decision encourages insurance companies to improve accuracy and professionalism in the risk selection process (underwriting) before the policy is issued. This is in line with the principle of Utmost Good Faith, which now no longer only imposes the responsibility for full disclosure of information on the insured, but also requires the insurer to act carefully, fairly, and transparently. In the context of credit life insurance, the Constitutional Court's decision reduces the potential losses that can be borne by the insured's family as heirs. This provision provides certainty that the insured's heirs will receive legal protection from unilateral claim rejection actions by the insurance company, while minimizing the risk of unfair financial losses.On the other hand, in the case of credit life insurance specifically which has a three-tier relationship framework like this, the legal protection for the insured is has not been regulated at all according to the norms that should be in POJK No. 20/2023 concerning Insurance Products linked to Credit. Basically, there is an insurance where the Insurer does not know the type and how much risk will be received from the Insured at the beginning of the insurance closing. The same thing is also experienced from the Insured's side where the Insured does not know for sure the risks that are guaranteed and risks that are not guaranteed in the insurance policy he has. This imbalance of information can cause problems later if it is not resolved properly at the beginning of the policy closing. One of the problems that arises is when a loss event occurs (when a claim occurs) where the Insured may feel that the policy he has guarantees all risks even though the claim is caused by risks that are not guaranteed. For example, in this case the risk of original disability in life insurance (a disability that existed before the insurance policy was closed and cannot be guaranteed by insurance) in this case is the absence of a medical check up.

Based on the description above, regarding repressive protection related to the insured as the policyholder for the practice of closing a credit life insurance policy without a medical check-up if there is a refusal to pay a claim that is linked to the principle of utmost good faith, one of the efforts that can be made is to file a lawsuit for the failure to pay the claim in order to pay off the policyholder's credit from the insurance company to the bank.

Customers/insured or debtors who feel disadvantaged by the actions of the insurance company can also resolve this problem through mediation. This is in accordance with Article 54 paragraph 1 of Law No. 40/2014. The repressive protection provided is through settlement through a court known to the general public to resolve various disputes that occur, starting from examining documentary evidence, witnesses and even expert examinations. However, going to court sometimes takes a long time to get a decision that has permanent legal force (inkracht van gewisjde) because the levels are District Court (PN), High Court (PT), and Supreme Court (MA), even Judicial Review (PK) at the Supreme Court.

Based on the description above, it can be concluded that legal protection for the heirs of the insured for the practice of closing a credit life insurance policy without a medical check-up consists of 2 (two) things, namely preventively and repressively. Preventively, legal protection for the heirs of the insured of the credit life insurance is regulated in Article 22 to Article 26 of POJK No. 20/2023 concerning Insurance Products Linked to Credit which emphasizes the importance of information transparency in the insurance relationship between the insurer, policyholder/insured. However, legal protection for the insured of credit life insurance in the framework of a three-party relationship like this has not been regulated in detail, even in POJK No. 20/2023. The provisions of credit life insurance do not fully cover aspects that protect the position of the insured. However, legal protection for the insured in this three-party relationship has not been regulated in detail in POJKmentioned, the provisions of credit life insurance do not fully protect the position of the insured. However, with the Constitutional Court Decision No. 83/PUU-XXII/2024, it opens up space that every claim cancellation or insurance policy closure must go through a court mechanism. Repressively, if there is a claim rejection from the insurer on the basis of the absence of a medical check-up, the insured's heirs have the right to file a lawsuit in the District Court by demanding losses caused by the rejection. This legal path provides certainty for the insured to fight for their rights and obtain compensation for the negligence of the bank or the insurer in carrying out their obligations.

Analysis of Judges' Considerations and Decisions Based on Legal Objectives (Justice, Certainty, Benefit)

The Panel of Judges in its legal considerations stated that "in this case, AsepHendraIrawan bound himself in an insurance cooperation agreement with the Defendant in order to be a debtor of the Co-Defendant according to the Evidence that the debtor can protect himself with life insurance from the Bank's partner insurance company for a certain period of time to protect the Debtor against various risks. Regarding the investigation conducted by the Defendant on AsepHendraIrawan's health history after his death, according to the Panel of Judges' considerations, it is wiser when the investigation is conducted before a legal relationship occurs if indeed the principle of caution against various risks is desired by the Defendant before binding himself with AsepHendraIrawan in an insurance cooperation agreement in a large value without reducing human values."

The Panel of Judges in its legal considerations stated that "after AsepHendraIrawan passed away, the Plaintiffs as heirs filed a death claim for the policyholder named AsepHendraIrawan (deceased) to the Defendant in accordance with the Insurance Agreement in the Insurance Policy in Chapter III number 1: "If the participant dies and/or suffers from Permanent Total Disability before the end of the Protection Period and the coverage is still active, the insurer will pay the Insurance Benefits in the form ofInsurance money with the provisions as stated below as chosen by the Designated Participant. The Panel of Judges also stated that "in accordance with Article 1338 paragraph (1) of the Civil Code, all agreements made legally apply as law for those who make them or are usually referred to as the principle of pactasuntservanda, therefore because the Agreement between AsepHendraIrawan (deceased) and the Defendant has previously been considered and declared as a valid Agreement, then the entire contents of the agreement must apply as law for both parties, meaning that it must be obeyed and implemented, likewise in relation to AsepHendraIrawan (deceased) who has carried out his obligations by paying insurance premiums, the Defendant is also obliged to carry out his obligations to provide insurance benefits when the Insured dies, namely by granting and/or approving and/or disbursing the Plaintiffs' insurance claim application.

The judge's decision stated that "declared the Defendant to have committed a breach of contract and/or committed an act of breach of promise that has harmed the Plaintiffs". In addition, the judge's decision stated that "sentenced the Defendant to grant and/or approve and/or disburse the Plaintiffs' insurance claim application". Judges basically have to be careful, precise and mature in assessing and considering legal issues related to the closing of credit life insurance policies without medical check-ups. Because errors in assessment and considering trial facts can result in injustice,uncertainty, and lack of benefits, and can cause greater losses for the parties.

After understanding the legal issues in the case study raised in this research, legal considerations related to protection for the insured regarding the closing of a credit life insurance policy without a medical check-up need to be analyzed using the theory of legal objectives which include justice, certainty, and benefit.Gustav Radbruch said that “justice includes the principle that the law must respect human rights.”(Timbo, 2016). The application of this principle in the context of closing a credit life insurance policy without a medical examination shows the issue of justice for the insured as in the Tegal District Court Decision Number 38/Pdt.G/2023/PN Date

In the case outlined in Decision Number 38/Pdt.G/2023/PN Date, AsepHendraIrawan (deceased) as the insured has fulfilled the obligation to pay premiums as agreed in the policy agreement. However, after the death of the insured, the insurer refused to pay the claim to the heirs on the grounds of the absence of a medical check-up. In the context of an insurance agreement, justice should be reflected in the fair treatment of the parties, namely between the insured and the insurer. The insured has bound himself to the insurance policy and carried out his financial obligations by paying premiums regularly. regular. Therefore, the insurer, in this case the insurance company, should carry out the obligation to pay claims in accordance with the policy agreement, regardless of whether or not a health check was carried out before the policy was approved.Fairness in insurance law requires that the insured be protected from terms or conditions that are not clearly stated or that may not be fully understood by the insured at the time the agreement is made (Article 251 of the Commercial Code) (Elda, 2020). If the medical examination requirement is considered a substantial condition, then the insurance company is required to inform the condition transparently at the time of policy formation. Thus, the absence of a medical examination should not be used as a basis for rejecting a claim if it was not previously informed or understood by the insured as a major condition.

In this case, justice can also be seen from the principle of good faith, where the insurer should pay attention to the interests of the insured who has fulfilled his obligations, especially regarding premium payments. Rejection of claims without reasons based on fair and acceptable provisions actually indicates injustice that is contrary to the purpose of the law to provide certainty and protection to the insured.As stated in Article 1320 of the Civil Code regarding the requirements for a valid agreement, an insurance agreement must fulfill the elements of justice which providerights and obligations in a balanced manner to both parties. Thus, when viewed from the perspective of justice, the rejection of claim payment to the heirs of AsepHendraIrawan (deceased) can be categorized as an unfair act, because it does not respect the principle of substantive justice. The insured has fulfilled his obligations, while the insurer avoids his obligations for reasons that were not clearly stated from the start. Legal protection that provides justice to the insured and heirs in this case has been accommodated by the Tegal District Court Decision in case Number 38/ Pdt.G/2023/PN Date, so that a fair balance of rights and obligations is created for all parties in the credit life insurance agreement.

Furthermore, Gustav Radbruch stated that "legal certainty in this case means that the first demand for the law is that it be positive, that is, it applies with certainty (Achmad, 2010). Legal certainty also does not only mean articles in the law, but also includes fair implementation of the law. This also means that the law must be implemented with integrity, where legal decisions are taken based on clear evidence and a fair process, so that a sense of justice is created.In the case of Decision Number 38/Pdt.G/2023/PN Date, there is a fundamental problem related to the unclear policy clause regarding the need for a health check as a condition for closing the policy and disbursing claims. The judge's decision in this casehas guaranteed legal certainty, because it determines whether the medical check-up requirements are metshould be explicitly stated in the agreement or not.

In its consideration, the Panel of Judges emphasized that an insurance policy is an agreement that binds both parties, namely the agreement between the insured and the insurer. Thus, the contents of the agreement must be complete, clear, and must not cause uncertainty for the parties. If there is an important clause that affects the disbursement of claims such as the requirement for a medical check-up, then this clause must be clearly stated when the insurance policy is closed. In other words, the Judge has considered that the ambiguity in the policy leads to legal uncertainty that is detrimental to the insured.In his decision, the Judge considered that the rejection of the claim by the insurer on the grounds that a medical check-up was not carried out was contrary to the principle of legal certainty, especially because the reason was not explicitly stated in the policy. The Judge was of the opinion that the insurer could not unilaterally reject the claim on the basis of conditions that were not clearly communicated from the start to the insured. Therefore, this decision strengthens the insured's right to receive protection based on the provisions agreed upon in the agreement, without additional conditions that are not stated in the policy.This decision has a significant impact on the implementation of the principle of legal certainty in insurance practices, especially in the context of credit life insurance policies. First, the judge's decision reminds insurance providers toensure that all terms affecting the rights and obligations of the insured are clearly stated in the policy. Thus, there is no loophole for the insurer to add new terms after the insurance agreement is in effect. Second, this decision confirms that the insurer cannot change or add unilateral terms that are contrary to the contents of the agreement, thereby reducing the potential for abuse of power by the insurer and ensuring better protection for the insured.

The judge in the decision has provided guidance that insurance agreements must reflect the principle of transparency and certainty, which means that all terms and conditions that affect the rights of the insured must be conveyed transparently. This is in line with the principle of legal certainty, where the parties involved in the agreement have the right to obtain clarity regarding their obligations and rights, and to know for sure the terms that affect the agreement. In short, this decision underlines the importance of legal certainty as a protector for the insured in insurance agreements, by preventing practices that can cause losses through unclear terms. Therefore, by siding with the interests of the insured who have fulfilled their obligations, the Judge emphasized that legal certainty must be maintained through the implementation of fair and transparent agreements, so that the insurer cannot evade its responsibilities through unclear clauses in the agreement.

Furthermore, on the side of utility emphasized by Gustav Radbruch, "law must serve social goals and public benefits, including social and economic welfare(Timbo,2016). From Radbruch's statement, the law does not only function to provide certainty and justice, but must also be beneficial to society at large. A beneficial law is a law that can fulfill social goals, economic welfare, and provide protection for the interests of individuals and society. In the context of Decision Number 38/Pdt.G/2023/PN Date, this principle is important to determine the extent of the benefits provided by the judge's decision for the insured and society in the context of credit life insurance.The judge in this decision considered that rejecting the insured's claim based on unclear conditions or conditions not stated in the insurance agreement would hinder the achievement of legal benefits for the insured and the wider community. Benefits in this context include the existence of an insurance agreement as an instrument of economic protection for the insured and his family. Thus, every requirement or clause that can affect the payment of the claim needs to be clearly understood by the insured, so that the agreement can provide real benefits.

The judge emphasized that the rejection of insurance claims without valid and clear reasons will reduce the benefits of the insurance product itself. If the insurednot getting certainty of claim payment when fulfilling its obligations, then the function of insurance as a form of guarantee and economic protection for the insured party becomes ineffective. Therefore, the judge considered that the decision that provides protection for the insured's claim will create greater benefits, namely providing certainty for the community that they can trust insurance as a risk management instrument.The judge’s decision in this case makes it clear that insurance policy clauses must benefit the insured through clarity of the applicable terms and conditions, including the requirement for a medical check-up if required. By stating that the insurer cannot reject a claim on the basis of a condition that is not clearly stated in the agreement, the judge provides a real benefit to the insured, namely the assurance that their claim will be fulfilled in accordance with the applicable provisions. Overall, this decision shows that the benefits of the law include not only individual benefits, but also broader positive impacts for the insurance system and society. By siding with the insured who have fulfilled their obligations, the judge ensures that the law functions not only as a regulatory instrument, but also as a means to improve the social and economic welfare of society.

CONCLUSION

Based on the research and discussion above, the following research conclusions were obtained that The regulation of life insurance policy closure according to Indonesian laws and regulations emphasizes the need for transparency and protection of the insured through established procedures. Then, Legal protection for the heirs of the insured as policyholders for the practice of closing credit life insurance policies without a medical check-up is carried out preventively and repressively. Preventively, protection insured credit life insurance is regulated in Article 22 to Article 26 of POJK No. 20/2023 concerning Insurance Products Linked to Credit, which emphasizes the importance of information transparency in insurance relationships.

Last, the Judge's consideration and decision on the importance of a medical check-up before closing a credit life insurance policy so as to protect the interests of the policyholder based on Decision Number 38/Pdt.G/2023/PN Date where the Panel of Judges has included considerations and decisions that reflect the objectives of the law, namely justice, certainty, and benefits in the context of protecting credit life insurance policyholders. In terms of justice, the Judge's Decision ensures that the rights of policyholders are respected and protected, so that they are not harmed by non-transparent conditions, emphasizing that it would be wiser if the investigation related health is carried out before a legal relationship occurs, especially considering the principle of caution and the principle of utmost good faith that must be applied by the insurer and the insured in binding themselves in an insurance agreement with a large value.

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