

**LEGAL CONSEQUENCES OF FALSIFYING DATA IN LIFE INSURANCE
APPLICATION LETTER BY POLICY HOLDERS WHEN FILING AN
INSURANCE CLAIM**

(Case Study Decision Nomor 269/Pdt.G/2023/PN Jkt. Sel)

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ABSTRACT;

Insurance is considered important when connected with the development of today's society. Where insurance can be the first step towards a guarantee system. Therefore, the main function of insurance is to replace losses arising from unexpected events and restore conditions to their original state before the risk occurs. Insurance is regulated in the Insurance Law Number 40 of 2014 and regulations issued by the Financial Services Authority. However, there are still various problems related to the insurance sector. The insurance application process is not just signing a contract, but also includes the application of the principle of good faith, including in submitting health data on the life insurance application form (SPAJ). Both the insurer and prospective insurance customers have an obligation to exercise their rights and responsibilities, including the obligation for prospective customers to provide accurate and precise health information, so that the premiums and insurance benefits received are in accordance with the actual conditions. This article discusses the requirements for SPAJ, the importance of good faith in insurance contracts, and the legal impacts that arise if the policyholder falsifies data in the SPAJ. The research used in writing this article is a normative legal approach, which means that this article is compiled based on applicable theories, concepts, legal principles, and regulations. The purpose of this study is to improve the understanding of readers and writers regarding the legal consequences of data falsification caused by inaccurate information provided by policyholders.

Keywords: Insurance Claims, SPAJ, Polic;

INTRODUCTION

Human life is always faced with risk problems, both in personal life and in company management, every activity, action and legal action is often accompanied by risks, both due to damage, theft and not receiving the expected profits and so on which can hinder creation of the business that will be implemented. Therefore, humans look for ways and efforts to reduce the costs that they should bear alone and share with other parties who are willing to share the risk. One way for humans to overcome this risk is through transfer to another party, in this case through an insurance agreement.

Insurance is an agreement that is consensual in nature, where the things that have been agreed upon in the insurance agreement are stated in a deed called a policy, the policy functions as evidence in providing coverage in terms of providing guarantees such as compensation for uncertain events or risks that arise. This policy plays an important role because it is very useful when filing claims for compensation or claims for performance contracts as a result of insurance premiums being paid to the insurer. Insurance activities do not always run well, sometimes problems arise related to fulfilling the obligations of each party entering into an insurance agreement.

Losses that can occur in human life have great potential to affect life, so many people try to anticipate the possibility of these losses occurring. One of the steps taken is to have insurance, both for health, life and loss of certain items. Based on the provisions in Article 1 paragraph (1) of Law Number 40 of 2014 concerning Insurance, insurance is defined as an agreement between two parties, namely the insurance company and the policy holder. This agreement is the basis for the insurance company to receive premiums in return for providing protection against risks, compensating for losses incurred, and providing payments to heirs if the insured dies.

In the context of an insurance agreement, the requirements for the validity of the agreement must be complied with by both parties, namely the insurer and the policy holder, in accordance

with the definition of insurance as regulated in Article 1 paragraph (1) of Law Number 40 of 2014 concerning Insurance. This definition emphasizes that insurance is an agreement between two parties. Therefore, the legal requirements for an agreement stated in the Civil Code (KUHPerdata), such as the ability to act legally (competent) and the existence of an agreement between the parties involved (agree), must be fulfilled. Thus, the insurance agreement can have valid legal force and give rise to legal consequences, including the possibility of cancellation of the agreement if these requirements are not fulfilled.

In the insurance policy document, there are rights and obligations that must be fulfilled by all parties involved, namely the insurer and the insured. A problem that often arises in the insurance context is non-compliance in fulfilling agreed obligations, both by the insured and the policy holder. This non-compliance can result in a lawsuit because one of the parties does not fulfill the obligations stated in the agreement or policy.

The insurance agreement, known as a policy, is the result of an agreement between the insurer and the policyholder, and cannot be separated from the Life Insurance Application Letter (SPAJ). SPAJ is a form provided by insurance companies to be filled in with accurate information by prospective customers regarding their condition. The policy itself contains the rights that will be obtained by the insurer, insured and heirs, as well as obligations that must be fulfilled by the insurer and policy holder. However, in practice it is still often found that SPAJ is filled in with incorrect data, so that the principle of good faith in insurance is not applied. This can cause problems when submitting claims, which are then resolved through litigation. The discussion and research in this journal will discuss the process and conditions for implementing faith good (utmost good faith) in the Life Insurance Application Letter in Insurance and Consequences Law on Falsifying Data on Life Insurance Application Letters in Decision Number 269/Pdt.G/2023/PN JKT.SEL.

Based on the background that has been described, the author is interested in studying the problem with the title "LEGAL CONSEQUENCES OF FALSIFYING DATA IN LIFE INSURANCE APPLICATION LETTER (SPAJ) BY POLICY HOLDERS WHEN FILING AN INSURANCE CLAIM (Studi kasus putusan Nomor 269/Pdt.G/2023/PN Jkt. Sel)"

RESEARCH METHODS

This research uses a normative juridical approach, which focuses on legal theories, concepts and principles as the basis for writing. Apart from that, statutory regulations are also the main basis for this writing. This study examines previous research related to legislation and legal consequences arising from falsifying data in the Life Insurance Application Letter (SPAJ), as well as its impact on the insurance claims process. In this research, primary and secondary legal data were used to explore this problem.

DISCUSSION

A. process and conditions for implementing faith good (utmost good faith) in the Life Insurance Application Letter in Insurance

The insurance process is not only limited to signing the policy as a form of agreement between the parties involved. Before the policy is signed, there are a series of stages that must be carried out by both parties, both by the policy holder and by the insurance company as the guarantee provider. The insurance agreement itself is an agreement between the guarantee provider (insurance company) and the policy holder, which is regulated in Law Number 40 of 2014 concerning Insurance, specifically in Article 1 paragraph (1). In this article it is explained that insurance is an agreement between two parties, namely the insurance company and the policy holder, which is the basis for receiving premiums by the

insurance company in exchange for providing payments for losses arising from risks that occur, as well as providing payments to heirs if the insured die. In the insurance context, the policy holder can also be the insured. However, in some situations, the policyholder and the insured may be different people. For example, when a father buys health insurance for his child, the father acts as the policy holder, while the child becomes the insured person in the policy.

The initial process in insurance, before signing the policy, begins with an insurance offer submitted by the insurance agent. The next step is insurance closure, where the policyholder is asked to fill out a Life Insurance Application Letter (SPAJ) with the identity data of the policyholder and the insured. At this stage of filling out the SPAJ, policy holders are expected to apply the principle of good faith (utmost good faith), because the SPAJ asks policy holders to provide accurate information regarding the health and financial conditions of prospective customers. This information will be used to determine the amount of premium that must be paid.

The application of the principle of good faith is very important, especially for policyholders and insureds, because they are the ones who know their condition best. Apart from that, insurance companies as insurers also apply the principle of good faith by providing a clear explanation of the contents of the policy, including the rights that will be given to the insured if the risks guaranteed in the policy occur. Thus, the principle of good faith applies reciprocally between both parties, both the policy holder and the insurance company.

In the settlement stage, apart from filling out the Life Insurance Application Letter (SPAJ), insurance companies also ask prospective customers to provide personal documents such as Resident Identity Cards (KTP) and Taxpayer Identification Numbers (NPWP) of individuals applying for insurance. The main objective of this document request is to better understand the customer profile, in accordance with the guidelines set out in the Capital Market and Financial Institution Supervisory Agency Regulation Number PER-01/BL/2011 concerning the Implementation of Know Your Customer Principles for Insurance Companies. The next process will only continue if the prospective customer has provided complete and appropriate information. If the prospective customer is not willing to provide the requested information, the insurance company has the right to cancel the insurance coverage. After filling in the SPAJ and completing the documents, the premium to be paid will be determined. After the premium is paid, the insurance process will proceed to the next stage. After the insurance has been closed, the next step is the underwriting process, which is the risk selection stage in insurance. At this stage, the insurance company will determine whether the prospective insured is eligible for insurance benefits or not. The underwriting process includes several stages, including: data completeness analysis, data input, risk selection, risk selection authority, data verification, and policy printing. At the risk selection stage, there are two possible outcomes: accepted or rejected. If the prospective insured is accepted, an insurance policy will be issued and the customer can continue the process by paying the premium according to the provisions. However, if the prospective insured is rejected, the premium paid will be returned, and the insurance process cannot continue.

After the prospective insured has completed the underwriting process, the next stage is printing the policy. At this stage, prospective customers are given the opportunity to read and study the contents of the policy through a free look period, which usually lasts 14 calendar days. During this period, policy holders can check and understand all the provisions stated in the policy. If after 14 days the policy holder agrees with the contents of the policy, then no further confirmation is needed, and the policy will continue to be valid according to the provisions. However, if the policy holder does not agree with the contents of the policy, then he is obliged to provide notification or information regarding policy cancellation to the

insurance company. Thus, the policy will be canceled and the premium paid will be returned in accordance with the applicable provisions.

The Life Insurance Application Letter (SPAJ) which has been filled out and equipped with the required documents has the provisions of Incontestability (cannot be refuted) after passing the policy validity period. This Incontestability Provision serves to ensure that the information contained in the SPAJ, which is important data for policy issuance, has been filled in with truthful information and no facts are hidden after the insurance agreement is executed. Thus, this provision serves as a testing period in the insurance contract to confirm the correctness of the data provided by the policyholder. As an example of the application of the principle of Incontestability, the validity of an insurance policy cannot be questioned after the insurance period lasts for 2 (two) consecutive years, which is calculated from the date of issuance of the policy. In other words, after the two-year period, the insurance company cannot deny a claim or cancel a policy based on errors or falsification of information in the SPAJ, unless there is very clear fraud or deliberate fraud.

In an insurance policy, if the validity of the insurance policy is tested or questioned within a period of less than 2 years (contestable period), the insurer (insurance company) has the right to refute the claim or risk that occurs and prove the correctness of the data provided by the policy holder or insured. During the contestable period, which usually lasts for the first two years after the policy is issued, the insurance company has the right to conduct an investigation regarding the condition of the insured if the guaranteed risk occurs. This investigation process aims to verify the correctness of the information provided by the policyholder in the Life Insurance Application Letter (SPAJ). Investigations can include actions such as visiting the hospital or health facility closest to the insured's residence to check whether the insured has a history of previously undisclosed illnesses or medical conditions, which could influence the decision to issue the policy. If it is proven that the insured is hiding important information or providing incorrect data, the insurance company has the right to reject the claim or cancel the policy in accordance with applicable provisions. In insurance, one of the problems that often arises is the application of good faith, especially when the risk occurs during the contestable period. At this time, if the policy holder or party who receives the benefit (beneficial) makes an insurance claim, they may make a claim even though the agreed provisions of the policy have not been fully fulfilled. In fact, the purpose of the contestable period provision is to protect both the policy holder and the benefit provider (insurer). The contestable period, which usually lasts for the first two years after the policy is issued, provides time for the insurance company to verify the correctness of the information provided in the Life Insurance Application Letter (SPAJ). If during this period a risk occurs, the insurer has the right to investigate and prove whether there is hidden or incorrect information that could affect the policy. However, after the contestable period has passed, even if there is incorrect or hidden information in the SPAJ, the insurer no longer has the right to dispute the policy. This means that insurance claims must still be given to the policy holder or heir (beneficial) as the beneficiary, because the policy is considered valid and cannot be questioned anymore after the contestable period ends.

B. Consequences Law on Falsifying Data on Life Insurance Application Letters in Decision Number 269/Pdt.G/2023/PN JKT.SEL

Discusses research results that are strengthened by the researcher's ideas and relevant previous research results. Make sure the literature in the form of theories from books and previous research results are listed in the bibliography.

The Life Insurance Application Letter (SPAJ) is a document which is the main requirement for the issuance of an insurance policy, because the SPAJ contains information regarding the

identity and condition of the policy holder and the insured. Every policy issuance always has a SPAJ attached, so that the existence of a SPAJ cannot be separated from the insurance policy itself. The legal relationship between the insurance company as the guarantor and the policy holder is formed through a written agreement, which is in the form of a deed, in accordance with the provisions contained in Article 255 of the Commercial Code. However, if filling out the SPAJ is not done in good faith, namely by providing correct and accurate information, then this can have a negative impact on the policy issued. Because, the policy is a form of binding agreement between the insurance company and the policy holder. Dishonesty or inaccuracies in filling out the SPAJ can result in the cancellation of the policy or cancellation of insurance claims at a later date, as well as having other legal impacts for both parties.

The case filed in lawsuit 269/Pdt.G/2023/PN JKT.SEL reveals problems related to the contestable period and the application of the principle of good faith (utmost good faith) in the insurance claim process. This problem started with the submission of an insurance claim on February 26 2021 between Yawasadodo Sihura (policy holder) and PT AXA Financial Indonesia (insurer). The policy issued is AXA Magnif Cent Link, with a basic benefit in the form of a death benefit worth IDR. 728,000,000 (seven hundred twenty eight million rupiah), with policy number 570-5148491. In this case, Yawasadodo Sihura as the policy holder has completed and signed the necessary documents, including the Life Insurance Application Letter (SPAJ), which is one of the requirements for obtaining an insurance policy. PT AXA Financial Indonesia has approved the proposed SPAJ and issued a policy with the number listed above. Since the policy's effective date, namely February 26 2021, Yawasadodo Sihura has paid an insurance premium of IDR 1,000,000 per month. However, on May 08, 2021, Ritiba Zagoto, who was listed as the insured in the policy, died at his home in Bawomataluo Village, Fanayama District, South Nias Regency. The death of the insured is then proven by various death documents, such as a Death Certificate issued by the South Nias Regency Civil Registration Officer, a death certificate from the village, and a death certificate from the doctor who treated the insured. This case shows the potential for disputes in the contestable period, namely the first two years after the policy is issued, where the insurer has the right to verify the correctness of the information provided in the SPAJ. In this case, the insurance company has the right to investigate whether there are any untruths or hidden information in filling out the SPAJ, especially related to the insured's health condition which may affect the issuance of the policy or insurance claim. The issue that arises in this lawsuit is whether the information submitted in the SPAJ is in accordance with the principle of good faith, and whether the insurance claim can be accepted or canceled based on the findings during the contestable period.

Based on the case 269/Pdt.G/2023/PN JKT.SEL, the plaintiff in the petition requested to:

1. Fully grant the lawsuit filed by the plaintiff;
2. Affirm that the Life Insurance Agreement Number 570-5148491 is valid and legally binding;
3. Declare that the defendant has committed a breach of contract by not fulfilling the obligations as stipulated in the policy;
4. Order the defendant to pay the Right to Death Benefit based on the basic benefit policy (Death Benefit) of Policy Number: 570-5148491 with an Insurance Amount of IDR 728,000,000 (Seven hundred twenty eight million rupiah);
5. Determine that the defendant must pay interest of 5% per month multiplied by Rp. 728,000,000 per month for a monthly period starting from the time the plaintiff filed a claim against the defendant, namely since June 18, 2021, until the defendant fulfills its obligations in full.

6. Determine the defendant's obligation to pay immaterial compensation to the plaintiff in the amount of Rp. 500,000,000 (Five Hundred Million Rupiah);
7. Declare that the collateral seizure placed on the defendant's assets is valid and applies to the Defendant, both movable and immovable, in the form of:
 - a. All movable and immovable assets owned by PT. AXA Financial Indonesia located in the AXA Tower Kuningan City Building;
 - b. Land and building property and its contents located at Jalan Prof DR Satrio Kav 18, RT 014/RW 04, Kuningan, Karet Kuningan, Setiabudi District, South Jakarta City, DKI Jakarta, known as the AXA Tower Kuningan City Building;
8. Ordering the defendant to pay a fine (Dwangsom) of Rp.1,000,000 (one million rupiah) every day if he fails to implement the decision in this case;
9. Determining that this decision can be implemented immediately even though there is an objection, appeal, or cassation (Uit Voerbaar Bij Voorraad);
10. Declaring that the defendant is obliged to pay the court costs.;

In case 269/Pdt.G/2023/PN JKT. The insured died during the contestable period and the insurance party (defendant) did not obtain valid evidence, in providing evidence the Insured provided evidence of information from a statement letter from one of the staff of the UPTD Bawamantulo Health Center (Nicolaus) which stated that the insured Ritiba Zagoto had a medical history with the Number RM 755 and based on the statement letter, the insured Ritiba Zagoto before the effective date of the insurance had a history of high blood pressure/hypertension and also stroke, while the Plaintiff also provided evidence of a Doctor's Certificate from the Bawamatulo UPTD Health Center Number: 440/076/PKM-BWT/III/2022 on dated March 21, 2022, signed by Invokavit doctor T Satumaha, stated that Ritiba Zagoto, based on the results of the check, the person's medical record had never been treated at the Bawamantulo Health Center UPTD.

In terms of the petitum requested by the plaintiff in lawsuit 269/Pdt.G/2023/PN JKT.SEL, against petitum number 2, the legal relationship between the plaintiff and the defendant is based on the agreement as policyholder and insurer, as stated in Article 1233 of the Civil Code, agreement can occur with an agreement and in accordance with the provisions of the law. In this case, the legal relationship between the plaintiff and the defendant occurs through an agreement written in the form of a document called a policy. In this case, the Insurance Agreement with Policy Number: 570-5148491 is considered valid and legally binding. Furthermore, in petitum number 3 regarding default, the forms of default are:

1. Not fulfilling obligations at all
2. Fulfilling obligations, but exceeding the specified deadline
3. Fulfilling obligations, but not in accordance with the agreement that has been made
4. Carrying out actions prohibited by the agreement

In this context, the defendant is declared to have violated his contractual obligations, namely not fulfilling the promised performance. On the other hand, the plaintiff has fulfilled his obligations by paying premiums and providing evidence of the insured's death, and there is evidence that the defendant has been warned about this

In petitum number 4 in terms of Sentencing the Defendant to pay the Right to death insurance benefits based on the basic benefit policy (Death Benefit) from Policy Number: 570-5148491 with an Insurance amount of Rp. 728,000,000 (Seven hundred twenty eight million rupiah), must be given by the defendant to the plaintiff because the amount of insurance is stated in the insurance agreement in a deed in the form of a policy agreed upon by the insurer and the policyholder.

In claim number 5, the Defendant was ordered to pay interest of 5% per month of the amount of Rp. 728,000,000, starting from the date the Plaintiff filed a claim with the Defendant, namely

on June 18, 2021, until the Defendant fulfills all of his obligations in full. There is no agreement in the insurance agreement that regulates this matter, so the Defendant does not need to pay what is requested in petition number 5.

In petition number 6 to request immaterial losses equivalent to Rp. 500,000,000 (Five hundred million rupiah), there needs to be a breakdown of the immaterial losses suffered by the plaintiff, otherwise petition number 6 cannot be given to the plaintiff because compensation for immaterial losses is not agreed upon in the insurance agreement.

In petition number 7 regarding the seizure of assets, it has nothing to do with the insurance agreement and the plaintiff has no interest in the seizure of the defendant's assets, and the assets are tools used to support the defendant's work activities.

The judge in giving a verdict in case Number 269/Pdt.G/2023/PN JKT SELATAN must look at the insurance agreement agreed by the defendant and the plaintiff, because the legal relationship between the plaintiff and the defendant exists because of the agreement. The petition in the lawsuit must be based on reasons and legal basis so that the judge can consider what is requested by the parties along with clear reasons. In this case, the judge granted part of the petition requested by the plaintiff, based on the judge's consideration, petition numbers 5, 6, 7, 8 and 9 could not be granted, because the petition requested was not related to the insurance agreement. The results of the decision 269/Pdt.G/2023/PN JKT.SEL granted part of the plaintiff's lawsuit with the following details:

1. Affirming that the Life Insurance Agreement stated in the policy Number: 570-5148491 is valid and legally binding;
2. Affirming that the Defendant has committed a violation by not fulfilling the obligations stated in the policy;
3. To order the Defendant to pay the right to death benefit based on the basic benefit policy (Death Benefit) Policy Number: 570-5148491 with the amount of insurance money amounting to Rp.728,000,000 (Seven hundred twenty eight million rupiah).
4. To order the Defendant to pay the estimated court costs of Rp.574,000 (Five Hundred Seventy Four Thousand Rupiah).
5. To reject the plaintiff's lawsuit other than and beyond.

CONCLUSION

Based on the discussion of the two problems above, the following conclusions can be drawn: Insurance is a binding agreement between the insurer and the policyholder, in accordance with the definition of insurance stated in Article 1 Paragraph (1) of Law Number 40 of 2014 concerning Insurance. In an insurance agreement, there are several stages that must be passed, starting from the offer, closing, premium determination, underwriting process, to the issuance of the insurance policy.

One of the important stages in an insurance agreement is filling out the Life Insurance Application Form (SPAJ). In filling out this SPAJ, policyholders are required to apply the principle of good faith, which requires them to provide true information regarding the condition of the insured. The truth of the information provided in the SPAJ is very important, because it will affect whether the insurance application is accepted or rejected by the insurance company. The application of the principle of good faith not only affects the acceptance or rejection of insurance applications, but also affects insurance claims submitted in the future, especially if unexpected risks or events occur. If there is any inaccuracy or concealment of information in the SPAJ, the insurance company has the right to reject the claim at a later date.

The process of filling out the SPAJ is a pre-contractual stage in the insurance agreement, because filling out the SPAJ is carried out before the party issuing the policy which is an

insurance agreement deed in accordance with Article 255 of the Commercial Law Code. The principle of good faith in insurance is not only required to be implemented by the policyholder, but the insurance company as the underwriter must also provide the policy in clear language and be understood by the parties bound by the agreement regarding the rights of the policyholder, the insured and the interests and obligations of the insurance company to the insurance customer.

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