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LEGAL PROTECTION FOR THE PARTIES AS A PREVENTIVE AFFORT AGAINST DISPUTES IN HEALTH INSURANCE CLAIMS

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Abstract

The central idea of this research is to propose an ius constituendum *for legal protection of the parties involved in order to prevent disputes in health insurance claim settlements. This study is a normative legal research, employing both conceptual and statutory approaches, with the urgency of legal protection and the* ius constituendum *of legal protection in health insurance agreements serving as the primary legal issues. The findings reveal that the frequent occurrence of disputes, coupled with the fact that health insurance agreements are often adhesion contracts prone to abuse of circumstances, highlights the urgency of strengthening legal protection. Such protection should be enhanced particularly in the form of preventive legal measures, including regulations that prohibit unfair standard clauses in health insurance contracts and the establishment of a mandatory pre-contractual assessment before the insured signs the agreement. These elements can be regulated through Financial Services Authority Regulations (POJK)***.***

Keywords: *Ius Constituendum, Legal Protection, Health Insurance Agreement.*

I. INTRODUCTION

Since its earliest days, insurance law has been inseparable from contract law. Baker even notes that insurance is, at its core, a derivative of contract law[1]. Historically, modern insurance institutions developed from two distinct roots: (1) insurance as a mutual-benefit mechanism that protects a fraternity or guild, and (2) insurance as a commercial enterprise that promotes trade and investment[2]. Despite these two origins, the essence of insurance remains the same: it is a voluntary undertaking whose obligations are determined almost exclusively by the rules that later came to be known as contract law.[3]

In the mid-19th century, courts in Europe and America began to recognize that insurance contracts differ from general contracts—which are typically based on

[1] Tom Baker & Kyle D Logue, *Insurance Law and Policy,* Aspen, New York, (2008), p.29
[2] *Ibid.,*
[3] *Ibid.,*

voluntariness and equal bargaining power between the parties.[4] Developments in legal cases across Europe and America revealed that insurance agreements are generally structured as adhesion contracts.[5] These types of contracts carry three inherent disadvantages: they are drafted unilaterally, often lack transparency in their terms, and place one party in a disadvantaged or constrained position within the agreement.[6]

Furthermore, in addition to being an adhesion contract, an insurance contract is also often categorized as an aleatory contract. Article 1774 of Book 3 of the *Burgerlijk Wetboek* (Dutch Civil Code) defines an aleatory contract (*kansovereenkomst*) as an agreement that generates benefits for all or some parties, depending on balance or uncertainty. Such chance-based agreements include insurance, gambling, betting, and other contracts dependent on specific uncertain events. Article 1774 of the *BW* classifies insurance as a chance-based agreement because it involves the element of "possibility." The insurer's obligation to compensate the insured is conditional upon the occurrence of an uncertain event. If such an event occurs and causes a loss to the insured, the insurer must provide compensation. However, if the event does not occur, the insurer bears no obligation to compensate for any loss.

Contrary to the *Burgerlijk Wetboek (BW)*, Purwosutjipto argues that classifying insurance under gambling and betting is inappropriate. This is because the relationship between the potential for profit or loss and uncertain events in insurance can still be measured and anticipated. For example, if the probability of profit or loss is high, the insurance company may reject the application or increase the premium. In contrast, in gambling or betting, the relationship between these concepts is inherently unmeasurable and unpredictable. Profit and loss in such cases rely entirely on the luck of the individual involved. Therefore, it may be inaccurate to equate insurance with gambling or betting. In fact, insurance contracts should be excluded from the category of aleatory agreements and instead be specifically regulated under the *Wetboek van Koophandel* (Commercial Code/KUHD). This effort has been reflected in the establishment of Chapters IX and X in Book I, and Chapters IX and X in Book II of the KUHD[7].

In relation to the classification of insurance contracts, Article 246 of the *Wetboek van Koophandel*(KUHD/Commercial Code) defines insurance as a contract in which the insurer binds itself to the insured, in exchange for a premium, to compensate for losses

[4] Shauhin A. Talesh, *Insurance and the Law, International Encyclopedia of the Social and Behavioral Science 11, Issue 2, Elsevier,* (2015), p.2

[5] *Ibid*.,

[6] Purwahid Patrik, *Asas Iktikad Baik dan Kepatuhan dalam Perjanjian*, Semarang, Badan Penasehat, (1986)

[7] Purwosutjipto, H. M. N., *Pengertian Pokok Hukum Dagang Indonesia: Hukum Pertanggungan*. Cetakan Ketiga, Djambatan, Jakarta, (1990)

suffered by the insured due to a certain uncertain event. In line with this, Article 1 point 1 of Law of the Republic of Indonesia Number 40 of 2014 concerning Insurance (Insurance Law) defines insurance as a contract between two parties, namely the insurance company and the policyholder, in which the company receives a premium in return for providing compensation for any loss or legal liability to third parties suffered by the insured as a result of a specific, uncertain event, or for providing a payout based on the death or survival of the insured, with the benefit amount predetermined and/or based on fund management.

One form of insurance contract is a health insurance agreement**.** In such agreements, the principle of good faith plays a crucial role. In this regard, Merkin states that good faith in health insurance contracts requires the insured to carefully and clearly disclose all material facts related to the insured object.[8] Any information that the insurance company needs to know must be fully and transparently disclosed by the insured in relation to the risks that the insurer will bear.[9]

The importance of good faith is further reinforced by Article 251 of the Commercial Code (KUHD), which provides that: "Any incorrect statement or concealment of a fact known by the insured, even if done in good faith, which is of such a nature that the insurance agreement would not have been made, or would not have been made under the same conditions if the insurer had known the true circumstances, shall render the insurance agreement void." However, regarding the principle of good faith, referring to the aforementioned article, it appears that the provision tends to offer greater protection to the insurer—whether in shielding or releasing them from any improper risks imposed upon them—without considering whether the insured has acted in good faith or not. In other words, Article 251 of the Commercial Code (KUHD) unilaterally obliges the insured to accurately disclose any material condition, while the insurer is protected from all violations of the good faith principle committed by the insured.

Based on the previous explanations, a simple conclusion can be drawn that insurance agreements are generally adhesion contracts, they contain elements of uncertainty in several aspects, and the principle of good faith is of paramount importance—even though, in Indonesia, the law tends to favor the insurer. These three factors frequently give rise to disputes. Such disputes are evident, for instance, in conflicts involving health insurance claims, which occur quite often in Indonesia. A few example cases include:

1. Handoyo insured himself and his family with PT Allianz under a life-insurance policy that provided, among other benefits, a payout of IDR 150 million (≈ USD 9,300) for natural death

[8] Robert Merkin, *Practical Insurance Guides: Insurance Law-An Introduction*. Informa, London, (2007)

[9] Victor Dover, *A Handbook to Marine Insurance*, 8th edition. Witherby & Co. Ltd., London, (1975).

and IDR 300 million (≈ USD 18,600) for accidental death, plus any accumulated investment funds. If Handoyo survived to the end of the term, the total investment balance would also be paid out. The ten-year coverage ran from 10 September 2006 to 10 September 2016, with an annual premium of IDR 8,154,000 payable for five years (source: *kompcyber*, "Klaim Asuransi," accessed 30 May 2023). All policy-issuance requirements—such as the Life Insurance Application Form (*Surat Permintaan Asuransi Jiwa*, SPAJ) and medical examinations by doctors, clinics, or laboratories appointed by the insurer—were duly completed by the insured. After only 13 months and 9 days in force, the insured died at home without prior hospitalization; the body was later cremated at Nirwana Crematorium, Bekasi. The heirs demanded payment of the policy benefit of IDR 150 million in accordance with Article 7 of the General Policy Conditions. The insurer refused, arguing—after investigation—that material misrepresentation had occurred during the SPAJ application. The refusal was based on Article 251 of the Commercial Code (KUHD) and the relevant policy clauses, which void the coverage if material facts are not truthfully disclosed.

The insurer stated the following: First, based on the investigation they conducted, it was found that prior to the commencement of the insurance coverage, the insured had previously undergone medical treatment or consultations at the following institutions: Siloam Hospital, Lippo Karawaci on December 10, 2004, with a diagnosis of acute hydrocephalus, for which a CP-shunt was performed; Siloam Hospital, Lippo Karawaci on April 27, 2005, with a diagnosis of bronchiectasis; and Medistra Hospital, Jakarta, where the insured was hospitalized from March 12 to 29, 2006, with a diagnosis of bronchopneumonia duplex accompanied by sputum retention. All of these medical treatments and consultations were not disclosed in the insurance application form (SPAJ). Second, these illnesses could not have been detected through the standard medical examinations required by the insurer, but only through special examinations—assuming that the insured had disclosed their prior medical history. Third, based on the aforementioned findings, the insurer concluded that the insured acted in bad faith and committed either misrepresentation or non-disclosure of material facts. Fourth, upon the discovery of this misrepresentation, the insurer conducted a re-underwriting or re-assessment process to evaluate whether the misrepresentation was material. The result showed that had the insurer been informed of such medical treatments at the time of application, the policy would not have been issued under the same terms and conditions. Thus, it was established that the misrepresentation was material in nature. Fifth, based on these facts and referring to Article 251 of the Indonesian Commercial Code (KUHD), as well as

the General Policy Conditions (Pasal 7) and Article 8 of the SPAJ, the insurer rejected the claim submitted by the beneficiary.

2. The next case concerns a health insurance claim rejection in Decision No. 309/Pdt.G/2016/PN.Jkt.Sel, involving the insured party and PT Prudential Life Assurance in 2016, with the final ruling issued under Supreme Court Decision No. 309/Pdt.G/2016/PN.Jkt.Sel jo. 582/Pdt/2017/PT.DKI. It was agreed that PT Prudential Life Assurance would provide coverage in the form of healthcare funds or death benefits if the insured passed away due to illness or accident, with a monthly premium of IDR 500,000. The insured, Ratua Artha Uli, underwent medical examinations at Siloam Hospital MRCC. On June 13, 2014, the insured modified her primary policy from IDR 500,000 to IDR 1,000,000 per month, which was formally approved on June 17, 2014. In the 17th month after the major policy modification was issued, the insured submitted a claim to obtain benefits from the Pru Hospital and Surgical Cover Plan C and Prumed, during which time the insured had already undergone medical treatment.

The two aforementioned cases serve as examples of health insurance claim disputes. One of the primary causes behind the insurer's denial of claims is the absence of preliminary medical examinations conducted by the insurance provider prior to issuing the policy. However, this does not imply that insurers can be entirely and automatically blamed for such disputes. Misrepresentation and fraud are also frequently committed by the insured or policyholders. Furthermore, as evidenced in the two cases, it is apparent that there remains a legal vacuum regarding the obligation to conduct a pre-insurance medical examination before an individual becomes an insured party or policyholder.

Based on the above, legal certainty within health insurance agreements and their clauses is essential. Such certainty is necessary to prevent legal violations by either party. In addition, a more attentive legal framework that offers stronger protection to the insured is also needed, particularly to safeguard against the potential for unlawful acts committed by insurance companies[10]. Legal certainty, as theoretically described by Canaris, does not merely refer to the existence of legal norms, but also to whether those norms are capable of anticipating and addressing events and developments that occur in society[11].

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[10] Fajrin Husain, *Perlindungan Hukum terhadap Pemegang Polis Asuransi Menurut UU No.40 Tahun 2014 tentang Perasuransian*, Manado: Universitas Sam Ratulangi, Lex Crimen, Vol. V, No.6, (2016)

[11] Claus Wilhelm Cannaris, 1969, *Systemdenken und Systembegriff in der Jurisprudenz*, Berlin: Dunker & Humblot, Berlin, (1969).

II. RESEARCH METHOD

This study employs normative legal research. According to Peter Mahmud, legal research is "a process of discovering legal norms, legal principles, and legal doctrines in order to answer the legal issues at hand."[12] This research utilizes two types of approaches: the conceptual approach and the statutory (statute) approach**.**

III. ANALYSIS AND DISCUSSION

The Urgency of Legal Protection in Insurance Agreements

The concept of legal protection has evolved and become a fundamental part of various societal needs. In the context of administrative law, for instance, legal protection—as stated by Philipus M. Hadjon—remains essential for the people, comprising both preventive and repressive measures. Preventive legal protection serves to minimize the occurrence of disputes by guiding public authorities to act carefully and prudently in decision-making, especially in matters involving discretion. Meanwhile, repressive legal protection ensures that disputes are addressed and resolved through proper judicial mechanisms[13].

Furthermore, in the context of investment, La Porta argues that state-provided legal protection for investors essentially manifests in two forms: prevention through prohibitions and the imposition of sanctions for violations of those prohibitions[14]. The clearest expression of such protection is typically found in regulations that comprehensively outline the prohibitions and corresponding penalties. What is particularly noteworthy in these examples of legal protection is the shared characteristic of the state's central role. The state consistently emerges as the primary actor in ensuring the realization of legal safeguards. Based on the above explanations, three key points can be identified as the core pillars of legal protection:

1. Legal protection is a fundamental obligation of the state.
2. Such protection is implemented through legal instruments (e.g., regulations), encompassing both preventive and repressive measures—typically in the form of prohibitions and sanctions.
3. The primary objective of legal protection is to ensure legal certainty, guaranteeing that every individual receives their rightful entitlements.

Based on the above explanation, the frequent occurrence of disputes in health insurance claims often disrupts the fulfillment of the rights of the involved parties. Therefore, the existence of legal instruments that offer protection becomes a matter of urgency. Moreover, the presence of legal frameworks that tend to protect the insured

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[12] Peter Mahmud Marzuki, *Penelitian Hukum*, Kencana Prenada, Jakarta, (2010)

[13] Philipus M Hadjon, *Perlindungan Hukum Bagi Rakyat Indonesia,* Surabaya: Bina Ilmu, Surabaya, (1990)

[14] Rafael La Porta, "Investor Protection and Corporate Governance", *Journal of Finance Economics*, (1999)

is particularly important, given that health insurance agreements are often *adhesion contracts*. An adhesion contract refers to an agreement in which one party is in a weaker bargaining position—often under pressure or compulsion—while the other party, possessing stronger authority or advantage, dictates the terms. Due to this nature, adhesion contracts commonly exhibit three negative characteristics: unilateral drafting, a lack of transparency in the terms and conditions, and the disadvantaged position of one party entering the agreement[15].

This imbalance of power can be clearly observed in the case of Handoyo, who, as described earlier in this study, was ill and the sole breadwinner of his family. In such a vulnerable condition, his bargaining position was significantly weakened. In principle, however, contractual relationships—according to Yudha Hernoko—should emphasize the proportional exchange of rights between the parties involved[16]. The unequal position in adhesion contracts often leads to a high risk of exploitation or abuse of circumstances, particularly by the party in a stronger position.

Abuse of circumstances refers to a condition in which one party suffers harm due to the other party's exploitation of a particular opportunity. This exploitation can generally be categorized into two forms: the abuse of economic superiority and the abuse of psychological superiority[17]. Abuse of economic superiority occurs when one party possesses significant economic advantage over the other, compelling the disadvantaged party to enter into a contract under pressure. In contrast, abuse of psychological superiority arises when one party exploits the relative dependence of the other (e.g., the relationship between a doctor and patient, or an advocate and client) or takes advantage of the other party's special psychological condition (such as mental disorders, inexperience, or lack of knowledge).

The concept of abuse of circumstances is not explicitly regulated under the Indonesian Civil Code (Burgerlijk Wetboek/BW). However, it has developed over time in Indonesia through various judicial decisions (*jurisprudence*) and legal doctrines. The BW itself only recognizes three forms of defects in consent, as stated in Articles 1321 and 1449: mistake (*dwaling*), fraud (*bedrog*), and coercion (*dwang*). In legal theory, abuse of circumstances is classified into three categories[18]:

1. Economic superiority (Economische Overwicht): Abuse arising from a significant disparity in economic conditions between the parties.

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[15] Purwahid Patrik, 1986, *Op.Cit.,*

[16] Agus Yudha Hernoko, *Asas Proporsionalitas Sebagai Landasan Pertukuran Hak dan Kewajiban Para Pihak dalam Kontrak Komersial*, Jurnal Hukum dan Peradilan, Volume 5 Nomor 3, (2016)

[17] Agus Yudha Hernoko, 2010, *Hukum Perjanjian Asas Proporsionalitas Dalam Kontrak Komersial,* Edisi Pertama, Cet. 3, Jakarta: Prenadamedia, (2010)

[18] Miru, Ahmadi dan Sakka Sakti, *Hukum Perikatan Penjelasan Makna Pasal 1233 Sampai 1456 BW*, Jakarta: Rajagrafindo Persada, (1981).

2. Psychological superiority (Geestelijke Overwicht): Abuse resulting from psychological imbalance, such as dependency or special mental conditions.
3. Emergency situations (Noodtoestand): Abuse arising from urgent or desperate circumstances. Although often viewed as a separate category, this is generally considered a subset of abuse of economic superiority.

Another critical aspect that must be considered in health insurance agreements is the principle of good faith. In this regard, Merkin (2007) defines insurance as "*a rare species of contract where both parties, the insured and the insurer, are under a mutual duty of utmost good faith.*" This statement clearly underscores the essential role of good faith in insurance contracts. In Indonesian law, the principle of good faith is regulated under Article 1338(3) of the *Burgerlijk Wetboek (BW)*. Specifically in the context of insurance, it is further addressed in Article 251 of the Commercial Code (KUHD)[19].

Article 251 of the Indonesian Commercial Code (*KUHD*) regulates the pre-contractual duty of good faith based on a subjective standard. This pre-contractual good faith refers to the obligation to disclose (mededelingsplicht) and investigate (onderzoekplicht) all material circumstances relevant to the terms being negotiated by the parties. The subjective standard relates to the mental state and intent of the parties at the time the insurance contract is formed. The principle embedded in Article 251 is known as *uberrima fides* (or *uberrima fidae*)—a Latin phrase meaning "utmost good faith." It represents the ideal that contracts must be formed with complete honesty, without concealing any material facts. In the context of insurance, this principle imposes a duty on the insured to act with the highest level of good faith toward the insurer, particularly by disclosing all relevant health conditions and risk factors that could affect the insurer's decision to accept the risk [20].

Uli Foerstl argues that the word *fides* originates from the name of the Roman goddess *Fides*, who personified good faith, honesty, oaths, and the moral obligation to keep one's promises. The core concept of *bona fide* is derived from *fides*. This principle was developed into a contractual norm known as exceptio doli[21], a defense mechanism against deceitful or bad faith behavior in contract enforcement. The principle of good faith in Roman law later evolved and was incorporated into both Civil Law and Common Law traditions. In the Netherlands, it developed into the doctrine of *te goeder trouw*, and in English law, it became known as the principle of *good faith*. In Dutch insurance law, the principle of good faith is codified under Article 7:17.1.928

[19] Engelbrecht, 1989. *De Wetboeken Wetten en Verordeningen, Benevens de Grondwet van de Republiek Indonesie.* Ichtiar Baru - van Hoeve, Jakarta

[20] Robinson, Q.C. Douglas F., and John Neocleous. *Issues of Insurance Fraud, International Symposium on The Prevention & Control of Financial Fraud.* Beijing: 19th -22nd, October. 1998

[21] Ulil Foerstl, *The General Principle of Good Faith under the United Nations Convention on Contracts for the International Sale of Good (CISG)- A Fungtional Approach to Theory and Practice*, Dissertation, University of Cape Town School for Advanced Legal Studies, 2005

paragraph 1 of the *Nieuwe Burgerlijk Wetboek* (NBW)**,** which requires the insured to disclose all material facts**.** The full provision of the article stipulates:

"Prior to concluding the contract the policyholder must disclose to the insurer all facts of which he is or ought to be aware and on which, as he knows or ought to understand, the decision of the insurer whether, and if so, on what terms, the latter is willing to conclude the insurance will or may depend" The article emphasizes that, prior to entering into an agreement, the insured must disclose all facts that they know or ought to know**,** and which they realize—or should reasonably realize—may influence the insurer's decision to accept the risk, and if so, under what conditions. Furthermore, Article 7:17.1.928 paragraph 4 of the Dutch Civil Code (NBW) elaborates on the obligation to disclose material facts relevant to the insurer's assessment. It states that: "The disclosure obligation does not extend to facts of which the insurer is already or ought to be aware, or to facts which would not have resulted in a less favourable decision for the policyholder. However, a policyholder or a third person referred to in paragraph 2 or paragraph 3, who has given an incorrect or incomplete answer to a specific question on the matter may not claim that the insurer was already or ought to have been aware of specific facts. The disclosure obligation shall also not extend to facts for which no medical examination may be performed and on which no questions may be raised pursuant to Articles 4 to 6, inclusive, of the Wet op de medische keuringen (Medical Examinations Act) in the instances mentioned therein."

Referring to the preceding explanations, good faith in insurance contracts can be understood as a condition in which all parties are required to clearly disclose all relevant facts and conditions before the agreement is concluded. However, under the provisions of the Indonesian Commercial Code (*KUHD*), this duty appears to be emphasized solely on the insured**.** In other words, good faith is treated as a unilateral obligation**,** where the insured must act in utmost good faith, while the insurer is not explicitly held to the same standard. This is problematic, especially considering that insurance contracts are adhesion contracts**,** in which the insured typically has little to no bargaining power[22]. Therefore, it is essential to recognize that the insurer should also be bound by the same duty of good faith toward the insured.

In this regard, the House of Lords, in the case of *Banque Financière v. Skandia (UK) Insurance Co. Ltd*, concluded that the duty to act in good faith and to disclose material facts applies equally to both the insurer and the insured. The court emphasized that both parties are mutually obligated to maintain good faith throughout the formation and execution of the insurance contract. The full statement reads: "The duty of disclosure arises because the facts relevant to the estimation of the risk are most likely

[22] Kun Wahyu Wardana, *Hukum Asuransi: Proteksi Kecelakaan Transportasi*. Mandar Maju, Bandung, (2009).

to be within the knowledge of the insured and the insurer therefore has to rely upon him to disclose matters material to that risk. The duty extends to the insurer as well as to the insured: Carter v.Boehm. The duty is, however, limited to facts which are material to the risk insured, that is to say facts which would influence a prudent insurer in deciding whether to accept the risk and, if so, upon what terms and a prudent insured in entering into the contract the terms proposed by the insurer. Thus any facts which would increase the risk should be disclosed by the insured and any facts known to the insurer but not the insured, which would reduce the risk, should be disclosed by the insurer, There is, in general, no obligation to disclose supervening facts which come to the knowledge of either party after conclusion of the contract… Although there have been no reported cases involving the failure or an insurer to disclose material facts to an insured the example given by Lord Mansfield in Carter v.Boehm is of an insure who insured a ship for a voyage knowing that she had already arriver."

In light of the House of Lords' statement in the aforementioned case, it can be concluded that the principle of good faith, in relation to the insured, refers to the obligation to honestly and accurately disclose all existing conditions or circumstances prior to the formation of the insurance contract. Conversely, the insurer is equally required to clearly inform the insured of all necessary steps to be taken before the agreement is finalized, including the consequences of such steps and any material information known to the insurer but not to the insured. This mutual transparency ensures that both parties enter into the contract with a full understanding of their rights and obligations.

Based on the above discussions, there are three key reasons that underscore the urgency of strengthening legal protection for parties involved in health insurance agreements:

1. To reduce the frequent occurrence of disputes related to health insurance claims;
2. To prevent abuse of circumstances by insurance companies, particularly given that insurance contracts are often adhesion contracts containing standard clauses that may disadvantage the insured;
3. To uphold the principle of good faith between all parties in the insurance relationship.

For these reasons, state intervention through regulatory frameworks that offer balanced protection for both insurers and insureds is essential. Such legal safeguards are crucial to addressing these three core issues and ensuring fairness, clarity, and accountability in the execution of health insurance agreements.

***Ius Constituendum* of Legal Protection in Health Insurance Agreements**

Research on legal protection in health insurance claim disputes is not uncommon. However, most existing studies tend to focus on the obligations of insurance companies to ensure fairness and proportionality in drafting standard clausesin insurance contracts, as well as on the mechanisms for dispute resolution. One such study is conducted by Soraya Hafidzah and Paramita Sekarayu, which proposes that the formulation of health insurance agreements should take into account several key considerations, including:[23]

a) Position of the Insured

When applying for an insurance policy, the insured must comply with the terms unilaterally determined by the insurance company, leaving no room for negotiation. These include aspects such as premium amounts, payment periods, payment systems, and other predetermined conditions. This lack of bargaining power is also influenced by the economic capabilities of the parties involved. Therefore, the insured's position must be recognized as a non-detachable element in the contract, requiring careful identification and consideration to ensure fairness.

b) Negotiation

Negotiation is a crucial factor in the formation of any agreement or contract. Through negotiation, both parties can gain a clear understanding of their respective rights and obligations. It reflects the fact that each party may have its own goals, and negotiation serves to bridge differences in pursuit of a win-win solution. However, in standard-form contracts (*contracts of adhesion*), where the terms are pre-established by one party (typically the insurer), opportunities for negotiation are significantly limited. This is evident when clauses are predetermined and the insured is only given the option to accept or decline.

c) Proportionality

Proportionality in contract clauses can be observed through the mutual transfer of interests between the insured and the insurance provider. A proportional contract reflects a balance of rights and obligations between both parties. The material substance of each clause should be assessed for fairness and whether it disproportionately favors one party. Ensuring proportionality requires transparency of information and alignment with the objectives of consumer protection laws, especially in the context of standard contracts.

d) Balance

The principle of balance in an insurance policy can be evaluated by examining the conditions under which both parties enter into the agreement. Balance is achieved when all parties act equally and voluntarily in binding themselves to the terms of the contract. Legal actions taken by either party should reflect

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[23]Soraya Hafidzah dan Paramitha Sekarayu, *Perlindungan Hukum bagi Tertanggung atas Gagal Klaim Asuransi Akibat Ketidaktransparanan Informasi Polis Asuransi*, *Jurnal USM Law Review*, Volume 5 Nomor 1, 2022

mutual awareness and intention, not asymmetry or compulsion. A well-balanced contract is one that results from the equally informed and conscious participation of all parties. Conversely, a contract formed under misalignment or unequal standing between parties lacks true balance. Thus, balance in policy clauses is strongly tied to awareness and mutual agreement during contract formation.

While the solutions proposed—particularly those focusing on the insurance agreement—are logically sound, in practice, they remain heavily dependent on the willingness of insurance companies to comply. As such, the author offers an alternative approach that emphasizes the preventive legal protection aspect of insurance agreements. This proposed solution may take the form of guidelines issued through regulations by the Financial Services Authority (Otoritas Jasa Keuangan/POJK)**.** These guidelines should regulate which clauses are permissible or prohibited in health insurance contracts, and also set out the obligations of both insurers and insureds to disclose material information during the contracting process. A useful reference for this proposal is Article 7:928 of the Dutch Civil Code (NBW)**,** which states:

1. Before the conclusion of the insurance agreement the policyholder must inform the insurer of all circumstances of which he is aware or ought to be aware and of which he knows or ought to know that the insurer's decision whether or not to enter into the insurance agreement, and if so, on which terms and conditions, depends or may depend on it.
2. If the interests of a third person, whose identity is known at the moment of the conclusion of the insurance agreement, are covered by the insurance, then the duty to inform the insurer meant in paragraph 1 also includes circumstances concerning that third person of which this third party is aware or ought to be aware and of which he knows or ought to know that the insurer's decision depends or may depend on it. The previous sentence is not applicable in the event of an insurance on a person.
3. Where an insurance on a person relates to a risk run by a third party whose identity is known and who has reached the age of sixteen years, the duty to inform the insurer includes as well circumstances concerning this third party of which this third party is aware or ought to be aware and of which he knows or ought to know that the insurer's decision depends or may depend on it.
4. The duty to inform the insurer does not relate to circumstances which the insurer already knows or ought to know and neither to circumstances which could not lead to a more unfavourable decision for the policyholder or insured person. The policyholder or third party, meant in paragraph 2 or paragraph 3, cannot appeal to the fact that the insurer already knows or ought to know certain circumstances if he has given an incorrect or incomplete answer to a specific question that the insurer has asked o this end. Furthermore, the duty to

inform the insurer does not relate to circumstances to which no medical examination may relate or about which no questions may be asked pursuant to Article 4 up to and including 6 of the Act on Medical Examinations in the events meant in these Articles of that Act.

5. The policyholder is only obliged to inform the insurer about facts of his criminal past or that of a third party as far as these facts have occurred within eight years prior to the conclusion of the insurance agreement and as far as the insurer has explicitly asked a question about that past in not to be mistaken words.
6. When the insurance agreement has been concluded on the basis of a questionnaire formulated by the insurer, the insurer cannot appeal to the fact that other questions are not answered or that circumstances about which no questions were asked are not mentioned by the policyholder or third party and neither to the fact that a question which was formulated generally has been answered incompletely, unless this is done with the wilful intent to mislead the insurer.

In light of the provisions under the Dutch Civil Code (*NBW*), it can be observed that although paragraphs (1) through (5) are largely consistent in orientation with the Indonesian *Commercial Code (KUHD)*—namely, focusing on the insured's duty of utmost good faith—they emphasize that all material facts disclosed by the insured are subject to evaluation by the insurer**.** These disclosures may significantly influence the insurer's decision to accept or reject the risk, or to adjust the premium accordingly**.** Thus, prospective insured parties must be assessed in accordance with insurance standards of eligibilit**y**[24]. However, paragraph (6) provides an important protective mechanism for the insured. It stipulates that if the insurer conducts a questionnaire or inquiry regarding the insured's health or other material conditions prior to entering into the contract, then the insurer cannot later claim ignorance of such conditions. This clause affirms that the responsibility for risk assessment rests equally with the insurer once specific information has been formally sought and obtained.

The insurer's obligations are further regulated under Article 7:929 of the Dutch Civil Code (NBW), which provides that:

1. The insurer who discovers that the pre-contractual information duty of Article 7:928 has not been observed, may only invoke the effects thereof if he has notified the policyholder of this non-observance within two months after it has been discovered, mentioning as well the possible consequences thereof.
2. The insurer who discovers that the policyholder has mislead him with wilful intent or who would not have entered into the insurance agreement if he would

[24] Zahry Vandawati Chumaida, *Prinsip Itikad Baik dan Perlindungan Tertanggung Pada Perjanjian Asuransi Jiwa,* Disertasi, Program Doktor Ilmu Hukum Fakultas Hukum Univesitas Airlangga, Surabaya, (2013)

have been aware of the true state, may terminate the insurance agreement with immediate effect within two months after this discovery.

3. The policyholder may terminate the insurance agreement with immediate effect within two months after the insurer has acted in accordance with paragraph 1 or, in the event of the materialisation of an insured risk, after he has invoked the non-observance of the pre-contractual information duty. Where it concerns an insurance on a person the insurer may restrict the ending of the insurance agreement to the person to whose risk the appeal to non-observance relates.

In reference to the above article, even if the insurer identifies indications of fraud committed by the insured, the insurer is still obligated to notify the insured of such findings within two months of their discovery. This provision clearly provides legal protection to the insurer, enabling them to respond to potential fraud. However, the time limit also functions as a protective mechanism for the insured, ensuring that if no actual fraud has been committed, the insured is not subjected to indefinite uncertainty or retrospective accusations. It promotes legal certainty and fairness for both parties.

In addition, to also protect insurance companies—as it is undeniable that health insurance policyholders may potentially commit fraud—the Financial Services Authority (Otoritas Jasa Keuangan/POJK) should also regulate the obligation to conduct a preliminary examination before the insurance agreement is signed. Such a requirement could help prevent legal disputes related to health insurance claims, especially as demonstrated in the two case examples previously discussed, where the absence of a preliminary assessment prior to contract signing contributed significantly to the dispute. This measure is particularly important given that the main legislative framework for insurance in Indonesia (the Insurance Law) does not currently regulate this matter. Establishing such preventive procedures would strengthen legal certainty and balance the protection of both parties in health insurance agreements.

From the perspective of repressive legal protection, Indonesia's positive law already provides various mechanisms to resolve such disputes. For instance, if the insurer is proven to have committed a breach of contract (wanprestasi) by refusing to pay a valid health insurance claim, the insured party may file a civil lawsuit for breach of contract at the district court (*Pengadilan Negeri*). In addition to litigation, non-litigation alternatives are also available, as governed by Law No. 30 of 1999 on Arbitration and Alternative Dispute Resolution, which provides the legal framework for out-of-court dispute settlement. Unlike proceedings in the district court, the arbitration process begins with the submission of an arbitration request along with a petition for the appointment of an arbitrator. The claimant must also submit supporting

documentation and evidence (statement of claim) relevant to the dispute, which will be examined by the appointed arbitrator throughout the arbitration process.

Another relevant legal instrument is POJK No. 1/POJK.07/2012, which regulates dispute resolution through a mechanism known as consumer complaint settlement, as stipulated in Article 39, as follows:

1. In the event that no agreement is reached through the complaint resolution process, the consumer may pursue dispute resolution either through out-of-court mechanisms or via litigation;
2. Out-of-court dispute resolution as referred to in paragraph (1)
3. Is conducted through an alternative dispute resolution (ADR) institution;
4. If the dispute is not resolved through an ADR institution as referred to in paragraph (2), the consumer may submit a request to the Financial Services Authority (OJK) to facilitate the settlement of complaints involving financial service providers.

IV. CONCLUSION

Based on the analysis presented in the previous sections of this study, it can be concluded that strengthening legal protection in health insurance agreements is urgently needed due to the frequent occurrence of disputes over health insurance claims. Furthermore, the adhesive nature of most insurance contracts creates the potential for abuse of circumstances, particularly when one party possesses significantly stronger bargaining power. Legal protection is also crucial to ensure that both parties uphold the principle of good faith when entering into the agreement. From a legal protection perspective, preventive legal measures must be reinforced. This includes the prohibition of certain standard clauses in health insurance agreements, the requirement for full pre-contractual disclosure of material facts and consequences—drawing from the principles outlined in the Dutch *NBW*—and the obligation to conduct a preliminary assessment before the insured signs the insurance agreement. These elements can be effectively regulated through a Financial Services Authority Regulation (POJK), which would serve to protect both insurers and insureds, reduce the likelihood of disputes, and promote fairness and transparency in the insurance contracting process.

REFERENCES

Claus Wilhelm Cannaris, 1969, *Systemdenken und Systembegriff in der Jurisprudenz,* Berlin: Dunker & Humblot, Berlin, (1969).

Engelbrecht, 1989. *De Wetboeken Wetten en Verordeningen, Benevens de Grondwet van de Republiek Indonesie.* Ichtiar Baru - van Hoeve, Jakarta

Fajrin Husain, *Perlindungan Hukum terhadap Pemegang Polis Asuransi Menurut UU No.40 Tahun 2014 tentang Perasuransian*, Manado: Universitas Sam Ratulangi, Lex Crimen, Vol. V, No.6, (2016).

Agus Yudha Hernoko, 2010, *Hukum Perjanjian Asas Proporsionalitas Dalam Kontrak Komersial,* Edisi Pertama, Cet. 3, Jakarta: Prenadamedia, (2010)

______________________, *Asas Proporsionalitas Sebagai Landasan Pertukuran Hak dan Kewajiban Para Pihak dalam Kontrak Komersial*, Jurnal Hukum dan Peradilan, Volume 5 Nomor 3, *(*2016)

Kun Wahyu Wardana, *Hukum Asuransi: Proteksi Kecelakaan Transportasi*. Mandar Maju, Bandung, (2009).

Miru, Ahmadi dan Sakka Sakti, *Hukum Perikatan Penjelasan Makna Pasal 1233 Sampai 1456 BW*, Jakarta: Rajagrafindo Persada, (1981).

Peter Mahmud Marzuki, *Penelitian Hukum*, Kencana Prenada, Jakarta, (2010)

Philipus M Hadjon, *Perlindungan Hukum Bagi Rakyat Indonesia,* Surabaya: Bina Ilmu, Surabaya, (1990)

Purwahid Patrik, *Asas Iktikad Baik dan Kepatuhan dalam Perjanjian*, Semarang, Badan Penasehat, (1986)

Purwosutjipto, H. M. N., *Pengertian Pokok Hukum Dagang Indonesia: Hukum Pertanggungan*. Cetakan Ketiga, Djambatan, Jakarta, (1990)

Rafael La Porta, "Investor Protection and Corporate Governance", *Journal of Finance Economics*, (1999)

Robert Merkin, *Practical Insurance Guides: Insurance Law-An Introduction*. Informa, London, (2007)

Robinson, Q.C. Douglas F., and John Neocleous. *Issues of Insurance Fraud, International Symposium on The Prevention & Control of Financial Fraud.* Beijing: 19th -22nd, October. 1998

Shauhin A. Talesh, *Insurance and the Law*, *International Encyclopedia of the Social and Behavioral Science 11, Issue 2, Elsevier,* (2015).

Soraya Hafidzah dan Paramitha Sekarayu, *Perlindungan Hukum bagi Tertanggung atas Gagal Klaim Asuransi Akibat Ketidaktransparanan Informasi Polis Asuransi*, *Jurnal USM Law Review*, Volume 5 Nomor 1, 2022

Tom Baker & Kyle D Logue, *Insurance Law and Policy,* Aspen, New York, (2008).

Ulil Foerstl, *The General Principle of Good Faith under the United Nations Convention on Contracts for the International Sale of Good (CISG)- A Fungtional Approach to Theory and Practice*, Dissertation, University of Cape Town School for Advanced Legal Studies, 2005

Victor Dover, *A Handbook to Marine Insurance*, 8th edition. Witherby & Co. Ltd., London, (1975).

Zahry Vandawati Chumaida, *Prinsip Itikad Baik dan Perlindungan Tertanggung Pada Perjanjian Asuransi Jiwa,* Disertasi, Program Doktor Ilmu Hukum Fakultas Hukum Univesitas Airlangga, Surabaya, (2013)