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RESEARCH ARTICLE

The Nature Of The Legal Responsibility Of Insurance Companies In Increasing Individual Claims In The Southern Sulawesi Region

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ABSTRACT

This study aims to explore, analyze, and uncover the legal responsibilities of insurance companies in safeguarding customer rights based on the principle of good faith. It also seeks to determine whether the responsibilities of insurance companies align with statutory regulations and to identify the factors influencing the implementation of individual claims services in insurance companies within the South Sulawesi region. The research adopts a legal framework, combining empirical and normative legal research methods. Conducted in Makassar City, South Sulawesi, the study focuses on branch offices of PT. BNILife Insurance, PT. Axa Mandiri, PT. Jasindo General Insurance, FWD Insurance, BPJS Health, and PT. Ramayana Insurance. Data sources include primary and secondary legal materials, with a sample size of 50 respondents. Data collection methods comprise observation, interviews, questionnaires, and documentation, while the data analysis employs qualitative techniques, including the interpretation of operational definitions. The findings reveal that the legal responsibilities of insurance companies in protecting customer rights are rooted in the principle of good faith, emphasizing adherence to policy agreements to ensure protection, claim settlements, and benefits. The implementation of these responsibilities in accordance with statutory regulations obligates insurance companies to guarantee protection, defend customers, provide compensation, and address disputes, including any harmful actions by insurance agents. Factors influencing individual claims services in South Sulawesi include the expectation (das sollen) that claims payments are realized, supported by digital, transparent, and accountable systems. However, practical implementation (das sein) remains less effective due to issues such as the legal framework, organizational structures, facilities, infrastructure, and legal culture. The study underscores the need for insurance companies to enhance claims services by aligning responsibilities with policy agreements and human values, guided by Pancasila, Law No. 40 of 2014 on Insurance, the Civil Code (KUHPer), the Commercial Code (KUHD), and other relevant laws.

INTRODUCTION

Every individual needs protection in life, both for themselves and their loved ones. This protection covers various important aspects, such as health, education, old-age benefits, and possessions.[1] The need for this protection is even more pronounced as life is always exposed to various risks that can threaten one's economic stability and well-being. Poorly managed risks can have significant impacts, including loss of assets and disruption to peace of mind. Risk is essentially the potential loss caused by a future hazard, which cannot be ascertained when or how it will occur. In this context, understanding and managing risk is an important step to minimise its negative impact. Several steps can be taken to overcome these risks, such as avoiding actions that have the potential to cause losses, taking precautions so that risks do not occur, accepting risks by bearing the consequences, or transferring risks to other parties through insurance.

Transferring risk by purchasing insurance products is an effective and commonly used way. Insurance itself is a mechanism for collecting funds that aims to provide compensation to the insured party if an unwanted event occurs. In addition, insurance has important benefits, including helping to minimise the financial impact of an adverse event, becoming a guarantee against loss or bankruptcy, supporting economic growth by providing a sense of security for parties involved in development, and becoming a means of raising funds or investments that support broader economic development.

With such great benefits, insurance is an important form of self-protection to deal with unexpected events in the future. Insurance becomes a fair risk transfer mechanism and provides a sense of security, so as to maintain life stability and support sustainable development efforts. It can be said that insurance is a system created with the aim of protecting people, groups and business activities against the risks that will arise with the onset of financial losses by transferring or sharing risks through the payment of premiums. Insurance can provide a guarantee of protection to someone who prioritises their services called the insured for the risks that will be faced by themselves or the risks that will be faced by the company. Based on an uncertainty of events that create these losses, there is a human effort to avoid losses from the uncertainty of events by entering into an insurance agreement or coverage between the insurance company or insurer and the insured. The insurance agreement is held by the insurer because the insurance company is a company that receives a risk transfer from another party, or the insurance company becomes the insurer of a risk transferred by another party (the insured). So, the role of the insurance company here is as a Protection Institution, which is an institution that is ready to provide protection in the form of guaranteed losses to the insured, in accordance with the agreement contained in the policy. Insurance according to Law Number 40 of 2014 Article 1 paragraph (1) concerning insurance states that:

> " *Insurance is an agreement between two parties, namely the insurance company and the policyholder, which is the basis for the receipt of premiums by the insurance company in return for providing compensation to the insured or policyholder for loss, damage, costs incurred, loss of profit, or legal liability to third parties that may be suffered by the insured or policyholder due to the occurrence of an uncertain event, or providing payments based on the death of the insured or payments based on the life of the insured with benefits that have been determined and / or based on the results of fund management."*

[1] Kamal Hidjaz, Ilham Abbas Vol.4 No.2 (2023). Efektivitas Hukum Pembagian Harta Perusahaan Yang Dinyatakan Pailit Kepada Kreditor. Journal Of Lex Philosophy (JLP). *https://mail.pasca-umi.ac.id/indeks.php/jlp/article/view/1706*.

Insurance, as stipulated in Law No. 40/2014 on Insurance, is an agreement between policyholders and insurance companies. Policyholders pay premiums to insurance companies to obtain compensation for loss, damage, cost, loss of profit, or legal liability due to an uncertain event, as well as payments based on the death or life of the insured with predetermined benefits. According to Prof Emmy Pangaribuan Simanjuntak, the main purpose of insurance is the transfer of risk from the insured to the insurer. Sri Redjeki Hartono calls insurance an effort to overcome uncertainty against pure loss, not speculative, thus providing a sense of security for the insured. Insurance is consensual, created through an agreement between the two parties that produces a policy as written evidence. Article 255 of the KUHD states that insurance is made in writing, but articles 257 and 258 confirm that the insurance agreement remains valid even though the policy has not been issued, because the policy only functions as evidence. In its development, the term insurance is more commonly used than the term coverage, which comes from the Dutch language. An insurance agreement transfers risk from the insured to the insurer, who acts as a protection organisation. The insurance policy contains the details of the agreement, including the rights and obligations of both parties, as well as the claims procedure. The insurer is obliged to submit the policy after receiving the premium, as the premium is the main source of funds for the insurance company. If the insured does not pay the premium smoothly, the claim may be rejected by the insurer. However, the claim settlement mechanism is often a source of disappointment for the insured, especially if the claim is rejected despite being in accordance with the contents of the policy. Several cases of default by insurance companies in Indonesia reflect this industry challenge. Cases such as Bakrie Life in 2008, Jiwasraya which experienced a large deficit, AJB Bumiputera 1912 which faced miss management issues, and Kresna Life which violated the rules, show the need for strict supervision of the insurance industry. These cases lowered public confidence in insurance companies, although insurance remains an important method of risk management.[2]

1. METHODS

The implementation of this research uses normative and empirical legal methods. Normative legal research focuses on law as norms or rules that apply in society, including inventories of positive law, legal principles, doctrine, legal discovery, legal systematics, synchronisation, comparison, and legal history, as explained by Syahruddin Nawi. Empirical legal research, or socio-legal research, uses primary data obtained directly from the field through observation. This approach sees law as an empirical phenomenon, not just as written norms, by examining the reality of law in practice. The non-doctrinal approach in this research aims to understand the law in the realm of experience, not only as an ideal norm or written in books.

The Nature of Legal Responsibility of Insurance Companies in Providing Protection for Customer Rights Based on the Principle of Good Faith

The history of insurance began during the reign of King Alexander the Great in Greece (356-323 BC) and developed rapidly in the 13th to 14th centuries as sea trade increased. In Indonesia, insurance was introduced by the Dutch who brought the influence of trade law through the application of the KUHDagang, so that the practice of insurance became institutionalised. The development of insurance in Indonesia included the establishment of the first loss insurance company in 1853, Bataviasche Zee en Brand Assurantie Maatschappij, which served the plantation and trade sectors. In 1912, the first life insurance company named Boemi Poetra 1912 was established. The insurance business was halted during the physical revolution period 1942-1945, but revived in 1950 as the economy recovered. In 1973, a number of foreign insurance companies were merged into PT

[2] Markus Gunawan. (2022). Implementation of Legal Principles of Agreement Between Policyholders and Insurance Companies. LITERACY : International Scientific Journals of Social, Education, Humanities, 1(3), 208–218. https://doi.org/10.56910/literacy.v1i3.554

Asuransi Jasa Indonesia (Jasindo),[3] while in 1964 Perum Taspen was established to serve the savings and insurance of civil servants. In the context of the legal responsibility of insurance companies towards individual claims, the principle of utmost good faith is a fundamental principle, as stipulated in Article 251 of the KUHD. This principle demands honesty from both parties in the insurance agreement, both the customer and the company. If one party violates this principle, such as hiding important information, the agreement can be cancelled or the claim rejected. Conversely, if the company provides false information, the customer can file a lawsuit, which has an impact on the company's reputation. This principle provides protection, certainty of claim payments, and mutual benefits for customers and companies.

The principle of utmost good faith is a fundamental concept in insurance agreements that requires both parties involved, namely the insurance company and the customer, to act with honesty and openness. In this context, the principle serves to ensure that neither party is harmed or misled in transactions involving insurance products. Therefore, it is imperative for both parties to realise this principle with full responsibility. In this case, the first party (customer) is required to provide honest and complete information, while the second party (insurance company) is expected to provide clear information about the products offered. For customers, the obligation to act in good faith begins when they apply for insurance. This process usually begins with the completion of the Life Insurance Application Form (SPAJ) which must be answered as honestly as possible by the prospective customer. In this form, prospective customers are asked to provide information on various matters relevant to insurance coverage, such as medical history, occupation, income, and other conditions that may affect the risk assessment by the insurance company.[4]

For example, if a prospective customer conceals information regarding health conditions or medical history relevant to the proposed policy, the insurance company has the right to reject the claim or even cancel the policy if it is proven that the information provided is incorrect or incomplete. This is in accordance with the principle of utmost good faith, which requires that each party not only disclose correct information, but also not hide important facts that could affect the other party's decision in the agreement. In addition to customer obligations, insurance companies also have an obligation to act in good faith. One way insurance companies fulfil this obligation is by providing clear and transparent information to customers about the products offered. This includes information about the terms of the policy, the benefits to be received, the premiums to be paid, as well as the exclusions contained in the policy. Marketers working in insurance companies must be given sufficient training so that they can explain the product well, and ensure that prospective customers understand every detail of the product they are buying. This is very important because often customer confusion and ignorance about the provisions in the policy can lead to claim disputes.

In the legal context, Article 1320 of the Civil Code (KUHPerdata) regulates the legal requirements of an agreement, which includes four important elements: agreement between the parties, capacity to make agreements, clear objects, and halal causes. The principle of utmost good faith is in line with this provision as it requires both parties to an insurance agreement to act honestly and openly, and to have a valid agreement based on complete and accurate information. In this case, any dishonest or hidden disclosure can invalidate the validity of the agreement.

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[3] Syahruddin Nawi, Isnayani. Vol. 2 No. 8 (2021). Peranan PT. Asuransi Jasa Raharja (Persero) Bagi Pengguna Jasa Penumpang Angkutan Laut Di Kota Makassar. Journal Of Lex Generalis (JLG). *https://pasca-umi.ac.id/index.php/jlg/article/view/576*

[4] Mulhadi Mulhadi and Dedi Harianto (2022). Utmost good faith principle in Indonesian insurance law as a legal reason to harm the insured party. Insurance Markets and Companies, 13(1), 81-89. doi:10.21511/ins.13(1).2022.07 https://www.businessperspectives.org/index.php/journals/insurance-markets-and-companies/issue-408/utmost-good-faith-principle-in-indonesian-insurance-law-as-a-legal-reason-to-harm-the-insured-party

Furthermore, according to Article 1 Paragraph (1) of Law Number 40 Year 2014 on Insurance, insurance is defined as an activity related to the collection of funds from the public to provide protection against the risk of financial loss due to uncertain events. In this case, insurance aims to manage and reduce the impact of financial losses that may occur to individuals due to unexpected events. The principle of utmost good faith plays an important role in ensuring that both parties have the same understanding of their rights and obligations in the insurance agreement, as well as in ensuring that the management of funds raised is conducted in a fair and transparent manner. Furthermore, Article 4 of Law Number 40 Year 2014 stipulates that insurance companies must have a valid business licence and conduct their business in accordance with the prevailing laws and regulations.

Insurance companies are also required to maintain their business continuity, ensure the stability of the insurance market, and provide guaranteed protection for customers in accordance with existing regulations. This is a guarantee that insurance companies operate by prioritising the interests of customers and not only pursuing profits. Article 9 of Law No. 40/2014 regulates the obligation of insurance companies to provide clear, correct, and complete information about insurance products offered to prospective customers. This obligation includes information about premiums, benefits, and other provisions related to the insurance product. This clear information is very important to avoid misunderstanding on the part of customers regarding the policy they choose and to ensure that the decisions made by customers are based on accurate and transparent information. Failure to provide clear and complete information can potentially lower customer trust and lead to legal problems in the future. In addition, Article 13 of Law Number 40 Year 2014 regulates the customer's right to obtain protection in accordance with the provisions stated in the policy. [5]

Customers also have the right to obtain correct information regarding the insurance products they purchase, as well as the right to submit claims in accordance with applicable provisions. In this case, the insurance company must ensure that claims submitted by customers are processed fairly and in a timely manner in accordance with the contents of the agreed policy. Article 28 of Law Number 40 Year 2014 regulates the obligation of insurance companies to pay claims in accordance with the provisions in the agreed policy.

Claim payment is the main right of the customer that must be fulfilled by the insurance company if the claim is submitted in accordance with the applicable provisions. If the insurance company refuses or is late in paying the claim without a valid reason, then this can be considered as a violation of the principle of utmost good faith. Article 52 of Law Number 40 Year 2014 regulates sanctions for insurance companies that do not fulfil their obligations in this regard, such as in the case of delays in payment of claims or neglect of other obligations. These sanctions aim to maintain the credibility of insurance companies and ensure that they are responsible for the agreements they have made with customers. Such sanctions also serve to protect the interests of customers and maintain public confidence in the insurance industry.[6]

Article 1 Paragraph (4) of Law Number 8 Year 1999 on Consumer Protection is also relevant in this context, as the law stipulates that consumers are entitled to clear, correct, and not misleading information in every transaction they make.

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[5] Eckardt, Martina & Räthke-Döppner, Solvig. (2008). The Quality of Insurance Intermediary Services – Empirical Evidence for Germany. Journal of Risk and Insurance. 77. 10.2139/ssrn.1272102. https://www.researchgate.net/publication/24112259_The_Quality_of_Insurance_Intermediary_Services_-_Empirical_Evidence_for_Germany/citation/download

[6] Musjab, I. (2024). Application Of Utmost Good Faith Principles In Resolving Insurance Claim Disputes In Indonesian Courts. Journal of Law, Politic and Humanities, 4(4), 973–983. https://doi.org/10.38035/jlph.v4i4.434

In this case, insurance companies must provide correct and clear information about the insurance products offered so that consumers can make decisions based on accurate information. In its application, insurance companies must have a good claims management system to ensure that claims are processed in a timely manner and in accordance with the provisions in the policy. A good claims process is also important to maintain the company's image and ensure that customers feel treated fairly. Success in claims management will increase customer confidence and build a good relationship between the insurance company and the customer.[7]

Table 1: Respondents' Knowledge of Understanding the Content of Policy Agreements as Protection of Customer Rights

No	Category	Frequency	Percentage
1	Understands	42	84%
2	Slightly Understands	5	10%
3	Does Not Understand	3	6%
	Total	**50**	**100%**

Based on what was stated by the respondents as in the table above, it shows that around 84% of respondents understand that the contents of the agreement on the policy have explained the risks and benefits that will be received by the insured / policy holder. Furthermore, there were 10% of respondents who stated that they did not understand and the remaining 6% of respondents who answered did not understand.

From the results of the respondent's questionnaire above, it illustrates that the respondents relatively know that the contents of the policy explain all the provisions that have been regulated by law as protection benefits and financial benefits that will be given to the insured / policy holder. From the results of data processing, there are still respondents who do not know 10% at all because they do not read and do not understand the contents of the agreement on the policy.

In relation to the theory and legal responsibility of insurance companies, it is necessary to describe how insurance was born and how it is implemented to provide benefits and protection to the insured. An insurance agreement is an agreement in which the insurer binds himself to the insured to provide compensation to the insured due to a loss, damage, or loss of expected profits. The insurer receives a premium from the insured to make the reimbursement. The most important principles that apply in insurance agreements are the good faith of both parties and balance. Balance means that the insurer can compensate the insured in accordance with what has been agreed between the two parties.

2. Implementation of the Responsibility of Insurance Companies Towards Customers According to Legislation

The legal basis for insurance in Indonesia is currently regulated under Law Number 40 of 2014, also known as the Insurance Law. This law replaced Law Number 2 of 1992 concerning Insurance Business. The Insurance Law consists of 92 articles organized into 18 chapters. One of the chapters, Chapter XI, focuses on the protection of policyholders, and the legal basis in this chapter requires both conventional and sharia insurance companies to become participants in policy guarantee

[7] Said, D. H., & Azizatur Rahmah. (2022). Application of Law no. 8 of 1999 concerning Consumer Protection to Minimize Consumer Disputes. LEGAL BRIEF, 11(2), 1584–1591. https://doi.org/10.35335/legal.v12i1.339

schemes. Furthermore, insurance companies are also mandated to become members of mediation institutions, which serve to resolve disputes.[8]

An insurance agreement aims to transfer the potential risk of loss from the insured party to the insurer, who agrees to compensate the insured for the loss. This agreement is formalized in a contract that can serve as evidence, such as in cases where an insurance company goes bankrupt. A life insurance agreement is valid once it has been concluded, meaning that even if the policy has not been issued yet, the rights and obligations of both parties (the insurer and the insured) can be proven through other means, such as premium payment receipts.

In a life insurance contract, the parties involved — the policyholder, the insurer, and the insured — each have reciprocal rights and obligations. The rights and obligations of the policyholder should ideally correspond with those of the insurer. According to Emmy Pangaribuan Simanjuntak, in her book Hukum Asuransi Indonesia by Djoko Prakoso, the characteristics of insurance, as outlined in Article 246 of the Commercial Code (KUHD), can be described as follows:

1. Insurance as a Contract of Indemnity: Insurance is fundamentally a contract of indemnity (scadevergoeding or idemniteitscontract), where the insurer is obligated to compensate for the loss suffered by the insured. The indemnity should be proportional to the actual loss experienced (principle of indemnity).

2. Conditional Nature of Insurance: Insurance is a conditional contract, meaning the obligation of the insurer to compensate is only triggered when a specific event, which the insurance policy covers, occurs.

3. Mutual Agreement: Insurance is a reciprocal agreement, meaning the insurer's obligation to pay indemnity is linked with the insured's obligation to pay the premium. The premium payment is not conditional or dependent on any other factor.

In the event of bankruptcy of an insurance company, the protection of policyholders is explicitly outlined in Law No. 40 of 2014 on Insurance, particularly in Article 52, Paragraph (1), which stipulates that policyholders have a preferential creditor status. This means that during asset distribution, policyholders will be prioritized for repayment over other creditors. According to Article 52, Paragraph (2) of the Insurance Law, the insurance fund — a pool of funds collected from premiums — is established to meet obligations arising from policies issued or insurance claims made.

The subjects of insurance are the parties involved in the insurance contract: the insurer and the insured, each having specific rights and obligations. The insurer is responsible for bearing the risks transferred to them and is entitled to receive premium payments, while the insured is obligated to pay the premium and has the right to receive compensation in case of loss of their insured property. The insurer must be a legal entity, which can be a limited liability company (PT), a state-owned enterprise (Persero), or a cooperative. The insured can be an individual, a partnership, or a legal entity, whether a business or non-business entity. In this context, an example of a legal entity subject to the law is PT. Asuransi Axa Mandiri, which enters into insurance agreements with potential policyholders for either general or life insurance.

According to Article 268 of the KUHD, the objects of insurance are interests that: a. Can be quantified in monetary terms. b. Can be exposed to various kinds of risks. c. Are not excluded by law.

[8] YUNIARTI, Shanty Ika. Duty of Disclosure for Insurance Contracts: A Comparative Note of the United Kingdom and Indonesia. Corporate and Trade Law Review, [S.l.], v. 1, n. 1, p. 80-97, dec. 2020. Available at: <https://journal.prasetiyamulya.ac.id/journal/index.php/ctlr/article/view/494>. Date accessed: 08 jan. 2025. doi: https://doi.org/10.21632/ctlr.1.1.80-97

The object of insurance can be property, rights or interests attached to property, and a sum of money known as a premium or compensation. Through these objects, the parties aim to achieve specific goals. The insurer seeks to receive payment of the premium as compensation for transferring the risk, while the insured seeks freedom from risk and compensation if any loss occurs to their property. The following is an explanation of the key elements in insurance:

1. Insurance Objects

Property: This refers to assets that have economic value and can be valued in monetary terms. Property insurance objects are tangible, such as commercial buildings, houses, and ships. These properties are always at risk of potential dangers or events that could cause damage, loss, destruction, or devaluation.

2. Interest

As regulated by Article 250 of the Indonesian Commercial Code (KUHD), an insurance agreement must have an interest involved. If no interest exists in the insured object, the insurer is not obliged to pay claims for damages. The insured will receive compensation from the insurer based on their declared interest in the insured property, which must be quantifiable in monetary terms (Article 268 KUHD).

3. Insurance Policy

According to Article 255 KUHD, insurance agreements must be written in the form of a policy. Further, Article 19 of Government Regulation No. 73 of 1992 states that policies or any form of insurance agreements must not contain ambiguous terms that could lead to misunderstandings regarding the coverage, obligations of the insurer, or the insured's rights.

4. Policy Function

The policy serves as written evidence of the insurance agreement between the insurer and the insured. It is the basis for the insured to claim compensation in the event of a loss. For the insurer, the policy clarifies the scope of responsibility for the loss that occurred. Article 259 KUHD lists the information that must be included in the policy, such as the date of agreement, the insured's details, coverage amount, risks covered, policy duration, premiums, and other pertinent terms.

5. Policy Delivery

An insurance agreement is formed after the insured and the insurer agree on the terms, with the provisional agreement (cover note) signed by the insured. According to Article 259 KUHD, the insurer must provide the policy within 24 hours of the insured’s request, unless otherwise specified by law.

6. Rights and Obligations of the Parties

Once an insurance agreement is made, legal obligations arise. The rights and duties of the parties are clearly stated in the policy. Commonly, the insured has the right to receive coverage for risks and the obligation to inform the insurer about the property being insured, while the insurer has the right to receive premiums and the duty to cover the insured against the risks.

7. Event (Evenemen)

An event refers to an unforeseen occurrence that triggers an insurance claim. Events cannot be predicted and may cause damage to property or persons. Risks are the potential threats, and when the event materializes, it results in the insurer’s obligation to pay compensation.

8. Termination of the Insurance Agreement

Insurance agreements can end for various reasons, including the expiry of the insurance term, the conclusion of a trip (in transportation insurance), the occurrence of a covered event leading to a claim, or mutual agreement between the insurer and insured to terminate the policy. Specific provisions allow for the termination of insurance if false information is provided or if an insured event has already occurred.

9. Legal Responsibility in Insurance

Insurance companies are legally responsible for managing the benefits and executing claims according to ethical standards. This responsibility entails paying or rejecting claims based on the agreed terms. As emphasized by Muhammad Saleh Suratmin, this responsibility is grounded in achieving fairness and the true essence of justice in the industry.

Regarding the operation of insurance companies like PT. AXA Mandiri, the company ensures the correct management of funds paid by the insured, which are then invested to generate returns. The proceeds are divided among the insured, and the company as part of the claim settlement process. In the case of an insurance claim, if an insured event occurs, claims are processed based on the policy's stipulations, and in some cases, surplus underwriting funds may be refunded to the insured.

This detailed understanding helps ensure transparency and fairness in the management of insurance agreements, safeguarding the interests of both parties. Insurance is a form of agreement that involves four main elements that must be present to ensure its validity. First, there is an agreement between two parties, namely the insured and the insurer, which creates a legal bond between them. This agreement is the basis of the civil relationship that arises between the two parties. Second, the premium, which is the amount of money that must be paid by the insured to the insurer as an obligation to obtain protection from certain risks. Third, there is compensation given by the insurer to the insured in the event of a claim or after the agreement period ends. Fourth, an uncertain event or occurrence, which in the world of insurance is referred to as risk, which may or may not be experienced by the insured.

This risk is an event that is unknown or cannot be predicted in advance, but if it occurs, it will give rise to an obligation for the insurer to provide compensation in accordance with the applicable provisions in the insurance policy. The definition of insurance based on Article 246 of the KUHD and Article 1 point 1 of Law No. 2 of 1992 concerning Insurance Business is very clear, namely insurance is an agreement that regulates the rights and obligations between two parties, the insured and the insurer. Thus, the legal ties that occur between the two parties stem from this agreement. However, because the provisions regarding agreements are not specifically regulated in the KUHD or Law No. 2 of 1992, all provisions of agreements in general regulated in the Civil Code (KUHPerdata) still apply.

In insurance agreements, the principles of equality and freedom of contract are very important, where both parties make agreements in good faith without pressure from any party. This reflects the application of the principle of equality in contract, where both parties bind themselves based on a clear and fair agreement. In addition, the insurance industry plays a role in providing legal protection to policyholders and serves as an effort to share risks that may arise. In this context, insurance companies not only provide protection for individuals but also contribute to the financial stability of society. One of the main purposes of an insurance agreement is to enable a party who has a risk of loss (the insured) to transfer that risk to another party who is willing to bear it (the insurer).[9]

[9] Padmo, Aditya & Joesoef, Iwan. (2020). COVID-19 as Force Majeure in Insurance Agreement. Mulawarman Law Review. 114-125. 10.30872/mulrev.v5i2.329. https://www.researchgate.net/publication/361988139_COVID-19_as_Force_Majeure_in_Insurance_Agreement/citation/download

Law No. 21/2011 on the Financial Services Authority (OJK) also regulates the rights and obligations of policyholders, including the right to receive compensation when the insured event occurs, and the obligation to pay premiums and provide true and honest information to the insurer. Furthermore, to assess the effectiveness of the implementation of the insurance company's responsibility, it is important to analyze each stage in the purchase of insurance products in accordance with applicable regulations, as stipulated in Law No. 40 of 2014 concerning Insurance. This responsibility process involves three main components: first, corporate governance, which includes the implementation of effective risk management and social responsibility. In this case, the insurance sector must be able to manage risks appropriately, transform uncertainty into manageable risks, and provide a higher level of security assurance for society.

Good corporate governance also includes protection against environmental and social impacts that may arise in the company's operations. Trust is one of the most important things in the insurance business, because it is a long-term business where clients must be confident that the insurance company will be able to fulfill their claims in the future. Therefore, insurance companies must implement governance systems and procedures in accordance with applicable regulations, including ensuring that all processes are carried out with high transparency and accountability. This is very important to avoid irregularities that may occur, which can harm both the company and the customer. On the other hand, marketing in the insurance industry also plays an important role. However, marketing that is not done ethically can be a weakness for the company. Therefore, it is important to apply the concept of responsible marketing, one of which is to provide clear and transparent explanations to customers about the products offered, thus avoiding potential misunderstandings such as ill-advised products, overselling, or miss-selling. This is part of an insurance company's social responsibility to the public.[10] and play a role in maintaining the integrity and sustainability of the industry.

Table 2: **Respondents' Knowledge on the Implementation of Insurance Company Responsibility According to Legislation**

No	Category	Frequency	Percentage (%)
1	Effective	19	38
2	Less Effective	22	44
3	Not Effective	9	18
	Total	**50**	**100**

Source: Data processed from primary data, 2024

The results of the data processing above show that 38% of respondents stated that the effective implementation of the responsibilities of insurance companies according to the Law. So for respondents who stated that it was effective because they understood the contents of the agreement in the policy so that when the customer's claim followed the rules issued by the insurance company. Meanwhile, 44% of respondents who stated that it was less effective because the respondent experienced disappointment because his insurance claim was rejected on the grounds that the insurance company had given the customer to read and sign a statement before buying the policy and 18% stated that it was not effective. From the data above, if it is related to the respondent's view that so far the insurance company does not properly supervise insurance agents in providing information not in accordance with customer expectations. Even though the insurance company provides supporting documents in the Life Insurance Application Letter and illustrations for prospective customers to read and understand all the provisions imposed by the insurance company.

4. CONCLUSSION

[10] Askari Razak, Cece Karai. (2012). Hukum Pelayanan Publik. Arus Timur. Makassar Https://repository.umi.ac.id/5307/1/Hukum%20Pelayanan%20Publik.pdf.

The essence of the legal responsibility of insurance companies is to provide protection for the rights of customers based on the principle of good faith by upholding the contents of the policy agreement. This allows the insurance company to achieve its objectives in providing protection guarantees and fulfilling claim payment obligations, which ultimately provide benefits and benefits for both parties, insurance companies and customers. However, if one party violates the principle of good faith, there will be legal consequences, such as cancellation of coverage if the customer does not disclose honest information. In addition, based on laws and regulations, insurance companies are required to provide protection guarantees to customers, defend customers, provide compensation, and investigate and resolve cases that arise. Insurance companies are also responsible for the actions of their agents, including losses suffered by customers due to agent misconduct.

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Achmad Ali, Menguak Tabir Hukum, Jakarta: Ghalia Indonesia, 2008, p. 12.

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