AL-IKTISAB: Journal of Islamic Economic Law
P-ISSN 2580-4251 | E-ISSN 2615-661X
https://ejournal.unida.gontor.ac.id/index.php/aliktisab

Settlement of Remaining Financing Due to Rejected Insurance Claims from the Perspective of POJK Number 69/POJK.05/2016 (Case Study at BPRS Puduarta Insani Medan)

Author (s):
Hotma Sari Siregar *
UIN Sumatera Utara, Indonesia
hotma0204191017@uinsu.ac.id
Fatimah Zahara
UIN Sumatera Utara, Indonesia
fatimahzahara@uinsu.ac.id

*Corresponding Author

Available at:
https://ejournal.unida.gontor.ac.id/index.php/aliktisab/article/view/13021

DOI:
10.21111/aliktisab.v8i2.13021

Pages:
187-200

Keywords:
Insurance
Settlement
BPRS Puduarta Insani Medan

Abstract:
Insurance constitutes a risk transfer mechanism or a contractual agreement among multiple parties, wherein the insurer obligates itself to the insured by accepting a premium in exchange for compensation related to losses, damages, or anticipated profit losses. This research aims to identify the factors contributing to customer claim failures and to understand the resolution of issues faced by customers at BPRS Puduarta Insani Medan. The text subsequently details the resolution of the outstanding insurance claim payment financing that was denied at BPRS Puduarta Insani Medan, analyzed in accordance with POJK Number 69/POJK.05/2016. The author utilizes the empirical legal research method in this study, incorporating data collection techniques including direct interviews and observation within the company. This is subsequently presented as descriptive report. The customer's claim was unsuccessful due to their failure to comply with the pertinent legal provisions. BPRS Puduarta Insani Medan discovered that the customer had acted dishonestly by concealing their ailment from the bank when insuring themselves as a customer. The customer's claim failure at BPRS Puduarta Insani Medan was resolved as a consequence of data manipulation disguised as a health history letter. As a result, the bank and the heirs achieved an agreement that the payment would continue and be settled by the heirs, as it was not regulated in the agreement regarding the customer's demise. POJK Number 69/POJK.05/2016 has established a comprehensive framework for safeguarding the interests of financing companies and the heirs of customers when navigating delicate and intricate circumstances, such as the passing of a debtor. Heirs should carefully examine the financing agreement and the relevant insurance policy to confirm their obligations and rights in these circumstances.

Introduction

The insurance industry provides a range of services that shield people or businesses from various risks for a fee. An insurance policy is a written deal between the insured and the insurance company. It keeps track of what was agreed upon. Insurance protects you and covers you against things that could cause you to lose money (Zulkifli et al., 2020).

Insurance is referred to by a number of Arabic terms, including *ta'min*, *takaful*, and *tadhammun*. Islamic economic law defines insurance as an arrangement in which two or more parties agree that the insurer will pay the insured for losses, damages, or anticipated profit losses, as well as unexpected legal responsibilities to third parties, in exchange for a insurance premium (Rahmalia, 2023). The complexity of modern life is increasing, which may endanger people. Individuals require life insurance, health insurance, and other safeguards against unforeseen dangers. Purchasing insurance is one method to receive the benefits. The community will feel safe and secure because of the assurances given in the event of a dangerous incident. The act of shifting the risk of an occurrence that could result in financial loss to another person is known as danger transfer. Risk in the context of insurance refers to the potential for financial loss due to unforeseen hazards that could occur at any time. When it comes to risk, the policyholder may be asked to reimburse the insurance company or another party for losses brought on by circumstances beyond their control. Therefore, the insurance company may assume the risk as long as it complies with the firm's policies (Mardani, 2014).

BPRS Puduarta Insani Medan has worked with an insurance company to make a variety of insurance goods, such as life insurance and plans for retirement. When people file a claim at BPRS Puduarta Insani Medan, they have to show proof of their loss. For a number of reasons, though, the company can't take all of its clients' cases.

Law Number 8 of 1999 on Consumer Protection formally protects the rights of consumers. Customers now have more negotiating leverage and legal rights according to the Consumer Protection Law, which makes it easier for them to get their issues resolved. If clients believe they were treated unfairly due to compensation that violates the provisions of the agreement and contract, this law ensures they receive the appropriate amount of money (Ardana, 2022). This law outlines several crucial provisions that must be adhered to in order to safeguard the rights of customers: (1) The right to consume products and/or services in a comfortable, secure, and safe manner; (2) The freedom to select products and/or services and to obtain them in accordance with the terms and exchange value, as well as the assurances that have been given; (3) The right to truthful, transparent, and accurate information about the

guarantees and state of products and/or services; (4) The right to have their grievances and thoughts about the products and/or services utilised taken into consideration; (5) The right to appropriate consumer dispute resolution procedures, protection, and advocacy; (6) The right to consumer education and advice; (7) The right to appropriate, truthful, and discrimination-free treatment and service; (8) The right to get paid, get your money back, or get new goods or services if the ones you got don't match what was agreed upon or aren't right (Nurhotia Harahap, 2021).

In order to guarantee the fulfilment of their rights, customers of financial services are safeguarded by pertinent legislation that regulates financial service providers (Muhammad et al., 2023).

Dewangga Galih Aji Daru Kusuma, among others, conducted prior research on a comparable matter in 2022, which was entitled "*Causes of Claim Denials by Customers at Cigna Insurance Company*". This study investigates the reasons for insurance benefit claim denials that result from the insured's inadequate understanding of the benefits and obligations of their policy. As a result, there are misunderstandings regarding the interpretation of each provision of the insurance policy (Fina Rohmatika, 2024). The distinction between the aforementioned issue and this research is that the previous customer experienced a claim failure as a result of a misinterpretation, which led to an insufficient understanding of the benefits and conditions of the policy they held. The primary objective of this research is to investigate the resolution of outstanding payment finance that arises from denied insurance claims. The analysis is conducted in accordance with POJK Number 69/POJK.05/2016, with the intention of resolving disputes between the insurer and the insured. In 2021, customer (xxx) was the subject of a financing case at BPRS Puduarta Insani Medan that involved a deceased client and a claim failure in the *murabahah* financing agreement. On July 13, 2021, the agreement was executed. The following specifications are provided for the financing options for the acquisition of one unit of a four-wheeled vehicle, brand (xxx): (1) Bank purchase price IDR 120.000.000,-; (2) Selling price IDR 171.300.000,-; (3) Margin (difference) IDR 51.300.000,-; (4) Term 60 months (Bayinah et al., 2017).

The time it takes to pay is 60 months. The customer passed away before the end of the finance deal term in August 2021 because they were sick. The outstanding payment obligations of the deceased customer add up to about IDR 119.000.000,- at the same time. According to the *kafalah* contract in this financing agreement, the heirs of the dead debtor send a claim to BPRS Puduarta Insani Medan about the unpaid debts, which are listed by the sharia insurance. The BPRS Puduarta Insani Medan claim rejection was for a customer who was careless and broke the terms of their contract with BPRS in 2021. When the customer went to BPRS Puduarta Insani Medan

to get insurance, they didn't tell them they had a heart problem before. The bank didn't find out about this problem until after the customer had died. Because they told the insurance company to look into the hospital where the customer got care before they died (Suprima et al., 2019).

Based on the answer given by the Office Manager at BPRS Puduarta Insani Medan, it may be known that in 2021, a customer made an insurance claim to bank, but the company turned it down. The covered have a hard time getting compensation payments because their employers have strict requirements that must be met. A customer with Sharia Life Insurance is involved in the 2021 insurance claim failure at BPRS Puduarta Insani Medan. The customer's claim was turned down because they didn't follow the law and were dishonest when they registered at BPRS Puduarta Insani Medan, hiding their illness from the bank officers. Most of the time, insurance cases are turned down because the policyholder didn't follow company rules or broke the law. Claims are turned down by the company because there isn't enough proof, the client broke the law, or they did something wrong on purpose. This is the basis of the problem that was already mentioned, so this subject will be looked into and explained in this scientific study.

Methodology

This study employs the empirical legal research methodology. This empirical legal research utilises factual data from human behaviour and constitutes a type of legal inquiry that analyses and evaluates legal issues concerning established norms and legal theories. The data is subsequently analysed qualitatively via data collection methods such as observation and interviews. The legal analysis will scrutinise the provisions in POJK Number 69/POJK.05/2016, the insurance law, and various other legal statutes. The results will be given in a detailed report, detailing a mechanism for addressing outstanding payment finance resulting from customer-rejected insurance claims (Amriani, 2011). This research intends to thoroughly investigate the causes of customer claim failures and identify solutions to these difficulties, confirming the validity of the data produced. This study addresses the outstanding payment financing resulting from denied insurance claims at BPRS Puduarta Insani Medan, concluding that the insurance business has successfully addressed claims that faced challenges through talks with the insured party.

Results and Discussion

Terms and Conditions for Insurance Claims Based on POJK Number 69/POJK.05/2016

According to the insurance policy, insurance claims are demands for compensation from the insurer (Afrida, 2016). The company verifies the insurance claim before paying the covered party. Insurance claims are the insured's declarations about the contract. Each party must ensure that the insurer pays benefits if the insured pays the premium and suffers a disaster. The insured files a claim to receive benefits under the insurance policy (Zainal & Laniza, 2020).

An insurance policy is a formal contract for coverage that typically requires written documentation in the form of a deed between the parties involved. A policy is a written document. A policy is a formal document that functions as an official record of the coverage agreement. The insured is obligated to pay a monthly premium as a condition of enrolment in the insurance policy. The insurance company determines the insurance premium by evaluating the insured's circumstances (Ansyah, 2024). According to Article 1 of Law Number 40 of 2014, insurance is a contractual agreement between the insurance company and the policyholder. This agreement authorises the insurer to receive premiums as compensation for compensating the insured or policyholder for losses, damages, incurred expenses, or legal liabilities to third parties that arise from unforeseen events, or for disbursing payments upon the insured's death or related to the insured's life. The benefits of this agreement are predetermined and contingent upon the results of fund management (Rambe & Sekarayu, 2022).

Sharia insurance comprises agreements between sharia insurance businesses and policyholders, designed to manage contributions in accordance with sharia standards. It facilitates collaborative support and protection by offering reimbursement for incurred losses or damages, as well as disbursements upon the policyholder's death or benefits during their lifetime, contingent upon fund management outcomes. As per Fatwa DSN-MUI Number 21/DSN-MUI/X/2001, sharia insurance constitutes a cooperative initiative for mutual aid and safeguarding among persons or businesses. It entails investing in assets or *tabarru'* that produce a return mechanism to mitigate certain risks via contracts adhering to sharia standards. It is devoid of usury, deceit, gambling, and oppression (Aisya, 2023).

The Financial Services Authority (OJK) established POJK Number 69/POJK.05/2016, a rule that governs the activities of insurance and reinsurance companies. This rule covers a wide range of restrictions and situations related to insurance claims. *First*, obligations of the insurance company in the claims process: (1) Policyholders, insured individuals, or participants must get accurate information from the insurance provider on the terms and conditions of claims; (2) The insurance

provider is required to settle claims in line with the policy's requirements within a set time frame after receiving complete claim paperwork. *Second*, claim settlement period, the payment process must be completed within 30 days of the insurance company declaring the claim documents to be complete. *Third*, claim rejection, are fused claim must be explained in writing by the insurer. Rejections must follow insurance policy terms. *Fourth*, documents required for claims, the insurance must specify what claims paperwork are needed, and the insured or policyholder must handle them. Examples include the claim form, incident proof, and additional supporting documents depending on the claim. *Fifth*, assurance of claim payment, it is the insurance provider's responsibility to ensure that the permitted claim is paid in accordance with the policy's terms and within the specified time limit (Dewi, 2008).

These clauses protect consumer rights and ensure a fair claims process. Insurance companies must meet this POJK's minimum service requirements. In Article 36, "*Insurance companies or sharia units are required to have claim settlement guidelines for marketed products that demonstrate that claim handling has been carried out in a quick, simple, easy-to-use manner, and processed fairly in accordance with generally accepted insurance practices*" (Aulia Sidabariba et al., 2023).

As per Article 38 of POJK Number 69/POJK.05/2016, insurance, sharia insurance, reinsurance, and sharia reinsurance companies execute business operations: (1) Insurance companies, sharia insurance companies, or sharia units are permitted to request documents for claim submissions solely as outlined in the policy; (2) Documents and/or other requirements for submitting claims, as specified by the policy, must be pertinent to the coverage and fair in the claim settlement procedure (Kusuma, 2022). As a result, the court system doesn't clearly control the specifics of claims. POJK Number 69/POJK.05/2016, on the other hand, says that the insurance covers the terms and conditions of claims (Nurainiyah et al., 2024).

The Causes of Customer Insurance Claim Failures at BPRS Puduarta Insani Medan Company

Insurance policies are legally enforceable contracts that delineate the terms and conditions of an arrangement between an insurance provider and an insured entity. These policies are executed by the insurer to guarantee their legitimacy. This case study concerns a life insurance policy acquired by the insured customer from BPRS Puduarta Insani Medan, serving as the insurer. The customer's breach of contract regarding the stipulated insurance coverage resulted in the insurance company rejecting the customer's claim, as per the author's conversation with the bank.

When these kinds of problems happen, the insurance company is usually to blame, but the insured can also be to blame. One reason a customer might be

responsible for a claim being denied is that they did not fully understand the policy's terms. If the policyholder leaves out important health information when applying for life insurance, the claim may be denied under Article 251 of the Commercial Code. This is because the policyholder did not disclose the information. Law Number 40 of 2024 about Insurance says that if the insurance company is at fault, the insured can go to the Indonesian Insurance Mediation Agency, which is an OJK-registered alternative dispute resolution entity, or the District Court or Commercial Court in their home country to get justice (Azzahra & Sinilele, 2024).

This individual obtained insurance from BPRS Puduarta Insani Medan in 2021. The salesperson had earlier informed the self-insured client about the advantages and disadvantages of obtaining his own coverage. Subsequently, the consumer received an overview of the functionality of these insurance products from the bank or insurer. In 2021, BPRS Puduarta Insani Medan provided official life insurance coverage to the customer after the consumer indicated interest in the sharia life insurance product subsequent to the bank's explanation. The consumer was found to have been deceitful regarding their health history on the insurance application, resulting in the denial of the claim. The bank will definitely incur a financial loss if the claim from the customer's heirs is disbursed as a result of that incident. The documented protocols for the acceptance and management of claims, disbursement of claims, denial of claims, and resolution of claims disputes are founded on the overarching regulations of Article 38 POJK Number 69/POJK.05/2016: (1) Insurance companies, sharia insurance companies, or sharia unit in insurance companies only can request documents as requirements submit claims in accordance with what is stated in policy; (2) In the event that the policy includes documents and/or other conditions as requirements for submitting a claim, these documents and/or other requirements must relevant to coverage and reasonable in the claims settlement process; (3) Insurance companies, sharia insurance companies, or sharia units in insurance companies are prohibited from making insurance claim payments through third parties, except for insurance broker companies, claim service providers, or parties who have obtained approval from the beneficiary (Rambe & Sekarayu, 2022).

If an insurance company decides not to pay a claim, they have to tell the policyholder, insured, or member in writing and explain why they made their choice. If there is a disagreement between the insurance company and one of its policyholders, insureds, or participants, the insurance company must, as required by law, try to settle the matter through negotiation and/or offer an alternative conflict resolution process. Also, according to Article 38 of POJK Number 69/POJK.05/2016, which controls how claims are handled and how to deal with bad financing rates, the insurance company

can do certain things if the client doesn't pay. The customer didn't include their medical history when they signed up for self-insurance, which led to their claim being denied, as the piece above shows. This was seen as a default by the company. This was found out after the fact, and a review by the insurance company showed that the client had died of a sickness they had before they bought BPRS Puduarta Insani Medan insurance.

Due to the customer's negligence, they are ineligible to collect the insurance on this basis. The insurance company denied the claim for this reason. The remaining principal and margin, often referred to as rescheduling, will be assumed by the customer's successors.

Solutions and Settlement of Remaining Insurance Claim Payments at BPRS Puduarta Insani Medan Based on the Perspective of POJK Number 69/POJK.05/2016

Junaedy Ganie asserts in his book Indonesian Insurance Law that insurance claims will be denied in the case of a catastrophic or unforeseen occurrence. The claimant seeks to have their rights honoured under the policy. Nevertheless, the insurance company rejects the claim for the following reasons: (1) Errors made by the customer when filling out the insurance application proposal; (2) The risk suffered is not listed in the insurance policy or covered by the company; (3) The customer does not have evidence or cannot prove the loss; (4) The insurance company was not given the opportunity to conduct a survey or investigation before deciding on the claim payment; (5) The customer submitted the insurance claim after the due date (Sikellitha et al., 2021).

The insurance claim for BPRS Puduarta Insani Medan was rejected because the insured provided incorrect information, resulting in a failure to adhere to policy requirements. In 2021, BPRS Puduarta Insani Medan rejected an insurance claim from a deceased customer, reportedly due to a heart condition. The successors of the insurance enterprise later filed a claim. The insurance company denied the heirs' claim because of a legal violation, as the deceased had hidden their illness from the firm. The discovery came to light following a thorough examination conducted by the insurance company at the hospital where the client received treatment. The insurance company consequently denied the claim put forth by the heirs of the deceased (Milati & Arifin, 2021).

This signifies various grounds for the company's denial of insurance claims. The initial lack of client knowledge results in the company's denial of insurance claims. The lack of literacy among clients hinders their understanding of the insurance claims submission process. Consequently, clients must have reading skills to prevent misunderstandings, as claim denials stem from rigorous claim criteria. The clients'

poor literacy levels, coupled with the company's severe standards, offer considerable challenges for claim submissions, leading to a high proportion of insurance claim rejections. In contrast, these rigorous standards are enforced to avert document fraud and alteration (Soemitra, 2009).

POJK Number 69/POJK.05/2016 delineates a comprehensive framework for protecting the rights of financing firms and the heirs of clients in delicate and intricate situations, such as the death of a debtor. The resolution to this issue is delineated in Article 29 of POJK Number 69/POJK.05/2016, specifically: (1) The company or sharia unit can provide an opportunity for policyholders, insured parties, participants, or ceding companies to make premium or contribution payments through insurance brokerage firms or reinsurance brokerage firms; (2) In the case where the payment of premiums or contributions received by the insurance brokerage company or reinsurance brokerage company has been handed over to the company or sharia unit, the payment of claims or benefits that arise is the responsibility of the company or sharia unit; (3) Payment of claims or benefits arising as referred to in number 2 is applicable if: (a) The policyholder, insured, participant, or ceding company pays the premium or contribution within the payment period of the premium or contribution specified in the policy or reinsurance agreement; and (b) The risk that occurs is covered in the policy or reinsurance agreement; (4) In the event that the company or sharia unit has not received the premium or contribution payment from the insurance brokerage company or reinsurance brokerage company within a maximum period of 1 (one) working day after the expiration of the period specified in the policy, the company or sharia unit may issue a policy cancellation letter or reinsurance agreement to the insurance broker to be delivered to the policyholder, insured, participant, or ceding company, and the company or sharia unit shall not be responsible for the payment of claims or benefits arising; (5) In the event that the company or sharia unit does not cancel the policy or reinsurance agreement and receives premium or contribution payments through an insurance brokerage company or reinsurance brokerage company after the expiration of the period specified in the policy or reinsurance agreement, the company or sharia unit is obligated to be responsible for the payment of claims or benefits arising from the receipt of the premium or contribution; (6) In the event that the company or sharia unit receives premium or contribution payments through an insurance brokerage company or reinsurance brokerage company after the expiration of the period specified in the policy or reinsurance agreement and does not cancel the policy or reinsurance agreement within 3 (three) days from the receipt of the premium and contribution, the company or sharia unit is obligated to be responsible for the payment of claims or benefits arising from the receipt of the

premium or contribution; (7) In the event of a claim before the company or the sharia unit receives the premium payment or contribution from the insurance brokerage company or the reinsurance brokerage company, the company or the sharia unit is obliged to assist the policyholder, insured, participant, or ceding company in the settlement of the claim to the insurance brokerage company or the reinsurance brokerage company; (8) In the case of claim settlement as referred to in number 6 using an insurance loss adjuster, the costs incurred may be charged to the insurance brokerage company or the reinsurance brokerage company; (9) In the case of insurance closure through insurance brokerage companies, insurance companies, sharia insurance companies, or sharia units within insurance companies, offsetting between premiums or contributions and claims is prohibited.

According to Article 251 of the Commercial Code, for an insurance agreement to be deemed valid, the insured must reveal all known circumstances pertaining to the insured goods. Article 1320 of the Civil Code is the source of this provision. Article 251 of the Commercial Code states that if material facts are concealed or false or misleading statements are made, the insurance is void.

There are four guiding concepts in the insurance industry, and they all have to do with property, principle of insurable interest, principle of indemnity, principle of loss, and principle of good faith.

What this article indicates by "*good faith*" is that the agreement has to be carried out in an appropriate and fair way. The creation, signature, and execution of the agreement constitute its execution. It is critical to keep the client's good faith in check by giving them all the information you know about the situation, but also honouring the trust the company has in them (Lestari, 2015).

There are a number of processes and restrictions that the heirs of dead policyholders must follow in order to pay insurance claims. The following are included in these regulations. *First*, as soon as the covered person dies, their heirs need to contact the insurance company to file a claim. Claim notification, if the insured person dies, their relatives must call the insurance company right away. Because it's required by the insurance policy, this notice usually has to be given in writing. *Second*, heirs must furnish all supporting papers for the claims process. These documents contain, death certificate from the relevant authority, copy of the insurance policy, heir identification document, and heir certificate or other documents proving that they are the legitimate heirs. *Third*, after receiving the notification and supporting documents, the insurance company will verify the claim. After receiving the notification and supporting documents, the insurance company will verify the claim. It verifies document authenticity, policy conditions, and heirship. *Fourth*, claim decision, based

on the findings of the verification, the insurance company will determine whether to accept or reject the claim. The heirs must be made aware of this alternative within the time frame given by the policy or relevant regulations. *Fifth*, the business will give the heirs the insurance benefits if the claim is approved. The insurance benefit will be paid to the heirs by the company after the claim has been accepted. In compliance with the policy's requirements, payments must be made in full or in installments. *Sixth*, disputes resolution, POJK regulated mediation, arbitration, or Alternative Dispute Resolution (ADR) may be used by the insurance company and heirs to settle the claim.

Claims are settled under insurance and reinsurance company business in Article 40 POJK Number 69/POJK.05/2016. Customers are protected and the procedure is fair. Notable claims settlement quotations include, section Article 40, part 1, "*The company or sharia unit is required to settle the payment of claims within the claim payment period or benefit period specified in the insurance policy or at the latest 30 (thirty) days from the agreement between the policyholder, insured, or participant with the insurance company, sharia insurance company, or sharia unit at the insurance company, or the certainty regarding the amount of the claim to be paid, whichever is shorter*". Section Article 40, part 2, "*In the event that the company or sharia unit is required to pay a claim based on the decision of the related alternative dispute resolution institution, the company or sharia unit at the company is required to pay the claim at the latest 30 (thirty) days from the decision being made or as otherwise determined in the decision of the related alternative dispute resolution institution*". Section Article 40, part 3, "*In the event that the claim settlement process has been submitted to the court, the company or sharia unit is required to pay the claim at the latest 30 (thirty) days after the claim payment decision with permanent legal force (inkracht) or as otherwise determined in the court decision*". Article 40, part 4, "*Sharia companies or units are prohibited from making claim payments through insurance brokerage companies or reinsurance brokerage companies except with the written approval of the policyholder, insured, participant, or ceding company*".

These statements demonstrate how crucial it is for insurance firms to provide a clear, easy-to-follow claims process and legal protections for policyholders. The heirs can ensure the insurance claim process is done appropriately and legally by following POJK Number 69/POJK.05/2016.

Insurance is utilised to satisfy the debts of deceased consumers, Fatwa DSN-MUI, KHES, and Insurance Law Number 40 of 2014. The arrangement and implementation are fine as long as they don't violate sharia law. Chapters 130–830 of the second book of the Civil Code, which covers inheritance upon death, also cover inheritance in general (Suratman & Junaidi, 2019).

When a client dies without meeting the contract, bank allows their heirs to settle their liabilities under the *murabahah* contract. The bank asks the heirs to continue making installment payments on the client's debts. This is done when the contract is unregulated and does not identify an insurance party, the client's heirs receive the unpaid payments. Deceased customer cannot do their duty. Bank can then demand the outstanding sum from the insurer per contract. If the plan excludes an insurance, the heirs will take liability after consideration. Alternative Dispute Resolution (ADR) can complete the customer's obligation if the heirs cannot in sharia. Discourse, mediation, arbitration, and religious tribunals resolve disputes (Mardani, 2014).

Conclusion

The customer's claim was unsuccessful due to their failure to comply with the pertinent legal provisions. BPRS Puduarta Insani Medan discovered that the customer had acted dishonestly by concealing their ailment from the bank when insuring themselves as a customer. The customer's claim failure at BPRS Puduarta Insani Medan was resolved as a consequence of data manipulation disguised as a health history letter. As a result, the bank and the heirs achieved an agreement that the payment would continue and be settled by the heirs, as it was not regulated in the agreement regarding the customer's demise. The following is the regulation of the settlement of remaining payments by heirs in the event of the customer's death in Article 29 of POJK Number 69/POJK.05/2016: (1) The remaining payments are settled in the event of the customer's death as follows, (a) The deceased customer's obligations under the financing agreement must be fulfilled by the heirs or other legal parties in compliance with applicable laws, (b) The implementation of rights over the collateral or security, if present, can be used to satisfy the remaining payments in accordance with the relevant legal provisions; (2) The heirs must be informed by the financing firm about the duties that need to be performed and how the remaining payments will be settled; (3) In order to clear the outstanding payments, the finance business may ask the heirs for the required paperwork. POJK Number 69/POJK.05/2016 has established a comprehensive framework for safeguarding the interests of financing companies and the heirs of customers when navigating delicate and intricate circumstances, such as the passing of a debtor. Heirs should carefully examine the financing agreement and the relevant insurance policy to confirm their obligations and rights in these circumstances. The heirs and the BPRS Puduarta Insani Medan have come to an agreement to resolve the matter amicably, opting for a solution in which the responsible heirs will manage and fulfil all outstanding insurance premium payments until they are fully settled.

References

Afrida, Y. (2016). Analisis pembiayaan Murabahah di Perbankan Syariah. *Jurnal Ekonomi Dan Bisnis Islam (JEBI)*, *1*(2), 157–166.

Aisya, Y. P. (2023). *Analisis Fatwa DSN-MUI Nomor:04/DSN/MUI/IV/2000 Tentang Produk Pembiayaan Murabahah di BMT Surya Mandiri Jetis Ponorogo*. IAIN Ponorogo.

Amriani, N. (2011). *Mediasi Alternatif Penyelesaian Sengketa Perdata Di Pengadilan, 1st ed*. Raja Grafindo Persada.

Ansyah, R. (2024). Penyelesaian Sengketa Asuransi Melalui Mediasi Di Lembaga Alternatif Penyelesaian Sengketa Sektor Jasa Keuangan (Laps Sjk). *TAQNIN: Jurnal Syariah Dan Hukum*, *5*(02), 142–158. https://doi.org/10.30821/taqnin.v5i02.13442

Ardana, K. (2022). *Faktor-faktor yang Mempengaruhi Perilaku Konsumen terhadap Keputusan Pembelian Produk Asuransi Jiwa Syariah (Studi Kasus PT. Asuransi Jiwa Syariah Bumiputera 1912 Cabang Medan)*. Universitas Islam Negeri Sumatera Utara Medan.

Aulia Sidabariba, A., Hendra, M., & Ginting, P. (2023). Perlindungan Hukum Terhadap Lembaga Perbankan Akibat Klaim Asuransi Jiwa Kredit Apabila Terdapat Penolakan Pembayaran Klaim. *Jurnal Notarius*, *2*(2), 265–276.

Azzahra, A. W., & Sinilele, A. (2024). Perlindungan Konsumen Pengguna Asuransi Gagal Klaim Berdasarkan Perspektif Hukum Ekonomi Syariah. *El-Iqtishady: Jurnal Hukum Ekonomi Syariah*, *6*(1), 38–48.

Bayinah, A. N., Mardian, S., Mulyati, S., & Maulidha, E. (2017). *Akutansi Asuransi Syariah*. Salemba Empat.

Dewi, A. (2008). Analisis Prosedur Pengajuan dan Pembayaran Klaim pada Perusahaan Asuransi. In *Media Wisata* (Vol. 3, Issue 2, pp. 33–47). https://doi.org/10.36276/mws.v3i2.48

Fina Rohmatika. (2024). Perlindungan Hukum Klaim Asuransi Pemegang Polis Asuransi. *Jurnal Riset Ekonomi Dan Akuntansi*, *2*(1), 182–190. https://doi.org/10.54066/jrea-itb.v2i1.1310

Kusuma, D. G. A. D. (2022). Analisis Yuridis Penyebab Gagal Klaim oleh Nasabah di Perusahaan Asuransi Cigna (Studi Kasus Polis Nomor AU000000000760W). *Jurnal Penelitian Serambi Hukum*, *15*(02), 89–95. https://doi.org/10.59582/sh.v15i02.578

Lestari, N. M. (2015). *Sistem Pembiayaan Bank Syariah Berdasarkan UU No. 21 Tahun 2008*. Grafindo Books Media.

Mardani. (2014). *Hukum Asuransi Syariah*. Prenadamedia Group.

Milati, A., & Arifin, T. (2021). Penyelesaian Wanprestasi Nasabah Dalam Akad Mudharabah (Studi Kasus Di BJB Syariah KCP Patrol). *Jurnal Al-Muamalat (Jurnal Ekonomi Syariah)*, *8*(2), 66–80. https://doi.org/10.15575/am.v8i2.14002

Muhammad, N., Husnul, H., Moh, Y., Faisal, W., Fattahul, I., & Papua, M. (2023). Penyelesaian Kewajiban Debitur Wafat oleh Ahli Waris pada Bank Syariah Indonesia KCP Jayapura Abepura. *Al-Qanun: Jurnal Pemikiran Dan Pembaharuan Hukum Islam*, *26*(1), 43–56.

Nurainiyah, N., Astawa, I. K., & Setiady, T. (2024). Perlindungan Hukum bagi Pemegang Polis dalam Konteks Pengalihan Liabilitas dan Restrukturisasi Asuransi Berdasarkan Undang-Undang Nomor 40 Tahun 2014 Tentang Perasuransian. *UNES Law Review*, *7*(1), 169–183.

Nurhotia Harahap. (2021). Perlindungan Hukum Terhadap Konsumen Terkait Dengan Kenaikan Harga Masker Dimasa Pandemi Covid-19. *Yurisprudentia: Jurnal Hukum Ekonomi*, *Vol.7*(1), 112.

Rahmalia, Y. S. (2023). Insurance law Perusahaan Asuransi Dilindungi Secara Hukum Terhadap Tindakan Klaim Asuransi Yang Disalahgunakan. *Jurnal Ilmiah Wahana Pendidikan*, *9*(13), 649–662.

Rambe, S. H., & Sekarayu, P. (2022). Perlindungan Hukum Nasabah Atas Gagal Klaim Asuransi Akibat Ketidaktransparanan Informasi Polis Asuransi. *Jurnal Usm Law Review*, *5*(1), 93–109. https://doi.org/10.26623/julr.v5i1.4073

Sikellitha, A., Sunarmi, S., & Purba, H. (2021). Pertanggungjawaban Hukum Perusahaan Asuransi. *Jurnal Darma Agung*, *29*(3), 332–341. https://doi.org/10.46930/ojsuda.v29i3.1216

Soemitra, A. (2009). *Bank & Lembaga Keuangan Syariah*. Perdana Media.

Suprima, Rizkianti, W., & Khoirur Rizal Lutfi. (2019). Implikasi Hukum Penunjukan Ahli Waris Berdasarkan Klausul Asuransi Dalam Perspektif Hukum Waris Perdata. *Esensi Hukum*, *1*(1), 109–118. https://doi.org/10.35586/esensihukum.v1i1.12

Zainal, & Laniza, E. A. (2020). *Hukum Asuransi*. PT Cipta Gadhing.

Zulkifli, S., Meidina, L., Dhalimunthe, S. H., & Ginting, I. C. (2020). Implementasi Prinsip Subrogasi pada Asuransi Kendaraan Bermotor: Studi pada PT Pan Pacific Insurance. *SIGn Jurnal Hukum*, *2*(1), 20–29. https://doi.org/10.37276/sjh.v2i1.65