



Life insurance company policy on insurance claims from beneficiaries based on policy discoveries outside the claim period (case study of Manulife Medan insurance company)

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Abstract: This study examines the policies of life insurance companies regarding claims from beneficiaries who discover a policy after the claim deadline has passed. The case study was conducted at PT Asuransi Jiwa Manulife Medan. Problems arose when beneficiaries only learned of the policy several years after the insured's death, resulting in claims being filed outside the timeframe. This study used an empirical legal method with a statutory approach and direct interviews with the company. The results showed that although the policy stipulates a claim deadline of between 30 days and one year, PT Manulife still allows for review if the policy is still active and the reason for the delay is justifiable. Policies that still have cash value are still considered active, allowing claims to be processed. These results demonstrate the importance of fairness and consumer protection in life insurance. In conclusion, there needs to be a balance between legal certainty in contracts and protection of beneficiary rights, particularly in cases of late claims caused by ignorance of the policy's existence.

Keywords: Insurance Claims; Life Insurance; Insurance Policy.

1. Introduction

Risk or danger can cause harm to humans, giving rise to fear and anxiety. This drives people to seek ways to avoid these risks. One possible approach is to transfer the risk to a party willing to accept it. One solution to managing this risk is through insurance (Ayu Sintya Kartika Dewi, 2023).

Risk management by insurance companies is carried out based on a special agreement aimed at mitigating risks, known as an underwriting agreement. Conceptually, insurance is essentially a risk transfer mechanism. In this case, the risk borne by the policyholder is transferred to the insurer or insurance company. In return, the policyholder is obliged to pay a premium according to the agreement, while the insurance company is obliged to compensate the insured in the event of an event or loss (Afrita & Arifalina, 2021).

As insurance products evolve, they are now increasingly diverse and easily tailored to meet people's needs. In Indonesia, life insurance is a highly sought-after and frequently used insurance product, considered capable of meeting people's needs. Every individual has the right to insure their life. Furthermore, life insurance can also be created for the benefit of a third party. Life insurance coverage can last for the insured's lifetime or for a specific period of time, as agreed upon in the agreement (Muhammad, 2019).

Life insurance is a product designed to provide financial protection against loss of income caused by the death of the insured. The insured individual (insured) is generally the primary breadwinner or breadwinner of the family. Life insurance is valid if it meets the principle of insurable interest, namely the existence of interests between the parties involved, whether personal, family, or other interests. Insurable interest refers to the right of one person to insure another party based on a legally recognized financial rela-

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Received: Jul 03, 2025;

Revised: Jul 17 2025;

Accepted: Jul 26, 2025;

Published : Aug 30, 2025;



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tionship between the policyholder and the insured party (Ayu Sintya Kartika Dewi, 2023).

In the insurance clause, there are provisions regarding the obligation to appoint heirs or beneficiaries (Wuhanbino et al., 2024). The beneficiary in life insurance is an individual selected by the insurance policyholder to receive insurance benefits, with their name listed on the insurance policy. This designation does not follow the provisions of civil inheritance law, but is entirely based on the wishes of the insured, which are submitted through a Life Insurance Application Letter (SPAJ) and agreed to in the insurance policy. The insured has the freedom to designate who will be the beneficiary in the insurance policy, provided that the designated party still meets the principles of Insurable Interest and fulfills the provisions of civil law regarding the elements of the agreement as stipulated in Article 1320 of the Civil Code.

To receive insurance coverage, the policyholder or beneficiary is required to submit a report to the life insurance company, known in insurance as a claim. Thus, a claim is a demand filed by the policyholder or beneficiary for insurance coverage, which arises after the conditions stipulated in the insurance agreement have been met. (Badruzaman, 2019a)

When entering into a life insurance contract between the insurer and the insured, greater care and in-depth knowledge of the standard clauses is required, especially regarding the stages of disbursement of life insurance claims as regulated in the provisions of each insurance company. (Rosmawati, 2018) Regulations related to life insurance claim benefits are not only regulated in the policy, but also in the Republic of Indonesia Law Number 40 of 2014 concerning Insurance. Specifically regarding the settlement of insurance claims, this is regulated in Article 31 paragraph (3), which reads:

“Insurance companies, Sharia insurance companies, reinsurance companies, Sharia reinsurance companies, insurance brokerage companies, and reinsurance brokerage companies are required to handle claims and complaints through a fast, simple, easily accessible, and fair process.”

In practice, various problems arise in filing claims. Many claims from beneficiaries are rejected or complicated by insurance companies due to delays in filing claims for various reasons. One reason is that beneficiaries only discover the existence of the insurance policy after the insured has died. Many beneficiaries are confused about filing claims due to the delay in finding the insurance policy. One of the main causes of this problem is a lack of information or outreach from the insured to the heirs regarding the existence and benefits of the policy. This situation usually occurs when the insured dies without informing the family or heirs of their life insurance policy ownership. As a result, the policy documents may be stored in a location unknown to the family or poorly organized, resulting in them not being discovered until several years after the insured's death.

Generally, life insurance companies have regulations that stipulate a time limit for beneficiaries to file claims after the insured's death. This policy provides the legal basis for the company to reject claims submitted after the specified time limit. Claim rejections due to late submissions for specific reasons then create a dilemma between the legal certainty of the contract and the rights of each party.

At PT Asuransi Jiwa Manulife Medan, problems were found in the claims process, particularly related to inaccuracy, such as claims being submitted beyond the due date due to the policy's existence being unknown. There was an issue where a wife, unaware that she had been designated as a beneficiary by her husband, only discovered the life insurance policy in a safety deposit box seven years after her husband's death. This issue raises the question of whether the policy can still be claimed to obtain benefits for the premiums already paid by her husband due to the beneficiary's ignorance of the policy's existence.

As a service provider, it is imperative to provide optimal service to insurance customers. When customers are satisfied, they tend to show their appreciation by potentially repurchasing the same product. This satisfaction stems from direct experience, which has

a significant impact on the company. Therefore, every insurance company should strive to understand the values expected by its customers (Malwa Umpu, nd).

Overall, life insurance companies' policies regarding claims from beneficiaries who discover their policies outside the claim period require a better balance between contractual certainty and consumer protection. Given the significance of this issue, a thorough analysis and reform of insurance companies' policies regarding claims filed outside the claim period are needed to create a fairer and more balanced system for all parties.

Based on the background description above, the research questions that will be the focus of this study are: First, what are the deadlines for submitting life insurance claims at Manulife Insurance Company Medan? Second, what is Manulife Insurance Company's policy for accepting or rejecting life insurance claims submitted outside the claim period? Third, what is the procedure for submitting claims outside the claim period by beneficiaries at Manulife Insurance Company Medan?

Therefore, it is crucial to find a fair solution for all parties. This solution could include regulatory changes that allow for flexibility in claim deadlines for certain cases, with the hope of improving public education and understanding of insurance, as well as a notification system from insurance companies to potential beneficiaries. Furthermore, standardization of insurance company policies for handling claims filed after the deadline is also needed to ensure clarity and fairness across the life insurance industry.

2. Materials and Methods

This research applies empirical legal research techniques, namely research methods aimed at understanding law in real contexts and analyzing how law functions and is applied in community life (Widiarty Sri, 2024). The research approach used is the statute approach, namely an approach carried out by examining various written legal provisions and regulations or rules relating to the legal problem currently being researched.

The type of data used as a research source is primary data, which originates from fieldwork involving respondents, informants, and sources through structured interviews. In other words, field data includes information obtained directly from relevant parties (Muhaimin, 2020). The primary data in this study was based on an interview with Juliana, a representative of Manulife Medan Insurance Company. Secondary data was obtained through literature review, including books, journals, scientific papers, dictionaries, and other documents relevant to the problem under study.

These data sources include legal materials, both primary, secondary and tertiary legal materials.(Widiarty Sri, 2024)Primary legal materials, as Soerjono Soekanto put it, are sources of law that are binding because they contain basic norms or rules. This material encompasses all laws and regulations officially established by authorized state institutions (Purwaningsih, 2022). The primary legal materials used in this study are: the Civil Code, the Commercial Code, Law Number 40 of 2014 concerning Insurance, POJK Number 36 of 2024 concerning the Implementation of Insurance Company Business, Sharia Insurance Companies, Reinsurance Companies, and Sharia Reinsurance Companies. Secondary legal materials are obtained through legal literature, such as textbooks, research results, articles, and journals that discuss the basic principles of legal science and contemporary legal issues (Purwaningsih, 2022). Tertiary legal materials are reference sources that explain or present primary and secondary legal materials in more detail. These include statutes, legal dictionaries, and so on.

3. Results and Discussion

3.1. Deadline for Submitting Life Insurance Claims at Manulife Life Insurance Company Medan

In an insurance agreement, the insurer or insurance company promises to provide compensation for losses arising from risks covered by the policy, while the insured is obliged to make regular premium payments to the insurer (Badruzaman, 2019b).

When an event (death of the insured) occurs under life insurance, the beneficiary can file a claim with the insurance company. A life insurance claim is a form of demand

for the policyholder's or chosen party's rights to the insurance company for settlement in the form of insurance money or cash value, after the conditions stipulated in the insurance agreement have been met.

To ensure the smooth process of claim payments by the insurance company, there are a number of important provisions that must be met when submitting a claim (Darmawi, 2017):

a. Compliance of claim with policy

Make sure that the benefits requested are in accordance with those stated in the insurance policy before submitting the application.

b. The police are still active (in force)

Make sure your insurance policy is still valid or active. To keep your policy in force, especially during the first two years, there should be no delays in premium payments.

c. The policy is not in the waiting period

Make sure the policy is not in the waiting period, which is the initial period before insurance coverage comes into effect.

d. Claims are included in the coverage scope

Before filing a claim, make sure that the claim does not fall within the exclusions listed in the insurance policy.

Furthermore, one important aspect that policyholders and beneficiaries must pay attention to is the claim submission deadline. This provision plays a role in determining whether a claim can be processed and approved by the insurance company. Insurance companies establish rules that the insured or beneficiary must comply with to ensure that claims can be submitted and accepted in accordance with their policies.

In Indonesia, the deadline for submitting life insurance claims is not explicitly regulated by law. Each insurance company sets a specific deadline for submitting life insurance claims, in accordance with the applicable policy provisions. Generally, life insurance companies provide a deadline of up to 90 days or three months for submitting claims. Within this period, heirs are required to submit a claim no later than 90 days after the insured's death (2025).

These deadlines can vary depending on the type of policy the insured holds. Some insurance products may offer more flexibility in filing deadlines, while others impose stricter deadlines. If a claim is submitted after the specified time limit, the insurance company will most likely reject the claim. Generally, the expiration or expiry date in an agreement is regulated in Article 1946 of the Civil Code, which states:

"The lapse of time is a legal means to obtain something or a reason to be released from an obligation by the lapse of a certain time by fulfilling the conditions stipulated in the law."

This is the insurance company's standard for rejecting claims if they are submitted after the claim period has passed. However, each insurance company has its own policies that consider the interests and fairness of each party. The insurance company will request an explanation for the delay.

According to Mrs. Juliana as a representative of Manulife Medan Life Insurance Company in an interview, she said that the period for submitting insurance benefit claims at Manulife Medan Life Insurance Company is set between 30 days to a maximum of 1 year from the occurrence of the insured event, as stated in the insurance policy provisions. However, if the beneficiary submits a claim after the specified time limit, the claim process will not be immediately rejected, but will be returned to the company for further review and consideration to determine whether the claim can still be disbursed or not, taking into account the reason for the delay and the completeness of the documents submitted by the claimant (Juliana, Personal Interview, 2025).

3.2. Manulife Medan Insurance Company's Policy on Accepting or Rejecting Life Insurance Claims Submitted Outside the Claim Period

In insurance, it's not uncommon for beneficiary claims to be rejected by insurance companies. A common reason for insurance claim rejections is a discrepancy with policy clauses, which is generally due to the customer's lack of understanding of the policy's contents. Many customers simply pay premiums without reviewing the terms and conditions of the policy they purchased. On the other hand, insurance claim rejections also occur due to the discovery of fraud committed by either the customer or the insurance company (Puspita Cahya & Novita Reni, 2022).

A lack of understanding by customers or beneficiaries regarding policy terms, such as premium payment deadlines and claim submissions, can also lead to rejection by insurance companies. This is often due to a failure to carefully read and understand the terms and conditions outlined in the policy. Furthermore, a lack of effective communication between policyholders and beneficiaries exacerbates the situation, as important policy information is not clearly communicated.

As happened at the Manulife Life Insurance Company in Medan, there was a problem regarding the delay in submitting a life insurance claim. Where a wife filed a claim with the Manulife Insurance Company in Medan after 7 (seven) years after her husband's death. This problem arose because the wife was completely unaware that her husband had a life insurance policy. When the wife was cleaning and tidying up the items in the safety box, she found a life insurance policy document that she had not previously known existed, then she realized that her husband had a life insurance policy that might provide financial benefits to the family after his death. After finding the policy, the wife immediately contacted and visited the Manulife Insurance Company in Medan to ask whether the claim could still be submitted considering that it had been more than seven years since her husband's death.

Based on an interview with Ms. Juliana, it was discovered that the company did not notify the beneficiaries of their status as beneficiaries. This is because determining the beneficiary is entirely the policyholder's prerogative, and they also have the authority to change the beneficiary at any time. Therefore, the insurance company's customers are the policyholders themselves, and the company has no obligation or interest in notifying the beneficiaries. Therefore, if the beneficiary is unaware of their status as a beneficiary and the insured dies, there will be no claim or payment (Juliana, Personal Interview, 2025).

Based on the time limit provisions set by the insurance company according to the applicable policy, of course, the policy cannot be claimed. However, because the determination of the claim submission deadline is the policy of the insurance company, it allows the insurance company to have the discretion to consider whether the insurance claim is rejected or accepted. James E. Anderson defines policy as a series of actions with a specific purpose that are followed and implemented by an actor or group of actors to solve a particular problem (Islamy, 2009).

Regulations regarding insurance companies that are required to have policies in handling claims are regulated in Article 36 of the Financial Services Authority Regulation Number 36 of 2024 which states that: "Sharia Companies or Units are required to have claims settlement guidelines for marketed products, which reflect that claims handling has been carried out through a fast, simple, easily accessible, and fair process and is in accordance with generally accepted insurance practices."

Based on the interview results, according to Ms. Juliana, the policy status of Manulife Medan's life insurance company determines whether to reject or accept an insurance claim. This policy status significantly determines whether a claim can be processed or rejected. In insurance, an active policy is one that remains in effect and offers benefits that can be claimed by the policyholder or their beneficiaries. This active status is determined by various factors, depending on the insurance product purchased (Juliana, Personal Interview, 2025).

a. Unit Link Life Insurance

With unit-linked life insurance, the policy remains active as long as there is sufficient cash value to cover insurance costs and administration fees. This product combines investment elements with life protection, where a portion of the premium paid is allocated to investments. The cash value in unit-linked insurance is generated from the premium allocation invested in financial instruments. (a) If the insured dies, but the policy is still active even though it has been years since death, then a claim can still be submitted by the heirs. (b) The policy remains active in this case because the cash value in the investment is still sufficient to cover the ongoing insurance costs. (d) Therefore, the insurance company must pay the life insurance money and the existing cash value to the beneficiary.

However, if the cash value in a unit-linked policy is exhausted and the insured no longer makes additional payments (top-ups) to cover the insurance costs, the policy will become inactive (lapse). If the policy lapses before the risk (death of the insured) occurs, any subsequent claims will be rejected by the insurance company.

b. Traditional Life Insurance

Traditional life insurance differs from unit-linked insurance in that it lacks an investment element. A traditional life insurance policy remains active once the policyholder has fulfilled their obligations or paid the premiums according to the agreed-upon terms. (a) Lump Sum Premium Payment: If the insured pays the premium in one lump sum at the beginning of the contract, the policy will remain active until the end of the coverage period or for life (depending on the type of product), without the need for additional premium payments. (c) Premium Payment Period Fulfilled: In some traditional products, after a certain premium payment period (for example 10 or 15 years), the policy remains active even if no further premium payments are made. (d) Cash Value Utilization: Similar to unit-linked policies, some traditional products allow the accumulated cash value to be used to pay premiums, keeping the policy active. If the policy has sufficient cash value, it can remain active even if the policyholder no longer pays premiums directly.

In a case where a wife filed a claim seven years after her husband's death, having just discovered the policy in the safety deposit box, Manulife checked to see if the policy was still active. In this case, the insured purchased a unit-linked insurance product and the cash value in the policy was still available. Therefore, even though the claim had passed the deadline stated in the policy, the company still considered the claim. Because the policy value was still valid and in accordance with applicable regulations, the wife, as the beneficiary, was still able to file a claim, and the insurance company disbursed the Life Insurance Sum Insured (UP) to her.

So, the active policy status is the main factor that determines whether an insurance claim is accepted or rejected. If the policy status is still active, the claim can be accepted by the insurance company. However, if the policy status lapses, the claim is rejected by the insurance company and the insurance money/premiums previously paid are forfeited. If the policy lapses, the insurance company has the right to reject the submitted claim. Therefore, it is very important for policyholders to ensure that the policy status remains active by regularly checking the insurance balance so that insurance benefits can still be claimed and previously paid premiums are not forfeited.

Article 246 of the Commercial Code (KUHD) states that the insurer binds itself to the insured by accepting a premium payment. This demonstrates that the premium is a key element in an insurance contract, as it constitutes the primary obligation the insured must fulfill to the insurer. In an insurance legal relationship, the insurer assumes the risk from the insured, while the insured pays a premium in return for the transfer of that risk (Muhammad, 2019).

The situation where premiums are forfeited and cannot be claimed raises questions regarding the rights that beneficiaries should receive to receive compensation upon the death of the insured. Protection of the insured's rights is essentially in line with the legal

protection provided to consumers as stipulated in Law Number 8 of 1999 concerning Consumer Protection. In this context, the insured in an insurance agreement is classified as a consumer, so that the Consumer Protection Law can be used as a legal basis for providing protection to them. The rights of the insured that are the obligation of the insurance company to fulfill are regulated in Article 4 of Law Number 8 of 1999. (Fitriana Wulan et al., nd)

However, Article 5 of Law Number 8 of 1999 also regulates the obligations that must be fulfilled by the insured, one of which is acting in good faith when carrying out service purchase transactions. This is in line with Article 1 number 1 of Law Number 40 of 2014 concerning Insurance which explains that:

"Insurance is an agreement between 2 (two) or more people in which the insurer binds the insured by accepting an insurance premium, to provide compensation to the insured for loss, damage or loss of expected profits or legal liability to a third party that may be suffered by the insured, arising from a payment based on the death or life of an insured person."

Based on this definition, it can be understood that each party has rights and obligations. The insurance company has the right to receive premium payments from the insured party according to the time and amount agreed upon in the agreement and determined by the fund management. Meanwhile, the insurance company is obligated to cover or compensate the beneficiary for any losses, damages, costs incurred, lost profits, or legal liability in the event of an unforeseen event (Listyaningsih et al., 2022).

Based on interviews conducted by the author with the Manulife Medan life insurance company, it was explained that this provision complies with and fulfills the requirements for a valid agreement as stipulated in Article 1320 of the Civil Code. As part of a civil law agreement, the valid conditions of an agreement as stipulated in the Civil Code also apply to insurance agreements (Juliana, Personal Interview, 2025). The conditions of such an agreement are: (a) Agree those who bind themselves, (b) Able to make an agreement, (c) Regarding a particular matter, (e) A lawful cause

An insurance agreement contains an agreement between the two parties, each of whom is bound by the applicable contract. Each party has rights and obligations that must be carried out according to the agreed-upon provisions. Therefore, each party must fulfill its obligations first to obtain its rights. In this case, if a customer fails to pay the premium, causing the policy to become inactive (lapse), and then the claim is rejected by the insurance company, this is a consequence of the customer's own negligence. It is important for customers to understand the contents of the policy and fulfill their premium payment obligations on time so that insurance coverage remains valid and claims rights can be processed properly.

If a beneficiary files a claim after the filing deadline and the policy is in a lapsed state (non-payment of premiums), the beneficiary has violated the terms of the insurance policy agreement. Therefore, all resulting consequences, including the forfeiture of previously paid premiums, must be accepted by the beneficiary.

That based on Article 1338 paragraph (1) of the Civil Code it is clearly stated that every agreement made in accordance with legal provisions has binding force like a law for the parties who make it. The agreement can only be canceled if agreed by both parties or based on valid legal reasons. In addition, the agreement must be implemented in good faith. Thus, the agreed contract applies as a special rule (*lex specialis*) which overrides general provisions, and is legally binding on the parties who sign it (Mugiri & Nuryanti, 2022). If the policyholder is negligent or does not fulfill the obligations in the life insurance agreement, the insured party will not receive benefits or reimbursement from the insurance company in the event of death and the agreement will automatically be deemed void.

3.3. Procedure for Submitting Claims Outside the Term by Beneficiaries at Manulife Medan Insurance Company

The life insurance claims process is a series of steps or procedures that must be followed by heirs or beneficiaries to receive payment of the insurance benefit from the insurance company after the insured (policy owner) dies. The claims process is one of the main reasons people purchase life insurance, as they need coverage funds when the insured dies or suffers a loss. To fulfill their obligations to policyholders and heirs, insurance companies must ensure that payments are made promptly and accurately to the rightful recipients (Widia Angraini et al., 2023).

Based on the interview results, the procedure for filing a claim outside the timeframe is the same as for filing a claim in general. If the beneficiary is unaware of a claimable policy until the day it is discovered, they are advised to immediately visit the insurance company's office to confirm and inquire further regarding the possibility of filing a claim. In such situations, even if the claim submission has passed the specified time limit, the insurance company may still consider disbursing the claim under certain conditions. The beneficiary is required to write a statement explaining the reason for the delay in filing the claim, outlining the chronology of the policy discovery, and attaching a statement or other relevant supporting documents (Juliana, Personal Interview, 2025).

The procedure or flow of the life insurance claim process goes through several stages, namely: (a) The occurrence of an event in life insurance is the death of the insured (b) Upon reporting by the insured, the insured must immediately contact the insurance company to report the incident. This report can be submitted in person to the office, through an agent, a call center, or online. (c) Written statement: The insurance company requires the insured to submit a written report of the incident. This report should include the location of the incident, a chronology of events, and other important information. (d) Complete and fill out the life insurance claim form correctly. (e) Beneficiaries attach the required documents to support the claim process. (b) Claim survey and evaluation, insurance companies conduct direct checks or surveys of insured objects to assess the validity of claims. If the claim is deemed valid, the company will determine the amount of the loss. If the claim does not meet the requirements, it will be rejected because it is not included in the insurance coverage. (c) Notification of claim value, the insurance company notifies the beneficiary of the assessment results in the form of compensation value. (d) Claim payments will be made to beneficiaries via bank transfer after the documents are declared complete and processed within 14 working days at the latest. (Budiman et al., 2022)

After understanding the insurance claim submission procedure, the next step is to prepare the documents that must be attached in the insurance benefit claim submission process, including the following: Original insurance policy. Photocopies of the identity of the policy holder, insured and heir (if the three are different, all must be attached), Photocopy of identity and documents showing the relationship between the policy holder, insured, and beneficiary (family tree if the beneficiary is not husband/wife/child), Original death claim form, filled out completely and honestly, and signed by the beneficiary, Death certificate from the Village Head/Village Head legalized by the Sub-district Head/Death Certificate, Original payment receipt of the last premium, Policy holder savings book, Police report (original or legalized) if death occurs due to an accident or unnatural causes, Medical examination results or medical records (if any), Other additional documents that may be requested by the insurance company, If the beneficiary has not met the legal age requirements and his/her parents have died, then a guardianship determination letter issued by the District Court is required, If the policy holder appointed as beneficiary has died, a letter of heir determination from the District Court must be included.

Insurance claim documents submitted by the insured must undergo a process of inspection, analysis, and completeness verification. Once all documents are complete, the claims department will proceed with the process. In the claims submission procedure at PT. Asuransi Jiwa Manulife, the insured is required to follow the claim submission pro-

cedures without violating the company's provisions. If the insured is a disciplined participant and complies with applicable regulations, every claim submitted will be processed smoothly. Furthermore, it is important for the insured to understand each stage of the claims submission process to avoid errors during the process. (Bella Larasaty Yuandra & Jannah, 2023)

4. Conclusions

In Indonesia, there are no explicit regulations regarding the deadline for submitting life insurance claims. Each insurance company sets a specific deadline for submitting life insurance claims, as stated in the insurance policy. At Manulife Medan, the claim submission deadline is between 30 days and a maximum of one year from the occurrence of the insured event, as stated in the insurance policy terms.

However, if the beneficiary submits a claim beyond the specified time limit, the claim process will not be immediately rejected, but will be returned to the company for further review and consideration. Manulife Medan's life insurance policy in considering insurance claims in considering whether to reject or accept insurance claims on this issue is the policy status. If the policy is still active (still has cash value) even though it has passed the time limit, the claim can be disbursed, but if at the time of the claim submission the policy has lapsed, the claim will be rejected and the premium that has been paid previously is forfeited.

The procedure for filing a claim outside the timeframe is the same as for filing a claim in general. If the beneficiary is unaware of a claimable policy until they discover it, they are advised to visit the insurance company's office immediately to confirm and inquire further about the possibility of filing a claim. For further research, it is recommended to involve more than one life insurance company as the object of study, in order to obtain a more comprehensive picture of the policy for handling claims outside the general claim period in the life insurance industry in Indonesia. Flexibility in accepting claims outside the fixed period can be justified legally and ethically as long as it is based on the principles of fairness, good faith, and consumer protection, without neglecting the principle of *pacta sunt servanda*. The Manulife Medan case study shows that consideration of late claims accompanied by reasonable reasons, as long as the policy is still active, reflects a fair and proportional approach. This finding supports the need for the OJK to establish a minimum standard for claim submission periods that applies nationally, while allowing discretion under certain conditions. Such recommendations can be accommodated through technical regulations in OJK regulations to ensure consistency, legal certainty, and fair protection for beneficiaries across all insurance companies.

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