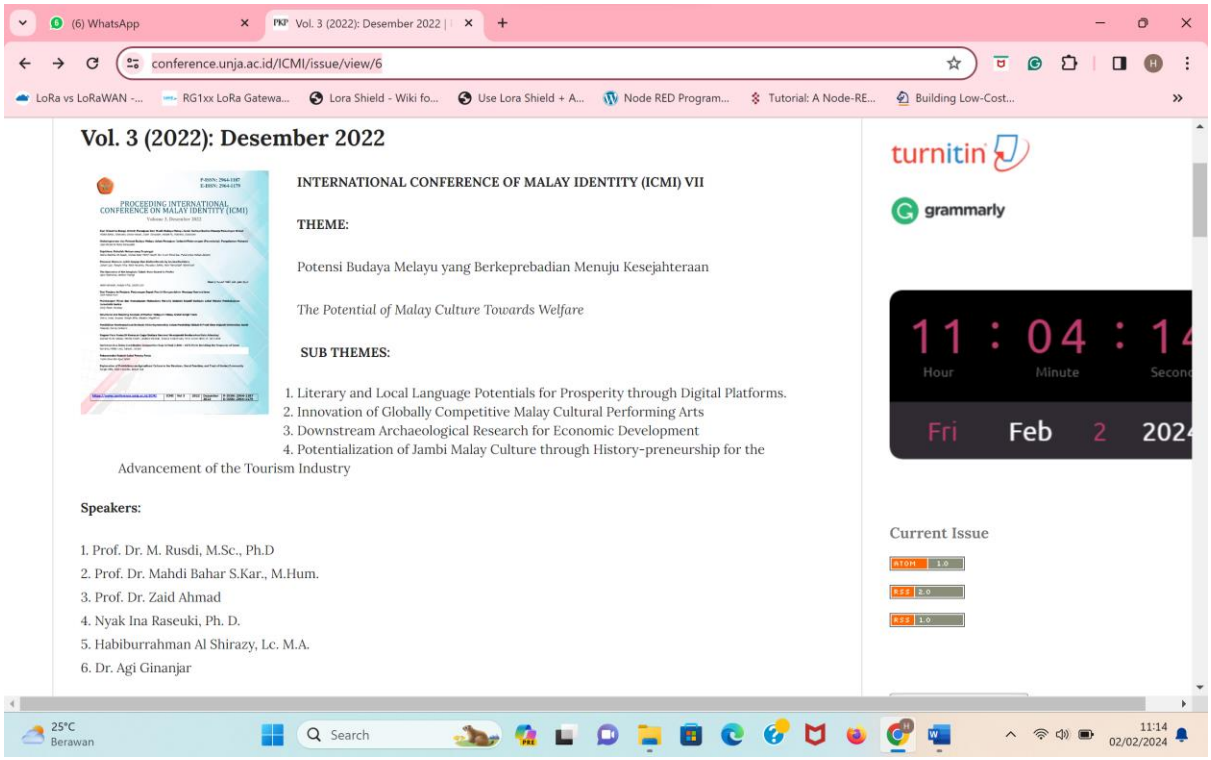
ARTIKEL 6

Refusal Of Health Insurance Claim That Experienced The Policy Waiting Period

SAMPUL PROSIDING

https://www.conference.unja.ac.id/ICMI/issue/view/6



Vol. 3 (2022): Desember 2022

INTERNATIONAL CONFERENCE OF MALAY IDENTITY (ICMI) VII

THEME:

Potensi Budaya Melayu yang Berkeprebadian Menuju Kesejahteraan

The Potential of Malay Culture Towards Welfare

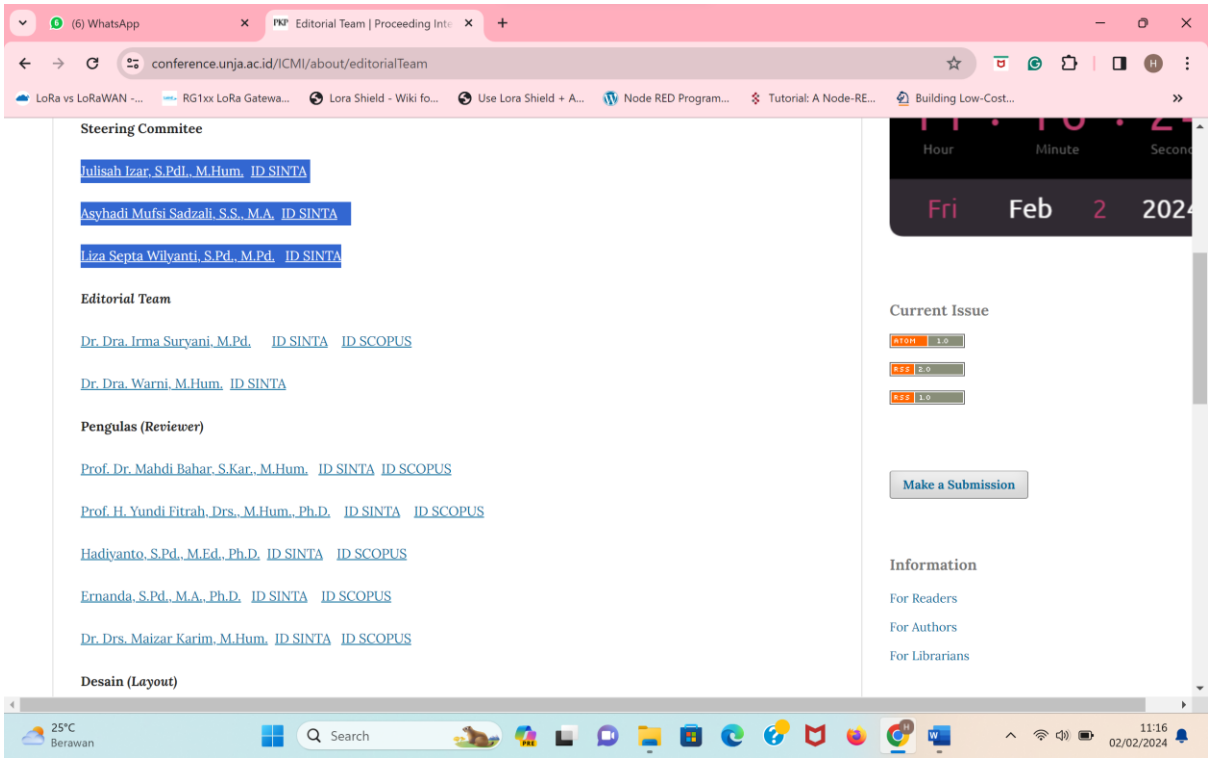
SUB THEMES:

1. Literary and Local Language Potentials for Prosperity through Digital Platforms.
2. Innovation of Globally Competitive Malay Cultural Performing Arts
3. Downstream Archaeological Research for Economic Development
4. Potentialization of Jambi Malay Culture through History-preneurship for the Advancement of the Tourism Industry

Speakers:

1. Prof. Dr. M. Rusdi, M.Sc., Ph.D
2. Prof. Dr. Mahdi Bahar S.Kar., M.Hum.
3. Prof. Dr. Zaid Ahmad
4. Nyak Ina Raseuki, Ph. D.
5. Habiburrahman Al Shirazy, Lc. M.A.
6. Dr. Agi Ginanjar

DEWAN REDAKSI



Steering Commitee

Julisah Izar, S.Pdl., M.Hum. ID SINTA

Asyhadi Mufsi Sadzali, S.S., M.A. ID SINTA

Liza Septa Wilyanti, S.Pd., M.Pd. ID SINTA

Editorial Team

Dr. Dra. Irma Suryani, M.Pd. ID SINTA ID SCOPUS

Dr. Dra. Warni, M.Hum. ID SINTA

Pengulas (*Reviewer*)

Prof. Dr. Mahdi Bahar, S.Kar., M.Hum. ID SINTA ID SCOPUS

Prof. H. Yundi Fitrah, Drs., M.Hum., Ph.D. ID SINTA ID SCOPUS

Hadiyanto, S.Pd., M.Ed., Ph.D. ID SINTA ID SCOPUS

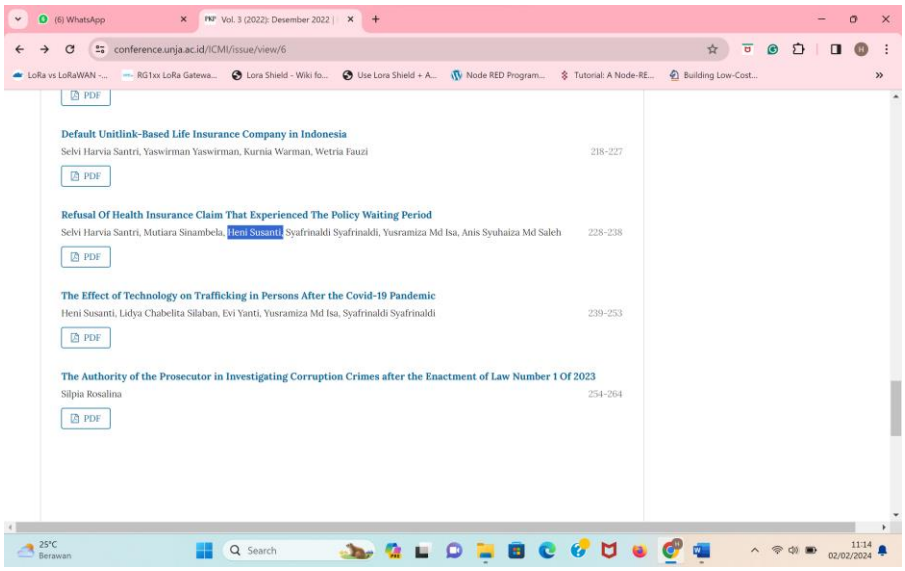
Ernanda, S.Pd., M.A., Ph.D. ID SINTA ID SCOPUS

Dr. Drs. Maizar Karim, M.Hum. ID SINTA ID SCOPUS

Desain (*Layout*)

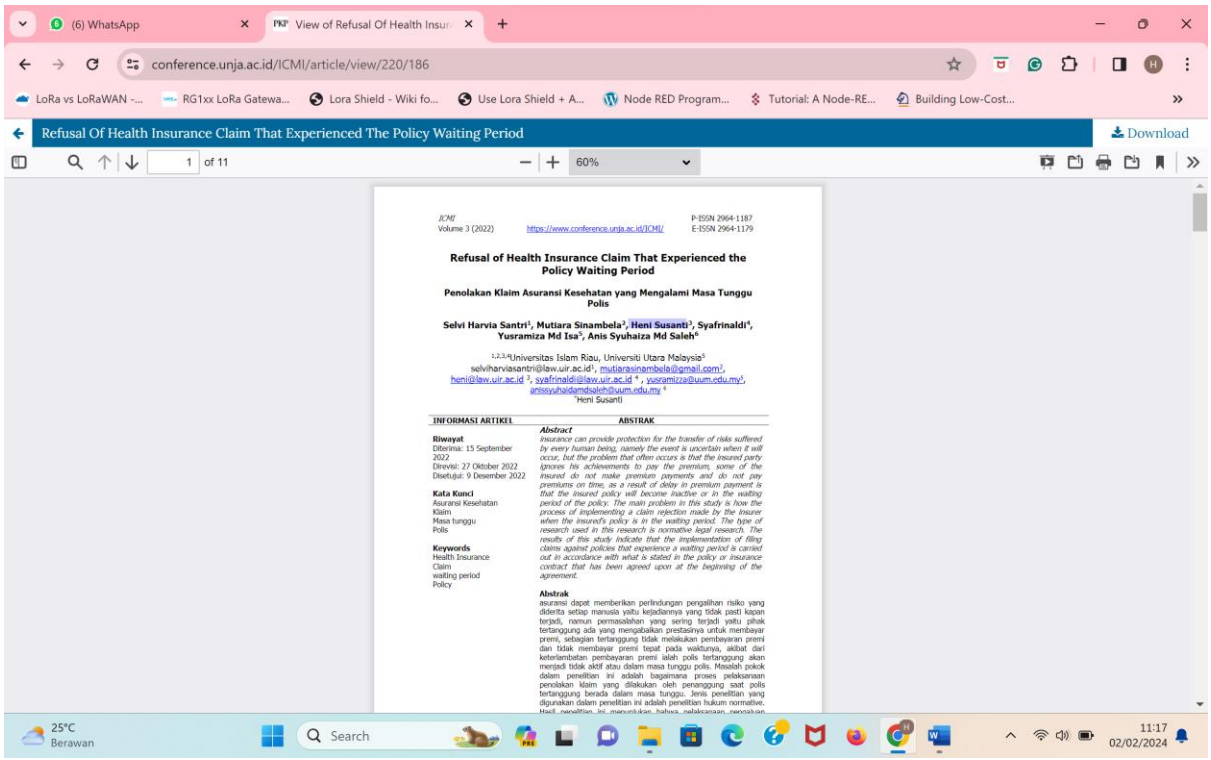
DAFTAR ISI

https://www.conference.unja.ac.id/ICMI/issue/view/6



FULL ARTIKEL

https://www.conference.unja.ac.id/ICMI/article/view/220/186



Refusal of Health Insurance Claim That Experienced the Policy Waiting Period

Penolakan Klaim Asuransi Kesehatan yang Mengalami Masa Tunggu Polis

Selvi Harvia Santri[1], Mutiara Sinambela[2], Heni Susanti[3], Syafrinaldi[4], Yusramiza Md Isa[5], Anis Syuhaiza Md Saleh[6]

[1,2,3,4]Universitas Islam Riau, Universiti Utara Malaysia[5]
selviharviasantri@law.uir.ac.id[1], mutiarasinambela@gmail.com[2], heni@law.uir.ac.id [3], syafrinaldi@law.uir.ac.id [4] , yusramizza@uum.edu.my[5], anissyuhaidamdsaleh@uum.edu.my [6]
[*]Heni Susanti

INFORMASI ARTIKEL

Riwayat
Diterima: 15 September 2022
Direvisi: 27 Oktober 2022
Disetujui: 9 Desember 2022

Kata Kunci
Asuransi Kesehatan
Klaim
Masa tunggu
Polis

Keywords
Health Insurance
Claim
waiting period
Policy

ABSTRAK

Abstract

insurance can provide protection for the transfer of risks suffered by every human being, namely the event is uncertain when it will occur, but the problem that often occurs is that the insured party ignores his achievements to pay the premium, some of the insured do not make premium payments and do not pay premiums on time, as a result of delay in premium payment is that the insured policy will become inactive or in the waiting period of the policy. The main problem in this study is how the process of implementing a claim rejection made by the insurer when the insured's policy is in the waiting period. The type of research used in this research is normative legal research. The results of this study indicate that the implementation of filing claims against policies that experience a waiting period is carried out in accordance with what is stated in the policy or insurance contract that has been agreed upon at the beginning of the agreement.

Abstrak

asuransi dapat memberikan perlindungan pengalihan risiko yang diderita setiap manusia yaitu kejadiannya yang tidak pasti kapan terjadi, namun permasalahan yang sering terjadi yaitu pihak tertanggung ada yang mengabaikan prestasinya untuk membayar premi, sebagian tertanggung tidak melakukan pembayaran premi dan tidak membayar premi tepat pada waktunya, akibat dari keterlambatan pembayaran premi ialah polis tertanggung akan menjadi tidak aktif atau dalam masa tunggu polis. Masalah pokok dalam penelitian ini adalah bagaimana proses pelaksanaan penolakan klaim yang dilakukan oleh penanggung saat polis tertanggung berada dalam masa tunggu. Jenis penelitian yang digunakan dalam penelitian ini adalah penelitian hukum normative. Hasil penelitian ini menunjukan bahwa pelaksanaan pengajuan klaim terhadap polis yang mengalami masa tunggu dilakukan

sesuai dengan apa yang tertera dalam polis atu kontrak asuransi yang telah di sepakati di awal perjanjian.

1. Introduction

Insurance or coverage arises from human needs. In carrying out the activities of daily activities, humans are always faced with unexpected events, which may generate profits, or vice versa. Humans expect a sense of security over their possessions, health and well-being. To reduce this risk, humans are looking for a way out so that it is not too heavy to bear the risks they suffer. Risk is the burden of loss resulting from an uncertain event. Insurance grows because there are more and more various risks faced in various aspects of life. One way to deal with this risk is insurance. This risk can be transferred to the loss insurance company in the form of paying a premium to the insurance company (guarantor) every month or year depending on the agreement contained in the insurance policy. It is this transitional benefit that the consumer (the insured) gets.

In Indonesia, insurance law is written in the Civil Code, KUHD (Book of Commercial Law), statutes, government regulations and ministerial decrees. These insurance laws and regulations are used as a basis of reference for the guidance and supervision of insurance businesses in Indonesia since the Dutch colonial period until now. Because the insurance business concerns the interests of the public at large, especially in relation to the funds collected by them which are quite large and sometimes last for quite a long time. So it is clear that regulations regarding insurance always need to be up to date and meet the development of the community's economy, especially the problem of refusal of claims that often occurs. The current insurance law is Law No. 40 of 2014 concerning Insurance Business

Several financial services companies operating in the insurance sector sell insurance policies as well as investments in the health sector. Insurers as a company always try to provide the best products and services for customers and prospective customers. which has the aim of helping the community in planning their finances and their families, by providing products to deal with financial risks in accordance with the chosen financial plan.

As a service provider, insurance companies try to reduce the uncertain consequences of an adverse situation, which cannot be predicted in advance so that the cost or financial consequences of the loss are certain or relative. Currently there are many business actors/insurance providers who have a tendency to set aside their consumer rights (partnership) without having to accept legal sanctions. This is due to the lack of awareness and knowledge of the consumer community so that it is not impossible to be used as land for business actors in transactions that do not have good faith in running a business, namely the principle of seeking maximum profit by making the best possible use of existing resources. Insurance insurers cannot develop properly and cannot provide benefits to the wider community if there are no customers

or consumers. Therefore, as an insurance provider business actor, it is very dependent on its consumers to be able to maintain its business continuity.

The growing public trust in insurance does not mean there is no disappointment from the public towards insurance companies. There are also many complaints from customers as insurers regarding the difficulty of filing insurance claims and claims rejection from insurance companies as insureds while customers have paid insurance premiums according to what was agreed. The element of compensation is the main reason customers use insurance. However, this element of compensation has not run smoothly according to the objectives of the insurance policy holder who is bound by the insurance agreement. Often customers experience difficulties in filing claims for compensation. Insurance companies often give various reasons as a basis for not paying compensation claims submitted by customers.

So many products are offered by various insurance companies, such as Health Insurance, Life Insurance, Education, Premium Free Protection, Investment Funds, Sharia Products, Employee Protection, etc. However, of the many insurance products, it is undeniable that the process that must be passed in claiming insurance is difficult. The problem that often occurs is the difficulty of getting compensation payments when the event occurs. While the main purpose of the customer or consumer to bind themselves to the insurance agreement is to receive compensation if an event occurs which is suspected to befall the object of insurance. Insurance customers, especially health insurance, are victims of the insurance company's obscurity in accepting payment of claims for unexpected events. Therefore, a firm legal action is needed so that health insurance customers get their rights, namely payment of claims in accordance with the contents of the policy.

There must be a strong correlation between the legal basis that supports society and the reality on the ground. So that the community as users of insurance services can move forward to uphold their rights and obligations in accordance with applicable law in Indonesia. The public as users of insurance services in this case are defined as consumers in insurance companies. Consumers in carrying out their activities in insurance have the right to obtain legal protection from anything that is detrimental to the consumer. In Indonesia, laws and regulations that regulate consumer rights have been regulated, namely Law Number 8 of 1999 concerning Consumer Protection, but in reality consumers as service users often do not get their rights. The situation in the field is often inversely proportional to the expected situation. can take place effectively with the existence of laws that function to regulate the interests of society. This can be seen from insurance customers who still do not feel the benefits of the services they should receive. Its implementation is often seen in the field, such as the failure of insurance claims and the insurer's neglect in responding to filing insurance claims.

In the health insurance policy, it is stated that there are conditions for making a claim. However, in practice it often happens that the insured in

submitting a claim to the insurance is not always accepted because there are things that cause the application to be rejected, the problem that often occurs is that the insured party ignores his achievements to pay the premium, some of the insured do not make premium payments and not paying premiums on time, the result of late premium payments is that the insured's policy will become inactive or in the waiting period for the policy.

2. Method

The type of research in this study uses normative legal research by using secondary data as the main data, namely by researching library materials. Meanwhile, the nature of the research used is descriptive by describing facts, symptoms or legal phenomena, then linked to the normative level. three materials namely primary legal materials, secondary legal materials and tertiary legal materials. Primary legal materials are used as an analytical tool for the object of study raised from laws and regulations that are relevant to the topic of reinsurance. Secondary Law materials are taken from books and previous research results. While tertiary legal materials use legal dictionaries and encyclopedias. For drawing conclusions using legal materials and if necessary also non-legal as a support. Data analysis was carried out from library research, namely qualitative analysis. The research results are presented in a descriptive way, done deductively.

3. Resul and Discussion

A. Risk Theory in Health Insurance

Every daily activity and in silence humans have the potential to face risks (risks). In English known as the word "risk". In the online Big Indonesian Dictionary (KBBI), the word "risk" means an unpleasant (harmful, harmful) result of an action or action. Risk in general is the hazard, consequences/consequences that can occur as a result of an ongoing process/future event. Wise people say that what is constant or certain to happen is change. The outcome of the incident can be a success as expected or a failure that is avoided. Uncertainty about success or failure results in potential losses for interested parties. Uncertainty and risk are something that cannot be ignored, but must be considered carefully, if an individual or company is to be successful. The word risk is widely used in various meanings and is commonly used in everyday conversation by most people. Someone stated that there are risks that must be borne when doing certain jobs. Understanding the concept of risk broadly is an essential basis for understanding risk management concepts and techniques.

Risk is always associated with the possibility of unexpected/unwanted adverse events occurring. So, it is an uncertainty or the possibility of something happening, which if it happens will result in a loss. Thus, the risk has the following characteristics:

1. an uncertainty over the occurrence of an event,
2. an uncertainty that if it occurs will cause a loss. The manifestation of this risk can vary, including:

    a. the form of loss of property/wealth or income, for example caused by fire, theft, unemployment and so on.
    b. the form of a person's suffering, for example illness / disability due to an accident.
    c. the form of legal responsibility, for example risks from actions or events that harm other people.
    d. the form of losses due to changes in market conditions, for example due to price changes, changes in consumer tastes and so on.

Whether or not the risk can be transferred to another party, then the risk can be distinguished into:

a. Risks that can be transferred to other parties, by insuring an object that will be exposed to risk to the insurance company, by paying an insurance premium, so that all losses become borne (transferred) by the insurance company.
b. Risks that cannot be transferred to other parties (non-insurable); generally includes all types of speculative risk.

B. Implementation of Rejection of Health Insurance Claims Against the Waiting Period of the Insurance Policy

Insurance and coverage is an agreement between 2 or more parties, where the insurer binds himself to the insured, through receiving insurance premiums to compensate the insured for loss, damage, or loss of desired profit or legal responsibility to a 3rd party that the insured may suffer , which arises through an event that is not fixed or to provide a payment based on the life or death of the insured person.

A number of the main contexts regarding insurance are an agreement that is obliged to fulfill Article 1320 of the Civil Code: The agreement has adhesive properties meaning that the contents of the agreement have been determined through the insurance company. However, this context is inconsistent with the provisions of Law Number 8 of 1999 dated 20 April 1999 regarding Consumer Protection: Two parties were found, namely the insured and the insurer, but it can also be agreed that the insured is not the same party who can get dependents; The existence of the premium is proof that the insured agrees to enter into an insurance agreement; The existence of an insurance agreement causes 2 parties to be bound to carry out their obligations.

Every life insurance company has a Standard Operating Procedure (SOP) in the process of registering a potential insured until they become the insured of the life insurance company. Insurance companies have insurance agents who act as intermediaries as well as marketing insurance services for and on behalf of the insurer. Agents must comply with the procedures available in the

company's Standard Operating Procedures (SOP). The procedure for applying for life insurance, first of all the insurance agents offer their products to the prospective insured, the agents explain the description of the various types of products that life insurance companies have which explains the various benefits, functions, uses and other things that make the prospective insured interested in covering life insurance offered it. In addition, the agent also explains the list which contains the premium rate and the amount of insurance money from various insurance products, which the prospective insured himself determines his choice.

Furthermore, if the prospective insured has made a choice of insurance product, the insurance agents make a policy summary proposal containing the request for life insurance from the prospective insured and the benefits to be received as well as the premium payment period and the amount of the premium to be paid by the prospective insured. The insurance agent submits to the prospective insured for approval and signature. If the prospective insured has agreed to the policy summary proposal made by the agent then the agent will provide a Life Insurance Request Letter (SPAJ).

The Life Insurance Request Letter (SPAJ) and other statements filled out by the prospective insured form the basis of the insurance agreement between the insurer and the policyholder. The insurance agent as the insurer will examine and examine the Life Insurance Request Letter (SPAJ) and other certificates whether the insured is eligible to be covered or not, if necessary a medical check-up can be carried out to check the medical history of the prospective insured.

The life insurance agent will submit the SPAJ and the certificates to the underwriting department, which will then select whether or not the insured is approved. If approved, then the underwriter sends the SPAJ and the certificates and the insured is required to pay the policy money and the first premium payment to the head office.

The underwriter himself is a functionary of the underwriting technique, whose main task is to analyze the risks offered, determine terms and conditions and determine the amount of premium that reflects the level of risk being borne. The source of information for carrying out risk selection or underwriting comes from SPAJ and other documents, the underwriter as the party responsible for the life insurance company will conduct an examination of the prospective insured.

In regulating insurance as an agreement, the Civil Code contains provisions regarding the following matters:

a. The validity of an agreement
   1) Agree those who bind themselves
   2) Talk to make an alliance
   3) A certain thing, namely the existence of a party who promises to provide compensation and the insured party who is obliged to pay a premium.
   4) There is a valid reason.

5) In a legal form (not regulated under the Civil Code but already in the Insurance Business Law).

b. The legal basis of an agreement
   1) Fundamentals of freedom of contract
   2) The principle of consensualism
   3) The principle of pacta sunt servanda
   4) The principle of good faith
   5) Personality principle.

The legal basis for an insurance agreement is regulated in Article 1774 of the Civil Code which reads as follows: "A chancy agreement is an act whose outcome, in terms of profit and loss, both for all parties, and for some parties, depends on an uncertain event. Such is the insurance agreement, life annuity interest; gambling and betting. The first agreement is regulated in the Commercial Code. According to the Article above, insurance agreements are classified as chancy agreements. The classification of an insurance agreement as a chance agreement is not in accordance with the nature of the actual insurance agreement, namely as follows:

a. Insurance agreement subject:
   The main issue agreed upon is the insurer's promise to provide compensation and the premium payment from the insured.
b. The birth of the insurance agreement:
   Starting from the agreement on the outcome of the bargain between the insurer and the insured and the date the coverage begins.

Provisions Regarding Premiums (Article 246 of the Criminal Code) From this article, it is concluded that the premium is the obligation of the insured to pay it to the insurer as a counter-performance of the compensation that the insurer will give him. Likewise in Article 256, point 7 of the Criminal Code, the policy must include the relevant insurance premium. In this regard, the premium is an essential requirement in the insurance agreement.

The obligation of the insurer which is the right of the insured to demand it only arises when the agreed event has occurred. So that the insurance company will pay compensation to the insured or the policyholder if an event has occurred. This is stated in the general terms of the policy Article 256 paragraph 4 of the Commercial Law Code which reads "The amount of money to be insured for this". This payment is an obligation for the insurer to bear the risk of the insured in accordance with the agreement stated in the insurance policy agreement. In the case of the insured or policyholder who wants to submit a claim application if an event has occurred.

An insurance claim is a claim from the insured in connection with a contractual agreement between the insurer and the insured in which each party binds itself to guarantee payment of compensation by the insurer if the payment of insurance premiums has been made by the insured party when a disaster occurs to the insured party.

Basically, the requirements for submitting an application for a life insurance claim are also regulated in the life insurance policy which is contained in the special provisions for additional insurance in Article 7 (Terms of Application/Claim for payment of Insurance Benefits), namely as follows:

1) Submission of requests/claims for payment of insurance benefits must be accompanied by the documents listed below:
   a) Claim forms that have been filled in correctly and completely (original);
   b) Doctor's Certificate for Claims in connection with additional insurance;
   c) Medical records/medical resume of the insured if requested by the insurance company;
   d) Copy of all laboratory and radiological examination results;
   e) Receipt (original) or receipt that has been legalized in connection with hospitalization, intensive care and/or surgery along with the details;
   f) Other documents deemed necessary by the insurance company. The above documents must be made in or translated into Indonesian or Bahasa. English. If a translation is made into Indonesian or English, the translation must be carried out by a translator under oath. (Article 7 paragraph 1)
2) Notification of hospitalization (whether accompanied or not accompanied by intensive care and or surgery) experienced by the insured must be notified to the insurance company within 60 (sixty) days from the date of hospitalization. (Article 7 paragraph 2)
3) Submission of requests/claims for payment of insurance benefits along with the documents as stated, must be submitted to the insurance company within 3 (three months) after the notification regarding hospitalization as referred to above. (Article 7 paragraph 3)
4) All costs incurred in connection with the application/claim or payment of insurance benefits must be borne and must be paid by the insured. (Article 7 paragraph 4)
5) Submission of requests/claims for payment of insurance benefits is valid if the conditions referred to have been met in full and the insurance company has the right to apply for Claims for the benefits of insurance payments submitted and/or refuse to pay for insurance benefits if the conditions are not met, (Article 7 paragraph 5).

If the insured has completed the requirements or complete claim data, the insurance company will process the claim submitted by the insured in accordance with a predetermined time limit. However, in insurance transactions the term "No Premium No Insurance" applies, so if the premium has not been paid in full, the insurer is not bound in the transaction to pay compensation if a risk arises. This premium is usually set as a percentage of the amount insured.

The insurance company also has the possibility to refuse the application demanded by the insured, but there are various reasons why the company rejects the claim from the insured.

Failure in filing claims is often experienced by many insurance customers. Claim failure is one of the reasons why people do not want to be insured. However, not all claims submitted by customers are approved by the company. There are five most common reasons why life insurance or health insurance claims are rejected. First, it could be because the filing period has expired, because each insurance claim has a certain deadline for the customer to submit his application. Second, it is dishonest to reveal a history of illness when buying an insurance policy, alias having certain health conditions that pre-existed before the application of the related protection benefits (pre-existing conditions). Third, make sure when submitting a claim, you have completed all the documents requested by the insurance company, because incomplete documents will cause delayed claim payments. Fourth, claims are included in the exclusion, alias risks that occur are not included in the customer's policy agreement. While the fifth factor that causes claims to be rejected is because the insurance policy is inactive (lapse) due to non-payment of premiums on policies that are past due.

This is the main topic of this research, if the insurance premium is not paid at the scheduled time, the insurance company will not operate. If an event occurs that causes a loss, the insurer is not obliged to pay the insured's claim. In this case, the insured is considered to have not fulfilled the obligation to pay insurance premiums on time, so that the insurance claim submitted is rejected by the insurance company. On the other hand, the reason for not paying insurance premiums in this question is not because of the insured's desire, but because the insured's condition is less likely to cause delays in paying insurance premiums.

Furthermore, for the claim rejection procedure, if there are requirements that are not met by the insured, the claim will be rejected. Refusal of an insurance claim does not rule out the possibility that an error came from the company, so if the insured feels that the requirements in submitting an insurance claim have been met but are still rejected, the insured can submit a review to the insurance.

4. Conclussion

The process of rejecting claims to insurance companies often occurs which can be caused by various things, one of which is due to the waiting period. Refusal of a claim due to a waiting period is not always due to an error on the part of the customer but also because it can occur due to the negligence of the insurer. The legal consequences if a life insurance claim is rejected on the grounds of a waiting period can cause losses to the community because they cannot exercise their rights to enjoy the economic benefits of the insurance policies they have, besides that the legal consequences are also the loss of

public trust in insurance institutions because it is not uncommon for phenomena This creates a negative stigma in the community who think that when dealing with or disputing with an insurance company, the customer will never win and is always in a weakened position, when in fact the rejection of an insurance claim can occur due to the negligence of the insurance owner or because at the time of filing a claim, the requirements and the procedures that apply are contrary to the policies of the insurance company as the provider of financing facilities.

Reference

Ana Rokhmatussa dyah dan Suratman. (2010). *Hukum Investasi dan Pasar Modal*, Sinar Grafika, Jakarta

Alfina Izza, skripsi *Pertanggung jawaban Pemegang Kuasa Pendaftaran Jaminan Fidusia Kepada Penerima Fidusia Akibat Keterlambatan Pendaftaran Jaminan Fidusia* https://dspace.uii.ac.id/bitstream/handle

Djoko Prakoso. (2004). *Hukum Asuransi Indonesia*. Rineka Cipta, Jakarta

Dinda berta ivana, arif suryono, *Pelaksanaan penyelesaian klaim asuransi unit link bancassurance* di PT. Astra aviva life, Jurnal Hukum Unsrat

Eri bukhar. (2015). *Peranan Asuransi dalam Investasi,* Jurnal kajian Ilmiah, Volume 15 No.2

Hans Kelsen. (2008). *Pure Theory of Law*, terjemahan oleh Raisul Muttaqien*, Teori Hukum Murni, Dasar-Dasar Ilmu Hukum Normatif*, Cetakan Keenam, Penerbit Nusa Media, Bandung.

Ketut Sendra. (2004). *Konsep dan Penerapan Asuransi JiwaUnit-Link: Proteksi Sekaligus nvestasi*, Jakarta, Penerbit PPM.

Rio.2017, *Kenapa Premi Asuransi Jiwa Unit Link Anda, Tidak Kembali Semua*, https://duwitmu.com/asuransi/kenapa-premi, diakses tanggal 6 Maret 2021 Pukul 15.00 WIB.

S. Saravanakumar and A. Mahadevan, "*Multi Dimensions of Unit Linked Insurance Plan Among Various Investament Avues", International Journal of*

Enterprise and Innovation Management Studies (IJEIMS) Vol 1 No3.

Soesno Djojosoedarso. (2003). *Prinsip-Prinsip Manajemen Resiko Dan Asuransi*, Salemba Empat, Jakarta.

Soejono Soekanto. (1982). *Pengantar Penelitian Hukum,* UI Press, Jakarta.

Sri Rejeki Hartono. (1992). *Hukum Asuransi Dan Perusahaan Asuransi*, Sinar Grafika, Jakarta.

Selvi Harvia Santri. (2020). *Application of proxima cause principle in insurance of loss according to book of trade law and law no 40 of 2014*, Jurnal international bereputasi, Scitepress, vol 1 lihat : http://https://www.scitepress.org/Public

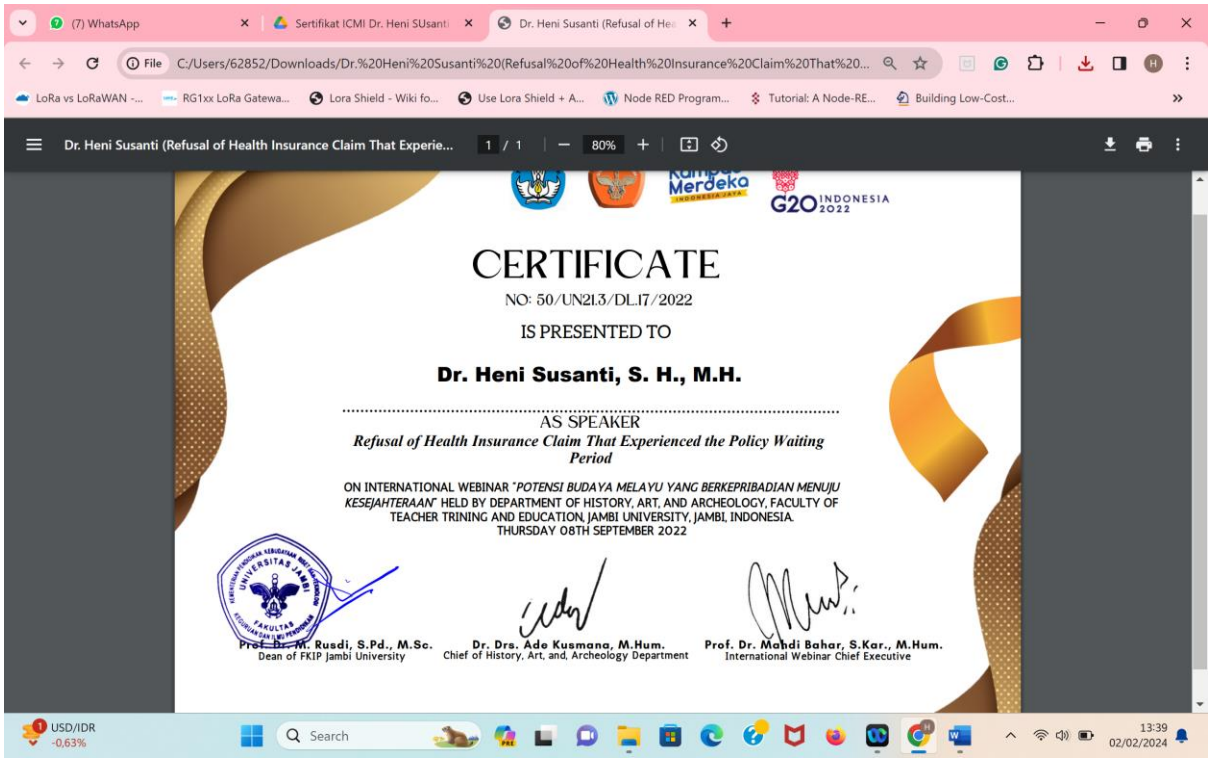
Selvi Harvia Santri. (2019). *Application of Insurance Principles According to the Book of Trade Law and Law Number 40 of ,* Jurnal Internasional Ter Indeks Scopus Volume 10, Issue 2, 2019. Bisa lihat link: https://www.ijicc.net/index.php/volume-10-2019/136-vol-10-iss-2. Diakses 16 November 2020 Pukul 23.00 WIB

Selvi Harvia Santri. (2017). *Prinsip Utmost Good Faith Dalam Perjanjian Asuransi Kerugian*, Jurnal Uir Law Riview, Vol 1 Nomor 1

Selvi Harvia Santri. (2019). *Penerapan prinsip indemnitas pada asuransi kendaraan bermotor,* Jurnal Uir Law Riview, Vol 3 Nomor 1

Selvi Harvia Santri. (2018). *Pelaksanaan Prinsip Subrogasi Asuransi KendaraanBermotor Menurut Kita Undang-undang Hukum Dagang*, Jurnal Uir Law Riview, Vol 2

SERTIFIKAT


(7) WhatsApp
Sertifikat ICMI Dr. Heni SUsanti
Dr. Heni Susanti (Refusal of Hea
File C:/Users/62852/Downloads/Dr.%20Heni%20Susanti%20(Refusal%20of%20Health%20Insurance%20Claim%20That%20...
LoRa vs LoRaWAN -...
RG1xx LoRa Gatewa...
Lora Shield - Wiki fo...
Use Lora Shield + A...
Node RED Program...
Tutorial: A Node-RE...
Building Low-Cost...
Dr. Heni Susanti (Refusal of Health Insurance Claim That Experie...
1 / 1
80%
Kampus Merdeka
INDONESIA JAYA
G20 INDONESIA 2022
CERTIFICATE
NO: 50/UN21.3/DL.17/2022
IS PRESENTED TO
Dr. Heni Susanti, S. H., M.H.
AS SPEAKER
Refusal of Health Insurance Claim That Experienced the Policy Waiting Period
ON INTERNATIONAL WEBINAR "POTENSI BUDAYA MELAYU YANG BERKEPRIBADIAN MENUJU KESEJAHTERAAN" HELD BY DEPARTMENT OF HISTORY, ART, AND ARCHEOLOGY, FACULTY OF TEACHER TRINING AND EDUCATION, JAMBI UNIVERSITY, JAMBI, INDONESIA.
THURSDAY 08TH SEPTEMBER 2022
Prof. Dr. M. Rusdi, S.Pd., M.Sc.
Dean of FKIP Jambi University
Dr. Drs. Ade Kusmana, M.Hum.
Chief of History, Art, and, Archeology Department
Prof. Dr. Mahdi Bahar, S.Kar., M.Hum.
International Webinar Chief Executive
USD/IDR
-0,63%
Search
13:39
02/02/2024