Determinants of Insurance Claim Denials and Their Impact on Customer Trust: An Empirical Qualitative Study on Life and Health Insurance in Indonesia

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ABSTRACT

This study investigates the primary determinants of insurance claim rejections, evaluates the compliance of claim documentation with contractual policy requirements, and analyzes the post-rejection follow-up mechanisms and their resulting impact on customer trust. Utilizing a descriptive qualitative research methodology within a field study design, empirical data were gathered from PT Insurance Sequis Life (Medan Cemara Branch), Indonesia, spanning the observation period from 2023 to 2025. Data collection involved in-depth interviews with key agency personnel, administrative staff, and policyholders with rejected claims, complemented by direct observations and secondary financial disclosures. Empirical analysis reveals that annual claim rejection rates consistently ranged between 12.6% and 15.8% (24 rejections in
2023, 21 in 2024, and 25 in 2025). The principal drivers of claim repudiation include administrative non-compliance (incomplete application forms, missing policy booklets, illegible identification, and uncertified medical certificates), substantial data discrepancies between medical records and policy declarations, non-disclosure of pre-existing conditions (violating the principle of utmost good faith), policy lapse, and submission beyond mandatory reporting deadlines. Furthermore, claim rejections trigger significant

negative emotional reactions among policyholders, leading to diminished corporate reputation and eroded trust. The study highlights critical agency problems where sales intermediaries fail to

comprehensively explain policy provisions during onboarding. Recommendations emphasize strengthening digital document pre-screening, enhancing agent education roles, and improving multi-channel policyholder communications.

1. INTRODUCTION

The life and health insurance industry serves as a fundamental pillar of modern financial stability, providing dynamic risk transfer mechanisms that mitigate the catastrophic financial consequences of unpredictable life events, such as illness, disability, and premature death (Darmawi, 2016; Mohammad Hifni, 2024). From an economic standpoint, insurance reinstates an insured individual or entity to their pre-loss financial position through the collective pooling of risk and premium contributions (Ronaldo, 2024). Consequently, the claim settlement process represents the core operational realization of the insurance contract, serving as the definitive moment where customer expectations intersect with corporate contractual performance (Soehaiya, 2022).

Despite the critical importance of prompt claim execution, claim rejections remain a prevalent and contentious phenomenon within the global and Indonesian insurance sectors (Rehulina et al., 2023). When an insurance claim is repudiated, policyholders face severe financial exposure, emotional distress, and a profound breakdown in trust towards financial institutions (Nasution & Atika, 2023). Empirical preliminary observations at PT Insurance Sequis Life (Medan Cemara Branch), a major life insurance branch in North Sumatra, indicate that a notable percentage of customer claims are systematically rejected annually. Annual data from 2023 to 2025 reveals consistent claim rejection rates ranging from 12.6% to 15.8%. Specifically, in 2023, out of 152 claims submitted, 24 were rejected (15.8%); in 2024, out of 167 claims, 21 were rejected (12.6%); and in 2025, out of 180 claims, 25 were rejected (13.9%).

Previous empirical literature highlights that claim rejections originate from multifaceted structural and behavioral factors. Administrative non-compliance, incomplete documentation, policy lapse, delay in notification, and non-disclosure of material information represent common drivers of claim disputes (Ariski & Daulay, 2024; Febrianti & Batubara, 2024; Suhaila Zulkifli et al., 2020). However, most prior studies have overwhelmingly utilized quantitative paradigms that fail to capture the nuanced, subjective perspectives of policyholders, frontline sales intermediaries (agents), and operational administrative personnel. Moreover, the dynamic interactions between agency conflicts, asymmetric information during pre-contractual marketing, and post-rejection corporate follow-up mechanisms remain insufficiently explored in life and health insurance contexts.

To address these critical knowledge gaps, this study undertakes a comprehensive qualitative investigation into the root causes of claim rejections at PT Insurance Sequis Life (Medan Cemara Branch). The primary objectives of this research are threefold: (1) to identify and analyze the fundamental technical, administrative, and substantive determinants of customer claim

rejections; (2) to evaluate the exact degree of document compliance against standardized corporate policy guidelines; and (3) to examine the post-rejection follow-up procedures executed by the branch and assess their direct consequences on customer trust and corporate reputation. By integrating theoretical frameworks of Agency Theory and Risk Management, this study provides actionable strategic insights for insurance practitioners, regulators, and academic researchers.

2. RESEARCH METHOD

2.1 Research Design and Study Site

This study adopts a descriptive qualitative research approach utilizing a single-case empirical field study design. Qualitative inquiry was chosen to deeply explore the social dynamics, operational procedures, and subjective experiences surrounding claim rejections. The research was conducted at PT Insurance Sequis Life (Medan Cemara Branch), located at Komplek Cemara Ruko Golden Gate No. 18G & 18H, Sampali, Percut Sei Tuan, Deli Serdang Regency, North Sumatra, Indonesia. Data collection was performed from November 2025 to February 2026, capturing corporate claim performance across the 2023–2025 operational period.

2.2 Informant Selection and Data Sources

Informants were selected using purposive sampling, targeting individuals with direct operational involvement, technical expertise, or personal experience with claim rejections. The primary informants included: (1) William Halim (Senior Agency Personnel); (2) Ricky Tanady (Mid-level Agency Personnel); (3) Cyndy Ariesty Manurung (Branch Administrative / Operational Staff); and (4) Andra Suwanto (Policyholder with a rejected claim). Both primary data (in-depth semi-structured interviews and field observations) and secondary data (branch claim registers, formal policy guidelines, and corporate audited financial disclosures from Sequis Life corporate website) were collected.

2.3 Data Analysis and Methodological Rigor

Data analysis was performed following the interactive qualitative analysis framework of Miles and Huberman (2014), comprising three concurrent activity streams: (1) Data Reduction, involving filtering, categorizing, and coding interview transcripts and documentary evidence; (2) Data Display, organizing structured narrative text and thematic comparative tables; and (3) Conclusion Drawing and Verification. Methodological rigor and trustworthiness were ensured through source triangulation (comparing responses across agents, administrative staff, and policyholders) and data type triangulation (cross-verifying qualitative testimonies with quantitative claim records).

3. DISCUSSION

3.1 Quantitative Claim Trends (2023–2025)

Empirical operational data collected from PT Insurance Sequis Life Cabang Medan Cemara reveals a consistent annual increase in total claim submissions alongside stable rejection percentages, as summarized in Table 1.

Operational Year	Total Claims Entered	Claims Approved	Claims Rejected	Rejection Rate (%)
2023	152	128	24	15.8%
2024	167	146	21	12.6%
2025	180	155	25	13.9%

Table 1: Claim Submission and Processing Performance at Sequis Life Medan Cemara (2023–2025). Source: Empirical Field Data (2026).

The rejection rate is calculated mathematically using the standard ratio formula: Rejection Rate = (Claims Rejected / Total Claims Submitted) x 100%. In 2023, the rejection rate stood at 15.8% (24/152). In 2024, increased administrative compliance and enhanced agent screening brought the rate down to 12.6% (21/167). In 2025, claim entries expanded to 180 cases, resulting in 25 rejections (13.9%). The stability of rejection rates within the 12.6%–15.8% corridor highlights the corporate enforcement of standardized risk management controls.

3.2 Triangulation of Qualitative Findings

Source triangulation reveals distinct perspective alignments and cognitive gaps across the three informant groups regarding claim documentation, rejection causes, and post-rejection follow-up procedures, as detailed in Table 2.

Thematic Focus	Agency Perspective (Agents)	Administrative Staff Perspective	Policyholder Perspective
Mandatory Claim Documentation	Original claim form, legal identity copy, original policy or certified copy, original medical receipts (health), certified death certificate (life).	Standardized forms, official identification, physical policy booklet, physician statement filled completely with clear diagnostic codes.	Understood basic forms and ID requirements; expressed difficulty acquiring specialized physician statements and medical coding.

Primary Rejection Determinants	Incomplete documents, non-disclosure of pre-existing health history, policy lapse, exceeding late filing window (90 days limit).	Uncertified doctor forms, missing policy booklet, data discrepancies between hospital records and application declarations, dishonesty.	Felt rejection was sudden; attributed issues to minor administrative missing items or unclear policy exclusion instructions from agents.
Policyholder Emotional Reaction	Extreme disappointment, anger, hostility towards agents, accusation of misrepresentation during initial sales.	Disappointment, erosion of trust, hesitation to renew other policies, formal complaints to branch management.	Deep frustration, feeling mislead by initial agent promises, severe loss of trust in insurance institution.
Post-Rejection Follow-Up Procedure	Re-explain rejection letter, notify missing items, grant 14-day grace window for document resubmission.	Receive formal rejection notice from Head Office, log decision into system, issue explanation letter to agent for client delivery.	Contacted by agent after rejection, given opportunity to supply missing doctor notes, but process felt complex.

Table 2: Triangulation Matrix of Qualitative Findings across Informant Categories. Source: Primary Research Data (2026).

3.3 Discussion of Core Findings

1. Substantive Determinants of Claim Rejection: The empirical analysis demonstrates that claim repudiations at PT Insurance Sequis Life Medan Cemara stem from both administrative and ethical non-compliance. Non-disclosure of pre-existing medical conditions (pre-existing conditions) represents a severe violation of the Utmost Good Faith principle. In multiple instances, policyholders failed to disclose prior medical diagnoses during policy underwriting. When medical claims were submitted, hospital verification records revealed prior treatments, forcing the Head Office underwriting team to issue formal rejection decisions. Furthermore, policy lapses due to premium default beyond grace periods directly invalidated coverage.

2. Administrative Compliance Gaps and Policyholder Literacy: A critical finding is that policyholders frequently display low insurance literacy regarding contractual documentation rules. Common omissions include incomplete Attending Physician Statements (APS), illegible identification cards, failure to attach original policy booklets, and missing legal signatures. While

Sequis Life enforces a 90-day notification window (with a target processing timeline within 60 days), delays in obtaining hospital records frequently cause submissions to exceed mandatory operational deadlines.

3. Agency Conflict and Pre-Contractual Misrepresentation: The findings heavily validate Agency Theory predictions (Satria, 2018). Agents, in their eagerness to close policy sales, often focus exclusively on policy benefits while skimming over exclusions, waiting periods, and strict document requirements. This asymmetrical communication creates realistic client expectations that are shattered upon claim evaluation. When rejections occur, policyholders direct their hostility toward agents, destroying interpersonal trust and damaging corporate brand equity.

4. Corporate Financial Solvency Context: Secondary financial analysis of Sequis Life corporate disclosures confirms strong financial solvency, with Risk-Based Capital (RBC) ratios exceeding 520%—far above the statutory requirement of 120% set by the Financial Services Authority (OJK). Total claim and benefit payments exceeded IDR 2.1 trillion nationwide. This financial strength underscores that claim rejections at the branch level are not driven by corporate liquidity constraints, but strictly by contractual risk control and compliance protocols.

4. CONCLUSION

This study concludes that insurance claim rejections at PT Insurance Sequis Life (Medan Cemara Branch) are driven by a combination of administrative non-compliance, material non-disclosure of pre-existing health conditions, policy lapse, and late submission. While the branch maintains a robust claim approval rate exceeding 84%, the annual rejection rate of 12.6%–15.8% inflicts considerable damage on customer trust and retention. The principal root cause of policyholder dissatisfaction lies in information asymmetry created during initial product marketing, where sales agents fail to thoroughly educate policyholders regarding policy conditions, exclusions, and mandatory documentation.

REFERENCES

AAJI. (2018). Hidup Cerdas dengan Asuransi Jiwa [Smart Living with Life Insurance]. Indonesian Life Insurance Association. https://www.aaji.or.id

Anshori, M. I. (2023). Manajemen Kerja Agen Asuransi [Performance Management of Insurance Agents]. Empatdua Media.

Ariski, M., & Daulay, A. N. (2024). Analisis faktor-faktor penyebab terjadinya penolakan suatu klaim nasabah asuransi (Studi kasus pada Perusahaan Askrindo Syariah). Journal of Education Transportation and Business, 1(2), 605–611. https://doi.org/10.57235/jetbus.v1i2.4176

Darmawi, H. (2016). Manajemen Risiko (Edisi 2) [Risk Management (2nd ed.)]. Earth Aksara Publisher. Febrianti, Y., & Batubara, M. (2024). Analisis penyebab penolakan klaim nasabah di PT Asuransi Umum Bumiputra Muda 1967 (Cabang Medan). VISA: Journal of Vision and Ideas, 4(3), 1266–1271. https://doi.org/10.47467/visa.v4i3.5654

Fratiwi, D., & Atika. (2022). Faktor-faktor penyebab terjadinya penolakan suatu klaim nasabah

asuransi syariah. EKOMA: Jurnal Ekonomi, Manajemen, Akuntansi, 1(2), 169–175.

Huda, K. K. (2020). Hukum Asuransi Jiwa: Masalah-Masalah Aktual di Era Disrupsi 4.0 [Life Insurance Law: Actual Issues in Disruption Era 4.0]. Scopindo Media Pustaka.

Ismiyanti, P. A. M. F. (2022). Manajemen Risiko [Risk Management]. Graha Ilmu.

Keuangan, I. K. (2024). Financial Statements of PT Asuransi Jiwa Sequis Life (December 2024 Period). Sequis Life Official Corporate Publication.

Miles, M. B., & Huberman, A. M. (2014). Qualitative Data Analysis: A Methods Sourcebook (3rd ed.). SAGE Publications.

Mohammad Hifni. (2024). Aspek hukum perjanjian asuransi dalam perspektif hukum perdata di Indonesia. Jurnal Al-Ahkam: Jurnal Hukum Pidana Islam, 6(1), 25–32. https://doi.org/10.47435/al-ahkam.v6i1.2677

Nasution, N., & Atika. (2023). Faktor-faktor penyebab terjadinya penolakan suatu klaim nasabah asuransi syariah. EKOMA: Jurnal Ekonomi, Manajemen, Akuntansi, 1(4), 169–175. https://doi.org/10.56799/ekoma.v1i2.361

Parera, A. (2019). Hukum Asuransi di Indonesia [Insurance Law in Indonesia]. Kanisius Publisher.

Rehulina, F., Purba, B., Lestari, S., Nasution, R., & Girsang, E. (2023). Analysis of the causes of claim rejections by Mandiri Inhealth Insurance Company. Journal of Health Sciences and Research, 6(1), 23–33.

Ronaldo, R. (2024). Manajemen Risiko dan Asuransi [Risk Management and Insurance]. Deepublish Digital.

Satria, N. (2018). Menjadi Agen Asuransi Dahsyat [Becoming a Powerful Insurance Agent]. C-KLIK MEDIA.

Selina, R., Yanti, Y., & Suryono, A. (2024). Analisis yuridis tanggung jawab perusahaan asuransi terhadap asuransi jiwa kredit. Jurnal Kajian Ilmu Sosial, Politik Dan Hukum, 1(1), 192–203.

Soehaiya, N. (2022). Analisis yuridis penerapan prinsip insurable interest dalam praktik asuransi jiwa. Locus: Jurnal Konsep Ilmu Hukum, 2(1), 18–26.

Sugiyono, D. (2022). Metode Penelitian Kuantitatif, Kualitatif, dan R&D [Research Methods: Quantitative, Qualitative, and R&D]. Alfabeta.

Suhaila Zulkifli, Melati Panjaitan, & Gia Arrahman. (2020). Penyebab ditolaknya suatu klaim asuransi (Studi penelitian PT Prudential Life Assurance Medan). Jurnal Mutiara Hukum, 3(2), 21–29.

Yohana Ariska Putri Nasution, & F. A. L. (2022). Manfaat dan mekanisme penyelesaian klaim asuransi pada PT KPM Asuransi Prudential Medan. Jurnal Manajemen dan Bisnis, 1(6), 687–698.