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ANALYSIS OF THE CAUSES OF CLAIM REJECTIONS BY MANDIRI INHEALTH INSURANCE COMPANY

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ABSTRACT

Claim rejection by insurance companies often occurs and in practice not all claims submitted by customers can be accepted. Facts at the research location, namely the Mandiri In health Insurance Company, claim rejection data for the period January-December 2023, namely individual Indemnity 47,730 cases and Managed Care 5,525 cases. The purpose of the study was to analyze the causes of customer claim rejection by the Mandiri In health Medan Insurance Company. Types of qualitative research with methods descriptive. The research informants were determined by purposive sampling consisting of 1 key informant and 5 main informants. The results of the study showed that the procedure for submitting insurance claims at the Mandiri In health Insurance Company in Medan City is by filling out the claim submission form, submitting the original valid and stamped receipt, including the account number, completing all claim document files and submitting them to the company. The causes of claim rejection are incomplete claim files, policy exceptions, ceiling benefit limits, claim expiration, double claim submissions, indications of fraud and administration. The conclusion of the research results is that the cause of the rejection of customer claims by the Mandiri In health Insurance Company came from the customer's error in not being able to fulfill the requirements needed for their insurance claim to be accepted It is recommended that the insurance company management provide training to officers to improve skills in dealing with and explaining problems that cause customer claims to be rejected and increase socialization of insurance products to the public or prospective customers.

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1. INTRODUCTION

In human life, we are certainly faced with something uncertain and that uncertainty can be a risk that must be faced. Something that is not certain to happen will certainly not be as desired, such as accidents, death, property damage due to earthquakes, floods, or other natural disasters, health problems, preparation for old age and guarantees for children's education if parents face dangers that can happen at any time. No human being knows exactly when the risk will occur and no one wants it. However, all that can be done is to make predictions about the uncertainty that will lead to overcoming the risks that overshadow human life.

Risk is generally the possibility of undesirable events that cause losses. Risk can also be called a condition that implies the possibility of a worse deviation from the expected results. For that, it is a fact that society as humans needs guarantees or coverage against the risks that occur. One of the best places for people to get guarantees or coverage is through insurance. Insurance will provide protection if there is a potential threat of risk so that people feel safe [1].

The relationship between risk and insurance is a close relationship between one and the other that will always exist. This is because risk is the core of insurance and insurance is a form of risk management that can be done by transfer. Insurance is considered one of the best ways to overcome risk in risk management because insurance is a form of risk transfer [2]. As in Law Number 40 of 2014 Article 1 concerning Insurance, insurance or coverage is an agreement between two or more parties, in which the insurer (insurance company) binds itself to the insured (customer) by receiving insurance premiums from the insured, which then the Insurance Company promises to provide material compensation to the insured due to losses, damages, or loss of expected profits, or legal liability to third parties (TPL) that may be suffered by the insured in the future according to the insured risk, which arises from an uncertain event (general insurance), or to provide a payment based on the death or life of an insured person (life insurance).

In the insurance claim process, customers must comply with certain policies and requirements so that the insurance claim process can continue [3]. Facts show that related to claims, problems or disagreements often occur or arise between the insured and the risk bearer. Rejection of claims by insurance companies often occurs and in practice not all claims submitted by the insured can be accepted at the time of claim submission [4].

Insurance companies are not free from many things that contradict their guidelines regarding certain claims made by the insured, causing some of these claims to be rejected by the company. Many aspects cause customer claims to be rejected and this is proven by several previous research findings, including research Peace and Consent (2023) with research findings that claim settlement was rejected due to the risk of participants not being suspended in the policy and the estimated value of the loss experienced by the insured being below 71% of the actual price, the damage was small compared to the Total Loss Only protection type which covers estimated damage of more than 75% of the actual price.

The factors causing customer claims to be rejected are customers who do not submit the required documents, do not complete the stages listed in the claim document and customers manipulate data and policy participants violate legal provisions. The solution is for customers to receive savings only. Examined the rejection of life and health insurance claims at PT. Allianz Indonesia, with the finding of claim rejection due to the

failure to fulfill the medical record requirements submitted by the customer [5].

The claim implementation has not been fully implemented, the reason for the rejection of the insured's claim is because the insured did not provide correct personal data information and the efforts made to overcome obstacles are always to provide solutions so that the insured can get out of their problems, but without ignoring the agreement of both parties stated in the policy so that both parties do not suffer losses and the agreement continues to run [6].

Facts show that at the insurance company Asuransi Mandiri Inhealth Medan City, there was a case of insurance claim rejection based on the results of an interview with the Claims Section. Dor rejection of individual indemnity claims in the period January-December 2023 amounted to 47,730 cases with a total cost of IDR. 514,712,048,519. Meanwhile, for individual claims for Managed Care for the period January-December 2023, claim rejections amounted to 5,525 cases and the total cost was IDR 4,638,230,324. In general, the aspects that caused claims submitted by customers to be rejected by the company were non-compliance with procedures such as completeness of claim files, claim submissions not included in the benefits covered in the policy/policy exceptions, claim benefits exceeding the ceiling, claim expiration, no referral from a Mandiri Inhealth provider doctor and indications of fraud (Initial Research Survey Results, 2024).

2. RESEARCH METHOD

This This type of research is a study using a qualitative approach developed using a descriptive method. Qualitative research is a type of research that explores and understands the meaning in a number of individuals or groups of people who come from social problems. Qualitative research can generally be used for research on community life, history, behavior, concepts or phenomena, social problems, and others [7].

The type of qualitative research used by researchers in this study is a case study. A case study is a study that explores a case in depth, collecting complete information using various data collection procedures based on a predetermined time. This case can be an event, phenomenon, activity, process, and program [7]. The location of this research is at the Mandiri Inhealth Insurance Company, Medan Operational Office, located at Jl. T. Amir Hamzah No.12 AB, Sei Agul, West Medan District, Medan City, North Sumatra Province. The research was carried out from March 2024 to March 2025, starting with the submission of the title, preparation of the proposal and research. Informants are subjects who know information related to the research topic. The research subjects are informants, which means people in the research setting who are used to provide information about the situation and conditions of the research setting. Informants in research consist of key informants, main informants and additional informants [8].

The determination of informants in the study was based on the consideration that informants were considered able to provide data and information about the causes of customer claim rejection by Mandiri Inhealth Insurance Company. Informants in this study were limited to key informants and primary informants with the following details:

1. Key informant 1 person, namely the Head of the Health Service Unit of the Mandiri Mandiri Inhealth Insurance Company in Medan City.
2. The main informants were 3 Verifiers and 2 Customers.

3. RESULT AND ANALYSIS

A. Characteristics of Informants

Informants in research are parties whoconsidered to be able to provide data and information about the reasons for the rejection of customer claims by the Mandiri Inhealth Insurance Company.Informants consist of key informants and main informants with details as in the following table.

TABLE 1: CHARACTERISTICS OF INFORMANTS

No.	Initials of Name	Gender	Age (Year)	Education	Position/ Profession/ Status	Length of Service (Years)
	Key Informant					
1.	H (Ik1)	Lk	32	S1 Health Profession	Head of Health Service Unit	5
	Key Informant					
1.	SGL (Iu1)	Lk	23	S1 Information Systems	Verifier	5
2.	CS (Iu2)	Pr	40	S1 Public Health	Verifier	16
3.	Simanis (Iu3)	Pr	43	S1 Public Health	Verifier	15
4.	AF (Iu4)	Pr	36	S2	Customer	-
5.	F (Iu5)	Pr	23	S1	Customer	-

Based on table 1 above, it can be seen that there is 1 key informant with the characteristics of the initials H, male, 32 years old, S1 education, position as Head of Health Service Unit and length of service 5 years. The main informants are 5 people, namely 3 Verifiers and 2 Customers. The characteristics of each are the main informant Iu1 with the initials SGL is male, 23 years old, S1 education, position as Verifier and length of service 5 years. The main informant Iu2 with the initials CS is female, 40 years old, S1 education, position as Verifier and length of service 16 years. The main informant Iu3 with the initials Simanis is female, 43 years old, S1 education, position as Verifier and length of service 15 years. The main informant Iu4 with the initials AF is female, 36 years old, S2 education and is a Policyholder Customer. The main informant Iu5 with the initials F is female, 23 years old, has a Bachelor's degree and is also a Policyholder Customer.

B. Research Results and Analysis of Research Results

Results of field research on Analysis of Causes of Rejection of Customer Claims by Mandiri Inhealth Insurance Companyobtainedthrough direct interviews with key and main informants recorded using a mobile phone and then recorded in the form of transcripts and simplified by selecting and focusing on important things to get a sharper picture in the matrix table. The interview results are grouped based on questions in the interview guide associated with the research objectives.

Information obtained from informants about the stages that customers must go through when making a health insurance claim to the Mandiri Inhealth Insurance Company, each informant gave a different response. The response from the key informant (Ik1), namely the Head of the Health Service Unit, was that the stages of submitting a claim by the customer began with pfilling out the claim form, completing the supporting documents and submitting the form and documents to the Mandiri Inhealth Insurance Company where the customer is domiciled.

Key informant's response (Iu¬1¬) namely verifier-1 that after the submission of claim requirements by the customer, the verifier carries out the verification process on

the claim file, validates the place where the customer received treatment, and validates the truth of the actions taken by the doctor treating the Mandiri Inhealth customer.

Key informant's response (Iu¬2¬) namely verifier-2 that when the customer makes a claim, the verifier carries out the process of validating the claim files received by the claim admin as complete and eligible, verifies the reimbursement of costs according to the participant's benefits, requests approval of the verification results from the Head of Unit and submits the participant's claim payment to the Head Office.

Key informant's response (Iu¬3¬) namely verifier-3 that the stages that must be undergone by customers when making a health insurance claim are by cross-checking, validating, the claims/files submitted by participants to Mandiri Inhealth.

Key informant's response (Iu¬4) namely customer-1 that the stages that customers must go through when making a health insurance claim are as follows:submit an insurance claim online through the Fit Aja application on the FitClaim menu by uploading all files in softcopy form or photographing the files one by one. In addition, customers can also submit insurance claims directly to the nearest Mandiri Inhealth office by attaching files in hardcopy (original) form".

Key informant's response (Iu¬5) namely customer-2 that the stages that customers must go through when making a health insurance claim are ncustomers submit insurance claims online through the FitAja application on the FitClaim menu by uploading all files in soft-copy form. In addition, customers can also submit insurance claims directly to the nearest mandiri inhealth office by attaching files in hard-copy form.

The following table explains the facts.The stages that customers must go through when making a health insurance claim have fulfilled the established rules, both directly through the online process and the conclusions from the results of all informant answers.

TABLE 2: STEPS THAT CUSTOMERS MUST GO THROUGH WHEN MAKING A TRANSACTION HEALTH INSURANCE CLAIMS

Thematic	Answer	Conclusion
Steps that customers must go through when making a health insurance claim	- It starts with preparing complete claim files according to the rules and submitting them online or directly (Ik1) - The verifier carries out verification stages on the claim files that have been submitted by the customer (Iu1) - The verifier carries out verification stages on the claim files that have been submitted by the customer (Iu2) - The verifier cross-checks and validates the claim files submitted by participants to Mandiri Inhealth (Iu3) - Customers submit insurance claims online with softcopy files or directly to the office by attaching hardcopy (original) files (Iu4) - Customers submit insurance claims online with softcopy files or directly to the office by attaching hardcopy (original) files (Iu5)	In general, both officers from within the Mandiri Mandiri Inhealth Insurance Company and customers stated that the stages are the same, namely starting with the preparation of complete files and sending them online with data in softcopy form or directly with data in hardcopy form.

Requirements that must be met by customers who submit claims

The results of the informants' answers regarding the requirements that must be met by customers who submit claims toMandiri Inhealth Insurance Company in Medan City as described below.

From the results of the informant's answers above, it can be seen that information aboutrequirements that must be met by customers who submit claimsto the Mandiri Inhealth Insurance Company, each informant gave a different response. The response from the key informant (Ik1) wasmust complete the documents according to the requested requirements and fill out the claim form in full. The response of the main informant (Iu1) is the requirements that must be met by the customer according to the type of claim whether Outpatient, Inpatient or HCP (Hospital Cash Plan). The response of the main informant (Iu2) is to prepare a claim submission form that has been filled in with complete patient personal data and documents on the amount of costs as proof of having received treatment from the hospital.

The following table explains the facts.requirements that must be met by customers who submit claimsto Mandiri Inhealth Insurance Company, some of them are notcomply with the established rules.

TABLE 3: REQUIREMENTS THAT CUSTOMERS MUST FULFILL WHEN SUBMITTING A CLAIM

Thematic	Answer	Conclusion
Requirements that must be met by customers who submit claimsto Mandiri Inhealth Insurance Company	- Must complete the documents according to the requested requirements and fill out the claim form in full. (Ik1) - Meet the requirements according to the type of claim, whether Outpatient, Inpatient or HCP (Hospital Cash Plan (Iu1) - Claim submission form that has been filled in with complete patient personal data and documents showing the amount of costs as proof of having received treatment from the hospital (Iu2) - The form contains complete personal data of the customer accompanied by proof from the hospital treating the patient (Iu3) - The requirements that must be met by customers submitting a claim are to attach the required documents and fill out the form provided by the insurance company (Iu4) - The claim form has been filled out completely, complete with proof of payment files from the hospital or clinic, the claim has not expired, the benefits are still there, and the claim submitted does not include policy exceptions (Iu5)	In general, both officers from within the Mandiri Mandiri Inhealth Insurance Company and customers state that the requirements for submitting a claim must follow the agreed rules, namely that the policy is still valid, benefits are still available, the form has been filled in with complete customer data and various document files as proof of treatment from health facilities.
Obstacles encountered when serving customers who submit insurance claims		

The results of the informants' answers regarding the obstacles encountered when serving customers who submitted claims toMandiri Inhealth Insurance Company in Medan City was obtained from informants from within the insurance company (Ik1 and Iu1, Iu2 and Iu3) as described below.

From the results of the informant's answers above, it can be seen that information aboutobstacles encountered when serving customers who submit claimsto the Mandiri Inhealth Insurance Company, each informant gave a different response. The response from the key informant (Ik1) was that the obstacles encountered included p"Customer's oil is inactive, documents are incomplete, late claim submission, claims are included in exceptions, claims are outside insurance benefits and the ceiling has expired and there is suspicion of fraud."Response from key informants (Iu1) that the obstacles encountered included angry customers, impatient customers who wanted to be given priority and the doctor's writing being illegible.

Response from key informants (Iu2) that the obstacles encountered include participants submitting claims that are not in accordance with procedures and not in accordance with benefits; and there is no diagnosis in the claim file.Response from key informants (Iu3) that the obstacles faced include medical resumes/diagnostic information not being attached; there being thickening, crossing out or overlapping of dates on receipts and supporting examination results not being attached.

The following table explains aboutobstacles encountered when serving customers who submit claimsto Mandiri Inhealth Insurance Company, most of which are related to incomplete documents and the desire of insurance participants to be served as soon as possible.

TABLE 4: OBSTACLES ENCOUNTERED WHEN SERVING CUSTOMERS WHO SUBMIT CLAIMS TO MANDIRI INHEALTH INSURANCE COMPANY

Thematic	Answer	Conclusion
What obstacles are encountered when serving customers who submit insurance claims?	- The customer's policy is inactive, the documents are incomplete, the claim is submitted late, the claim is included in the exceptions, the claim is outside the insurance benefits and the ceiling has been exhausted and there is suspicion of fraud (Ik1) - Angry customers, impatient customers who want to be given priority and the doctor's writing is not legible (Iu1) - Claims are not in accordance with procedures and do not match benefits; and there is no diagnosis in the claim file (Iu2) - Medical resume/diagnostic information not attached; there is thickening, crossing out or overlapping of dates on the receipt and supporting examination results not attached (Iu3)	In general, officers from the internal Mandiri Mandiri Inhealth Insurance Company encounter obstacles in serving customers in the form of incomplete documents; evidence of receipts that are not clean or there are attempts to repair them and the emotions of angry or impatient customers.

C. Reasons for Rejection of Customer Claims at Mandiri Inhealth Insurance Company

Information aboutreasons for rejection of customer claims at Mandiri Inhealth Insurance Companyobtained from key informants and primary informants. The interview results are based on 3 (three) aspects of the questions, namely what are the reasons that cause customer insurance claims to be rejected, how to explain the reasons for the rejection of insurance claims submitted by customers and the obstacles faced during the process of explaining the reasons for the

rejection of customer insurance claims. Key informants from the customerin the third aspect is not involved.

1. Reasons why customer insurance claims are rejected

The results of the informants' answers regardingreasons why a customer's insurance claim application was rejectedMandiri Inhealth Insurance Company in Medan City as described below.

"Unpaid premiums cause the policy to be inactive; claims do not comply with the policy provisions; late filing of claims/expired; not supported by sufficient evidence; and fraudulent actions". (Ik1)

“Incomplete claim submission form; receipt crossed out/changed/obscured; no details of medical costs attached; discrepancy between the total amount in the details of costs and the receipt; and no medical resume and lab results attached.” (Iu1).

“Non-emergency claims; fake/scanned receipts or crossed out or overwritten; claims do not match benefits; participants submit the same claim twice in the same policy period; do not attach supporting data; and are proven to have marked up costs.” (Iu2)

"There are submissions such as claims (for example glasses) after being validated by opticians, the location is not found or there is no optical permit or participants mark up the price of glasses and mark up the cost of dental prostheses". (Iu3)

“The claim does not comply with the applicable provisions and procedures; the ceiling has been exhausted; included in the policy exception; and the claim is proven to be fraud and the claim has expired”. (Iu4)

“The claim does not comply with the applicable provisions and procedures; the benefit ceiling has been exhausted; it is included in the policy exceptions and the claim has been proven to be fraud after being validated..(Iu5)

Information obtained from informants about the reasons why customers' insurance claims were rejectedMandiri Inhealth Insurance Company in Medan CityEach informant gave a different answer. The answer from the key informant (Ik1), namely the Head of the Health Service Unit, was that the reason the claim was rejected was punpaid remi, claims do not comply with policy provisions; late filing of claims/expired, insufficient evidence and fraudulent actions. The answer of the main informant (Iu4) was that the claim did not comply with the provisions, the ceiling had run out, was subject to policy exceptions and was proven to be fraud or had expired. The answer of the main informant (Iu5) was that the claim did not comply with the provisions, the ceiling on benefits had run out, including policy exceptions and the claim was proven to be fraud after being validated.

The following table explains the facts about the reasons why customers' insurance claims were rejected.The majority of errors in participants such as incomplete documents and fraud.

TABLE 5: REASONS WHY CUSTOMER INSURANCE CLAIMS ARE REJECTED

Thematic	Answer	Conclusion
Reasons Why Customer Insurance Claims Are Rejected	- Punpaid remi, claim not in accordance with policy provisions; late filing of claim/expired, insufficient evidence and fraudulent action(Ik1)	In general, both officers from within the Mandiri Mandiri Inhealth Insurance Company and customers stated that the reasons for rejecting claims were because the policy was inactive, the claim submission time had expired, the forms and documents were incomplete, and there was an attempt at fraud.
	- The claim submission form is incomplete, the receipt is crossed out/changed/obscured, no details of medical costs are attached, the total amount in the details of costs is not the same as the receipt and the medical resume and lab results are not attached (Iu1)	
	- Non-emergency claims, fake receipts, claims not in accordance with benefits, claims for the same policy submitted twice, supporting data not attached and proven to mark up costs (Iu2)	

Thematic	Answer	Conclusion
	- There is optical location fraud in eyeglass claims, no optical license, participants mark up the price of glasses and mark up the cost of dental prostheses (Iu3)	
	- Claims do not comply with the provisions, the ceiling has been exhausted, are subject to policy exclusions and are proven to be fraudulent or have expired (Iu4)	
	- Claims do not comply with the provisions, the benefit ceiling has been exhausted, including policy exceptions and claims proven to be fraud after validation (Iu5)	

of Research Results on Insurance Claim Submission Procedures at Mandiri Inhealth Insurance Company, Medan City

The study analyzed the procedures for submitting insurance claims at Mandiri Inhealth Insurance Company, Medan City, focusing on three themes. The first theme was the stages customers must go through when making a health insurance claim, which were the same for both internal officers and customers. The second theme was the requirements customers must meet, such as valid policies, available benefits, complete customer data, and proof of treatment from health facilities. The third theme was the obstacles encountered when serving customers who submit claims, such as incomplete documents, unclean receipts, attempts to repair them, and customer anger.

The study found that while the claim submission procedure was carried out according to the rules, the requirements were not followed, and obstacles were still found related to claim rejections, such as incomplete data and customer anger. This is in line with research by [6], which found that many customers did not meet the claim requirements and did not comply with established procedures.

E. Discussion of Research Results on the Causes of Customer Claim Rejection at Mandiri Inhealth Insurance Company

The study focuses on the reasons for customer claims rejection at Mandiri Inhealth Insurance Company in Medan City. The reasons for the rejection include inactive policies, expired claim submission times, incomplete forms and documents, and fraud attempts. Officers from the company use easy-to-understand language to explain the reasons for the rejection, but customers often lack clear information. Obstacles encountered during explaining the reasons for the rejection include customers refusing explanations, appealing to superiors or HRD, slow validation responses from opticians or dentists, and customers insisting on accepting the claim.

Research by [5][6] found that the reasons for the rejection of the insured's claim were due to incorrect personal data information, failure to fulfill medical record requirements, and failure to submit required documents. Customers who do not submit required documents, such as policies, ID cards, hospital fee receipts, doctor's certificates, death certificates, and claim forms, are also factors causing claim rejections.

The study supports [5] statement that to avoid claim rejection, insured should complete specified documents and follow established procedures. However, the researcher's assumptions suggest that customers do not understand the terms of the agreement related to their chosen product, and officers lack skills due to limited training.

Other obstacles faced include customers' emotional nature and the need to provide clear information.

4. CONCLUSION

The Based on the research results, analysis results and discussion, the conclusions of this research are:

1. The procedure for submitting an insurance claim to the Mandiri Inhealth Insurance Company in Medan City is:
   a. Filling out the FPK (Claim Submission Form).
   b. Submit the original receipt/proof of payment that is valid and stamped.
   c. Include the insured's account number or other account number designated by the company.
   d. Claim documents must be submitted no later than 90 calendar days.
   e. Claims are submitted to the Operational Office/Service Office/Mandiri Inhealth Application.
   f. Claim documents will be completed within 5 working days at the latest.
   g. If there are no objections within 14 days, the claim is considered complete.
2. The reasons for rejecting customer claims at the Mandiri Inhealth Insurance Company in Medan City are:
   a. Completeness of claim files
   b. Policy exclusions
   c. Limitation of ceiling benefits
   d. Claim expiration
   e. Double claim submission
   f. Indications of fraud
   g. Administration
3. Settlement and follow-up of rejected insurance claims at the Mandiri Inhealth Insurance Company, Medan City, namely:
   a. Educating customers through socialization of the claims process
   b. Employee training on claims handling
   c. Improvement of the claims process by developing an online platform that makes it easier to file claims and track claim status.
   d. The use of technology to automate the claims process to speed up and simplify it.
   e. Claims data analysis to identify patterns and reasons for claims denials
   f. Providing communication channels before filing a claim as well as good and friendly customer service in responding to customer feedback.

5. REFERENCES

[1] Pawitri, Rosiani Niti. (2017). "Position and Legal Protection of Policyholders in Bankrupt Insurance Companies Based on Law Number 40 of 2014 Concerning Insurance", Legal Discourse Vol. XXIII, Number 1.

[2] Rachman, Afifah Nabila. (2018). "Rejection of Insurance Claims Due to Loss of Motor Vehicles (Case Study at PT. Asuransi Purna Artanugraha and PT. Asuransi Bumiputera Muda 1967." Thesis. UIN Sunan Kalijaga, Yogyakarta.

[3] Dewi, G. (2019). Legal Aspects of Islamic Banking and Insurance in Indonesia (Third Edition). Prenada Media Group.

[4] Nurulita, Shavira. (2022).Analysis of Causes of Customer Claim Rejection by Insurance Companies (Case Study at PT. Bumiputera Muda 1967 Serang Branch. Thesis. Banten: Sultan Maulana Hasanuddin State Islamic University, Banten.

[5] Nurkholidah, Susi. (2018). "Rejection of Life and Health Insurance Claims at PT. Allianz Indonesia." Az Zarqa', Vol. 10, No. 1.

[6] Zulkifli, Suhaila., Panjaitan, Melati, Arrahman, Gia and Silitonga, Jhosua. (2020). "Causes of Rejection of an Insurance Claim (Research Study of PT Prudential Life Assurance Medan)". Journal of Mutiara Hukum, Vol. 3 No. 2: 21-29.

[7] Creswell, JW. (2023). Research Design Qualitative, Quantitative, and Mixed Approaches. Yogyakarta: Pustaka Pelajar

[8] Moleong, LJ. (2023). Qualitative Research Methodology. Bandung: PT. Remaja Rosdakarya.